EXTENSIVE DEGLOVING INJURY INVOLVING LEFT LOWER LIMB AND PENOSCROTAL SKIN: A CASE REPORT

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Summary

A case of post traumatic extensive degloving injury involving left lower limb from groin to the ankle and whole of penoscrotal skin is reported, which was successfully managed by primary split thickness skin cover.

Traumatic avulsion injuries of the external male genitalia and limbs are increasing in number due to the use of the high speed machinery in industry and the rapid mechanisation of agriculture. Isolated penoscrotal avulsions due to such injuries have been reported in the literature (Balakrishnan 1956, Manchanda et al 1967, Khanna 1969 and Tripathi et al 1982), which were successfully treated by split thickness skin grafts. Vasconez and McCraw (1979), advocate primary split thickness skin graft cover for avulsions of skin and subcutaneous tissue in the lower extremity. Extensive degloving injury of the entire lower limb and whole of the penoscrotal skin is not seen in literature.

Case Report

Mr. B. 50 yrs. male patient was brought to the plastic surgery outdoor on 6.12.83 with complete degloving injury of left lower limb from groin to the ankle including whole of the penoscrotal skin, while working on a cotton weaving machine. The mechanism of injury was typical, due to indirect trauma, the loose garment (Dhoti) being caught suddenly in the fast moving belt of the machine. The ‘Dhoti’ (a loose cloth about 6 metres long and 2 metres wide) was tightly worn around his waist with a knot on the back. The patient rolled three times around the belt. when the undergarments were also caught, and by the time the machine was stopped he had already sustained an extensive injury (Figs. 1). There was a circumferential loss of skin from groin to the ankle, and whole of the penoscrotal skin was avulsed, the two testes hanging separately.

![Image](image-url)

**Fig. 1** Appearance of limb, penis and testes immediately after avulsion injury (Black and White).

The raw surface, slightly contaminated due to machine oil, was thoroughly cleaned with soap and water, then with other, patient was transferred to operation table, and split thickness skin grafting was done to cover whole of the raw surface, using right lower limb and both upper limbs as donor areas.

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Post operative result was acceptable (Figs. 2 & 3). The only long term complication included lymphoedema of the foot, which was managed by elastic crepe bandaging.

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References


