Indications for partial phallectomy of the horse include chronic paraphimosis (either primary or secondary to priapism, debilitation, drug-induced paralysis, traumatic injury, such as from a breeding accident, or systemic disease), neoplasia that is either too extensive to allow local treatment or non-responsive to therapy, and stenosis of the distal aspect of the urethra. Partial phallectomy is generally regarded as a salvage procedure in stallions and is commonly performed with the horse anesthetized to facilitate surgery. Previously described techniques of partial phallectomy include Vinsot’s, 1 William’s, 2 and Scott’s 3 techniques, which are used to amputate various lengths of the free portion of the penis. Regardless of technique used, the technical challenges of partial phallectomy involve compressing the corporeal tissue at the end of the stump and creating a new urethral orifice. Complications of partial phallectomy include hemorrhage from corporeal tissue with potential disruption of the compression sutures, edema resulting in acute urinary obstruction, and urethral stricture.

Performing partial phallectomy with the horse standing, using regional anesthesia of the penis, has been reported 4 and can be useful for horses that are either a poor risk for general anesthesia or for horses whose owners have imposed financial restrictions that do not allow for the expense of general anesthesia. A modification of Vinsot’s technique for phallectomy has been adapted for use in the standing horse. 5 The modifications to Vinsot’s technique of partial phallectomy include: 1) the creation of a linear urethrostomy as opposed to a triangular shape urethrostomy 2) altering the location of the urethrostomy to include subischial urethrostomies in certain cases 3) application of latex tourniquet using a Callicrate Bander (St. Francis, Kansas.), 4) concurrent castration of affected stallions and 5) the use of the procedure in the standing horse.

To date, we have performed this procedure on 16 horses, with a follow-up period of 1-5 years. Median follow-up time is 3.8 years. Two horses received distal urethrostomies, while 14 horses received subischial urethrostomies. None of the horses experienced hemorrhage at the site of amputation, stranguria, or dysuria after surgery. Short term complications affected 2 horses and consisted of minor hemorrhage from the perineal urethrostomy following urination for 24 hours after surgery. Long term complications included mild urine scalding in 2 horses and the formation of an adhesion between the distal portion of the amputated penis and the sheath in 1 horse. The author has developed a preference for the subischial urethrostomy, and now performs most of these procedures on an out-patient basis. One other application of this technique has been the use of the Callicrate bander as a penile tourniquet during en bloc resection in 2 cases to shorten surgery time.

References

**Figure 1.**
Side view of the Callicrate bander with the latex loop loaded.

**Figure 2.**
Top view of the Callicrate bander with the latex loop loaded.
Figure 3. Placement of the tourniquet and transection of the penis.

Figure 4. Ischemic necrosis seven days after band placement.