CASE REPORTS

PRIAPISM-A CASE REPORT

By

M. RAMACHANDER,* M. SARALA** and C. PRABHAKARA RAO,***

The word Priapism is derived from PRIAPUS, a Greek fertility God, who is represented as an ugly man with an enormous erect penis.

Priapism is the condition where there there is a persistant, painful, involuntary erection of the penis.

Priapsm differs from the physiological erection of the penis in the following aspects.

1. Painfullness of the erection.
2. Lack of sexual desire.
3. Ability of the patient to void urine in a state of erection.
4. Not associated with ejaculation.
5. Efforts of patients to relieve themselves by sexual intercourse always result in failure.

Priapiam is an uncommon condition occassionally seen in the venereal diseases clinics. It is a very distressing and embarassing condition to the patient and often taxing to the physician.

The onset of priapism is usually sudden, often taking the patients by complete surprise. True priapism may be receeded in some cases by chronic intermittent priapism of short duration. Priapism may occur during sleep, or may continue after masturbation.

MECHANISM OF PRIAPISM

Normal erection of the penis is supposed to be purely a vascular phenomen on resulting from a rapid increase of flow of blood in to the convernous spaces and the resulting distension of the corpora cavernosa causes a restricted venous return by pressing on the veins. It is completely of muscular compression either by ischiocavernosus or bulbocavernosus. Restriction of venous afflux usually results from obstuction of the cavernous spaces associated with haematoma, thrombosis, abscess or malignant growth.

Arterial dilataion is induced by the stimulation of the pelvic splanchnic system (nervi erigentes) where as vasoconstriction and subsidence of erection depends upon a stimulation of the sympathetic nervous syssem. Any disturbance which interferes with this mechamism results in dysfunction.

Civil Surgeon Venereologist,* Civil Assistant Surgeon,** Assistant to Venereologist.*** General Hospistal, & Tuter in Venerology, Guntur Medical College, GUNTUR.

Received for publication on 3-7-1967.

AETIOLOGY

There are many causes which either contribute directly to the causation or indirectly to the precipitation of priapism. They are briefly ennumerated below.

1. *Trauma.*
   (a) Direct trauma:—Even a trivial trauma to penis may produce priapism.
   (b) Indirect trauma:—Trauma to the peritoneum or concussion of the pelvis may be followed by priapism.
   (c) Priapism may occur due to incarceration of intra urethral concrements.

2. *Urethral inflammation or Irritation.*
   a. Sexual excess.
   b. Habitual masturabation.
   c. Acute gonorrhoea, especially of the posterior urethra,
   d. Intraurethral papillomas.
   e. Thrombophlebitis caused by
      i. Periurethritis.
      ii. infection of the pelvic veins as observed in complicated appendicitis.
   f. Transurethral resection of prostate gland.

3. *General Infectious Diseases.*
   a. Rheumatic fever. (IMBERT).
   b. Febrile relapse. (PATEL).
   c. Typhoid (Post Typhiod Phlebitis (CHALIER).

4. *Malignant Priapism.*
   (a) Primary neoplasms of cavernous bodies are rare.
      i. Round cell carcinoma (VINTICI AND ALTERESCU)
      ii. Haemangioendothelioma (YAMAMOTO)
      iii. Sarcoma-very rare.
   (b) Secondary malignancy. Not uncommon.
      (i) Primary carcinoma of the urethra.
      (ii) Carcinoma of the bladder or prostate.
      (iii) Metastatic hypernephroma (CRAIG)

The erections resulting from tumour infiltrations assume a state of semierection which may persist even after death.

5. *Priapism due to Blood diseases.*
   (a) Acute or chronic leukaemia, predominantly of the splenomylogenous type. The histopathology revealed that the cavernous spaces consisted of a homogenous connective tissue, a metaplastic end-product of leukamic thrombosis, (A. KAST).
   (b) Sickle cell anaemia.

6. *Priapism due to chemical intoxication.*
   (a) Carbondioxide intoxication.
      i. Cleaning old wells, ii. Suffocation. iii. Hanging. iv. Strangulation.
   (b) Chronic lead intoxication.
      i. Printing plants. ii. Chemical factories.
   (c) Overdose of aphrodisiac or of hormones.
   (d) Tetanus antitoxia (LIPTON & TOOMEY).

7. *Diseases of Metabolism.*
   (a) Diabetes.
   (c) Gout.

8. *Priapism due to diseases of the nervous system.*
   Priapism has been reported as occuring in may unrelated nervous diseases.
   i. Injury to the spinal cord.
   ii. Injury to the brain.
   iii. Encephalitis.
   iv. Meningomyelitis.
   v. Vertebral Tuberculosis.
   vi. Neoplasms of the spinal cord.
   vii. Tabes dorsalis (FOURNIER).
   viii. Epilepsy.
   xi. Hysteria.
   x. Mental Diseases.

9. *Idiopathic Priapissm.*

Priapism due to un-known or obscure origin are placed in this category.

CHAUVIN is of the opinion that many cases of idiopathic priapiam is due to capillary stasis rather than to thrombosis.

CASE REPORT

Male 35 Years. M. V. 3752/68.

Complaint.—Persistant painful exection of the penis of 5 days duration.

Married	2 children.
Extramarital exposure	1 Year ago.

Previous venereal diseases.— Nil.

Past History.

The patient had a similar attack of painful erection of the penis one night about a month prior to the onset of the present complaint. The patient revealed that the erection of the penis persisted after sexual intercourse with his wife and had no relief on repeated sexual intercourse. The condition subsided by itself without any treatment after 5-6 hours of onset.

Examination.

A middle aged male of robust health.

On examination the penis was erect, much enlarged in size and almost touching the suprapubic region. No genital lesion or urethral discharge were noticed. The inguinal glands were just palpable and soft.

There was no distension of the bladder. The patient informed us that though he had to strain a little to void urine, at no time after the onset of the disease, he had actual retension of urine. Even during the treatment, the patient was never catheterised for retention of urine.

Patient attempted for the subsidence of erection by repeated sexual intercourse with his wife without any relief, and on the other hand there was increased distension of the penis with aggravation of pain.

Investigations.

Blood V. D. R. L.	..	..	..	Negative
Urine-Clear	..	..	..	No puscells. No. Sugar. No Albumin.

All other investigations were normal. Since we could not detect any cause, we consider this case as an idiopathic type of priapism.

Treatment:—

Various lines of treatment have been advocated.

1. Heavy sedation with morphia and atropine.
2. Ice compresses.
3. Sitting spinal anaesthesia.
4. Aspiration of corpora cavernosa.
5. Venous by pass between corpora and saphenous vein (GRAYBACK 1964).
6. Caverno-spongiosum anastamosis (QUACKELLS 1964).
7. Irrigation of corpora cavernosa with anticoagulants (FERRER 1961).
8. Fibrinolytic enzymes used locally and systemically. No single line of treatment was found to be uniformly effective. Often a trial and error method had to be adopted to find out the procedure which gives the maximum relief to the patient.

The following lines of treatment was adopted in our patient:—

1. P A M 3 Lakhs I. M. daily to prevent secondary infection.
2. Heavy sedation with pethidine and siquil parenterily-produced no relief.
3. Ice compresses applied to the penis. There was no benefit, on the other hand the pain was aggravated.
4. Corpora cavernosa was aspirated repeatedly without any improvement in the condition.
5. (a) Hyalurodinase, 1500 I. U. and
   (b) Betamethasone 4 mgm. were combined and given locally into the corpora cavernosa with a little Xylocaine.

On the next day there was much improvement both in the size of the penis and in the pain. The improvement was sustained. 5 days after the first injection another

local injections of Hyalurodinase and Betamethasone was given into the corpora cavernosa. Within a week of the second local injection, the erection of the penis assumed normal position. According to the patient the penis was still slightly larger in size.

SUMMARY

A case of idiopathic priapism is presented because of the paucity of recorded reports in the Indian literature.

The aetiology, pathogenesis and the treatment are discussed in detail.

The case under review responded dramatically to local injection of hyalurodinase and betamethasone into corpora cavernosa. We feel that this method deserves trial in the treatment of priapism.

ACKNOWLEDGEMENTS

We are grateful to Dr. L. Surayanarayana, M.S., FACS., Superintendent, Government General Hospital, Guntur for permitting us to utilise the records of the hospital. We thank Sri. Sk. H. Rahiman, for the Secretarial help.

REFERENCES

1. Gurmohan Singh, Sardarilal-Chronic Intermittent priapism B.J.V.D. 42, 134, 1966.
2. Gallomon, F. T; Wilson, J. F:—The Non-veneral disease of the Genitals, springfield, Charles C. Thomas, 1956.