Prima Giornata Nazionale di Studi in Medicina d'Emergenza Urgenza
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Titolo

DIE HARD

Identificativo

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CASE REPORT

A 53 years old male referred to ER for a persistent 3 days priapism. The onset was progressive and not trauma related.
The patient did not report drug intake anyways his past medical history was positive for drug intake (cocaine) and alcoholism and at time he followed a detox therapy.
Laboratory investigations were normal, excluding haematological troubles justifying a low flow priapism. The toxicological tests were negative.
The poenis was painful and appeared hard and blueish.
At ER, with the urologist, we performed numerous attempts of shunts with 12 G needle under local anesthesia, with only a temporary relief of priapism. The haemogasanalysis on poenis blood showed a mixed arterial-venous blood, with SatO2 93%, pO2 73%, Lactate 3.0.
The Doppler US revealed a normal IR and a bilateral normal VPS, with absence of fistula. We decide for urgent angiography that was negative for fistulas. The main penile artery was undetectable. The radiology decided to exclude the arterial supply bilaterally, embolizing the main pudendal vessels. After a brief relief, the poenis appeared again hard.
A new angio CT scan revealed finally the presence of an anomalous, never described, collateral arterial flow from the inferior epigastric artery to guarantee the vascular supply to poenis (Fig. 1). After the closure of this artery the clinical situation came back to normal. (Fig. 2)
After 2 days of clinical observation, we removed the catheter and the patient was scheduled for a new Doppler scan after 1 month and following penile prosthesis implantation.

DISCUSSION

Traditionally the priapism is classified in low and high flow. The first one is more common and usually caused by drug intake (alprostadil, iPDE5), cocaine abuse or hypercellularity such as lymphoma. The second one is post traumatic, with the presence of an arterial-venous fistula that carry out an abnormal and continuous arterial blood supply. Another anecdotal cause of high flow priapism is a pelvic mass or a cavernous tumor.
An untreated or late treated priapism could lead out a severe fibrosis of the corporate cavernosa with relative erectile dysfunction
Substantially at ER the urgentist should asses the problem, formulating a correct clinical suspicion, addressing the patient to the correct specialist, avoiding waste of time, especially whereas in hospital without interventional radiology.
Herein the dilemmas were multiple: low or high flow? What is the urgency after 3 days? Do the patient say the truth?
The case revealed a great challenge also for urologist and radiologist, fighting for about 24 hours with a "die hard" poenis.
Anyway this case in our opinion dresses a great relevance for urgentist in country hospital or peripheral centers. Urgentist should be aware of this clinical conditions that are not so well differentiated, confident with shunt procedure and always consider the possibilities of the workplace to avoid delay in the treatment, potentially critical for erectile function.

Fig. 1 Pre embolization

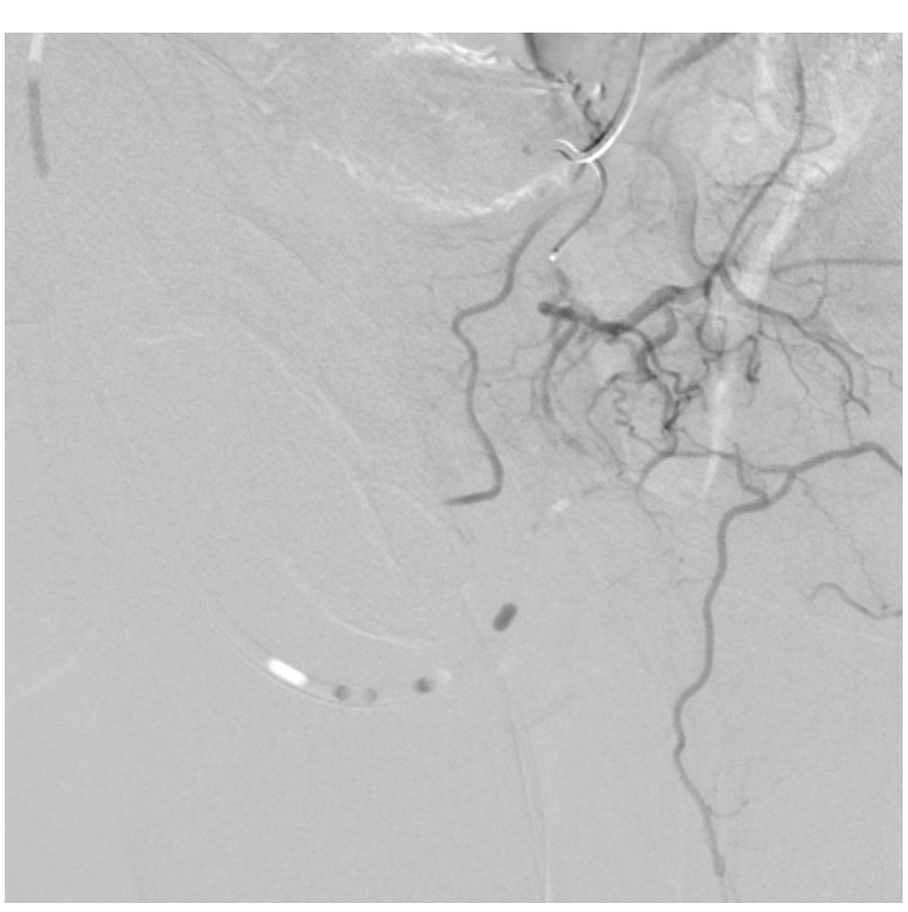

Fig. 2 Post embolization

CONCLUSION

Priapism could be a great challenge especially in peripheral Centers.
In a resistant low flow priapism, anomalous arteries should be assessed and treated

Affiliazioni

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CASO CLINICO