Acute Management of Priapism in Adults with Sickle Cell Disease

South Thames Sickle Cell & Thalassaemia Network

DISCLAIMER: This guideline is for information purposes only and is not intended to inform any individual clinical decisions. STSTN and its members do not accept any responsibility for outcome of clinical decisions made as a result of reading these guidelines. All guidelines have been peer-reviewed and agreed to be published by the relevant lead consultants in the network.

DO NOT PACK THE PRIAPISM IN ICE

Priapism (painful persistent erection) is a well-described complication, occurring most commonly in young men with Sickle Cell Disease (SCD). It can be stuttering (lasting <2 hours) or fulminant (lasting >2 hours)

Any case lasting >1 hour should be treated as a medical emergency.

In A+E

Examination

- Confirm priapism
- If bladder palpable – encourage passing urine, catheterize if attempts fail

Management

- Inform Urology SpR on call and Haematology (Sickle SpR during normal working hours or on call SpR via switch)

- Haematology SpR should advise:
    - Analgesia (this will often be opiates, as per the patients usual pain protocol)
    - Oral hydration, or if unable to tolerate this, give iv hydration
    - Encourage patient to take moderate exercise, for example going up and down stairs, to create steal syndrome
    - Encourage ejaculation
    - Give oral Etilefrine
    - Check routine blood tests (fbc, U+E, LFTs, G+S, CRP, sickle screen if new patient).

- Urology SpR will need to review the patient for an aspiration if there is no initial relief.
    - Arrangements for transport of the patient should be made if necessary (if no urology service on site)
    - **By 4 hours of total duration, the Urology SpR must be informed that the priapism has not settled and needs urgent aspiration.**

- History

A history of previous shunting procedures and a long history of semi-erect priapism may imply High Flow Priapism

Patients with Priapism of 6 hours + duration

Must be admitted under urology

Top up transfusion if Hb <6.5g/dl

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Urologist team will:

Review the patient and arrange any appropriate investigation and intervention as required.
This will include Aspiration/ ABG sampling of aspirate if required, appropriate shunt procedure dependant on the timing of the priapism, and biopsy at the time of shunt to look for necrosis. Imaging may be required on a case by case basis, and may include a Doppler USS or MRI penis (both without caverject).

Non responsive priapism after initial surgery

Consider exchange blood transfusion
Definitive urology surgery

Contacts:

Sickle team at Guys and St Thomas:
Dr Jo Howard Consultant Haematologist.
Dr R Kesse-Adu Consultant Haematologist

0207 188 2741

Sickle team at Kings College
Dr Moji Awogbade Consultant Haematologist
Prof Thien, Consultant Haematologist and Professor of Molecular Haematology
0203 2999 000

Urology contacts:

Out of hours: On call urology SpR or consultant via switchboard (Guys/St George's)

During normal working hours:

- **Guys Hospital:**

Acutely: Guys Hospital: **Mr Majed Shabbir / Mr Evangelos Zacharakis**
(Consultant Uro-Andrologist) –
Mobile via switchboard – 0207188 7188
Karen Briggs. Andrology Clinical Nurse Specialist
(Bleep 2902 - work mobile 07717 346 821 mon-fri 9-5)

Chronically: Erectile Dysfunction Service at Guy's

- **St George's Hospital:**

Acutely and chronically: **Mr Nick Watkins**
Consultant Urologist
Mobile via St Georges switchboard: 020 8672 1255