Objective: High-flow Priapism (HFP) is an extremely rare condition. It may affect the erectile function in a third of the patients. This study aimed to evaluate the efficacy of various treatment methods and the risk for erectile dysfunction (ED) in such cases.

Design and method: Between January 2000 and June 2006, 15 patients with priapism were treated in our department. The investigative protocol (including assessment of patient’s history, clinical examination, blood tests, Doppler ultrasonography and cavernous blood gases) identified 6 patients with HFP. Erectile function after treatment was assessed using the IIEF questionnaire. Penile Doppler ultrasonography evaluation was performed in patients with erectile dysfunction.

Results: The cause of HFP was perineal and/or genital trauma in 5 cases. No etiologic cause was identified in the other case. Spontaneous resolution was encountered in one case. Angiography with selective embolization of the cavernous artery was necessary in the other 5 cases. Repeated embolization was necessary in one case. Four patients - including the spontaneous resolved case - (66.7%), reported preserved erectile function at 1 year after treatment. In these patients, Doppler ultrasonography described the rechanelling of the cavernous artery without fistula recurrence. In the other 2 patients (33.3%), subsequent persistent deterioration of the erectile function was reported, with no rechanelling of the cavernous arteries.

Conclusion: In patients with HFP, selective embolization may be a safe and effective treatment option. The spontaneous rechanelling of the cavernous arteries is probably responsible for sexual function’s preservation in these patients.

T09-O-13

Low-flow priapism and post-treatment sexual activity

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Objective: Low-flow Priapism (LFP) is a rare condition, but with potential severe effect on the erectile function. This study aimed to evaluate the efficacy of various treatment methods and the risk factors for erectile dysfunction (ED) in these patients.

Design and method: Between January 2000 and June 2006, 15 patients with LFP have been treated in our department. Patient’s history, clinical examination, blood tests, Doppler ultrasonography and cavernous blood gases identified 9 patients with LFP. Erectile function after treatment was assessed using the IIEF questionnaire. Penile Doppler ultrasonography evaluation was performed in patients with ED.

Results: The causes of priapism were intracavernosal injection in 4 cases or idiopathic in 5 cases. Five patients presented at more than 48 hours after the Priapism’s onset. Coronal blood aspiration and intracavernous injection with sympatomimetics was initially performed in all patients. In 4 patients (3 of them with Priapism’s onset more than 48 hours before), failure of conservative management imposed cavernoglandular shunts (3 Winter procedures and 1 Al-Ghorab procedure). All cases were managed successfully. Five patients (55.6%) reported preserved erectile function after treatment. All 4 patients in which cavernoglandular shunt was performed reported subsequent deterioration of the erectile function. In these patients Doppler ultrasonography described extensive penile fibrosis and venous leakage in various sites.

Conclusion: In patients with LFP, delayed presentation to the urologist and aggressive surgical interventions may induce venogenic ED. The venous leakage may appear at shunt’s site as well as in other locations, induced by penile fibrosis.

T09-O-14

The penis as a cause for female dyspareunia. Size matters!

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Objective: In unexplained cases of female dyspareunia there are good reasons to consider the size of the penis as a potential cause. In deep dyspareunia one should know the length of the erect penis and in superficial dyspareunia one should know the diameter. To develop the competency of questioning this and have it measured, gynaecologists should be aware of the variety in penile size. However, most gynaecologists have been taught only one size (their own index and middle finger).

So we gathered data on the variety in length and diameter of the erect penis.

Method: Male partners of women attending sexology with vaginismus, deep or superficial dyspareunia were asked to measure at home in full erection the circumference of shaft and glans of the penis and the length. The biggest circumference of either glans or shaft is then converted to ‘the diameter’.

Results: We got data from 131 men.

The smallest diameter was 29,9 mm, the average 47,7 mm and the largest 54,1 mm.

The smallest length was 91 mm, the average 157,9 mm and the largest 250 mm.

Conclusions: There is a wide range of penile sizes. Gynaecologists should be aware of this wide range. In the upper size diameter range the female partner runs an increased risk of superficial dyspareunia. Whereas a penile length in the upper size range will give more risk for deep dyspareunia.

Approaches how to tackle dyspareunia caused by penile size will be explained.