Mr. Q, a college sophomore, stops taking his anxiolytic after experiencing a 4-hour erection. The problem: He’s too embarrassed to tell his psychiatrist about the episode, which could impair his sexual function.

Getting patients to talk about priapism

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Why did Mr. Q. develop priapism? How would you counsel him at this point?

He finally experienced detumescence after several cold showers. He did not inform her of the episode because he felt embarrassed to discuss “such a thing” with a female physician.

After his anxiety and insomnia resurfaced, Mr. Q was referred to one of the authors.

Dr. Freed’s and Dr. Muskin’s observations
Priapism refers to a prolonged and painful erection that results from sustained blood flow into the corpora cavernosa. In contrast to a normal
erection, both the corpus spongiosum and glans penis remain flaccid. Medical complications and reactions to drugs are well-documented causes.

An erection in priapism may result from sexual stimulation/activity, although this is not typical. Sexually stimulated erections in priapism persist hours after the stimulation ceases.

High-flow priapism is rare, painless, and occurs when well-oxygenated blood stays in the corpora cavernosa. It may result from perineal trauma creating a fistula between an artery and the cavernosa. Because the blood is oxygenated, there is no tissue damage, intervention is not urgent, and the prognosis usually is good.

Low-flow priapism, the more prevalent type, is painful and occurs when venous blood remains in the corpora, resulting in hypoxia and ischemia. Approximately 50% of low-flow priapism cases can result in impotence.1

Because men often are embarrassed by priapism, they may not seek medical attention or mention a prior episode to their physicians. This neglect can be dangerous: Painful erections that persist for more than 4 hours can lead to impotence if left untreated.

The physician must surmount the patient’s reluctance to discuss the symptom. Inquiring about past priapism episodes as part of a complete patient history is essential. We suggest routinely asking patients taking priapism-causing psychotropics (Table 1) if they’ve had a recent erectile problem. Mentioning that a medication can cause uncomfortable and serious sexual side effects may prompt the patient to discuss such problems.

Above all, be direct. A straightforward inquiry about a sensitive medical condition usually draws an honest answer; the patient then realizes the subject is important and should not be embarrassed about it.

After the patient discloses a priapism episode, ask him:

- Was the erection related to sexual activity or desire?
- Were you using any other medications or illicit drugs when the erection occurred?
- Do you have a systemic blood disorder?
- Did you feel any pain during your erection? If so, how long did it persist?

Men who present during a priapism episode should immediately be sent to the ER for urologic treatment. Patients reporting a recent sustained erection should be referred to a urologist if they need to keep taking the priapism-causing drug. Urologic treatment is not necessary if the patient stops the medication and the priapism resolves.

Men who have had at least one past priapism episode and those taking alpha-adrenergic blockers should be instructed to visit the ER immediately if a painful, persistent erection develops. Patients also should be warned not to induce detumescence (such as by taking cold showers, drinking alcohol, or engaging in sexual activity) if the erection persists for more than 2 hours. Any delay in emergency care could lead to impotence.

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Because Mr. Q had no other past erectile problems, we strongly suspected his priapism was medication-induced. He reported he had neither been drinking nor taking illicit drugs or other medications when the erection occurred.

Mr. Q also was convinced that the trazodone had caused the sustained erection. He said, however, he was never informed that priapism was a potential side effect of that medication.

**HISTORY | A probable side effect**

**Would you resume trazodone, switch to another sleep-promoting or antianxiety medication, or consider other therapy?**

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**Dr. Freed’s and Dr. Muskin’s observations**

The prevalence of priapism is not known, although yearly estimates range from 1/1,000 to 1/10,000 patients who take trazodone.²

Trazodone, an alpha-adrenergic blocker, is most commonly implicated among psychotropics in causing priapism.² Blockade of alpha-adrenergic receptors in the corpora cavernosa creates a parasympathetic imbalance favoring erection and prevents sympathetic-mediated detumescence. Histaminic, beta-adrenergic, and adrenergic/cholinergic components may also contribute to priapism.

Other medications associated with priapism include antipsychotics, antihypertensives, anticoagulants, some antidepressants, and anti-impotence medications injected into the penis.

Low-flow priapism can also be caused by systemic disorders (Table 2), including malignancies—particularly when a tumor has infiltrated the penis—and carcinoma of the bladder or prostate. Prostatitis has been implicated in some cases.

Because Mr. Q has had at least one priapism episode, we would avoid prescribing any agent with alpha-adrenergic blocking properties.

**Systemic illnesses and conditions that can cause priapism**

- Carcinoma of the bladder or prostate
- Diabetic neuropathy
- Fabray’s disease (genetic disorder that causes heart, kidney, and brain damage)
- Blood disorders, including leukemia, thrombocytopenia, sickle cell disease, thalassemia, polycythemia
- Lymphomas
- Malignancies, particularly when a tumor has infiltrated the penis
- Mumps
- Spinal cord trauma
- Prostatitis
- Rocky Mountain spotted fever

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**Dr. Freed’s and Dr. Muskin’s observations**

No findings indicate that trazodone-related priapism is dose-related. Several cases of men develop-
Despite its association with priapism, trazodone is used frequently in men and is a popular medication for disordered sleep. Nierenberg et al demonstrated improved sleep in 67% of depressed patients with insomnia who received trazodone either for depression or disordered sleep.8

When prescribing a priapism-causing agent, make sure the patient understands that erectile effects—though rare—can occur. Consider giving patients an informed consent form explaining the association between psychotropics and priapism and the potential long-term health implications (Box 1). Include the form in the patient’s record for documentation in the event of a malpractice lawsuit (Box 2).

**Priapism** is a rare—but serious—medical emergency associated with some psychotropics. Clinicians need to encourage patients to discuss recent or previous erectile problems in order to devise safe, effective psychiatric treatment.

**Self-hypnosis/relaxation therapy** was initiated to address Mr. Q’s anxiety and insomnia. The patient quickly learned the hypnosis techniques and
his anxiety/insomnia symptoms began to resolve almost immediately.

Mr. Q’s priapism resolved spontaneously with no apparent erectile dysfunction. He was referred back to the university health service and has been in apparent good health since.

References

Related resources
- National Center on Sleep Disorders Research http://www.nhlbi.nih.gov/about/ncsdr/

DRUG BRAND NAMES
Bupropion • Wellbutrin
Chlorpromazine • Thorazine
Clozapine • Clozaril
Fluphenazine • Prolixin
Haloperidol • Haldol
Labetalol • Trandate
Levomepromazine • Nozinan
Mesoridazine • Serentil
Metoclopramide • Reglan
Molindone • Lдолone
Perphenazine • Trilafon
Phenelzine • Nardil
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Thiothixene • Navane
Trazodone • Desyrel

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