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EDITORIAL NOTE

Editorial Note on: Priapism in acute spinal cord injury

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Mr Macfarlane has responded to my paper;[1] this prompted me to review my paper and the relevant literature.

Gordon *et al.*[2] reported priapism in six patients with traumatic spinal cord injury (SCI). In my paper[1] I had mistakenly said that all six of Gordon *et al.*'s patients had a complete, ASIA A, motor and sensory paraplegia. This needs to be corrected. The severity of SCI was known in five patients. The SCI was complete in 4 (80%) and incomplete in 1 (20%). A reasonable conclusion (and accepting that there are only small patient numbers) is that priapism in men is more likely to be associated with complete SCI, but it can occur less commonly in incomplete SCI.

All six SCI patients[2] were assessed 4–8 h after SCI; priapism was present in all six on first assessment. No patient developed priapism subsequent to the initial assessment. In three children with transverse myelitis causing quadriplegia, priapism was also present at the time of first assessment (timing not recorded); in no patient, following quadriplegia, was there initially no priapism with the subsequent development of priapism.[3] The presence of priapism immediately following judicial hanging has been taken as evidence of successful execution;[4] again, priapism seems to occur at the moment of execution, not subsequently.

In my initial paper I overstated the concept that priapism is always a feature of complete SCI. I probably did not overestimate the concept that 'it is reasonable to assume that in SCI patients who have priapism it occurs at the moment of, or very shortly after, the complete cord lesion'.

The following appear to be reasonable conclusions: (i) most male patients who have priapism have complete spinal cord lesions,[2–4] although (ii) a minority of acute SCI patients have priapism with incomplete SCI;[2] (iii) if priapism occurs, it is identified at the moment of first assessment following the cord injury and not subsequently,[2–4] and, probably, it occurs rapidly, possibly immediately, following severe cord injury.

NV Todd
Department of Neurosurgery, Newcastle General Hospital, Newcastle upon Tyne, UK
E-mail: jackie@northernmedicalservices.co.uk

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