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Response to Commentary to 'Priapism in children: A comprehensive review and clinical guideline'

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The article "Priapism in children: a comprehensive review and clinical guideline" [1] was conceived to act as a reference to all urologists. We feel this topic is complex enough to warrant specialist input, although we hope it will also be useful for paediatricians, emergency physicians, and, haematologists/paediatric haematologists. We feel that paediatric priapism is best managed jointly by a paediatric urologist and an andrologist.

Priapism in any child presents multiple challenges: the taboo of an erection in a child must be overcome by the child, the parents, and even healthcare professionals. This will heighten a child's natural anxiety when admitted to hospital acutely, particularly with a painful condition. Further, the paucity of evidence may lead to anxiety in decision-making for even the experienced specialist. This can be a heady mix in a busy emergency department in the lonely small hours.

Ideally, general anaesthesia would be provided for all children, but in treating a "cardiac arrest of the penis" the provision of anaesthesia must not incur significant delay. Whatever anaesthesia is chosen, transfer to a level 2 or 3 environment (emergency department resuscitation room, high dependency unit, or theatre) for aspiration should ensure rapid access to blood gas analysis and phenylephrine or epinephrine.

The reliability of predicting erectile dysfunction in a child is extremely contentious: a 14-year-old with ischaemic priapism for 72 h reportedly regained potency after shunt formation [2]. However, intra-operative frozen-section analysis of a corporal biopsy has been used in adults to confirm the presence and extent of necrosis [3]. Immediate prosthesis insertion in adults avoids the difficulties created by corporal fibrosis and is associated with higher success rates and fewer complications (including preventing penile shortening).

Researching a condition of which even major quaternary centres see only a few cases annually is clearly very difficult, particularly as it is seen as a taboo by the public. We hope that further collaboration between paediatric urologists and andrologists will expand the evidence base.

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