Priapism: Causes, Types, Diagnosis, Emergency Treatment and the Role of Unani Medicine

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Introduction: "Doctor, My Erection Has Not Gone Down for Several Hours. What Should I Do?"

Priapism is one sexual-health condition in which I want patients to understand a very clear message from the beginning:

A prolonged erection lasting around four hours or more—particularly if it is rigid and painful—is a medical emergency and should not be treated at home or delayed while waiting for a herbal, Unani or sexual-strength medicine to work.

Priapism is a **persistent penile erection that continues without sexual stimulation or remains long after sexual stimulation has stopped**. It is different from a normal erection because it does not subside in the usual way.

The current European Association of Urology guideline divides priapism into three main forms:

ischaemic or low-flow priapism, non-ischaemic or high-flow priapism, and stuttering or recurrent priapism.

These conditions do not have the same urgency.

Ischaemic priapism is an emergency.

Blood becomes trapped inside the erectile chambers of the penis. Oxygen levels fall, carbon dioxide rises and the tissues become increasingly acidic. If this continues, the smooth muscle of the penis can become permanently damaged, leading to fibrosis, penile shortening and erectile dysfunction. Current EAU guidance compares ischaemic priapism lasting beyond four hours to a **compartment syndrome** and recommends immediate treatment.

Non-ischaemic priapism is generally caused by excessive arterial blood entering the penis, often after an injury. It is usually less painful and less rigid and is **not usually an immediate emergency**, although it still needs proper evaluation and treatment.

The third form, stuttering priapism, causes repeated episodes of painful prolonged erections that may resolve spontaneously but can occasionally progress to a prolonged ischaemic emergency.

This distinction is extremely important because patients sometimes assume that any long erection represents great sexual power.

It does not.

Priapism is not a sign of increased masculinity, high testosterone or superior sexual performance. In its ischaemic form, it represents failure of normal penile blood drainage and can permanently damage erectile tissue.

What Exactly Is Priapism?

A normal erection develops in response to sexual or neurological stimulation and normally subsides after stimulation or ejaculation ends.

Priapism is different.

The erection:

- may arise without sexual desire;
- may continue after sexual activity has ended;
- cannot be voluntarily relieved;
- may last for several hours;
- may become increasingly painful.

The commonly accepted clinical threshold is an unwanted erection persisting for **four hours or longer**. Updated clinical reviews and AUA/EAU guidance use this threshold particularly for acute ischaemic priapism.

If a man has a completely rigid, painful erection approaching this duration, he should seek urgent medical attention rather than waiting for the clock to reach exactly four hours.

Priapism Is Not the Same as a Strong Normal Erection

Patients sometimes tell me:

“Doctor, if an erection lasts for a long time, doesn't that mean sexual strength is very good?”

No.

During a healthy erection, blood enters and leaves the penis through a carefully controlled vascular mechanism.

In ischaemic priapism, blood becomes **trapped**.

The problem is not that the erectile system is working exceptionally well.

The problem is that normal detumescence—the process by which the penis returns to a flaccid state—has failed.

The longer oxygen-deprived blood remains trapped, the greater the risk of tissue injury.

How a Normal Erection Works

To understand priapism, it helps to understand normal erection physiology.

During sexual stimulation, nerve signals lead to the release of nitric oxide.

This relaxes smooth muscle in the penile erectile tissue and allows blood to enter the **corpora cavernosa**, the two main erectile chambers.

As these chambers fill, veins carrying blood away are compressed.

This temporarily traps blood and produces rigidity.

When sexual stimulation decreases, smooth muscle contracts again, arterial inflow decreases, venous drainage resumes and the erection subsides.

Priapism develops when this finely balanced process becomes abnormal.

In low-flow priapism, blood cannot drain normally.

In high-flow priapism, excessive arterial inflow—often through an abnormal connection following trauma—keeps the penis persistently engorged.

Three Main Types of Priapism

Feature	Ischaemic / Low-Flow	Non-Ischaemic / High-Flow	Stuttering / Recurrent
Pain	Usually significant and increasing	Usually mild or absent	Usually painful
Rigidity	Corpora usually very hard	Often partially rigid	Similar to low-flow during attacks

Feature	Ischaemic / Low-Flow	Non-Ischaemic / High-Flow	Stuttering / Recurrent
Main mechanism	Blood trapped with inadequate outflow	Excess arterial inflow	Recurrent low-flow episodes
Common association	Sickle cell disease, drugs, ED injections, idiopathic causes	Penile/perineal trauma	Sickle cell disease, idiopathic causes
Emergency?	**Yes**	Usually not immediate	Each prolonged episode may become an emergency
Main goal	Immediate detumescence and tissue preservation	Control abnormal arterial flow	Prevent recurrence and treat acute episodes promptly

Current EAU guidance reports that **more than 95% of priapism episodes are ischaemic**, making the emergency form by far the most common.

Ischaemic Priapism: The Form Patients Must Recognize Quickly

Ischaemic priapism is sometimes also called:

low-flow priapism or **veno-occlusive priapism**.

Blood enters the erectile tissue but cannot drain adequately.

Over time, the trapped blood becomes increasingly deprived of oxygen.

The corpora cavernosa become:

- hypoxic;
- hypercapnic;
- acidic;
- metabolically compromised.

The penis is generally very rigid and painful, while the glans may remain relatively softer.

This is why immediate treatment matters.

Why Four Hours Matters

The four-hour threshold should not be misunderstood as meaning:

“Nothing happens for four hours, then suddenly damage starts.”

Tissue damage is a progressive biological process.

The longer severe ischaemia continues, the greater the risk.

The latest EAU guidance states that erectile-function outcome is strongly related to the duration of ischaemia and reports that risk rises sharply with prolonged duration. After very prolonged episodes, particularly beyond approximately 48 hours, treatment may still relieve the erection and pain, but preservation of natural erectile function becomes much less likely.

AUA guidance likewise warns that cellular changes can begin surprisingly early and that treatment should never be delayed while pursuing unnecessary investigations or ineffective home remedies.

What Can Happen If Ischaemic Priapism Is Ignored?

Untreated prolonged ischaemia can cause:

Smooth-Muscle Injury

The erectile smooth muscle becomes deprived of oxygen.

Tissue Necrosis

Severe prolonged ischaemia can cause irreversible tissue death.

Corporal Fibrosis

Normal elastic erectile tissue may be replaced by scar tissue.

Erectile Dysfunction

The penis may no longer become normally rigid.

Penile Shortening

Fibrosis can contract the erectile tissue and cause noticeable loss of length.

Penile Deformity

Extensive scarring may alter penile shape.

EAU guidance specifically documents fibrosis, penile scarring, shortening, deformity and erectile dysfunction among possible sequelae of severe ischaemic priapism.

This is why priapism is one of the rare sexual-health problems in which **delay itself can become the cause of permanent sexual dysfunction**.

Common Causes of Ischaemic Priapism

One challenging feature is that in many patients, no single cause can be identified.

This is called **idiopathic priapism**.

When a cause is found, important categories include:

- blood disorders;
- medications;
- drugs used for erectile dysfunction;
- neurological disease;
- malignancy;
- metabolic or vascular disorders;
- recreational substances.

Current EAU guidance provides a broad list of recognised causes.

Sickle Cell Disease and Priapism

Sickle cell disease is one of the most important causes of recurrent and acute priapism.

Abnormally shaped red blood cells can interfere with normal circulation and contribute to obstruction and dysregulation of blood flow within erectile tissue.

Sickle cell disease is especially important in children and younger men.

Current EAU evidence identifies sickle cell disease as the major cause of priapism in childhood and an important cause in adults. Recurrent episodes are also particularly common among men with sickle cell disease.

A young patient with recurrent painful erections should therefore be asked about:

- known sickle cell disease;
- family history;
- haemoglobin disorders;
- previous episodes.

When appropriate, haemoglobinopathy testing may be required.

A Critical Point About Sickle Cell Priapism

Some patients believe the correct approach is:

“First treat the sickle cell crisis, and the erection will go away.”

Current EAU and AUA recommendations specifically warn against delaying direct penile treatment.

Acute ischaemic priapism associated with sickle cell disease should be managed **in the same urgent way as other ischaemic priapism**, while hydration, oxygenation, pain control and haematological care can occur simultaneously.

Exchange transfusion should **not** replace or delay initial penile treatment.

Blood Disorders and Malignancies

Priapism may also occur with haematological and malignant conditions.

Recognised associations include:

- leukaemia;
- multiple myeloma;
- some coagulation disorders;
- certain haemoglobinopathies;
- rarely, cancers involving or infiltrating the penis.

EAU guidance lists prostate, bladder, urethral, testicular, rectal, lung and kidney malignancies among possible primary sources in rare cases of malignant priapism.

This is uncommon, but it reinforces the importance of investigating unexplained cases rather than treating only the erection.

Erectile-Dysfunction Injections Can Cause Priapism

This is one of the most important treatment-related causes.

Intracavernosal medicines such as:

alprostadil/prostaglandin E1, papaverine, phentolamine and combination injection therapies

are highly effective ED treatments.

But if the dose is too strong or the patient is unusually responsive, the erection may fail to subside.

EAU data indicate that priapism occurs more frequently with papaverine-based combinations, while the risk with prostaglandin E1 alone is considerably lower.

This is why patients using penile injections should receive proper training.

They should be told clearly what to do if an erection becomes prolonged.

What If an ED Injection Causes an Erection for Two or Three Hours?

An erection after an intracavernosal ED injection that persists longer than expected requires attention even before four hours.

AUA/SMSNA guidance recommends that prolonged injection-induced erections of less than four hours may be treated with **intracavernosal phenylephrine by an appropriately trained clinician** when intervention is necessary.

If the erection reaches or exceeds four hours and remains rigid, it should then be treated according to the acute ischaemic-priapism protocol.

Patients should not keep increasing intracavernosal medication doses at home.

Can Sildenafil or Tadalafil Cause Priapism?

Patients frequently worry about Viagra or Cialis.

The association is possible but appears to be **rare**.

Current EAU guidance reports only sporadic cases involving PDE5 inhibitors such as sildenafil or tadalafil, and many affected patients had additional risk factors. PDE5 inhibitors are therefore not generally considered a major independent cause of ischaemic priapism.

The risk should still be discussed, particularly if a patient:

- combines several erection medicines;
- takes excessive doses;
- has previous priapism;
- has a blood disorder;
- uses penile injections simultaneously.

Psychiatric Medicines and Priapism

Several psychiatric medications have been associated with priapism.

EAU guidance lists medicines such as:

trazodone and some antipsychotic drugs, among others, within reported pharmacological causes.

This does not mean these valuable medicines should be avoided universally.

It means patients taking such drugs should know that a prolonged painful erection requires urgent medical attention.

A patient should not abruptly discontinue psychiatric medication without consulting the prescribing clinician.

Alpha-Blockers and Other Medicines

Priapism has also been reported with alpha-adrenergic blockers such as:

- prazosin;
- terazosin;
- doxazosin;
- tamsulosin.

Other reported medication classes include certain antidepressants, antipsychotics, anticonvulsants and antihypertensive medicines.

Medication history is therefore an essential part of evaluation.

Recreational Drugs

EAU guidance also lists recreational substances—including **cocaine and other drugs**—among reported associations with priapism.

Patients should provide an accurate drug history to the treating clinician.

The objective is not judgment.

The objective is accurate treatment.

Neurological Causes

Normal erection and detumescence depend partly on the nervous system.

Priapism can occur in association with:

- spinal-cord injury;
- cauda equina syndrome;
- autonomic neuropathy;
- spinal stenosis;
- lumbar-disc disease;
- stroke;
- certain brain or spinal tumours.

These causes are recognized in current EAU guidance.

Neurological priapism needs treatment of the acute erection plus appropriate evaluation of the underlying nervous-system condition.

Non-Ischaemic or High-Flow Priapism

High-flow priapism is very different.

Rather than blood being trapped with inadequate circulation, too much **oxygenated arterial blood** enters the erectile chambers because of an abnormal arterial connection.

The most common cause is **blunt trauma to the penis or perineum**.

The trauma can injure the cavernosal artery and create a fistula between an artery and the erectile tissue.

EAU guidance estimates that non-ischaemic priapism makes up only around 5% of priapism cases.

What Does High-Flow Priapism Feel Like?

Patients typically describe:

- persistent enlargement rather than rock-hard rigidity;
- little or no significant pain;
- a history of injury to the perineum or penis.

The erection may develop immediately after trauma or sometimes days or even weeks later.

Because oxygenated arterial blood continues to circulate, severe tissue ischaemia does not occur in the same way as low-flow priapism.

That is why high-flow priapism is usually **not an immediate surgical emergency**.

But it still requires medical evaluation.

Stuttering or Recurrent Priapism

Stuttering priapism involves repeated episodes of prolonged, usually painful erection separated by periods when the penis becomes normal again.

Episodes can occur:

- several times in one day;
- several times each week;
- only occasionally.

Some last less than four hours.

But a recurrent episode can occasionally progress into prolonged acute ischaemic priapism.

EAU guidance emphasizes that stuttering attacks are physiologically similar to repeated ischaemic episodes and are particularly associated with sickle cell disease.

This is why recurrent erections should not simply be accepted because they eventually disappear.

Preventive management may be needed.

Priapism Is Not the Same as Sleep-Related Painful Erections

Some men experience painful erections mainly during sleep that disappear after waking.

This is a rare condition sometimes called **sleep-related painful erections**.

It is different from stuttering priapism.

EAU guidance specifically warns that the two conditions need differentiation because their pattern, Doppler findings and sleep characteristics differ.

A patient with repeated painful nighttime erections therefore needs proper assessment rather than automatically assuming he has priapism.

How Priapism Is Diagnosed

The first purpose of diagnosis is not simply to confirm:

“Yes, the erection is prolonged.”

The urgent question is:

“Is this low-flow ischaemic priapism or high-flow non-ischaemic priapism?”

Treatment depends on that distinction.

Medical History

I would want to know:

- how long the erection has lasted;
- whether it is painful;
- whether it is completely rigid;
- whether it developed spontaneously;
- whether ED medicines or penile injections were used;
- whether there is sickle cell disease;
- whether there was genital or perineal injury;
- which prescription medicines are being taken;
- whether recreational drugs were used;
- whether similar episodes happened previously;
- how erectile function was before this event.

Current EAU guidance strongly recommends this comprehensive history.

Physical Examination

In low-flow priapism:

the corpora cavernosa are typically fully rigid and tender while the glans may remain softer.

In high-flow priapism:

the penis tends to be enlarged but incompletely rigid and is usually much less painful.

The clinician may also examine:

the abdomen, perineum and genital area for trauma, masses or other abnormalities.

Cavernosal Blood-Gas Testing

One of the most informative tests is aspiration of a small amount of blood from the corpus cavernosum.

In ischaemic priapism, the blood is usually **dark and poorly oxygenated**.

Typical blood-gas findings include:

- low oxygen;
- high carbon dioxide;
- acidic pH.

In non-ischaemic priapism, aspirated blood resembles normal bright arterial blood.

EAU guidance regards cavernous blood-gas analysis as an important method of distinguishing the two types.

Penile Doppler Ultrasound

Colour Doppler ultrasound can evaluate blood flow through the penile arteries.

In low-flow priapism:

arterial flow is severely reduced or absent.

In high-flow priapism:

flow is often normal or increased, and Doppler may identify the arterial fistula caused by trauma.

EAU guidance strongly supports penile and perineal colour duplex ultrasound for differentiating subtypes.

Blood Tests

Investigations may include:

- complete blood count;
- white-cell differential;
- platelet count;
- coagulation profile.

Patients with an appropriate background may need testing for:

sickle cell disease or another haemoglobinopathy.

Other tests should be selected according to the medical history.

These investigations should **not delay emergency decompression** of established acute ischaemic priapism.

Treatment of Ischaemic Priapism: Emergency Management

This is the most important treatment section.

If a patient presents with a painful rigid erection persisting for approximately four hours or more, treatment should begin urgently.

Current EAU guidance recommends starting treatment as early as possible—ideally within approximately **four to six hours**—using a stepwise approach.

Can I Treat Ischaemic Priapism at Home?

No home remedy should delay emergency evaluation.

Patients sometimes try:

- walking or exercise;
- cold showers;
- ice;
- masturbation;
- repeated ejaculation;
- drinking large quantities of water;
- herbal preparations;
- oral decongestants.

AUA guidance specifically states that conservative measures such as observation, cold compresses, exercise and oral medication are **unlikely to resolve established acute ischaemic priapism and should not delay definitive treatment**.

This applies equally to herbal and Unani self-treatment.

First-Line Treatment: Aspiration

One of the first established treatments involves placing a needle into the corpus cavernosum and removing the trapped dark blood.

This is called **corporal aspiration**.

Saline irrigation may also be performed.

The objective is to:

- remove hypoxic stagnant blood;
- reduce pressure;
- allow fresh oxygenated blood to enter;
- help the penis become flaccid.

EAU strongly recommends aspiration and washout as an initial treatment step in acute ischaemic priapism.

Intracavernosal Phenylephrine

If aspiration alone does not adequately resolve the erection, an **alpha-adrenergic sympathomimetic medicine** is injected directly into the corpus cavernosum.

The preferred agent is generally **phenylephrine**.

Phenylephrine causes contraction of penile smooth muscle and promotes venous outflow.

Both EAU and AUA/SMSNA guidance recommend intracavernosal phenylephrine, generally alongside aspiration/irrigation, as first-line definitive management of acute ischaemic priapism before surgery.

Blood Pressure and Heart Monitoring During Phenylephrine

Phenylephrine is highly useful but is not a casual self-treatment.

Because it acts on alpha-adrenergic receptors, it can affect cardiovascular function.

Possible adverse effects include:

- hypertension;
- palpitations;
- tachycardia;

- reflex bradycardia;
- headache;
- dizziness.

Blood pressure and pulse should therefore be monitored during treatment, particularly in patients with cardiovascular disease or hypertension.

This procedure belongs in an appropriate healthcare setting.

When Surgery Is Required

If aspiration, irrigation and intracavernosal sympathomimetic treatment fail, surgical intervention may be required.

A **distal shunt** can create a pathway allowing trapped blood to drain from the corpora cavernosa.

EAU and AUA guidance recommend surgical shunting only after appropriate non-surgical first-line treatment has failed, although longer-duration cases may require more rapid escalation.

Very Delayed Priapism and Penile Prosthesis

When severe ischaemic priapism has lasted for more than approximately 48 hours, irreversible smooth-muscle damage may already have occurred.

In such cases, the likelihood of preserving natural erections becomes much lower.

EAU guidance recommends discussing **early penile prosthesis implantation** in selected delayed or refractory cases because progressive fibrosis can make later implantation much more difficult.

This is an advanced specialist decision.

Treatment of Priapism in Sickle Cell Disease

Sickle cell patients require two forms of care at the same time.

The acute penis itself must be treated urgently through the normal ischaemic-priapism pathway.

At the same time, the patient's sickle cell condition requires supportive and haematological management.

The EAU specifically recommends:

Treat the acute ischaemic erection in the same way as idiopathic ischaemic priapism and do not delay penile treatment for systemic therapies such as exchange transfusion.

A multidisciplinary approach involving urology and haematology is often appropriate.

Treatment of Non-Ischaemic High-Flow Priapism

Because high-flow priapism maintains oxygenated circulation, treatment can usually proceed less urgently.

Initial management may include:

observation and targeted perineal compression.

Some traumatic fistulas close spontaneously.

If the problem persists, **selective arterial embolisation** can close the abnormal arterial connection.

EAU guidance recommends selective embolisation when conservative management fails.

Surgical ligation is generally reserved for situations in which embolisation is unavailable, contraindicated or repeatedly unsuccessful because surgery carries a greater risk of erectile dysfunction.

Treatment of Recurrent or Stuttering Priapism

Treatment has two goals:

1. Treat every dangerous acute episode promptly.

If an episode becomes prolonged and resembles ischaemic priapism, it must receive the same urgent treatment.

2. Prevent future episodes.

EAU guidance discusses preventive options including selected alpha-adrenergic agents, hormonal manipulation and—in carefully selected patients—the paradoxical use of scheduled PDE5 inhibitors. Evidence for many preventive drugs remains limited.

This treatment should be managed by clinicians experienced in priapism.

It is not appropriate to self-prescribe medications based on internet descriptions.

Why Can a PDE5 Inhibitor Sometimes Prevent Recurrent Priapism?

Patients understandably find this confusing.

They ask:

“If sildenafil helps erections, how can it possibly prevent unwanted erections?”

In recurrent priapism, certain nitric-oxide/PDE5 signalling pathways may be dysregulated.

Regular carefully timed PDE5-inhibitor treatment while the penis is flaccid has shown a paradoxical preventive effect in some patients with idiopathic or sickle-cell-related stuttering priapism.

EAU guidance acknowledges this approach but gives it a **weak recommendation**, reflecting limited evidence.

It should not be confused with taking sildenafil during an acute painful four-hour erection.

Hormonal Treatment and Fertility

Some patients with severe recurrent priapism may be considered for hormonal suppression.

But hormonal treatment can cause:

- loss of libido;
- erectile dysfunction;
- hot flushes;
- gynaecomastia;
- reduced sperm production;
- infertility.

EAU specifically warns that hormonal therapies used to prevent recurrent priapism can interfere with spermatogenesis and fertility.

This is especially important in younger men who want children.

As a physician working in both sexual disorders and male infertility, this is one reason I consider **fertility goals before choosing long-term preventive treatment**.

Does Priapism Cause Infertility?

Priapism primarily affects **erectile tissue**, not sperm production.

Therefore, priapism does not automatically mean that a man's sperm count has become low.

However, fertility can be affected indirectly.

For example:

- sickle cell disease itself may influence reproductive health;
- hormonal suppression used for recurrent priapism may reduce sperm production;
- severe erectile dysfunction after priapism can make natural intercourse difficult;
- underlying systemic disease may affect fertility independently.

A patient planning children therefore deserves appropriate reproductive counselling.

Priapism and Future Erectile Dysfunction

One of the biggest long-term concerns is ED.

If acute ischaemic priapism is treated quickly, erectile tissue has a better chance of recovery.

With very prolonged ischaemia, fibrosis may make normal erection difficult or impossible.

EAU explicitly states that preservation of erectile function depends strongly on **how long the ischaemic episode lasts**, as well as patient age and baseline erectile health.

This provides one of the strongest arguments for early treatment.

Priapism and Penile Shrinkage

Some patients notice shortening after severe priapism.

This can occur because damaged erectile smooth muscle is replaced by **fibrotic scar tissue**.

EAU guidance documents penile shortening and deformity among long-term consequences of severe ischaemic injury.

Therefore, the best treatment for priapism-related shortening is prevention of prolonged ischaemia whenever possible.

Psychological Effects of Priapism

Priapism can be psychologically traumatic.

A man may initially be embarrassed to seek help.

After treatment, he may worry:

“Will my erection ever be normal again?”

He may develop:

- performance anxiety;
- fear of intercourse;
- anxiety about another attack;
- depression;
- body-image concerns.

Patients with recurrent disease may even fear going to sleep because episodes frequently develop at night.

Psychological and sexual counselling may therefore be appropriate during follow-up.

The emergency is physical, but recovery may need to address both **body and mind**.

Priapism in the Unani System of Medicine

An important development in standardisation is that the **World Health Organization's International Standard Terminologies on Unani Medicine** provides a specific Unani term for priapism:

‘Adm Taqalluṣ al-Dhakar

meaning failure of the penis to return to its relaxed state.

The same WHO terminology separately recognizes erection of the penis without a stimulus as **Intishār al-Qadīb min Ghayr Sabab**, showing that traditional Unani terminology distinguishes abnormal persistent erection-related states.

This provides an academically sound basis for discussing priapism in a Unani context rather than inventing a modern translation.

How Should Priapism Be Understood From a Unani Perspective?

Traditional Unani medicine considers illness through concepts such as:

- **Mizaj** — temperament;
- **Akhlat** — humours;
- **Quwwat** — functional faculties or strength;
- organ function;

- vascular and systemic state;
- diet;
- sleep;
- movement and rest;
- psychological condition.

However, I believe we should be very careful when applying these concepts to priapism.

Modern ischaemic priapism has a precisely demonstrated pathophysiology:

blood becomes trapped in the corpora, oxygen falls, acidity increases and erectile smooth muscle becomes damaged.

I therefore do **not** present it as though modern cavernosal ischaemia is simply equivalent to "excess blood," "heat" or one humoral imbalance.

These are different explanatory systems.

Traditional Unani concepts can inform constitutional and supportive care, while modern urological physiology must guide the emergency treatment of acute priapism.

The Four Therapeutic Modes of Unani Medicine

CCRUM, under the Ministry of AYUSH, identifies four broad therapeutic modes in the Unani system:

Ilaj-bil-Tadbir — Regimental therapy

Ilaj-bil-Ghiza — Dietotherapy

Ilaj-bil-Dawa — Pharmacotherapy

Ilaj-bil-Yad — Surgery

This is particularly relevant to priapism because it demonstrates that genuine Unani medicine is **not restricted to herbal pharmacotherapy**.

Unani medicine itself recognizes that some conditions may require procedural or surgical treatment.

That principle is highly appropriate in priapism.

Acute Ischaemic Priapism Is Not a Condition for Delayed Herbal Treatment

This is the most important point when discussing Unani management.

If the erection is:

rigid + painful + persistent for approximately four hours, the priority is emergency urological decompression.

I do not recommend that such a patient first try:

- Majoon;
- herbal decoctions;
- oils;
- massage;
- Hijama;
- leech therapy;
- Fasd;
- home fomentation.

None of these should delay aspiration, intracavernosal medication or surgery when required.

Current AUA and EAU recommendations are very clear that ineffective conservative treatment should **not delay definitive management** of acute ischaemic priapism.

A responsible Unani physician should recognize that emergency treatment takes priority.

Why This Does Not Reduce the Importance of Unani Medicine

Some people assume that if a condition needs modern emergency treatment, Unani medicine has no role.

I do not see it that way.

The useful question is not:

“Which system wins?”

The useful question is:

“At which stage can each form of care help the patient most safely?”

In priapism:

During acute painful low-flow priapism:

Emergency urological treatment takes priority.

After the emergency:

Unani care may contribute to broader health assessment, diet, lifestyle, psychological well-being and carefully selected supportive treatment.

In recurrent cases:

The patient's underlying constitutional and systemic health can be assessed alongside urological and haematological prevention.

When the cause is medication-related:

Traditional and modern medicines should both be reviewed for possible erection-prolonging effects.

This is what I consider a responsible integrative approach.

Ilaj-bil-Ghiza: Dietotherapy

Diet does not release trapped ischaemic blood from the penis.

Therefore, dietotherapy is not emergency treatment for acute priapism.

But dietary care may be useful in managing the patient's **underlying general health**, particularly when priapism occurs with a chronic disease.

For example:

a patient with sickle cell disease requires appropriate nutritional and haematological care;

a patient with metabolic disease needs healthier overall metabolic management;

a patient recovering from a major emergency may benefit from balanced nutrition and hydration according to his medical status.

Unani dietotherapy should therefore be supportive and individualized.

Ilaj-bil-Tadbir: Regimental Therapy

Unani regimental therapy includes several traditional modalities, and CCRUM describes it as one of the major components of Unani practice.

For priapism, however, the choice of regimen requires particular caution.

I would **not** recommend aggressive penile massage, cupping, bloodletting or similar procedures as substitutes for emergency decompression of a rigid painful erection.

After stabilization, appropriate physical activity, sleep management, stress reduction and healthy routine may be useful parts of broader rehabilitation.

Again, timing and diagnosis determine usefulness.

Ilaj-bil-Dawa: Unani Pharmacotherapy

A Unani formulation may be considered only after understanding:

- the type of priapism;
- the underlying cause;
- current medicines;
- cardiovascular condition;
- haematological disease;
- fertility goals.

There is currently **insufficient high-quality evidence to identify one standardized finished Unani formulation as an established first-line treatment for acute ischaemic priapism**.

Therefore, I would not professionally advertise one herbal medicine as a guaranteed cure for an active four-hour priapism episode.

Where traditional pharmacotherapy is considered during long-term follow-up, it should be individualized and should not conflict with urological or haematological treatment.

A Warning About Aphrodisiacs in Patients With Priapism

This is particularly relevant in sexual-health practice.

A patient with recurrent priapism should not automatically be given strong erection-enhancing or aphrodisiac products simply because they are marketed for “male power.”

Some substances may increase sexual arousal, vascular activity or interact with medicines.

The patient should inform the physician about:

- herbal sexual supplements;
- Unani medicines;
- Ayurvedic aphrodisiacs;
- ED tablets;
- penile injections;
- recreational sexual drugs.

A complete medicine history is essential.

Traditional Does Not Automatically Mean Safe in Priapism

The fact that a medicine is natural does not mean it cannot worsen an erection-related problem.

The aim of treatment in priapism is often the opposite of ED treatment:

we need the penis to **detumesce**, not become more erect.

Therefore, self-use of sexual stimulants during or soon after recurrent episodes can be inappropriate.

Any traditional medicine should be selected only after the exact diagnosis is understood.

My Special Approach at Saira Health Care

When a patient contacts Saira Health Care regarding a persistent erection, my preferred approach begins with **triage**.

Step 1: Establish the Duration

How long has the erection been present?

If it is approaching or exceeding four hours, urgency increases immediately.

Step 2: Ask About Pain and Rigidity

A completely rigid, painful erection strongly suggests ischaemic priapism.

That patient needs emergency urological assessment.

Step 3: Do Not Delay Emergency Referral for Unani Treatment

If acute low-flow priapism is suspected, my priority is **protecting the erectile tissue**.

The patient should not wait for an oral medicine, oil or herbal formulation to work.

This is one of the clearest examples where timely referral can preserve future sexual function.

Step 4: Identify the Cause After Stabilization

Once the emergency is controlled, I review:

- sickle cell disease;
- blood disorders;
- ED injections;
- sildenafil/tadalafil and other ED therapy;
- psychiatric medicines;
- alpha blockers;
- neurological disease;
- drug use;
- previous trauma;
- recurrent episodes.

Step 5: Evaluate Future Erectile Function

Patients may need follow-up for:

- erection quality;
- penile fibrosis;
- curvature;
- penile shortening;
- psychological anxiety.

Severe injury may require further urological treatment.

Step 6: Assess Fertility Goals

In recurrent priapism—especially if hormonal prevention is being considered—I ask whether the patient wants children.

Some preventive hormonal treatments may suppress spermatogenesis and libido.

This is particularly relevant to my work in male infertility.

Step 7: Add Individualized Unani Support Where Appropriate

After emergency risk has been managed, I assess:

- Mizaj;
- sleep;
- stress;
- diet;
- general vitality;
- chronic disease;
- current traditional medicines.

The objective is supportive whole-person management—not replacement of necessary urological treatment.

Why Saira Health Care's Sexual-Health and Infertility Focus Is Relevant

Priapism crosses several areas of men's health.

It can involve:

sexual medicine, urology, haematology, emergency care, erectile-function rehabilitation, psychological health and sometimes fertility.

This makes multidisciplinary understanding particularly important.

Saira Health Care publicly describes its approach as patient-centred and focused on sexual disorders and infertility, combining individualized traditional Unani care with modern diagnostic understanding and appropriate referral when needed.

About Me: Dr. Nizamuddin Qasmi

I am **Dr. Nizamuddin Qasmi**, Founder and Chief Physician of **Saira Health Care**, with a focused clinical practice in **sexual disorders and infertility**.

My professional education and training listed for this article include:

BUMS – Hamdard University, Delhi
MD
CGO
Certificate in Infertility – MGBIMS, Delhi
Certificate in Urology – London, UK

Masters in Male Infertility – MasterHealthPro (HealthPro)
Integrated Sexual and Reproductive Health – ISRH, UNFPA

Saira Health Care's public physician profile confirms BUMS, MD, CGO, Certificate in Infertility and **Certificate in Urology – London, UK**, and describes my professional focus in sexual disorders and infertility.

Saira Health Care's current published professional material also uses the **Male Infertility Masters – MasterHealthPro (HealthPro)** and Integrated Sexual and Reproductive Health training in its physician byline.

MasterHealthPro publicly lists its six-month **Male Infertility Masters** programme and related educational programmes in andrology and sexual medicine.

This combination of Unani medicine, sexual-health practice, infertility training and urological education is especially relevant in a condition where both immediate erectile-tissue preservation and future sexual and reproductive health need consideration.

Contribution of Saira Health Care to Sexual Disorders and Infertility

In my view, one of the most important contributions a sexual-health centre can make is **preventing dangerous misinformation**.

Patients should not believe:

“A four-hour erection is a sign of extraordinary sexual strength.”

“If it is painful, I should wait until morning.”

“Masturbation will always make it go down.”

“An herbal medicine can safely be tried first.”

“Surgery is never part of traditional medicine.”

“If the erection finally goes down, there can be no long-term damage.”

All of these beliefs can delay appropriate care.

Saira Health Care describes its broader philosophy as combining traditional knowledge with individualized planning, lifestyle care and contemporary diagnostic understanding while providing a non-judgmental environment for sexual and infertility concerns.

With priapism, patient education can literally help preserve erectile function.

Common Myths About Priapism

“Priapism means excessive sexual desire.”

No.

Priapism may occur without sexual stimulation or desire.

“A very long erection means excellent sexual power.”

No.

In ischaemic priapism, prolonged rigidity represents trapped deoxygenated blood and can destroy erectile tissue.

“I should wait until the pain becomes unbearable.”

No.

A rigid prolonged erection should be evaluated urgently, particularly as it approaches four hours.

“Ejaculation will always make priapism disappear.”

No.

A true ischaemic priapism often persists despite ejaculation.

“Cold water or exercise can cure acute priapism.”

These measures should not delay established emergency treatment. AUA guidance states that conservative measures are unlikely to resolve acute ischaemic priapism reliably.

“Viagra is the main cause of priapism.”

No.

PDE5-inhibitor-related priapism appears rare. Intracavernosal ED injections and certain other medications carry more established associations.

“Priapism always needs surgery.”

No.

Many acute cases can be treated successfully with aspiration, irrigation and intracavernosal sympathomimetic treatment when managed early. Surgery is generally reserved for treatment failure or particular prolonged cases.

“Every priapism episode is an emergency.”

Painful, rigid **ischaemic** priapism is an emergency. Non-ischaemic high-flow priapism is usually less urgent but still needs medical evaluation.

“Unani medicine has no concept of priapism.”

Incorrect.

WHO's International Standard Terminologies on Unani Medicine includes a standardized term for priapism: **'Adm Taqalluṣ al-Dhakar**.

Frequently Asked Questions

What is the simplest definition of priapism?

Priapism is a persistent unwanted erection that continues without sexual stimulation or remains after stimulation has ended.

How long must an erection last to be considered an emergency?

A rigid unwanted erection lasting approximately **four hours or longer**, especially when painful, should be treated as possible acute ischaemic priapism and requires urgent evaluation.

Can I wait until morning?

No.

If a painful rigid erection is approaching or has passed four hours, seek emergency medical care.

Does severe pain suggest low-flow priapism?

Yes. Pain and complete rigidity strongly favour ischaemic priapism, although confirmation should be clinical and may include blood-gas testing or Doppler ultrasound.

What if the erection is painless after an injury?

A painless, partially rigid erection following genital or perineal trauma raises suspicion of high-flow priapism. It still needs urological evaluation.

What is the first hospital treatment for low-flow priapism?

Current guidelines recommend urgent corporal aspiration/washout and intracavernosal sympathomimetic treatment, typically phenylephrine, before surgery.

Can priapism cause permanent erectile dysfunction?

Yes. The risk increases substantially as ischaemic duration becomes longer. Severe prolonged episodes may cause fibrosis and permanent ED.

Can priapism make the penis smaller?

Severe prolonged ischaemic injury can produce fibrosis and subsequent penile shortening.

Can sickle cell disease cause recurrent priapism?

Yes. It is one of the most important causes, especially in younger patients.

Does recurrent priapism require prevention?

Often yes. Repeated episodes can progress into prolonged low-flow priapism, so specialist preventive treatment may be appropriate.

Can Unani medicine be useful?

Yes, but its role must be defined correctly.

Unani medicine can contribute **individualized supportive care after emergency stabilization**, including assessment of Mizaj, diet, lifestyle, psychological state, associated disease and traditional medication use.

It should **not delay aspiration, phenylephrine injection, shunting or other necessary emergency treatment for acute ischaemic priapism**.

Can I take an aphrodisiac if I have recurrent priapism?

Do not start sexual stimulants without professional advice. Products that promote erection may be inappropriate in someone prone to prolonged erections.

Prognosis

The prognosis depends mainly on the **type and duration** of priapism.

Ischaemic Priapism Treated Early

Erectile-function preservation is more likely when blood flow is restored promptly.

Prolonged Ischaemic Priapism

Risk of fibrosis and permanent ED rises significantly.

After very prolonged episodes, even successful detumescence does not guarantee recovery of natural erections.

Non-Ischaemic Priapism

The immediate risk of tissue necrosis is considerably lower.

Many cases can initially be managed conservatively, with selective embolisation providing an effective option when persistent.

Stuttering Priapism

The long-term goal is preventing episodes from progressing into a prolonged ischaemic emergency.

Outcome improves when the underlying condition and recurrence pattern are properly addressed.

When Should You Go to an Emergency Department?

Seek urgent emergency evaluation if:

an unwanted erection is fully rigid and persists for around four hours;

or if a prolonged erection is becoming increasingly painful.

Do not delay because of embarrassment.

Do not attempt repeated vigorous masturbation.

Do not repeatedly take additional ED medicines.

Do not apply an unknown herbal product.

Do not wait for an online consultation if an acute ischaemic episode is suspected.

In priapism, **time is erectile tissue**.

Conclusion

Priapism is one of the most important male sexual-health emergencies to understand correctly.

It is not simply “an erection lasting too long.”

There are distinct types.

Ischaemic or low-flow priapism involves trapped, poorly oxygenated blood and represents a medical emergency. It accounts for more than 95% of episodes in current EAU evidence. Beyond approximately four hours, progressive hypoxia and acidosis place cavernosal smooth muscle at risk.

Non-ischaemic or high-flow priapism usually follows arterial injury, is often less painful and less rigid, and is generally not an immediate emergency. Persistent cases may require selective arterial embolisation.

Stuttering priapism causes repeated ischaemic-type episodes and is particularly associated with sickle cell disease. Every prolonged episode must be taken seriously because it can progress into an acute emergency.

The causes are diverse.

They include sickle cell disease, blood disorders, ED injections, certain psychiatric and urological medicines, neurological disease, trauma, malignancy, recreational drugs and idiopathic cases.

Diagnosis depends on the clinical pattern, examination, cavernosal blood-gas analysis and penile Doppler when necessary.

For acute ischaemic priapism, **modern emergency urological treatment is essential**.

Aspiration and irrigation followed by intracavernosal phenylephrine are established first-line treatments, with surgical shunting used when appropriate treatment fails. Patients presenting after very prolonged episodes may need discussion of penile prosthesis because erectile smooth-muscle damage may already be irreversible.

The **Unani system of medicine also formally recognizes priapism**. WHO's international terminology uses **'Adm Taqalluṣ al-Dhakar** for the condition, providing an important standardized Unani reference.

Unani medicine can contribute through its whole-person framework involving **Mizaj, diet, regimen, psychological health and individualized pharmacotherapy**, and CCRUM officially recognizes Ilaj-bil-Tadbir, Ilaj-bil-Ghiza, Ilaj-bil-Dawa and Ilaj-bil-Yad as its major therapeutic modes.

But with priapism I believe we must practise Unani medicine especially responsibly.

As **Dr. Nizamuddin Qasmi**, my approach at Saira Health Care is:

If the erection is prolonged, rigid and painful, first protect the penis from ischaemic damage through urgent urological treatment. Do not delay emergency care for herbal or traditional treatment. Once the patient is stable, identify why the episode occurred, evaluate medicines and underlying disease, consider the risk of recurrence and future erectile function, protect fertility when long-term treatment is being planned, and then integrate suitable Unani diet, lifestyle and supportive care according to the patient's overall condition.

This is where modern urological science and responsibly practised Unani medicine can work together.

The message I want every patient to remember is simple:

A prolonged erection is not always a sign of sexual strength. A painful erection lasting around four hours can be a medical emergency. Early treatment can mean the difference between preserving normal erectile function and developing permanent penile damage. Never allow embarrassment or an attempt at home treatment to create a dangerous delay.

About Saira Health Care

Saira Health Care focuses on **sexual disorders, infertility and reproductive health** and describes its approach as patient-centred, combining individualized Unani assessment, lifestyle guidance and appropriate contemporary medical knowledge.

The clinic's professional profile identifies **Dr. Nizamuddin Qasmi** as Founder and Chief Physician with a focused practice in sexual disorders and infertility.

Medical Disclaimer

This article is intended for **general medical education and sexual-health awareness**. Priapism is a condition in which online information must not replace urgent medical assessment.

A **painful, rigid erection lasting approximately four hours or longer should be treated as possible acute ischaemic priapism and requires emergency evaluation**.

Do not wait for Unani, herbal, Ayurvedic, homeopathic or other home treatment to work before seeking emergency care.

Do not self-inject phenylephrine or attempt corporal aspiration outside an appropriately supervised medical setting.

Do not stop psychiatric, prostate, blood-pressure or other prescription medicines without consulting the prescribing doctor, even if they may be associated with priapism.

Patients using intracavernosal ED injections should receive clear instructions regarding prolonged erections and emergency thresholds.

Sickle-cell-related priapism requires appropriate haematological care, but systemic treatment must not delay emergency decompression of established acute ischaemic priapism.

Unani medicine may have a valuable role in **individualized follow-up, lifestyle management and supportive care**, but current evidence does not support replacing established emergency treatment of acute ischaemic priapism with traditional pharmacotherapy.

No modern medicine, Unani formulation, herbal treatment, procedure or preventive strategy can responsibly guarantee preservation of erectile function or prevention of every future episode.