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Annals of Reproductive Medicine and Treatment

Research Article

Partial Segmental Thrombosis of the Corpus Cavernosum: A Comprehensive Literature Review

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Submitted: 05 July 2025

Accepted: 05 September 2025

Published: 06 September 2025

ISSN: 2573-1092

OPEN ACCESS

Keywords

• Partial segmental thrombosis of the corpus cavernosum; Partial priapism; Perineal pain; Sildenafil; Phosphodiesterase 5 inhibitor; Erectile dysfunction

Abstract

Perineal pain is a common and diagnostically challenging clinical presentation in urologic practices, with a broad range of potential etiologies. One potential, yet often underrecognized, cause is partial segmental thrombosis of the corpus cavernosum (PSTCC), a rare urologic condition with limited available descriptions. The exact etiology and pathophysiology remain poorly understood, though associations with trauma and hypercoagulable states have been identified. While patient presentations of perineal pain can be diverse and complex, providers should obtain a detailed history and appropriate imaging to consider PSTCC as part of the differential diagnosis. This review aims to enhance clinical awareness of PSTCC and provide a comprehensive literature review of the treatment options, outcomes, and likely etiology of previously reported cases. We hope to offer providers a concise, evidence-based approach to recognizing and managing PSTCC within the broader context of perineal pain.

INTRODUCTION

Partial segmental thrombosis of the corpus cavernosum (PSTCC) is a rare urologic condition with limited documentation in the literature. Originally characterized as "partial priapism" by Gottesman et. al in 1976, PSTCC typically presents in young male patients with a painful, perineal mass and is often associated with a history of ED [1,2]. Clinically distinct from priapism, PSTCC's symptoms develop over several days with localized pain and swelling rather than an acute painful erection. Imaging plays a pivotal role in confirming the diagnosis, with magnetic resonance imaging (MRI) offering superior diagnostic utility over computed tomography (CT) in distinguishing PSTCC from other etiologies of penile or perineal pain [2]. With fewer than 60 cases reported in the literature, PSTCC's etiology and pathophysiology are not well understood. Associations have been observed with hypercoagulable disorders, mechanical trauma, sexual intercourse, and illicit drug use [3]. Existing cases document conservative management with anticoagulation or antiplatelet medications, nonsteroidal anti-inflammatory drugs (NSAIDs), and a phosphodiesterase 5 inhibitor (PDE-5i) prior to surgical intervention [4]. This review seeks to improve clinical recognition of PSTCC by presenting a thorough analysis of existing literature on its potential causes, treatment strategies, and patient outcomes. We ultimately aim to equip providers with a clear framework for identifying PSTCC in patients presenting with perineal pain and appropriately managing symptoms to prevent potential long-term complications.

Literature Search Methods

A literature search was performed through PubMed using the primary search terms of "partial segmental thrombosis of the corpus cavernosum", "PSTCC", "idiopathic partial thrombosis of the corpus cavernosum", "IPTCC", "partial segmental priapism", "partial priapism", and "partial penile thrombosis". Of the 268 resulting articles, titles, abstracts, and keywords were initially screened to identify relevant studies, and the selected studies were further evaluated using the inclusion and exclusion criteria. Our inclusion criteria included information from case reports, case series, and scoping reviews of the literature between 1976 and 2023. Relevant cited references were also included. Articles that did not align with the scope of this review and those unavailable in English were excluded from this study. In addition, to ensure the inclusion of relevant studies, duplicate articles

were identified and removed through a manual screening process. These were cross-checked by comparing titles, authors, and publication details to ensure accuracy of the review. We found that 58 articles were eligible for our scoping review which included 45 single case reports, 6 cases series, and 7 literature reviews. Of these manuscripts, 28 patient cases were related to PSTCC, 9 to IPTCC, 2 to partial segmental priapism, and 21 to partial priapism.

DISCUSSION

Partial segmental thrombosis of the corpus cavernosum (PSTCC) was first reported in 1976 after a patient presented with a painful perineal mass after prolonged sexual intercourse [1]. Since then, there have been less than 60 reported cases with the etiology remaining unclear. Various etiologies have been described, all of which have been summarized in Table 1. The most common reported etiologies include sexual activity, idiopathic, and perineal compression due to cycling or long plane rides [1-58].

Patients with PSTCC typically present with subacute perineal pain, and a pelvic MRI confirms the diagnosis. The underlying pathophysiology of this condition is not well understood, but previous reports have suggested mechanisms such as the "two-hit model". Ilicki et al., proposed that the first hit is the presence of a congenital defect, as seen in our patient's case, or trauma-induced transverse membrane dividing the corpus into two portions. Microtrauma, medications, or a hypercoagulable state serve as the second hit leading to thrombus formation in the permeable portion of the membrane [2]. Medication as a cause of the "second hit" is supported by other reports hypothesizing that prolonged penile engorgement with PDE-5i use can lead to increased venous stasis, and in the presence of sexual activity induced microtrauma, can lead to clot formation and the development of PSTCC [3].

PSTCC treatment includes medical or surgical intervention based on symptom severity, physical exam

Table 1: Partial segmental thrombosis cases

	Author	Study type	Number of patients	Average age of patient(s)	Condition reported	Possible etiology	Treatment	Treatment outcome
1	Gottesman J, 1976 [1]	Case report	1	34	Partial priapism	Sexual intercourse	Corporal incision	Resolution of symptoms
2	Hillis and Weems, 1976 [5]	Case report	1	24	Partial priapism	Transverse membrane separating turgid and flaccid erectile tissue	Surgical removal of transverse membrane	Difficulty maintaining erection six weeks post operatively
3	Johnson and Corriers, 1980 [6]	Case report	1	34	Partial priapism	Sexual intercourse and transverse membrane separating distended proximal right corpus and distal flaccid corpus	Removal of transverse membrane	Resolution of symptoms
4	Llado et al., 1980 [7].	Case report	1	23	Partial priapism	Cycling	Corporal incision and cavernosal spongiosum shunt	Resolution of symptoms
5	Roa and Roa, 1981 [8].	Case report	1	46	Partial priapism	Idiopathic	Analgesics	Resolution of symptoms
6	Burkhalter and Morano, 1985 [9]	Case report	1	21	Partial priapism	Idiopathic	Corporal incision	Resolution of symptoms
7	Borrelli et al., 1986 [10].	Case report	1	27	Partial priapism	Idiopathic	Surgical evacuation and irrigation of the corpus cavernosum	Resolution of symptoms
8	Kimball et al., 1988 [11].	Case series	2	51, 37	IPTCC	Idiopathic	No intervention	Symptomatic improvement and decrease in penile and perineal mass sizes
9	Sparwasser et al., 1988 [12]	Case report	1	24	Partial priapism	Congenital spherocytosis	Corporal incision	Not reported
10	De Zan et al., 1993 [13]	Case report	1	34	Partial priapism	Sexual intercourse and bent penis	Surgical exploration, drainage, and necrotic tissue removal	Resolution of symptoms
11	Ptak et al., 1994 [14]	Case report	1	27	IPTCC	Sexual intercourse and former cyclist	Aspirin and opioid agonists	Resolution of symptoms
12	Albrecht and Stackl, 1997 [15]	Case report	1	29	Partial priapism	Idiopathic	Intracavernous injection of etilefrine	Resolution of symptoms
13	Machtens et al., 1998 [16]	Case report	1	44	Partial unilateral penile thrombosis, PSTCC	Cycling	Heparin for two weeks and aspirin for six months	Resolution of symptoms
14	Thiel R et al., 1998 [17]	Case report	1	35	IPTCC	Idiopathic	IV heparin and prophylactic aspirin	Resolution of symptoms

15	Schneede et al., 1999 [18]	Case report and literature review	1	24	Partial priapism	Sexual intercourse and fibrous septum	Surgical excision	Resolution of symptoms
16	Lewis et al., 2001 [19].	Case series	2	33, 24	Partial segmental priapism	Patient 1: sexual intercourse with prior history of idiopathic priapism and marijuana use Patient 2: sexual intercourse and sickle cell anemia	Patient 1: proximal left corporotomy Patient 2: corporal irrigation and right proximal cavernosal spongiosum shunt	Patient 1: Resolution of symptoms over one year later Patient 2: ED that resolved one year later
17	Pegios et al., 2002 [20].	Case report	1	46	Partial priapism	Idiopathic, hepatitis A	30,000 units of IV heparin and aspirin 100 mg/day	Resolution of symptoms
18	Goeman et al., 2003 [21].	Case series	3	18, 22, 27	IPTCC	Patient 1: cycling Patient 2: cycling and 8-hour plane ride Patient 3: cycling	Patient 1: enoxaparin 40mg once daily for six weeks Patient 2 and 3: acetylsalicylic 160 mg once daily for six months	Symptomatic improvement and mass reduction after six months
19	Horger et 1al., 2005 [22].	Case report and literature review	1	37	PSTCC	Sexual intercourse, smoking 1 pack/day, cocaine and marijuana use prior to injury	Oral pain medication and discharged with two weeks of oral pseudoephedrine	Resolution of symptoms
20	Asbach et al., 2008 [23]	Case report	1	26	Partial priapism	Sexual intercourse	LMWH twice daily, oral aspirin 100 mg once daily, ibuprofen 400 mg twice daily, and ciprofloxacin 500 mg twice daily	Resolution of symptoms
21	Blaut et al., 2008 [24]	Case report	1	23	PSTCC	Idiopathic and elevated homocysteine	LMWH, aspirin, analgesics, and ciprofloxacin	Resolution of symptoms
22	Galvin et al., 2009 [25]	Case report	1	22	PSTCC	Sexual intercourse	NSAIDs and Aspirin	Resolution of symptoms
23	Kilinc et al., 2009 [26]	Case report	1	59	Partial priapism	Tamsulosin (0.4 mg)	Surgical corpus cavernosal spongiosum shunt	Resolution of symptoms
24	Patel et al., 2010 [27]	Case report	1	21	IPTCC	Idiopathic	Aspirin	Resolution of symptoms
25	Głuchowski et al., 2011 [28]	Case report	1	32	PSTCC	Sexual arousal	LMWH	Resolution of symptoms
26	Hulth et al., 2013 [29].	Case series	3	19, 32, 35	IPTCC	Patient 1: cycling Patient 2: masturbation Patient 3: long plane ride, cycling, and prior history of non-seminoma seven years prior	Patient 1: LMWH, NSAIDs, and IVF Patient 2: LMWH for one month and aspirin for two months Patient 3: oral pain medication,10,000 units LMWH once daily for two days, and aspirin 75 mg once daily for seven weeks	Patient 1: resolution of ED six months later Patient 2: Resolution of symptoms Patient 3: thrombus still present two weeks later and complete resolution of symptoms seven months later
27	Ilicki et al. 2012 [2].	Case report	1	20	PSTCC	Idiopathic Excessive alcohol intake (binge drinking)	NSAIDs for pain management. 10,000 units of low-molecular weight heparin followed by 5,000 units twice daily for one week. Then 7,500 units daily for the subsequent six weeks.	Resolution of symptoms
28	Pepe P et al., 2012 [30].	Case report	1	51	Partial priapism secondary to IPTCC	Idiopathic	Systemic anticoagulation and phenylephrine injection	Erectile dysfunction persisted
29	Hoyerup et al. 2013 [31]	Case report and literature review	1	50	PSTCC, partial priapism	100 mg sildenafil prior to sexual intercourse	Unresponsive to analgesics proceeded with surgical incision for clot evacuation	Minor loss of rigidity during erection but retained capacity for penetration. Resolution of symptoms otherwise.
30	Kropman and Schipper, 2014 [32]	Case report	1	38	Partial priapism, PSTCC	Sexual intercourse	NSAIDS, Aspirin, IV heparin, and LMWH	Resolution of symptoms

31	Sauer et al. 2014 [33]	Case report	1	23	PSTCC	Medical history of varicocele ligature 6 years prior	Enoxaparin 40 mg and acetylsalicylic acid 100 mg once daily.	Pain relief and preserved erectile function
32	Boomgaert et al, 2015 [34]	Case report	1	16	PSTCC	Cycling	Not reported	Not reported
33	Cooper et al., 2015 [35]	Case report	1	26	Partial priapism	Motocross riding and recent alcohol use	Ibuprofen 800 mg three times daily, Aspirin 325 mg daily, and nonspecific oral phosphodiesterase inhibitor 400 mg twice daily	Resolution of symptoms
34	Eovaldi and Dunn, 2015 [36]	Case report	1	23	IPTCC	Long plane ride	LMWH 1mg/1kg and oral ibuprofen 400 mg twice daily. Transitioned to LMWH 1.5 mg/kg for two months then aspirin 81 mg indefinitely	Resolution of symptoms
35	Gresty et al., 2015 [37]	Case series	2	19, 37	PSTCC	Patient 1: Sexual intercourse Patient 2: Sexual intercourse and cycling	One month of LMWH injections and three months aspirin 75 mg daily	Resolution of mass but persistent ED
36	Weyne et al., 2015 [38]	Case series and literature review	18	35.5	Partial thrombosis	Thrombotic event (3), cycling (11), long plane (1)	LMWH (15) and surgical intervention (3)	Resolution of symptoms (9), persistent ED (6), and "de novo" ED (3)
37	Christodoulidou et al., 2016 [39]	Case report	1	43	PSTCC	Microtrauma during cycling and presence of fibrous septum	Aspirin 75 mg, tadalafil 5 mg once daily, and rivaroxaban 20 mg. Pain control with NSAIDs and paracetamol	Complete resolution of symptoms one year later.
38	Fabiani et al., 2016 [40]	Case report	1	52	Partial priapism	Idiopathic	NSAIDs	Resolution of symptoms
39	Faddan et al., 2016 [41]	Case report and literature review	1	26	PSTCC	Long plane ride	Enoxaparin	Resolution of symptoms
40	Gomez Gomez et al., 2016 [42]	Case report	1	21	PSTCC	Regular horseback riding	Subcutaneous enoxaparin 60 mg and aspirin 100 mg daily. Transitioned to aspirin 100 mg daily three months later	Resolution of symptoms
41	Smetana et al., 2016 [43]	Case series	2	29, 42	PSTCC	Idiopathic	Patient 1: Surgical intervention Patient 2: enoxaparin and warfarin	Resolution of symptoms
42	Autran et al., 2018 [44]	Case report	1	24	PSTCC	Fibrous septum	Not reported	Not reported
43	Ranasinghe et al., 2019 [45]	Case report	1	27	Partial thrombosis	Idiopathic	80 mg LMWH for ten days and aspirin 100 mg	Resolution of symptoms
44	Ozden et al., 2020 [46]	Case report	1	23	Partial segmental priapism	Idiopathic	Transcatheter embolization of the fistula	Resolution of symptoms
45	Singh et al., 2020 [47]	Case report	1	36	PSTCC	Idiopathic	Injection of 200 mcg of phenylephrine	Resolution of symptoms
46	Vieira-Leite et al., 2020 [48]	Case report	1	30	PSTCC	Bilateral transverse membrane and heterozygous for Factor V Leiden	LMWH	Resolution of symptoms
47	Wray et al., 2020 [49]	Case report	1	39	PSTCC	Idiopathic	Anticoagulation	Resolution of symptoms
48	Baraças et al., 2022 [50]	Case report	1	49	PSTCC	Malignancy (gastric cancer)	NSAIDs and systemic anticoagulation	Resolution of symptoms
49	Baaklini et al., 2021 [51]	Case report	1	39	PSTCC	Off-label sildenafil use	Rivaroxaban 15 mg twice daily for 21 days followed by 20 mg once daily for 6 months	Resolution of symptoms
50	Militello et al., 2022 [52]	Case report	1	28	PSTCC	History of motorcycle use and horse riding		

51	Koller et al., 2021 [53]	Case report	1	29	PSTCC	Idiopathic	Apixaban 10 mg twice daily for seven days followed by 5 mg twice daily for three months. Pelvic rest and pain control with NSAIDS, gabapentin, and low dose narcotic as needed for three days at discharge.	Resolution of symptoms at 6 months
52	Terkmane et al., 2021 [54]	Case report	1	19	Partial priapism	Idiopathic	NSAIDs	Resolution of symptoms
53	Ocampo Flórez et al. 2022 [4]	Literature review	34	28.2	PSTCC, partial priapism, hard flaccid syndrome	Microtrauma/prolonged perineal compression (84%)	Varying treatments	
54	Labra et al., 2023 [55]	Case report and literature review	1	36	PSTCC	Cycling	Oral anticoagulants and aspirin	Resolution of symptoms
55	Nguyen et al., 2023 [56]	Case report	1	25	IPTCC	Idiopathic	Apixaban	Resolution of symptoms
56	Rybár et al., 2023 [57]	Case report	1	44	PSTCC	Prolonged running	NSAID 100 mg once daily, LMWH twice daily	Resolution of symptoms one week later but residual thrombus detected three years later
57	Senthilkumaran et al., 2023 [58]	Case report	1	32	PSTCC	Snake bite	Antivenom and enoxaparin	Resolution of symptoms
58	Danchi et al. 2024 [3]	Case report	1	39	PSTCC	Inappropriate use of sildenafil prior to sexual activity	Sildenafil, anticoagulation with rivaroxaban 15 mg twice daily for three weeks followed by 20 mg once daily for six months, and conservative pain management	Pain resolved completely within two to three weeks with no recurrence

findings, and radiographic imaging. Commonly utilized treatments are summarized in Table 1, and our review found that many patients were managed conservatively with anticoagulation, namely low molecular weight heparin (LMWH), for thrombosis management and non-opioid analgesics, such as NSAIDs, for pain control. In addition, sildenafil is often added to the treatment regimen to prevent penile fibrosis and scarring. Escalated treatment modalities, including procedural or surgical intervention, may be considered in cases refractory to medical management. Our review found that the most common procedures were intracavernosal injection of vasoactive medications, corporal incision, surgical removal of membranes, clot evacuation, or corporal cavernosal shunt [1,5-7,9,10,12,13,15,18,19,26,30,31,38,43,46,47]. Given that conservative management provides comparable outcomes, a stepwise approach is typically recommended for treating PSTCC [2]. Further studies are required to assess the complications of this condition; however, some cases noted erectile dysfunction as a long-term sequela.

To our knowledge, our narrative review of the literature is the most comprehensive and up-to-date review of PSTCC cases currently available. By providing an overview of previously published cases, this review highlights the importance of a thorough patient history and physical exam, prompt radiographic imaging, and timely intervention. Previous reports hypothesize the underlying pathophysiology of this condition; however, further information is needed to better understand the disease's etiology, mechanism and development, and long-term outcomes.

CONCLUSION

Patient presentations of perineal pain can be diverse and complicated. It is essential for providers to obtain imaging and a detailed history to evaluate PSTCC as a potential cause. Treatment should aim to provide symptomatic relief and prevent long term complications such as fibrosis, scarring, or persistent erectile dysfunction. We aim to increase provider awareness of this rare urologic condition and provide a comprehensive review of the various etiologies and treatment of PSTCC.

AUTHOR CONTRIBUTION STATEMENT

All authors contributed to the production, review, and revision of this manuscript.

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