SOP Conservative (Medical and Mechanical) Treatment of Erectile Dysfunction

Hartmut Porst, MD,* Arthur Burnett, MD, MBA, FACS,† Gerald Brock, MD, FRCSC,‡ Hussein Ghanem, MD,§ Francois Giuliano, MD,¶ Sidney Glina, MD,** Wayne Hellstrom, MD, FACS,†† Antonio Martin-Morales, MD,‡‡ Andrea Salonia, MD,§§ Ira Sharlip, MD,¶¶ and the ISSM Standards Committee for Sexual Medicine

*Private Urological/Andrological Practice, Hamburg, Germany; †The James Buchanan Brady Urological Institute, The Johns Hopkins Hospital, Baltimore, MD, USA; ‡Division of Urology, University of Western, ON, Canada; §Sexology & STDs, Cairo University, Cairo, Egypt; ¶Neuro-Urology-Andrology Unit, Department of Physical Medicine and Rehabilitation, Raymond Poincaré Hospital, Garches, France; **Instituto H.Ellis, São Paulo, Brazil; ††Department of Urology, Section of Andrology and Male Infertility, Tulane University School of Medicine, New Orleans, LA, USA; ‡‡Unidad Andrología, Servicio Urología Hospital, Regional Universitario Carlos Haya, Málaga, Spain; §§Department of Urology & Urological Reseach Institute (URI), Universiti Vita Saluta San Raffaele, Milan, Italy; ¶¶University of California at San Francisco, San Francisco, CA, USA

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ABSTRACT

Introduction. Erectile dysfunction (ED) is the most frequently treated male sexual dysfunction worldwide. ED is a chronic condition that exerts a negative impact on male self-esteem and nearly all life domains including interpersonal, family, and business relationships.

Aim. The aim of this study is to provide an updated overview on currently used and available conservative treatment options for ED with a special focus on their efficacy, tolerability, safety, merits, and limitations including the role of combination therapies for monotherapy failures.

Methods. The methods used were PubMed and MEDLINE searches using the following keywords: ED, phosphodiesterase type 5 (PDE5) inhibitors, oral drug therapy, intracavernosal injection therapy, transurethral therapy, topical therapy, and vacuum-erection therapy/constriction devices. Additionally, expert opinions by the authors of this article are included.

Results. Level 1 evidence exists that changes in sedentary lifestyle with weight loss and optimal treatment of concomitant diseases/risk factors (e.g., diabetes, hypertension, and dyslipidemia) can either improve ED or add to the efficacy of ED-specific therapies, e.g., PDE5 inhibitors. Level 1 evidence also exists that treatment of hypogonadism with total testosterone < 300 ng/dL (10.4 nmol/L) can either improve ED or add to the efficacy of PDE5 inhibitors. There is level 1 evidence regarding the efficacy and safety of the following monotherapies in a spectrum-wide range of ED populations: PDE5 inhibitors, intracavernosal injection therapy with prostaglandin E1 (PGE1, synonymous alprostadil) or vasoactive intestinal peptide (VIP)/phentolamine, and transurethral PGE1 therapy. There is level 2 evidence regarding the efficacy and safety of the following ED treatments: vacuum-erection therapy in a wide range of ED populations, oral L-arginine (3–5 g), topical PGE1 in special ED populations, intracavernosal injection therapy with papaverine/phentolamine (bimix), or papaverine/phentolamine/PGE1 (trimix) combination mixtures. There is level 3 evidence regarding the efficacy and safety of oral yohimbine in nonorganic ED. There is level 3 evidence that combination therapies of PDE5 inhibitors + either transurethral or intracavernosal injection therapy generate better efficacy rates than either monotherapy alone. There is level 4 evidence showing enhanced efficacy with the combination of vacuum-erection therapy + either PDE5 inhibitor or transurethral PGE1 or intracavernosal injection therapy. There is level 5 evidence (expert opinion) that combination therapy of PDE5 inhibitors + L-arginine or daily dosing of tadalafil + short-acting PDE5 inhibitors pro re nata may rescue PDE5 inhibitor monotherapy failures. There is level 5 evidence (expert opinion) that adding either PDE5 inhibitors or transurethralPGE1 may improve outcome of penile prosthetic surgery regarding soft (cold) glans syndrome. There is level 5 evidence (expert opinion) that the combination of PDE5 inhibitors and dapoxetine is effective and safe in patients suffering

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from both ED and premature ejaculation. **Porst H, Burnett A, Brock G, Ghanem H, Giuliano F, Glina S, Hellstrom W, Martin-Morales A, Salonia A, Sharlip I, and the ISSM Standards Committee for Sexual Medicine. SOP conservative (medical and mechanical) treatment of erectile dysfunction. J Sex Med 2013;10:130–171.**

Key Words. Erectile Dysfunction; Oral Drug Treatment; Phosphodiesterase Inhibitors; Intracavernous Self-Injection Therapy; Transurethral Alprostadil Therapy; Combination Therapies; Vacuum Device Therapy

Introduction

Sexuality is a key domain in the lives of humans. In the majority of partnerships, sexuality remains the most important or at least a very important bonding factor regardless of an individual's homosexual or heterosexual orientation. Until recently, sex (which in this context refers both to an active sex life and interest in sexual activities) is commonly associated in the public domain with younger age groups, whereas sexual activities in elderly individuals (>70 or even 80 years) are considered in many cultures to be somewhat uncommon or even strange. Therefore, in the scientific literature, few representative data exist regarding the importance of sex life in the elderly population. In a population-based cohort study from Perth, Australia of 3,274 men, aged 75–95 years, sexual life and activities were explored via questionnaires from 1996 to 1999, from 2001 to 2004, and from 2008 to 2009 [1].

A total of 2,783 (85%) provided data on their sexual activity (Table 1).

In two previous studies from Germany and Japan investigating sexual activities in age groups between 30 and 80 years of age, the frequency of sexual activity (coitus, masturbation, erotic movies, etc.) over the months prior to the study was between 70% and 96% (Table 2).

These three large studies from three different cultures provide convincing evidence that for the majority of older men, sexual activities play an important role as a bonding factor for partnerships.

Table 1 Results of a population-based cohort study from Perth, Australia, with 2,783 (85%) of 3,274 men, aged 75–95 years, providing data on sexual life and activities from 1996–1999, 2001–2004, and 2008–2009 [1]

Item	Yes responses
Sex at least somewhat important	48.8%
At least one sexual encounter in the past 12 months	30.8%
Satisfied with frequency of sexual activity	56.5%
Sex less often than preferred	43%

Table 2 Age-dependent frequency of sexual activities in Germany and Japan [2,3]

	German (Cologne) study		Japanese study	
Age (years)	No. of patients	Sexually active	No. of patients	Sexually active
Total	4.489		9.880	
30–39	Not reported	96%	679	96%
40–49	Not reported	92%	1.010	96%
50–59	Not reported	89%	883	92–95%
60–69	Not reported	84%	3.552	80–88%
70–79	Not reported	71%	2.308	55–70%
>80	Not evaluated		220	44%

Alternatively, many studies suggest that sexual health is not maintained in many elderly men. Declining sexual health is a process that usually starts in the fifth decade and increases progressively with age. This statement applies generally for all male sexual functions including sexual desire, sexual arousal, erectile function, and ejaculatory/orgasmic capacity, as has been shown in a Norwegian epidemiologic study (see Figure 1).

From a clinical standpoint, erectile dysfunction (ED) is categorized in two major subtypes: (i) primary ED defined as ED that occurs from the beginning of sexual activities and (ii) secondary or acquired ED defined as ED that occurs after a period of normal sexual life in which erectile function is intact.

Many men experience erectile problems that are clearly related to temporary life circumstances or problems. These erectile problems disappear once the temporary circumstances are resolved. In these cases, consultation with a physician is not needed.

In contrast to these temporary erectile problems, a man experiencing longer-lasting ED of greater than 3–6 months should seek professional help and undergo a thorough medical evaluation both because of the increasing risk of partnership

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