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Clinical, cultural and psychosocial impediments to self reporting of erectile dysfunction by men in Edo state, Nigeria

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Abstract

Introduction: Organic ED is presently considered as vasculogenic in the majority of affected middle age and elderly men and a sentinel event for cardiovascular disease. When men present with ED, it is advised that the opportunity should be used to assess their cardiovascular health.

Objective: To determine the impediments to self reporting of ED and to assess the help seeking habits of men in Edo state with regards to ED. The secondary objective is to evaluate how acceptable sexual assessment is to these men when they present.

Subjects and methods: This is a cross sectional study using a multi-facet, questionnaire with a section consisting of the international index of erectile function (IIEF). All men above 30 years who consented were included.

Results: The response rate was 71.1%. The mean IIEF score was 20.33 with standard deviation of 4.656. The overall prevalence of ED was 51.2. Three hundred and eight of the respondents (33.3%) did not know where ED is treated, 273 (29.5%) thought that it is treated by complementary and alternative medicine practitioners while 237 (25.6) opted for the hospital as a point of care. This had a statistically significant correlation with location of the respondent (P = 0.000), level of education (P = 0.000) and senatorial zone (P = 0.000). Sexual evaluation was acceptable to 384 (41.5%) respondents when men present without ED and 757 (81.8%) when ED has occurred. This had a statistically significant correlation with level of education (P = 0.000), alcohol consumption (P = 0.000) and senatorial zone (P = 0.000).

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Conclusions: ED is highly prevalent in this community. Alcohol consumption, low educational level, ignorance of who and where ED is treated, location of respondent (rural) indifference, presence of co-morbidities and tribal beliefs appear to be associated with low self reporting. Affected men are more likely to patronize complementary and alternative medicine (CAM) practitioners than medical practitioners or may be out rightly indifferent. Acceptability of sexual evaluation of men is low when ED is absent and high when it has occurred.

Introduction

Erectile dysfunction (ED) is the inability to achieve and/or maintain penile erection sufficient for satisfactory sexual intercourse [1]. In the past, it was ascribed to aging and therefore considered not treatable. Currently, its causes are well documented with good evidence of a cause–effect relationship. Hypertension, diabetes mellitus, hyperlipidemia, cigarette smoking and low serum testosterone level cause vasculogenic erectile dysfunction through endothelial dysfunction and/or atherosclerosis [2]. These life style abnormalities are also known as cardiovascular risk factors.

ED has been documented as a forerunner for coronary and cerebral artery disease [3]. For this reason, physicians are being advised to evaluate men who present with ED for cardiovascular risk factors. By extension, there is need to evaluate the sexuality of middle aged and elderly men when they present with or without ED as they may not self report ED. According to Moser et al. [4] "the weak link in the chain of events leading to prompt and effective treatment for coronary artery disease is patient delay in seeking care. More than 50% of the 1.2 million people who suffer an acute myocardial infarction (AMI) or coronary death each year in the United States die in an emergency department (ED) or before reaching a hospital within an hour of symptom onset. About 700 000 individuals will have a stroke each year, 167 000 of those who have strokes will die, and more will suffer a major disability. Of the stroke deaths that occur each year, almost half occur before the patient reaches the hospital. Many of these deaths and significant disability could be prevented". A good proportion of these cases are men and there is good evidence that a reasonable number of them had ED predating the coronary artery event for up to five years or more especially those with diabetes mellitus [5].

The African culture encourages the discussion on sex and sexuality to be done in low tunes and reverence. Spiritual teachings and beliefs also tend to suppress such discussions during child up-bringing and these in the long run influence the help seeking habit of men when they develop ED. According to Ngubane [6], in South Africa for instance, adults often assume that young people are too young to discuss and be concerned about sex when in truth, such assumptions are often as a result of their own embarrassments about the subject. In all these, the young ones are at a loss as they are prevented from having access to vital information they need for healthy living. Though his work was done on HIV/AIDS mostly in youths, the poor information base on healthy living affects their help seeking habit when ED develops as the men age. This may explain the embarrassment faced by the elderly in discussing sex and sexuality because they themselves probably lack the requisite information on the subject. The former name, impotence, carried with it a stigma which men in these communities may not want to be associated with. According to Pommerville [7], an impotent man was in the past considered powerless and worthless and the topic was hardly discussed until the early 1980s when ED became a diagnostic entity and a subject of intense research.

This work aims primarily to determine the clinical, cultural and psychosocial impediments to self reporting of ED, assess the help seeking habits of men with regards to ED and secondarily to evaluate how acceptable sexual assessment is to men in Edo state. Acceptability would mean early detection of ED and by extension, risk factors for coronary and cerebral artery disease while the reverse would mean that men may not give a true history of themselves with regards to ED.

Subjects and methods

This is a cross sectional, questionnaire based study of the subject of erectile dysfunction in middle age and elderly men. Following approval by the Ethic Committee, a list of the towns and major villages in each local government, including the local government headquarters, was made and villages for sampling were selected. A four page questionnaire was administered to men above thirty years who consented to participate within the study period. The only exclusion criteria were failure to give consent and the age limit of thirty years. To ensure confidentiality, the names of the participants were excluded from the questionnaire. However, consent was obtained from them.

Participants were informed of their right to withdraw from the study at any time if they so wish without any consequences. A consultant who is knowledgeable in research methodology of this nature and who is multilingual was employed for the day to day supervision in order to ensure professionalism and confidentiality.

The predictor variables assessed were age, educational attainment, location (urban or rural), number of wives, awareness of ED treatment, quality of exercise, use of local stimulants, cigarette smoking, alcohol consumption, sex and sexuality, ED severity from participants perspective, need for ED treatment and the reason, awareness of who treats ED in the index community and the awareness of the relationship between ED and cardiovascular health. The outcome variables assessed were the international index of erectile function (IIEF) score, the proportion of men in relation to the predictor vari-