Sexual Dysfunction

Behavioral, Medical, and Surgical Treatment

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KEYWORDS

• Sexual dysfunction • Erectile dysfunction • Phosphodiesterase inhibitors
• Penile prosthesis

KEY POINTS

- Follow a stepwise approach for evaluation and management of erectile dysfunction. Low-risk simple interventions initially, followed by more complex and invasive options.
- Improvements of modifiable risk factors should occur at every stage of evaluation and management of sexual dysfunction.
- Referral to a sexual medicine specialist should be considered after failure of oral medications.

INTRODUCTION

When considering the initiation of erectile dysfunction (ED) treatment of a patient, a complete medical history and physical should be completed. Contraindications to sexual dysfunction treatments, oral medications, surgical interventions, and behavioral modifications should be noted. Cardiac reserve should be assessed according to Princeton III criteria. A stepwise approach for evaluation and management of ED, as per Esposito and colleagues,[1] is still valid. The simplest and lowest-risk interventions are completed first, followed by increasingly complex and invasive options (Fig. 1).

NONPHARMACOLOGIC TREATMENT OPTIONS

Because ED is often a manifestation of generalized vascular disease, it makes sense in theory and has been shown in practice that lifestyle modifications that improve cardiovascular health may also improve erectile function. When ED is identified,

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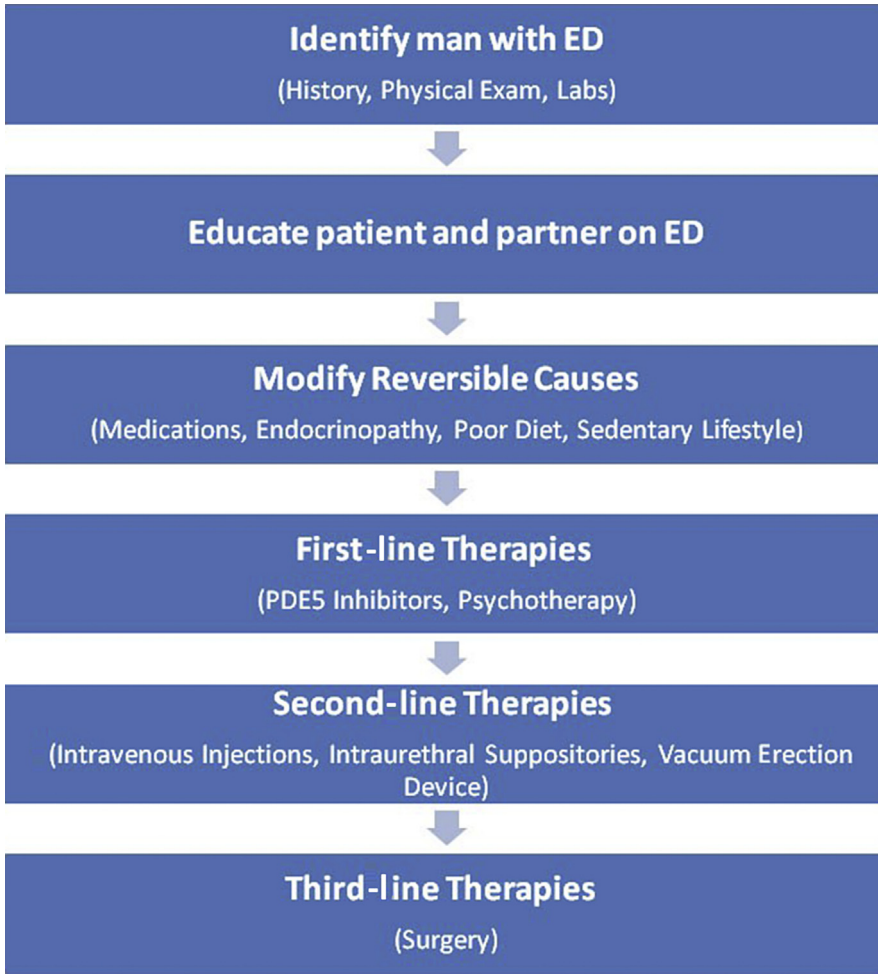

Fig. 1. Algorithm for ED management. PDE5, phosphodiesterase type 5. (*Adapted from* The process of care model for evaluation and treatment of erectile dysfunction. The process of care consensus panel. Int J Impot Res 1999;11(2):62; with permission.)

interventions to optimize the patient's cardiovascular health should be considered. Eliminating, managing, or minimizing risk factors for cardiovascular disease may also improve erectile health and function. Evidence from the Massachusetts Male Aging Study indicates that lifestyle changes are most effective for prevention/resolution of ED when they are started before age 50 years; it may be hypothesized that lifestyle interventions in later life may be too late to reverse penile vascular disease.[2]

Diet

Animal and human studies have shown that obesity is a significant independent risk factor for ED.[3] Obesity may contribute to ED through a variety of mechanisms, including the presence of proinflammatory molecules (C-reactive protein, free radicals) and alterations of hormone levels, such as testosterone deficiency. Obesity and the metabolic syndrome (the combination of central obesity, insulin resistance,