

What patients are looking for in erectile dysfunction therapy

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Before I explore this question, I want to describe my unique patient population to you.

Practicing sex therapy in South Africa is a wonderfully dynamic experience. We are a unique multicultural country. There are 11 official languages. Amongst our blacks there are large groups who are still deeply traditional and who have limited access to westernised medicine. There is also a growing urban population of sophisticated blacks who are entering every facet of a new industrialised world. There are some two million coloured individuals. We have approximately a million Indians. They are an equal mix of Hindu and Moslem people. Many of them are strongly traditional and conservative. There is a reluctance to call for help. The women are by and large, struggling to find a voice. Each cultural group brings their own background and heritage into the therapy. They each have their own unique metaphors. The five million whites are a polyglot mix. The preponderance are Afrikaans. The youth in this group are losing the reserve of their parents and seek out medical advice early. There is a greater ease with sexual words and a willingness to learn.

Almost daily, I am faced with new challenges in this amazing mix of cultures.

Sipho is a Venda male. He is a bank manager. More significantly he is the first son of the second wife of an important Venda chief. He is deeply traditional. He describes the norm for making love in his culture. His wife will go to bed first. He will wait an appropriate period and then he will follow her. He gets into bed at her side. His erection has to be there. She cannot help him. A good Venda wife has to be deeply passive and available. This is above and beyond the words of praise built into their communication styles. This a behaviour that acknowledges the male as being supremely potent. Only bad girls and girls who are hopelessly ignorant of the cultural norm reach out and touch. Loose Township girls would unhesitatingly caress his penis. Failing to erect, he is trapped. His wife can't help him and he can't call for help. Like his white brothers he hides behind the excuse of being too busy. Too tired. Too

stressed. Like the partners of all erectile dysfunction (ED) patients, his wife is left wondering if he still loves her. Is she still attractive to him? Is he having an affair? This problem is compounded by the fact that his wife is a social worker from Soweto. She is totally sophisticated and desperately wants to help him. But she dare not break this cultural expectation.

Tabo is a black radio announcer in his thirties. He tells me that he loses his erection on penetration. He is a very attractive, lively young man with a great deal of charm. All the women in his radio station vie with each other to get him into their beds. We have a long session. He is unbelievably articulate and bright. He is clear about the use of medication. I am satisfied that we have had a most fruitful meaningful hour. At the doorway while shaking his hand he says,

"You know Doc, in my kind of work we have many enemies. Do you think someone is doing this to me...?"

I keep forgetting this. Almost all of my black patients have secretly or openly seen their Sangoma or Inyanga. Because this has failed they now seek a conventional medical opinion. They are hoping I will have a powerful magic antidote.

Most of the Indian patients, Moslem or Hindu, are brought by their wives. There is an immediate disparity. He minimizes the problem. "Things are not so bad." She is left with the painful reality – "We don't make love. He doesn't have an erection." There are desolate silences in the interview. An awkwardness, an embarrassment.

Zaheer runs his fathers supermarket. He has been married for ten years. He breaks the general pattern of Indian patients. He calls for help and arrives alone. He does not want his wife to know he is calling for help for his year long erectile problem. This is his problem and he must deal with it.

Monash and Fatima are in an unconsummated marriage. This is their fourth year in this hapless empty situation. They have been pushed to call for help by their respective parents who are wanting grandchildren. We discuss their marriage. The communication is convoluted and vague. I am aware there is a hidden agenda. I wait for it to unfold. It seems she is unable to be penetrated. "The door is closed," he says.

I know that 6% of the Indian women I see do have a vaginismus. But before I can focus on her, she leans forward and says in a loud conspiratorial whisper – "Doctor, his penis never gets hard. My door is open...."

The older Afrikaans couples I see are generally reserved and

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deeply conservative. They are shy and struggle with appropriate words.

Jan is a farmer. He is overweight. He smokes heavily. He is being treated for hypertension. He and his wife sit before me. She does most of the talking. She looks to him for confirmation of each sentence. I feel they have rehearsed this at home. This is a major ordeal and they are determined to get help. For the past two years he has struggled to maintain an erection. He has begun to avoid any intimacy. It becomes clear that his problem has been compounded by a depression. He is taking anti-depressive medication.

I see an army of men in their thirties, frantic with the pace and stress climbing the managerial grid.

Martin tells me –“I’m afraid to date girls. It’s so embarrassing. We inevitably get down to heavy petting and I’m afraid I will lose my erection or even fail to get it up.”

George is unusual. He is a professional cyclist. He enters many overseas cycling events. 12% of these young men suffer from an erectile problem.

“George, you tell me you are numb after every ride. Surely it’s obvious, this is the cause of your impotence....”

“Doc, I can’t stop riding. It’s too important. Have you got something that will work and let me still compete?”

What are these patients looking for in erectile dysfunction therapy? What do they need?

It doesn’t matter where they come from or how disparate the culture, all men and their partners want the same thing.

They desperately need to talk. Doctors are not great listeners. We are doers. We like prescribing. This is a moment to reclaim the art of listening. The patient needs to be reassured that they are not alone. Over the age of fifty, some 52% of men struggle to have a satisfactory erection.

Over 70% of the men I see do not have an organic problem. There is a ‘performance anxiety’. They are desperately afraid of failing, and they fail. There is often a life style of smoking and drinking that makes it impossible to be an adequate lover. We have to listen to the uniqueness of their cultural demands and work as best we can in the confines of their beliefs. We have to listen to them as couples and with our listening help them communicate with each other.

We have to give them permission to be sexual. To explore their sexuality. To have sexual desires.

Edward is seventy years old. His wife six years younger is convinced that making love is no longer appropriate for couples of their age (and their culture...). She is upset by his determination to overcome his erectile problem. Edward does not accept this. He wants to reclaim the loving and deep satisfaction he always had in their sex life.

We have to educate our patients. We have to gently allow them to explore their sexual potential. Our role is to help men reclaim their normal erections and to return to their normal routine of loving.

What do men expect from sexual therapy?

Mostly they want an instant fix. A magic pill that works at all times, that can be taken without their partners awareness, and will without fail return a strong ‘user-friendly’ erection to them.

Certainly a universal need is the need for an intact self esteem.

Harry used a vacuum pump for years. He says “It was a sort of team effort. My wife would help. In the beginning we were

curious and it was adventurous and we did it together. Then it somehow became a chore. It became undignified. I lost all confidence in myself. It destroyed all possible spontaneity. We couldn’t face the performance. It was easier not to make love. I would love a pill I could take and just know I could have a good erection”.

Sipho desperately wanted a medication he could take and just perform. I opted for education. For loosening the boundaries of his cultural bind. I explained to them both that if I prescribed medication, he will not experience a spontaneous erection, but the act of actually making love will trigger a useable erection. He looked thoughtful. I noticed his wife was smiling.

The window of opportunity is important. If loving has to follow soon after taking a pill, there is an unfortunate pressure on the partner to respond.

I remember a conversation with Harry’s wife. “The moment Harry took that pump out of the drawer, my heart sank. I didn’t want to hurt him. I couldn’t say I didn’t feel like making love. But there was very little loving....”

The scenario taking the pill could be similar.

Ann reports back. “Bill tells me he has taken his pill. I wish he didn’t tell me. I know he now wants to make love whether I’m in the mood or not. He says if he doesn’t tell me, I might not be in the mood and he has wasted a pill”.

“But Ann – why don’t you discuss this? Why don’t you decide – yes this is a good moment. Take your pill and I’ll go and find some candles and put some lovely music on?”

“Yes I know – Bill wants it to be a kind of spontaneous thing. But it’s more complex than that. I might feel like it once we decide to take the pill, but baby wakes and I’m gobbled up by life.”

An extended window of opportunity (through an agent with a longer duration of action) will make for more unplanned opportunities for making love. There will be no compulsion to hurry before the medication wears off. It will allow couples to recapture their customary life style, the spontaneous romantic intimate moments that naturally lead to sex.

Zaheer is delighted that he can take a pill and for the next 36 hours any attempt at loving could be entirely successful. And his wife doesn’t need to know he has a problem... I resisted this, but he refused to involve his wife in the therapy. I feel I may have lost an opportunity to help him understand the cause of his erectile problem..

An erectile dysfunction is a couples problem. Therapy should as far as possible be a couples experience. There is the potential for growth, a greater understanding not only of the problem but a more meaningful expectation of the medication. There will be greater compassion, and an opportunity to share in the overcoming of their problem. Not his problem – but their problem. Knowing that her husband will ultimately take a pill in the course of therapy, and that this pill will have a window of opportunity of some 36 hours, and that the act of loving will set the secret chemistry of their medication in motion – does not destroy the romantic nature of their loving.

“I know you have taken the pill. We don’t have to make love immediately. There’s time. We have a closeness now and that always sets the stage for sex. I understand his anguish now and I revel in his joy of being able to satisfy me.”

Patients are looking for normality in ED therapy. They want a comfortable, safe, uncomplicated medication that works. They want to love again and be loved.

What doctors should look for in patients presenting with erectile dysfunction

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Dr Levinson's lecture is a compelling testimony to the challenge of providing quality medical care in a culturally diverse country such as South Africa. Therapy for sexual dysfunction, in particular, calls for sensitivity and perception to ensure that the patient is managed appropriately in their particular personal circumstances and social context.

Erectile dysfunction (ED) is defined as the inability to achieve and maintain an erection sufficient to permit satisfactory sexual intercourse. The relatively recent advent of highly effective medical therapy for this condition has had a profound effect on health professionals and the public. In particular, the introduction of the drug class known as the phosphodiesterase type 5 (PDE5) inhibitors, has led to wide public and professional awareness of ED. The launch of these agents has been accompanied by powerful campaigns aimed at both medical professionals and the general public. Very recently, second generation PDE5 inhibitors have been introduced and the cumulative effect of marketing by powerful multinational companies has raised public and professional expectations.¹ Easily administered, acceptably safe, and often highly effective – PDE5's have shifted the treatment of ED beyond the realm of specialists, and enable primary care physicians to satisfactorily manage many patients ED. Valuable new therapeutic options, as well as healthy societal attitudes regarding sexual function should be welcomed by health professionals. However, we should take great care to avoid trivialising ED, and to manage patient expectations realistically. We also need to be aware that certain categories of patients are difficult to treat, such as those with severe cardiovascular disease, corporal fibrosis and those with low libido as a result of chronic disease.² Significantly, ED may be the first clinical manifestation of cardiovascular disease, making it a helpful, early disease marker.³

In a series of case profiles, Dr Levinson stresses the psycho social aspects of patients who present to his practice with ED. Being receptive to these factors is crucial, and few other complaints present doctors with such a potentially complex interplay of emotional, cultural and physical factors. Over 70 % of the ED patients seen by Dr Levinson are reported as not having an organic problem. This is likely to be a reflection of his unique practice profile. Broad consensus now attributes organic factors as contributing to ED in the overall majority of cases.⁴ Certainly one of the beneficial spin offs of research into the mechanism of action of the PDE5 inhibitors has been a much greater understanding of the patho-physiology of ED. The possible aetiology of ED is extensive and may result from psychogenic or organic (neurologic, hormonal, arterial, cavernosal or drug-induced) causes or from a combination of these factors. Intuitively we accept a link between aging and ED (pointing to organic factors) and this is supported by two landmark studies. The Massachusetts Male Aging Study and the Cologne Male Survey convincingly correlate increasing incidence of mild, moderate, and severe ED with aging. 5 & 6 52% of men between 40 and 70 years of age were found to have some degree of ED in the former study. The latter study demonstrates a steep age related increase and a high co-morbidity of ED with hypertension, diabetes, pelvic surgery and 'lower urinary tract symptoms'. This underscores the fundamental importance of a detailed patient history, systematic physical examination and adequate diagnostic workup. This is essential, not only for accurate diagnosis of responsible aetiological factors, but also to offer patients individualised treatment options.

Dr Levinson's case reports include an elderly Afrikaans farmer presenting with ED. His co-morbid conditions ring alarm bells for the attending physician. He is an obese, hypertensive smoker, who is also depressed. Clearly he is at substantial risk of cardiovascular disease, and consequently ED (for which there are 4 other distinct risk factors in this patient). His particular profile is also accurately reflected as "The mutually reinforcing triad of depressive symptoms, cardiovascular disease and erectile dysfunction" described by

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Another case profile describes a professional cyclist complaining of ED. This complication of a popular recreational and sporting activity is suspected of being widely under reported, although it has led to the development of the 'anatomical saddle' as a cycle accessory to minimise the risk of ED. The mechanism of injury is due to repeated blunt trauma or sustained pressure on the erectile nerves traversing the perineum. This may cause neuropraxia, with transient ED, or even permanent nerve damage. I have unsatisfactorily managed a 28 year old male, who was a socially competitive mountain bike enthusiast, with severe impotence. The patient reported ED of 2 years duration following an intense period of training and downhill races. Refractory to all forms of oral or injectable therapy, the patient declined the option of a vacuum constriction device or a surgically implanted prosthesis.

I strongly concur with Dr Levinson's concluding remarks that ED is a couple's problem. Also consider that identifying a causative or contributory organic factor may be doing the affected couple a great service. Clear explanation of a disease process may well relieve the burden of an unsatisfactory sexual relationship for both partners, as well as creating the opportunity for crucial medical intervention to minimise further morbidity. So-expressed slightly differently, accurately diagnosing possible organic aetiology of ED could be described as having 'triple bottom line' benefits:

1. Validating ED in the context of the couple's relationship
2. Instituting medical intervention
3. Commencing appropriate therapy for ED

In conclusion, it may be prudent medical practice to regard ED as a sensitive indicator of organic disease, which should be presumed to be contributory until proven otherwise.

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