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 (PDFE5) 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 PDFE5 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 – PDFE'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]

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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 PDFE5 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

Goldstein.[7]

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.

References

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