Erectile Dysfunction: The Need for a Scientific Approach to this Taboo Topic

A MOHSIN I HUSSAIN M AHMAD M NAEEM A SHAH A A SHAH
Department of Medicine, King Edward Medical College/Mayo Hospital, Lahore
Correspondence to: Dr. Aftab Mohsin

Erectile dysfunction is a problem that needs to be explored. This is an illness that has always been under discussed. Our study was carried in Mayo Hospital on 1252 patients. Out of these 434 (34.6%), were found to have some degree of erectile dysfunction. 114/434 (26.22%) did not seek medical advice. 192/434 (44.2%) went to quacks and 128/434 (29.4%) consulted doctors. 37.3 % of patients with erectile dysfunction had diabetes mellitus as concomitant disease. 12.4 % patients had hypertension while 6.9 % and 3.9 % patients had ischemic heart disease and tuberculosis respectively. These results emphasize the need that this disorder should be dealt scientifically. People and doctors should be made more aware of the recent advances in medical management of erectile dysfunction so that more people can seek a qualified medical advice and may benefit from the treatment. This article addresses the diagnosis of erectile dysfunction and identifies diagnostic tests that can be used by primary care physicians to determine the patients most at risk and the treatments most suited to meet the patients and their partners goal for therapy.
Keywords: erectile dysfunction , scientific approach , taboo topic

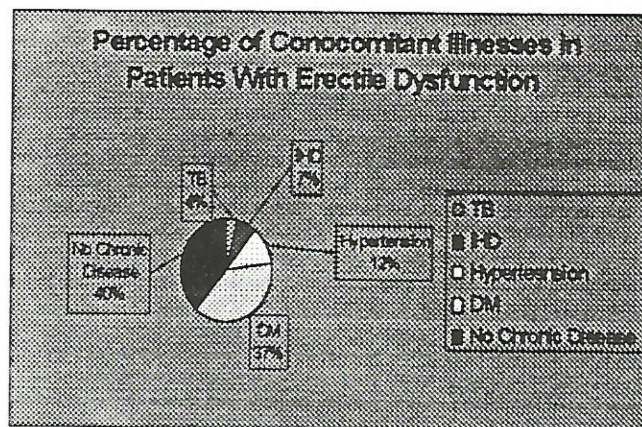
Male erectile dysfunction is defined as " the inability to achieve or maintain an erection sufficient for sexual intercourse". This is one of the most common sexual dysfunction in men[1]. It is estimated that the erectile dysfunction of any degree is 52% in men 40-70 years old [2]. It affects 10 to 20 million men in the United States [3].

Some men assume that erectile dysfunction is a part of aging but for most of the men it is quite devastating. Withdrawal from sexual intimacy because of fear of failure can damage relationships and lead to depression [4]. Since erectile dysfunction accompanies chronic illnesses, such as diabetes mellitus, heart disease, hypertension and many other diseases it becomes important for every physician to recognize it and know the newest treatment modalities [5].

Despite of the fact that ED is a very common problem, only few people seek medical help [6]. Especially in our country where sex is considered an issue not to be discussed, most people find it embarrassing to talk about their sexual problems. Even if they want to consult somebody, they do not know who is the person capable of solving their problem. Because of the fact the Hakims and Quacks claim to solve sexual dysfunction, many people consult them instead of qualified physicians. Doctors are generally reluctant to discuss this topic with their patients [6]. So this gives the patients an impression that medical science does not have a solution for sexual disabilities. Most men are reluctant to admit or even discuss this problem with their peers. Some men even try to hide their difficulty with erection from their partners. It is important to face the problem and discuss it and find a scientific solution[7].

Recent advances in our ability to diagnose and treat a number of causes of erectile dysfunction have improved the prospects for durable restoration of sexual function, although many impotent men and their general practitioners are still unaware of it [7]. As with the advancement of treatments available the number of patients consulting physicians is likely to increase, it is important to develop a rational and scientific approach to the diagnostic evaluation and treatment of erectile dysfunction.

A study was carried out in Mayo Hospital to find out the prevalence and trends of help seeking in patients with erectile dysfunction The aim of this study was to realize that erectile dysfunction is a problem that needs to be discussed. The reluctant behavior of the doctors and the patients towards this topic needs to be changed and a more scientific approach should be opted. So that most people can benefit from the recent advances that medical science has made for the management of this socially important disability.



Patients and Method

In this study 1252 patients were questioned about erectile dysfunction. The patients were those coming to medical and surgical wards, and medical and surgical and venereal diseases OPD of Mayo Hospital during the last week of April and first week of May 2000. The patients not cooperating to answer and unmarried men were excluded from the study. Patients who were debilitated or disabled or had a serious illness were also excluded. Patients were

divided in various age groups and their concomitant chronic illnesses were also noted. The question about consulting a doctor or quack was also asked.

Results

Out of 1252 patients questioned about any degree of erectile dysfunction 434 patients were found complaining of this problem which is 34.66% of the total number. Out of these 54 were hypertensive, 162 diabetic, 17 tuberculous and 30 were having IHD.

Table 1. Patients with erectile dysfunction (n=434)

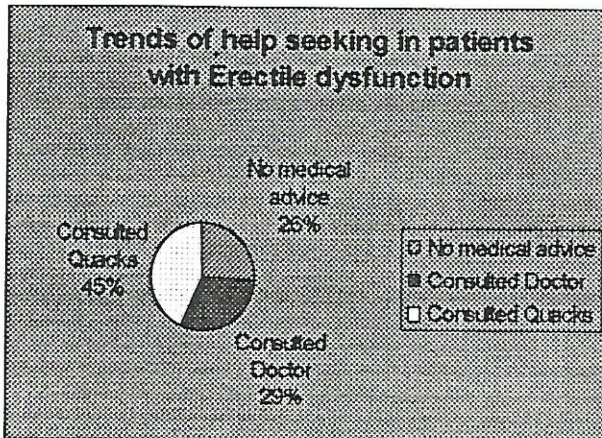
	No.	%age
Hypertension	54	12.4
Diaetes mellitus	162	37.3
Tuberculosis	17	3.9
Ischaemic Heart Disease	30	6.9

The ages ranged from 20 to 80 years will following percentage of distribution of dysfunction in various age groups.

Table 2 (n=434)

Age	20-29	30-39	40-49	50-59	60-69	70-79
Erectile Dysfunction	65 (14.97%)	80 (18.43%)	87 (20.04%)	111 (25.57%)	66 (15.20%)	25 (5.81%)

The important thing was that 114/434 patients did not seek medical advice for the dysfunction. 192/434 consulted Quacks and only 128/434 consulted qualified doctors.



Discussion:

Prior to the 1970's erectile dysfunction commanded little clinical interest. Physicians rarely questioned patients about sexual function and patients rarely discussed sexual concerns with their Physicians. Minimal diagnostic testing was available and treatment options were also limited. Because treatment was ineffective only few patients were seen by medical practitioners for this very common problem. Due to the awareness and availability of good treatment options things are now rapidly changing in the Western Countries. But in a country like Pakistan where sex is considered to be a hidden topic and a very personal issue, many people do not seek medical advice for erectile dysfunction. Because of the lack of awareness and education, many people consult Quacks and Hakims for sexual problems. This is also due to the fact that many patients and even doctors are not aware of the new treatment modalities available[8].

In our study 114/434 patients with erectile dysfunction did not consult any body which is 26.2% of the total number. 192/434 patients consulted a quack which is 44.2% of the total patients with ED. This may be because of the big claims and advertisements by the quacks to solve sexual problems. As compared to this only 128/434 consulted qualified doctors. This again raises the concern that a more scientific and rational approach should be considered for these patients, so that they may be maximally benefited from recent medical advances. Diabetes mellitus was the commonest concomitant disease present in patients with ED. It was present in162/434patients with ED. Hypertension was present in 54/434 patients while ischemic heart disease and tuberculosis was present in 30/434 and 17/434 patients respectively.

As a first step in breaking down the communication barriers between, patients and practitioners, it is important that physicians have a thorough understanding of the wide variety of conditions associated with ED and how the different risk factors for the Ed may be readily identified[8].

A goal directed approach has been successfully used by workers such as lue for the management of patients with ED[9]. The patients medical and sexual history should be taken. Detailed questions should be asked about medications, tobacco, alcohol consumption and risks factors for erectile dysfunction. If nocturnal and early morning erections are preserved, it means there is no organic cause for erectile dysfunction[7]. The quality of erections during sleep can be assessed with portable home devices (Rigiscan) that measure changes in penile girth and rigidity[10].

On clinical examination blood pressure should be measured and peripheral pulses palpated. A complete neurological examination should be performed including the bulbocavernous reflex and anal sphincter tone. The secondary sexual characters should be examined and abnormalities in external genitalia should be noted. The penis should be palpated for Peronies plaques and the testes examined for size and consistency. Further investigations will be guided by clinical findings but should include measurements of free testosterone and prolactin.

A full vascular assessment may not be required in many patients as a few will benefit from surgical management [11]. The most frequently used diagnostic screening method is the intracavernous injection of vasoactive drugs[12]. Inadequate response to large doses of these drugs are generally thought to show vasculogenic impotence. The best minimally invasive method available to study arterial blood supply to the penis is color duplex

Doppler ultrasound which assesses the integrity of arterial blood supply to penis and provides useful information on the veno-occlusive mechanism[13].

Currently there is no reliable clinical test for neurological function of the corpus cavernosum. There is considerable interest particularly in Europe in elecctromyography of the corpus cavernosum[14].

As has been said about the diagnosis, a similar approach should be used for managing the patients with erectile dysfunction. Approach should be more scientific and tailored for individual needs and preferences of the patients. Nowadays many acceptable treatment options are available. A few will be discussed now.

Psychosexual counseling may be an important part in the treatment of ED in patients with a psychological causes. Testosterone therapy may be used for patients with hypogonadism[7]. Trazodone and Yohimbine have been found effective in some studies for psychogenic erectile dysfunction[15 16 17]. Initial reports of Sildenafil (Viagra) suggest that it can produce an effective response in upto 88% of the patients with largely psychological erectile dysfunction.[18,19]. Intracavernosal injections of papaverine, alprostadil and phentolamine have been used with considerable success[20].

Vacuum devices are another treatment available for erectile dysfunction .These devices are generally safe and effective. These are often easily accepted by old men rather than younger people[21]. Surgical options for the management of erectile dysfunction include arterial reconstructive surgery and penile prosthesis .

Conclusion

From this study it is concluded that many people do not want to discuss their sexual disability even with their physicians. Others are ignorant and are often trapped by non-qualified people and ultimately mismanaged leading to further frustration of the patient. Although the ideal treatment for erectile dysfunction has not yet been found, but important advances have been made. Greater openness in the society is required if we want the patients to seek help. However doctors are generally reluctant to discuss this topic with their patients.

Training in the management of sexual dysfunction needs to improve at both undergraduate and postgraduate level. The public too requires better information about the availability of treatment.

References:

1. Korenman SG. Advances in the understanding and management of erectile dysfunction. J Clin Endocrinol Metab 1995; 60:1985-1988.
2. Melman A, Gingell JC. The epidemiology and pathophysiology of erectile dysfunction. J Urot, 1999; 1; 5-11.
3. Colpo LM. Evaluation, treatment and management of erectile dysfunction; an overview. Urol Nurs, 1998; 18:2 100-6.
4. Krane RJ, Goldstein I, Saenz de Tejada I. Impotence. New Eng Journ Med 1989; 321: 1648-1649.
5. Feldman et al. Impotence and its medical and psychosocial correlates: results of the massacheusists male aging study. J Urol 1994; 151: 54-61.
6. Wagener G, Tejad Saenz DI. Update on male erectile dysfunction BMJ, 1998; 316: 678-682.
7. Kirby Rs. Impotence diagnosis and management of male erectile dysfunction. BMJ 1994; 308: 957-961.
8. Korenman SG. New insights into erectile dysfunction: a practical approach. Am J Med 1998; 105: 135-44.
9. Lue TF. Impotence; A patients goal-directed approach to treatment. World J Uerol 8:67, 1990.
10. Kropman et al. Analysis of continuous penile rigidity measurements with the use of Regiscan summary analysis software program Int J Impol Res 1995; 7:71.
11. Li MK, Law KO. Clinical evaluation of impotence. Ann Acad Med 1995; 24:741-744.
12. Meulmann et al. Assessment of penile blood flow by duplex ultrasonography in 44 men with normal erectile potency in different phases of erection. J Urol 1992; 147:51.
13. Lewis RW, Mayda J II. Diagnosis and treatment of vasculogenic impotence. Acta Chir Hung 1994; 34: 231-241.
14. Fabra et al. Single potential analysis of corpus cavernosum electromyography for the assessment of erectile dysfunction. Provocation, reproducability and age dependant finding in 36 healthy volanteers and 324 patients. Jurol 1997; 158:: 444.
15. Kurt U,Ozkarde SH,Atug U et al. The efficacy of antiserotonergic agents in the treatment of erectile dysfunction. J Urol 1994; 152: 407-409.
16. Morales A, Heaton JPW, Johnston B, Advas M. oral and topical treatment of erectile dysfunction,l present and future. Urol Clin N Am 1995; 165: 60-63.
17. Reid K, Surridge DHC, Morales A et al. Dkouble blind trial of Yohimbine in the treatment of psychogenic impotence Lancet 1987; ii: 421-423.
18. Boolell M, Gepi-Atee S, Gingell JC, Allen MJ. Sildenafil, a novel effective oral therapy for male erectile dysfunction. Br J Urol 1996; 78: 257-261.
19. Gjingell C,kl Jardin A, Gulliano FA et al. The efficacy of |Sildenafil, a new oral treatment for erectile dysfunction, domonstrated by four different methods in a double blind placebo controlled, multinational clinical trial. Eur Urol 1996; 30(Suppl):353.
20. Dimsmore WE, Evans C. ABC of sexual health. BMJ 1999; 318:387.
21. Guaye AT. Erectisle dysfunction: Are you prepared to discuss it? Postgrad Med 1995; 97: 127-143.