Erectile dysfunction and men's awareness

Erectile dysfunction is one of the most common sexual problems and affects around half of all men over 40 years at some point. It becomes more common and severe as men get older. However, only a fraction of affected men seek help. With Men's Health Week taking place this month (June 11–17), **Dr Ken O'Neill** reviews management of erectile dysfunction in primary care.

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The prevalence of erectile dysfunction (ED) increases with age. ED affects some 50 per cent of men over the age of 40 years to some degree. Ten per cent of these men will have persistent problems getting any sort of erection while the remainder have less severe or intermittent problems. Diabetes mellitus, hypertension, cardiovascular disease and hypogonadism are all major risk factors for ED and likewise their prevalence increases with age[1]. There is little doubt that the introduction of Phosphodiesterase type-5 inhibitors (PDE5 inhibitors) and increasing public awareness of these therapies has led more men to present to their GPs with ED rather than suffering in silence. This article considers the management of ED in primary care.

As always the most critical aspect of the consultation is the history. It is important to recognise that men often do find it difficult to discuss sex in general and the clinician's attitude will be very important in putting patients at ease. Routinely asking about possible ED especially when men are taking drugs that may cause ED as a side-effect helps to open up the discussion.

Reasons for failure to produce a satisfactory erection include psychogenic, vascular, neurogenic and endocrine abnormalities. Drugs are often implicated in the cause of ED and a complete drug history is essential. Alcohol intake should be enquired about in particular. The presence of morning erections implies that psychogenic causes should be sought. It is important that patients expectations are explored during the consultation and that any relationship difficulties are brought into focus. It is not uncommon for men to present looking for PDE5 inhibitors without having discussed the situation with their partner even though sexual relations may have ceased some years earlier.

My advice is always to discuss the situation with their partner prior to commencing medication; vaginal lubrication may be necessary and it is important to create an open trusting environment where potential problems can be openly discussed.

Examination should also assess the penis for the presence of Peyronie's disease or other abnormalities that may create a difficulty in using PDE5 inhibitors. Inspection of the pubic hair and assessment of the testicles for possible atrophy may point to low testosterone levels as a cause. Testosterone up-regulates PDE5 activity and low levels may be implicated in treatment failure with PDE5 inhibitors[2].

Given the association with cardiovascular disease it is important to measure blood pressure and assess the peripheral arterial tree eg, femoral pulses/bruits. The 10 year cardiovascular disease risk should be measured and treatment initiated as appropriate.

Although I mentioned earlier the importance of medication as an aetiological factor in ED, it is important to note that PDE5 inhibitors are contra-indicated with certain drugs such as nitrates and nicorandil (potassium-channel activator with a nitrate component) and need to be used with caution with other drugs commonly used in the treatment of cardiovascular disease.

It is important to review potential interactions prior to initiating treatment. Alprostadil (prostaglandin E1) can alternatively be given by intra-urethral application for ED but again drug interactions must be sought prior to treatment.

Drug treatment for ED may only be prescribed on the NHS under certain circumstances:

- If the patient has diabetes, multiple sclerosis, Parkinson's disease, poliomyelitis, prostate cancer, severe pelvic injury, single gene neurological disease, spina bifida or spinal cord injury
- The patient is receiving dialysis for renal failure
- The patient has had radical pelvic surgery, prostatectomy (including transurethral resection of the prostate) or kidney transplant
- They were receiving certain ED drugs at the expense of the NHS on September 14th 1998
- Are suffering severe distress as a result of impotence (prescribed in specialist centres only).

The following criteria should be considered when assessing distress:

- Significant disruption to normal social and occupational activities
- A marked effect on mood, behaviour, social and environmental awareness
- A marked effect on interpersonal relationships.

Prescriptions initiated in the community, that satisfy the above criteria, should be endorsed: 'Special List Scheme (SLS)'. Counselling patients prior to commencing PDE5 inhibitors is very important as there may be a significant mismatch between patient's expectations and the reality of treatment.

There are certain conditions such as severe cardiovascular disease where PDE5 inhibitors are contra-indicated. Treatment should be initiated with the lowest dose and gradually increased. The commonest side-effects should be explained including headaches, dyspepsia, facial flushing and nasal congestion. The risk of priapism should be addressed and patients advised that treatment must not be delayed for more than six hours.

A review[3] in 2006 highlighted some issues to consider when PDE5 inhibitors don't appear to work. Up to 81 per cent of patients do not take the drugs properly and with proper education some 40 per cent of men who had not previously had a response to PDE5 inhibitors did so.

The timing of the medication is important as sildenafil and vardenafil should be taken some 30–60 minutes before sexual intercourse but food and alcohol will reduce plasma concentrations and effectiveness. Tadalafil is unaffected by food and alcohol but maximum effect may not be reached until two hours after taking it. It also has a longer action and benefit can accrue for up to 36 hours.

As always in primary care the key to effective therapy is good communication. A good history including review of all pharmacotherapy and a detailed explanation of all the factors implicated in ED will be critical to successful management.

Men's Health Week

National Men's Health Week (NMHW) was first held in June 2002 and since then has grown in size and impact, firmly establishing itself as a key part of the public health improvement calendar. Each year NMHW concentrates on a different area of policy relevant to men's health and in 2007, the Men's Health Forum turns its focus to men and the management of long-term medical conditions.

One in three people in the UK is currently living with a long-term medical condition and a significant proportion of this number will be men. However, men are increasingly unlikely to visit a doctor or engage with other health services and health promotion campaigns often fail to take account of the need for 'gender-sensitivity' in reaching male audiences.

References

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3. McMahon C, Smith C, Shabsigh R. Treating Erectile Dysfunction when PDE5 Inhibitors Fail. *BMJ* 2006; **332**: 589–92