Erectile dysfunction

- ICD–10: ***Failure of genital response*** F52.2 (https://mkn10.uzis.cz/prohlizec/F52.2)

In clinical practice, **the most common** sexual dysfunction is insufficient rigidity of the genital organ . The vast majority of men will encounter this problem at least at some point in their lives. We consider clinically **relevant sexual dysfunction** when an erection repeatedly does not reach the level that would be sufficient to satisfactorily connect the genitals.

Occurrence

The incidence of erectile dysfunction increases with age, especially in men over forty. In the popular Massachusetts study of aging men aged 40-70 years, the lifetime prevalence of erectile dysfunction was higher than 52%.

Division

Erectile dysfunction can be **isolated** . Then it is only a problem of stiffness (or rather "hardness") of the genital organ. All other sexual functions proceed reliably. In most cases, we note **a combination** of erection disorders with other sexual dysfunctions. Above all, with reduced sexual appetite , reduced excitability or premature ejaculation .

We distinguish erectile dysfunction:

1. **complete**
2. **incomplete**

In ***a complete disorder***, the hardness of the genital organ is insufficient in all circumstances. Thus, spontaneous erections (nocturnal and morning erections) and masturbatory erections and erections induced by non-coital stimulation are insufficient.

Incomplete erectile dysfunction is much more common in clinical practice. Problems with insufficient hardness of erection occur in these patients only sometimes and in some situations. There are difficulties with erection during coitus , but spontaneous and masturbatory erections are not significantly impaired. Even in this category, however, organic causes cannot be ruled out without further examination. While there is usually no doubt about the organic nature of complete erectile dysfunction, incomplete dysfunctions are typically multifactorial in nature. Biological, psychological, partner and social influences intertwine with them.

The distinction between primary and **secondary** erectile dysfunction is of great importance . The primary disorder occurs from the very beginning of sexual life. If it is not a simple debut failure of a transient nature, it has a worse prognosis than disorders of a secondary nature.

The following table shows indicative discriminating characteristics of "organic" and "psychogenic" erectile dysfunction:

	organic p.	**psychogenic p.**
Sudden onset	–	+
Creepy start	+	–
Disturbance instability	–	+
Age over 30 years	+	–
Psychopathology	+	+
Partnership conflicts	+	+

It is clear from the table that psychopathological symptoms or partner conflicts in themselves do not mean that erectile dysfunction is "functional". A thorough sexual anamnesis as well as a physical examination are necessary to determine adequate therapy . In the first phase, the nature of the disorder must first be thoroughly described. Also, a single man can fully explore his erection abilities. Erections at night, in the morning and especially erections during masturbation are an important guide here .

Treatment

Psychotherapy

Psychotherapy is used in the treatment of erectile dysfunction . It is especially important for incomplete and combined disorders. Classical couple sex therapy is not always necessary. Sometimes a rational and explanatory approach with the man himself is enough.

Pharmacotherapy

Dopaminergic preparations (ergoline preparations, bromocriptine , apomorphine , yohimbine) increase sexual activity through a central effect.

Vasodilatation drugs can be tried wherever we suspect an arterial lesion. Stimulants do not have a peripheral beneficial effect on erection. On the contrary. However, they can improve the mood and, by increasing the level of alertness, also increase the sexual entrepreneurship of the patients.

Phosphodiesterase 5 (PDE 5) inhibitors potentiate the effect of nitric oxide in the axillary bodies of the penis (sildenafil , vardenafil, tadalafil). Acts in the axis: L-arginine/NO/guanylate cyclase/cGMP. These are medications that improve erectile dysfunction in up to 80% of cases. They marked a significant advance in the treatment of these disorders.

Traditionally, androgens have been administered to men with erectile dysfunction . There is no doubt about the activating effect of exogenous testosterone on the sexual activity of hypogonadal men.

Intracavernous application of vasoactive substances : After applying an effective dose of papaverine , phentolamine, prostaglandin E1 (alprostadil), or their mixture into the hollow shaft of the penis, an erection will occur in a healthy man. An erection induced in this way starts within a few minutes after administration and wears off in 1-2 hours. If even a high dose of vasodilators fails to induce a firm erection, then it is a serious vascular lesion, usually not only of an arterial nature, but also with a venous component. The main risk of this procedure is a prolonged erection. Every application of vasoactive substances into the cavernous bodies therefore requires good availability of qualified urological care in case of prolonged erection (pripaism). In men with erectile dysfunction, it is sometimes possible to consider *autoinjection therapy* . In doing so, the patient applies a predetermined dose of vasoactive substance to the cavernous bodies of the penis at home and performs sexual intercourse with this enhanced erection.

Penile endoprosthesis

Finally, it is possible to solve otherwise uncontrollable erectile disorders **by implanting penile endoprostheses** . These are silicone fillings that are implanted into the cavernous bodies of the penis. There are semi-rigid simple systems. However, inflatable endoprostheses have also been constructed, equipped with a complicated hydraulic system, which allows external manipulations to induce rigidity and extend it as needed.

Links

References

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