

Penile erections

Report from the Better Sex Summit, Athens, Greece

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Sexual health remains an important topic in Urology. At the “Better Sex Summit” in Athens, we discussed important information about penile rigidity or hardness and therapeutic strategies.

Sexual health is described as physical, emotional, mental and social well being in sexual life.

Although the fact that the erectile dysfunction clinic is well known and open to every patient, only 10% of men with sexual dysfunction seek help today. Why? Mostly because sexual dysfunction remains an embarrassing and stigmatising disease, associated with the image of old men.

In 1998 the introduction of sildenafil opened a real sexual revolution for patients and researchers.

Since the availability of two newer compounds of phospho-diesterase 5-inhibition based compounds, vardenafil and tadalafil, medical literature is overwhelmed with studies.

Today, the three pharmaceutical companies try to demonstrate the superiority of their product by the so-called preference studies. Most of these studies focus on quality of life. Parameters for preference differ in function of which company conducted the study.

Surprisingly, only a few patients switch from their initial medication. Also 92% of the partners seem happy with their partner’s phospho-diesterase-5-inhibitors intake and 95% would like their partner to continue it’s use.

A recent study in Belgium showed that **rigidity or hardness of his erection** is patient’s biggest concern.

If the hardness of an erection plays an important role, we might need to categorize it. Four grades of erection are defined. Grade 1 is described as a longer

penis, but no changes in hardness. Grade 2 is a broader penis but still not hard enough for sexual intercourse. Grade 3 erections are hard enough for a sexual intercourse, but with insufficient rigidity. The ultimate goal must be grade 4 rigid erections, hard and rigid. A recent study presented at the ESSM in Copenhagen showed that sildenafil citrate is able to give grade 4 erections in 53 to 78% of the cases. Furthermore, sufficient hardness is an important base for maintaining the erection (Table I).

Other very important issues in erectile dysfunction is the **treatment strategies**.

Most urologists and sexologists start with the maximal dose. Patients who are well informed about the side effects of oral phosphodiesterase-5-inhibitors, they are not too concerned about flushing and dyspepsia.

Optimal strategies after radical prostatectomy are under debate. “To start as early as possible” is mostly recommended. Most urologists start treatments 3 to 4 weeks after surgery. Only when no adequate erections are achieved after 8 maximal dosages of phosphodiesterase-5-inhibitors, a switch to intracavernous injections or vacuum devices is recommended. Six month later, a second attempt with phosphodiesterase-5-inhibitors can still be successful.

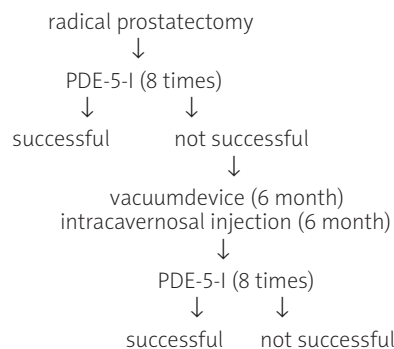


Table I.

Start	End	Sildenafil	Placebo
Grade 1	Grade 4-5	53%	12%
Grade 2	Grade 4-5	73%	25%
Grade 3	Grade 4-5	78%	38%

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