

NEWSLETTER

EUROPEAN SOCIETY for IMPOTENCE RESEARCH

Nº 4 AUGUST 1998

EDITORIAL:

The ESIR presents its Physicians' and Patients' Guides

The ESIR had a number of ambitious objectives at the beginning of this new two-year term among which the following were considered of prime importance for the future development of our society:

- To enhance general public awareness and information of erectile dysfunction
- To provide guidance and leadership to the medical community, regulatory agencies, and industry in the field of E.D.

Today we are happy to present an update on the tools that have helped us to achieve our goals.

The first of these objectives led us to the publication of a Newsletter, of which this is the fourth issue, to provide general information as well as detailed scientific know-how to the specialist in the field of E.D throughout the world. This publication was intended to be both informative and entertaining whilst publishing articles on research by leading figures in the field.

In order to expand our communication field we created the new ESIR Web site. Aimed at the medical specialist as well as the general public it has helped to make information available to an even wider audience. The comprehensive web page contains an edition of each of the newsletters published to date ready for download, background information about the society, scientific activities, application form, links to medicine and a guest book to record comments about the site and to request further services or suggestions. A "flash" page helps to get important messages across quickly and effectively, such as congress dates and abstract deadlines. Our statistics show that more and more people are visiting our site from countries around the world. The ESIR's physicians' and patients' guidelines have been put together by specialists and will be made available to both the healthcare providers and the general public.

The physicians' guide to the management of erectile dysfunction represents the culmination of a long process by which this Society wanted to have a leading role in providing information and education to health care professionals.



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In this issue:

- Editorial: The ESIR presents its guides on erectile dysfunction for physicians and patients
- More news and updates of international events in Edoardo Pescatori's calendar section
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- The Rigiscan: Objective assessment of Erectile Dysfunction
- Interview with Václav Michal from Prague
- What's up Doc!

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www.esir.com

It is our belief that many physicians who do not currently treat men with erectile dysfunction may start doing so with the eruption of oral pharmacological therapy on the market. These physicians will therefore require an update on the range of therapies available as well as simple guidelines for the basic work-up procedure.

The patients' guide aims to provide basic information for the patient on erectile dysfunction in a way which is easy for him to understand and to answer key questions. It is also meant to be reassuring, emphasising just how common this problem is and to stress the availability of effective therapies for the vast majority of cases.

Both of these guides will eventually be translated into most European languages and we foresee their distribution through clinics/offices of health care providers, societies and in the case of the patients' guide possibly as inserts in newspapers and magazines.

The ESIR Executive Committee asked Drs. John Pryor and Yoram Vardi to prepare the original drafts which, once finalised, were sent to the members of the newly elected Advisory Board and all of the Executive Committee for their approval. At this stage various comments and suggestions were received at the Madrid Secretariat and these were taken into consideration before the final version was approved. The ESIR Secretariat was responsible for the design and printing of the guides before their presentation at this 8th World Meeting on Impotence Research in Amsterdam in August 1998. The ED specialists who provided us with their comments on these guides were the following:

Vincenzo Mirone	Italy
Eric Meuleman	The Netherlands
François Giuliano	France
Halim Hattat	Turkey
Antonio Allona Almagro	Spain
Alexandre Moreira	Portugal
Hartmut Porst	Germany
David Ralph	United Kingdom
Konstantinos Hatzimouratidis	Greece
Hans Christoph Klinger	Austria
Benny Verheyden	Belgium
Iñigo Sáenz de Tejada	Spain
Gorm Wagner	Denmark
Francesco Montorsi	Italy
Dimitrios Hatzichristou	Greece
Hans Hedlund	Norway

The ESIR Executive Committee would like to express its gratitude to the people who invested a significant amount of time and effort in this important communication project. The efforts of Drs. Pryor and Vardi are specially appreciated.



Iñigo Sáenz de Tejada

We would like to apologise to those of you who are having problems receiving the Newsletter, specially the second issue. The Spanish postal service has had strikes recently and this was further complicated by an error on behalf of the company that handles the mailing. The error consisted of them mailing some of the international newsletters with national postage tariffs, so bear with us if you are asked to pay the difference when it reaches you or if arrives much later than usual. We expect to review this problem after the summer and look for a different company to handle the mailing service.

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 - New products
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IÑIGO SAENZ DE TEJADA

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Management of the buried penis in adults

Michael Sohn

The buried or trapped penis is mostly seen in children. Scarce information can be obtained from literature concerning treatment in adults. In the latter, the condition is mainly due to postoperative scar tissue formation, contracting balanoposthitis, obesity or diabetes mellitus. The condition may interfere with normal urinary function and proper hygiene and may preclude normal sexual activity. In these cases surgical treatment becomes mandatory. Motivated by a recent publication on this topic in the Journal of Urology, we would like to present two typical cases treated at our institution with good surgical outcome.

Case 1:

The first patient (58 years old; no diabetes mellitus) had undergone radical circumcision for severe phimosis and recidivant balanoposthitis one year earlier. Due to ongoing inflammation and abundant foreskin loss during circumcision he developed rigid scar tissue formation and retraction of the penis, even in the flaccid state



Fig. 1

(see Fig. 1). During erection the corpora elevated the surrounding infrapubic skin like a tent which precluded sexual intercourse. There was no significant abdominal fat pad, requiring liposuction or resection.

A circumferential incision was made and a plane just superficial to Buck's fascia developed on the lateral surface of the penile shaft. The dorsal neurovascular bundle was identified and preserved, before resecting all contracting subcutaneous tissue. Ventral dissection was carried down to the scrotum and dorsal dissection down to the suspensory ligament. In order to gain sufficient penile length the suspensory ligament was divided and a small leaf was fixed to Buck's fascia with interrupted 5-0 resorbable sutures (see Fig. 2).

Fig. 2



Adequate skin coverage was only possible by transferring a thick split-thickness skin graft from the right inner thigh to Buck's fascia (see Fig. 3). The graft was mashed 1:1.5 not in order to obtain more surface, but to permit better exudation from the wound bed. More elasticity was obtained by applying the

graft in a spiral fashion. The urethra was mounted with a silastic transurethral catheter and the penis was entrapped in silastic rubber foam (Cavi-Care,) (see Fig.4) for seven days.

Three months later the functional and cosmetic result was excellent and the skin graft maintained its elasticity.



Fig. 3

Case 2:

A 25-year-old man consulted for complete loss of foreskin after ritual circumcision during childhood in Morocco. He had never started sexual relationships with females, because he



Fig. 4

thought his erection would be insufficient for intercourse. The normally developed corpora cavernosa were completely fixed in prepubic scar tissue. The operative procedure was identical to that of case number 1. Division of the suspensory ligament was not necessary because of less infrapubic fat tissue and sufficient penile length. A similar but more excessive split-skin graft was taken from the right inner thigh and applied in a spiral fashion to Buck's fascia. Graft take was uneventful with excellent functional and aesthetic results.

In both cases excessive foreskin loss and subcutaneous scar tissue demanded skin grafting. In other cases adequate skin coverage can be obtained by direct closure, Z-plasty or distant or pedicled flaps. Additional transection of the suspensory ligament should only be carried out in cases of inadequate corporal length after complete scar dissection.

The interposition of a thin leaf of silicone between Buck's fascia and symphysis pubis in or hands prevents subsequent scar formation and adhesion between both structures. Shrinkage of transplanted split-skin graft is less probable, if sufficient amounts of grafts are placed and if a spiral application is chosen.

From the successful operative possibilities described previously, hope for complete relief should be suggested to patients with retracted penises after excessive penile surgical skin loss or inflammations.

John Pryor, Eric Wespes,
Michael Sohn

Clinical Cases



Dear
Colleagues,

Of the many events that will take place in the near future I would like to draw your attention to the 1st International Consultation On Erectile Dysfunction, scheduled for next July in Paris. This new exciting Meeting is sponsored by the World Health Organization (WHO) and the International Union Against Cancer (UICC), and co-sponsored by all the major International Associations in Urology and Impotence Research, including of course both ESIR and ISIR.

The main objectives of the Consultation will be to define the present state of knowledge of the field, to explore and highlight areas of controversy, to propose standardised measures for the assessment of ED, to make recommendations for both basic and clinical research in ED, to recommend standard criteria of response to assess treatment intervention, and to provide clinical practice guidelines for the assessment and management of ED.

1998

August 25-28, 1998 **Amsterdam,**
THE NETHERLANDS

The 8th World Meeting on IMPOTENCE RESEARCH (ISIR) and the 11th Symposium on CORPUS CAVERNOSUM REVASCULARIZATION

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September 17-20, 1998 Singapore,
REPUBLIC OF SINGAPORE
4th ASIAN CONGRESS ON UROLOGY
Contact: Congress Secretariat
Tel. +65 297 7633
Fax +65 297 7560
Email wocp@pacific.net.sg

September 18-20, 1998 **Chieti, ITALY**
LIVE SURGERY: PENILE AND URETHRAL

RECONSTRUCTION

Contact: Clinica Urologica Università di Chieti
Tel +39 871 347803
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October 8-10, 1998 **Munster, GERMANY**
Annual Congress of the GERMAN SOCIETY OF ANDROLOGY
Contact: Ms. F. Seifert
Hauptstrasse 93a, D-61440 Oberursel, FRG
Tel +49 6172 306199

November 13-15, 1998 **Athens, GREECE**
3rd Congress of the HELLENIC SOCIETY OF ANDROLOGY
Contact: Congress Secretariat
MEDLINE, 114 Zan Moreas str., 15231 Athens
- GREECE
Tel +3 1 6773316 or 6755473
Fax +3 1 6722849

December 10-12, 1998 **Pisa, ITALY**
VI International Congress on THERAPY IN ANDROLOGY
Contact: Prof. F. Menchini-Fabris, Pisa
University
Via Roma 67, 56126 Pisa - ITALY
Tel +39 50 553404
Fax +39 50 550033

1999

February 10-12, 1999 **Cairo, EGYPT**
2nd Continental Meeting of the AFRICAN SOCIETY OF IMPOTENCE RESEARCH (ASIR)
Contact: Congress Service Center
14 Syria St., Mohandeseen Guiza - EGYPT
Tel +20 2 3371482
Fax +20 2 3368304
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March 10-12, 1999 **Oviedo, SPAIN**
9th SPANISH CONGRESS of ANDROLOGY
Contact: Dr. C. Garcia-Ochoa
Tel +34 939 949898
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April 7-11, 1999 **Stockholm, SWEDEN**
XIVth Congress of the EUROPEAN ASSOCIATION OF UROLOGY

CARDIOVASCULAR DISEASE, SEXUAL ACTIVITY AND IMPOTENCE

Hartmut Porst

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April 11-13, 1999 **Louisville, Kentucky, USA**
24th Annual Meeting of the AMERICAN SOCIETY OF ANDROLOGY

Contact: ASA Executive Offices
Tel +1 415 7644823
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May 1-6, 1999 **Dallas, Texas, USA**
96th Annual Meeting of the AMERICAN UROLOGICAL ASSOCIATION

Contact: AUA - 1120N Charles St.
Baltimore, MD - 21201 USA
Tel +1 410 2234308
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Email convention@AUAnet.org

June 16-19, 1999 **Copanello (Catanzaro), ITALY**
12th Congress of the ITALIAN SOCIETY OF ANDROLOGY

Contact: Divisione Urologia Ospedale
"Pugliese"
88100 Catanzaro - ITALY
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July 1-3, 1999 **Paris, FRANCE**
1st INTERNATIONAL CONSULTATION ON ERECTILE DYSFUNCTION

Contact: Prof. Saad Khoury
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September 6-9, 1999 **Cairo, EGYPT**
6th Congress of the MEDITERANEAN UROLOGICAL ASSOCIATION

Contact: M. El-Dimiri

October 3-6, 1999 **Istanbul, TURKEY**
3rd Meeting of the EUROPEAN SOCIETY FOR IMPOTENCE RESEARCH (ESIR)

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•Feldman, H.A., McKinlay, J.B., Goldstein, I., Longo, C.: Erectile dysfunction, cardio-vascular disease, and cardiovascular risk factors: Prospective results in a large random sample of Massachusetts men. *J Urol* 159, No.5, Suppl, 91:347

•Anderson, M., Nicholson B., Louie, E., Mulhall, J.P.: An analysis of vasculogenic erectile dysfunction as a potential predictor of occult cardiac disease. *J Urol* 159, No.5, 30:118

•Muller, J.E., Mittleman, A.A., Maclure, M., Sherwood, J.B., Tofler, G.H.: Triggering myocardial infarction by sexual activity. *JAMA* 275, 1405-1409, 1996



These articles consider the co-incidence of erectile dysfunction and cardiovascular risk factors, especially coronary heart disease and the risk of myocardial infarction during sexual activity.

The long-term follow-up of the Massachusetts Male Ageing Study concluded that the risk of moderate or complete ED in patients with cardiovascular risk factors was

(31 %) higher than in an age-matched disease-free control cohort (19,6 %) (Feldman et al). Anderson et al were able to provide evidence that patients with severe arteriogenic impotence, assessed by duplex-sonography, revealed a 16 % risk of suffering from severe, although clinically occult, coronary heart disease if specific cardiovascular investigations were performed. Finally, a retrospective analysis of 1774 patients with acute myocardial infarction referred to 45 US hospitals, came to the conclusion that the relative risk of triggering onset of heart infarction during sexual activity was 2,9 % for patients with a prior angina or infarction, and 2,5 % for patients without a history of prior cardiac disease. In the light of sildenafil already boasting millions of consumers, the first sudden heart deaths reported in the mass media, and the contraindicated use of nitrates in patients taking sildenafil, the aforementioned publications yield an increasing importance.

Before initiating sildenafil therapy it is advisable to assess the cardiovascular status of patients that have risk factors. In addition consideration should be given to the possible risk that resuming sexual activity may have for older men with cardiovascular health problems. We should keep in mind that if cardiac ischemia develops it should not be treated with nitrates, which are routinely used as first line therapy for this emergency situation.

Hartmut Porst

Don't miss...
Literature Review

ESIR

Neural Control of Sexual Function in Males and Females

Kevin McKenna

Research on the neural control of sexual function in males and females has been proceeding largely on parallel paths that are now converging. Recently, a variety of techniques have been used to directly compare sexual pathways in the two sexes. The results of these studies indicate that there is a significant similarity in the pathways controlling male and female sexual function. Sexual responses are produced by spinal centers, which can be activated by genital sensory stimulation and by pathways from the brain.

The pelvic organs of males and females are innervated by sympathetic, parasympathetic and somatic nerves, the hypogastric and sympathetic chain, the pelvic nerve and the pudendal nerve. All three nerves provide a sensory innervation in addition to efferent nerves. The pudendal nerve is primarily responsible for conveying sexual stimulation from the male and female genitalia.

The role of the autonomic sensory fibers in sexual function is unclear. It is well established that penile erection is primarily due to parasympathetic stimulation of vasodilation due to the release of nitric oxide. It is highly probable, but not firmly established, that clitoral and vaginal engorgement, as well as vaginal lubrication are also mediated by nitric oxide mechanisms controlled by the cavernous nerves.

The importance of the cavernous nerves in penile erection has led to the development of nerve-sparing surgery of the prostate. In the female, the pelvic plexus lies on the lateral surface of the cervix. Interruption of these nerve pathways results in the decreased clitoral and vaginal responses of sexual arousal. There is an urgent need for the development of nerve-sparing hysterectomy procedures to prevent the female sexual dysfunction that so often results.

Neuroanatomical studies have demonstrated that the spinal organization of pelvic afferents, efferents and interneurons are very similar. There are quantitative differences due to the peripheral differentiation. The physiological manifestations of sexual arousal and climax can be demonstrated following spinal transection in experimental animals and spinal cord injured patients. The rhythmic pelvic contractions during climax are remarkably similar in both sexes.

These findings indicate that spinal sexual pathways are functionally similar.

The spinal reflex pathways are under excitatory and inhibitory control by supraspinal brain areas. A strong inhibitory control is provided by serotonergic neurons in the nucleus paragigantocellularis in the rostral medulla. This pathway may be the substrate for the anorgasmia commonly seen in both sexes following SSRI antidepressants.

An excitatory pathway that has been identified is from the paraventricular nucleus (PVN) in the hypothalamus. The neurotransmitter is oxytocin. The PVN is stimulated by genital stimulation. Oxytocin is released in both sexes during sexual arousal and climax. The PVN is also extensively connected with a variety of limbic structures intimately involved with reproductive behavior, especially the medial preoptic area (MPOA), the medial amygdala and the bed nucleus of the stria terminalis (BNST). Neurons in these areas are activated during copulation in both sexes. These areas are also sensitive to gonadal hormones, providing a substrate for the endocrine control of sexual behavior.

Andersson, K.-E. and G. Wagner (1995) The physiology of penile erection. *Physiol. Rev.* 75: 191-236.

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Rose, J. D. (1990) Brainstem influences on sexual behavior. In: *Brainstem Influences on Sexual Behavior*. Edited by W. R. Klemm and R. P. Vertes. John Wiley & Sons, Inc., New York.



Karl-Erik Andersson
and François Giuliano

BASIC RESEARCH
HIGHLIGHTS

A contribution from Portugal

Alexandre Moreira



The treatment and diagnosis of erectile dysfunction in Portugal has experienced tremendous development in recent years, and the number of impotent patients who visit the physician to help them solve their problem has increased accordingly.

The Portuguese Society of Andrology founded in 1980, has worked hard to raise public and professional awareness of the field of erectile dysfunction through its scientific meetings and especially the National Congress. Meetings to discuss this pathology have also been held in different hospitals throughout the country. This Society presided by Dr. Antonio Requixa a urologist from Coimbra, has about 250 members from different specialities including endocrinologists, vascular surgeons, geneticists and sexologists. It is however urologists

and endocrinologists who are the most active in the treatment of patients suffering from impotence.

The Portuguese Society of Sexology, founded in 1984, whose president is Dr. Jose Pacheco, a psychologist from Lisbon, now numbers about 380 members, mainly psychiatrists and psychologists. This association has been very active in the field of erectile dysfunction and the co-operation between both societies is very positive.

Medical centres dealing with the care of impotent patients are located in Lisbon, Coimbra and Porto. Like many other countries in Europe only a small percentage of the total number of impotent patients, an estimated 500 000, seek medical help for their problem. Currently, the most common treatment used is the auto-injection of Prostaglandin (PGE1), followed by the implantation of penile prostheses and the use of vacuum devices. The MUSE intraurethral system, moxislyte and sildenafil are expected to be available at the end of 1998.

Scientific exchange and collaboration with Spanish colleagues has been a constant feature of our scientific activity. Two Iberian meetings have been held to date, one in 1994 (Povoa do Varzim, Portugal) and another in 1996 (Badajoz, Spain). In the last meeting of the European Society for Impotence Research in Madrid a joint Portuguese-Spanish meeting was also held to strengthen the links that exist between the two countries in the area of Impotence Research.

From 17th- 20th September, the Portuguese Society of Sexology will organise the 4th Congress of the European Federation of Sexology and the first Iberian Meeting of Sexology with discussion and debate on the subject and treatments for erectile dysfunction. This is a meeting of great interest in the field of ED which we invite members of ESIR to keep in mind for 1998.

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The Objective assessment of erectile dysfunction: THE RIGISCAN

Clive Gingell
and S. Gepi-Attee

Introduction

Erectile dysfunction (E.D.) is a continuum of sexual dysfunction ranging from the complete inability to achieve an erection to almost full erection but failure to penetrate or maintain.

Against the background of patients' expectations and the notorious unreliability of self-



Fig. 1

assessment, the uro / andrologist has first to confirm the presence of erectile dysfunction (E.D.) and then determine its likely aetiology and severity in order to institute appropriate treatment. The difficulty with the management of E.D. lies partly in the fact that the patient's case history, in most instances, forms the basis upon which the diagnosis is made. Significant findings on clinical examination are usually absent with the exception of Peyronie's disease and hypogonadism.

The clinical history, however, reflects the patient's perception of his performance which is entirely subjective. Although the distinction between organic and psychogenic E.D. is not critical in the goal orientated approach to management, there are certain clinical situations when it is extremely important to establish whether the patient does or does not have erectile activity when exposed to visual sexual stimulation (V.S.S.) or erections on nocturnal penile tumescence monitoring (N.P.T.).

Erectiometer and Snap-Gauge

Following the early work of Karacan monitoring N.P.T. a readily applicable method to monitor nocturnal erections was

the introduction of postage stamps circumferentially applied to the penis. An adequate erectile event was indicated by rupture of the stamp ring. The main disadvantage was the variability of the force required to rupture the stamps, making standardisation impossible. This simple principle was better refined and applied in the introduction of circumferential bands for measurement of rigidity.

The two in common use are the erectiometer (Walter Koss, Geisenheim/Rhein, Germany) and the snap-gaug (DACOMED, Minnesota, USA) (Fig. 1). The former uses the resistance between a band and sliding collar which requires a minimum specified force for extension.

There are two such bands in a kit, each requiring forces of 250 and 450 grams respectively to extend the band. The bands are re-usable and the measurements are taken nightly, alternating the bands and altering their position on the penis over a period to obtain an overall semi-quantitative assessment of erections. The snap-gauge, in contrast, is not re-usable. It uses an arrangement with three colour-coded strips which would rupture in a predetermined order under force applied for a specific duration. The pattern of rupture indicates the quality of erection - all the strips rupture with adequate erection.

The main problem with snap gauges and erectimeters is that they are indicators of single events. Even though the measurements can be repeated, they do not give detailed information in terms of duration of erection, frequency of erections and variation of quality during an episode of erection. The main advantage is their suitability for outpatient application, but their usefulness is restricted by the limited information they provide.

RIGISCAN

The Rigiscan (DACOMED, Minnesota, USA) is increasingly becoming established as a clinical and research tool for objectively assessing erectile activity. It is an innovative device which combines comprehensive monitoring with portability. The main apparatus is a small unit approximately 21.0 x 5.0 cm and weighs 1.65 kg. It houses a clock, data logger, communications unit and two torque motors.



Fig. 2

The motors intermittently winch steel cables which run freely through the conduits called cable guides. The system applies the principle of tonometry, by which deformity of a surface caused by a force of known magnitude is measured similar to the measurement of intraocular tension using the Schiøtz tonometer. In ocular tonometry, the deforming force is applied to the eyeball by a solid cylinder causing local denting of the surface of the eye-ball. In contrast, the Rigiscan uses two steel cables noosed around the base and distal parts respectively of the penis.

The "slip-knot" of the noose is a snap-clip capable of disengaging when pulled firmly. The motor applies a force of 3 ounces every 15 seconds to measure tumescence. Once an increase in tumescence of 1 cm or more is detected, a force of 10 ounces is applied every 30 seconds to measure rigidity. During a rigidity measurement the cable will fail to shorten around an unyielding object.

This is 100% rigidity and is the basis on which lesser degrees of rigidity, as indicated by cable shortening, are calculated by the device. Though this is not a measure of true axial rigidity, it correlates well with intracavernosal pressure and axial rigidity measured by bucklometry.

Monitoring with Rigiscan

The unit is strapped to the patient's thigh or abdomen and the loops are placed round the base and the tip of the penis - colour coded blue and white respectively. Once the monitor is turned on it samples and records continuously during the session. A normal recording during Visual

Sexual Stimulation (V.S.S.) comprises persistent good quality erections (greater than 70% rigidity). A normal nocturnal pattern varies from 4 - 6 erections in which the base and tip activity shows a similar pattern and rigidity corresponds with increase in penile girth. (Fig. 2.)

The rigiscan has a maximum capacity to monitor and store information from three 10-hour sessions. This must then be downloaded through a computer using proprietary Rigiscan software onto floppy disks for storage. Detailed quantification of erectile activity can be obtained using the Summary Analysis Software. The numerical data produced include values of rigidity and tumescence and their absolute durations in addition to time-related activity measurements of rigidity and tumescence, TAU and RAU. These data are of enormous value in comparing the effectiveness of different treatments, particularly in placebo controlled prospective double blind cross-over studies to evaluate new pharmaceutical preparations.

Summary

The Rigiscan is an effective, convenient and accurate system for recording nocturnal erectile activity and response to V.S.S. with very high patient acceptability. It is suitable for home use and is an invaluable tool to assess the potential of new preparations designed to treat E.D.

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Interview with Professor Michal

Hans Hedlund



Almost twenty years have passed since papaverine was introduced as a diagnostic and therapeutic tool in the management of male erectile dysfunction (ED). Today, there is worldwide experience with self-injection programmes. On the other hand, intraurethral application is already in the market, and very soon oral therapy will be available to patients and doctors.

How much has pharmacological development changed our attitude and consideration of impotent patients, and how much will the global aspect of ED change, when oral therapy becomes available on the market?

Intracavernous injections of the smooth muscles-relaxing pharmaceuticals changed the basic diagnostic procedures and therapeutic approach to ED. They do substitute efferent vegetative impulses and are effective in all types of ED, except in severe impairments of the hemodynamics of erection. The introduction of PGE₁ was a very important step for safety aspect of self-injections and represented a substantial decrease in the risk of priapism and fibrosis. The latter appears mostly after ineffective injections due to an incorrect injection application-technique into the tunica, septum or trabecules.

I have no experience with urethral application. However, in my opinion, intracavernous injections will always be more effective than transurethral application and associated with a lower incidence of general side effects.

The development of oral pharmaceuticals with a specific relaxing effect on the cavernous smooth muscles (sildenafil) could have an effect on the management of ED similar to that of nitrates in the handling of coronary heart disease. However, intracavernous application of PGE₁ should (in my opinion) also be effective in a certain portion of non-respondents to oral therapy.

We have accepted a high drop-out rate in men following self-injection programmes, specially during the early treatment period. Given your experience, do you have any practical advice which could help to reduce this number of drop-outs?

It has been reported for example, that the use of more "friendly" application systems such as autoinjectors have considerably reduced the early drop-out rate. What is your reaction to this?

I have no experience with autoinjectors. There is probably a greater danger of misapplication and development of fibrosis.

Intracavernosal injection therapy is widely accepted as the gold standard treatment for ED. Do you believe we run the risk of forgetting about the deeper and main aspects of sexual disturbance (dysfunction) and are more concerned about "creating" erectile athletes?

This is true in part. Vascular disease (macroangiopathy of afferent arteries, microangiopathy of the cavernous vascular bed) is a substantial component of ED in the age groups around and over 40 years. We should try to eliminate or minimise the influence of the risk factors of further development of arterial disease (smoking, hypercholesterolemia, diabetes, hypertension). Usually, we are only concerned with restoration of erections.

Within a wider perspective, the results of vascular surgery for ED are not encouraging, although some young patients with insufficient arterial inflow may restore their erectile function and revascularisation. Should we try to treat such patients medically with intracavernosal or intraurethral alprostadil today and with oral medication such as sildenafil tomorrow, without any work-up, or shall we refer them to national centres with certain expertise in this field?

Special (angiologic) examinations should be indicated in the patients who also have symptoms of arterial disease in the tributary of the iliac and/or hypogastric arteries (intermittent claudication, buttock claudication, pelvic steal syndrome, murmurs or non-palpable pulse over common femoral arteries). Invasive radiology (percutaneous transluminal angioplasty) or vascular surgery can often restore not only blood-flow to the lower extremities and/or gluteal muscles but also to the corpora cavernosa and improve erection.

Intracavernous injections of PGE₁ in increasing dosage up to 30 ug of PGE₁ will differentiate severe organic impairment of the hemodynamics and candidates for self-injection treatment. These patients can be recommended this medication as the best modality of management (sildenafil to a proportion of them in the future).

The non-respondents should be offered further investigation and some possibility of improvement and restoration of erection via revascularization procedures, penile implants or by trying with a vacuum device.

What's up doc!

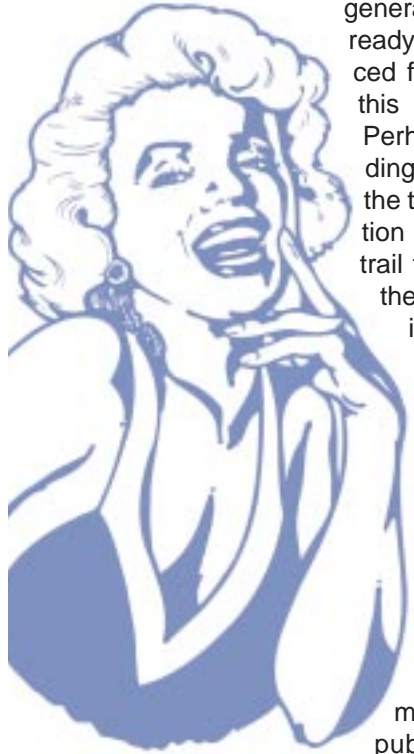
Even before Marilyn Monroe brushed away any doubts about the sensual attraction most Americans felt for the impressive Niagara falls, generations of newly-weds had already discovered and experienced for themselves the power of this impressive natural wonder. Perhaps it is the similar-sounding name of a new product for the treatment of erectile dysfunction which has helped blaze a trail from the urologist's office to the local chemist. Or maybe it is the naive hope of endless youthful erections, which has made the average American man prick up his ears and really listen for the first time since the last pledge to bring down taxes.

After all, who would think that an innocent little blue pill for a medical condition more apt to be hidden from public notice would provoke hundreds of born-again machos to take to the streets and boast about using and abusing this "vigour-restorer".

My guess is that this pill has touched an even more sensitive organ than that for which it was originally created, namely the brain. Just when we all thought it was safe to talk about new-age sexual relationships in terms of commitment and sharing, sex in the form of strong and enduring erections rears its head to claim lost territory. Middle-aged men, brought up to admire traditional symbols of virility have found a chemical ally for their varied sexual handicaps.

Comments from such sources as Penthouse magazine claiming it will "free the male libido from the emasculating doings of feminism" have helped send share prices of the manufacturing company of this "surpriser" sky-rocketing, marrying two timeless values, money and sex, into the bargain.

Why have men without erection problems jumped on the bandwagon? Is it because they think action speaks louder than words in relationships?



MILLY

HUMOUR