

NEWSLETTER

The ESIR expands to include female sexual dysfunction among its scientific activities



Women have sexual problems and these have received little scientific, psychological or medical attention. Only recently has this issue been revisited largely influenced, in some scientific communities, by the impetus brought about by the successful treatment of sexual problems in the male. Consensus conferences and specialised meetings are working towards defining female sexual dysfunction and its types, how to diagnose these alterations and finally how to treat them.

To approach female sexual dysfunction it seems reasonable to look back at the work, scarce but significant, that has been carried out in the field and to delve further into the many unresolved issues. It would be naive to extrapolate what we have learned about the physiology and pathophysiology in the male over the last fifteen years to the female. Avoiding this oversimplification would seem to be critical since it appears that investigators in the field of male sexual dysfunction are taking a leading role in steering the way towards research in female sexual dysfunction.

Women have been given sildenafil for a variety of sexual problems but it's efficacy is unclear and we are presently awaiting results of appropriately controlled studies. An example of an overly simplistic approach to female sexual dysfunction is the current clinical use of sildenafil in women with a variety of sexual complaints and in whom its efficacy is as (yet) unknown, presently awaiting results of appropriately controlled studies. The physiology and pathophysiology of sexual response in the female needs to be investigated before the ad libitum administration of "pills" known to be effective in the male.

Scientific societies such as ours dedicated to male sexual dysfunction want to expand and incorporate female sexual dysfunction among their interests and scientific activities. The ESIR has hosted sessions in its scientific meetings on female sexual dysfunction. This was the case in ESIR '97 in Madrid and will be the case in the forthcoming meeting in Istanbul, (January 30th - February 2nd 2000). Incorporating female sexual dysfunction into the ESIR will mean that new people with different backgrounds will join us and I believe that our young scientific society has the flexibility and open-mindedness to adapt to these changes. The name of our society will also have to change to reflect its interest in the female and its more global approach to the scientific issues relating to human sexuality. Specific proposals on this issue will be brought to the membership in the business meeting in Istanbul. We welcome these exciting times of change and scientific expansion.

Iñigo Sáenz de Tejada - President ESIR

NEWS FLASH 3rd Meeting of the European Society for Impotence Research

It is a great pleasure to announce that following exhaustive efforts on behalf of the Turkish local organisers and the ESIR Secretariat in Madrid an alternative site has been secured for the Istanbul meeting. **This meeting will now be held in Barcelona, Spain on the same dates 30th January - 2nd February 2000.** The scientific programme will remain the same and we will keep everyone informed of any minor changes if and when they happen. All information about the venue will be available in the next few days on our Website.

All registered participants will have their registrations transferred to the new site and new registrations can be made through the ESIR Secretariat in Madrid. If you have any doubts please contact us at any time.

The Executive Committee of the ESIR would like to thank the Local Organising Committee in Istanbul for all their hard work and understanding with regard to this change of venue. We would also like to express our sincere desire and support for a meeting of our Society be held in Istanbul in the near future.

We look forward to seeing you all in Barcelona very soon.

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- *And finally, how do you measure up?, a humorous look at size and vice!*

VISIT OUR WEBSITE
www.esir.com

Barcelona Congress

January 30th 2000, Sunday

1. OPERATIVE TEACHING SESSION

(Pre-registration required)

Venue: Cerrahpasa School of Medicine, Operating Room (live broadcasting to audience)

09.00 – 13.00 CASES

- 1- Venous patch in Peyronie's Disease **E. Austoni**
- 2- Penile prosthesis (3 piece) **S. Wilson**
- 3- Penile prosthesis **H. Hattat**

2. TEACHING COURSE (ESIR SPEAKERS)

Basic Management of Erectile Dysfunction

08.30 -10.30

A) Chairman: **E. Akkus**

- 1- Introduction, Definition, Prevalence **E. Akkus**
- 2- Mechanism of Erection **F. Giuliano**
- 3- History taking, Questionnaire **R. Lewis**
- 4- Physical and Endocrine Evaluation **E. Meuleman**

Basic Tests and Indications for Further Investigations.

- 5- Assessment of Vascular State **F. Montorsi**
- 6- Assessment of Neurological State **Y. Vardi**

10:30-10:50 **Coffee Break**

10.50-12:00

B) Chairman: **Y. Vardi**

- 1- General Management and Objectives **J. Pryor**
- 2- Psychosexual Counselling **T. Barnes**
- 3- Oral Therapy and Hormones **J. C. Gingell**
- 4- Erectile Dysfunction in Primary Care and Vacuum Device **J. Dean**

12:00-12:20 **Coffee Break**

12.20 -13.30

C) Chairman: **S. Tellaloglu**

- 1- Injection Therapy and MUSE **H. Porst**
- 2- Surgical Management of E.D. **E. Wespes**
- 3- Peyronie's Disease **A. Kadioglu**
- 4- Future Aspect of E.D **D. Hatzichristou**

13.30 – 15.30 **Lunch**

15.30- 17.00

17.15 – 19.00

SATELLITE SYMPOSIUM (ABBOTT)

19.30 – 20.30

OPENING CEREMONY

20.30 – 22.30

WELCOME RECEPTION

January 31st 2000, Monday

08.00 - 08.30 **STATE OF THE ART LECTURE**

Chairman: **I. Sáenz de Tejada**

“Overview of current perspective of Pharmacotherapy **H. Padma- Nathan of E.D.**”

08.30 – 09.50 **PODIUM SESSION**

Pharmacological Experiences
Chairmen: **H. Porst / R. Lewis**

09.50 – 10.10 **Coffee Break**

10.10 – 11.10 **SYMPOSIUM**

Cardiovascular considerations in E.D.

Chairman: **E. Pescatori**

Basic Concepts **J. P. W. Heaton**

PD inhibitors and cardiovascular effects **Y. Vardi**

Cardiovascular effects of alpha blocking agents

Dr. Drori

Cardiovascular risk factors in erectile dysfunction

A. Ledda

11.10 – 12.20 **PODIUM SESSION**

Diagnostics

Chairman: **J. Buvat / E. Austoni**

12.20 – 13.00 **POINT & COUNTERPOINT**

Chairman: **E. Meulemann**

Does testosterone have importance in the treatment of E.D.?

In favour **A. Kadioglu**

Against **W. Alexander**

13.00 – 14.00 **Lunch**

14.00 – 15.30 **SYMPOSIUM**

A) **Central Mechanism of Erection**

Chairman: **F. Giuliano**

Role of the paraventricular nucleus of the hypothalamus **A. Argiolas**

Central nitregic pathways **A. Benelli**

Opioids and male sexual behaviour **A. Agmó**

Descending oxytocinergic pathways to the spinal cord **O. Rampin**

B) **Surgery of E.D.**

Chairman : **M. Sohn**

Vascular penile surgery in E.D.-The Pros **D. Hauri**

Vascular penile surgery -The Cons **E. Wespes**

Surgery in Peyronies Disease **C. Bettocchi**

Surgical Reconstruction of the Penis **M. Sohn**

15.30 – 16.00 **Coffee Break**

16.00 – 17.15 **POSTER SESSION**

A- **Surgery**

Chairmen: **C. Gingell / V. Mirone**

POSTER SESSION

B- **Pharmacology**

Chairmen: **J. Chen / I. Eardley**

Barcelona Congress

- 17.30-19.00 **PFIZER SATELLITE SYMPOSIUM**
- "Viagra :1st Line Pharmacological Therapy for ED"
Introduction I Sáenz de Tejada
- Viagra in the treatment of ED I Eardley
- Viagra in special populations H Porst
- Treatment of ED and referral Criteria in primary care G Hackett
- Criteria for referral to a cardiologist G Jackson
- Treatment guidelines from the 1st International Consultation on ED F Giuliano
- What guidance should be given to non-ED specialists ? I Sáenz de Tejada

February 1st 2000, Tuesday

- 08.00 -08.20 "HIGHLIGHTS"
A. Allona
F. Sasso
- 08.20 -08.50 **STATE OF THE ART LECTURE**
Chairman: S. Tellaloglu
"Serotonin and Ejaculation" S. Haensel
- 08.50 -09.50 **PODIUM SESSION**
Basic Science
Chairmen: O. Rampin / H. Hedlund
- 09.50 -10.15 Coffee Break
- 10.15 -11.30 **ROUND TABLE**
Female Sexual Dysfunction
Chairman:G. Wagner, R. J. Levin, A. Graziottin
K. Fugl Meyer
- 11.30 -12.30 **PODIUM SESSION**
Sexual Function & Dysfunction
Chairmen: A. Graziottin / P. Bondil
- 12.30 -13.00 "SPECIAL LECTURE"
Report on First International Consultation on Erectile Dysfunction" A. Jardin
- 13.00 -14.00 Lunch
- 14.00 -15.30 **SYMPOSIUM**
Who needs Guidelines for E.D?
Chairman: J. Pryor
European guidelines E. Wespes
USA guidelines Process of Care
H. Padma-Nathan
ESIR- guides J. Pryor
- POSTER SESSION**
Sexual Dysfunction
Chairmen: D. Ralph / A. Moreira
- 15.30 -16.00 Coffee-Break
- 16.00 -17.00 **SYMPOSIUM**
Prevention of E.D. Chairman: D. Hatzichristou
Predictors of ED A.M. Morales

Chronic diseases U. Simonsen
Iatrogenic ED F. Montorsi
Drug-induced ED E. Akkus
Development of prevention strategies for ED
D. Hatzichristou

POSTER SESSION
Basic Science
Chairmen: G. Wagner / B. Verheyden

17.15 -18.30 **BUSINESS MEETING**

20.30 **GALA DINNER**

February 2nd 2000, Wednesday

- 08.00 – 08.20 "HIGHLIGHTS" B. Alici. Popken
- 08.20 - 08.50 **STATE OF THE ART LECTURE**
Chairman: H. Hattat
"Psychosexual therapy for erectile disorders.
M. Crowe
Still necessary in spite of Viagra?"
- 08.50 -09.10 "SPECIAL LECTURE"
The Physiology of Ejaculation S. Haensel
- 09.10 -10.35 **PODIUM SESSION**
All about E.D
Chairmen: H.C. Klingler/ K. Hatzimouratidis
- 10.35 -10.50 Coffee- Break
- 10.50 -11.10 "SPECIAL LECTURE"
Future Management of E.D. R. Lewis
- 11.10 -12.10 **ROUND TABLE**
Patient Education
Chairman: J. Pryor. M. Lemos
D. Hatzichristou A. Craig
- 12.10 -13.10 **PODIUM SESSION**
Surgical Considerations
Chairmen: I. Moncada/ F. Montorsi
- 13.10 -13.40 **TAKE HOME MESSAGE**
Basic - I. Sáenz de Tejada
Clinical - F. Giuliano



Meetings Calendar and Reports



Edoardo Pescatori

November, 25-27, 1999 Milan, **ITALY**
EUROPEAN SOCIETY FOR MALE GENITAL SURGERY - SECOND CONGRESS
Consulting Organizer: OMNIA MEETING & CONGRESSI S.r.L., Via Torino 29, 00184 Rome
Tel. +39 06 4871366
Fax +39 06 4815399
Email omniameeting@interbusiness.it
web site www.omniameeting.com

January 30th-February 2th, 2000 **Istanbul, TURKEY**
3rd Meeting of the EUROPEAN SOCIETY FOR IMPOTENCE RESEARCH (ESIR)
Contact: Congress Secretariat PERA Organization
Rumeli cad. 124/5, 80260 Osmanbey, Istanbul -TURKEY
Tel. +90 212 2305535
Fax +90 212 2304923
Email serpilb@antmarin.com.tr

February, 9-13, 2000 **Geneva, SWITZERLAND**
THE 2nd WORLD CONGRESS ON THE AGING MALE
Contact: Kuoni Congress, PO Box 1731
7 Rue de Berne, CH-1211, Geneva 1, SWITZERLAND
Tel. +41 22 9081855 Fax +41 229081835
Email CONGRESS.GENEVA@KUONI.CH
<http://www.kenes.com/aging/>
Deadline for abstract submission: November 1st, 1999

March 29-31, 2000, **Cairo EGYPT**
1st MEDITERRANEAN CONGRESS OF SEXUAL DYSFUNCTION
Contact: Congress Service Center (C.S.C.), 14 Syria St., Mohandeseen, Guiza - EGYPT
Tel. 202 3371482
Fax 202 3368304
Email cscasf@pacc.com.eg
Deadline for abstract submission: December 31st, 1999

March 30 - April 1, 2000 **Palma de Mallorca, SPAIN**
8th INTERNATIONAL SYMPOSIUM ON ANDROLOGY
1st INTERNATIONAL MEETING ON FEMALE SEXUAL DYSFUNCTIONS
Contact: Centro de Urología, Andrología y

Sexología
c/o Santiago Rusiñol, 9; Planta, 07012 Palma de Mallorca, Baleares, SPAIN
Tel. +34 971 714733
fax +34 971 726519
Email cuasba@atlas-iap.es
web site <http://www.atlas-iap.es/cuasba>

April 9-11, 2000 **Cambridge, Massachusetts, U.S.A.**
25th ANNUAL MEETING OF THE AMERICAN SOCIETY OF ANDROLOGY
Organizing Secretariat: ASA Executive Offices,
74 New Montgomery, Suite 230
San Francisco, CA 94105, USA
Tel: 415-764-4823 Fax: 415-764-4915
E-mail: 105037.1120@compuserve.com

April, 12-15, 2000 **Brussels, Belgium**
XVth CONGRESS OF THE EUROPEAN ASSOCIATION OF UROLOGY (EAU)
EAU Congress Office - EAU 2000: PO Box 30016, 6803 AA Arnhem, The Netherlands
Tel. +31 26 3890680
fax +31 26 3890686
Email p.debont@uroweb.nl
n.vandervoort@uroweb.nl

April 29 - May 4, 2000 - **Atlanta, GA, U.S.A.**
95th ANNUAL MEETING OF THE AMERICAN UROLOGICAL ASSOCIATION (AUA)
Email: convention@auanet.org

May 24-27, 2000 Chiba, Japan
3rd ASIAN AND OCEANIC CONGRESS OF ANDROLOGY
Scientific secretariat: Haruo Ito, M.D., Ph.D,
Dept. of Urology, Chiba
Tel: 0081-43-2262134; Fax: 0081-43-2262136
E-Mail: itoh@med.m.chiba-u.ac.jp

November 26-30 2000 **Perth, Australia**
9th WORLD MEETING ON IMPOTENCE RESEARCH, incorporating the 12th SYMPOSIUM ON CORPUS CAVERNOSUM REVASCULARIZATION
Conference Secretariat: Promaco Conventions Pty Ltd, PO Box 890, Canning Bridge WESTERN AUSTRALIA 6153
Email: promaco@promaco.com.au

Modena, November, 1999
Edoardo S. Pescatori
(E-mail: urolpoli@unimo.it)

INTERVIEW

with John Pryor, incoming president of the ESIR

The 3rd biennial congress of the ESIR is taking place in Istanbul at the end of January 2000. This meeting will be chaired by John Pryor who is also chairman of the scientific committee and will take over as the next president of ESIR from Iñigo Sáenz de Tejada.

John, may I first congratulate you on becoming the next president of ESIR.

You need no further introduction being well-known to our readers and one of the leading authorities in both urology and andrology.

The ESIR was the result of political discussions close to the ISIR congress in Singapore. I remember the quite emotional process, when ESIR was initiated. I think that our European association for impotence has really had a shock start considering that our first meeting in Thessaloniki was only four years ago,

What is your view of the ESIR and what do you expect of yourself and our association in the near future?

And do you think that the two organisations will continue to co-operate, when we have crossed over to the next century with a new generation of experts in penile physiology and erectile dysfunction ?

My belief is that ESIR was founded to co-ordinate the European continent's organisation for impotence and its research and has since been broadened not only to include education of both physicians and patients but also to sexual dysfunction as a whole. I see myself as the conductor who is orchestrating this change in ESIR. I am sure that ESIR should work closely not only with ISIR but also with organisations in individual countries or groups of countries. It is important that doctors, patients and the pharmaceutical industry should have a clear perception of organisations dealing with ED and its associated problems.

The ESIR Newsletter followed the Madrid meeting led by Iñigo Sáenz de Tejada, who was elected second president of ESIR. To my knowledge, the Newsletter has found its readers and is well accepted. Also, you yourself have obligations together with Eric Wespes and Michael Sohn in the "Questions and answers about clinical cases" section. Will you as the next president of the ESIR maintain the present

structure of the Newsletter or do you have ideas or suggestions for innovations?

I agree that the Newsletter has been an outstanding success and expect it to continue as such. I would not set out to change it but would expect it to evolve in keeping with the evolution of our society.

In general, we are now almost avoiding the use of the word impotence. Erectile dysfunction or ED has become the standard expression. I think it is natural as most medical alternatives focus on the erectile component of the impotent male. Also, we are now dealing with female sexual dysfunction. Would you suggest that we replace ED with female and male sexual dysfunction, FSD and MSD, as two separate definitions and subdivide the two different concepts according to the individual problem?

I am wary of semantics but changes have occurred over the past ten years. Most patients understand the term impotence but the use of erectile dysfunction by physicians emphasises their increased understanding of the pathophysiology of the disorder. It is a pity that the acceptance of ED as a complex medical problem has been jeopardised in some quarters by the cost implications of pharmacological treatment. I hope that we have now progressed beyond saying that ED is organic or psychological and I think that it would be wrong to rigidly divide sexual function into male and female disorders. An overlap is common and it seems sensible to talk about specific disorders and recognise the effect that it may have on the other partner.

The concept of female sexual dysfunction and different aspects of research in the female was initiated as you know by Irwin Goldstein and the Boston group. Personally, I think this field will become as interesting as male erectile dysfunction has become over the last decade. John, what is your opinion about female sexual dysfunction? Can we expect gynaecologists and sexologists to appear on the scene, or will the frontiers between urology and psychiatry continue to control the female issue?

Certainly female sexual dysfunction is now on the agenda and research groups are beginning



INTERVIEW

to understand its pathophysiology. I suspect that other research laboratories will follow the lead given by Boston and extend their research in sexual function into females. I also suspect that gynaecologists and sexologists will be awakened by the outcome of this research and show an increased interest in female sexual dysfunction. On a more practical level I suspect that the numbers of urologists who become involved in the management of female sexual dysfunction will not be large. I think that urologists came into male sexual dysfunction by accident and by the realisation that our basic understanding of male sexual function was limited. There is not this drive from surgical experience on the female side and therefore I do not think that urologists will be concerned with the treatment.

Referring to the present ESIR congress in Istanbul Iñigo Sáenz de Tejada wrote a special invitation letter to all members, encouraging them to participate in this meeting. Do you think, that our members will follow this lead? Will you also please comment on the number and quality of the abstracts received for the meeting.

I am sorry that the Istanbul meeting has had to be postponed but with earthquake activity in the region persisting I think that there was no alternative. The first priority must be for the region to start reorganising following this terrible tragedy and I am sure that this will be well under way by the end of January. We had almost 350 abstracts of good quality and each member of the Scientific Committee marked the anonymised abstracts. We were therefore able to chose excellent presentations and I am sure that the meeting will have a high scientific quality. We have tried to make for a varied meeting with podium presentations, posters and round tables etc.

At the ESIR congress in Amsterdam some national European representatives, including yourself, participated in a special informal conference initiated by The Impotence Association in UK. The proposal of that meeting was to investigate the degree of interest in an alliance of European countries to set-up national help-lines or associations providing help for sexual dysfunction sufferers. Do you think that such programs will count with the

support of the ESIR and the EAU, and shall we try to create a special communication system or structure for all the individual help-lines?

The European Sexual Dysfunction Alliance (ESDA) is a central organisation to help individual countries run independent help-lines and information services for the benefit of patients – as opposed to doctors. Since the UK one was established in 1996 it has received more than 50 000 telephone calls and has had 285 000 hits on its web site in its first 11 months. It is also seen as an information service by journalists in the UK and overseas. I am delighted to say that there are now similar organisations in Germany, Spain, Greece, Italy and Portugal and three or four other countries are following this autumn. I believe that as such groups act locally for each country, they must be locally organised but at the same time it is helpful for there to be a central means of facilitating their establishment, funding and organisation.

Finally, I want to hear your own personal view of what is around the corner in terms of treatment for erectile and sexual dysfunction. Will gene therapy become a realistic alternative within 10 years? Do you think that special combination programs with available medical alternatives will become reasonable treatment options, which we as medical authorities will prescribe?

I will confine myself to the next five years. During this time we will see other agents established in the treatment of ED and a more holistic approach to its management. We will see an increase in the number of patients seeking help for a wider range of dysfunctions. This will in turn increase the amount of basic research that is performed. I suspect that the next decade will be a period of expansion rather than consolidation.

The readers of the Newsletter including myself wish you a good presidentship and we all look forward to an excellent congress in Istanbul.

*John Pryor
The Lister Hospital
LONDON UK*

Clinical Cases

Michael Sohn

A 26 year old male presented with complete erectile failure after priapism due to intracavernosal self-injection of soap-solution under ecstasy-consumption. This rare episode of self-stimulation leading to self-mutilation took place one year before presentation. Following the soap-injection he developed a long lasting priapism and necrosis of the urethra and part of the glans. Treatment with



Fig. 1

Winter-shunts and Grayhack-shunts could not resolve the priapism nor prevent tissue necrosis. After six months of suprapubic urinary drainage the penile urethra was reconstructed with preputial skin. Due to repeated fistula formation several operative sessions for urethral reconstruction were necessary until May 1998. Fig 1 shows the penile aspect at presentation for complete erectile dysfunction. At palpation, no intact corpora could be identified on either side. Only at the crural level perineal

palpation revealed remainders of erectile tissue inside the corpora. The glans showed severe mutilations, half of the penile circumference was occupied by the neourethra, surrounded by scar tissue (see fig. II). Cavernosography demonstrated complete destruction of both corpora and injection of 20 mg PGE1 had no effect on tumescence or rigidity.

The young patient desperately wanted to restore erectile function. He agreed to a trial of prosthesis implantation and penile remodelling. In case of failure or infection, a secondary procedure with neopenis reconstruction from a radial free forearm flap was determined in advance.



Fig. 2

During the operation the urethra was completely freed from the obliterated tunica albuginea and surrounding scar tissue (see fig. III). The glans was remodelled and the remaining tunica of both corpora flattened to a single plate. On the right side the crus penis could be reopened and sharply dilated, using the cavernotom produced by UROAN Electromedicina, Palma de Mallorca. This instrument allowed a dilation up to 11mm for a

length of 5 cm. For coverage of the remaining circumferential defect, woven Dacron" was used as a modified wind-sock (see fig. IV). A single cylinder of 14 cm in length of an AMS CXM prosthesis (9.5 mm Δ) was selected for implantation. The pump was implanted



Fig. 3

into the right scrotum through the same longitudinal penoscrotal incision, , and a second inguinal incision facilitated the intraperitoneal implantation of a 50 ml reservoir. The tube systems were connected and the second tube from the pump occluded by a metal plug, fixed by prolene suture. The neourethra was shortened and sutured into a coronal position (see fig. V). The wound was repeatedly irrigated with betaisodona-refobacine-solution and H2O2. Double intravenous antibiotics in the mid-shaft region immediate coverage by a pedunculated scroted flap was performed.



Fig. 4

The patient was able to leave hospital with a functioning prosthesis after a 4-week hospital stay with the possibility of neopenis-formation from free radial forearm flaps in the background, aggressive surgical attempts at penile reconstruction may be justified as presented in this case.

Imminent skin necrosis after penile prosthesis implantation should be immediately covered by well-vascularised scrotal-flaps in order to prevent foreign body infection.



Fig. 5

John Pryor, Eric Wespes, Michael Sohn

CLINICAL CASES

ALCOHOLISM AND MALE SEXUAL FUNCTION

Juza Chen (Israel)

As early as six million years ago, in western Iran (Godine Tepe), and later, during the Palaeolithic age, man is known to have produced various alcoholic beverages through fermentation of either fruit juices (wine), cereals (beer) or honey. Since then, one of the most popular trades has been commerce with spirits, such as beer and wine. A wide spread belief among manifold cultures and peoples was that alcohol consumption is beneficial for physical, intellectual and sexual capabilities, and moderate drinking was even encouraged. Indeed, many contemporary scientists claim that a reasonable intake of alcohol is indispensable for the satisfactory functioning of various systems in the human body.

Etymologically, the word "alcohol" comes from the Arabic, and means "essence". Even in ancient times in Arabic countries it was customary to refrain from drinking large amounts of alcohol. With the passing of time, alcohol abuse became an socio-economic issue. Countries like the USA, Russia, France and a large number of other European States made a strenuous effort, both financially and socially, to fight this affliction, which affected as much as 10-15% of the population in these parts of the world. With the recent increase in the number of immigrants arriving from countries where drinking of alcoholic products is socially acceptable, Israel has also become a country where heavy drinking has reached alarming proportions, with the associated grave social consequences and serious health damage.

One of the most frequent undesirable after-effects of alcohol abuse is sexual dysfunction. Despite the first impression - albeit partially true - that moderate drinking of alcohol actually improves mood, liberates the individual from certain inhibitions and frees him or her to be sexually "daring", there is no scientific proof that the act of intercourse while under the influence of alcohol is more satisfying. In fact, the result is quite the opposite. At a certain point, the fragile line between feeling elated and being inebriated becomes obscure, especially among alcoholics, creating difficulties in sexual functioning and thus diminishing the gratification achieved. Research publications and relevant literature revealed impairment of certain aspects of the sexual function, and this is found to occur twice as frequently among alcoholics than in the normal population. According to various reports,

the damage can range from 8-58%, and it is associated with the severity of the problem and its complications. Hepatic dysfunctions are the most common pathologies among heavy drinkers; also affected can be the central and the peripheric nervous systems. Endocrine disorders may also appear and be mainly expressed by a decrease in testicular function caused by atrophy. These are the primary causes that lead to erectile impairment, decreased sexual desire, lack of or only moderate sexual satisfaction, ejaculatory disorders, and a low sperm count which lead to sterility. Various reports have shown that among alcoholics, 63% suffer from decreased sexual desire and enjoyment, as compared to only 10% within a normal population of the same average age.



Hepatic disorders are severe complications of heavy drinking when there is involvement of the gastrointestinal system. A small group of scientists attempted to demonstrate that poor nutrition and not alcohol consumption alone leads to hepatic cirrhosis. However, the vast majority of investigators still claim that alcohol is the main cause of the disease, and that poor eating habits only accelerate the process. There is a compelling evidence that sexual disorders in the male alcoholics are the direct consequence of a form of this disease, i.e. "Laennec's cirrhosis", which is known to be caused by chronic alcoholism. There is further proof that the frequency, the severity and the duration of episodes of impotence are directly related to the extent of liver dysfunction in alcoholics, as compared to the non-alcoholism related type of cirrhosis. Liver damage directly influences the male endocrine system, i.e. the hypothalamic-pituitary-testicular functions, causing a decrease in the production of testosterone on the one hand, and an increase in the levels of LH and FSH on the other. The testicles are also directly affected by the production of a toxin that attacks the testicular (Leydig) cell. The same scientists have also shown that treatment is still possible, and can be highly successful in cases where testicular atrophy has not yet occurred, but there is only hormonal involvement. Moreover, following a period of abstinence from alcohol, many subjects were noted to experience spontaneous recovery of sexual drive and erectile capability.

On the other hand, testicular atrophy is irreversible and no treatment of this condition has yet been proven efficient.

Laboratory tests and clinical research on humans showed conclusively that alcoholism causes severe damage to the central and peripheral nervous systems. Impairment of the gamma aminobutyric acid (GABA) receptors, the glycine and glutamate receptors, the calcium and sodium channel system, the dopamine as well as the arginine receptors - can all cause sexual dysfunction.

Studies of sleep patterns in alcoholic men have indicated increased lower limb motility demonstrating injury of the peripheral nervous



system. And, indeed, these subjects had difficulty in achieving sexual gratification and had erectile and ejaculation problems. Moreover, there was evidence of atrophy of vital brain parts, such as the cortical and frontal lobes, which normally play a very important role in human sexual functioning.

Examination of the nocturnal penile tumescence has shown unequivocally that in alcoholics, the duration and intensity of erections were lower compared to non-alcoholic subjects. This result is also compatible with the

alcoholics' sexual partners reporting that these men had definitely sustained longer and stronger erections prior to their becoming addicted.

Recent studies performed on penile cavernous tissue, which is known to play an important role in erectile capacity, show that the damage is caused in the morphology and structure of these fine smooth muscles in the alcoholics. Thus these patients' ability to attain and maintain erection is impaired as a result.

In conclusion, it is certain that alcohol abuse, causes, amongst other undesirable after effects, severe disorders in certain aspects of sexual function, which are, partly, irreversible. Newly developed treatment options have been employed quite successfully in the management of most sexual disorders. Sobriety often leads to spontaneous recovery of sexual desire and erectile capacity, with no additional treatment.

Recent years have witnessed the opening of specialised centres in hospitals and outpatient clinics, offering a variety of treatment possibilities for sexual dysfunction. Many people who had suffered from these impairments have been helped to resume a normal sexual and family life. It is always advisable to choose these centres for evaluation and treatment and alternative costly and possibly unsafe procedures that could cause even more damage.

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The Impotence Association UK



The Impotence Association was officially launched on July 4th 1995. Our aim to help raise public and professional awareness of the incidence of impotence and the wide range of available treatments. By means of a telephone Helpline service (open weekdays 09.00hrs-17.00hrs) and the availability of free patient literature we provide confidential advice, support and comprehensive information to sufferers, their partners and healthcare professionals. We aim to provide a service which is non - judgemental and which removes the negative attitudes associated with being impotent. It is the only charity and patient support group for impotence sufferers in the UK.

In 1995 there was one member of staff answering the telephone helpline - there are currently seven members of staff and one voluntary worker.

The Trustees of the association are Mr John Pryor (Chairman) a Urologist and President-Elect of ESIR, Professor Alan Riley (Secretary) a Professor in Sexual Medicine, Mr Phillip Hodson a Fellow of the British Association of Counselling and Ms Moyna Kennedy who has a scientific and marketing background. There is also an advisory panel including specialists in endocrinology, diabetes and psychiatry who can be called upon for advice and as spokespeople.

The main activity of the Association is its helpline, manned by psychosexual therapists and trained counsellors. To date the helpline has received over 50,000 calls. The calls average around 1,000 a month and the staff answer around 500 letters a month. Following the launch of new treatments and any media coverage the association can receive as many as 4,000 calls per month. Through the helpline free leaflets and factsheets covering subjects such as erectile dysfunction, ejaculatory problems, peyronies disease and all treatment options are distributed to sufferers and their partners as well as health professionals.

In June 1996 "Friends of the Impotence Association" was launched and for a small subscription members receive three newsletters a year as well as updates on new treatments. The association currently has 1,050 members which include sufferers and their partners, healthcare professionals and other interested bodies.

The last two years have seen an increase in the Association's activities. In February 1998 a survey on sufferers and their partners and the effect impotence has on their lives was published. March 1999 saw the association's first conference for sufferers and their partners as well as healthcare professionals. This was a great success and the next conference will be a two day event in March 2000.

There has been increasing media coverage on impotence over the last four years and the Association has been the first point of contact for journalists. The Director and Trustees of the Association have spoken to over 600 journalists over the last year often appearing on TV and radio.

The Association dealt with journalists from overseas including TV companies in Australia, Japan and Hong Kong. There was also an increase in calls to the helpline from countries such as Spain, Russia and France. This highlights the need for similar Associations to be set up in other countries. The Association is currently working with ESIR in helping to set up and give guidance to European countries as part of ESDA (European Sexual Dysfunction Alliance) formerly known as EANOSD. Doctors from six European countries have already visited the association's offices in London.

In March this year the Association held a press conference in the House of Commons in response to the British Government's restrictions on impotence treatments and presented the government with coalition statements signed by other charities and patient groups as well as professional bodies, doctors and hospital consultants. This helped the Association to establish close links with other charities and patient bodies and the Association is now producing leaflets and factsheets with charities such as the prostate cancer charity, the MS Society and the British Diabetic Association. We also have involvement in the conferences of other associations and are currently working on a joint campaign with the Men's Health Forum. The Association's website was also set up with links from many other organisations.

On a lighter note February 14th is National Impotence day in the UK and the Association organised fundraising with a sponsored bungee jump in 1999 to be followed by sponsored sky-diving in February 2000.

WHAT'S UP DOC

Little did the likes of Hippocrates and Aristotle suspect hundreds of years ago when their privileged minds began to ponder the mysteries of the erectile mechanism, that centuries later the subject would, far from having lost its interest, become the hot potato of the medical world. It would be fair to say that man and penis have walked hand in hand through history and have become inextricably linked forever. No longer a mere reproductive organ it is today a symbol of what every man aspires to in terms of ambition, pleasure, and physical perfection.



One of the most interesting areas of debate has always been penile size and its implications in terms of sexual performance. Opinions have clashed as to whether a larger penis guarantees a better performance, and people's "objective" opinions may be just a tiny bit influenced by their own anatomy. I am assured however, that in terms of blood flow a large one has considerably more difficulty, (phew!) which should make a lot of people stop worrying, get a good night's sleep and put the tape measure away. But it is not that simple. Those well-endowed individuals may still be laughing all the way to the sperm bank until they are halted by old-age and have to start taking up DIY (and we are not talking of putting up shelves here) but of the medical kind, with the help of an autoinjection intracavernous kit.

"Precious things come in little packages" may be a comforting thought for those other individuals less favoured by Mother Nature, but as with most things in life these days, extensions and enlargements have come to fulfil many an expectation. And why not "if you've got it flaunt it, if not fake it"!

Do I hear women chuckling and whispering "for once nature has given them the short straw", I wouldn't be so sure because however much or little they've got they will, in their generous manner, want to share with you. However there is nothing to stop you lending a hand with the DIY when the chips are down and that is what it is all about "a problem shared is a problem halved".

HUMOUR

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