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I am delighted to welcome you to this 2014 first issue of the ESSM Newsletter. We have in our society great things coming soon.

Our Editorial Team wishes all ESSM Members & Friends a great 2014 for you and your families.

We will have the opportunity to meet colleagues during the Istanbul Meeting that will be held very very soon.

Just to remind you that this year our Annual Meeting will be held in January 2014 – from 29 January to 1 February 2014 – in Istanbul, rather than the classic December. Also, all people interested will have the chance to take the exam to become Fellow of the European Committee of Sexual Medicine (FECSM). In cooperation with EFS and MJCSM the ESSM provides two qualification examinations on a regular basis. The upcoming examination will be on 28 January 2014.

In this issue, we have included an interesting interview with our ESSM Meeting President Prof. Ates Kadioglu – a world-wide known expert in Sexual Medicine and Reconstructive Urology.

We cover main abstracts that will be presented during Istanbul Meeting prepared by our Scientific Committee Members (Drs. Corona, Burri and Albersen), along with our classic sections by my Associate Editors (Drs. Mondaini and Angulo). Also we included a very interesting ISSM List Case Report commented by Dr. Cruz.

Finally, I would like to thank you all for your continued support of our society and I look forward to seeing you in Istanbul at the end of this month.

My very best

Juan I. Martinez-Salamanca
Editor-in-Chief
Men’s Health Issue

Men’s health issue represents a crucial topic of ESSM Congresses. Numerous high quality studies have submitted and presented at the 16th ESSM Congress in Istanbul.

According to current guidelines patients with obesity and/or type 2 diabetes (T2DM) represent a population at risk for male hypogonadism. Accordingly, it has been reported that testosterone replacement therapy (TRT) in these subjects might improve glycometabolic control and fat mass. In line with these data, Aversa et al., (PS-02-002) in a 54-weeks prospective controlled study showed that TRT is able to improve body composition and cardio-metabolic outcomes in a series of 24 severely obese men (mean BMI 42 kg/m²). Similar results were reported by Saad et al., (PS-02-003) in accumulative observational registry study involving 561 T2DM hypogonadal men from two urological centres followed up to six years and by Zitzman et al., (PS-02-004) in an other register survey on 381 hypogonadal receiving testosterone undecanoate up to 16 years. The data reported by Shortridge et al., (PS-02-001) empathized the concept that in the routine clinical practice the screening for hypogonadism in the diabetic population remains poor if not ignored. Where or not TRT might represent a new therapy for T2DM has not be completely clarified and must be confirmed in further longer double-blind placebo controlled studies. Recent meta-analysis (HP-10-005) documented that weight loss whatever obtained is able to improve testosterone levels in hypogonadal men. Hence, according to current guidelines weight loss and lifestyle modifications should be considered the first approach to overweight or obese hypogonadal men.

Several reports have even documented that low T might increase the risk of overall and cardiovascular (CV) mortality in men. The link between reduced T levels, T2DM and obesity can explain, at least partially, these data. Interestingly, recent data have suggested that not only low T but also elevated LH could represent independent risk factor for mortality in men. Accordingly Rastrelli et al., (HP-07-003), in a series of 2,809 men with ED showed that elevated LH represented an independent marker of CV risk.

Obesity has been previously associated with decreased levels of circulating prolactin (PRL) and with impaired PRL responsiveness to several pharmacological stimuli, including insulin-induced hypoglycaemia and TRH. In line with these data, Corona et al., (PS-02-005) in the cross-sectional analysis of the European Male Ageing Study, a prospective, observational cohort of community dwelling men aged 40-79 years, report that PRL is negatively associated with an unhealthy metabolic phenotype as well as with the metabolic syndrome.

The relationship between erectile dysfunction (ED) and increased CV risk is well documented. However, the knowledge of this link among health care professionals remains poor. Kalka et al., (PS-08-005) reported data on 412 patients evaluated during cardiac rehabilitation after myocardial infarction. Only 8.89% of all participants had an interview about ED and in only 2.18% of cases ED had been diagnosed earlier and was treated.

Phosphodiesterase type 5 inhibitors (PDE5i) represent the first line therapy for patients with ED. However, the drop-out rate remains quite high. Tadalafil one daily (OaD) is a well documented safe and effective treatment for ED subjects. Buvat et al., (PS-08-008) reported that data on EDATE study evaluating time to switch or discontinuation from ED-treatment with Tadalafil 5 mg OaD. They reported that under routine conditions, more than 68% of men starting/switching Tadalafil OaD continued treatment more than 6 months. In another elegant double-blind placebo controlled study Patel et al., (PS-07-003) documented positive effects of tadalafil OaD on erectile function recovery in patients who underwent radical prostatectomy for clinically localized prostate cancer. Similar results were reported by Moncada et al., (HP-06-002) in 203 patients treated with robotic prostatectomy.

Vardenafil orodispersible (ODT) represent a quite recent new formulation of Vardenafil which significantly improves erectile function in men with ED regardless of age, baseline severity, or underlying conditions. Salonia et al., (PS-08-010) in one of the first post-marketing study, evaluated the impact of Vardenafil ODT on 100 subjects with ED. They found that one out of three ED patients taking Vardenafil ODT reports a satisfactory erection less than 30 minutes after the drug intake in the real life setting.

Much evidence has already confirmed that Low Intensity Shock Wave therapy (LI-ESWT) should represent a further treatment option in patients with ED. In a long term efficacy (up to 2 years) study Vardi et al., (PS-08-013) showed that more than 50% of patients treated with this approach maintained their initial success.

Penile implant surgery the last option in unresponsive ED subjects. Pereira et al., (HP-02-003) presented the frequency data on 202 patients with severe ED who underwent penile implantation between 1993 and 2012. The overall satisfaction rate was 75% and complications which required surgical management occurred in 7% of subjects.

Peyronie’s disease (PD) represent a rare clinical condition which pathogenesis remains poor understood. Salonia et al., (PS-09-001), reported that PD was diagnosed in 13% of patients with 1140 patients seeking medical care for sexual dysfunction. Autoimmune diseases remerged as a common associated morbidities in subjects with PD being present in 9.5% of cases. The medical treatment of PD is essentially based on intralesional verapamil and oral antioxidants. Privitera et al., (PS-09-003) documented a pos-
sible synergic effect of the combined therapy in more than 100 subjects with PD. Surgical treatment of PD includes excision of the plaque and using autologous or hererologous graft material for defect closure. The optimal graft material has not been defined yet. Herwig and Kuehhas (PS-09-004) reported good outcomes in 51 patients treated using a derma-graft which could be considered another viable approach.

Premature ejaculation (PE) has been considered the most common male sexual complaint in the general population. The pathogenesis of lifelong PE remains poor understood. Jern et al., (HP-01-007) reported a possible association between PE polymorphism of catechol-o-methyltrasferase (COMT) and PE providing a possible further insights to the pathogenesis of PE.

In conclusion ESSM Istanbul congress confirmed the high quality of studies submitted and presented. The contribution of all other communications not emphasized in this section, for obvious space limitation, should be considered equally valuable.

**Women’s Health Issue**

Similar to what observed in past years a strong focus has been laid on female sexuality with a number of posters, podium sessions and master lectures being dedicated to this particular research area.

Out of 961 couples with unconsummated marriage, Promodu et al., (PS-04-004) reported that in 327 cases female factors alone was the main cause of the problem. In particular, vaginismus accounted for 96.33% of cases. In line with these data, vaginismus is considered as one of the most common psychosexual female sexual dysfunction. Muammar and McWalther (PS-10-001) reported that insufficient education was the major contributor to vaginismus in 100 Arab women. Molaei et al., (PS-04-007) developed a new multidimensional case-history tool which represents a valid and reliable self-reported questionnaire for women complaining of lifelong vaginismus. Various therapeutic approaches have been proposed for vaginismus. Beronio et al., (PS-04-006) presented a two steps approach for this problem on 135 couples. In the first step, the female participant performed vaginal penetration exercise on herself in the presence and with the direct help of a therapist. In the second step the couple performed at home vaginal penetration exercises on themselves. With this approach 95% of the women were able to achieve full vaginal penetration. The mean duration for the treatment was between 8 and 9 therapy sessions. The use of sex therapy was a successful approach used also by Promodu to treat couples with unconsummated marriage (PS-04-012). Out of 78 couples, 76 had successful coitus by the end of therapeutic programme. Conversely, Sabra and Eid (HP-08-003) used cognitive-behavioural therapy based on education (visual illustrations and mirror), desensitization and vaginal dilators in Lebanon patients with vaginismus with good outcomes.

Lack of sex education represents a crucial point in the evaluation of both women and male sexual problems. In a telephone counselling survey on more than 1000 subjects Tripodi et al., (PS-06-008) reported that reduced sexual desire and vaginismus were the most common women sexual problems. Interestingly, among the patients evaluated almost 60% had never consulted for their problems.

Chronic pelvic inflammatory diseases (CPID) could profoundly affect both female sexual function and quality of life. Romashchenko et al., (PS-06-001) reported data on more than 400 women with CPID. Decreased sexual desire was reported by 25.5%, decreased arousal in 26.2%, anaorgasmia in 10.2% and dyspareunia in 52.6%. All these problems improved after a specific inflammatory therapy.

Women sexual dysfunction and urinary incontinence should be frequently associated, both representing a marker of pelvic floor dysfunction.

Cayan et al., (PS-10-004) documented for the first time the association between female sexual dysfunction and urinary incontinence in a series of 1217 Turkey women.

Metabolic syndrome (MetS) is a multifactorial disease characterized by impaired glucose tolerance / diabetes, central obesity, elevated triglyceride levels, reduced HDL levels and hypertension. The association between MetS and male sexual dysfunction is well documented. Otunctemur et al., (HP-08-007) in a series of 400 pre and postmenopausal documented that sexual dysfunctions were present even in women with MetS being more frequent in postmenopausal than in premenopausal women. Polycystic ovarian syndrome (POS) is frequently associated with MetS. Altay and Erkurt (HP-08-004) reported that total female sexual function index score, lubrication, orgasm and pain scores were significantly lower in women with POS but sexual desire and arousal scores were found similar to normal controls.

Other factors affecting female sexual function include liver cirrhosis (HP-08-005), HIV (HP-08-006) and diabetes mellitus (PS-06-004). In particular, diabetic women may be affected by sexual dysfunction mainly due to peripheral vascular diseases. Caruso et al., (PS-06-004) in an open label study involving a limited number of women with type 1 diabetes documented that daily tadalafil 5 mg treatment improved clitoral blood flow improving women sexual aspects.

Similar results were reported by Krychman et al., (PS-06-005) in a double blind placebo controlled trial using bremelanotide (a melanocortin-receptor-4 agonist) in 397 premenopausal women with hypoactive sexual desire and or female sexual arousal disorder.

In conclusion ESSM Istanbul congress confirmed the high quality of studies submitted and presented. The contribution of all other communications not emphasized in this section, for obvious space limitation, should be considered equally valuable.
Scientific Highlights from Istanbul: Preclinical Research
by Maarten Albersen

Translational and basic science provides new insights in the pathophysiology of sexual disorders and is aimed at identifying new treatment targets that may provide hope for the future treatment of a variety of sexual dysfunctions. As such, the basic and translational science section provides delegates of the conference not only with a deeper and broader insight in the mechanisms underlying the diseases they treat day-by-day, but also gives an outlook onto the future of our practice.

This year in Istanbul, the first round table session encompasses basic research geared towards elucidating the pathophysiology of premature ejaculation, but on the other hand is combined with clinical practice advise. So the delegates get a broad overview of this disorder from bed-to-beside. In RT-07, an overview is given of pathophysiological aspects of development of erectile dysfunction in aging, diabetes, cavernous nerve injury and patients with vascular risk factors and oxidative stress, while Prof. Giuliano will update us on the role of the spinal cord in sexual disorders in EFS gold medal session GM-03. Two master lectures, ML-07 and ML-08 will deal with basic and translational hot topics being sexual desire in animal models and with clinical practice advise. The delegates are experiencing in seeking support for FSD preclinical research.

At this note, I would like to initiate the abstract highlights with two FSD basic research abstracts that have investigated determinants of NO signaling in the female genital organs. Ückert et al. (PS-01-015) have looked into the distribution of TRPA1 channels in the human clitoris and vagina and found that this ion channel might be involved in afferent transmission in female genital organs and work synergistically together with the NO/cyclic GMP pathway. Vignozzi et al. (PS-01-016) have worked on the NO-cGMP pathway in the rat clitoris and found that that testosterone improves the NO-mediated signaling, whilst estradiol stimulates the contractile RhoA/ROCK signaling in clitoris, thus confirming a positive role of testosterone in female genital arousal.

A topic that keeps driving basic and translational researchers is metabolic syndrome and its effects on erectile function. Various determinants of metabolic syndrome are discussed this year including diabetes, hypercholesterolemia, but also a direct interaction of insulin with NO-signaling in the corpus cavernosum smooth muscle. In PS-01-005, Filippi et al. studied the role of steatohepatitis as a new player in metabolic syndrome-associated erectile dysfunction in rabbits on a high-fat diet. They performed a mRNA expression analysis of genes related to steatohepatitis and found that genes related to inflammation (TNFalpha, various interleukins and chemokines, CX3-C), immune-response (CD68 – a macrophage marker, TLR2, TLR4, GATA3), activation of stellate cells (RhoA, TGFbeta, alphaSMA, ETA, ETB), fibrosis (matrix proteases), and lipid metabolism were negatively associated to penile maximal responsiveness to acetylcholine in in vitro contractility studies. When all these putative liver determinants of penile relaxant capacity to acetylcholine were introduced as covariates in a multivariate model, only TNFalpha was an important determinant, and circulating levels of TNFalpha were increased by a factor of five in high fat diet rabbits as compared to controls (p<0.02). In my personal view this is a very well conducted study that is definitely one of the basic science highlights of this conference. The same group investigated the effects of metformin on adenosine signaling in the penis of high fat diet animals (PS-01-006). Metformin treatment reduces gluconeogenesis and was used to chronically treat high fat fed animals. Metformin treatment normalized the decreased expression of various adenosine receptors and increased relaxant responses to adenosine in-vitro.

In PS-01-008 Martinez-Salamanca and colleagues further investigated the link between diabetes and erectile dysfunction. In addition to regulate glucose homeostasis, insulin has been demonstrated to influence vascular function at local level. The aim of their work was to characterize the effects of insulin in human corpus cavernosum and penile resistance arteries and analyzing its interactions with NO/cGMP pathway. They conclude that insulin causes human penile smooth muscle relaxations that are mediated by NO/cGMP pathway, contributed by endothelium, and impaired by the presence of ED. Altered regulation of penile smooth muscle tone by insulin could contribute to ED in metabolic disorders. Costa et al. investigated circulating endothelial progenitor cells (EPCs) in ED (HP-01-007). Results revealed that in the diabetic bone marrow there was a reduced production of (CXCR4+) EPCs, when compared to controls. Regarding peripheral mobilized cells, the authors observed a more pronounced decreased in the overall CXCR4+ population in diabetic animals. Additionally, a decrease in SDF-1α protein expression in diabetic erectile tissue was detected. Since SDF-1 is a chemokine that attracts CXCR4-expressing cells, the authors came to the conclusion that effective recruitment of endothelial progenitor cells to diabetic erectile tissue may be impaired.
When we look at submissions aimed at the use of regenerative disease, local injection of mesenchymal stem cell preparations for the treatment and/or prevention of Peyronie’s disease plaques seem to be a hot topic, with three abstracts accepted and Dr. Castiglione from Milan commenting on this technique in RT-05 on Peyronie’s disease. Abstracts on this topic were sent in from both Tulane University in New Orleans (PS-01-002) and San Rafeale University in Milan (PS-01-001 and HP-09-002) and respectively describe treatment and prevention of PD-induced fibrosis with the use of either adipose-tissue derived stem cells (ADSC), or it’s autologous, easy-to-use counterpart the adipose stromal vascular fraction. In the first study (the Tulane study included both a treatment and a prevention group), erectile dysfunction was either prevented or reversed, while in the latter two, an improvement of structural characteristics (collagenization, fibrosis) was observed by means of immunohistochemistry and western blotting directed against various collagen subtypes. It has previously been proposed that these actions may be an effect of modulation of myofibroblast activity, which Stebbeds et al. (PS-01-003) now elegantly prove to be an important cell type in the development of Peyronie’s disease in the human setting.

The contribution of all other communications that have not been highlighted in this overview, due to space limitations, is without a doubt equally valuable and relevant to Sexual Medicine. The overall level of submissions in the basic and translational categories has been very high, although we pitifully still face a disproportion of basic sexual medicine reports on FSD, compared to an overwhelming amount of preclinical research going on in the field of MSD. It is our role as the ESSM to push and promote this branch of sexual research. We aimed to provide speakers on basic and translational research in the more clinical sessions as well, to provide the more clinically oriented sexual medicine specialist with a profound understanding of the disorder he or she is treating every day. We hope that this approach may fuel interest among delegates and will continue to integrate preclinical and clinical research towards Copenhagen 2015.
PROF. ATES KADIOGLU is an internationally known figure and world-class leader in the field of sexual medicine and especially in Genitourinary Reconstructive and Prosthetic Surgery. He is the current Chairman of ESSM 2014 Congress will be held in Istanbul and also a great human being. He is an outstanding contributor to the field of sexual medicine as a researcher, patient advocate, educator, innovator, author, and international recognition as an expert in erectile dysfunction, priapism, Peyronie’s Disease and many aspects in Andrology. Having you here is a real pleasure and honor not only for me but also for all ESSM Members.

JIMS: Dear Ates, could you make us a brief journey throughout your professional background? I earned my medical degree at the Istanbul Faculty of Medicine in 1983; served as Urology Resident and clinical instructor until 1994. I spent 7 months as an andrology observer in UCSF and Baylor College of Medicine with Dr. Lue and Dr. Lipshultz respectively. The time of my associate professor and full-professor degree is 1994 and 2000 respectively. Since 2002 I have the privilege of being chief instructor of Andrology Division in our institution. Besides my academic interests, I also work as an administrator since 2002 as President of Turkish Society of Andrology followed by my presidency of Turkish Association of Urology at 2008. I’m still carry the titles of Turkish Association of Urology Vice President and Honorary President of Turkish Society of Andrology. In addition I have been in the position of Vice Dean in Istanbul Medical Faculty since 2011.

JIMS: During you dilated career, which has led to the passage from “Andrology” to “Sexual Medicine”, and what do you prefer “Sexual Medicine” or “Men’s Health”? In the 1980’s, andrology consisted of infertility, male and female sexual medicine. After the ICSI era, evidence base approach to male infertility surgical treatment led to a decline in patient population whereas surgical volume of sexual medicine increased relatively. Until recently the focus of an andrologist had been in a narrow width of vision which led to the term sexual medicine. However, today we know that man’s sexuality is an inseparable part of his overall physical and psychological health. Sexual dysfunctions, lower urinary symptoms are only projections of the same disease on different organs. Furthermore these diseases are also accepted as the forewarnings of ischemic heart disease and other cardiovascular events. Instead of being only sexual specialist, I like to consider myself as a part of multi-disciplinary team (urologist, cardiologist, endocrinologist and psychiatrist) which is the initial inspector of my male patients who probably meet and receive an examination for the first time in their adult lives. As a male health specialist I hope prevent and get the patient prepared for additional diseases in addition to his sexual dysfunction.

JIMS: What do you think the role of the urologist should be in the management of Peyronie’s Disease? And what are our major challenges? There are three goals in the management of Peyronie’s disease in my perspective. The conservative medical treatment of an early phase PD patient (<1 year) and the surgical treatment which is required for patient who present later than 1 year. Despite the promising new conservative modalities such as collagenase and interferon treatments, the mainstream treatment for late presenting patients is still surgical treatment. The third objective of an urologist should be increasing the public awareness in order to catch the patients at the early phases of PD and administer the treatment. For the major challenges: Accompanying erectile dysfunction, hour glass and complex deformities are on top of my list. Although grafting procedures may increase the ED rate, this outcome might be prevented with careful patient selection. Furthermore ED may be managed by synchronous penile prosthesis implantation or oral pharmacotherapies. For challenging deformities, an expert andrologist with sufficient experience might be required.

JIMS: Dr. Kadioglu, PDE5 Inhibitors (Tadalafil) have been approved patients with ED & LUTS, which do you consider being the ultimate role of this drug in all treatment options of this group of patients? As the paradigms in male sexual health change, daily tadalafil 5mg treatment became a major candidate for the mainstream management modality of coexisting LUTS and ED. The already established place of PDE 5 inhibitors for ED is completed with their additional efficacy on LUTS. We describe this concept with the phrase: “Hit two birds with one stone”.

JIMS: In the field of Priapism in which you worked and contributed very hard, what do you think are the main challenges to achieve? In my opinion 3 different types of the priapism disease leads to their individual challenges: For ischemic priapism the choice of shunting and early penile prosthesis implantation surgery and the timing of those are the most controversial issue of today. The threshold of irreversible penile necrosis and refractory status varies for different authors changing between 36 – 72 hours. For the choice of shunt surgery, T-shunt has proven its superiority in my opinion.
Although non-ischemic priapism is not accepted as emergency and usually treated with radiological intervention, the long term erectile function deteriorating effects of oxidative stress caused by non-ischemic priapism should not be overlooked and investigated thoroughly. The time limit of ED development is still under investigation through animal studies and human case observations. Finally there is still no established mainstream treatment for stuttering priapism despite the numerous options such as PDE 5 inhibitors, CAMP inhibitors. In addition there is insufficient data in the literature to identify and treat high flow stuttering priapism.

**JIMS:** Dr. Kadioglu, also you are involved in the research of new PDE5I as Udenafi l/ Avanafi l, what do you think would be the major contribution to the field? Avanafi l stands out with its fast onset time and highly selective PDE 5 inhibition. This oral drug keeps its efficiency even in patients who took the pill 15 minutes prior to the intercourse. The short onset time of the drug fills the niche of patients who cannot plan sexual activity ahead of time. It also has lower PDE 1 and 6 inhibition in comparison to sildenafil and as a result does not affect retinal functions and decreases hypotension side effect. Udenafi l targets another spectrum of patients with its relatively rapid onset time (1.3 hours) and longer half life (13 hours). The drug might be administered daily or demand depending on the patient choice. While longer half time of udenafi l is a significant advantage of the drug in comparison with sildenafil, udenafi l has fewer adverse effects than tadalafil.

**JIMS:** And last but not least, which do you consider the most important challenges for our specialty (Sexual Medicine) and for our society (ESSM) in the next 5 years? The innovative and fast pacing nature of technology makes the sexual surgeons’ work challenging. The ever developing pharmaceutical therapeutics rapidly challenge surgical treatments in every aspect of sexual medicine. Our objective should be keeping up with this prompt pace of medical technology, present our patients with updated solutions to their problems and integrate developments to our daily practice.

The promising new techniques such as stem cell treatment should be administered by the urologists in the future. Peyronie’s disease surgery will continue to be a part of our lives. I think that the pathophysiology of the priapism will be explained in 10 years. We will continue to implant penile prosthesis for post radical prostatectomy patients. For the society, the government system should be democracy under meritocracy. All people with merit should be represented in the government without regard to their geographical origin. Although I believe that the society should take necessary action in order to protect itself, oligarchic club nature of the society should be changed. Because of the decline in industrial financial support, organization of ESSM meetings should be in attachment to national congresses. In addition the meetings length should be decreased in order to cut back expenses.

It was a great pleasure to interview you; I am convinced that your points of view, fruits of a lifetime devoted to your work, will be highly appreciated by our readers. Thanks once again.
Erectile Function

The potential rehabilitative and protective effect of phosphodiesterase type 5 inhibitors (PDE5-Is) on penile function after nerve-sparing radical prostatectomy (NSRP) remains unclear. The primary objective was to compare the efficacy of tadalafil 5mg once daily and tadalafil 20mg on demand versus placebo taken over 9 mo in improving unassisted erectile function (EF) following NSRP, as measured by the proportion of patients achieving an International Index of Erectile Function-Erectile Function domain (IIEF-EF) score ≥ 22 after 6-wk drug-free washout (DFW).

Secondary measures included IIEF-EF, Sexual Encounter Profile question 3 (SEP-3), and penile length. Randomised, double-blind, double-dummy, placebo-controlled trial in men ≤ 68 yr of age with adenocarcinoma of the prostate (Gleason ≤ 7) and normal preoperative EF who underwent NSRP at 50 centres from nine European countries and Canada.1:1:1 randomisation to 9 mo of treatment with tadalafil 5mg once daily, tadalafil 20mg on demand, or placebo followed by a 6-wk DFW and 3-mo open-label tadalafil once daily (all patients). Logistic regression, mixed-effects model for repeated measures, and analysis of covariance, adjusting for treatment, age, and country, were applied to IIEF-EF scores ≥ 22, SEP-3, and penile length. Four hundred twenty-three patients were randomised to tadalafil once daily (n=139), on demand (n=143), and placebo (n=141). The mean age was 57.9 yr of age (standard deviation: 5.58 yr); 20.9%, 16.9%, and 19.1% of patients in the tadalafil once daily, on demand, and placebo groups, respectively, achieved IIEF EF scores ≥ 22 after DFW; odds ratios for tadalafil once daily and on demand versus placebo were 1.1 (95% confidence interval [CI], 0.6-2.1; p=0.675) and 0.9 (95% CI, 0.5-1.7; p=0.704).

At the end of double-blind treatment (EDT), least squares (LS) mean IIEF-EF score improvement significantly exceeded the minimally clinically important difference (MCID: ΔIIEF-EF ≥ 4) in both tadalafil groups; for SEP-3 (MCID ≥ 23%), this was the case for tadalafil once daily only. Treatment effects versus placebo were significant for tadalafil once daily only (IIEF-EF: p=0.016; SEP-3: p=0.019). In all groups, IIEF-EF and SEP-3 decreased during DFW but continued to improve during open-label treatment. At month 9 (EDT), penile length loss was significantly reduced versus placebo in the tadalafil once daily group only (LS mean difference 4.1mm; 95% CI, 0.4-7.8; p=0.032). Tadalafil once daily was most effective on drug-assisted EF in men with erectile dysfunction following NSRP, and data suggest a potential role for tadalafil once daily provided early after surgery in contributing to the recovery of EF after prostatectomy and possibly protecting from penile structural changes. Unassisted EF was not improved after cessation of active therapy for 9 months.


Phosphodiesterase type 5 (PDE5) inhibitors have recently been shown to have cognitive-enhancing effects in animal models and in our previous pilot study. To investigate the efficacy of daily low-dose treatment with a PDE5 inhibitor on cognitive function, depression and somatization in patients with erectile dysfunction (ED), 8-week, double-blind, placebo-controlled study enrolled 60 male patients with ED for ≥ 3 months without cognitive impairment. Forty-nine patients completed the study. Patients were randomized to receive either daily low-dose udenafi 150 mg or placebo for 2 months. The International Index of Erectile Function-5 (IIEF-5), the Korean version of the Mini-Mental State Examination (K-MMSE) for general cognitive function and the Seoul Neuropsychological Screening Battery for comprehensive neuropsychological examination, the Physical Health Questionnaire-9 (PHQ-9) for depression and the Physical Health Questionnaire-15 (PHQ-15) for somatization were administered at baseline and at 2 months. The change in the mean IIEF-5 was significantly higher in the udenafi group than the placebo group (6.08±4.72 vs 2.20±3.50, P=0.008). The changes in the PHQ-9 and PHQ-15 were -2.04±3.14 and -2.17±2.87 in the udenafi group, and 1.20±1.63 and 0.56±2.48 in the placebo group (both P<0.001). The changes in the K-MMSE and Digit Span Forward were 1.25±1.26 and 0.92±1.02 in the udenafi group, and -0.52±1.19 and -0.24±1.13 in the placebo group (both P<0.001). However, there were no differences in the other neuropsychological tests. Daily dosing with a PDE5 inhibitor seems to improve cognitive function, depression and somatization, as well as erectile function, in patients with ED.

Fertility

‘Prostatitis-like symptoms’ (PLS) are a cluster of bothersome conditions defined as ‘perineal and/or ejaculatory pain or discomfort and National Institutes of Health-Chronic Prostatitis Symptom Index (NIH-CPSI) pain subdomain score ≥ 4’ (Nickel’s criteria). PLS may originate from the prostate or from other portions of the male genital tract. Although PLS could be associated with ‘prostatitis’, they should not be confused.
The NIH-CPSI is considered the gold-standard for assessing PLS severity. Although previous studies investigated the impact of prostatitis, vesiculitis or epididymitis on semen parameters, correlations between their related symptoms and seminal or scrotal/transrectal colour-Doppler ultrasound (CDU) characteristics have not been carefully determined. And no previous study evaluated the CDU features of PLS in infertile men. This study was aimed at investigating possible associations among NIH-CPSI (total and subdomain) scores and PLS, with seminal, clinical and scrotal/transrectal CDU parameters in a cohort of males of infertile couples. PLS of 400 men (35.8 ± 7.2 years) with a suspected male factor were assessed by the NIH-CPSI. All patients underwent, during the same day, semen analysis, seminal plasma interleukin 8 (sIL-8, a marker of male genital tract inflammation), biochemical evaluation, urine/seminal cultures, scrotal/transrectal CDU. PLS was detected in 39 (9.8%) subjects. After adjusting for age, waist and total testosterone (TT), no association among NIH-CPSI (total or subdomain) scores or PLS and sperm parameters was observed. However, we found a positive association with current positive urine and/or seminal cultures, sIL-8 levels and CDU features suggestive of inflammation of the epididymis, seminal vesicles, prostate, but not of the tests. The aforementioned significant associations of PLS were further confirmed by comparing PLS patients with age-, waist- and TT-matched PLS-free patients (1 : 3 ratio). In conclusion, NIH-CPSI scores and PLS evaluated in males of infertile couples, are not related to sperm parameters, but mainly to clinical and CDU signs of infection/inflammation.

Peyronie’s Disease

To assess the literature on published outcomes and complications associated with surgical treatments for Peyronie’s disease (PD). To assist clinicians in the effective management of PD by increasing understanding and awareness of the outcomes associated with current surgical treatment options. A PubMed literature search was conducted to identify relevant, peer-reviewed clinical and review articles published between January 1980 and October 2013 related to outcomes of surgical correction of PD. Search terms for this nonsystematic review included “Peyronie’s disease,” “outcomes,” “complications,” “erectile dysfunction or ED,” “patient expectation,” “patient satisfaction”; search terms were searched separately and in combination. Case studies and editorials were excluded, primary manuscripts and reviews were included, and bibliographies of articles of interest were reviewed and key references were obtained. The current literature was reviewed and refined evidence-based selection of the surgical approach. The current literature was reviewed to assess the published short- and long-term outcomes of surgical treatments for PD. Each surgical treatment option among the standard surgical procedures for PD (tunical shortening, tunical lengthening [plaque incisions or partial excision and grafting], or inflatable penile prosthesis) carries its own advantages and disadvantages. Surgical outcomes of the most commonly used procedures are not substantially different; therefore, patients’ preference, surgeons’ expertise, and risk of complications should play a major role in treatment selection. Surgeons should thoroughly educate patients about surgical options, realistic outcome expectations, and potential complications to manage postsurgical satisfaction. Larger clinical studies of the effectiveness of currently employed and newly emerging surgical approaches are needed.

Priapism

Priapism is defined as a penile erection that persists beyond or is unrelated to sexual interest or stimulation. It can be classified into ischemic (low flow), arterial (high flow), or stuttering (recurrent or intermittent). To provide guidelines on the diagnosis and treatment of priapism. Systematic literature search on the epidemiology, diagnosis, and treatment of priapism. Articles with highest evidence available were selected to form the basis of these recommendations. Ischemic priapism is usually idiopathic and the most common form. Arterial priapism usually occurs after blunt perineal trauma. History is the mainstay of diagnosis and helps determine the pathogenesis. Laboratory testing is used to support clinical findings. Ischemic priapism is an emergency condition. Intervention should start within 4 – 6 h, including decompression of the corpora cavernosa by aspiration and intracavernous injection of sympathomimetic
Have you read? Best of the Best: Clinical

Have you read? Best of the Best: Clinical

Drugs (e.g., phenylephrine). Surgical treatment is recommended for failed conservative management, although the best procedure is unclear. Immediate implantation of a prosthesis should be considered for long-lasting priapism. Arterial priapism is not an emergency. Selective embolization is the suggested treatment modality and has high success rates. Stuttering priapism is poorly understood and the main therapeutic goal is the prevention of future episodes. This may be achieved pharmacologically, but data on efficacy are limited. These guidelines summarize current information on priapism. The extended version is available on the European Association of Urology Website (www.uroweb.org/guidelines). Priapism is a persistent, often painful, penile erection lasting more than 4h unrelated to sexual stimulation. It is more common in patients with sickle cell disease. This article represents the shortened EAU priapism guidelines, based on a systematic literature review. Cases of priapism are classified into ischaemic (low flow), arterial (high flow), or stuttering (recurrent). Treatment for ischaemic priapism must be prompt in order to avoid the risk of permanent erectile dysfunction. This is not the case for arterial priapism.

The European Society for Sexual Medicine (ESSM) is a not-for-profit, multidisciplinary, academic and scientific organisation dedicated to male and female sexual health and dysfunction.

Benefits from Becoming an ESSM Member

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There are two levels of ESSM membership available:

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www.essm.org

( including regularly updated scientific material, monthly updated literature reviews, the most recent guidelines, lecture recordings and presentations from past ESSM congresses), the opportunity to participate in the ESSM educational programs, and to apply for scientific and support grants and a reduced fee for the ESSM annual congress.

ESSM Annual Membership Fees (January to December)

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<th>Membership Type</th>
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<tr>
<td>Combined ESSM/ISSM Fee incl. JSM Journal</td>
<td>EUR 130</td>
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<tr>
<td>ESSM only Fee</td>
<td>EUR 50*</td>
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* A reduced fee EUR 25 is available for residents in training against proof of evidence.

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Female Sexual Dysfunction – Incentive motivational animal model  
Ágmo A: Animal models of female sexual dysfunction: Basic considerations on drugs, arousal, motivation and behavior.  

The availability of adequate and convenient animal models is fundamental for preclinical research in every specific field. Animal models are especially important for the development of new therapeutic strategies. However, it is essential to perfectly know the divergences with respect to humans and the limitations of these models to make an adequate choice and to provide a correct interpretation of the results obtained with their use. This is obviously applicable to preclinical research in Sexual Medicine and the search for most reliable and informative animal models is an essential focus of researchers.

Anders Ágmo provides a critical review of the utility of behavioral animal models for the study of female sexual dysfunction but also provides a nice discussion of important concepts of female sexual function and dysfunction that need to be considered when facing preclinical research in this field. A first important concept is that the term female sexual dysfunction comprises different disorders, such as hypoactive desire disorder, sexual arousal disorder and orgasmic disorder that represent different entities. Thus, it makes no much sense to look for female sexual dysfunction models and seems more reasonable to use different models that respond to the questions raised by each specific problem to solve.

The model should be ideally based on the cause or causes of the dysfunction but unfortunately the causes for most, if not all sexual disorders remain obscure. Ágmo suggests that models should, at least, reproduce the particular behavioral characteristics of the dysfunction we want to model. He also highlights the fact that diagnostic criteria of most female sexual disorders do not only include the existence of behavioral or organic alterations but also require the presence of marked distress or interpersonal difficulty. The symptom and the perception of the symptom as problematic. Animal models are inevitably limited to model symptoms and cannot reflect the complexity of human disorder. However, this is not the purpose of any model. Human social context cannot be reproduced in non-human animal models but no animal model has the pretension of being an image of the human condition, it concentrates in some aspect that can be reproduced in non-humans.

Ágmo considers that sexual behavior is dependent on a central motive state that determines the ability of the organism to respond to sexual stimuli. In fact, no response is produced in the absence of a sexually relevant stimulus. This stimulus may substantially vary, being learned or unlearned, but only in humans the external incentive can be replaced by a mental representation. This is never the case in rodents. Central motive state responds to adequate incentive stimuli with sexual behaviors: Approach and copulatory behaviors.

There are substantial differences in the neurobiology of the sexual central motive state in non-humans and humans. Estrogens are essential for sexual behavior in rodents while estrogens do not seem to be essential for sexual response in women while androgens appear as responsible for sexual drive in women but not in rats. The role of neurotransmitters, namely acetylcholine, serotonin, norepinephrine, oxytocin and melanocortin, with demonstrated relevance in female sexual responses in rodents is unknown in humans.

However, drugs acting on serotonin receptors, such as flibanserin, or melanocortin receptors, such as bremiranolide, proceeded into clinical development for hypoactive sexual desire disorder and sexual arousal disorder, respectively, without achieving satisfactory results.

Most of drugs intended for treating female sexual dysfunctions have been evaluated in behavioral studies determining copulatory behaviors in rodents that consist of lordosis and proceptive behaviors. Since the structure of copulatory behavior in rodents and humans is entirely different, the adequacy of this model could be compromised. Ágmo suggests that approach behaviors in rodents and humans could share important similarities since both implies the reduction of the distance between the individuals involved and both end in tactile stimulation of the partner, particularly at perigenital area. He proposes that analyses of rodent sexual approach behaviors offer more information of relevance for human sexual behavior than analyses of copulation do. These studies can be easily performed evaluating the willingness of female rats to approach incentive sexual stimuli (male rat) and the time spent approached.

Based on results obtained in preclinical models, oxytocin agonists are proposed to be the most obvious candidates for pharmacological treatment of sexual disorders since they have prosexual effects and do not have dramatic side effects. Cholinergic agonists have prosexual effects but are likely to have relevant side effects. Serotonin antagonists are not considered by Ágmo as an attractive alternative due to their complex, often contradictory effects on sexual behavior.

Probably only the availability of a pharmacological strategy proving undoubtedly clinical benefit for the treatment of any specific female sexual disorder would allow for establishing what model is the more predictive for a success in the therapeutic application.
**Diabetic ED – Role of fibrosis**

On the other hand, functional alterations of cavernosal tissue and penile arteries caused by diabetes ultimately result in structural and morphological alterations such as fibrosis which account for the development of erectile dysfunction (ED) and, possibly, for the reduced response to PDE5 inhibitors in diabetes. The two recent papers here commented have analyzed the implication of Wnt and TGF-ß signaling in ED caused by diabetes in rodents and its therapeutic implications.

These research works point to a role of Wnt and TGF-ß pathways in cavernosal fibrosis accompanying diabetic ED, suggesting that inhibition of these pathways would prevent/reverse fibrosis and improve erectile function and/or the response to conventional therapy (i.e., PDE5 inhibitors) in diabetes. P144 is a peptide that could have administration limitations while some small molecule inhibitors of Wnt signaling have entered in clinical development. However, the role of Wnt proteins in tissue homeostasis and stem cell renewal, together with the fact that Wnt signaling differ in tissue-, cell type-, and environment-specific manner, prompt to carefully watching potential side effects of this therapeutic strategy.

**Implication of Wnt family proteins**

Recently, a key role of morphogen and stem cell pathways in fibrotic diseases has been suggested. These pathways include Notch, Hedgehog and Wnt pathways. Wnt signaling is fundamental in embryonic development and also in stem cell renewal and tissue homeostasis in adults. Canonical Wnt pathway involves binding to Frizzled receptors which, once activated, prevent degradation of ß-catenin allowing its nuclear translocation and transcription of target genes. Aberrant activation of Wnt signaling has been suggested to be a common denominator in fibrotic diseases. Wnt activation in vitro stimulates the differentiation of resting fibroblasts into myofibroblasts and increases the secretion of extracellular matrix proteins while in vivo results in rapid and progressive fibrosis. In addition, Wnt signaling interacts with transforming growth factor-ß (TGF-ß) another important profibrotic pathway. Inhibition of TGF-ß reduces Wnt signaling while disruption of Wnt pathway prevents the ability of TGF-ß to promote fibrosis.

On the other hand, functional alterations of cavernosal tissue and penile arteries caused by diabetes ultimately result in structural and morphological alterations such as fibrosis which account for the development of erectile dysfunction (ED) and, possibly, for the reduced response to PDE5 inhibitors in diabetes. The two recent papers here commented have analyzed the implication of Wnt and TGF-ß signaling in ED caused by diabetes in rodents and its therapeutic implications.

Shin and collaborators studied the expression of Wnt proteins in the penile tissue from mice with streptozotocin-induced diabetes. Sixteen different Wnt proteins were detected in corpus cavernosum from mice and 14 Wnts were detected in human fibroblasts derived from tunica albuginea. Up-regulation of Wnt10b and down-regulation of Wnt16 was observed in cavernosal tissue from diabetic mice together with increased TGF-ß1 protein expression, reduced endothelial content and increased cavernosal fibrosis. Wnt10b is known to contribute to fibrotic processes while Wnt16 has been suggested to be involved in hematopoiesis and to influence bone mineral density. Stimulation of human fibroblasts with TGF-ß1 also results in up-regulation of Wnt10b and down-regulation of Wnt16. However, inhibition of Wnt10b expression did not decrease the production of extracellular matrix proteins in these cells. In contrast, overexpression of Wnt16 in cultured cavernosal endothelial cells from mice enhanced angiogenic phenotype.

These research works point to a role of Wnt and TGF-ß pathways in cavernosal fibrosis accompanying diabetic ED, suggesting that inhibition of these pathways would prevent/reverse fibrosis and improve erectile function and/or the response to conventional therapy (i.e., PDE5 inhibitors) in diabetes. P144 is a peptide that could have administration limitations while some small molecule inhibitors of Wnt signaling have entered in clinical development. However, the role of Wnt proteins in tissue homeostasis and stem cell renewal, together with the fact that Wnt signaling differ in tissue-, cell type-, and environment-specific manner, prompt to carefully watching potential side effects of this therapeutic strategy.
In July 2013 Richard Grunet posted a very interesting and practical case in the ISSM Forum:

I have a 38 yr white male that I was consulted on in the emergency room last night who described a 4 day history of right perineal pain after sexual activity. He initially presented 4 days earlier to our ER and underwent an exam that demonstrated a tender firm right cavernosum at the base. He underwent a duplex US that confirmed a dilated right cavernosum and otherwise normal flow. The call team at that time diagnosed him with “Partial Priapism” and discharged him on full dose aspirin.

He continued to have discomfort and sight progression on self exam and came back to the ER. I was consulted and obtained a Hx of this occurring in the past about 10 years ago, and on several episodes after that that according to the patient all resolved with sexual activity.

His exam demonstrated a tender, thrombosed right cavernosal base. His left side and distal right cavernosum were normal. I obtained a pelvic MRI which confirmed the diagnosis of segmental thrombosis and additional views of the pelvic venous anatomy were normal.

He has had a negative work-up including the usual sickle prep, he has no Hx of illicit drug use, no Hx of trauma and had normal coagulation labs. We consulted hematology that ordered additional coagulation studies and started him on Lovenox. They felt that it was essential to prevent any additional clot propagation. He is being seen in their clinic today.

Any one else who has experience with this? Any thoughts about any additional work-up or therapies to reduce his future risk of recurrence, i.e. ASA and tadalafil?

Maarten Albersen posted immediately:

Dear Richard,

This is not such an uncommon manifestation as you might initially think. We pooled three cases with two institutions and wrote practice recommendations:


Your case most certainly has a ‘web’, too. We have seen it in cyclists, but I believe it is congenital (and predisposing to partial priapism, or crural thrombosis), although I am not able to explain it by embryology as there is no fusion go embryological structure at that spot… In our experience, patients with such kind of a ‘web’ will easily recur, although we have not dared to operate on it because of the risk of damage to the cavernous artery right there in the junction of crus and corpus. What are you planning to do? Please note you can see the ‘web’-like structure in the contralateral corpus, too. The cycling is likely the luxating factor in our cases, while the web is likely the underlying, predisposing condition…

Best, Maarten

Tuan Le Anh posted:

Dear Richard,

I think that:

You asked about the position of the patient in every painful sex intercourse, there is any relationship between the position woman – on – top and pain after sex or not.

1. A repetitive trauma related to posture could create some small lesions in the tunica albuginea and hematoma around the crura of the penis (chronic Penile fracture), which this can create chronic pain condition, and fibrosis around the lesion location.

2. Another condition is that there is a NIDUS (lesions web – like/Arterio – venous Malformation – AVM) in the proximal corpora cavernosa.

Checking with MRI (focus on the region of Proximal corpora cavernosa), combined with a prostaglandin injection in the survey will give clearer picture. You can see the link below to have more information of MRI technique. [http://radiographics.rsna.org/content/28/3/837.full](http://radiographics.rsna.org/content/28/3/837.full)
Raul Alberto Belen posted:

Dear colleague,

I have seen more than 70 priapism with different etiologies, high and low flow. I’ve never seen partial or segmental priapism of a corpus cavernosum. It’s more about the clinic is more a cavernous fracture with four days of evolution: Pain four days after sexual intercourse, regional dilatation of corpus cavernosum, decrease flow (may be hematoma) with segmental thrombosis post in resonance. I ask because a segmental dilatation of the corpora cavernosa? Segmental priapism? What would be the cause? I find no explanation.

If the diagnosis had been a fracture in the penis I would have recommended to the patient the following:

1) Sexual abstinence
2) Anti-inflammatory drugs (surgery in case of penile fracture) in this case would be justified if the dilatation cavernous body is aneurysma
3) Explain to the patient carefully
4) The erection should be normal by intercavernous communication
5) Do not administer tadalafil up to 30 days if necessary

Dr. Raul Alberto Belen

… and finally Richard Grunert answered:

Thanks for the replies,

I will be seeing him back in clinic tomorrow. He will be returning to South America to work in August. Note that he has had recurrent episodes and that sexual activity in the past helped resolved this until this time.

My plan is to re-study him with the MRI (great review article above!) in the future, and hopefully when he is a non-thrombosed state, to see if he has a congenital or acquired vascular disorder that can explain this.

If this is a vascular abnormality I hopefully may be able to offer him an interventional radiology procedure to correct this.

Editorial Comment

Interestingly, few weeks after reading this post I received in my office a South American patient with a similar history: Perineal pain after sex. Asked deeper, the patient reported having previously had a relationship with the woman on top and penetration in “awkward position”. He reported having noticed a crack in the perineum with sudden partial loss of erection.

I thought it was a fracture proximal penis (corpora cavernosa), in this case, as in the above-mentioned, without hematoma (partial fracture). In my case the position of women (on top) was clearly related, as mentioned Tuan Le Anh.

There could be a predisposing factor as discussed in the forum. However, with the images and complementary test (MRI, U.S. Duplex, etc.) we found it difficult to differentiate acute lesions of other pre-existing.

We do not know which was the clinical course of the patient discussed in the forum. My patient had a satisfactory clinical outcome with conservative maneuvers.

It is difficult to think of a partial priapism and even harder to prove thrombosis in the context of a sexual relationship.

We think it is useful to share cases like this, certainly rare to hear the views of other colleagues, and keep in mind the different diagnostic possibilities and therapeutic options.

This post is particularly interesting because it includes two useful references: A clinical reference on potentially similar cases, and the other on technical details of the MRI. Very interesting.

Dr. Natalio Cruz
ESHA Focuses on Sexuality and Urinary Incontinence

During my 4-years of ESHA presidency, I participated in many projects that made me understand that sexuality is an important part of every person’s physical and mental health and that sexuality can be embarrassing for many people to discuss. The same goes for urinary incontinence. So it can be doubly difficult to address when incontinence gets in the way of a satisfying sex life. This is why ESHA has chosen as this year’s topic “Sexuality and Urinary Incontinence”. We would like to remind the patients that there is hope for them and their partners to restore sexuality, or to improve problems that may develop. Incontinence does not have to be a barrier to a healthy sex life.

Like every year, we are again organizing an interactive role-playing session on January 24th at 13:00 – 14:00 “Incontinence and Sex”

Like every year, we will try to demonstrate the issues for the couple visiting their physician. As ESHA we always advice the couples to talk to their doctors, but are we sure that the doctors know how to communicate with their patients? While the patients shouldn’t be afraid to tell their doctors about their incontinence problem, or about its effect on their sex life, are their physicians ready to understand them, to ask the right questions and to give practical advice?

I certainly hope that this session will give some important tips regarding precisely these issues. I invite all ESSM members to attend. The attendees will be presented with ideas on how to tackle pre-conceived ideas; what information to provide and how to deliver this information; how to listen to the patient and his partner, as well as how to create a positive environment in which both parties can feel at ease discussing issues of sexuality and urinary incontinence.

European Sexual Awareness Event of 2014

Every year, when it comes to choose the topic for the European Sexual Awareness Event, we encounter the same difficulty: “How to focus on a current topic without repeating ourselves!” This year I believe we conquered this obstacle by choosing as our 2014 topic: “The effects of neurological disorders on sexual health.” When a healthy adult is diagnosed with a neurological disorder such as Parkinson’s disease, multiple sclerosis (MS), Stroke or Spinal Injuries, many aspects of his or her physical and mental well-being are often shaken including sexuality. Where male patients may experience erectile failure, premature ejaculation and decreased sexual desire; female patients may deal with vaginal tightness, loss of lubrication, involuntary urination, anxiety and inhibition as well as dissatisfaction with the quality of their sexual experiences.

Because sexuality plays a significant role in a healthy lifestyle, worries often surface for the patient when his or her sexual desires and needs change. With the onset of the neurological disorder, the development of sexual problems may be frustrating. As ESHA we will underline that there is hope for the patients and the partners with in being able to restore sexuality, or to improve problems that may develop. We will show how in fact, this condition and its challenges can actually deepen and strengthen their relationship.

Communication is the Key

Finally, I would like to repeat a definition that I really like and cherish: According to the World Association of Sexology Declaration of Sexual Rights: “Sexuality is an integral part of the personality of every human being. Its full development depends upon the satisfaction of basic human needs such as desire for contact, intimacy, emotional expression, pleasure, tenderness and love…Sexual rights are universal human rights based on the inherit freedom, dignity, and equality of all human beings.”

Sexual difficulties have a negative emotional and behavioral effect on the couple. The research shows that men and women whose communication with their partner is absent/limited report negative feelings such as depression and frustration. The research also shows that, when couples speak to each other about the problem, both partners are reassured and treatments are more likely to be sought. At the end of the day, the successful treatment is not JUST to help the patient, but to help the RELATIONSHIP. ESHA plays an important role as the bridge between the couple and the physician.

About ESHA

The European Sexual Health Alliance (ESHA) is an umbrella organization for patient support groups across Europe. The main role of this patient focused organization is to assist patients suffering from sexual dysfunction, inform them about the solutions available as well as providing awareness and understanding of the condition to their partners, media and other interested parties. ESHA’s purpose is to help every couple affected by sexual dysfunction to communicate openly about their sexual concerns in order to find a solution that improves the patient’s sexual function and the couple’s quality of life.

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Spain Center: Asociacion Espanola para la Salud Sexual: http://www.salud-sexual.org
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<td>2º Master en Andrología</td>
<td>February 2014 Location: Fundación Puigvert. Barcelona, Spain Website: <a href="http://www.fundacio-puigvert.es">www.fundacio-puigvert.es</a> Email: <a href="mailto:dguart@fundaciopuigvert.es">dguart@fundaciopuigvert.es</a></td>
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<td>2nd Biomarker Meeting: Personalized Reproductive Medicine; Biomarkers for the Assessment of Ovarian Reserve, Gametes, Embryos, Endometrium and Pregnancy</td>
<td>April 10 – 13, 2014 Location: Valencia, Spain Contact: <a href="mailto:biomarker@comtecmed.com">biomarker@comtecmed.com</a> Website: <a href="http://www.comtecmed.com/biomarker">www.comtecmed.com/biomarker</a></td>
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<td>February</td>
<td>18th European Testis Workshop, ETW 2014</td>
<td>May 13 – 16, 2014 Location: Elsinore, Denmark Website: <a href="http://www.etw18.dk">www.etw18.dk</a></td>
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<td>8th Copenhagen Workshop on Carcinoma in situ Testis and Germ Cell Cancer (8th CIS Workshop)</td>
<td>May 18 – 20, 2014 Location: Copenhagen, Denmark Website: <a href="http://www.cis-workshop.dk">www.cis-workshop.dk</a></td>
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<td>XXX Congreso de la Sociedad Española de Fertilidad y V Congreso de la Enfermería de la Reproducción</td>
<td>May 29 – 31, 2014 Location: Barcelona, Spain Website: sefbarcelona2014.com/</td>
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<td>April</td>
<td>ASA – 39th Annual Meeting</td>
<td>April 4 – 8, 2014 Location: Atlanta, Georgia, USA Website: <a href="http://andrologysociety.org/meetings">http://andrologysociety.org/meetings</a></td>
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<td>34th Annual Meeting of the American Society for Reproductive Immunology</td>
<td>June 1 – 4, 2014 Location: Long Beach, NY, USA Website: <a href="http://theasri.org/">http://theasri.org/</a></td>
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<td>ICE/ENDO 2014</td>
<td>June 21 – 24, 2014 Location: Chicago, USA Contact: <a href="mailto:societyservices@endo-society.org">societyservices@endo-society.org</a> Website: <a href="http://www.endo-society.org">www.endo-society.org</a></td>
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<td>BAUS 2014</td>
<td>British Association of Urological Surgeons June 23 – 26, 2014 Location: BT Arena and Convention Centre, Liverpool, UK</td>
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<td>ESHRE 2014</td>
<td>June 29 – July 2, 2014 Location: Munich, Germany Contact: <a href="mailto:Info@eshre.eu">Info@eshre.eu</a> Website: <a href="http://www.eshre.eu/annual_meeting/page.aspx/11">www.eshre.eu/annual_meeting/page.aspx/11</a></td>
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<td>August 8 – 10, 2014 Location: Newcastle, Australia Contact: <a href="mailto:androfest@newcastle.edu.au">androfest@newcastle.edu.au</a></td>
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* A letter of the Chairman of the Department is necessary

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In order to process your membership of the European Society for Sexual Medicine (ESSM) we will store your details in an electronic database. This information will be used to process your application only and will not be used for any other communications. The information will not be sold, lent or otherwise divulged to third parties, other than where it is necessary to process your application.

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Should you have any concerns about the use of your personal details, please email admin@essm.org or write to AIM Congress Srl – AIM Group – Via Ripamonti 129, 20141 Milano – C.a. Ms. Lavinia Ricci
For your consent on data processing and communication as described in the above report:

Date: _____________________________ Signature: _____________________________

For more information please visit www.essm.org
Announcement for the next Congress

17th Congress of the European Society for Sexual Medicine
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