

ESSM TODAY

European Society for Sexual Medicine

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Dimitris Hatzichristou, MD, FECSM
Co-founder and Past President of ESSM

ESSM becomes of age: a look to the Past, Present and Future of our Society

THE IDEA OF THE ESTABLISHMENT OF ESSM AND THE EUROPEAN DIPLOMA OF SEXUAL MEDICINE: MEMORIES FORM AN UNFORGETTABLE PERSONAL JOURNEY

25 years celebration! So many memories, so many events, difficult moments, but mostly happy moments. All of them finally productive! I will share with you two unique events, which I consider as my most important contribution to the Society: a) the foundation of our Society (first name was European Society of Impotence Research-ESIR) and b) the initiative for the European Qualification Exams and the Oxford School.

THE FOUNDATION OF THE SOCIETY AND THE FIRST MEETING (1994-1995)

The International Society of Impotence Research (ISIR) meeting takes place in Singapore in 1994. After the dinner, Yoram Vardi and I, decided to have a drink in a bar nearby our hotel. Discussing about the meeting, we had noticed that a limited number of Europeans were present due to the distance. This was despite the fact that the modern era of sexual medicine had started in Europe by the pioneers V. Michal (penile revascularization), R. Virag and G. Brindley (intracavernosal injections). During the discussion it was obvious that European researchers should have an organization to exchange knowledge and ideas. Yoram Vardi proposed to establish a research club, while my opinion was that we need something broader to also serve as an educational organization for physicians. We decided to go back to the hotel in order to find a common friend of us, Inigo Saenz de Tejada and share with him our discussion. Inigo reacted enthusiastically and proposed the development the European chapter of ISSM. The same night we decided to have a meeting inviting some European researchers to ask their support. The next day the three of us met with about 10 European researchers, including Eric Mueleman (The Netherlands), Eric Wespes (Belgium), Francois Giuliano and Pierre Bondil (France), Ates Kadioglu and Emre Akkus (Turkey), Klaus-Peter Juenemann (Germany). All of them were supportive and decided to have our inauguration meeting next year. The problem was that without an organization and without funding it was almost impossible to organize a meeting of 200 people, as we estimated the number of participants by that time. Being young and passionate as a character, I proposed them to allow me to explore the possibility of hosting it in Greece. My proposal was accepted. Furthermore I proposed that at that stage we needed a highly respectable personality to lead us in the first step. For that I proposed Gorm Wagner who was just finishing his term as ISIR President. With those two decisions we closed our historical meeting.

The next day I approached Gorm Wagner and explained to him our initiative; the next day he accepted to become the Chairman of the Planning Committee.

Coming back to Greece, my task was to find the venue. I thought of having our meeting near the sea, as September is a shiny month in Greece. I visited a few places trying to convince them to block the dates but without requiring a deposit. Finally, the booking officers of Porto Carras hotel in Chalkidiki, Greece were convinced to book the meeting with a deposit of about 10000 Euros, an amount that I was able to cover personally with the support of my family. I immediately changed my University office to "ESIR secretariat office" and hired a young scientist to help me run the meeting, without any professional congress organizer, due to complete lack of sponsorships. We prepared the first announcement on our own, and together with 2 residents and the support of my chairman we did all the contacts and mailing.

Gorm Wagner and Inigo Saenz de Tejada visited twice Thessaloniki and we prepared the scientific program and reviewed the abstracts. One of my residents by that time, Kostas Hatzimouratidis was responsible to organize everything on a laptop. We decided to have presentations of 15 min plus 15min discussion. This was key to the success of the meeting!

In May 1995 the first sponsor, Swartz pharma – a German company that was preparing to launch an injectable alprostadil- decided to come to the meeting and a month later Pharmacia, the owner by that time of Caverject. We immediately hired a professional organizer to run the meeting, with the support of the residents of my department and four outstanding medical students. In August 4 other companies decided to have a booth, while the registrations approached 400 people. That was the moment that the meeting reached the break even point. I will never forget that night as I was signing all contracts at a personal level.



1st MEETING OF THE EUROPEAN SOCIETY
FOR IMPOTENCE RESEARCH (ESIR)

September 13-16, 1995

Venue : Porto Carras, Chalkidiki, Greece

FINAL PROGRAM



Pictures from the first ESIR meeting 1995. Above the elected president and secretary of ESIR.

Finally, the meeting was attended by 422 attendees, offering long lively discussions in all subjects of interest, as the field was immature by that time. The venue by the sea, isolated from any town nearby proved to be ideal. A painting exhibition was also organized by two friends –owners of a gallery in my city- at the venue entitled “Eros and Art”. The last day of the meeting the general assembly voted the establishment of the Society, which was celebrated with a beach party. Gorm Wagner was elected as first President and Inigo Saenz de Tejada as President elect to organize also the next meeting in Madrid. The Executive Committee proposed me as Secretary General to run all the administrative work as there was no budget to have a professional organization to run the administration. Within two years the ESIR was legally established, well organized and ready to have a second successful meeting!

THE IDEA FOR A EUROPEAN DIPLOMA IN SEXUAL MEDICINE AND THE ESTABLISHMENT OF THE OXFORD SCHOOL

Following the fast development of the field, physicians from different specialties were attending our meetings. I felt that we needed to establish an educational program and to ask the European Union for the establishment of a European Diploma in Sexual Medicine through UEMS. As President of ESIR, first of all I approached Alan Riley and Kevin Willey, both by that time running academic programs in Sexual Medicine and Sexology. I strongly supported the idea that this effort for a Diploma should involve not only physicians but sexologists too. I was invited by Kevan Wiley to present my idea/proposal to the General Assembly of the European Federation of Sexology in Brighton (2004), where I went together with our past President John Pryor and President Elect Francesco Montorsi. It was a difficult meeting with many pros and cons but the discussion between the two Societies started.

The next step was to visit Brussels having the first exploratory meeting with the European Union officers and then UEMS. I immediately understood that the path is going to take years and the negotiations are going to be difficult. The Past President of ESIR John Pryor was the father of European Andrology and an excellent and experienced negotiator. So I asked him to support me and take over the negotiations with UEMS. Although he was retired, I convinced him. In my opinion, both my proposals for Gorm Wagner as first President and John Pryor as a negotiator of ESSM to UEMS were key decisions for the development of the field in Europe.

My first decision of my Presidency was that the President cannot be reelected – this way we could offer space to more members to serve the society – and my last decision was the approval of my proposal for the negotiations with UEMS for the European exams and Diploma. When Francesco Montorsi started his term, the executive Committee accepted a budget for the establishment of the European Academy of Sexual Medicine. It was requested by UEMS that members of the Academy should be scientists who have proven teaching skills in the field of sexual medicine at a University curriculum. UEMS had asked us to produce a definition of Sexual Medicine and a brief curriculum in order to start the negotiations. The Academy produced both, which were accepted by UEMS and the dialogue started. At that time UEMS asked for an established school – as summer school was proposed- in order to prepare candidates for the Diploma. John Pryor proposed Oxford University as a venue. Such venue will offer credibility to our initiative. I accepted and then I proposed to ESSM EC the plans and requested the budget. The EC fully supported the idea. At that point -2005- John Pryor asked me to leave his task and we decide that Ian Eardley can take over. Moreover I felt that my dream for a European Diploma is on the right path so it was time to step back as soon as John Dean was elected as the Oxford School Coordinator.



Oxford School of Sexual Medicine group 2008 with Johan Dean laying

In 1994, I was 34 years old, in 2005 45 years old; productive years for the field which I served with passion, working nonstop and risking almost everything.

As Inigo Saenz de Tejada passed away so young, Yoram and myself (the co-founders of ESSM) decided to continue following the steps of the Society and try to play the role of the mentors for the Society. In any conflict we try to find bridges and serve the goals of the organization. We continuously served our initiative, for 25 consecutive years!

THE NEXT STEPS

ESSM nowadays is a well-established organization, serving education, research and public awareness. During those 25 years, the Society developed some important principles:

1. We serve a medical field, therefore we overpassed politics and national constraints.
2. Officers serve one term, offering space to many other members to contribute.
3. Young physicians and scientists are priority in our Society; we need them, as they are the future.
4. Education is the ultimate goal, supporting not only Europeans but scientists from all over the world.
5. Adaptation to the current needs is an ongoing process, in order to answer specific needs in a world that changes so fast.
6. Finally, the most important: we are a big FAMILY!

The future is bright for ESSM, as we have so many high quality young members, fully involved already in most Society's actions. What need to be done can be summarized in the following:

1. Keep a balance between members with exceptional research accomplishments and clinicians with experience in the committees; both are needed;
2. Invite members with educational credentials and appropriate training to lead the education program and the exam committees;
3. Develop programs to approach young scientists, introducing Sexual Medicine to them;
4. Develop an independent Committee, including senior personalities who have served the Society successfully, to examine the existing educational agenda, evaluate the actions and propose to the Executive Committee the steps for improvement.

My personal journey in Sexual Medicine continues. In Prague, together with Yoram Vardi, we have a lot to remember from our first meeting; we will miss Inigo. But we will be with our FAMILY once again!

HAPPY BIRTHDAY ESSM!



Y. Reisman, ESSM President

ESSM becomes of age: a look to the Past, Present and Future of our Society

ESSM FROM PAST TO PRESENT

The history tells us that in 1994 during the ISIR (now ISSM) Annual Congress in Singapore, the impregnation of the ESIR (European Society for Impotence Research) started by young urologists from Europe. The founders of the idea were Dimitris Hatzichristou, Yoram Vardi and Inigo Saenz deTejada, who unfortunately too early passed away. Several reasons justified such effort; important one, was that the contribution of European investigators to this field is strong and growing and the European chapter would strengthen both ISIR and a unified European effort. This idea was quickly transferred to action and in 1995 ESIR was born with the first Congress in Porto Carras, Greece. The final program of that meeting included citation from Hippocrates (460-377BC) *"veins and nerves from all over the body come together in the genitals; as they rubbed and warmed, they swell up and a kind of irresistible itching feeling is created, bringing great pleasure and warmth to the whole body"*. A wonderful sentence which still describes the target of our research and clinical work. As you can see from the pictures, this meeting was largely attended and the first president (Gorm Wagner) and Secretary (Dimitris Hatzichristou) have been chosen.

Two years later the second Congress was held in Madrid with Inigo Saenz de Tejada as president. More than 800 participants took part of the congress and more than 100 journalists show interest in our field. ESIR that was founded on the idea of promoting research within the area of impotence (as ED was named that time) and to broaden the awareness within the European region of the necessity to target this sexual dysfunction as an integrated part of medicine.

The following Congress was in 2000 in Barcelona to which the intended 1999 congress in Turkey needed to move after a tremendous earthquake of 1999. The Society started to grow and moving from infancy to childhood more broader perspectives in the field were visible. In 2001 the name of the Society changed into ESSIR (European Society for Sexual and Impotence Research) in order to embrace more deeply the broad field of sexual medicine, both male and female.

This brought also to the need to be held our congresses each year, so in 2001 the Congress was held in Rome and the year after, in 2002, in Hamburg. Starting from 2001 the Society continued its development, changing again its name into the actual ESSM (European Society for Sexual Medicine) in 2003. According to publication of Alan Riley, the first professor of sexual medicine in the UK, the term "Sexualmedizin" was first published in German literature as early as 1908 and it encompassed both organic and psychological issues of sexual function and its problems and was more popularized in the 1970s. The change of the name of our society was characterizing once again the need to improve and spread the research into sexual medicine, a field which is continuously developing across the world, bringing sexual awareness to light more and more not only in the medical field but also among people.

In 2003 ESSM President, Dimitrios Hatzichristou, approached the past president of that time John Pryor, with an idea of seeking to develop a regulatory framework for Sexual Medicine. The Healthcare Professionals (HCP) who provide this care have largely been self-taught and come from a variety of medical disciplines including urology, gynecology, venereology, psychiatry, primary care and latterly, the fields of endocrinology and cardiovascular medicine have also contributed to the development of the specialty. The quality of care provided by these physicians has thus far been unregulated and has only been demonstrable by audit, by presentation of data at meetings, by publication in peer-review journals, and by the publication of guidelines by scientific societies.



Gorm Wagner
First President



Inigo Saenz de Tejada
President



Julian Pryor
President

EXECUTIVE COMMITTEE



Francisco Guillamon



Haralamb Pircu



Francesco Miccinesi



Yoram Vardi

The elected executive committee of ESIR 1997

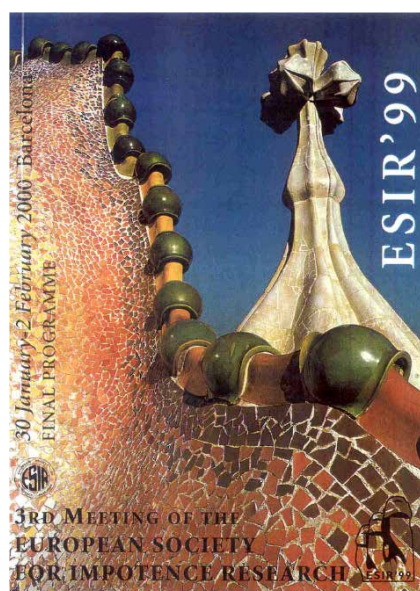


Pictures from second ESIR meeting in Madrid 1997



In 2004, during the presidency of Francesco Montorsi, The European Academy for Sexual Medicine (EASM) was established as an independent, not-for-profit, charitable organization that intend to “promote and encourage the highest standards of practice, education, training and research in the field of sexual medicine.” Its founder trustees, from ESSM and EFS, were John Bancroft, Hartmut Bosinski, Ian Eardley, Kerstin Fugl-Meyer, Marc Ganem, Dimitrios Hatzichristou, Willi Pasini, Robert Porto, John Pryor (chair), and Gorm Wagner. Soon after, the EASM have agreed upon a definition of sexual medicine and a short descriptive curriculum have been developed to guide clinicians from different specialty backgrounds, to have basic education in human sexuality and sexual function, in order to provide a holistic, patient-centered management of sexual health problems.

The curriculum has been developed for the guidance of candidates preparing for the European Examination in Sexual Medicine to become a Fellow of the European Academy of Sexual Medicine. Although the candidates may have different specialty backgrounds, they all need to have basic education in human sexuality and sexual function, in order to provide a holistic, patient-centered management of sexual health problems.



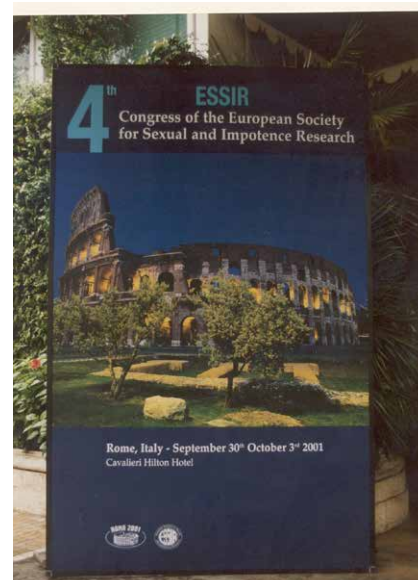
Flyer of the 3rd ESIR meeting

The year 2005 marked the 10th anniversary of ESSM, a society which is always stronger and more deeply rooted across Europe, with 13 National Societies affiliated to ESSM and about 1400 members.

In this period negotiations has been started with different related European Boards, to develop a regulatory framework for Sexual Medicine under the auspices of the European Union of Medical Specialists (UEMS). In 2007, under leadership of Ian Eardley, the first Director of Education, John Dean, have been appointed to organize the first teaching course in Sexual Medicine that found place at Oxford, UK, in July 2007.

Despite this growth in the field of Sexual Medicine, it was not currently recognized in Europe (and indeed in other parts of the world) from a regulatory perspective as either a specialty or as a subspecialty of another discipline. In addition, significant differences exist between the regulation and recognition of medical specialties in the different European countries, and this has had a major impact on, firstly, the way that sexual medicine health care is provided, secondly, on the standard of care that is provided, and thirdly, on the way in which the population can access the service. One way to improve care is through evidenced-based education and other way of of promoting high standards of care is by the regulation and assessment of training. The objectives of assessment are to improve the professional performance of the individual clinician on knowledge, skills and attitude.

In 2009, during the presidency of Ian Eardley and Hartmut Porst, the decision to establish an ESSM education committee was taken to provide large farm work of educational possibilities in the field and to support trainees in sexual medicine by providing educational opportunities to help them to be successful HCP. I was appointed as the chair. In 2010 Ian Eardley was able to present to the UEMS the concept of an overarching regulatory structure of a Multidisciplinary Joint in Sexual Medicine (MJCSM) via UEMS. The MJCSM with representatives of the European Board of Urology (EBU), the European Board and College of Obstetrics and Gynaecology (EBCOG), and the European Board of Psychiatry (EBPsych) together with representatives of ESSM was unanimously approved, and in October





Educational Committee meeting Majorca 2011

2011 the MJCSM met for the first time. The MJCSM bylaws were approved by the relevant Boards and by UEMS, with the appointment of Ian Eardley as Chairman, Yacov Reisman as Secretary. MJCSM aim to develop the highest possible standards of training in Sexual Medicine in Europe and decide to achieve this through development of an extensive curriculum in Sexual Medicine, setting of educational standards for training institutions, accreditation of training institutions, identification of minimal requirements for training and development of an assessment framework, including development of an examination.

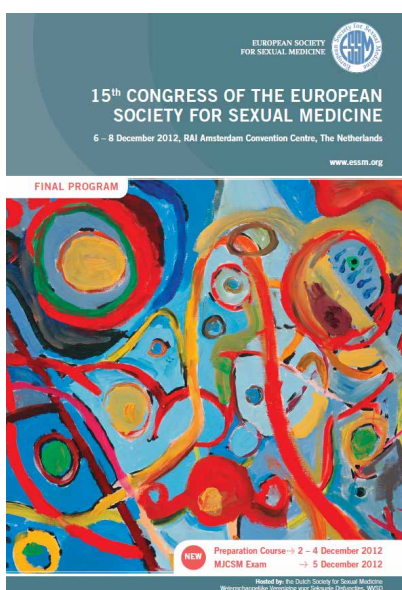
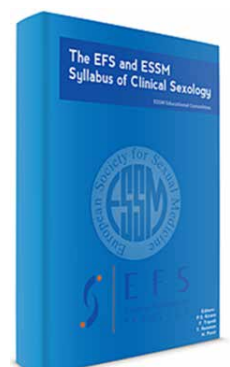
Meanwhile ESSM growing with 24 affiliated societies and during the congress Milan in 2011 the Educational Committee introduced the ABC master-course was introduced, which provided educational opportunities for

both beginners and specialists in the field, and which incorporated endocrinological, urological, surgical, gynecological, psychological, and psychiatric components. This was the first multidisciplinary course that took place simultaneously with the congress.

In that time there are a few textbooks in sexual medicine that actually cover the whole of the discipline. In response to this challenge, the Education Committee developed "The Syllabus for Sexual Medicine," a multi-author and multidisciplinary textbook covering all the different aspects of Sexual Medicine for all genders according to the MJCSM curriculum. Editors were H. Porst (ESSM President) and Y. Reisman and most of the authors of this comprehensive syllabus were members of the ESSM Education Committee, and the timescales for the development of the book were extremely short. The book was presented during the ESSM meeting in Amsterdam 2012 where the first MJCSM examination to become a Fellow of The European Committee of Sexual Medicine (FECMSM) took place with more than 350 candidates. Many of them were well known experts in our field. At the same year and prior to the exam the Educational Committee launched a 3-day "crash" course in sexual medicine. The course provided an overview of all the areas in the MJCSM curriculum and provided guidance about exam-taking skills and practice in completing a Sexual Medicine multiple choice question (MCQ). The objectives of the course were not only to revise the relevant knowledge in Sexual Medicine but also to enable attendees who routinely practice Sexual Medicine to improve their clinical skills.

As ESSM became more adult and discovered more disciplines and genders involved in our field, in 2013 we introduced a joint committee of members from the EFS and ESSM educational committee joined forces to construct a syllabus for psychologists intending to take the first European examinations for psychologists in psychosexology under the European PsychoSexologists Accreditation Committee (EPSA). In the same year the EFS/ESSM Syllabus, which has been published as a multidisciplinary textbook, with 63 authors from 16 countries covering all aspects of clinical sexology. This with the aim to standardize the quality of mental health providers who practice clinical sexology in countries from different areas of the globe. It is our belief that this program is one of many educational activities that are needed in the field of sexual medicine and clinical sexology to raise the standard of care.

In the same year a new format of the ESSM School has been introduced. Under leadership of Y. Reisman and F. Tripodi a new format had been constructed in which during 10 days physicians and psychologists can interact and gain more knowledge and skills in our field. Each edition was evaluated and validated by the participants who indicated that participation in the School increased their involvement in the field, as clinical practitioners, teachers, and researchers, and increased the amount of time that they devoted to the care of patients with sexual concerns and dysfunction. In the recent years this educational course became a flagship of our society and each year many are in the waiting list for participation.



ESSM flyer, Amsterdam 2012



Participants after the first MJCSM exam, Amsterdam 2012



ESSM first preparation course for the MJCSM exam, 2012

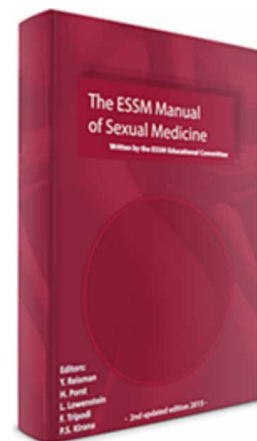


Participants of the ESSM School, Budapest 2018



In 2014 we had in Istanbul the 16th ESSM Congress which joint by the 12th Congress of the European Federation of Sexology. Here we hold the second examination to become a FECSM, together with the first examination to become an EFS & ESSM Certified Psycho-Sexologist (ECPs). Also, there we had a preparation course, this time even more multidisciplinary oriented. All this activities with the aim to facilitate the recognition and protection by the European authorities of medical doctors and psychologists in the field of sexual medicine and psychosexology.

In 2015, Copenhagen, we were celebrating the 20th anniversary of ESSM, always in shape, now with about 1700 members, and looking for sharing all our knowledge and innovation in the field of Sexual Medicine. In the same year an update of the ESSM syllabus of sexual medicine book has been published now under name of ESSM manual of Sexual Medicine.



In 2017, with Francois Giuliano as president, ESSM decide to defined our vision as "Sexual Health for everyone" and defined a mission statement "to promote sexual health and the highest standards of evidence based sexual medicine clinical care through education, research and the formulation of health care".

Sexology and sexual medicine are multidisciplinary specialties and sexual health is an important aspect of quality of life. Our insight into the anatomy, physiology, psychology, pharmacology, pathophysiology, clinical features, and management of patients with sexual dysfunctions has advanced enormously in the past couple of decades, but sexual medicine and sexology remain fragmented, not overall recognized and are practiced by doctors and psychologists who have very different backgrounds and expertise. A sexual medicine physician with knowledge and skills across the breadth of sexual medicine would be able to offer considerable benefits to patients. However, whether the full breadth of sexual medicine can be sensibly practiced by a single physician or therapist is debatable and unrealistic. Such a physician could not realistically be trained, which means that we instead need to train several different types of sexual medicine physicians and sexologists, with different practical skills but with a common understanding of the nature of the field and with the ability to collaborate with each other. Furthermore, scientific improvement and achieving competence in daily clinical practice can only be accomplished through scientific societies that collaborate on national and international levels.

To be able to ensure the future of our important field many actions need to be taken. In the last 2 years ESSM established more activities to make it possible. The involvement of young medical doctors and psychologists in education, research, and promotional activities is essential. This future generation has the opportunity to acquire the knowledge, skills, and attitude needed for clinical practice from recognized specialists in the field and also to shape their own future and the future of sexual medicine. Thus, in 2018, the ESSM launched the Young Sexual Medicine Academy (YoSeMa), a new committee to involve young health-care professionals in the field of sexual medicine.



ESSM executive committee strategic meeting, Paris 2017



ESSM School participants, Budapest 2017



First YoSeMa meeting, Lisbon 2018

To increase scientific content and to help clinicians in area with limited evidence, the Scientific Committee, with Giovanni Corona as chair, develop each year number of new position statements.

With advice of professional, representatives of the executive committee (M. Dewitte, F. Tripodi, Y. Reisman) are seeking for recognition of sexologist among the European authorities.

Our educational efforts are continuing. This year we introduced an Advanced Course in Sexual Medicine parallel to the established ESSM school, where experienced HCPs are able to increase their knowledge and skills. Both the School and advanced course under leadership of F. Tripodi, H. Pastoor, M. Fode and Y. Reisman, have been assessed as good to excellent by the participants. The ESSM Surgical Academy is getting shape and soon will start with practical activities in which surgeons will be able to gain objective and validated knowledge, skills and attitude in genital surgery.

A petition to the European authorities on educational needs of sexual health of undergraduates medical and psychology students are launched in collaboration with MJCSM and EFS.

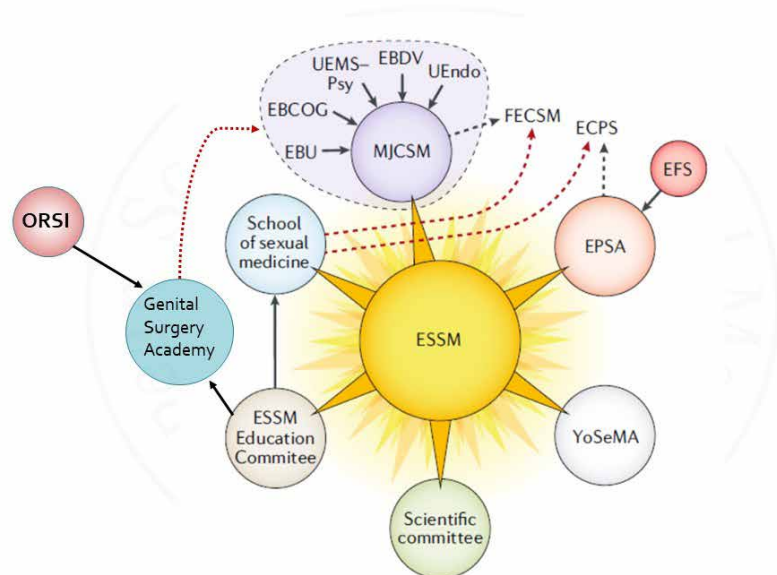
In January 2020 we are celebrating the ESSM 25 anniversary. ESSM is continue to work on our target of Education and Research to improve quality of care. ESSM count 34 affiliated societies in Europe, many members outside Europe and collaboration with many international and affiliated societies.

When combined, these initiatives should help to guarantee the future of the society and the profession of sexual medicine and offer a bright future for this new and evolving and important discipline.

It was great honor and a huge privilege to serve our society in all these years. To be inspired by the experienced ones, to push the young ones and make many friends.

Your almost past-president
Cobi Reisman

HAPPY BIRTHDAY TO ESSM FAMILY



ESSM different committees and actions

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Carlo Bettocchi, President Elect

The future

DEAR FRIENDS, DEAR COLLEAGUES,

it is exciting to start my 2 years period of ESSM presidency!

I have been serving our Society since 2005 when I firstly entered inside the Executive Committee with Prof Montorsi as President. After 3 years of EC member, I then took the position of Affiliates Societies Representative and I did it for an overall period of 4 years until my election as Treasurer in 2012. The 6 years passed in this position (2012-2017) helped me to fully understand not only the different activities but mainly to become acquainted in the control of the financial balance, looking carefully in our incoming/outcoming movements and acquiring experience in the many functional mechanisms of governance of our scientific Society.

Now after more than 15 years of ESSM work inside the EC, it is my time to guide the boat and maintain it in safe places, trying to lead it towards new shores. A long time has passed by since the Erectile Dysfunction and PDE5 inhibitors were the scientific core business of our Society. Nowadays, a number of new challenging horizons display in front of us.

We have set up a strong and effective Educational Office and we have planned and organized a robust educational program for the next future mainly in the field of penile surgery. The incoming surgical project will be the first educational program on "penile prosthesis implant" with a final CME recognized title and the industries involved in this field are enthusiastic to get started. Our School of Sexual Medicine, literally designed by Cobi Reisman in the last 10 years, is now a unique example in the world and all other scientific societies look at us trying to replicate our format. We are growing in number of attendants every year and expanding in terms of worldwide countries from where requesting people is coming.

In the meantime, we are also running some great changing in our Society structure. In fact, in view of the incoming European revolution due to the Brexit, we have recently decided to move our Charity Company from UK to Belgium, a stable European country ideal for our finance. We have also changed after nearly 20 years our services provider company and CPO Hanser has now been replaced by the new one named MCI, which is giving us a number of new ideas not only for the annual congress format but also for the website and social network. CPO deserves our deepest gratitude for the outstanding job that they have given us for such a long period of time. I am sure that also MCI will collaborate with us for many years as it is in the ESSM style to create strong and durable partnerships.

As all the dreamers, I have my personal vision for the next ESSM future.

I image a society without boundaries, able to be closer to each single affiliate Society and, even more, to each single member in his/her daily professional activities, teaching, educating, counselling and protecting. My first feeling is towards the young members of our Society, whose attitude is full of energy and ideas but still lacking experience and maturity. I give, therefore, great consideration to the recently born YOSEMA group. I really would like more and more young colleagues to get involved in the ESSM, getting the best of their ideas and experience in this field and in their countries, refreshing our Society mainly in communication and social activities. On the other hand, one of our main mission in the next few years should be to increase the connection with the other national and international Societies of Sexual Medicine worldwide. This strategy should be aimed to make the huge educational and scientific expertise of ESSM available also for extra European countries for a better information and training in sexual medicine.

To make dreams true, we need a very powerful team and a strong commitment. All the EC members are reliable, professionally valuable and good friends, as the ESSM members are hard workers and passionate care givers. All together, we can improve and fortify our Society, everybody being responsible of some specific task. We all have our busy professional life running in our countries, but we will find enough time to spend for the wellbeing of our Society. As it happens in the sports played by teams, we can win or loose together. I am sure that we are good and strong enough to win every year and so do not hesitate to stand up and be active every time you feel it is appropriate.

When I look back to all the previous ESSM Presidents I really feel honoured to belong to such a prestigious group of people which have contributes to create and develop such a strong and beautiful Society. I will do my best to ensure ESSM the brilliant future it deserves.

Best wishes to ESSM and to All of you.

Carlo

What's new? News from the Scientific Committee of the European Society for Sexual Medicine



G. Corona, ESSM Scientific Chair



Y. Reisman, ESSM President

The next ESSM meeting is approaching and several news will be presented during the congress. After several years of fruitful collaboration, in 2019 our Society has changed its congress organization, moving from CPO HANSER service to MCI Berlin. This has determined a productive discussion leading to a substantial changes and news for our congress. The number of classic round tables has been reduced whereas the debate sessions (DE) increased. In addition, the format of the debate sessions has been substantially revised. The duration of each DE has been increased from 30 minutes to 60 minutes. At the beginning of the DE, a 5 minutes clinical case will be presented concluding with 3 different questions which will be needed to be answer by the two different opponents. The chairs of the session will guide the match between the two opponent speakers, which will be based on 3 different rounds (one for each question). The speakers will take turns to support their own opinion. At the end of each session the audience will be asked to vote, using the congress app, in order to support the most convincing speaker. A final poll will establish the best speaker and the winner of the match.

The ESSM Scientific committee has selected 8 hot topics for the DE. The first two DE will deal with the use of energy-based technologies including radiofrequency (RF) or laser-based devices for the treatment of female genital pain or vaginal rejuvenation. These treatments have become increasingly popular during the last several years as an aesthetic alternative treatment for various gynecological medical conditions including genitourinary syndrome of menopause (GSM), stress urinary incontinence (SUI), vaginal laxity and sexual health. However, the evidence supporting this approach is conflicting. In addition, the United States Food and Drug Administration (FDA) issued on July the 30th 2018, a warning regarding the safety of energy-based technologies for indications such as vaginal "rejuvenation", cosmetic vaginal treatment, and vaginal conditions related to menopause, and symptoms of urinary incontinence and sexual function.

Another DE will specifically address the safety of the testosterone treatment (TRT) in subjects with benign prostate hyperplasia (BPH). The prostate safety during TRT still

represents a matter of intense debate. Recent data have paradoxically showed that TRT might improve and not worsen low urinary tract symptoms (LUTS), especially in patients with metabolic syndrome. However, the exclusion from the vast majority of the randomized controlled trials (RCTs) of patients with severe LUTS prevents, especially long-term, safety conclusions.

Hypogonadism issue represents the topic of another DE dealing with the efficacy and safety for TRT in men with functional hypogonadism (HG). The concept of a functional HG, in comparison to an organic one, is emerging. In particular, the latter is an irreversible condition, usually characterized by very low T levels, due to some organic damage occurring at any level of the hypothalamus-pituitary testis (HPT) axis, in which the benefit of TRT is well established. Conversely, functional HG – probably the most common and previously referred as age-related or late onset hypogonadism - is a potentially reversible form, with borderline low T levels, mainly associated with sexual symptoms, where the risk/benefit ratio of TRT is more debated.

Premature ejaculation (PE) represents one of the important male sexual complaints derived from the general population. For a long time off-label use of selective-serotonin inhibitors (SSRIs) has been the treatment of choice of this condition. Some years ago, dapoxetine, a short-acting SSRI has been introduced in the market as the first on label treatment for PE. Despite the promising data derived from RCTs, the real life use of this drug has not always confirmed the positive original data. Previous off-label use of topical drugs for the treatment of PE were based on a combination of topical anesthetic, which may be transferred to the partner and result in vaginal numbness. Hence, the patients are usually invited to use a condom after applying the cream on their penises. More recently, a new on label topical drug for the treatment of PE has been introduced in the market. It consist on a combination of lidocaine/prilocaine delivered in a metered dose spray. The drug-distribution and drug-delivery properties allow for reduced hypoesthesia to the penis and reduced time to onset of action without requiring the use of a condom after application. A potential intense DE will eventually establish the best (topical or oral) treatment for PE.

A specific surgical topic will be also covered. Short penis is a quite frequent clinical condition during sexual medicine consultations. Although sometime it reflects only an underlying psychological problem, it can be the result of different surgical approaches including radical prostatectomy or a consequence of some organic conditions such as Induratio Penis Plastica. The surgical and non-surgical approach to the short penis will be intensively discussed and possible psychological underlying factors will be emphasized.

Relational factors, such as long, hostile and more than likely dissatisfying couple bonding, represent a key element in sexual medicine. Over time, everyday stressors can leave couples worn out and uninterested causing them to drift apart eventually leading to the development of sexual impairment. In addition, available data clearly show that sexual dysfunction in one member of the couple induces marked distress in the partner, which in turn can generate sexual dysfunction. The introduction of phosphodiesterase-5 inhibitors (PDE-5is) has theoretically simplify the treatment of erectile dysfunction (ED). However, pharmacological treatment alone does not respond to all the maintaining concurrent factors of ED, including anxiety, loss of self-esteem, depressed mood, couple's communication problems, relationship problems, or partner's sexual dysfunction. Similar considerations can be drawn for other male and female sexual complaints. During a specific debate, the two speakers will discuss the role of the best approach when marital problems play a major role in

determining the sexual symptom.

The last DE is related to an important female topic dealing with the condition of sexual aversion and asexuality in female. Several psychosocial and organic conditions can result in a reduction of the frequency of women sexual intercourse eventually inducing sexual abstinence. The specific evaluation of all the underlining factors can allow planning specific interventions in order to improve the sexual avoidance. Accordingly, whether sexual pain as a consequence of vaginal dryness in menopausal women represents a crucial issue, the use of topic estrogens can frequently improve to situation. Sexual aversion disorder occurs occasionally in males and much more often in females. It is defined as a persistent or recurrent aversion to and avoidance of all or almost all genital sexual contact with a sexual partner, causing marked distress or interpersonal difficulties. This clinical condition especially when lifelong and generalized is often the result of previous sexual trauma, such as incest, sexual abuse, or rape. Role of sexologist is to adequately address all the possible information in order to adequately support and treat the patient and/or the couple symptom.

The introduction and the modification of the DE does not represent the only news offered this year. Outstanding speakers and scientists will discuss clinical cases during the breaks on January 24th. Congress attendees are requested to register for these great opportunities. More information will be available soon.

Finally, new ESSM statements will be presented as the result of ESSM scientific committee hard work. This year the topic covered include, "Animal model for Peronie's diseases", "Male infertility and sexual health", "Gynecological cancer and sexual health", "Psychosocial aspects of male sexual dysfunctions", "Peronie's diseases surgical approach outcomes and satisfaction", "Transgender surgery with attention for sexual function and satisfaction", "The use of traction devices for ED", and "Digital technologies for research in sexual health". All ESSM members are invited to the statement presentation joining the discussion for their improvement.

The annual ESSM meeting is approaching, our President, Yacov Reisman, and me, hope to see all of you in Prague enjoying the congress and the city, and participating in the ESSM Statements discussion.

**ESSM
2020**

Prague

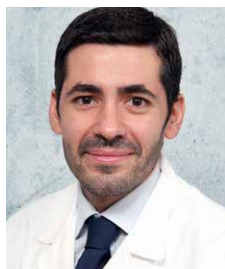


25 Year Anniversary

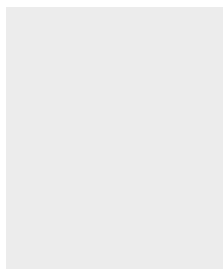
22nd ESSM CONGRESS

January 23–25, 2020
Prague, Czech Republic

25 Year Anniversary



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Department of Urology,
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Low intensity shock wave therapy in sexual medicine – clinical recommendations from the European Society of Sexual Medicine (ESSM)

In the last decade, low intensity shock-wave therapy (LISWT) has been tested as a physical treatment modality for several uro-andrological diseases including erectile dysfunction (ED), Peyronie's Disease (PD) and chronic prostatitis/chronic pelvic pain syndrome (CP/CPPS). Preclinical animal model studies have shown that the molecular mechanisms of LISWT may be related to different pathways of biological reactions: besides triggering neovascularization via the upregulation of the vascular endothelial growth factor (VEGF) and its receptor[1] shock wave focusing, coupling, and application have appeared that may address some of these problems. **OBJECTIVE:** To present a consensus with respect to the physics and techniques used by urologists, physicists, and representatives of European lithotripter companies.

EVIDENCE ACQUISITION

We reviewed recent literature (PubMed, Embase, Medline, LISWT has been found to promote progenitor cell activation, proliferation, migration and differentiation in penile tissue[2]. In vivo studies have demonstrated a differentiation of penile endogenous stem/progenitor cells toward smooth muscle cells and endothelial cells after localised LISWT treatment, resulting in a restoration of cavernosal tissue architecture in rat models of ED characterized by penile fibrosis and impaired vascularization[2]. In an animal model of cavernous nerve injury, LISWT was able to induce nerve regeneration by enhancing the recruitment and the activation of progenitor Schwann cells[3]. In the context of PD, it has been suggested that LISWT may exert a direct mechanical effect thus remodelling the penile plaque; moreover, the increase in local blood circulation could lead to the enhancement of inflammation and macrophage activity resulting in plaque lysis[4]. Finally, LISWT appeared to induce hyperstimulation of nociceptors, interrupting the flow of the nerve impulses responsible for pain in patients with CPPS[5] and may reduce the perineal muscle tone and spasticity when applied to the perineum[5]. However, all these findings deserve further investigation in order to come to any final conclusions. Several randomized clinical trials (RCTs)

and meta-analyses have investigated the role of LISWT for the treatment of ED, PD and CPPS, in humans but the clinical significance of this treatment method remains controversial. The European Society of Sexual Medicine (ESSM) has recently reviewed the evidence on LISWT for ED, PD and CP/CPPS and has proposed position statements for the use of LISWT in clinical practice, which are briefly summarized in this article.

ERECTILE DYSFUNCTION

1. TREATMENT EFFICACY

1.1. Patient reported outcomes (IIEF, EHS)

Current evidence is promising but is still controversial, therefore a clear clinical recommendation of LISWT for ED cannot be made and more high quality studies are needed.

To date eleven RCTs have investigated the clinical effects of LISWT on erectile function (EF). Most of them have a low-risk of bias and have been conducted in a double-blind fashion, although the blinding methodology has rarely been described in detail. Among them, the study by Srin and colleagues [6] suffers from high risk of bias due to a drop-out rate of 37% in the treatment group and 58% in the placebo group, casting doubts on the reliability of their findings. Likewise, the multi-centre trial conducted by Motil and coworkers [7] suffers from a poor description of methodology which results in a high risk of bias. Seven of the remaining studies were sham-controlled trials [8–14] and were considered by the ESSM committee to assess treatment efficacy. Of them, three trials [8,11,13] reported statistically significant results in regards to IIEF-EF and EHS improvement, two trials showed no difference [10,12] while two studies [9,14] reported a significant improvement only for one of the investigated outcomes (e.g. EHS or IIEF-EF).

Among the trials showing a positive effect of LISWT on EF there is the first published RCT [8], which included a total of 60 patients. The mean change from baseline IIEF-EF score after 1 month of follow-up was 6.7 points in the treatment group (n = 40) and

3 points in the sham group ($n = 20$) ($p = 0.03$) while the rate of patients reporting an EHS 3-4 score (meaning an erection hard enough for penetration) was 78% in the treatment group compared to 35% in the sham group. Similar data were reported by Kitrey and co-workers [11] in terms of IIEF-EF and EHS improvements after 1 month from the end of treatment. Interestingly the authors reported that 40.5% of patients in the LISWT group showed a clinically meaningful EF improvement according to the minimum clinically important differences (MCID) criteria compared to none in the sham group. In a more recent double-blind trial, the authors performed repeated follow-up assessments, showing no significant difference in the change of the IIEF-EF score after 1 month of follow-up, while significant results favouring treatment were observed at 3, 6, 9 and 12 months. Similar findings were reported by Yamacake et al. investigating the effect of LISWT among kidney transplanted men with ED: they reported a 5-point increase of the IIEF-EF in 70% of patients in the treatment group vs. only 10% in the sham group [14].

On the other hand, negative findings regarding treatment efficacy have been reported by other authors: in their RCT, Yee et al. showed no difference in the IIEF-EF or EHS scores at 1 month follow-up, although the study did not reach the minimum number of patients required to reach significance according to a power calculation [10]. Likewise, Fojecki and co-workers showed no statistically significant changes in the IIEF-EF and EHS score both at short and long-term follow-up [12,15]. However, it should be noted that in this trial the authors applied a gel pad delivering the shockwaves at skin level, which could have led to sub-optimal treatment due to poor penetration of the energy into the tissues. Finally, controversial findings were published in a last trial [9] where difference was observed in the IIEF-EF domain score changes between the LISWT and the sham group, but the rate of EHS 3-4 was 57% vs. 9% in the treatment and sham group respectively ($p = 0.0001$). Furthermore, five meta-analyses have investigated the effect of LISWT on ED showing an overall positive effect in terms of IIEF-EF score improvement, although the estimates are small (ranging from about 2 to 4 points of the IIEF-EF) and the heterogeneity among included studies is high [16–20].

1.2. Penile hemodynamics

LISWT significantly improves penile hemodynamic parameters of patients with vasculogenic ED. However, the clinical long-term significance of this improvement is uncertain (Level 2; Grade C).

Changes in penile hemodynamics, as assessed with penile Duplex ultrasound, have been reported only in 3 sham-controlled trials [8,11,13]. All of them showed a significant improvement in penile blood flow in the actively treated group as compared to controls.

1.3. Effect endurance

Current data suggest a variable effect of LISWT on EF up to 12 months after treatment (Level 2; Grade C). More data are needed to assess the longer-term effects of LISWT.

Overall, the above mentioned trials suffer from short follow-up, ranging from 1 to 12 months. In one non-sham controlled trial, Kalyvianakis and co-workers [21] randomized 42 patients to either 6 or 12 sessions of LISWT, with a repeated 6-session treatment course after 6 months: results suggested that repeating LISWT after 6 months could further improve the efficacy.

2. TREATMENT PROTOCOL

2.1 Energy source and type of SW (linear vs. focussed)

Currently, there are no studies comparing the two treatment methodologies. Further research should address the possible differences between focussed and linear SW.

Several types of SW generators have been used: most of the studies were performed with focussed SW generators and only 2 RCTs used a linear generator [7,12]. There are no data directly comparing the two types of generators; in one meta-analysis the authors performed a sub-group analysis according to the type of generators used, reporting a significant improvement of the IIEF-EF only for studies applying focussed SWs [18].

2.2. Settings and Protocol

There are only few data comparing different treatment protocols with the same SW generator, therefore a specific protocol cannot be suggested.

Treatment protocols vary widely among RCTs in terms of either energy flux density (EFD), number of SWs per session and length of treatment. There are no studies directly comparing different protocols.

3. INDICATION

LISWT for patients with vasculogenic ED, either treatment-naïve, responders or non-responders to PDE5-inhibitors, shows encouraging results, but unambiguous evidence for efficacy is lacking, pooled effect size is modest, and evidence quality is low. Patients should be informed about the conflicting results regarding efficacy of this treatment when discussing LISWT (Level 2; Grade D).

All RCTs included patients with vasculogenic ED with mild to severe levels of the disease. Data from meta-analyses showed controversial findings: Man et al. found a statistically significant EF improvement in patients with mild and severe ED [18]; moreover, patients who used PDE5is during treatment showed better results than those who did not. Lu et al. [17] reported a significant EF improvement only for patients with mild ED and for patients using PDE5is.

4. SAFETY

LISWT is a safe and well-tolerated procedure without clinically significant adverse events (Level 1; Grade A).

No adverse events (AEs) have been reported in sham-controlled trials.

PEYRONIE'S DISEASE

1. TREATMENT EFFICACY

1.1. Curvature:

Current data do not support the use of LISWT to reduce curvature (Level 2; Grade B).

Four RCTs were included in the analysis on the efficacy of ESWT in PD [22–25]. Of them, 3 were sham-controlled trials while one study compared LISWT with the combination of LISWT + tadalafil[25]. Mean curvature degree and plaque size were unchanged in 2 RCTs including only patients with stable disease [23,24]. In one trial including patients reporting a PD onset below 12 months, the authors observed a small decrease in curvature and plaque size in the LISWT group (-1.4° and -0.6 cm², respectively) which was statistically significant [22]. The same group performed a further RCT comparing LISWT vs. LISWT plus tadalafil 5 mg once daily: no significant effect was observed in terms of curvature and plaque size in both groups.

Penile pain as assessed with the Visual Analogue Score (VAS) was significantly improved by LISWT in several trials [22,24]. Gao et al. performed a meta-analysis including RCTs, cohort studies and case-control studies [26]. Pooled data analysis showed a higher chance of observing a lessening of the plaque, relief of pain and complete remission of pain in the LISWT group compared to controls. However, insignificant differences were found in improvement of penile curvature and sexual function [40].

2. TREATMENT PROTOCOL

No recommendation can be given on energy source and protocol. Further studies are needed

Concerning the energy delivered for PD treatment, there are no data comparing different treatment protocols and energy sources.

3. INDICATION

LISWT can be proposed as an option to reduce pain in patients with either acute or stable PD. (Level 2; Grade B)

Overall, two RCTs included patients with pain in the early acute phase of the disease [22,25], while in the other trials only patients with a stable PD were enrolled [23,24]. According to these data, the presence of pain should drive the indication for LISWT rather than the disease phase.

4. SAFETY

LISWT is a well-tolerated procedure without severe adverse events (Level 2; Grade B).

In 4 RCTs and 3 non-randomized, controlled studies [27–29] successfully used in orthopedic or salivary stones because of its lithotriptic power, can be used to break plaques in Peyronie's disease. \nMETHODS: A total of 130 patients affected with Peyronie's disease were entered into a prospective trial. Patients with completely calcified plaques as determined by ultrasound evaluation were excluded. We divided the patients into three treatment groups: (A LISWT was associated with petechiae along the wave direction on the penile surface (8.5%), skin haemorrhage (7%) and slight urethral bleeding (21%). No serious AEs were reported.

CHRONIC PELVIC PAIN SYNDROME

1. TREATMENT EFFICACY

1.1. Pain:

LISWT is an option to consider with the aim of improving prostatitis-like symptoms in patients with CP/CPPS. However, due to the limited evidence from clinical trials, and the off-label nature of this treatment, LISWT should not be considered the primary treatment for CP/CPPS (Level 2; Grade B).

Present knowledge on the efficacy and tolerability of LISWT in CP/CPPS treatment is based on 5 low-to-moderate quality studies, of these 4 are sham-controlled RCTs [30–33]setting, and participants: Sixty patients suffering from CPPS for at least 3 mo were investigated in two groups. Both groups were treated four times (once per week and 1 is a trial comparing LISWT to medical therapy with anti-inflammatory agents and alpha-blockers [34].

In CP/CPSS subjects, LISWT showed an improvement of prostatitis-like symptoms and pain observed after 12 weeks of follow-up [30–33]setting, and participants: Sixty patients suffering from CPPS for at least 3 mo were investigated in two groups. Both groups were treated four times (once per week. In particular, the decrease in NIH-CPSI total score was between 17 and 33% among the LISWT treated group and almost null or even increased in the sham-treated men [43–45]. However, these findings were not sustained after 24 weeks, as reported by the longest sham-procedure controlled trial [33]and the aim of this study was to evaluate the effect of extracorporeal shockwave therapy on CPPS due to non bacterial prostatitis in a long-term period. \n\nMATERIALS AND METHODS: In a follow-up survey, 40 patients with CPPS (that were randomly distributed into the treatment or sham groups were evaluated at 16, 20, and 24 weeks. In the treatment group, patients were treated by extracorporeal shock wave therapy (ESWT.

1.2. Other outcomes:

No specific recommendation could be made on the effects of LISWT in CP/ CPPS men regarding non-symptomatic outcomes, i.e. objective measures of prostate health.

Current evidence on the effects of LISWT on prostate characteristics at imaging or urodynamic parameters is insufficient to draw meaningful conclusions.

2. TREATMENT PROTOCOL

No specific recommendation can be made about technical details including number of pulses, energy and frequency to be used.

Concerning the energy delivered for the LISWT, most trials use perineal application with 3000 pulses, maximum total energy flow density of 0.25 mJ/mm² and a frequency of 3 Hz with a schedule of one application weekly for 4 weeks. All generators were used with focused SW. Unfortunately, there are no available data comparing different treatment protocols with the same SW generator, therefore a specific protocol cannot be suggested.

3. INDICATION

LISWT can be considered an option for patients with non-inflammatory CP/CPPS (NIH- IIIB).

All available RCTs have been conducted in patients with non-inflammatory CP/CPPS (category IIIB according to the National Institute of Health classification (NIH)).

4. SAFETY

LISWT as a therapy for CP/CPPS is not associated with any severe adverse events. LISWT is a safe and well-tolerated procedure (Level 2; Grade B).

No major adverse events were reported in all randomized trials assessing LISWT for CP/CPPS, thus suggesting that this is a safe and well-tolerated procedure.

CONCLUSIONS

In the last decade, great enthusiasm arose about the application of LISWT in sexual medicine. Evidence from pre-clinical studies along with the results of the first RCTs depicted LISWT as a promising therapy for ED. However, those encouraging results were not confirmed

in further published trials. In such a case, meta-analyses could be a useful research methodology to provide an answer to a controversial clinical question. Pooled-data analyses have supported the effectiveness of LISWT in improving the EF of patients with vasculogenic ED; however, these findings should be interpreted with caution, given the bias associated with the included studies and the high heterogeneity in terms of patients' baseline characteristics, treatment protocols and study design. Even more important, the reported treatment effect is rather small, casting doubts on the actual clinical significance of the observed improvement in psychometric scores.

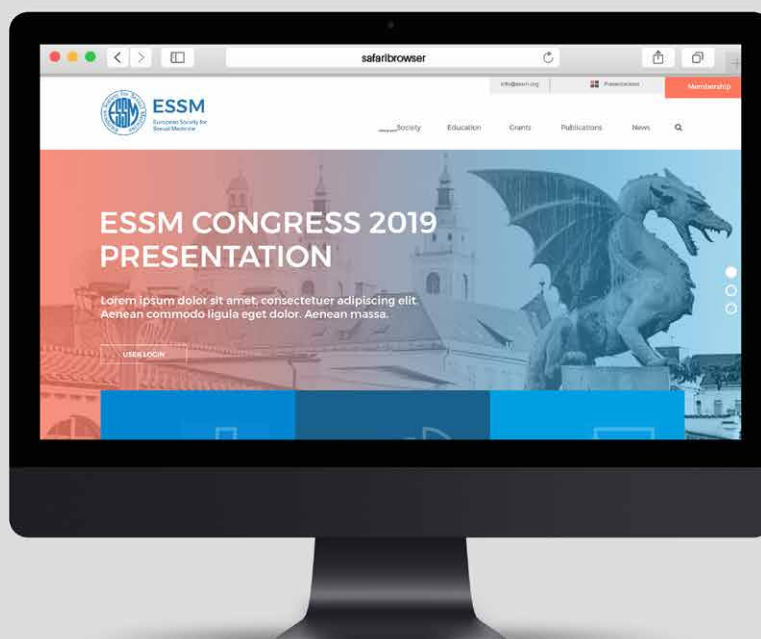
The application of LISWT in the context of PDs has shown less enthusiastic results. Available data are consistent regarding a lack of efficacy in terms of plaque size reduction and improvement of curvature. However, patients experiencing pain in the acute phase of the disease may benefit from this treatment.

Finally, LISWT could be a feasible option for the improvement of symptoms in men with CP/CPPS. However, this positive effect has been observed in few trials with a limited follow-up. The modification of non-subjective parameters has not been adequately studied so far.

New treatment methods have to be assessed in terms of both risks and

benefits. In the case of LISWT, the benefits are still controversial, while there is consistent evidence supporting the safety and tolerability of this treatment. As such, LISWT could be reasonably proposed as a treatment option in a research context after counseling the patient that its efficacy has not been definitively proven.

After approximately 10 years of intensive clinical research, several answers to important clinical questions are still missing: is LISWT an effective treatment? Is LISWT only effective for a few select patients? What is the best protocol to ensure a higher probability of treatment success? How long does the effect last? Futures studies are still needed to address these questions.



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Greetings from YoSeMA



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DEAR YOUNG SEXUAL HEALTH CLINICIAN,

Tired being a lonely wolf in your field and totally in need of some dose of inspiration? We feel you. As you may already know, the Young Sexual Medicine Academy (YOSEMA) is the most recent addition to the ESSM family. We are a young and motivated group of health clinicians who work in the field of sexual medicine, as part of the ESSM. We aim to facilitate younger members' engagement with the ESSM's more senior experts, thus operating as a stepping stone for ESSM activities. YOSEMA also aims to raise awareness for sexual health, particularly among young healthcare professionals and students, providing tools for them to do so. We also recognize the difficulties of working within the sexual medicine field, like, isolation in the workplace, difficulty in finding multidisciplinary teams to work with, or lack of established connections to ensure continuing medical education.

Here at YOSEMA we empower each other, especially the younger subset of professionals, students, residents, healthcare workers, nurses, physicians, physiotherapists and psychologists. Membership is free for ESSM members and just a few clicks away here.

As the offer of ESSM activities keeps expanding and online educational features are in demand like never, we make it super easy for you and drop all that you need as a young professional: education, health promotion and networking – on social media in the form of a super cool YOSEMA journal club.

This is no traditional journal club: YOSEMA Taskforce is working solidly together to present you the best digested sexual health research – so that you could enjoy the pleasure of reading the insights generated by peer young professionals and engage in the discussion.

WHEN? HOW? WHERE?

In late 2019, we hope to bring the Club online for all YOSEMA members. Coursing over 4 weeks, each monthly module will contain several components and will be a platform for education, discussion, debate and networking. We are truly excited for its fruition! After its debut and smooth start, more content JUST for YOSEMA Members will be added.

Don't get lost in the fast pace of the current world and join us for an efficient way of engaging with research and each other. Lonely super heroes are too much last year, join YOSEMA and be part of the change





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Hormonal Contraception and female sexuality – Position statements from the European Society of Sexual Medicine (ESSM).

INTRODUCTION

In the majority of industrialized countries about 60-75% of women of reproductive age married or in a stable relationship use some form of contraception [1]. The most commonly hormonal contraceptives (HCs) in European countries are short-acting reversible contraceptives (SARC), including Combined Oral Contraceptives (COCs), the patch and the vaginal ring, followed by long-acting reversible contraceptives (LARC), i.e. levonorgestrel (LNG) or copper IUD and the etonogestrel implant [1]. Fear of side effects and health concerns are among the main reasons for non-prescription or discontinuation. Although safety and efficacy of HCs have been extensively examined, little is known about their impact of on female sexual function, and the evidence on the topic is controversial. A position statement and recommendations for clinical practice about the effects of HCs on female sexuality have been recently published on behalf of the European Society of Sexual Medicine (ESSM) [2] and are briefly summarized in this article.

HCS, SEXUAL DESIRE AND THE ROLE OF (FREE) ANDROGENS DEFICIENCY

Statement #1.

Hormonal Contraceptives (HCs) can positively affect sexuality by different means, including a) overcoming fear of unwanted pregnancy during sexual activity, b) resolution of painful or troublesome gynecologic disorders such as endometriosis and dysmenorrhea and c) reduction of body image concerns with an increase in self-esteem for women with clinical hyperandrogenism (i.e., acne and or hirsutism) (Level 4; Grade C).

Statement #2.

All available combined HCs reduce androgen levels regardless of estrogen dosage and progestin type (Level 2; Grade B).

Statement #3.

Both combined oral contraceptives (COCs), transdermal patches and vaginal rings showed a similar effect in increasing Sex Hormone Binding Globulin (SHBG) levels and in reducing androgens levels (Level 2; Grade B).

Statement #4.

In the vast majority of the cases the use of COCs resulted in an increase or no change in sexual desire (Level 2; Grade B).

Statement #5.

Studies on the effects of non-oral forms of hormonal contraception are scarce precluding definite conclusions.

Testosterone is well known to be a pivotal positive modulator of male sexuality; its facilitating role in female sexuality, albeit less well-defined, has been consistently suggested in women with surgically induced menopause and reduced sex drive, who show an increase in sexual interest and activity after supplementation of transdermal testosterone [3]. Therefore, it has been acknowledged that androgen deficiency might be related to negative mood and sexual side effects of combined HCs. However, whether the reduction in the free testosterone fraction that occurs in women who have an increase in SHBG is clinically important is uncertain, and the sexual clinical implications of suppressed total and/or free androgen levels during COCs use are still a matter of debate [4].

Very few placebo-controlled randomized trials (RCTs) have been conducted on the topic. In a recent one, 340 women receiving COC [ethinylestradiol (EE)/levonorgestrel] or placebo for 3 months, significantly lower sexual desire, arousal and pleasure scores in COC users compared to placebo were observed, with a small effect size [5]. COC users showed a significant reduction in total and free testosterone, but no significant correlation with changes in sexual function was found [5]. Only one RCT in patients with COC-associated Female Sexual Dysfunction (FSD) evaluated the effect of switching to a COC containing either anti-androgenic or androgenic progestins; while both groups showed improvement of sexual function, no difference was observed between anti-androgenic or androgenic progestins [6].

Studies on the effects of non-oral forms of HCs (i.e. vaginal ring, patch, IUD and implant) are very scarce, but do not point to differential effects on desire versus oral contraception.

HCS AND ORGASM

Statement #6.

HCs induce a reduction in orgasm frequency (Level 3; Grade C). The LNG-IUD seems not to have an impact on orgasmic function (Level 2; Grade C).

No large and powered enough RCTs are available on the effect of HC on orgasmic function. A study performed on 1,101 women taking part in an online health and sexuality survey found that women using HC were more likely to report lower sexual pleasure and less frequent orgasms than women using non-hormonal methods [7]. However, other authors observed an increase in sexual enjoyment and orgasm frequency with COCs containing anti-androgenic progestins vs. baseline [8]. A multi-center cross-sectional study enrolling LNG-IUD and copper IUD users reported that the prevalence of problems with orgasm was comparable in both groups (7.1% vs. 10.2%) and to the prevalence reported in the general population [9].

HCS AND LUBRICATION

Statement #7.

Good quality data assessing the role of COC on vaginal lubrication and symptoms of vulvo-vaginal atrophy (VVA) are lacking and no conclusion can be drawn.

Statement #8.

No difference on lubrication and VVA symptoms are observed when COCs containing an anti-androgenic vs. an androgenic progestin are compared (Level 2; Grade C).

Statement #9.

Other types (etonorgestrel implant, the vaginal ring and the LNG-IUD) of HCs do not seem to show any negative effect on vulvo-vaginal morphology and lubrication (Level 3; Grade C).

Reduced levels of estrogens commonly determine VVA, leading to sensitivity to touch, burning, itching and dryness during sexual activity, as observed in menopause (also called genito-urinary syndrome of menopause, GSM) and – to a lesser extent – in HCs users [10]. Also hypoandrogenism is considered a pathogenic factor inducing or worsening VVA [10]. In this context some authors have suggested that COCs, in particular those containing low-dose (20 mcg or less) EE, were associated

with morphological alterations of the vulvar vestibular mucosa, leading to atrophy, secondary vulvar vestibulitis, and dyspareunia [11].

In a prospective study on women randomized to two different COCs (low and very-low EE dose) or to the vaginal ring, COC use was associated with a significantly higher prevalence of vaginal dryness than the vaginal ring (up to approximately 30% and 2% of women, respectively); however, the prevalence significantly decreased by cycle 12 [12]. Consistently, color Doppler ultrasonography performed in 22 healthy women in baseline conditions and after a 3-month treatment with a COC (30 mcg EE + 3 mg drospirenone), was able to highlight that labia minora thickness and vaginal introitus area were decreased, while vascular resistance indexes of clitoral and labial arteries increased [13]. In the same study, COC use exacerbated dyspareunia and worsened spontaneous arousability [13].

HCS AND PELVIC FLOOR AND UROLOGICAL SYMPTOMS

Statement #10.

Prior or current use of COCs has been associated with an increased risk of painful bladder syndrome (Level 3; Grade C).

Statement #11.

No sufficient evidence is available on the correlation between HCs and incontinence, pelvic floor function and urinary tract infection (UTIs) (Level 4; Grade D).

A meta-analysis of two trials showed a statistically significant association between painful bladder syndrome and the prior or current use of COCs (OR 2.31) [14]. In a large mail survey on more than 21,000 premenopausal women, the investigators highlighted a statistically significant 27% increased odds of developing urinary incontinence for prior or current users of COCs compared with never users; COCs use was specifically associated with urge – and not stress – urinary incontinence [15]. In contrast, a Swedish cohort study of 10,791 women observed that COCs was significantly related to a reduced risk for symptoms of stress (OR 0.57), mixed (OR 0.52) and urge urinary incontinence (OR 0.36), independent of age, body mass

index and pregnancy history [16]. In an internet survey conducted on a university population, low dose (<20 mcg EE) COCs appeared to increase the incidence of chronic pelvic pain symptoms and pain during sexual climax, while >20 mcg EE COCs users had similar incidence of pelvic pain to non-users; in fact, normal dose COCs showed a protective effect in individual pelvic pain symptoms [17].

HORMONAL CONTRACEPTION AND PARTNER PREFERENCE, RELATIONSHIP AND SEXUAL SATISFACTION

Statement #12.

HCs may be associated with changes in female perception of male attractiveness with a generally weaker overall preference for cues of genetic fitness (Level 3; Grade C).

Statement #13.

HCs discontinuation can induce women's sexual dissatisfaction due to less positive perception of partner's attractiveness (Level 3; Grade D).

Statement #14.

HCs use non-congruency between the initial phase (mate choice) and long-term relationship may have implications for relationship satisfaction related to the female preferences for partner genetic fitness (Level 4; Grade D).

Statement #15.

Women using HCs and their male partners manifest more frequent mate retention behaviors as compared to HCs non-users and their male partners (Level 3; Grade C). In a few controlled, non-randomized studies it was shown that women using HCs demonstrate weaker overall preferences for cues of genetic fitness (choosing less masculine faces) than do non-users [18, 19]. In a double-blind RCT using fMRI (functional Magnetic Resonance Imaging) it was found that the mechanism of oxytocin-related reinforcement of partner value representations via the brain reward system may be disturbed in women using HCs [20].

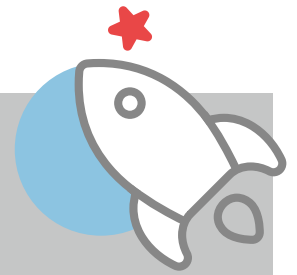
It has been suggested that congruency in current and previous HCs use (when the relationship formed), and not current use alone, predicted women's sexual (but not nonsexual) satisfaction with their partners ("congruency hypothesis") [21]. Finally, women using HCs and their male partners reported more frequent mate retention behaviors as compared to HCs non-users and their male partners in a cross-sectional study [22]. This is all in line with the preference of less-masculine but more reliable and responsible partners ("non-genetic" benefits), more intense affective responses to partner infidelity and greater overall sexual jealousy in HCs users [23].

CONCLUSIONS

Available evidence indicates that a minority of women experience a change in sexual functioning regards to general sexual response, desire, lubrication, orgasm and relationship satisfaction. However, the effects of HCs on sexual function have been understudied and remain to date controversial. The pathophysiological mechanisms leading to reported sexual difficulties such as reduced desire and VVA remain unclear. No sufficient evidence is available on the correlation between HCs and pelvic floor function and urological symptoms.

For these reasons, it is not possible to draw a clear algorithm for the management of HC-induced FSD. It has to be stressed that a careful psycho-sexual-relational assessment is necessary for the health care provider to evaluate eventual sexual effects of HCs, both at baseline and at follow-up. Potential sexual (and non-sexual) side effects for each method should be carefully explained and a patient-centered decision should always be supported.

In clinical practice, it is suggested to deal with HC-related distressing low desire by switching from hormonal to non-hormonal, from oral to non-oral (such as LNG-IUD, the vaginal ring or implants) or from estrogen-containing to no-estrogen containing forms of contraception (Level of Evidence 3). Similarly, in case of contraception-related reduced lubrication or VVA, it is suggested to switch from hormonal to non-hormonal or from oral to non-oral forms of contraception; in addition, a switch to COCs with higher EE doses may be advisable in these cases (Level of Evidence 3).



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Recognition and training for specialists in sexual medicine and sexology, still a critical issue: ESSM contributions to this developing matter



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ABOUT SEXUAL MEDICINE

Sexual medicine has historically been an unofficial specialty with no standards of training or recognition. In the early 20th century, therapy for sexual disorders was available on only a limited scale and only to a selected part of the population. However, during the second part of the 20th century, sexual medicine developed into a thriving branch of health care, which is now widely available. Historically, the physicians who provide care within the specialty of sexual medicine have largely been self-taught and come from a variety of medical disciplines including urology, gynaecology, venereology, psychiatry, cardiology, endocrinology, and primary care. The quality of care provided by these physicians has, therefore, been mostly unregulated and has only been demonstrable by audit, presentation of data at meetings, publication in peer-reviewed journals, and by the publication of guidelines by scientific societies (1,2).

One way of promoting high standards of medical care is by the regulation and assessment of education and training, regardless of the specialty (3). Thus, in 2011 on initiative of the European Society for Sexual Medicine (ESSM), the Union Européenne des Médecins Spécialistes (UEMS) established a Multidisciplinary Joint Committee on Sexual Medicine (MJCSM), which included representatives from the European Board of Urology (EBU), the European Board and College of Obstetrics and Gynaecology (EBCOG), and the UEMS Section for Psychiatry together with representatives of ESSM. Representatives from the European Board of Dermato-venereology (EBDV) joined in 2013 and UEMS Endocrinology (UEndo) joined in 2015. The primary purpose of the MJCSM is to develop the highest possible standards of training in sexual medicine in Europe.

In order to achieve this goal, beside the already running yearly ESSM School, a curriculum has been developed, educational standards for training set up, and an assessment framework – including development of an examination to become Fellow of the European Committee for Sexual Medicine (FECSM) – has been established (4). Concurrently with the

creation of the MJCSM, the ESSM also initiated the ESSM Education Committee. The primary responsibility of this committee is to build an educational programme for different levels of professions in sexual medicine, to increase knowledge and quality of patient care, and to support trainees in sexual medicine by providing educational opportunities to help them to be successful in the examinations required to become a FECSM (3). Concerning this last objective, two clear outcomes show the process:

1. the publication of The ESSM Manual of Sexual Medicine (5), indeed a world-wide unique opus, that covers all aspects of Sexual Medicine and should be considered a “must have” for all colleagues either interested in passing the European exam in Sexual Medicine or just in updating themselves in this special medical discipline to serve their patients with sexual problems at the highest available clinical standard in this field;
2. the condensed 3 days Preparatory Course for the MJCSM certification, which takes place biannually, offering a focused overview of Sexual Medicine through lectures delivered by renowned experts and aimed directly at increasing the chance of success in passing the FECSM exam.

Many efforts were done in these last 10 years to build educational courses for different levels of professions in sexual medicine and to increase knowledge and quality of patient care. Insights into the management of patients with sexual dysfunctions has advanced enormously in the past couple of decades and a multidisciplinary approach is accepted as the gold standard. That is why a sexual medicine physician with knowledge and skills drawn from clinical sexology, would be able to offer considerable benefits to patients.

ABOUT SEXOLOGY

The term Sexology includes the interdisciplinary science of sex but also the cumulated knowledge of sex that can be applied in professional practice – for example, in education, counselling, therapy,

and treatment. The persons who are active in these domains of sexual issues are called sexologists. The comprehensive history of training in sexology in Europe remains to be written, but based on the available documentation, some important improvements in sexological education in many European countries took place especially in the 1970s. The pioneers of that era were usually members of the medical profession, that had not been formally educated about sexual issues but had studied it informally on their own (6). In most cases, the organizers of the initial efforts at formal education in sexual issues were national or local associations that tried to fill the gaps in sexual knowledge and related skills for social and health professionals, who were understood to represent a very important recourse in promoting sexual well-being. An important step in the European collaboration on sexology was the founding of the European Federation of Sexology (EFS) in 1988, one of the major interests since its foundation being the promotion of education and training for sexologists and other professionals with an interest in sexual issues. In 2006, training in sexology was one aim to emerge from the "Euro-Sexo" study conducted in seven European countries and coordinated by Alain Giami (7). The results from the data collected indicated that most sexologists were non-physician health practitioners and mainly women: mental health and public health nurses, midwives, marital counsellors, and psychologists, who were the most commonly represented professionals. Unfortunately, only a few reported that they had been able to fully implement their knowledge and skills in sexology and sexual issues. From that time on, many efforts have been done, above all by the scientific societies, to establish a clear curriculum and improve the quality of education in the field. Nevertheless, in Europe and worldwide we are still far from a homogeneous situation concerning training programs and high-qualification standards. What is clearer, is that sexologists can be divided into several professional specialties, with different definitions, backgrounds and competencies (8), within which those who need specific clinical training are the following:

Sexual Counsellor:

A person with recognized professional qualifications in one or more of the behavioural sciences and trained

specifically in the practice of sexology as it applies to the provision of advice and guidance in personal, psychological, social or spiritual aspects of sexual life.

Sexual Psychotherapist:

A person with a recognised professional qualification in behavioural or clinical sciences, and trained specifically in the practice of sexology as it applies to the appropriate evaluation and psychotherapeutic treatment of sexual disorders.

The need of well-defined and identifiable certification of sexologists is necessary to provide informed choice for patients as well as to enhance the quality of care and facilitate collaborative and complementary work among specialists.

Concerning the recognition of Clinical Sexology specialists, no parallel system to the Union Européenne des Médecins Spécialistes exists for allied health professionals (AHPs) including psychologists; thus, the ESSM appointed a task force with the collaboration of the EFS for the development of similar accreditation processes (European Psycho-Sexologists Accreditation Committee - EPSA), in order to enable psychologists, psychiatrists, and MD with a training in psychotherapy to demonstrate their own competence in the field of sexology in a manner analogous to the FECSM examination and become an EFS & ESSM certified psycho-sexologist (ECPS) (9). Currently, this title is a "mark of excellence" to identify health care professionals who are trained and competent within the frame of a biopsychosocial approach to sexual problems. The EFS and ESSM aimed to provide candidates for the ECPS exam with educational support, beside the yearly ESSM School, in order to assist them in their preparation for the exam. The ESSM Educational Committee took a leading role in this by:

1. publishing the EFS/ESSM Syllabus in Clinical Sexology, a comprehensive multi-author book covering all topics of the ECPS curriculum (10). This book reflects the knowledge of 61 experts with various scientific backgrounds, contributing to a synthesis of today's state of the art knowledge on clinical sexology.

2. organizing a preparatory course for the ECPS exam, aiming to provide lectures on a broad range of topics according to the ECPS curriculum. This is also a great opportunity for candidates from different countries to meet and liaise with each other.

RECALLING THE PROBLEMS THAT REMAIN UNMET

AWARENESS AND BASIC EDUCATION

Although the World Health Organization (WHO) includes sexual health in the definition of overall health, well-being, and quality of life, Sexual Medicine and Sexology remain still neglected by most European universities. However, plenty of studies have shown not only the high prevalence of sexual dysfunctions and their impact on intrapsychic, relational, and general health, but also the exquisite ability of the sexual dysfunctions themselves to predict or to be comorbid with a number of Non-Communicable chronic Diseases (NCDs). Finally, the traditional belief that sexology grounds more on opinions than on evidence is no more tenable, considering the significant scientific developments in this field during the last two decades, being a part of the mainstream science.

Therefore, considering the importance of sexual education and counselling in general health during the lifespan and in the large majority of diseases, the large and widespread interest in sexual health, and the need of patients to get professional care and help for their sexual concerns, problems and dysfunctions, the students of medicine, psychology, and health care professionals within various specialties must be prepared to deal with medical and psycho-social aspects related to general sexual health.

HIGH STANDARD OF CARE

To guaranty high level of care, standard education and training programs are needed and recognition of those who are qualified are mandatory.

Although several national scientific associations provide sexology courses for physicians and psychologists at different levels and quality, it is still difficult to find training programs in many countries,

with expert and international well-known speakers. Many courses do not follow a biopsychosocial approach, meaning that they offer training from a medical point of view, neglecting psychological or cultural aspects involved in the onset of a sexual problem, or vice versa not considering the biological and medical part when teaching on sexual counselling/therapy.

Moreover, after an education course in sexual medicine or sexology, it could be arduous for one to find a good supervisor, with the amount of experience and clinical skills which are needed. Nevertheless, among the requirements to get qualified titles, individual or group supervision is almost always demanded.

SCIENTIFIC COMMUNITY

A community for sexual medicine and sexology is needed. Understanding why is important: these are multidisciplinary specialties and sexual health is an important aspect of quality of life. Our insight into the anatomy, physiology, psychology, pharmacology, pathophysiology, clinical features, and management of patients with sexual dysfunctions has advanced enormously in the past couple of decades, but sexual medicine and sexology remain fragmented and are practiced by doctors and psychologists who have very different backgrounds and expertise. A sexual medicine physician with knowledge and skills across the breadth of sexual medicine would be able to offer considerable benefits to patients. However, whether the full breadth of sexual medicine can be sensibly practiced by a single physician or therapist is debatable, and expecting all sexual medicine physicians to be able to operate on a penile deformity and also to be able to provide psychosexual counselling to couples is unrealistic. Such a physician could not realistically be trained, which means that we instead need to train several different types of sexual medicine physicians and sexologists, with different practical skills but with a common understanding of the nature of the field and – perhaps most importantly – with the ability to collaborate with each other. Furthermore, scientific improvement and achieving competence in daily clinical practice can only be accomplished through scientific societies that collaborate on national and international levels (2). Ensuring the future of this important field

means that involvement of young medical doctors and psychologists in education, research, and promotional activities is essential. This future generation has the opportunity to acquire the knowledge, skills, and attitude needed for clinical practice from recognized specialists in the field and also to shape their own future and the future of sexual medicine and sexology.

ESSM CONTRIBUTIONS IN DEVELOPING THESE ISSUES

Regarding the Awareness and basic training, in 2019 the ESSM brought out the need to improve the impact of Sexual Medicine and Sexology on academic and health care practice at the European level. Guiding this project, ESSM:

1. endorsed the MJCSM, with the support of the UEMS and its boards involved in sexual medicine, for a petition to the European Parliament and European University Authorities that advocates the need of all students of the European medical schools to receive specific education and formal academic learning in sexual medicine (sign it at <https://www.change.org/p/medical-faculties-and-european-union-sexual-health-education-to-all-medical-students-in-europe>);
2. involved the EFS in collaborating for a petition to the European Parliament and European University Authorities that advocates the necessity of all students of the European Psychological Faculties to receive specific education and training in sexual health and sexology by the next academic year (sign it at <https://www.change.org/p/european-parliament-sexual-health-education-to-all-psychology-students-in-europe>)

Hence, European medical school and psychology faculties should:

- develop students' knowledge and understanding about sexual function, gender identity, sexual orientation, and the diversity of human sexual expression and behaviour;
- teach diagnosis and integrated therapies of the major sexual dysfunctions from early to old age;

- recognize the role of sexual dysfunctions as an early biomarker for identifying NCDs
- promote the role of medical doctors in Sexual Medicine and psychologists in Sexology and in the prevention of sexual dysfunctions;
- improve student's ability to communicate about sexuality and sexual health and about mutual respect of genders and sexual orientations.

Concerning high standard of care, the ESSM developed multidisciplinary training programs intended for clinicians seeking to acquire the knowledge and skills necessary for practice (ESSM School of Sexual Medicine) or to gather advanced knowledge and improve skills (ESSM Advanced Course) in Sexual Medicine and Clinical Sexology, in the frame of the biopsychosocial approach. The International Society for Sexual Medicine (ISSM) and the European Federation of Sexology (EFS) support the School by giving grants for participants coming from developing country or in financial strain. The School program is intended for persons with post-graduate experience in any relevant clinical specialism. Interest in and enthusiasm for Sexual Medicine are the essential qualifications; whilst previous experience in the clinical practice of Sexual Medicine is an advantage, the program is also suitable for those starting out in this fascinating and rapidly developing area of medicine. Psychologists and therapists are welcome to join the program as well and special skills in surgery or psychotherapy are not a requirement for participation. The 10 days residential courses cover a wide range of Sexual Medicine and Clinical Sexology topics and provides the essential background learning from which clinical experience and research can be developed. Professionals who intend to apply for the Advanced course (a novelty of 2019) should have more than 5 years working clinically in Sexual Medicine or Clinical Sexology and attended specific training in Sexual Medicine/Clinical Sexology or ESSM school, plus work in multidisciplinary team or already FECSM or ECPS.

Beside knowledge and skills, these courses aim to offer an "precious experience", both from a professional and a personal point of view that is quite unique: participants are exposed to a multicultural and

multidisciplinary context (specialists coming from all over the world), with an estimated and well-known faculty available to share the clinical experience through lectures, workshops, supervision of clinical cases and role-plays. The social gathering allows participants and speakers to networking and hopefully keeping in contact far beyond the course attendance. This special opportunity is the most appreciate and acknowledged by participant's feedbacks in the last 7 years, presented officially each year during the ESSM annual congress.

Since 2018 ESSM devoted much energy and financial resources to support recognition of the profession by the European authorities. A task-force with representatives of the ESSM has been established to seek protection of the professional title among the European Commission and highlighting the importance of Sexual Health for quality of life.

Last, but not least, about the Scientific Community, in 2017, the ESSM launched the Young Sexual Medicine Academy (YoSeMa), a new committee to involve young health-care professionals in the field of sexual medicine. YoSeMa aims to promote sexual medicine among young clinicians (up to 40 years old) from various disciplines in order to increase knowledge and skills, to connect residents and young scientists with established specialists, and to define the needs of early-career sexual medicine specialists and sexologists. The committee recognize the difficulties of working within the sexual medicine field, like, isolation in the workplace, difficulty in finding multidisciplinary teams to work with, or lack of established connections to ensure continuing medical education. Therefore, YoSeMA aims to engage young health professionals with an interest in sexual health, to foster networking and education, support the goals of, as well as providing a bridge to ESSM activities. The term 'young' is somewhat misleading; in this context it applies to clinicians and researchers at the beginning of their medical career and is not that relevant to age. Eventually, YoSeMa is also in charge of creating initiatives to raise awareness of the specialty as a career option and encourage newly qualified medical doctors and psychologists to consider it.

CONCLUSION

The vision of ESSM is that Sexual Health will be for everyone and our mission is to promote the highest standards of evidence based sexual medicine clinical care through education, research and the formulation of health care. As describe above, tremendous efforts have been done to achieve these targets in the last decade.

The visionary view of ESSM's executives have led to an increase in scientific work and knowledge of sexual medicine and to the creation of high-level educational opportunities.

Through education, training, supervision and certification a lot has been done but there is still a way to go to achieve ESSM's vision and mission. Ultimately, we hope to achieve full recognition of the profession which in turn will ensure high quality of care and patient safety.

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Interview with Pedro Nobre

Filippo Nimbi interviews Pedro Nobre, President of the World Association for Sexual Health (2017-2021)



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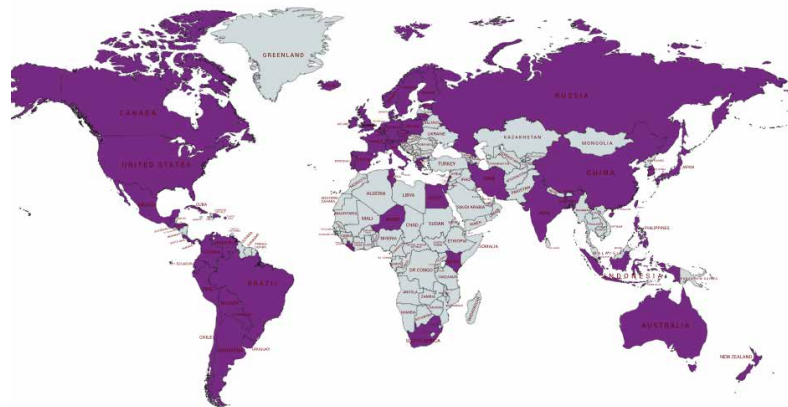
F.N.: The WAS congress in Mexico City was a great success. Congratulation! What are your best memories and results you bring back with you as the president from this edition?

P.N.: The WAS Congress in Mexico was a great example of a common achievement. I have never been in a WAS Congress (and my first congress was in Hong-Kong 20 years ago) with such a high level of involvement at the political level. The second figure of the Mexican Government addressed a great speech in defense of sexual health and rights in Mexico at the Opening Ceremony. Moreover, we had the active participation of some of the higher level representatives of the global organizations (UNFPA, UNESCO, IPPF, WHO, etc.) <https://www.was2019.org/>

Also, with over 1500 participants from more than 70 countries of the five continents (see map below) and almost 1000 presentation this was the second most attended and participated congress of the WAS history (thanks to the very hard work of the Local Organizing Team – FEMESS - and the WAS Scientific Committee).



Moreover, the Mexico City Congress Sexual Pleasure Declaration <https://worldsexualhealth.net/declaration-on-sexual-pleasure/>, was a landmark of the congress, which was only possible because of the fantastic work of so many colleagues from within and outside WAS (including work conducted during the congress). The Sexual Pleasure Declaration is a huge collective achievement that is gathering wide attention across the world.



Osmar Matsui Santana (Congress President) & Alain Giami (Chair WAS Scientific Committee)



Sexual Pleasure Team during meeting in NYC

Now it is time to start working for the WAS Cape Town Congress in 2021. This is already historic since it will be the first WAS Congress ever in Africa (see picture of the WAS AC team below).

F.N.: Where are we with the integration of sexual medicine, sexual health and advocacy? Which are the most urgent steps in this process?

P.N.: This is a very important question. One of the major strategic goals of the World Association for Sexual Health is exactly to build bridges between scientific knowledge of the multidisciplinary aspects of sexuality (including sexual medicine, clinical sexology, socio-cultural aspects of sexuality, sexual and reproductive health, sexuality education, gender studies, etc) and sexual rights. WAS mission is to “promote sexual health through the world by developing and supporting sexology and sexual rights for all”. Therefore an integrative approach and dialogue between the different disciplines dedicated to the study of sexuality, as well as a proactive attitude toward the translation of scientific knowledge to promote sexual health and well-being and sexual rights is a central aspect of our strategic action.



WAS Advisory Committee during its meeting in Mexico City

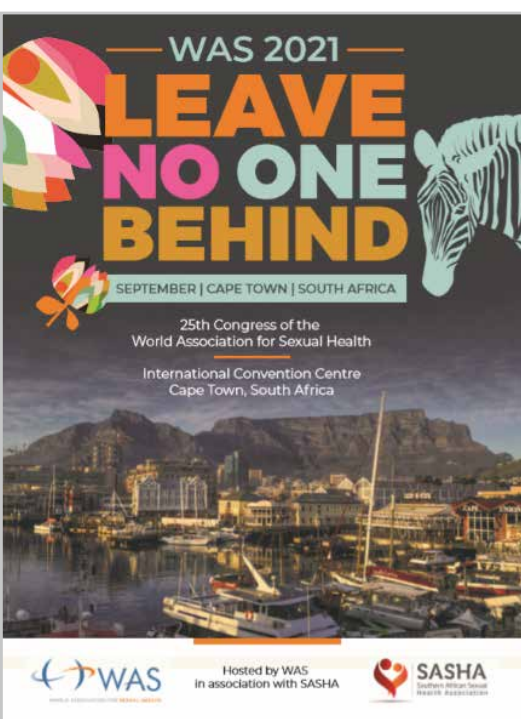
In this line, the partnership between WAS and ESSM as well as ISSM and the other regional societies of sexual medicine around the world is fundamental. Joining forces and exchanging scientific knowledge in the different domains of sexual health is one first important step (which is now consolidated through the exchange of invited symposia in each other congresses). However, I believe we should go beyond exchanging knowledge and dialoguing on sexual health topics.

In my opinion we could do more together regarding the translation of knowledge into actions that really benefit people in this key dimension of human life. In other words develop consistent actions aimed at promoting sexual health and well-being and sexual rights. One recent example is the WAS Declaration on Sexual Pleasure, where we DECLARE that: “Sexual pleasure is part of human experience and subjective well-being. Sexual pleasure is a fundamental part of sexual rights as a matter of human rights, and that the “inclusion of sexual pleasure to meet individuals’ needs, ultimately contributes to global health and sustainable development and it should require comprehensive, immediate and sustainable action”.

A WAS symposium will be hold in Prague during the ESSM meeting around the topic of Sexual Pleasure and why it matters to promote sexual health.

F.N.: Can you give us more examples of the main ongoing projects during your term as president of WAS?

P.N.: In order to be more effective in working toward achieving our main goals and mission WAS is building and strengthen partnership and alliances with global organizations, particularly UN agencies and WHO. This is crucial, since we cannot promote sexual health and rights throughout the world without a strong alliance with the major organizations working in the field.



Welcome to Cape Town 2021 for the 25th WAS World Congress

WAS PARTNERSHIP WITH GLOBAL ORGANIZATIONS:

UN ORGANIZATIONS

WAS has been involved in the UNESCO's International technical guidance on sexuality education: An evidence-informed approach (2018). Moreover, WAS has participated in a number of activities from UNFPA, UNDP, UNAIDS and UNICEF.

WHO

WAS had long history of official relations with WHO and have develop a number of important projects in collaboration including the development of working definitions of sexual health (2002; 2006), a conceptual framework of promoting sexual health, guidelines for sexual counseling, and assisting in the development of the sexual and gender diagnoses for ICD-11. Currently WAS is strengthening the collaboration with WHO, and we are together planning a number of important projects, namely the Global Survey on Sexuality, the Sexual Pleasure and Sexual Health Project, Trans Rights as Human Rights, continued assistance with implementation of ICD-11. Besides, **WAS** submitted a proposal for the **Global Health Survey Measure** <https://www.who.int/news-room/detail/03-09-2019-seeking-feedback-to-develop-a-population-representative-sexual-health-survey-instrument> a very important **WHO project in which WAS is a main partner**. In the WAS proposal we argued in favor of the inclusion of understudied dimensions related to sexual health, sexual rights and sexual pleasure.

Furthermore, and following the strong involvement with UN agencies, **WAS participated at the Nairobi Summit (ICPD25)** to celebrate the 25 years of the Cairo meeting <https://www.nairobisummiticpd.org/>. This summit was prepared by the UNFPD and was the **highest level meeting** in the field of **Sexual Health and Reproductive Rights at the global level**. I was fortunate to be in Nairobi representing WAS and be immersed by the **great enthusiasm of almost 10.000 participants** working on the field of sexual and reproductive rights and gender equality



WHO technical meeting to prepare the Global Health Survey Measure

from all around the world. During the summit I had the opportunity to **meet the highest level representatives** of **UNFPA, WHO** and some **governmental representatives** and discuss strategic partnerships. The conversation with **Dr. Natalia Kanem** (the UNFPA Director – see picture below) was especially rewarding given the interest expressed from her to establish a **partnership with WAS** for the organization of the **first WAS Congress in Africa**.



Finally, one major activity promoted by WAS is the **World Sexual Health Day**. In 2010, the WAS called on all their member organizations and all NGOs to celebrate, each September 4th, World Sexual Health Day (WSHD) <https://worldsexualhealth.net/news/world-sexual-health-day/> in an effort to promote a greater social awareness of sexual health and sexual rights across the globe.

Since then every year we have been celebrating the WSHD with increasing participation of organizations from regional and country level. The date has been recognized by many global organizations that have joined WAS in promoting the WSHD (WHO, UNAIDS, UNFPD, IPPF, etc.). The strategic goal is to have the WSHD officially recognized by the UN.



SEXUALITY EDUCATION FOR ALL
A bridge to sexual health





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Have you read? Best of the best: clinical research

FEMALE SEXUALITY

Both S, Lew-Starowicz M, Luria M, et al. Hormonal Contraception and Female Sexuality: Position Statements from the European Society of Sexual Medicine (ESSM). *J Sex Med* 2019; 16: 1681-1695.

Hormonal contraception is available worldwide in many different forms. Although the safety and efficacy of contraceptives have been extensively examined, little is known about their impact on female sexual function, and the evidence on the topic is controversial. This paper aimed to review the available evidence about the effects of hormonal contraceptives on female sexuality in order to provide a position statement and clinical practice recommendations on behalf of the European Society of Sexual Medicine. Several aspects of female sexuality have been investigated, including desire, orgasmic function, lubrication and vulvovaginal symptoms, pelvic floor and urological symptoms, partner preference, and relationship and sexual satisfaction. The effects of hormonal contraceptives on sexual function have not been well studied and remain controversial. Available evidence indicates that a minority of women experience a change in sexual functioning with regard to general sexual response, desire, lubrication, orgasm, and relationship satisfaction. The pathophysiological mechanisms leading to reported sexual difficulties such as reduced desire and vulvovaginal atrophy remain unclear. Insufficient evidence is available on the correlation between hormonal contraceptives and pelvic floor function and urological symptoms.

Davis SR, Baber R, Panay N, et al. Global Consensus Position Statement on the Use of Testosterone Therapy for Women. *J Sex Med* 2019; 16: 1331-1337 | *Climacteric*. 2019; 22(5): 429-434 | *Maturitas* 2019; 128: 89-93 | *J Clin Endocrinol & Metabol* 2019; 104(10): 4660-4666 This Statement is being simultaneously published in the journals *Climacteric*, *Maturitas*, *Journal of Sexual Medicine*, and *Journal of Clinical Endocrinology and Metabolism* on behalf of the International Menopause Society, The European Menopause and Andropause Society, The International Society for Sexual Medicine, and The Endocrine Society, respectively.

The international panel concluded the only evidence-based indication for testosterone

therapy for women is for the treatment of HSDD, with available data supporting a moderate therapeutic effect. There are insufficient data to support the use of testosterone for the treatment of any other symptom or clinical condition, or for disease prevention. Meta-analyses of the available data show no severe adverse events during physiological testosterone use, with the caveat that women at high cardiometabolic risk were excluded from study populations. The safety of long-term testosterone therapy has not been established. It was considered of utmost importance that the diagnosis of HSDD involves a full clinical assessment and that other factors contributing to FSD must be identified and addressed before testosterone therapy is initiated. A blood total testosterone level should not be used to diagnose HSDD. Treatment should only be with formulations that achieve blood concentrations of testosterone that approximate premenopausal physiological concentrations. As no approved female product is presently approved by a national regulatory body, male formulations can be judiciously used in female doses and blood testosterone concentrations must be monitored regularly. The panel highlighted the pressing need for more research into testosterone therapy for women and the development and licensing of products indicated specifically for women.

ERECTILE DYSFUNCTION

Jenkins LC, Hall M, Deveci S, et al. An Evaluation of a Clinical Care Pathway for the Management of Men with Nonorganic Erectile Dysfunction. *J Sex Med* 2019; 16: 1541-1546.

While there exists little literature on this specific topic, this study was conducted to assess the outcomes of men with nonorganic ED treated medically. All patients had normal hormone profiles and vascular assessment and were given a trial of a PDE5i. If no improvement, intracavernosal injection (ICI) therapy was administered. All patients met a mental health professional. 116 men with a mean age of 38 ± 19 (range 16-57) years were studied. 21% had mild ED, 47% had moderate ED, and 32% had severe ED. 81% of patients responded to PDE5i with a penetration hardness erection on follow-up. However, only 68% had a consistently good response. The mean Erectile Function domain score on PDE5i improved from 18

± 11 to 22 ± 6 , and for PDE5i responders it was 27 ± 4 . 28% of men attempted ICI, all obtaining consistently functional erections. At a mean time point of 11 ± 5 months, 83% of those responding to PDE5i had ceased due to a lack of need. 11% of those using ICI continued to use them 6 months after starting ICI; the remainder had been transitioned back to PDE5i. Of the 29 patients in the latter subgroup, 66% were no longer using PDE5i consistently due to a lack of need. In conclusion, medical management of nonorganic ED utilizing the process of care model results in cure in a large proportion of such patients. The transient use of ICI in some patients permits successful PDE5i rechallenge.

Capogrosso P, Ventimiglia E, Boeri L, et al. Should We Tailor the Clinical Management of Erectile Dysfunction According to Different Ages? J Sex Med 2019; 16: 999-1004.

This study intent to investigate the relationship between erectile function (EF), sexual satisfaction, and mood status among patients seeking medical help for ED. Data from 765 patients presenting at a single center for ED were analyzed. Patients were categorized as young (<50 years), middle-aged (>50 and 65 years), and old (>65 years) individuals and completed the IIEF and the BDI. Compared with older men, young and middle-aged patients showed significantly higher IIEF-OS and IIEF-Intercourse Satisfaction scores for increasing IIEF-EF scores. Older men showed no difference in terms of satisfaction scores for mild ED and normal EF status. At linear regression analysis, both IIEF-EF and age were significantly associated with sexual satisfaction. The interaction term between age and EF was also significant, suggesting that the older the patients, the higher the feeling of sexual satisfaction for the same EF status. Overall, 25% of patients reported depressive symptoms. Logistic regression analysis showed a 40% risk of depressive symptoms for patients <45 years with severe ED compared to a risk <20% for a man >65 years of age with the same EF status. Treating older patients with mild ED may not lead to a further improvement in sexual satisfaction as compared with younger patients with the same ED severity thus supporting the need for a comprehensive psychological counseling in younger ED patients.

Zhao B, Hong Z, Wei Y, et al. Erectile Dysfunction Predicts Cardiovascular Events as an Independent Risk Factor: A Systematic Review and Meta-Analysis. J Sex Med 2019; 16: 1005-1017.

This review aims to assess whether ED was a risk factor for CV events. The protocol of this meta-analysis is available from PROSPERO (CRD42018086138). 25 eligible studies involving 154,794 individuals were included. Compared with those of men without ED, the CVD risk of ED patients was significantly increased by 43%, CHD was increased by 59%, stroke was increased by 34%, and all-cause mortality was increased by 33%. Older individuals with ED (>55 years), those with ED of a shorter duration (<7 years), and those with higher rates of diabetes (>20%) and smoking (>40%) were more prone to develop CVD. Additionally, severe ED was proven to predict higher CVD and all-cause mortality risk. The standardized model proposed here can be properly applied for screening early CV events. The evidence suggests the need for diligent observation of at-risk men and reinforces the importance of early treatment to prevent CV events.

SEXUAL DYSFUNCTION

Miranda EP, Taniguchi H, Cao DL, et al. Application of Sex Aids in Men with Sexual Dysfunction: A Review. J Sex Med 2019; 16: 767-780.

This article aims to summarize medical literature regarding scientific uses of the most common sex aids in men with sexual dysfunction and assess their clinical applicability. An extensive literature review was done and authors present a comprehensive review of the most common sex aids currently available: pornography, lubricants, constriction bands, dildos, vibrators, vacuum devices, external erectile support devices, and aids to positioning. They also discuss their indications, outcomes, precautions, and complications in order to have a comprehensive understanding of the sexual dynamics of individuals and couples combined with the appropriate integration of sex aids that may have a positive effect in the treatment of male sexual dysfunctions.

Russo GI, Mauro M, Cocci A et al. on behalf of EAU-YAU Men's Health Working Group. Consulting "Dr. Google" for Sexual Dysfunction: A Contemporary Worldwide Trend Analysis. Int J Impot Res 2019; doi:10.1038/s41443-019-0203-2.

Google Trends (GT) is a free, easily accessible search tool which can be used to analyze worldwide "big data" on the relative popularity of search terms over a specific period of time. To determine worldwide public interest in Peyronie' disease (PD), erectile dysfunction (ED), premature ejaculation (PE) treatments, their penetrance, variation, and how they compare over time. The results showed that for PD it has been a decreased interest for Drug (AAPC: -3.1%, $p < 0.01$), ESWT (AAPC: -3.1%, $p < 0.01$), and vacuum therapy (AAPC: -1.2%, $p < 0.01$). In the field of ED, we observed trends toward an increased interest in prosthetic surgical treatment (AAPC: +1.7%, $p = 0.4$), for prostaglandins (AAPC: +0.7%, $p=0.7$), for traction (AAPC: +0.6%, $p=0.1$) and for ESWT (AAPC: +1.8%, $p=0.4$), but without statistical significance. On the contrary, we observed a slight reduction of search for Vacuum device (AAPC: -1%, $p < 0.01$). The interest in PE decreased from 2004 to today (AAPC: -1%, $p < 0.01$), for surgical treatment (AAPC: -3.1%, $p < 0.01$), drug treatment (AAPC: -3.1%, $p < 0.01$), and for psychotherapy (AAPC: -6.7%, $p < 0.01$). On the contrary, the interest in spray drugs has increased significantly (AAPC: +5.1%, $p < 0.01$). Patients are searching the web for sexual diseases treatment options. Understanding people inquisitiveness together with degree of knowledge could be supportive to guide counseling in the decision-making-process and put effort in certifying patient information, avoiding them to fall in the pernicious trap of 'fake-news'.

Capogrosso P, Frey A, Jensen CFS, et al. Low-Intensity Shock Wave Therapy in Sexual Medicine—Clinical Recommendations from the European Society of Sexual Medicine (ESSM). J Sex Med 2019; 16: 1490-1505.

LISWT has been investigated for the treatment of uroandrological disorders including ED, PD and chronic CP/CPSP with controversial findings. 11 RCTs and 5 meta-analyses investigated LISWT for

ED. RCTs provided controversial results on the efficacy of LISWT and were affected by high heterogeneity and the small number of patients included. Pooled-data analysis showed an overall positive effect in terms of erectile function improvement but reported small estimates and included a largely heterogeneous cohort of patients. 4 RCTs and 1 meta-analysis assessed LISWT for PD. All trials showed positive findings in terms of pain relief but no effect on penile curvature and plaque size. Inclusion criteria vary widely among studies, and further investigation is needed. 5 RCTs investigated LISWT for CP/CPPS. Data showed a possible effect on pain relief, although there is no evidence supporting that pain relief was maintained or any improvement in pain over time. LISWT is a safe and well-tolerated procedure but its efficacy for the treatment of ED is doubtful and deserves more investigation. Patients reporting pain associated with PD may benefit from LISWT, although no effect is expected on disease progression. LISWT is not a primary treatment for CP/CPPS, but it may be considered as an option to relieve pain.

Dwarica DS, Garbe Collins G, Fitzgerald C, et al. Pregnancy and Sexual Relationships Study Involving WOMen and MeN (PASSION Study). J Sex Med 2019; 16: 975-980.

PASSION Study intent to assess for sexual dysfunction in heterosexual couples during pregnancy by performing a cross-sectional study of pregnant women in the third trimester and their partners with a self-reported questionnaire, the Golombok-Rust Inventory of Sexual Satisfaction (GRISS) questionnaire. 52 couples were enrolled at or after 35 weeks' gestation. The mean age was 29.0 ± 6.4 and 31.3 ± 6.9 years for women and men, respectively. 60% of couples were married, and the remainder were cohabitating and in a committed relationship. When analyzing the results of the GRISS questionnaire for both partners, a significant difference was seen in mean avoidance of sex between women and men (3.31 vs 2.63) and non-sensuality (3.54 vs 2.75). Women reported more of a decrease in communication about sex when compared with their partners (3.79 vs 3.23). Vaginismus was more problematic during pregnancy than before (mean 4.17), and frequency of intercourse was decreased (mean 4.93) based on

GRISS scores. Pregnant couples reported decreased frequency of intercourse and more pain with intercourse in women. Women were more likely to avoid intercourse and reported more problems with communication regarding sexual needs. Overall sexual satisfaction and function were not problematic for these couples during pregnancy based on the GRISS scale.

TESTOSTERONE DEFICIENCY

Kwong JCC, Krakowsky Y, Grober E. Testosterone Deficiency (TD): A Review and Comparison of Current Guidelines. J Sex Med 2019; 16: 812-820.

This article compares current guidelines on the evaluation and management of TD to provide clarity for patients and clinicians, as well as to highlight areas of controversy. Key aspects in the approach were compared, with a focus on the biochemical definition (cutoff) for low testosterone (T), principles of management, and recommendations for testosterone therapy (TTh) in special patient populations. Guidelines from the Canadian Medical Association Journal, American Urological Association, European Association of Urology, Endocrine Society, International Society for Sexual Medicine, and British Society for Sexual Medicine were included for review. Recommendations were generally consistent across guidelines. Key differences include the biochemical cutoff for low T, and recommendations for patients with low to normal T, prostate cancer, or cardiovascular disease. The authors highlight several case scenarios in which management differs depending on the guideline adopted.

PREMATURE EJACULATION

Atalay HA, Sonkaya AR, Ozbir S, et al. Are There Differences in Brain Morphology in Patients with Lifelong Premature Ejaculation? J Sex Med 2019; 16: 992-998. This study aimed to investigate whether patients with lifelong PE exhibit macrostructural or microstructural alterations of the parts of the brain involved in the male sexual response. 42 healthy participants and 54 lifelong PE patients were enrolled. Lifelong PE was diagnosed according PEDT and IELT. By

using a voxel-based morphometry method from whole-brain T1-weighted magnetic resonance imaging the authors found that the mean volume of the caudate nucleus was significantly larger in the lifelong PE patients compared with healthy controls. Moreover, caudate nucleus volume was positively correlated with PEDT score and negatively correlated with the IELT. However, cortex morphology and the other subcortical volumes were not significantly different between the 2 groups. In conclusion, microstructural alterations in deep gray matter nuclei might be a useful parameter for studying the mechanism of the neurobiology underlying PE.

PEYRONIE'S DISEASE

Porst H, Burri A, the European Society for Sexual Medicine (ESSM) Educational Committee. Current Strategies in the Management of Peyronie's Disease (PD)—Results of a Survey of 401 Sexual Medicine Experts Across Europe. J Sex Med 2019; 16: 901-908.

This study aimed to investigate the current status quo in the management of PD across European experts in sexual medicine. Members of the ESSM and of various andrology and urology societies across Europe, with the majority (78%) being urologists, were contacted via e-mail and newsletters and asked to fill in an online questionnaire. 401 participants responded to the entire survey, with 277 reporting treating PD patients themselves and knowing this penile entity very well. Of the physicians treating PD patients, 94% performed penile palpation, and 74% perform ultrasonography. 45% assessed the degree of penile curvature by means of intravenous drug testing, but only 17% measured it accurately with a goniometer. Penile length, flaccid or in erect state, was measured by only 39% or 25%, respectively. Only 45% assessed testosterone. Primary treatment options were oral (65%), counseling (57%), and topical/local therapy (30%). Among oral drug users, tadalafil 5 mg was the most commonly used (57%), followed by vitamin E (40%). Regarding intralesional therapy, collagenase clostridium histolyticum was the leading drug (34%), followed by calcium channel blockers (17%). Considering surgical procedures, the original Nesbit technique was the preferred procedure (33%).

36% of the specialists expressed their dissatisfaction with the currently available treatment options, and 64% reported the impression that their patients were mostly dissatisfied with the treatment outcomes. Innovative and presumably multi-modal treatment protocols for PD are urgently needed.

PRIAPISM

Capece M, La Rocca R, Mirone V, et al. A Systematic Review on Ischemic Priapism and Immediate Implantation: Do We Need More Data? *Sex Med Rev* 2018; 7: 530-534.

Ischemic priapism (IP) is the most common form of priapism. In cases of priapism persisting for >36 hours, conservative management usually fails, and the patients' erectile tissue will be inevitably compromised, resulting in corporal fibrosis, shortening of the penis, and refractory erectile dysfunction. This review of nine studies (3 case reports and 6 retrospective analysis) intends to analyze the current literature with regard to the correlation between refractory ischemic priapism and immediate implantation of PP. All studies agreed that in patients with RIP, early insertion of a PP is a safe and effective procedure, and all studies but one preferred malleable implant to inflatable implants.

ONCOSEXUALITY

Santos-Iglesias P, Rana M, Walker L. A Systematic Review of Sexual Satisfaction in Prostate Cancer Patients. *Sex Med Rev* 2019; XX: XXX-XXX.

This study aimed to conduct a literature review of studies that have examined sexual satisfaction in men diagnosed with and treated for PCa because research to this date has mostly focused on the impact of PCa on sexual satisfaction. A systematic review was conducted using Scopus and PubMed databases to identify studies that had assessed sexual satisfaction in men with PCa. 38 articles were found regarding sexual satisfaction in PCa. Overall, PCa treatments had a low to moderate impact on sexual satisfaction, and psychosocial interventions were more successful at improving sexual satisfaction than medical interventions. Sexual satisfaction was correlated to a large number of sexual,

relational, psychological, and medical variables. This literature review shows very mixed results about the sexual satisfaction in men with PCa. Differences in research designs, methodologic limitations, and studies conducted a theoretically limit our understanding of the mechanisms that impact sexual satisfaction in men with PCa. We propose an alternative way of conducting research on sexual satisfaction by using solid theoretical models of sexual satisfaction.

Towe M, Huynh LM, El-Khatib F, et al. A Review of Male and Female Sexual Function Following Colorectal Surgery. *Sex Med Rev* 2019; 7: 422-429.

Sexual function after colorectal surgery is a largely ignored topic. In patients being treated for colon and rectal cancers, the risk of sexual dysfunction after surgery is high and is influenced by multiple factors. Aim: To examine the factors involved with sexual dysfunction after colorectal surgery and review gender-specific sexual complaints most reported on in the literature. A comprehensive review of peer-reviewed publications on the topic was performed. The type of excision and surgical technique strongly influences sexual dysfunction risk, where newer nerve-preserving techniques seem to be associated with better sexual outcomes in contrast to more extensive surgeries. Adjunctive radiotherapy negatively affects sexual health when combined with surgical resection. The most common postoperative sexual complaints reported by men include erectile dysfunction, ejaculatory dysfunction, and dysorgasmia, whereas for women dyspareunia and poor lubrication are common. In conclusion, sexual morbidity after treatment for colorectal cancer is common and inadequately addressed by healthcare providers in the preoperative setting.

BEHAVIOR

Burri A, Carvalheira A. Masturbatory Behavior in a Population Sample of German Women. *J Sex Med* 2019; 16: 963-974.

Human masturbation is and has been a very heatedly and controversially discussed topic in human sexuality. This paper aims to conduct an explorative study

on female masturbatory behavior to gain more insight into this nonreproductive sexual behavior and provide an empiric basis for future research. A total of 425 German women (mean age 26.6 years), 61.4% of whom were in a committed relationship, completed a comprehensive 76-item online survey consisting of study-specific, self-constructed questions and validated and standardized questionnaires. The majority (94.5%) of women indicated having masturbated at least once in their life, with a mean age at first masturbation of 14 years. 85.9% of women described masturbation as "genital self-stimulation until reaching orgasm". The majority of women reported masturbating 2 or 3 times a week (26.8%) or once a week (26.3%). Factors independently associated with masturbation frequency were relationship status, orgasm frequency, openness to new experience, and body acceptance. Almost all women (91.5%) reported masturbating also when in a relationship. For the 5.5% of women who had never engaged in autoerotic stimulation, the 2 main reasons were "I hardly ever feel sexual desire" and "sex is a partner-only thing". 7.6% reported never experiencing an orgasm during masturbation, whereas 50.3% indicated that they always reached orgasm during autostimulation. The reasons cited for engaging in masturbation were manifold, ranging from sexual desire to relaxation and stress reduction. The most common fantasy included the partner; however, 20.7% fantasized about being "defenseless", and 8.7% thought about a "disturbing" scenario that they chose not to elaborate further. For many women, masturbation does not represent "a partner substitute" to seek sexual pleasure, but rather is a stress coping and relaxation strategy.

SURGERY

Kominsky H, Beebe S, Shah N, Jenkins LC. Surgical Reconstruction for Penile Fracture: A Systematic Review. *Int J Impot Res* 2019; <https://doi.org/10.1038/s41443-019-0212-1>

Penile fracture is a rare condition that describes the rupture of the corpus cavernosum following direct, high-pressure trauma to the erect penis. There is no standardized management algorithm. The authors performed a systematic review of the past 10 years and determined that

immediate penile exploration and tunica repair is considered the most common and current management of penile fractures with experts demonstrating that it leads to the fastest in recovery in erectile function and positive cosmetic outcomes. Additionally, they also determined that the specific algorithm can be variable—down to the suture material, use of catheterization, urethroplasty when involved, and length of recovery/follow-up. In the last several decades, men with penile fracture have been treated, in most cases, with immediate surgical intervention. This review highlights the varying practices regarding surgical exploration, injury repair, and postoperative management in men with a penile fracture. Immediate penile exploration and tunica repair have been the mainstay approach of management.

Morris BJ, Hankins CA, Lumbers ER, et al. Sex and Male Circumcision (MC): Women's Preferences Across Different Cultures and Countries: A Systematic Review. *Sex Med* 2019; 7: 145-161.

This review intent to perform a systematic review examining whether MC status influences women's preference for sexual activity and the reasons for this, and whether women prefer MC for their sons. 29 publications with original data were included. In the overwhelming majority of studies, women expressed a preference for the circumcised penis. The main reasons given for this preference were better appearance, better hygiene, reduced risk of infection, and enhanced sexual activity, including vaginal intercourse, manual stimulation, and fellatio. In studies that assessed mothers' preference for MC of sons, health, disease prevention, and hygiene were cited as major reasons for this preference. Cultural differences in preference were evident among some of the studies examined. Nevertheless, a preference for a circumcised penis was seen in most populations regardless of the frequency of MC in the study setting. In conclusion, women's preferences generally favor the circumcised penis for sexual activity, hygiene, and lower risk of infection. The findings add to the already well-established health benefits favoring MC and provide important sociosexual information on an issue of widespread interest.

Gross MS, Reinstatler L, Henry GD, et al. Multicenter Investigation of Fungal Infections of Inflatable Penile Prostheses. *J Sex Med* 2019; 16: 1100-1105.

This multicenter investigation reviews a database of IPP infections to examine for common patient and surgical factors related to IPP fungal infections. Analysis of 217 patients at 26 institutions who underwent salvage or device explant between 2001 and 2018. 26 patients (12%) with fungal infections were identified. 23 of 26 patients (83%) with a fungal IPP infection were either diabetic or overweight. 15 patients had undergone primary IPP implantation, and the other 11 had previously undergone an average of 1.7 IPP-related surgeries. The average age at implantation was 63 years (range 31-92; median 63). 18 of the 26 patients with fungal infection had diabetes (69%). Ninety-one percent of implants were placed with IV antibiotics, consistent with current AUA guidelines: an aminoglycoside plus first- or second-generation cephalosporin or vancomycin or ampicillin/sulbactam or piperacillin/tazobactam. 65% (17 of 26) of infected IPPs had only fungal growth in culture. More than two-thirds of the fungal infections occurred in diabetic patients and 85% occurred in overweight or obese patients, suggesting that antifungal prophylaxis may be appropriate in these patients.



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FEMALE SEXUAL DYSFUNCTION

Hernández-Munive AK, Rebolledo-Solleiro D, Fernández-Guasti A. Does chronic hyperglycemia affect female rat sexual behaviour? Differences in paced and non-paced mating. J Sex Med. 2019; 16: 1130-42.

Type 2 diabetes mellitus (DM) has been clearly associated with male sexual dysfunction, but its role in female sexuality has been more controversial and few studies have evaluated the impact of DM on desire and excitement. The authors designed this study to determine, in a model that simulates DM type 2, the impact of chronic hyperglycemia on female rats receptivity, proceptivity, and aggressiveness. They used 37 hyperglycemic female rats (treated with streptozocin in the neonatal period) and 37 female rats as control. Their sexual behaviour (in paced mounting and non-paced mounting) was evaluated at week 12 of life. The authors found a reduced proceptivity in the DM model female rat, depending on their hormonal condition, suggesting that chronic hyperglycemia produces decreases in sexual behaviour.

ERECTILE DYSFUNCTION

Kim SW, Lee J, Park J, et al. Combination of LIM-kinase 2 and Jun amino-terminal kinase inhibitors improves erectile function in a rat model of cavernous nerve injury. Urology. 2019; 131:136-43.

Despite the advances in surgical techniques, the rates of erectile dysfunction (ED) after radical prostatectomy (RP) remain very high, with significant adverse impact on quality of life of patients with prostate cancer. The exact pathophysiology remains to be elucidated but cavernosal apoptosis and fibrosis, resulting from lack of erections in postoperative period, seem to play a role. The clinical role of penile rehabilitation with standard ED therapies is far from convincing so mechanism-specific therapies may be necessary to improve erectile function recuperation after RP. The authors had previously suggested that the target molecular pathway for cavernosal apoptosis and fibrosis could be Jun-amino terminal kinase (JNK) signalling and LIM-kinase 2 (LIMK2) inhibition, respectively. Targeting these pathways separately improved ED but failed to normalize erectile function and this led the authors

to hypothesize that a combination therapy could be a useful strategy for this condition. To test this hypothesis they used sixty male Sprague-Dawley rats categorized in 4 groups: sham-surgery, cavernosal nerves crush injury, cavernosal nerves crush injury treated with a combination of LIMK2-inhibitors and low-dose JNK-inhibitors and cavernosal nerves crush injury treated with a combination of LIMK2-inhibitors and a high dose of JNK-inhibitors. The erectile response was investigated 10 days after surgery, and they also performed histological and Western-blot studies. They found that dual inhibition of JNK and LIMK2 significantly improved erectile function by suppression of cavernosal apoptosis and fibrosis via restoration of JNK and LIMK2/Cofilin pathways.

Gu X, Shi H, Matz E, et al. Long-term therapeutic effect of cell therapy on improvement of erectile function in a rat model with pelvic neurovascular injury. BJU Int. 2019; 124: 145-54

Cell therapy has provided a promising outcome for improvements of erectile function in pre-clinical studies and human clinical trials. Several types of stem cell populations have been studied in short and middle-term experiments but not in long-term follow-up. The objective of the present study was to determine the long-term therapeutic effect among three types of human cell types on erectile function recovery in a rodent model of dual neurovascular injured erectile dysfunction (NVED). This model was established in athymic rats by crushing the bilateral cavernous nerves and ligating the internal pudendal nerve-vessel bundles. At the time of the defect creation, they injected intracavernously three different types of human cell populations (umbilical vein endothelial cells, adipose derived stem cells and amniotic fluid derived stem cells). The control group was injected with saline. They assessed erectile function and performed histomorphological analyses 12 weeks after. They found that the ratio of intracavernous pressure to mean artery pressure significantly increased in the cell therapy groups, compared to the saline injection group. Immunofluorescence staining showed increased numbers of cells expressing biomarkers of endothelial, smooth muscle, and nerve cells within the penile tissue in the cell therapy group when compared to the saline injection group.

Tang Z, Song J, Yu Z, et al. Melatonin treatment ameliorates hyperhomocysteinemia-induced impairment of erectile function in a rat model. J Sex Med. 2019; 16: 1506-17

Hyperhomocysteinemia (HHcy) has been reported to be strongly correlated with the occurrence of erectile dysfunction (ED), although the mechanisms are not fully understood. One of the possible mechanisms could be through enhancing oxidative stress. In past decades a close relationship between melatonin and HHcy has been discovered, and several reports have provided evidence that melatonin could regulate the total Hcy level and protect the cells against HHcy induced toxicities. Based on this, and the antioxidant, antiapoptosis and vascular protective functions of melatonin, the authors hypothesized that melatonin could be applied as a potential treatment method for ED. They used a Sprague-Dawley rat model of HHcy, induced by a 7% methionine-rich diet. Thirty-six male rats were randomised in 3 groups: control group, 7% methionine group and 7% methionine and melatonin group. After 4 weeks they evaluated the rats erectile function (by electric stimulation of the cavernous nerve) and analysed histologic and molecular alterations of the corpus cavernosum. They found that melatonin could preserve erectile function mainly through inhibition of oxidative stress via the Erk1/2/Nrf2/HO-1 signaling pathway and suppression of apoptosis. The authors concluded that melatonin could be a potential therapeutic method for HHcy-related ED.

Wortel RC, Mizrahi A, Li H, et al. Sildenafil protects endothelial cells from radiation-induced oxidative stress. J Sex Med. 2019; 16: 1721-33

The etiology of radiation-induced erectile dysfunction (ED) is complex and multifactorial, and it appears to be mainly atherogenic. The aim of this study was to focus on vascular aspects of radiation-induced ED and to elucidate whether the protective effects of sildenafil that have been suggested by some authors are mediated by attenuation of oxidative stress and apoptosis in the endothelial cells. They used bovine aortic endothelial cells (BAECs), with or without pretreatment of sildenafil to test endothelial dysfunction in

response to external beam radiation and studied the generation of reactive oxygen species (ROS). The authors measured extracellular and intracellular hydrogen peroxide (H₂O₂). ROS superoxide was also measured. Both H₂O₂ and superoxide are known to reduce the bioavailability of nitric oxide, which is the most significant chemical mediator of penile erection. Generation of cellular peroxynitrite was measured using a chemiluminescence assay with the PNCL probe. Subsequently, they measured the activation of acid sphingomyelinase (ASMase) enzyme and the generation of the proapoptotic C16-ceramide was assessed. Endothelial cells apoptosis was measured as a readout of these cells' dysfunction. The authors demonstrated that single high-dose radiation therapy induced NADPH oxidases (NOXs) activation and ROS generation via the proapoptotic ASMase/ceramide pathway. In addition, they showed that sildenafil significantly reduced radiation-induced superoxide and as a result there was reduction in the generation of peroxynitrite in these cells. The authors concluded that sildenafil protected the endothelial cells from radiation therapy-induced apoptosis and propose that these studies should be followed in an animal model of ED.

PREMATURE EJACULATION

Ongün S, Acar S, Koca P, et al. Can botulinum-A toxin be used to delay ejaculation: results of an ejaculation model in male rats. J Sex Med. 2019; 16: 1338-43.

The bulbospongiosus (BS) muscle seems to be closely associated with ejaculation latency. Botulinum toxin leads to flaccid paralysis in muscle by preventing the release of acetylcholine on the presynaptic nerve end at the neuromuscular junction. The authors hypothesized that the inhibition of contractions of the BS muscle by botulin toxin might have a beneficial effect in the treatment of premature ejaculation (PE). They randomly divided 21 Wistar male rats in 3 groups of 7: control, 1 unit of botulin-A toxin injected, and 5 units of botulin-A injected. Five days after the botulin-A toxin injection, the rats underwent surgery to evaluate ejaculation parameters induced by para-chloroamphetamine (PCA) injection. They found that the ejaculation latency time of the group receiving 5 units

of botulinum-A toxin was statistically significantly longer compared to the control group and the group receiving 1 unit of botulinum-A toxin. Furthermore, the BS EMG area under the curve values for the group receiving 5 units of botulinum-A toxin were significantly lower than those of the control group and the group receiving 1 unit of botulinum-A toxin. Although the present study didn't use a PE model, the authors conclude that botulinum-A toxin could be a potential treatment for PE and encourage further investigation in clinical studies.

PEYRONIE'S DISEASE

Castiglione F, Hedlund P, Weyne E, et al. Intratunical injection of stromal vascular fraction prevents fibrosis in a rat model of Peyronie's disease. BJU Int. 2019; 124: 342-48

Since there are no evidence-based treatment options for the acute phase of Peyronie's disease (PD), we always welcome the research in this field. Several studies have recently suggested a possible role of mesenchymal stem cells (MSCs) in the treatment of corpus cavernosum fibrosis and PD. Although the exact mechanisms behind the anti-fibrotic properties of MSC therapy remain to be elucidated, the leading theory is that MSCs influence various pro-fibrotic parameters simultaneously, working through immunomodulation, thereby limiting the host response to injury and preventing the onset of fibrosis. This group has previously showed the efficacy of human adipose tissue derived MSC (ADSC) in preventing fibrosis in a rat model of acute phase PD. ADSCs are isolated as part of the aqueous fraction derived from enzymatic digestion of lipoaspirate (the product of liposuction). This aqueous fraction, a combination of ADSCs, endothelial precursor cells, endothelial cells, macrophages, smooth muscle cells, lymphocytes, pericytes, and pre-adipocytes among others, is what is known as the stromal vascular fraction (SVF). In the current study, they investigated the effects of an early local injection of SVF on plaque formation and erectile function in a rat model for the acute phase of PD. A total of 24 male Sprague-Dawley rats were divided in three equal groups: sham, PD without treatment (TGFB) and PD treated with SVF (SVF) 1 day after disease induction. Sham rats

underwent 2 injections of vehicle into the tunica albuginea one day apart. TGFB rats underwent TGF- β 1 injection and injection of vehicle one day later. SVF rats underwent TGF- β 1 injection followed by SVF one day later. One month after treatment all rats underwent measurement of intracorporal pressure (ICP) and mean arterial (MAP) pressure during electrostimulation of the cavernous nerve. Following euthanasia, penises were again harvested for histology and Western blot. They showed that erectile function was moderately reduced in the TGFB group and was significantly improved after SVF treatment ($p < 0.05$). PD animals developed areas of fibrosis with a significant upregulation of collagen III, Collagen I and elastin protein expression. These fibrotic changes were prevented when treated with SVF. These results encouraged the authors to conclude that local injection of SVF may represent a treatment for the acute phase of PD.

SEXUAL MEDICINE CALENDAR

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