From ornamentation to mutilation
when you treat them, set them free

No other PDE-5 inhibitor provides the freedom of CIALIS.

- Unsurpassed efficacy—*up to 36 hours*
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CIALIS is contraindicated in patients taking any form of organic nitrates. Since there is a degree of cardiac risk associated with sexual activity, treatment for erectile dysfunction including CIALIS should not be used if sexual activity is undesirable.

The combination of CIALIS and alpha blockers is not recommended because of the potential for symptomatic hypotension in some patients. Side effects with CIALIS were generally mild to moderate. Most common side effects were headache and dyspepsia. Nasal congestion, flushing, dizziness, and back pain or myalgia were also reported. In placebo-controlled Phase III clinical trials, the discontinuation rate in patients treated with CIALIS 10 mg or 20 mg was 3.3%, compared to 1.4% in placebo-treated patients.
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Dear friends,

The summer is coming to an end and we hope you have enjoyed nice holidays and good weather.

The 11th World Meeting is very close now. In some weeks we will enjoy a good scientific program together with a special social program in Buenos Aires. Check the final program at: www.issir2004.org.

At the business meeting, on Wednesday October 20th, important matters will be discussed. Also the new name of the Society will be chosen and the Society’s By-Laws amendments will be presented for approval to the membership. Included with this issue you will find a concept of the revised By-Laws. Please send your comments or suggestions to Alvaro Morales, Chairman of the By-Laws Committee.

The ISSIR website shows a growing success with many visitors per day, thanks to the webmaster Alexandre Gilbert and the Website Committee. Please send any suggestions you may have to Alexandre.

The ISSIR affiliated societies are preparing their biannual meeting. The 10th APSSIR meeting will take place in Cairns, Australia, October 4-8, 2005 and the 8th SLAIS meeting in Punta del Este, Uruguay, December 1-3, 2005. Good luck with the organization!

In the past months many interesting meetings took place; of some of them you can find an extensive review in this issue. Of particular interest is the summary by Wayne Hellstrom of the sessions on sexual function and dysfunction at the 99th annual meeting of the American Urological Association that has been rich of innovative abstracts.

We invite you to read the paper (and even more to enjoy the pictures) by Johan Mattelaer on genital decorations and cultural operations in the male, taken from his beautiful book From ornamentation to mutilation, an idea for a superb present!

The Digest of the recent discussions on ISSIR List and the meetings calendar (again full of many scientific events in the coming months) will complete the News bulletin.

Enjoy reading this issue.

Luca Incrocci, MD, PhD  
Chief Editor

Jacques Buvat, MD  
Associate Editor
Letter from the President

Dear members of the ISSIR,

The biennial Congress of our Society is now imminent, and promises to be an outstanding event. Twelve State of the Art lectures are going to update us on most recent advances in basic and clinical sciences of male and female sexuality. Over 450 abstracts were submitted, from which 100 have been selected for presentation in 8 oral sessions, 120 in 10 moderated poster sessions and 150 in unmoderated poster sessions. In addition 4 round tables, 2 debates, several teaching courses and 5 industry-sponsored symposia will be held. We will be living 4 very exciting days.

The first issue of our new journal, the Journal of Sexual Medicine (JSM), owned and operated exclusively by the ISSIR, is on line since August 3 at: http://www.blackwell-synergy.com/servlet/useragent?func=showIssues&code=jsm. Free access has been given to the full contents until the Buenos Aires meeting. Then access to full contents will be reserved to ISSIR members and other subscribers by password, but access to the abstracts will remain free. This first issue has been mailed to ISSIR members on August 17. It contains an incredible amount of new science with a large part of the committees’ reports and the recommendations of the Second International Consultation on Erectile and Sexual Dysfunctions of men and women, held in Paris in July 2003. This consultation brought together more than 200 experts in Sexual Medicine from over 60 countries and 5 continents. It is going to be our Bible for the next 3 years, and this was an outstanding way of starting the JSM, in perfect agreement with its mission of publishing manuscripts of the highest quality on multidisciplinary basic science and clinical research related to male and female sexual function and dysfunction.

The proofs of the second issue are presently being corrected. This issue will be mailed mid-September and the third one on November 1. Until now there have been 108 manuscript decisions from new and revised manuscripts with an acceptance rate of 36% indicating the high standard of quality of the review process. The JSM will clearly rapidly become the best Sexual Medicine Journal published. Dr Irwin Goldstein, together with all the members of the Editorial Team, the Blackwell Publishing company and many others who have worked behind the scenes like Mrs Sue Goldstein have accomplished an incredible work in so few months. On behalf of the ISSIR, I thank and congratulate them. But you have also to realize that the JSM is your Journal, and can only be the best with support of the ISSIR members. I encourage you to volunteer to review for your Journal, to submit manuscripts to it, to read it faithfully and to cite it routinely.

Our Society has now more than 2000 paying members (2045). These include 1198 members from the ESSM, 186 from the APSSIR, 176 from the SLAIS, 147 from the SMSNA, and 25 from the ASSIR. This rapid membership growth is a consequence of 2 new policies: one is the “common membership”. It consists in linking the membership of the ISSIR to that of the Regional Affiliated Society (RAS) of the continent where the member is living, for example the ESSM for the Europeans. In this way there is no more direct application to the ISSIR in the corresponding region. The members applying to the RAS become ISSIR members at the time their application to the RAS is accepted. They pay a global membership fee for the 2 Societies (€ 80 in 2004). This gets the new members the many benefits of both the ISSIR and the RAS, and has resulted in the simultaneous registration to the ESSM and the ISSIR of most members of several European Scientific Societies involved in Sexual Medicine. The other new policy is already used by several RAS’s (APSSIR and ESSM) which subsidize the registration of a part of their members unable to pay themselves the full registration fee. In certain societies, the subsidies are taken from the money granted to the RAS in the framework of the Industry Sponsor Board Agreement.

This is my last presidential letter. I may now appraise the outcome of the 8 years I spent in the board of ISSIR, including 4 years as Secretary General and Treasurer at the time the 2 offices were still assembled. After having initiated the transformation of what was only, 8 years ago, a big club of scientists without any formal structure, into a true professional organization, thanks to the help of President Ronald Lewis and Mr Robert Kessler, now Executive Officer of the ISSIR, I have brought to the ISSIR in 1998 its Newsbulletin, which is now edited so nicely by Dr Luca Incrocci after I have managed it alone for several years. Then went the ISSIR website, which I created in 1999, soon assisted by Mr Alexandre Gilbert, our incredibly efficient web-administrator, then by the brilliant Dr Gregory Broderick. ISSIRList, which I created in 2000 and is now very effectively managed by Dr Hussein Ghanem, has proved to be another very important tool for cementing the relationships between our members worldwide. I am also proud of having contributed with President Sidney Glna, and Drs Ira Sharlip and Eric Meuleman to the design and implementation of the Industry Sponsor Board Agreement, which has brought since 2 years to the ISSIR and its RAS’s a significant increase in their income, on a more regular basis, resulting in more stability and more money available to implement scientific and educational projects. Also proud to have contributed to restore peace and harmony between the ISSIR and the ESSM after 2 years of very tense relationship, and lastly to have set up during my presidency 2 ISSIR Committees which will contribute to
the prestige of ISSIR in the future, the Standards Committee and the Ethics Committee, both including members of the 5 continents.

I am presently implementing my last project in the framework of the ISSIR, in setting up a French-speaking Society of Sexual Medicine. This "Société Francophone de Médecine Sexuelle" was founded in Paris last June with 100 founding members from 13 countries belonging to all the disciplines involved in Sexual Medicine. It will be affiliated to the ISSIR through the ESSM and the ASSIR, and could become their French-speaking chapter. One of the main aims of this multidisciplinary Society is to bring the French speaking sexual physicians closer to the English speaking scientific community. Because of linguistic barriers, French speakers stay often away from English speaking meetings. Whereas it is easy to translate into English the technical vocabulary of basic science or clinical urology, expressing in English the nuances and subtleties of the psychological and sexological reasoning requests a perfect fluency which very few non native English speakers have. Hence many French speakers, especially psychiatrists and sexologists, abandon the idea of presenting their work or discussing their experience in English speaking meetings. However both the French and the English speaking medical communities are missing something because of this lack of dialogue. May be an opportunity of somewhat increasing the meticulousness of their reasoning as concerns the French speakers. But the account of their experience of a often more holistic way of approaching the patient could also be useful for English speakers. Evidence Based Medicine is not all. It is of little help when you are in front of certain patients or couples. The experience of colleagues of different sensibilities sometimes proves to be more helpful.

I have in fact the feeling that this discussion about the French speaking community also applies to many other linguistic communities. The solution is not only simultaneous translation, which distorts the speeches, or spreading the English language, even if this is also necessary. Being fluent enough in English to express subtle things will remain an impossible task for many non native English speakers. In addition many cultural identities won’t accept to completely blend into the mould of the English speaking community. Many other linguistic communities would benefit of a specific space within the ISSIR, where their members could meet and communicate in their language. This would not prevent them from attending the English sessions of the official ISSIR or RAS meetings to which symposia in other languages could be combined, but would rather encourage them to do it in helping them to feel at home in our Society. Opening up to other languages would reinforce the really international essence of the ISSIR, resulting in increase of its membership, and of it influence.

It was an honour and a very exciting task to serve the ISSIR for 8 years. I anticipate a brilliant future for our Society, in a first time under the able leadership of my friends Drs Ganesan Adaikan, Ira Sharlip and Eric Meuleman. I will remain available for any advice during the 2 years of my term of Past-President.

See you all in Buenos Aires

Jacques Buvat MD
ISSIR President
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ISSIR meeting 2004 - Buenos Aires, Argentina

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ISSIR Websites – Alive!
by Alexandre GILBERT – ISSIR Website Administrator

The power of a website is done by contributors. By adding relevant and regularly new and updated documents, the website is alive! The result is here: the website is ALIVE and a SUCCESS! So, I thank you very much all contributors and the ISSIR Webteam for the splendid work done.

Actually, the ISSIR owns different websites:
- [http://jsm.issir.org](http://jsm.issir.org) the site dedicated to the Journal of Sexual Medicine, managed by Blackwell publishing.
- [http://www.issir.org](http://www.issir.org) the main one, created and managed by myself.

The ISSIR Congress and the creation of the new journal are important events that generated a lot of traffic on websites.

You don’t have to remember all these website address. Just keep in mind the main one. Others are reachable and highlighted on the main page.

A week of the ISSIR websites’ life
Analysed data started from 03/30/2004 to 06/05/2004

There were 2963 visitors on the website that week, representing an average of 423 people a day!
The ISSIR Congress and the creation of the new journal are important events that generated a lot of traffic on websites.

The latest added and updated document on the website
- The PASIR-SH : Sexual Health Update 3
- Proposed modified by-laws - Revision 2
- ISSIRList Digest Directory
- Newsbulletin 13
- ESSM Regional Society page

Top 10 visited pages
- ISSIRList digests.
- ISSIR Website main Page.
- ISSIR Newsbulletin 13
- The phallus in Art and Culture (bulletin 5)
- Erectile Dysfunction : "THE" Book
- The next meeting Page.
- The PASIR-SH : Sexual Health Update 3
- The European Society for Sexual Medicine
- The 4th ASSIR congress reports
- Penile lengthening and augmentation surgery
The ISSIR e-directory

Let you adapt yourself your membership information and the email address you want to receive ISSIR information, ISSIRList and ISSIRLetter. When you change some information on the e-directory, the secretariat is automatically informed and ISSIRList and ISSIRLetter are automatically updated when you change your e-mail address.

Actually, there are 706 members. I guarantee that 435 are up to date and sharp (61%).

You can also print an always up to date membership by using the ‘Print e-directory’ option in the members dedicated menu.
Asia occupies about a third of the world's land mass, and its residents, of diverse ethnic, cultural and religious background and tradition, constitute close to 60% of the world population. Asia Pacific countries are among those with the most rapid rate of population ageing and have therefore to grapple relentlessly with increasing problems of age-related co-morbidities of unprecedented dimensions, particularly when economic capabilities are limited. Peak regional organizations such as the Asia Pacific Society for Sexual & Impotence Research (APSSIR) have thus important roles to play and special challenges to meet. APSSIR has a long history and proud record of being one of the oldest societies in sexual medicine, holding regularly biennial meetings with varied scientific content of academic standard par excellence. The 9th Biennial Meeting was held in Cebu City, the Philippines, in October 2003. The proceedings have been reported in the December 2003 issue of the ISSIR Newsbulletin.

The 10th Biennial Meeting has been scheduled for October 4-8, 2005, to be held in the popular resort city of Cairns in Queensland, on the eastern seaboard of Australia. In addition to an interesting, informative and innovative scientific programme being planned for the meeting with the theme ‘Sexual Dysfunction: Old Problems-New Solutions’, the venue is also in the precincts of World Heritage listed rainforests and the Great Barrier Reef, with ample opportunities for memorable, exciting social and cultural experiences. Further details regarding the 10th APSSIR Biennial Meeting are available at the conference website: www.promaco.com.au/conference/2005/apssir or from the conference secretariat at: promaco@promaco.com.au.

Kew-Kim Chew, MD

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**1st Course in Continuous Education of the Latin American Society for the Study of Impotence and Sexuality (SLAIS)**

On November 1st, 2003, in the city of Lima (Peru) took place the 1st SLAIS Course in Continuous Education within the VIII International Congress of the Asociación Académica de Urología de las Fuerzas Armadas. 436 participants attended the congress, 80% of them were urologists. The SLAIS Course was coordinated by Dr. José Aris Delgado (Peru) and the speakers were: Dr. Maruicio Delgado (Colombia), Dr. William Uzcategui (Venezuela) and Dr. Miguel Rivero (Argentina). Dr. Rivero is also General Secretary of SLAIS. The scientific program included interesting subjects related to Sexual Medicine, and motivated the interest of an audience that filled up the conference room.

Also, nine professionals completed the ISSIR/SLAIS membership form and were subsequently accepted. 12 Courses in Continuous Education are scheduled by SLAIS for 2004 and can be checked on the ISSIR website–Regional Chapters–SLAIS (www.issir.org).
From the last meetings

1st Congress on Men’s Health Medicine, 5-8 April 2004, Paris, France

From April 5th to 8th Paris hosted the First Congress on Men’s Health Medicine-Technology and men’s health care-, organized at the UNESCO by the World Academy of biomedical Technologies (WABT), a prestigious organization. This was not a meeting only based on male sexual health but on all aspects of men’s medicine. The meeting was characterized by the impact of different new technologies on men’s health though with a clinical approach. Not sponsored by pharmaceutical companies, the Congress President, Dr Joseph Tritto put together a varied program specifically targeted to both medical technologists and clinicians. Many were the topics addressed. Of particular interest were the sessions on new advances in sexual surgery (male dysmorphisms), computed assisted surgery and telesurgery (robotic techniques in cardiac surgery for example), microrobots for biological and surgical applications. More specifically in the andrology sessions, the symposium on male genetics and human reproduction was very interesting, addressing new techniques for contraception and for reproduction (microrobots). Risk factors and organic pathologies in male sexual dysfunction were also discussed, in particular vascular pathology and erectile dysfunction, cancer and sexuality, efficacy of intracavernosal injections in sildenafil non-responders. Also the different aspects of body image from cosmetics and quality of life to plastic and cosmetic surgery in men were extensively addressed.

At the occasion of the meeting a new Journal was launched, Andrology One, which will only be published on-line with free access to everybody. More information on: www.wabt.com.fr.

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Introduction
With the recognition of the high prevalence of erectile dysfunction (ED) in the general population and the establishment of effective therapies for its treatment, the field of sexual medicine has now defined itself and is set to expand its horizons.

Epidemiology
To further study ED in general urologic practice, multiple urologists each enrolled 10 consecutive patients independent of the reason for their visit (1). From 1,303 patients (mean age 57.2 ± 14.5 years) the average IIEF-5 score was 13.0 ± 5.3 and 22.6 ± 4.0 in men with (n=818) and without (n=485) ED. The authors noted that the prevalence of ED in urological practice is much higher than in general medical practice, the severity of ED increased with advancing age, and the level of distress due to ED decreased in patients > 70 years, i.e. there is a reduction of sexual expectations with aging. They also recommend that the IIEF-5 needs to be age-adjusted for better interpretation of its norms.

Prostate Cancer
The introduction of nerve sparing radical retropubic prostatectomy (NSRRP) with eventual preservation of erectile function has done much to make RRP a mainstream therapy for men diagnosed with localized prostate cancer. Recently, sural nerve interposition has been advocated for men undergoing non-NSRRP as a means to preserve potency. In a German study, NSRRP was performed in 688 men with 82.3% completing all ED questionnaires and 432 having normal preoperative erectile function (2). Final analysis included 138 men after unilateral NSRRP, 273 men after bilateral NSRRP, and 21 men after unilateral NSRRP and contralateral sural nerve interposition. Erectile function following unilateral NSRRP with unilateral sural nerve interposition was not significantly different compared to unilateral NSRRP alone and was as expected significantly worse than bilateral NSRRP. At this juncture these authors infer that sural nerve interposition grafting is experimental and in need of more long-term study.

At last year’s AUA, improvement in unassisted erectile function was reported in 76 men treated with nightly sildenafil for nine months after bilateral NSRRP. This year these authors report
on long-term rigiscan monitoring in a subset of 54 such men with normal preoperative erectile function, defined as a combined score of ≥ 8 (Q3 and Q4 from IIEF) and normal rigiscan results (≥ 10 continuous minutes of base rigidity) (3). Patients were randomized to sildenafil 50 mg, 100 mg, or placebo four weeks postsurgery and received seven months of double blind nightly treatment. Two consecutive rigiscan nights were done at 4, 12, 24, 36, and 48 weeks postsurgery. In this subset, 10 of 35 (29%) sildenafil-treated and 1 of 19 (5%) placebo-treated patients demonstrated return of spontaneous erections. There was no significant difference in preoperative minutes of tip and base rigidity ≥55% in all treatment groups. The most discriminating measure at 48 weeks between responders and nonresponders was tip rigidity >55% and was longest in patients receiving 100 mg sildenafil. Chronic phosphodiesterase-5 (PDE-5) inhibition may improve cavernosal tissue oxygenation by way of nocturnal erections and/or may involve neuronal regeneration.

Oral ED Therapy

Oral agents have become the primary therapy for the majority of men presenting with ED. It is postulated that nocturnal erections contribute to the maintenance of morphodynamic integrity of smooth muscle cells within the corpora cavernosa. It is known that sildenafil at bedtime significantly improves nocturnal penile erections. Investigators from Germany prospectively studied the effects of longterm sildenafil therapy (4). In a prospective, randomized, controlled trial 76 men (mean age 47 years) with ED > six months were given either nightly sildenafil 50 mg or sildenafil 50-100 mg on demand for one year. A third group did not receive any medical therapy. After one-month washout, 59% of the nightly dosing group and 10% of the on-demand group had moved into the normal IIEF erectile function range. Similarly, the nightly dosing group had documented significantly improved cavernosal arterial inflows on duplex Doppler studies (from 29 ± 9.8 to 38 ± 10 cm/sec, p<0.05), while the on-demand group had a slight, but non-significant improvement, and the untreated group declined slightly. Further follow-up duplex studies six months later in these significantly improved nightly dosed patients documented sustained benefit. This preliminary data suggests that chronic PDE-5 inhibitor therapy may induce both structural and physiologic changes in the penis that may reverse or cure ED. More in-depth study of endothelial dysfunction in the penis is certainly warranted. While all 3 PDE-5 inhibitors have been available to the U.S. market for less than 6 months, Europeans have been exposed to all three drugs for >18 months. Real-world, non-pharmaceutical company sponsored studies on efficacy, safety, and preference generate much clinical interest.

In a multicenter PDE5-inhibitor naive study, 237 men were randomized to six weeks maximum approved doses of sildenafil (S, 100 mg), tadalfil (T, 20 mg), vardenafil (V, 20 mg) or placebo (P), while another 211 men received half doses of each (S). One-week washouts were required between medication changes. Primary endpoints were changes from baseline in Q3 (vaginal penetration), Q4 (erection maintenance), IIEF domains, GAQ, and patient preference scores. At time of abstract submission, partial data analysis for maximum dose changes from baseline for Q3 were: P: 03, S: 1.5, T: 1.5, V: 1.6 (p < 0.001) and for Q4 P: 0.5, S: 1.7, T: 1.6, V: 1.9 (p<0.001). Patient preference for maximum dose administration was V: 43%, S: 17%, T: 40% and for half dose V: 50%, S: 31%, T: 19%.

Another study from Germany sought to determine patients’ PDE-5 inhibitor preference when offered all three drugs in an open label trial (6). Two hundred twenty-two patients (mean age 57.9 years) with ED (mean duration 6.1 years) were exposed to an arbitrary sequence of all three PDE-5 inhibitors. All patients underwent comprehensive work-ups including IIEF, duplex Doppler, preference modules, etc. Overall preference rates were T: 44%, V: 32%, S: 14% and none: 10%. Among the 39 diabetics preference rates were V: 35%, T: 27%, S: 14% and none: 24%. In regards to reasons for preference for each respective agent 96% claimed duration of action for T, 61% stated quicker onset of action for V, and 77% cited better efficacy for S.

Prosthetic Surgery

Implantation of inflatable penile prostheses (IPP) in men who have failed other less-invasive ED therapies continues to provide high rates of satisfaction. Innovation in design and materials used for penile prostheses has translated into increased longevity. However, a major concern for patients and surgeons remains prosthetic infection, which occurs in 1-3% of virgin cases and 10-18% of revision cases. Both of the major manufacturers of penile prostheses in the U.S. (Mentor Corp., Santa Barbara, CA and American Medical Systems, Minnetonka, MN) have introduced products that aim to reduce the chance of prosthetic infection. The AMS 700 CX implants are impregnated with minocycline and rifampin to target against staphylococci, the most common pathogen in penile prosthesis infections. Data from revision cases from May 2001 to September 2003 for Inhibizone and non-Inhibizone prostheses were reviewed (7). From 8,754 revision cases, with implant times of 4-28 months, 5,310 (60.7%) were non-Inhibizone and 3,444 (39.3%) were Inhibizone revision implants. The infection rate of 2.41% with non-Inhibizone revision cases was reduced to 1.36% with Inhibizone devices (44% decrease in infection rate). The Mentor Titan inflatable penile prosthesis is coated with polyvinylpyrrolidone (PVP), a hydrophilic substance that reduces bacterial adherence and absorbs and elutes the antibiotics the device is immersed in intraoperatively. From October 2002 to August 2003, 2,357 Titan IPPs compared with 482 non-coated _-1 IPPs were implanted (8). The infection rate for the coated Titan IPP was 1.06% (25/2357) while the non-coated _-1 IPP was 2.07% (p<0.03). Staphylococcus species were the predominant microorganisms cultured in both groups. Long-term follow-up on both of these databases is required before these antiinfective innovations are considered the standard of care. Nevertheless, advances such as these should ultimately improve both patient satisfaction and overall results.

The ease of the transcrotal approach for the implantation of an IPP and the proximity of the urethra has allowed for a new strategy of dual implantation of the artificial urinary sphincter (AUS) and IPP. Concerns regarding increased infection rates and poor outcomes have
prevented widespread acceptance of the simultaneous implantation technique. A multi-institutional evaluation of synchronous dual prosthesis implantations in 22 patients between 2000 and 2003 revealed 2 urethral erosions and a reservoir migration, but no postoperative infections (9). Risk factors included diabetes in 7 (32%), hypertension in 6 (27%), and history of radiation therapy in 6 (27%). The overall revision rate was 14%. All patients reported <1 pad per day of urinary leakage. High-risk patients with complex urologic issues predispose to a higher complication rate; however, the inherent advantage of a single anesthetic event for patients employing a single trans-scrotal incision should encourage widespread acceptance of this technique.

**BPH and Ejaculatory Disorders**

At last year’s AUA, the Multinational Survey on Aging Males (MSAM)-7 study documented lower urinary tract symptoms (LUTS) as an independent risk factor for sexual function, with both ED and ejaculatory dysfunction (EjD) being equally common and bothersome in aging males. As a follow-up the Asian Survey of Aging Males (ASAM) sought to determine the prevalence of LUTS and sexual disorders in aging Asian males and to investigate the relationship between LUTS and sexual dysfunction in this population (10). The survey was conducted in seven Asian countries. The study evaluated demographics, urinary symptoms (IPSS and Quality of Life index), functional aspects (DAN-PSSsex and IIEF), and co-morbidity factors. A total of 1,155 males (aged 50-80 years) completed the survey. Prevalence and severity of LUTS were strongly correlated to age. A large portion of respondents (72%) were still sexually active. Overall, ED was common (63%), but EjD was more common (68%). However, the bothersomeness of these sexual dysfunctions reported in Asian males was low, a difference from both European and American men. Overall, these findings confirm an association between LUTS and sexual dysfunction.

On the topic of abnormal ejaculation, premature ejaculation (PE) is one of the most common forms of male sexual dysfunction, with a prevalence of >30%. It is for the most part under-recognized and under-treated, in part because of the stigma of the term PE. The Sexual Medicine Society Working Group convened to debate the need to rename the condition to rapid or early ejaculation (11). Using a multitude of inputs (e.g. sex experts, AUA guidelines committee reports, patient participants, focus groups, and healthcare representatives), the Working Group found that changing the name from PE would engender confusion, require extensive education, and delay efforts to increase public awareness of this condition. The ultimate recommendation was to continue the term PE and develop strategies to reduce the stigma associated with this condition and develop means to improve education and communication about PE.

**Hormone Replacement**

Using subjects from the Massachusetts Male Aging Study (MMAS) the authors sought to provide estimates and age-specific prevalence and incidence data of androgen deficiency in a randomly sampled population-based cohort of middle-aged and older men (12). Baseline prevalence of possible and definite androgen deficiency were 5.4% and 1.6%. At follow-up eight to ten years later baseline levels were 12.2% and 2.3%. Based on baseline prevalence there are almost 3 million men in the U.S., aged 40 to 70 years with possible or definite androgen deficiency.

**Female Sexual Dysfunction**

It is well recognized that female sexual dysfunction (FSD) is a largely untapped market. FSD has been categorized into problems with desire, arousal, lubrication, and pain (dyspareunia). In a study evaluating women with severe dyspareunia due to vulvar vestibulitis syndrome a sizable number of affected women were found to have concomitant androgen deficiency (low total/free testosterone and DHEA-S) and had a marked reduction of pain with androgen hormone replacement (13). Another 30 women underwent vestibulectomy due to refractory vulvar vestibulitis. Immunohistological studies on these excised tissues revealed that the majority had receptors for androgens, estrogens, and progesterone. This is the first scientific report linking androgen receptors to human minor vestibular glands and mandates a trial of medical management with androgens prior to consideration of surgical intervention.

In postmenopausal women the normal vaginal smooth muscle layer is normally replaced by fibrosis and increased collagen deposition. Nitric oxide (NO) has been implicated in normal vaginal physiology and its expression is subject to hormonal influences. NO plays a role in tissue fibrosis by modulating reactive oxygen species. An interesting study evaluated the role of NO, nitric oxide synthase (NOS) expression, and estrogen in vaginal tissue from 23 postmenopausal patients with vaginal prolapse (some on hormonal replacement) and 9 premenopausal controls (14). Endothelial NOS was identified in the smooth muscle as compared to the epithelium and was highest in premenopausal controls and lowest in postmenopausal women not on hormone replacement. Hence eNOS expression appears to be modulated by hormonal status and partially corrected by estrogen therapy. Future research on FSD needs to include NO’s role in vaginal physiology and its involvement with sexual function, particularly its antifibrotic effect.

**Basic Research**

There were a plethora of excellent basic research papers investigating the molecular aspects of erectile function and evaluating potential therapies for ED using experimental animal models. Representative papers focused on difficult-to-treat populations related to aging, nerve injury after radical prostatectomy, and diabetes.

One of the most important recent discoveries in biomedical research is that stem cells are found in many tissues of the adult and can provide new cells for normal tissue turnover and can regenerate damaged and diseased tissue. Marrow stromal cells (MSCs), also known as mesenchymal stem cells, are adult stem cells from bone marrow that have multilineage differentiation potential and contribute to the regeneration of mesenchymal tissue, such as bone, cartilage, fat, and muscle. Since MSCs are relatively easy to isolate, expand ex vivo, and gene engineer, genetically modified MSCs have recently been used for gene delivery and tissue regeneration in the treatment of a variety of diseases. In a study looking at ED in aging, researchers describe a method for endothelial nitric oxide synthase (eNOS) transfer of gene modified rat MSC (rMSCs) to the penis of aged men. 

**Conclusion**

In conclusion, ED and EjD are common and bothersome in aging males. As a follow-up the Asian Survey of Aging Males (ASAM) sought to determine the prevalence of LUTS and sexual disorders in aging Asian males and to investigate the relationship between LUTS and sexual dysfunction in this population (10). The survey was conducted in seven Asian countries. The study evaluated demographics, urinary symptoms (IPSS and Quality of Life index), functional aspects (DAN-PSSsex and IIEF), and co-morbidity factors. A total of 1,155 males (aged 50-80 years) completed the survey. Prevalence and severity of LUTS were strongly correlated to age. A large portion of respondents (72%) were still sexually active. Overall, ED was common (63%), but EjD was more common (68%). However, the bothersomeness of these sexual dysfunctions reported in Asian males was low, a difference from both European and American men. Overall, these findings confirm an association between LUTS and sexual dysfunction.
rats for the potential application of gene therapy for the treatment of erectile dysfunction (15). These findings demonstrated that rMSCs alone or genetically enhanced with eNOS can improve diminished erectile responses in the aged rat. Importantly, rMSCs gave rise to smooth muscle and endothelial cells, which were active and overexpressed eNOS in the corpus cavernosum, thereby aiding in the improvement of corpus cavernosum function and thus erectile function. These data suggest that this novel cell-based gene therapy approach may be used to restore diseased endothelial and smooth muscle cells in the penis, thus restoring erectile function.

With the advent of new vector systems for gene therapy, this novel therapeutic approach for the treatment of erectile dysfunction has become a reality in the last five years. The use of a genetic approach to restore neuronal signaling in injured nerves of the neurovascular bundle in patients’ post-radical prostatectomy represents an attractive option for this sub-set of patients with erectile dysfunction. In a German study, researchers investigated the effect of delivering Schwann cells genetically modified with a glial cell line derived neurotrophic factor (GDNF) to the cavernous nerves after bilateral excision of the cavernous nerve in the rat (16). Their findings demonstrated that animals receiving cavernous nerve resection had significant impairments in erectile function as measured by cavernous nerve stimulation. However, cavernous nerve resected rats receiving GDNF-hypersecreting Schwann cell grafts had significant improvements in erectile function and axon regeneration with new B- and C-fibers in the experimental group. These data suggest that GDNF-hypersecreting Schwann cell graft gene therapy might be applicable for the treatment of post-radical prostatectomy ED due to regeneration of neuronal capacity.

The mechanisms governing erectile failure in diabetic patients are dependent on a number of factors, including endothelial dysfunction, neuropathy, oxidative stress, and structural changes in the penile vascular bed. Such alterations in the peripheral vasculature may underlie the high prevalence (>50%) of ED in diabetic men. A major factor contributing to diabetic ED is a reduction in the number of nitricergic NOS containing nerve fibers, constitutive NOS activity, and impaired endothelial- and neurogenic-mediated corporal smooth muscle relaxation. Recently, the RhoA/Rho-kinase signaling pathway, which influences corporal smooth muscle tone, has been described. This novel signaling cascade has been shown to suppress endothelial nitric oxide synthase and thus reduce endothelial-derived nitric oxide in the systemic vascular bed. A recent study provides the first evidence, at both the molecular and functional level, for a biological role of RhoA/Rho-kinase regulating eNOS expression and function in the diabetic corpora cavernosa (17). These data suggest a possible mechanism by which diabetic men may develop ED resulting from decreased NO production and upregulation of the RhoA/Rho-kinase signaling pathway in the corporal vasculature. Inhibition of RhoA/Rho-kinase by adeno-associated viral gene transfer of the dominant negative RhoA mutant to the diabetic penes enhances penile eNOS expression, constitutive NOS activity and cGMP levels, thereby restoring endothelial-derived NO vasodilation and erectile function. Hence, RhoA/Rho-kinase may represent a novel therapeutic target for the treatment of diabetes-related ED.

**Miscellaneous**

Complementary and alternative medicine (CAM) continues to gain an increasing role in the management of a variety of conditions. The PDE-5 inhibitors for the treatment of ED have established themselves as being first line oral therapy. It is not surprising that marketed herbal products have claimed efficacy similar to PDE-5 inhibitors by acting through “natural means.” In a recent study, high performance liquid chromatography analysis on seven products claiming improvement in erection quality showed significant contamination with PDE-5 inhibitors in two out of the seven (30%) herbal preparations (18). Consumers and regulatory agencies must be aware of these findings, as these agents are recognized to have fatal interactions when used with some medications, e.g. nitrates. The public needs to be informed that the term “natural” does not necessarily imply safety. Tighter regulation of CAM marketed preparations is recommended. In a similar manner, many prospective patients gather information on ED from Internet search engines. Through hyperlinks a number of herbal remedies are offered for sale and practice recommendations are made. A study from England reviewed over 160,000 hits on herbal remedies for ED, with 80% of sites outlining the effectiveness of the drugs, 70% providing the ingredients, and only 21% giving the side effects and contraindications (19). Only 21% of the sites had medically trained personnel providing information and only 18% had referenced information. The commonest reported ingredients were yohimbine, ginseng, and gingko biloba. Although serious adverse effects (e.g. bleeding disorders and cardiac arrhythmia with gingko biloba) have been documented, most Web sites state these herbal remedies are harmless. The authors’ results clearly demonstrate the obvious dangers for consumers purchasing herbal remedies for ED from unregulated Internet sites.

**Conclusions**

Excellent basic and clinical research in the field of sexual medicine from the 2004 JUA have set the foundation for future advances. The coming years will witness new inroads in understanding and treating common conditions such as premature ejaculation, female sexual dysfunction, and Peyronie’s disease. Molecular studies are in their infancy and future developments in regards to centrally acting agents, topical treatments and gene-based therapies are anticipated.

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The 7th Congress of the European Federation of Sexology, 12-16 May 2004, Brighton, UK

The 7th Congress of the European Federation of Sexology (EFS) was held in the enjoyable city of Brighton with nice spring sunshine. About 800 participants made this meeting very successful. Together-Integrating Sexology was the theme of the 2004 EFS meeting, hosted by the British Association for Sexual and Relationship Therapy (BASRT). A multidisciplinary approach to sexual health and sexual function has been recognized by the EFS as an important way for intervention in the complexity of factors regarding human sexual behaviours and functioning. Many sessions with a huge diversity of topics have been presented. Five concurrent sessions, plenaries, the meet-the-expert lunch sessions, proffered oral papers, and posters. Dr Kevan Wylie, President of the Congress, has allowed this diversity offering a good level of science, without making the meeting very commercial.

Dr Gingell (UK) reported on the Global Study of Sexual Attitudes and Behaviours among men and women aged 40 to 80 years, from 29 countries all over the world. Of 27,500 respondents (about half men and half women), overall more than 80% of men and 65% of women reported they had sexual intercourse within the last 12 months; in about half of the sexually active persons intercourse was on a regular basis, i.e. at least 5 times/month. The most common sexual dysfunction was a lack of sexual interest which was reported by 36% of women and 16% of men. Inability to reach the climax was reported by 25% of the women while 24% complained of not being adequately lubricated. Erectile dysfunction was reported by 17% of men. The conclusion of the study is that the majority of men and women remain sexually active into middle and older age but although sexual problems are highly prevalent only a minority seeks help. Of particular interest was the session on sexuality and cancer, co-organized by the International Society for Sexuality and Cancer (ISSC). Four speakers faced the problem of sexuality and sexual dysfunction in the very difficult patient with cancer. Urological cancer (Dr Incrocci, The Netherlands), gynaecological cancer (Dr Grazierotti, Italy), the terminally ill (Dr Gianotten, The Netherlands) and prostate cancer (Dr Porst, Germany). A significant number of talks were held in the enjoyable city of Brighton with nice spring sunshine. About 800 participants made this meeting very successful. Together-Integrating Sexology was the theme of the 2004 EFS meeting, hosted by the British Association for Sexual and Relationship Therapy (BASRT). A multidisciplinary approach to sexual health and sexual function has been recognized by the EFS as an important way for intervention in the complexity of factors regarding human sexual behaviours and functioning. Many sessions with a huge diversity of topics have been presented. Five concurrent sessions, plenaries, the meet-the-expert lunch sessions, proffered oral papers, and posters. Dr Kevan Wylie, President of the Congress, has allowed this diversity offering a good level of science, without making the meeting very commercial.

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Netherlands) was extensively addressed. This was preceded by an overview of the problems linked to sexuality in cancer patients by Dr Fallowfield (UK). She indicated how an individual’s sexual well being may be altered by both the diagnosis and treatment of cancer estimating that between 25–30% of patients with cancer have depression at some stage of their illness which may in itself produce a loss of libido.

Some discussions were raised on sexology training in Europe and the different models already present in some European countries or being now developed. Dr Pasini (Switzerland) reported on 2 levels of training in Geneva: a first level, more academic, with representatives of medicine, psychology, sociology, law and art faculties, formulating the module. A 2nd level including a psychotherapeutic background. The first level can result in a Certificate of Clinical Sexology at the university after taking examinations. The difficulty of definition still remains: who is a sexologist? There is a segmentation of sexology into different disciplines and unfortunately no serenity has been reached in the field of sexology (Dr Caruso, Italy). Very interesting was the British Association of Urological Surgeons Joint Meeting varying from Peyronie’s disease (Dr Montorsi, Italy) to penile prostheses (Dr Ralph, UK) to enlargement surgery (Dr Eardley, UK). Female sexual dysfunction was represented in different sessions by well-known international speakers (Dr Leiblum, USA, Dr Graziotti, Italy, Dr Riley, UK). Of course it is impossible to present an overview of the many sessions, speakers and topics, this is just a very small impression of the meeting.

The abstracts of the meeting are published in a supplement of the Journal of the BASRT: Sexual and Relationship Therapy, volume 19 (Suppl 1), May 2004.

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3rd Mediterranean Symposium of Andrology, 27 May - 1 June 2004, Santorini, Greece

Santorini, a beautiful volcanic island that according to the Greek mythology was born from an erotic conflict of Gods, has been chosen to host the 3rd Mediterranean Symposium of Andrology. This yearly event is organized by the Mediterranean Association of Andrology (AMA) and combines proffered papers, state of the art lectures and invited papers from Mediterranean countries, covering all aspects of andrology. The meeting started with a symposium on congenital and Peyronie’s curvature in which Dr Egydio (Brazil) presented a new surgical technique based on Pitagora’s algorithms in order to properly incise the tunica albuginea avoiding a shortening of the penis. In the symposium Uro-Andrology interesting lectures reviewed different topics as erectile dysfunction (ED) after radical prostatectomy (Dr Thanos, Greece), ED following radiotherapy (Dr Incrocci, The Netherlands), male incontinence (Drs Theodorou and Kostakopoulos, Greece), ED and lower-urinary tract syndrome (LUTS) (Dr Drettas, Greece). Dr Giami (France) expressed his concerns on the fact that general practitioners in France do not have any education on sexual dysfunction. Dr Ganem (France) pointed out that in this era of pharmacotherapies for ED one forgets all the repercussions of oral drugs on the couples and stressed the importance to involve the female partner of the patient suffering from ED. A female sexual dysfunction session, a round-table on phalloplasty and cosmetic genital surgery, and a session on infertility completed the program. Although full of lectures the program was designed in a way that there was plenty of time to visit the beautiful Santorini with his picturesque villages, to enjoy good food and the warm hospitality of Greece. The 4th meeting of the AMA will take place in Alexandria, Egypt, May 25-27, 2005.

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A National Course of Andrology & Surgery was organized in Potenza (Italy) from April 15th to 17th, 2004, promoted by the Italian Society of Andrology and the Andrology Center of S. Charles Hospital. Important topics have been discussed as prostate cancer, male infertility, erectile dysfunction and transexualism, with implications for their treatment and prevention.

Moreover, live surgery has been predominant, with two radical prostatectomies performed, at the same time, by Prof. Austoni and Prof. Gallucci, two sexual conversions by Prof. Selvaggi and Prof. Mirone and operations for male infertility as well. During the infertility session, chairman Prof. Menchini-Fabris confirmed the necessity of collaboration between specialists in Andrology and Gynaecology also in the light of changes on assisted fertilization. The topics on transexualism have provoked an interesting discussion, and this gave great satisfaction: in fact, the object of the meeting was to give only a new reply to the old demand.

Angela Vita, MD

Special Issue

From ornamentation to mutilation: genital decorations and cultural operations in the male

At a certain point in history, primitive man began decorating his body with various marks. He applied these marks by using dyes, tattoos, scarring, etc. This type of biological distinction—which is also present in other animal species—was accentuated in humans. It was extremely important to primitive man that his group, which could be identified as a group through certain characteristics, should be able to survive. For this reason, marks on parts of the body and designs on the skin have been used from the dawn of time in order to distinguish between various tribes and peoples. It is perhaps not surprising that the difference between the sexes played an important role in body ornamentation from an early stage. If viewed in these terms, decoration of the genitals becomes a logical part of body ornamentation.

Penis sheaths are a good and universal example of this hypothesis. And it is exactly this “universal” occurrence that I wish to demonstrate in this book: penis sheaths are not an isolated phenomenon amongst the Papuans in Irian Jaya, but have also appeared in the past in large areas of Africa and South America. Attaching the foreskin to a belt or fastening objects to the foreskin or glans (also called infibulation) is an ancient practice that dates back to the Palaeolithic era. It was common among many peoples from Ancient Egypt to the Far East, and also in the rainforests of the Amazon and the islands around Australia. In the narrow sense of the term, infibulation refers to the closing off of the glans with the foreskin, as was practised by the Romans. In a broader sense, infibulation also means the fastening of various objects to the foreskin or penis in order to decorate the body, as is still practised by the Ashaninka people deep in Amazonia. Nor should we forget the modern practice of piercing the genitals, which is also intended as a form of “decoration”.
Later on, during the late mediaeval and early Renaissance period in Europe, the male genitals were further emphasised by clothing. This resulted in the very distinctive “braguette” in France, the “codpiece” in England and the “Viseldeck” in Germany. Tattoos and tattooing are considered by many to have strong sexual connotations. Whether one regards the sexual implications of tattoos as acceptable or not, there is no denying the powerful influence of love and eroticism on genital tattooing decoration.

The cutting of the visible genitalia—circumcision, subincision and infibulation—very clearly distinguish one people from another. These decorations (or mutilations?) are often associated with initiation rites that distinguish fertile adults from prepubescent children, thereby ensuring a stable social identity. Such practices can still be seen throughout Africa today. Sometimes a procedure of this kind—circumcision, for example—can also allude to the passing from a biological, human context into a more symbolic context. This is very obviously the case with regard to the Jewish and Islamic religions. In Genesis 17:7-13, Yahweh says to Abraham: “Every male among you shall be circumcised. You shall circumcise the flesh of your foreskins, and it shall be a sign of the covenant between me and you... So shall my covenant be in your flesh an everlasting covenant.” Thus was a covenant clearly established between Yahweh and His chosen people. Based on this same story of Abraham, which is also described in the Koran, the Muslim faith also later adopted the ritual of circumcision (although it is never explicitly referred to in the Koran itself).

Nevertheless, we must remember that the practise of male circumcision is much older than the Bible story of Abraham. According to James de Meo, different theories explain the origins of male circumcision. One of these theories claims that circumcision began as a means of “purifying” individuals and decreasing their sexual pleasure. De Meo suggests that circumcision developed in the desert regions of North Africa and the Near East, from where it spread further to sub-Saharan Africa, Oceania and possibly also to parts of the Americas (since the Maya civilisation also had a rite in which the male genitals were cut with agave leaves). In Africa, circumcision is generally associated with “initiation”. The word initiation comes from the Latin initiatio (from initiare: to begin or enter), meaning “inauguration”. The object of these rituals is the transition from child to adult. This may occur individually or collectively. The ceremony is one of ritual rebirth: the initiates “die” as children, which is symbolised through their seclusion from the village and their family. In order to be made into fully-fledged men, a “corrective” operation is necessary: here, the boys' foreskins are seen as a feminine “remnant”. Circumcision also gives the boys the ethnic characteristics of the group, so that they will be recognisable to their ancestors after their deaths.

In the United States, the practise of systematically circumcising newborn boys at birth became common from the end of the 19th century. This was first seen as a means of preventing masturbation and later as a means of preventing penis cancer and cervical cancer. The practise is now under severe attack and its opponents frequently use the term “mutilation”. In accordance with Darwin’s theory that “the struggle for survival is best understood as a struggle to breed”, some animal species seek to prevent other males from having sexual contact with their female partners. This leads to a kind of harem system, such as can be observed amongst gorillas and elephant seals. This system only functions to a limited extent amongst humans. While a dominant individual might indeed be able to attract various women, it is difficult for him to keep guard over them day and night. However, the introduction of
castration and the creation of eunuchs allowed a limited number of powerful men to operate a harem system. By increasing the number of eunuchs under his command, a man could increase his number of women, yet remain sure that they would not be impregnated by “outsiders”, thus guaranteeing the “purity” of his own family line. Eunuchs performed this function in both East and West. The most famous eunuchs are those of the Imperial Court in Peking, the Mogul palaces in India and the harems of the Ottoman Empire. However, eunuchs were also to be found in the classical Western world. Because women were not allowed to sing in the mediaeval church, much use was made of castrati singers. This was particularly the case in Italy, where the eunuch choir of the Sistine Chapel and the male sopranos of the opera houses were universally admired and acclaimed. Lesser well-known today are the Hijras eunuchs in India, who are estimated to be more than a million strong and who in 2001 even elected a representative to the Indian parliament! Equally anonymous was the Skoptzy sect in Russia, which was made up of castrated men and only disappeared with the Bolshevik revolution of 1917. Finally, castration is used in the medical world as a treatment for various medical disorders of the prostate gland. Hormonal castration (with medication and without surgery) today remains the most efficient treatment for advanced and widespread prostate cancer.

To end, there is a short piece about the “Koro” phenomenon. This is neither a decoration nor a mutilation of the penis, but rather a mass psychosis in which a nation’s entire male population fears that their penises will disappear, meaning certain death for the victims. This book is not only the product of years of study and reading, but also the result of personal observations as an urologist during the travels of the author to many distant lands. As with his earlier book The Phallus in Art and Culture, he has attempted to make this new book both enjoyable to read and enjoyable to look at. Many of the numerous illustrations are published here for the first time.

The book has 240 pages and 475 colourfull illustrations. It is available in English, Dutch and French (price 40 € + postage costs)

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* With regard to circumcision, in recent times there has been an increasingly heated debate as to whether it should be regarded a s a common ritual procedure or simply as a form of mutilulation. The discussion is a universal one, which keeps cropping up. In the chapter on circumcision and un-circumcision, it is dealt with in detail.
On behalf of the Scientific Committee it is my pleasure to welcome you to the 11th World Congress of the International Society for Sexual and Impotence Research – ISSIR.

The scientific program has been prepared considering the most relevant topics in the field of male and female sexual function and dysfunction, including the basic, clinical and surgical research. Therefore, it includes 12 state of the art sessions, round tables, interactive symposiums and postgraduate courses.

In the first place, I would like to thank the Congress Chairman, Dr. Edgardo Becher, for the support and confidence in us, and Dr. Guillermo Gueglio, Dr. Adolfo Casabé and Dr. Miguel Rivero, who actively took part in this process. My gratitude, also, to the Congress Committee: Dr. Jacques Buvat, Dr. Khaled Dabees, Dr. Carolyn Earle, Dr. Jeremy Heaton, Dr. Eric Meuleman, Dr. Francesco Montorsi, Dr. Ira Sharlip and Dr. Eric Wespes for their unconditional support for this event’s organization.

I am extremely grateful to the Scientific Committee members, to Dr. Sydney Glina, who, as co-chairman joined us in the programme design and analysis, to Dr. Edoardo Pescatori, Dr. Tom Lue, Dr. Gregory Broderick, Dr. François Giuliano, Dr. Ricardo Munarriz and Dr. Yoram Vardi, who, since the beginning, contributed with their valuable suggestions on different subjects and speakers for the program.

For this congress, an on-line abstracts review process has been implemented with outstanding results. This system allowed a safe and on time revision for the finalizing of this book, which makes it the first supplement to be edited for the new Journal of Sexual Medicine, supported by all ISSIR members and tenaciously promoted by Dr. Irwin Goldstein.

The scientific committee appointed more that 50 reviewers for the different topics, from all over the world. They were assigned the abstracts to review randomly, not knowing the author or country to which they belonged, seeking totally unbiased opinions. Two reviewers were assigned to each abstract who evaluated it based on originality, scientific merit and clinical relevance, grading it and making the recommendation for oral presentation, moderated poster or unmoderated poster. In those cases where there were different opinions regarding one abstract, a third reviewer was appointed in order to obtain a final verdict. Consequently they were classified by topics and distributed among the sessions based on the podium and poster sessions availability and considering, in the first place, the author’s preference, the abstracts grading and the reviewers’ opinions.

We received 411 abstracts, out of which 377 were approved for their presentation among the several sessions: 99 abstracts for podium presentation, 120 abstracts for moderated poster presentations, 153 abstracts for unmoderated poster presentations and 5 videos. The quality of the abstracts was optimum and all deserve a place for discussion. Unfortunately this is not possible due to time restrictions.

I would like to thank the reviewers Doctors Carmita Abdo (Brazil), Ganesan Adaikan (Singapore), Michael Adams (Canada), Marı́a Victoria Bertolino (Argentina), Gerald Brock (Canada), Gregory Broderick (USA), Serge Carrier (Canada), Adolfo Casabé (Argentina), Young Chan Kim (Korea), George Christ (USA), Mauricio Delgado (Colombia), Ian Eardley (UK), Carolyn Earle (Australia), Geraldo Faria (Brazil), Luis Finger (Argentina), Alex Fugl-Meyer (Sweden), François Giuliano (France), Sydney Glina (Brazil), Néstor González Cadavid (USA), Tulio Grazziotin (Brazil), Guillermo Gueglio (Argentina), Lawrence Hakim (USA), Jeremy Heaton (Canada), Wayne Hellstrom (USA), Luca Incrocci (The Netherlands), Yasuske Kimoto (Japan), Tom Lue (USA), Antonio Martin Morales (Spain), Osvaldo Mazza (Argentina), Chris McMahon (Australia), Kevin McVary (USA), Eric Meuleman (The Netherlands), Ignacio Moncada (Spain), Alexandre Moreira (Portugal), John Mulhall (USA), Ricardo Munárriz (USA), Alberto Nagelberg (Argentina), Ajay Nehra (USA), Edoardo Pescatori (Italy),
Miguel Rivero (Argentina), Abrie Schmidt (South Africa), Ridwan Shabsigh (USA), Mariano Sotomayor (Mexico), William Steers (USA), Hui Meng Tan (Malaysia), Luiz Otavio Torres (Brazil), Yoram Vardi (Israel), Fernando Ugarte y Romano (Mexico), Eric Wespes (Belgium), Federico Zeller (Argentina), and to all those who having accepted this task, for different reasons, were not available during the reviewing process.

We have tried to avoid parallel sessions which cover aspects of common interest so as to ensure that each delegate will be able to participate in all the sessions of their interest.

On behalf of the Scientific Committee I would also like to extend my gratitude to all the speakers and participants for their significant support. I would like to emphasize Mr. Robert Kessler’s professionalism and cordiality, with whom we have worked jointly, providing all that was necessary to accomplish a result in line with the magnitude of this meeting. Finally, I would like to thank Mrs. Pilar Signori and Mrs. María Claudia Iturregui, who set about each of the proposed activities for this meeting with exclusive dedication and with utmost responsibility for its achievement.

We hope that the work done during these years may meet our expectations of increasing our knowledge through everyone’s contribution and that it may also allow us to continue to tighten the bonds which unite specialists worldwide through our Society.

Welcome to Buenos Aires!

Amado Bechara, MD
Chairman of the Scientific Program Committee

8th Congress of the Latin American Society for the Study of Impotence and Sexuality (SLAIS)

Dear Colleagues and Friends,

SLAIS-Sociedad Latinoamericana para el Estudio de la Impotencia y Sexualidad (Latin American chapter of the ISSIR) has chosen Punta del Este (Uruguay) to host its VIII congress, that will take place on December 1-3, 2005 at the Conrad Hotel.

The Scientific Committee is working hard to prepare a scientific program that will cover most aspects and advances in our field: the Sexual Medicine. The program will also include several sessions for the presentation of scientific papers. Besides, SLAIS is planning to give grants again to the best projects on Basic and Clinical Research, which will undoubtedly represent an added value to the congress itself.

The Society of Urology of Uruguay will join us to give their local support to the VIII Congress, which means that it will contribute to the success of this important meeting.

Geographically, Punta del Este is ideal at this time of the year where the combination of the warm weather to enjoy the seaside or the countryside, together with the warmth and hospitality of the people of Uruguay and a great variety of hotels and places, will surely meet your requirements and expectations. These particular features of Punta del Este will allow us to develop a social program according to our Latin American tradition of friendship.

Moreover, a large area will be provided for the commercial exhibition where the participants will be able to have a direct contact with the industry.

At www.slais2005.org, you will find the updated information on the VIII SLAIS congress and all the touristic possibilities that will be available for you to choose so as to make of this meeting an unforgettable experience.

Your questions and inquiries can be sent to: info@slais2005.org.

We will be waiting for you!

Miguel Alfredo Rivero, MD
Secretary General – SLAIS
President of the VIII Congress
Baclofen in the treatment of stuttering priapism
Dr. Amr El-Meliegy inquired if any member used baclofen for the treatment of stuttering priapism. Treatment of recurrent idiopathic priapism with oral baclofen was suggested in a recent Journal of Urology article (Dec 2002;168:2552) by Rourke et al. Dr. Gregory Broderick found it effective for the suppressing nocturnal erections/stuttering priapism. However, neurologically normal patients noted unpleasant side effects. Dr. Hossein Sadeghi-Nejad tried Baclofen on 2 patients with stuttering priapism. One did not respond while the other noted mild temporary improvement. Side effects were not a significant problem in Dr. Sadeghi-Nejad’s cases at a dose ranging from (5-40 mg qhs). Both cases were later managed by self-injection of phenylephrine.

Dorsal neurotomy for premature ejaculation
Dr. Kevan Wylie initiated an interesting discussion about dorsal neurotomy for the treatment of premature ejaculation. Dr. Giuseppe La Pera made a very strong case against the use of this experimental technique. Many members contributed to this very interesting discussion that may be read online on www.issir.org.

Spontaneous Ejaculation
Dr. Frederick J . Snoy presented a case of spontaneous ejaculation at midday without any erotic thoughts. Dr. Pierre Assalian noted that spontaneous ejaculation has been reported in males who has been taking Prozac and other SSRIs, as well as natural drugs like St Johns wart and also inquired about street drugs. Dr. Zohier Murad suggested excluding a stimulating irritating factor affecting his ejaculatory neurological pathways.

Sildenafil and Antiandrogens in Gender Dysphoria
An unusual case of gender dysphoria was presented by Dr. Kevan Wylie. A transsexual women on anti-androgen therapy requested sildenafil to insure that her (male) partner sees her aroused. Dr. Mario Maggi noted that that anti-androgen treatment strongly decreased PDE5 gene and protein expression in human penis and therefore responsiveness to sildenafil. Dr. Hussein Ghanem and Dr. Pierre Assalian suggested that it was atypical that the patient was not upset that her partner shows interest in her male genitalia. Dr. Charles Moser reported prescribing PDE5 inhibitors to MTF transsexuals. Dr. Guillaume Guegliev inquired about culture and sensitivity testing and suggested an antibiotic trial. Dr. Eric Meuleman suggested the graft needs to be removed while Dr. Guillermo Guegliev inquired about culture and sensitivity testing and suggested an antibiotic trial. Dr. Eric Meuleman suggested the graft needs to be removed while Dr. Guillermo Guegliev inquired about culture and sensitivity testing and suggested an antibiotic trial. Dr. Eric Meuleman suggested the graft needs to be removed while Dr. Guillermo Guegliev inquired about culture and sensitivity testing and suggested an antibiotic trial.

Post-priapism penile fibrosis
Dr. Nguyen Tan Trung inquired about the management of severe post-priapism penile fibrosis. Dr. Andik Wijaya suggested the trial of a vacuum suction device. Definitive therapy appears to remain surgical by implanting a penile prosthesis by experienced implant surgeons.

Immunologic Reaction to Penile Implants
Dr. Oscar Diaz inquired about possible immunological reactions in relation to penile prosthesis implantation. Dr. Mustafa Usta and Dr. Gregory Broderick noted that they are not aware of any such reports. Dr. Broderick reported a paper by Dr. David Barrett that did address this issue regarding silicone in artificial urinary sphincters. The paper did note particles of silicone in remote locations from the implant site, but found no evidence of immunologic ‘syndromes’ as was being claimed by patients with breast implants. Dr. Ulrich Witzsch reported that an article in the lay press mentioned a case of a patient who went to court claiming an immunologic reaction.

Cutaneous Fistula Following Bovine Pericardium
Dr. Sidney Glina presented a case where he was asked for a second opinion regarding a cutaneous fistula that occurred following bovine pericardium grafting for Peyronie’s disease. Dr. Eric Meuleman suggested the graft needs to be removed while Dr. Guillermo Guegliev inquired about culture and sensitivity testing and suggested an antibiotic trial. Dr. Günter Witzsch suggested power-duplex and an MRI to find out where the infection is exactly followed by removing the graft if needed and covering the gap with resorbable material. Dr. Tom Lue reported his experience and suggested a Mulpahy salvage procedure, and replacing the pericardium with porcine small intestine submucosal graft. Dr. Sudhakar Krishnamurti suggested removal of the infected graft under sensitivity-directed antibiotic cover, irrigating the operative field well, and placing a penile dermal flap.

Unusual Ejaculatory Disorder
Dr. Eric Meuleman presented a very interesting case of an unusual ejaculatory disorder where the ejaculate dribbles out 2 minutes after orgasm. No abnormalities were noted on physical exam, TRUS & hormone profile. Dr. Andik Wijaya suggested the possibility of a neurotransmitter disorder. Dr. Krishnamurti suggested urethral studies - ’scopy, ‘graphy etc. Dr. John Dean suggested a possible urethral diverticulum or possible cyst. Dr. Santiago Richter found a discovered a urethral diverticulum (Cowper’s Syringoele) in a similar case. Dr. Pierre Assalian noted that this...
Erectile dysfunction (ED) is a highly prevalent health problem that affects approximately 30 million men in the United States. It is a common worldwide clinical problem with tens of thousands of new cases per year. Considering the increasing life expectancy and the high incidence of ED in the aging population, a further increase in patients with ED must be expected. Putative causes and clinical correlates of ED, many of them likewise associated with aging, include vascular insufficiency, hormonal derangement, interruption of neuronal pathway, diabetes, psychogenic factors and side effects of therapeutic drugs. The characteristics of ED have been reported in many studies; however, it was not yet well investigated in patients of our community. This prompted us to conduct a research project to identify the magnitude of the problem in the community. We demonstrated that ED is very prevalent and we noted that risk factors for ED were also very common in this community. We found that 20% of the patients had psychogenic while 80% had organic causes of ED. Of the patients about 10% had mild, 40% had moderate and 50% had severe ED. The high prevalence of severe ED in our patients could be attributed to: 1) the high prevalence of risk factors among our patients such as smoking, obesity and concomitant conditions as hypertension, IHD, and dyslipidemia; 2) the delay in seeking medical advice; 3) the poor control of diabetes in this community; 4) the incompletion to treatment. Further, we showed in experimental and clinical studies that important risk factors such as diabetes and heart diseases could negatively affect erectile function. In another part of our study we found an association between ED and certain categories of commonly used medications for treatment of concomitant conditions that usually associated with ED especially, diuretics, anti-hypertensive medications and lipid lowering agents. Regarding the available treatment for ED, the past two decades have witnessed a phenomenal advance in the understanding of penile physiology and several revolutionary new treatments for patients with ED. With the progress of basic and clinical research and its application in this field, we may see cure or significant improvement of various types of ED in the near future instead of symptomatic treatment. As new drugs are developed for ED, new issues will arise that are relevant to their safety, efficacy, tolerability and certainly their cost. With no doubt the birth of PDE5 inhibitors have opened a new field in medical literature and enhance more researches that deal with oral treatment for one that is probably a urologic disorder not a sexological one while Dr. Stacy Elliott suggested Kegel’s exercises if no physical abnormality was found. Drs Raviv, Bronner and Sarig outlined different possible physical, psychological and behavioral factors. Dr. Zohier Murad and Dr. Antonio Morales suggested a urethral stricture and recommended a uroflowmetry. Dr. Juza Chen inquired about medications mainly antidepressants or alpha blockers.

**Sexual Headache**

Dr. Brito Cunha presented a case of an 18 years old patient complaining of severe headaches occurring during sexual intercourse and becoming more intense at orgasm, and not responding to Beta-adrenergic blocking drugs. Interestingly, Dr. Pierre Assalian, Dr. Prithy Ramlachan and Dr. Shedeed Ashour had similar cases that responded to non steroidal anti-inflammatory drugs.

**Summary of the cases discussed on ISSIR List:**

- Baclofen in the treatment of stuttering priapism
- Dorsal neurotomy for premature ejaculation
- Spontaneous Ejaculation
- Sildenafil and Antiandrogens in Gender Dysphoria
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- Unusual Ejaculatory Disorder
- Sexual Headache

The detailed cases and discussions of the current and previous cases may be read online on http://www.issir.org by clicking ISSIR List / Digest directory.

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**H. Ghanem, MD**

**Erectile Dysfunction:**

Spotting light on a sizable health problem in our community

Erectile dysfunction (ED) is a highly prevalent health problem that affects approximately 30 million men in the United States. It is a common worldwide clinical problem with tens of thousands of new cases per year. Considering the increasing life expectancy and the high incidence of ED in the aging population, a further increase in patients with ED must be expected. Putative causes and clinical correlates of ED, many of them likewise associated with aging, include vascular insufficiency, hormonal derangement, interruption of neuronal pathway, diabetes, psychogenic factors and side effects of therapeutic drugs. The characteristics of ED have been reported in many studies; however, it was not yet well investigated in patients of our community. This prompted us to conduct a research project to identify the magnitude of the problem in the community. We demonstrated that ED is very prevalent and we noted that risk factors for ED were also very common in this community. We found that 20% of the patients had psychogenic while 80% had organic causes of ED. Of the patients about 10% had mild, 40% had moderate and 50% had severe ED. The high prevalence of severe ED in our patients could be attributed to: 1) the high prevalence of risk factors among our patients such as smoking, obesity and concomitant conditions as hypertension, IHD, and dyslipidemia; 2) the delay in seeking medical advice; 3) the poor control of diabetes in this community; 4) the incompliance to treatment. Further, we showed in experimental and clinical studies that important risk factors such as diabetes and heart diseases could negatively affect erectile function. In another part of our study we found a significant association between increasing severity of ED and the presence of diabetes, hypertension, dyslipidemia, smoking, increased body mass index (BMI), increased values of end diastolic velocity, decreased values of peak systolic velocity (PSV), resistive index (RI) in penile Doppler ultrasonography and rigidometer. We reported an association between ED and certain categories of commonly used medications for treatment of concomitant conditions that usually associated with ED especially, diuretics, anti-hypertensive medications and lipid lowering agents. Regarding the available treatment for ED, the past two decades have witnessed a phenomenal advance in the understanding of penile physiology and several revolutionary new treatments for patients with ED. With the progress of basic and clinical research and its application in this field, we may see cure or significant improvement of various types of ED in the near future instead of symptomatic treatment. As new drugs are developed for ED, new issues will arise that are relevant to their safety, efficacy, tolerability and certainly their cost. With no doubt the birth of PDE5 inhibitors have opened a new field in medical literature and enhance more researches that deal with oral treatment for one that is probably a urologic disorder not a sexological one while Dr. Stacy Elliott suggested Kegel’s exercises if no physical abnormality was found. Drs Raviv, Bronner and Sarig outlined different possible physical, psychological and behavioral factors. Dr. Zohier Murad and Dr. Antonio Morales suggested a urethral stricture and recommended a uroflowmetry. Dr. Juza Chen inquired about medications mainly antidepressants or alpha blockers.

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The detailed cases and discussions of the current and previous cases may be read online on http://www.issir.org by clicking ISSIR List / Digest directory.

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**H. Ghanem, MD**
possesses the utmost importance as a quality of life issue for men’s erectile function.

References:

Meetings Calendar

Luca Incrocci: lucaincrocci@cs.com

2004

September 2-4, Vienna, Austria
3rd International Congress of the History of Urology
EAU Central Office
Mr E.N. van Kleffenstraat 4
6842 CV Arnhem, The Netherlands
Phone: +31 26 38 90 680
Fax: +31 26 38 90 686
E-mail: congress.consultants@uroweb.nl
Web: www.uroweb.org

September 11-14, Münster, Germany
3rd European Congress of Andrology
Phone: +49 251 83 56 097
Fax: +49 251 83 56 093
E-mail: eca@uni-muenster.de
Web: www.3rd-eca.de

October 3-7, Honolulu, Hawaii
27th Congress of the Société Internationale d’Urologie (SIU)
SIU Congress Office
1155 University Street, Suite 1155
Montreal, Canada H3B 2A7
Phone: +1 514 87 55 665
Fax: +1 514 87 50 502
E-mail: info@siu2004.com
Web: www.siu2004.com

The ISSIR organizes one symposium

October 6-9, Athens, Greece
8th International Conference of the International Association for the Treatment of Sexual Offenders (IATSO)
Congress Center of Glyfada, Athens
Training Center, National Bank of Greece
41 Posidonos Av, 16675 Glyfada, Greece
Phone: +30 210 89 17 100
E-mail: giotakos@tri.forthnet.gr
Web: www.iatsoathens.gr

October 7-8, Berlin, Germany
Androgens 2004
Frank Claessens
Department of Biochemistry
Campus Gasthuisberg Q/N Herestraat 49
3000 Leuven, Belgium
E-mail: frank.claessens@med.kuleuven.ac.be
Web: www.kuleuven.ac.be/androgens2004

October 17-21, Buenos Aires, Argentina
11th World Congress of the International Society for Sexual and Impotence Research
ISSIR Executive Office
R.O. Box 97
3950 AB Maarn, The Netherlands
Phone: +31 343 44 38 88
Fax: +31 343 44 20 43
E-mail: office@issir2004.org
Web: www.issir2004.org

Ahmed I. El-Sakka, MD
Department of Urology, Suez Canal University, Ismailia, Egypt and Al-Noor Specialist Hospital, Makkah, Saudi Arabia
E-mail: aielsakka@yahoo.com
October 28-31, Atlanta, USA
4th Meeting of the International Society for the Study of Women’s Sexual Health (ISSWSH)
ISSWSH
1111 N. Plaza Drive, Suite 550
Schaumburg, IL 60173
Phone: +1 847 51 77 225
Fax: +1 847 51 77 229
E-mail: isswsh@wjweiser.com
Web: www.isswsh.org

December 5-8, London, United Kingdom
7th Congress of the European Society for Sexual Medicine (ESSM)
CPO Hanser Service
Zum Ehrenhain 34
22885 Barsbüttel, Germany
Phone: +49 40 67 08 820
Fax: +49 40 67 03 283
E-mail: essir@cpo-hanser.de
Web: www.essm2004.org

2005

January 23-28, Mauritius Island
International Meeting on Advances in Sexual Health and 1st Meeting of the Société Francophone de Médecine Sexuelle (SFMS)
NHA Communication
3, rue La Boetie
75008 Paris, France
Phone: +33 1 42 66 46 46
Fax: +33 1 42 66 45 45
E-mail: info@SFMS.dyndns.org
Web: www.SFMS.dyndns.org

February 2-5, Vancouver, Canada
North American Congress on The Aging Male of the Canadian (CSSAM) and International (ISSAM) Society for the Study of the Aging Male
Kenes International
PO Box 1726
1211 Geneva 1, Switzerland
Phone: +41 22 90 80 488
Fax: +41 22 73 22 850
E-mail: aging@kenes.com
Web: www.kenes.com/aging

March 4-6, Mombassa, Kenya
5th Biennial Congress of the African Society of Sexual and Impotence Research
ASSIR Executive Secretariat
14 Syria St., Mohandeseen, Guiza, Egypt
Phone: +202 33 68 304
Fax: +202 74 95 671
E-mail: asfour2712@yahoo.com

March 16-19, Istanbul, Turkey
20th Congress of the European Association of Urology (EAU)
EAU Central Office
Mr E.N. van Kleffenstraat 4
6842 CV Arnhem, The Netherlands
Phone: +31 26 38 90 689
Fax: +31 26 38 90 686
E-mail: congress咨询服务@uroweb.nl
Web: www.uroweb.org

April 13-15, Cairo, Egypt
4th Pan Arab Congress of Sexual Health and Genital Surgery
Pan Arab Society of Genital Surgeons Secr.
14 Syria St., Mohandeseen, Guiza, Egypt
Phone: +202 33 68 304
Fax: +202 74 95 671
E-mail: asfour2712@yahoo.com

May 21-26, San Antonio, USA
100th Annual Meeting of the American Urological Association (AUA)
AUA
1120 North Charles Street
Convention Department
Baltimore, Maryland 21201-5559, USA
Phone: +1 401 22 34 308
Fax: +1 401 22 34 372
E-mail: convention@auanet.org
Web: www.auanet.org

May 25-27, Alexandria, Egypt
4th Annual Meeting of the Mediterranean Association of Andrology (AMA)
Dr Ashraf Samir
P.O. Box 125
Ibrahimia, Alexandria, Egypt
Phone: +20 3 35 95 043
Fax: +20 3 35 95 044
E-mail: drashraf@aast.edu

June 12-16, Seoul, Korea
8th International Congress of Andrology (ICA)
Congress Secretariat
Meci International Convention Services, Inc
#301 Arin Bldg, 738-2 Yeksam 1-dong,
Gangnam-gu
Seoul 135-924, Korea
Phone: +82 2 56 95 802
Fax: +82 2 56 95 803
E-mail: ica2005@meci.co.kr
Web: www.ica2005.org

June 23-25, Cancun, Mexico
First Congress of the Latin-American Society for the Study of the Aging Male (LASSAM)
E-mail: lassam2005@grupodestinos.com.mx
Web: www.latinmale.org

July 10-15, Montreal, Canada
17th. World Congress of Sexology
Dr. Pierre Assalian
Human Sexuality Unit, Montreal General Hospital
1650 Cedar Avenue
Montreal, Quebec H3G 1A4
Phone: +1 51 49 34 19 34
Fax: +1 51 49 34 82 37
E-mail: pierre.assalian@muhc.mcgill.ca
Web: www.montrealsex.com

October 5-8, Cairns, Australia
10th Meeting of the Asia-Pacific Society for Sexual and Impotence Research (APSSIR)
E-mail: promaco@promaco.com.au

December 1-3, Punta del Este, Uruguay
8th Congress of the Latin American Society for Impotence and Sexuality Research (SLAIS)
SLAIS General Secretariat
Fax: +5 411 48 26 28 32
E-mail: slais_secretariat@hotmail.com
Web: www.slais2005.org
First International Meeting on Advances in Sexual Health
From Evidence to Practice
Mauritius Island - January 23-28, 2005

Call for abstracts
Contact the Scientific Secretary

Bilingual: French/English
Updates, State of the Art lectures, Symposia, Workshops, Post graduate courses, Cases studies

President: J. Buvat
Co-chair: B. Whipple
Vice President: R. Porto
Scientific Secretary: M. Bonierbale

CME Agreement reference: 11752789775

Registration and information:
NHA Communication, 3 rue La Boëtie, 75008 Paris - France
Tél.: (33) (0)1 42 66 46 46 - Fax: (33) (0)1 42 66 45 45
Email: a.bonechi@nha.fr
Scientific Secretary: Dr M. Bonierbale, CHU Ste-Marguerite - 13274 Marseille Cedex 9 - France
sexologies@wanadoo.fr - Fax: (33) (0)4 91 74 48 71

With the Scientific Collaboration of:

Organized by:

12 topics for scientific mini-symposia
- Medicalization of sexuality: where do we stand?
- Sexual Health in the world: cultural differences
- Depression, anxiety and sexuality
- Female sexual dysfunctions: marketing construction or everyday problem?
- What changes in our knowledge of the human sexual response since Masters & Johnson?
- Menopausal sexual dysfunctions: what hormonal therapy today?
- Testosterone and erectile dysfunction: evolution of concepts and indications
- Androgen therapy in the aging male: is there evidence of efficacy and safety?

- Pharmacological therapy of sexual dysfunctions: analysing and managing the failures (would include erectile and other sexual dysfunctions)
- PDE5 inhibitors: the new regimens
- Intracavernosal therapy: more valid than ever
- Sexual dysfunctions in diabetic patients: role of endothelial dysfunction

Workshops in English and in French...
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LEVITRA® film coated tablets containing 5mg/10mg/20mg vardenafil.

Indication: Treatment of erectile dysfunction (inability to achieve or maintain penile erection sufficient for satisfactory sexual performance).

Dosage: The recommended starting dose is 10 mg taken as needed approximately 25 – 60 minutes before sexual activity. In clinical trials vardenafil was shown to be efficacious when taken up to 4-5 hours before sexual activity. Based on efficacy and tolerability, the dose may be increased to 20 mg or decreased to 5 mg. The maximum recommended dose frequency is once per day. The maximum recommended dose is 20 mg once daily. A starting dose of 5 mg should be considered in patients ≥ 65 years. In patients with moderate hepatic impairment (Child-Pugh B), a starting dose of 5 mg is recommended, which may subsequently be increased to a maximum dose of 10 mg, based on tolerability and efficacy. LEVITRA® can be taken with or without food. Sexual stimulation is required for a natural response to treatment.

Contraindications: hypersensitivity to any of the drug’s components, in patients concomitantly treated with nitrates or nitric oxide donors as well as with HIV Protease inhibitors such as indinavir or ritonavir.

Warnings and Precautions: Cardiovascular status should be considered. Patients with left ventricular outflow obstruction can be sensitive to the action of vasodilators including Type 5 phosphodiesterase inhibition. Patients with congenital QT prolongation (long QT syndrome) and those taking Class IA or Class III antiarrhythmic medications should avoid using LEVITRA®. The use is not recommended in patients with severe hepatic impairment, end-stage renal disease, hypotension (resting systolic blood pressure of <90 mmHg), recent history of stroke or myocardial infarction (within last 6 months), unstable angina, and known hereditary degenerative retinal disorders such as retinitis pigmentosa. Patients with anatomical deformation of the penis (such as impotence, cavernosal fibrosis or Peyronie’s disease) or in patients who have conditions which may predispose them to priapism (such as sickle cell anaemia, multiple myeloma or leukaemia) should be treated with caution. Combination use with other treatments for erectile dysfunction is not recommended. Dose adjustment is necessary if alpha-blockers, erythromycin, ketoconazole or itraconazole are given concomitantly. Administration to patients with bleeding disorders or active peptic ulceration only after careful benefit-risk assessment. Side effects: headache, flushing, dyspepsia, nausea, dizziness, rhinitis, face edema, photosensitivity reaction, back pain, hypertension, abnormal liver function tests, GGT increased, increased creatine kinase, myalgia, somnolence, dyspnea, abnormal vision, watery eyes, pruritus (including pruritus of central nervous system), angina pectoris, hypotension, myocardial ischemia, postural hypotension, syncope, hypotension, epistaxis, glaucoma. Myocardial infarction (MI) has been reported post marketing in temporal association with the use of Levitra® and sexual activity, but it is not possible to determine whether this is related directly to Levitra®, or to sexual activity, or to the patient’s underlying cardiovascular diseases, or to a combination of these factors.

So next time you see a patient with erectile dysfunction, consider prescribing LEVITRA®.