SAPIENZA
UNIVERSITÀ DI ROMA

GIORNATA SCIENTIFICA DELLA FACOLTA' DI MEDICINA E PSICOLOGIA
«Sapienza» Università di Roma
Roma, 5 giugno 2019

SESSUOLOGIA

Fernando Mazzilli

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LA CAPACITA' DI MANTENERE L'EREZIONE (COME ATTO VOLUTTUARIO) E' PREROGATIVA DELL'UOMO

- **nel ratto : l'erezione e l' eiaculazione sono eventi quasi simultanei**
- **nel cane : la durata dell'accoppiamento è di 20 sec**
- **ostrica africana: la durata dell'accoppiamento è di circa 1 min**

“SEXUAL HEALTH”

*“Uno stato di **benessere fisico**, **emozionale**, **mentale** e **sociale** in relazione alla sessualità; non è semplicemente l’assenza di malattia, disfunzione o infermità”.*

WHO. Defining sexual health. 2002; 2006

DISFUNZIONI SESSUALI

DISFUNZIONE ERETTILE

DEFICIT

DESIDERIO SESSUALE

EIACULAZIONE PRECOCE

ALTRE DISFUNZIONI EIACULATORIE

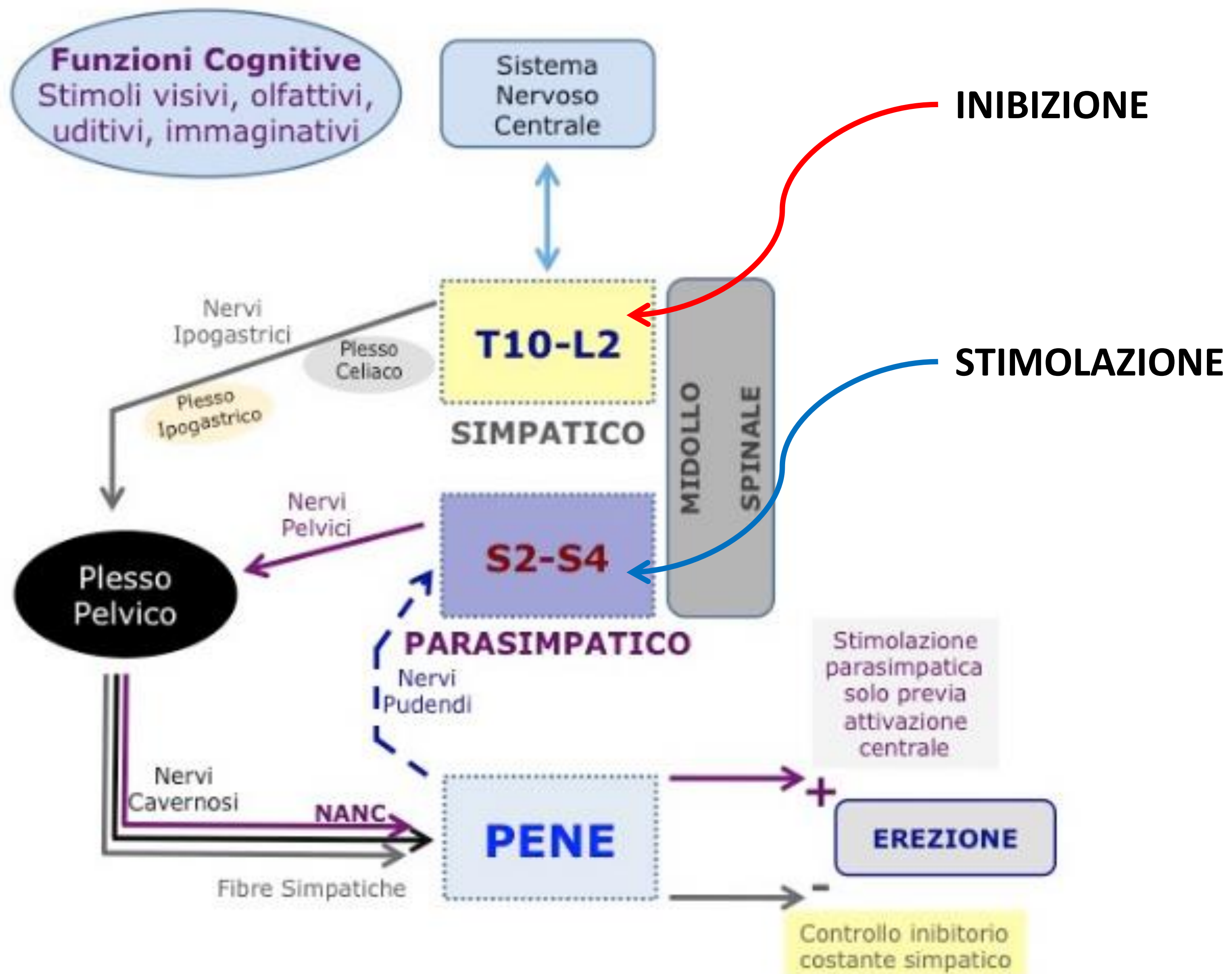
DISFUNZIONI SESSUALI

DISFUNZIONE ERETTILE

EIACULAZIONE PRECOCE

ALTRE DISFUNZIONI EIACULATORIE

EREZIONE



Meccanismi di controllo nervoso centrale e periferico dell'erezione e della risposta sessuale maschile (orgasmo ed eiaculazione).

DISFUNZIONE ERETTILE
Definizione

Ricorrente e persistente **incapacità**, *parziale o completa*, di raggiungere o mantenere l'erezione fino al completamento dell'atto sessuale

Prevalenza
1-10% (<40 aa)
2-9% (41-49 aa)
20-40% (>50-60 aa)

Shamlul, Lancet 2013

IIEF-5: International Index of Erectile Function (versione breve)

- **La Sua capacità di raggiungere e mantenere l'erezione è stata:**

● Molto bassa ● Bassa ● Moderata ● Alta ● Molto alta

- **Dopo la stimolazione sessuale ha raggiunto un'erezione sufficiente per la penetrazione:**

● Non ho avuto alcuna attività sessuale ● Quasi mai/mai ● Poche volte
● Qualche volta ● La maggioranza delle volte ● Quasi sempre/sempre

- **Durante il rapporto sessuale, è riuscito a mantenere l'erezione dopo la penetrazione:**

● Non ho tentato di avere rapporti sessuali ● Quasi mai/mai ● Poche volte
● Qualche volta ● La maggioranza delle volte ● Quasi sempre/sempre

- **Durante il rapporto sessuale, mantenere l'erezione fino alla fine del rapporto è stato:**

● Non ho tentato di avere rapporti sessuali ● Estremamente difficile
● Molto difficile ● Difficile ● Abbastanza difficile ● Facile

- **Quando ha avuto un rapporto sessuale, ha provato piacere:**

● Non ho tentato di avere rapporti sessuali ● Quasi mai/mai ● Poche volte ● Qualche volta ● La maggioranza delle volte ● Quasi sempre/sempre

Correlazione tra severità della DE e score relativo all'IIEF

Livello di gravità	Score totale relativo alla funzione erettile
Grave	1-7
Moderato	8-11
Da lieve a moderato	12-16
Leggero	17-21
Assenza di D.E.	22-25

Cappelleri JC, Siegel RL, Osterloh IH et al. Urology 2000;56:4777-81

DISFUNZIONE ERETTILE
Cause principali

- **ETA'**
- **STILE DI VITA (alcool, tabacco, stupefacenti)**
- **DISTRESS**

- **PSICOGENE, PSICO-RELAZIONALI**
- **INFIAMMATORIE**
- **MECCANICHE (IPP)**
- **VASCOLARI**
- **METABOLICHE / ENDOCRINE**
- **NEUROGENE**

(primitive o secondarie a lesioni) (Failure to initiate)

- **DA FARMACI**

(Anti-androgeni, H2-antagonisti, ACE-inibitori, Psicofarmaci)

Panel 1: Main organic causes of erectile dysfunction

Neurogenic
- Central (cerebral or spinal cord): for example, cerebral insult, multiple sclerosis, and spinal cord injury
- Peripheral: afferent (sensory neuropathy, eg, diabetes mellitus and polyneuropathy of various other causes)
- Efferent (autonomic neuropathy or after radical pelvic surgery)

Endocrinological
- Diabetes mellitus, hypogonadism, and hyperprolactinaemia

Vasculogenic
- Arterial: macro or micro angiopathy (eg, atherosclerosis and trauma)
- Venous: failure of the corporal veno-occlusive mechanism
- Sinusoidal: failure to relax (eg, fibrosis)

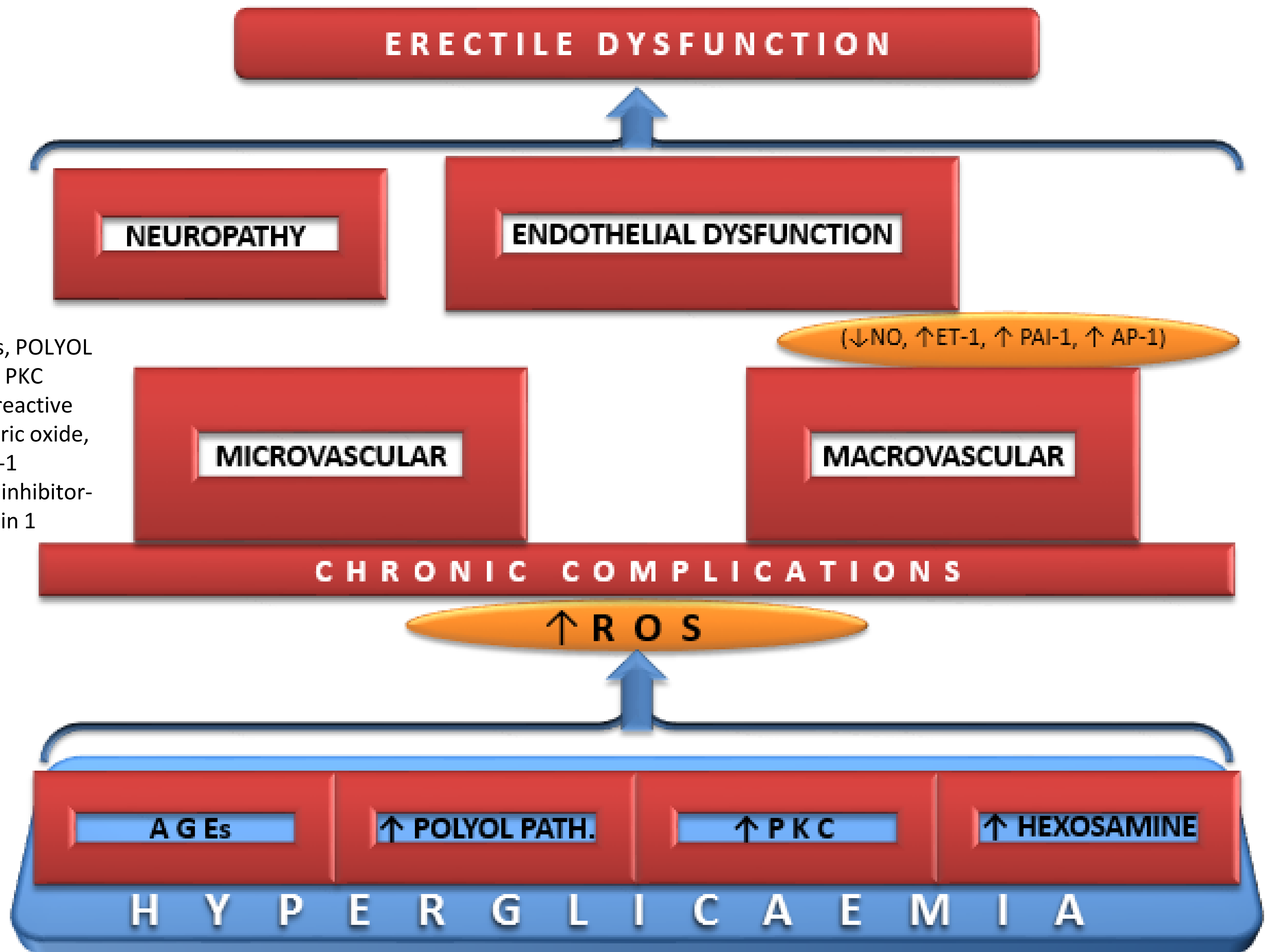
Drug-induced depression
- Drugs: for example, some antihypertensives, antidepressants, antiandrogens, and major tranquillisers
- Cigarette smoking, alcoholism, and recreational drug use (eg, marijuana and heroin)

Systemic diseases and general ill health
- For example, liver, renal, respiratory, and cardiovascular disease

Local penile(cavernous) factors
- For example, cavernous fibrosis after priapism or due to other reasons, Peyronie's disease, and penile fracture

Shamloul et al., Lancet 2013

THE DIABETIC ERECTILE DYSFUNCTION WALL



AGEs advanced glycation end-products, POLYOL PATH. polyol pathway, PKC protein kinase C, ROS reactive oxygen species, NO nitric oxide, ET-1 endothelin-1, PAI-1 Plasminogen activator inhibitor-1, AP-1 activator protein 1

Defeudis G, Gianfrilli D. et al, Rev Endocr and Metab Disord, 2015

L’altra faccia della medaglia

Clin Ter. 2015;166(5):e317-20. doi: 10.7417/T.2015.1885.

Prevalence of Diabetes Mellitus (DM) in a population of men affected by Erectile Dysfunction (ED).

Mazzilli R[1], Elia J[1], Delfino M[1], Benedetti F[1], Scordovillo G[1], Mazzilli F[1].

⊕ Author information

Abstract

AIMS: A) to evaluate the prevalence of patients affected by Diabetes Mellitus (DM) in a population of men with Erectile Dysfunction (ED); B) to define the epidemiological, biochemical and therapeutic aspects.

MATERIALS AND METHODS: N.934 subjects referred at our Andrology Unit for ED were studied. The diagnosis of ED was evaluated using the IIEF-5 questionnaire (Total score ≤21).

RESULTS: The prevalence of subjects affected by DM in a population of men with ED was 19.5% (182/934). The age ranges were: ≥55 years (108/182; 59.3%); ≥40<55 years (70/182; 38.5%); <40 years (4/182; 2.2%). HbA1c mean value was 7.9% ± 0.8%. No significant differences were found in DM onset timing or in anti-diabetic treatment. In n.125/182 cases (68.7%) the ED onset followed the diagnosis of DM; in n.34/182 cases (18.7%) it appeared at the same time; and in n.23/182 cases (12.6%) appeared before DM diagnosis.

ED TREATMENT: in n.18/182 subjects (9.9%) there was a concomitant hypotestosteronemia; these patients were treated only with testosterone replacement; this treatment was efficacious (IIEF-5 total score ≥22) in 8/18 subjects (44.4%). In n.146/182 subjects (80.2%) a treatment with PDE5-i was given. Of these 146 subjects, the therapy was given "on demand" to 108 subjects (efficacy in 50.9%; 55/108) and "once a day" to the remaining 38 subjects (efficacy 63.1%, 24/38) ($p=0.428$, n.s.). N.15/182 subjects (8.2%) were treated with intracavernous injections of Alprostadil (efficacy in 8/15, 53.3%). In n.3/182 subjects (1.6%) a penile prosthesis was implanted.

CONCLUSIONS: DM is one of the most frequent organic causes of ED; there were many strategies to treat this symptom without interfering with the antidiabetic treatment. Finally, ED can be predictive of DM.

The Aging Male, December 2008; 11(4): 193–199

informa
healthcare

Impotenza: che fortuna!

Why can patients with erectile dysfunction be considered lucky? The association with testosterone deficiency and metabolic syndrome

G. CORONA[1,2], G. FORTI[1], & M. MAGGI[1]

[1]*Department of Clinical Physiopathology, Andrology Unit, University of Florence, Florence, Italy, and* [2]*Endocrinology Unit, Maggiore-Bellaria Hospital, Bologna, Italy*

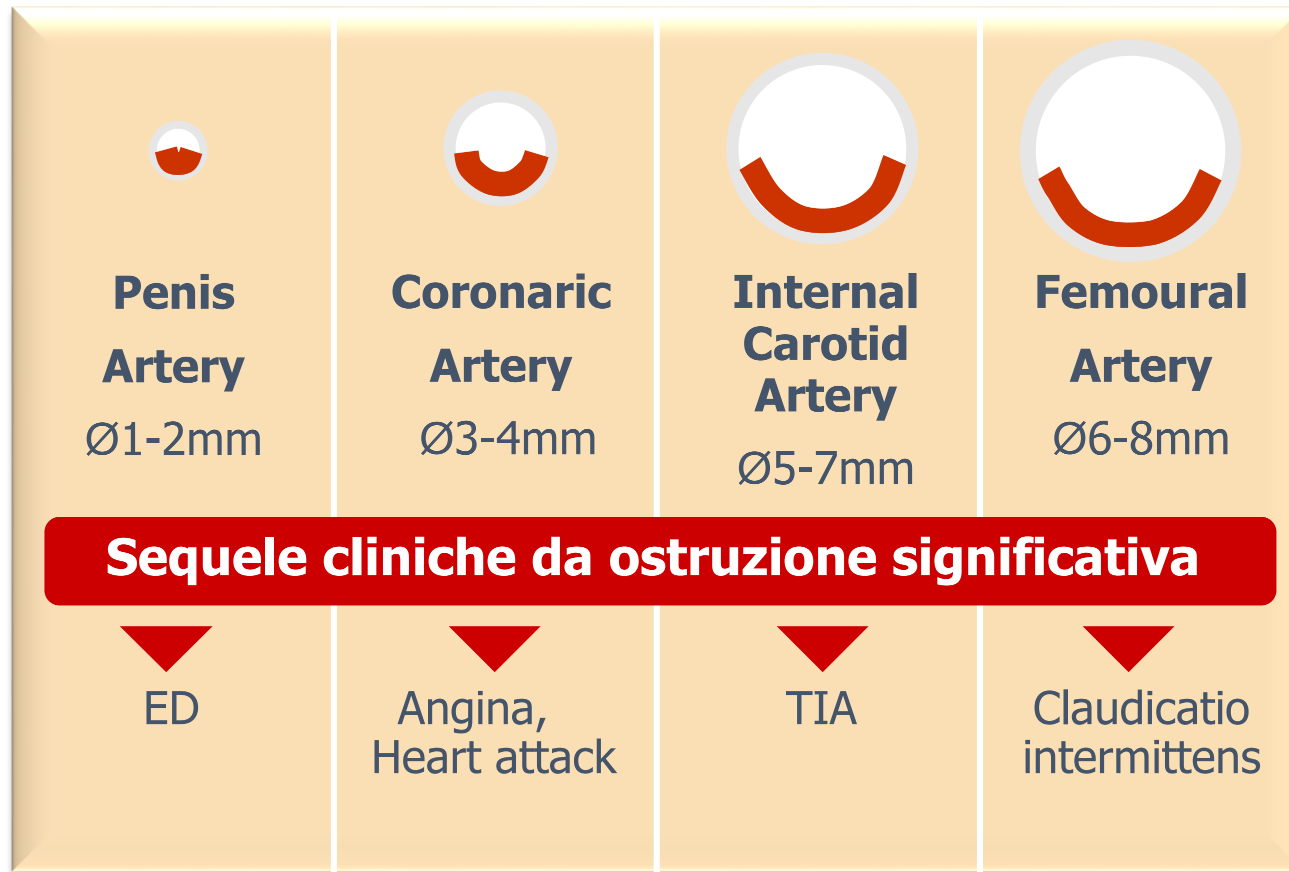
- **I pazienti con DE sono paradossalmente„fortunati“ poichè hanno la possibilità :**

  -Di essere sottoposti a visita medica

  -Di migliorare la qualità della propria sessualità

  -Soprattutto di eseguire a scopo preventivo lo screening dei fattori di rischio CV e metabolici

The artery size hypothesis: a macrovascular link between erectile dysfunction and coronary artery disease



Montorsi et al. Am J Cardiol 2005

J. Endocrinol. Invest. 33: 74-76, 2010

RAPID COMMUNICATION

The impact of a diagnosis of couple subfertility on male sexual function

J. Elia, M. Delfino, N. Imbrogno, and F. Mazzilli

Department of Medical Physiopathology, University of Rome "Sapienza", Rome, Italy

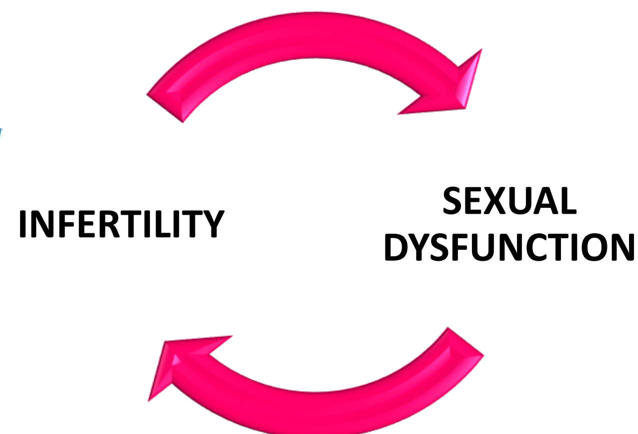


Table 1 - *Prevalence of subjects with sexual dysfunction (score <21) and International Index of Erectile Function domain scores in the 3 groups considered.*

	Control No.=8/156 subjects 5.1%	Sex for pleasure No.=14/156 subjects 8.9%	Sex for reproduction No.=37/156 subjects 23.7%[a]
Domain score ranges	Mean±SD	Mean±SD	Mean±SD
Total (1-25)	19.0±1.2	17.9±0.9[b]	13.9±2.1[c]
Erectile function (0-10)	7.1±0.3	6.1±0.7	5.9±1.1
Orgasmic function (0-5)	3.9±0.6	3.9±0.6	3.0±1.1[c]
Sexual desire (0-5)	4.2±0.7	4.2±0.7	2.6±1.0[c]
Intercourse satisfaction (1-5)	3.7±0.5	3.4±0.6	2.4±1.1[c]

[a]Chi Square, $p<0.01$ *vs* control and sex for pleasure; [b]Paired Student's t test, $p<0.05$ *vs* control; [c]Paired Student's t test, $p<0.01$ *vs* control and sex for pleasure.

ANAMNESI SESSUALE

Insorgenza della disfunzione erettile
tempo dall'esordio
periodicità
correlata con una sola partner
conflitti di coppia
erezione/rigidità
eiaculazione senza erezione
erezioni notturne spontanee

STORIA MEDICA

Lifestyle
Malattie

ESAME CLINICO

VALUTAZIONE PSICOSESSUALE E RELAZIONALE

Erection Hardness Score (EHS)

International Index of Erectile Function Questionnaire (IIEF-5) (DE≤21)

ACCERTAMENTI DIAGNOSTICI

- Glicemia a digiuno, emoglobina glicosilata
- Assetto lipidico
- VALUTAZIONE DELL'ASSE IPOTALAMO IPOFISI GONADI (FSH, LH, testosterone)

Prolattina, estradiolo, shbg, tsh, spermiocoltura, tampone uretrale

Ecografia peniena

ECOCOLORDOPPLER PENIENO, BASALE E DINAMICO (farmacoinfusione); POWER-DOPPLER

Valutazione delle erezioni notturne e della rigidita' (nocturnal penile tumescence test) (npt test)

Diagnostica della disfunzione erettile neurogena

Percezioni riferite:

- **”Non ci capiamo più!”**
- **“Dotto’ il foco s’è spento!”**
- **“A dotto’ me so’ irrigidito tutto, tranne là’”.**
- **“Il Cialis me lo fa stare solo in agitazione!!”**
- **“Diventa subito triste!!”**
- **“Turbe dell’erezione”**

Impero romano

- Olio di zenzero
- Cipolle

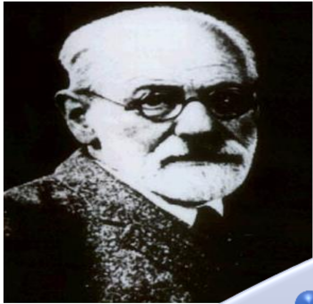
Cina

- zenzero, a scopo tonificante renale, ed inoltre:
- gingseng, zolfo, cannella……

Inoltre: …

- *Ostriche*
- *Caviale*
- *Tartufi*
- *Fichi*
- *Zuppa di nido d'uccelli*
- *Polvere di corno di rinoceronte*
- *Latte di cammello*
- *Sangue da testicoli di toro*

- **STRUMENTI DI PIACERE**
- **KAMASUTRA (Scienza dell'amore)**
- **YOGA**
- **SUONI AFRODISIACI**



1900 - 1980

- Psicoterapia
  (Ipotesi pan-psichica)
- Supplementi androgenici

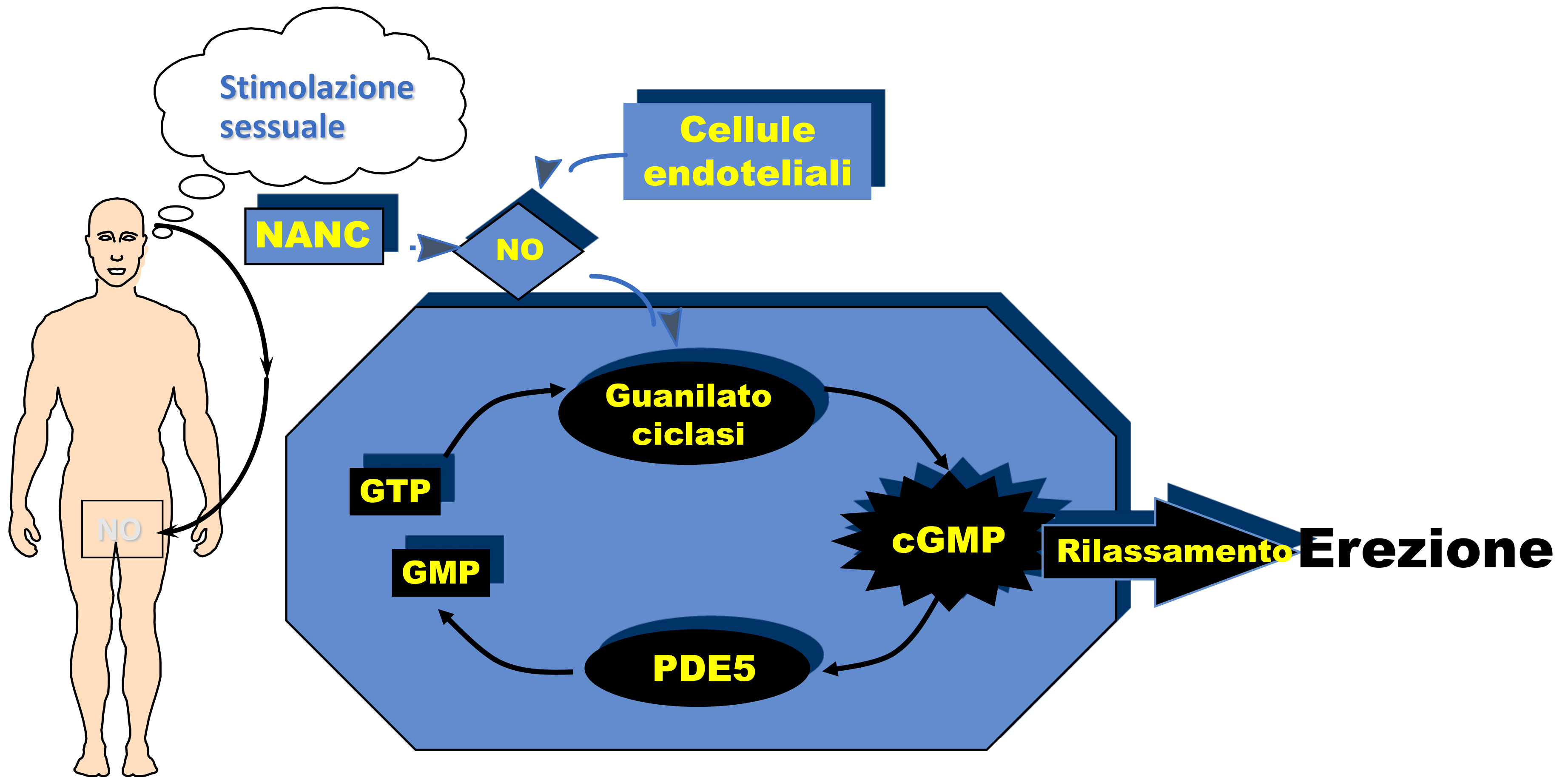
1980 - 1998

- Chirurgia protesica
- Chirurgia venosa
- Rivascolarizzazioni
- Farmacoprotesi intracavernosa

Dal 1998…
PDE5-i

l'evoluzione della terapia della DE puo' essere divisa in TRE TAPPE, tutte scandite dalla evoluzione delle conoscenze fisiopatologiche di base

Meccanismo d'azione



Ignarro LJ, et al. J Pharmacol Exp Ther. 1981; 218(3):739-749.

PDE5-i

SILDENAFIL (Viagra)

Confez da 25, 50 e 100mg
- *Efficacia: dopo 30’-60’; durata 8-10 h*

Terapia: on demand

SILDENAFIL (RABESTROM)

Confez da 25, 50 , 75 e 100mg FILM
- *Efficacia: dopo 30’-60’; durata 8-10 h*

Terapia: on demand

TADALAFIL (Cialis)

Confezioni: cp 5 mg, 10 mg, 20 mg

- *Efficacia: inizio 60’; massima tra 4-36 h*
- *Terapia :*

-on demand (10 mg e 20 mg)

-<u>long acting (5 mg)</u>

VARDENAFIL (Levitra)

Confez da 5, 10 e 20 mg

Efficacia: dopo 30’-60’ durata 4-5 h

Terapia: on demand

AVANAFIL (Spedra)

Confez da 100, 150 e 200 mg

Efficacia: dopo 20-30’ durata 4-5 h

Terapia: on demand

Farmacocinetica

Table 1 Summary of pharmacokinetics of avanafil, sildenafil, vardenafil, and tadalafil

Parameter	Avanafil	Sildenafil	Vardenafil	Tadalafil
T_{max} (min)	30–45	60	60	120
Onset of action	15	30–60	15–30	15–45
Delay with high-fat meal (min)	67–75	60	60	0
$T_{1/2}$ (hr)	3–5	4	4–5	17.5
Duration of action (hr)	6	12	12	36
Metabolism	Hepatic (CYP3A4)	Hepatic (CYP3A4)	Hepatic (CYP3A4)	Hepatic (CYP3A4)
Mode of excretion	Feces (62%), urine (21%)	Feces (80%), urine (13%)	Feces (91%–95%), urine (2%–6%)	Feces (61%), urine (36%)

Abbreviations: min, minutes; hr, hours; $T_{1/2}$, plasma half-life; T_{max}, time to maximum concentration; CYP, cytochrome P.

DISFUNZIONI SESSUALI

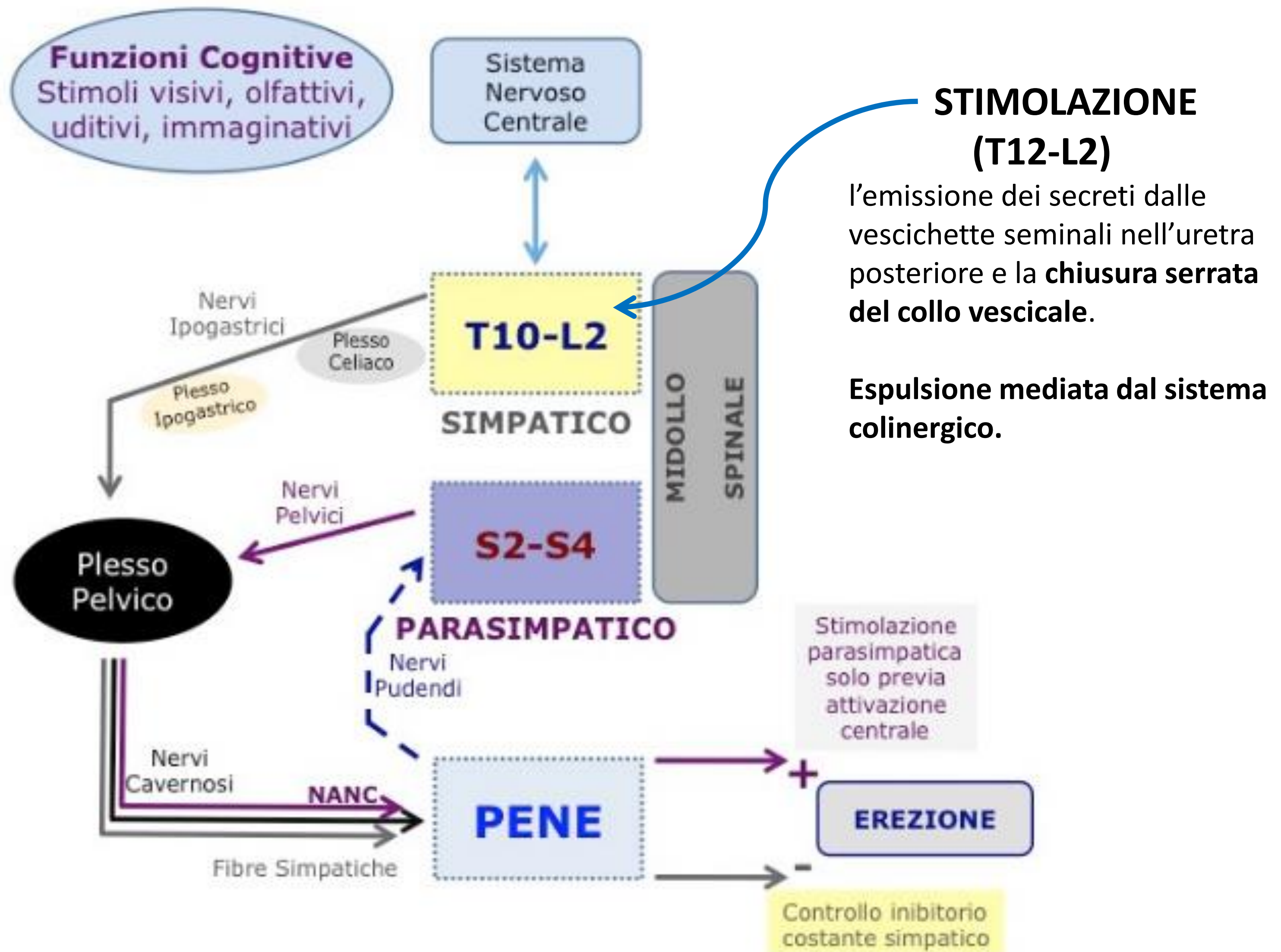
DISFUNZIONE ERETTILE

EIACULAZIONE PRECOCE

ALTRE DISFUNZIONI EIACULATORIE

ORGASMO e EIACULAZIONE: EMISSIONE e ESPULSIONE

Organi coinvolti: collo vescicale, prostata, vescichette seminali e vie seminali.



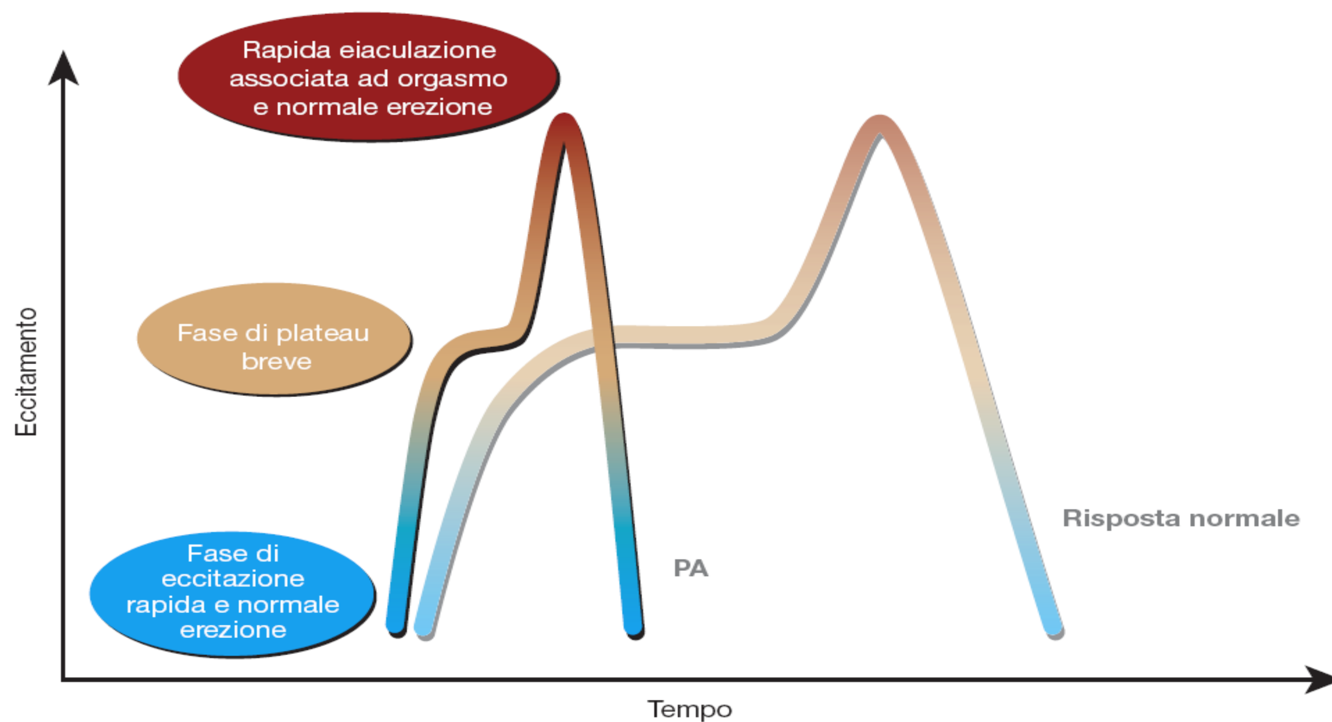
Meccanismi di controllo nervoso centrale e periferico dell'erezione e della risposta sessuale maschile (orgasmo ed eiaculazione).

STIMOLAZIONE (T12-L2)

l'emissione dei secreti dalle vescichette seminali nell'uretra posteriore e la **chiusura serrata del collo vescicale**.

Espulsione mediata dal sistema colinergico.

DEFINIZIONI



EUROPEAN UROLOGY 51 (2007) 816–824

available at www.sciencedirect.com
journal homepage: www.europeanurology.com

European Association of Urology

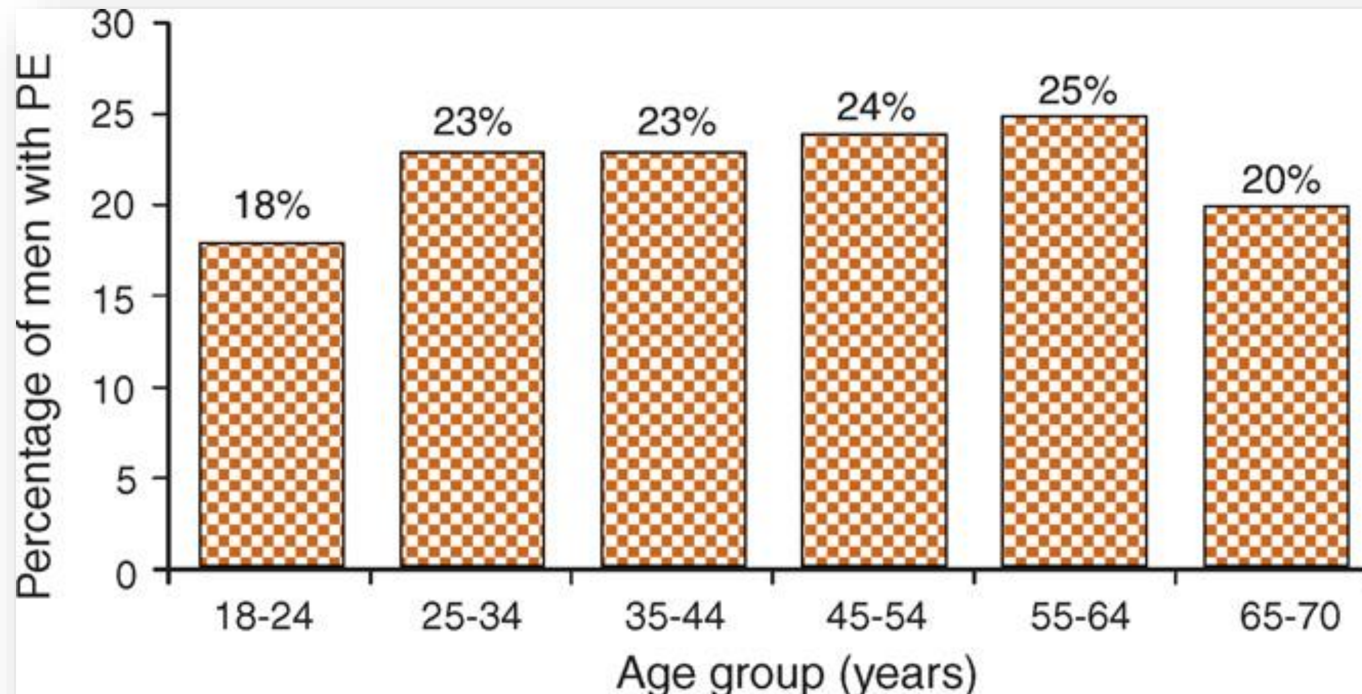
EPIDEMIOLOGY

The prevalence of PE among men in Italy was 20%

Sexual Medicine

The Premature Ejaculation Prevalence and Attitudes (PEPA) Survey: Prevalence, Comorbidities, and Professional Help-Seeking

Hartmut Porst[a,*], *Francesco Montorsi*[b], *Raymond C. Rosen*[c], *Lisa Gaynor*[d], *Stephanie Grupe*[d], *Joseph Alexander*[d]



The prevalence of premature ejaculation (PE) by age group.

IELT

INTRAVAGINAL EJACULATORY LATENCY TIME

- Stopwatch-measured IELT was defined as the duration of time when ejaculation occurred ‘‘intravaginally’’ or as 0 min when ejaculation occurred ‘‘prior to penetration.’’

EUROPEAN UROLOGY 53 (2008) 1048–1057

available at www.sciencedirect.com
journal homepage: www.europeanurology.com

Sexual Medicine

Premature Ejaculation: Results from a Five-Country European Observational Study

François Giuliano [a,], Donald L. Patrick [b], Hartmut Porst [c], Giuseppe La Pera [d], Andrzej Kokoszka [e], Sanjay Merchant [f], Margaret Rothman [f], Dennis D. Gagnon [f], Elena Polverejan [g]*

for the 3004 Study Group

Female Partner's Perception of Premature Ejaculation and Its Impact on Relationship Breakups, Relationship Quality, and Sexual Satisfaction

J Sex Med 2014;11:2243–2255

Andrea Burri, PhD,* François Giuliano, MD,† Chris McMahon, MD,‡ and Hartmut Porst, MD§

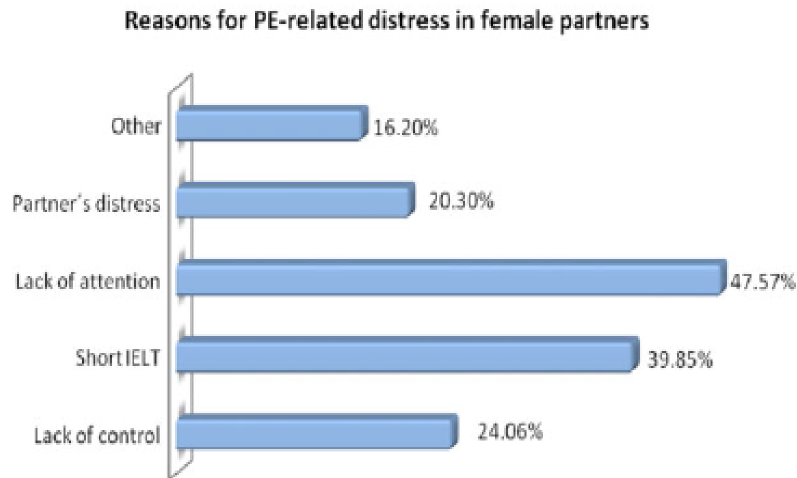


Figure 1 Specific reasons for PE-related distress in female partners

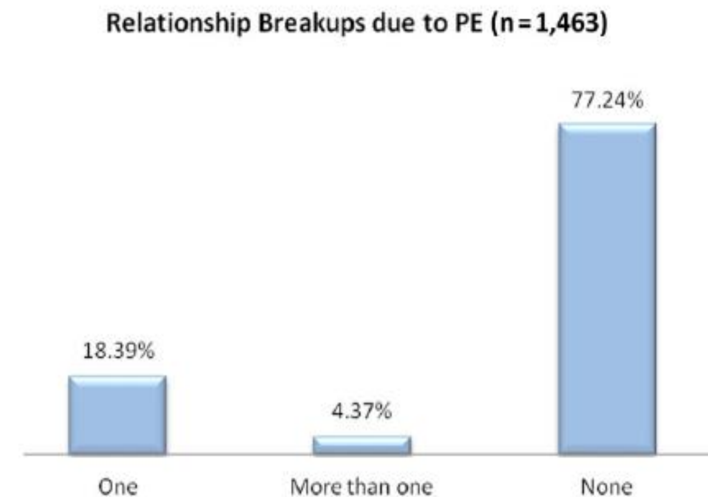


Figure 2 Percentage of women reporting that the partner's PE condition has previously led to relationship breakups.

The study highlights the detrimental effects of PE on relationship and sexual satisfaction in the female partner and how it can lead to the termination of the relationship.

✓ "Lifelong" PE

Lifelong PE is a syndrome characterized by a cluster of core symptoms including early ejaculation at nearly every intercourse — within 30–60 seconds in the majority of cases (80%) or in between 1 and 2 minutes (20%)—

with **every or nearly every sexual partner**

and **from the first sexual encounter onwards.**

Serefoglu EC *at al*. J Sex Med 2014.

REVIEWS

An Evidence-Based Unified Definition of Lifelong and Acquired Premature Ejaculation: Report of the Second International Society for Sexual Medicine Ad Hoc Committee for the Definition of Premature Ejaculation

Ege Can Serefoglu, MD,[*] Chris G. McMahon, MD,[†] Marcel D. Waldinger, MD, PhD,[‡] Stanley E. Althof, PhD,[§] Alan Shindel, MD,[¶] Ganesh Adaikan, PhD,[**] Edgardo F. Becher, MD,[††] John Dean, MD,[‡‡] Francois Giuliano, MD, PhD,[§§] Wayne J.G. Hellstrom, MD,[¶¶] Annamaria Giraldi, MD, PhD,[***] Sidney Glina, MD, PhD,[†††] Luca Incrocci, MD, PhD,[‡‡‡] Emmanuele Jannini, MD,[§§§] Marita McCabe, PhD,[¶¶¶] Sharon Parish, MD,[****] David Rowland, PhD,[††††] R. Taylor Segraves, MD, PhD,[‡‡‡‡] Ira Sharlip, MD,[§§§§] and Luiz Otavio Torres, MD[¶¶¶¶]

✓ "Aquired" PE

Acquired PE is often situational, after having previously had normal ejaculation experiences.

- ✓ **Psychological and Relationship Problems**
- ✓ **Comorbid Erectile Dysfunction**
- ✓ **Prostate Disease, Acute and chronic lower urogenital infection and chronic pelvic pain syndrome**
- ✓ **Hormonal disorders → Hyperthyroidism**

REVIEWS

An Evidence-Based Unified Definition of Lifelong and Acquired Premature Ejaculation: Report of the Second International Society for Sexual Medicine Ad Hoc Committee for the Definition of Premature Ejaculation

Ege Can Serefoglu, MD,[*] Chris G. McMahon, MD,[†] Marcel D. Waldinger, MD, PhD,[‡] Stanley E. Althof, PhD,[§] Alan Shindel, MD,[¶] Ganesh Adaikan, PhD,[**] Edgardo F. Becher, MD,[††] John Dean, MD,[‡‡] Francois Giuliano, MD, PhD,[§§] Wayne J.G. Hellstrom, MD,[¶¶] Annamaria Giraldi, MD, PhD,[***] Sidney Glina, MD, PhD,[†††] Luca Incrocci, MD, PhD,[‡‡‡] Emmanuele Jannini, MD,[§§§] Marita McCabe, PhD,[¶¶¶] Sharon Parish, MD,[****] David Rowland, PhD,[††††] R. Taylor Segraves, MD, PhD,[‡‡‡‡] Ira Sharlip, MD,[§§§§] and Luiz Otavio Torres, MD[¶¶¶¶]

Serefoglu EC *at al*. J Sex Med 2014.

Premature Ejaculation Diagnostic Tool (PEDT) = 15

Domanda	Risposte
Quanto è difficile per lei controllare l'eiaculazione?	0 = non è per niente difficile 1 = lievemente difficile 2= moderatamente difficile 3= molto difficile 4= estremamente difficile
Le capita di eiaculare prima di quando vuole?	0 = mai o quasi mai (0%) 1 =meno della metà delle volte (25%) 2 = circa la metà delle volte (50%) 3 = più della metà delle volte (75%) 4 = quasi sempre o sempre (100%)
Le capita di eiaculare anche dopo una minima stimolazione sessuale?	0 = mai o quasi mai (0%) 1 =meno della metà delle volte (25%) 2 = circa la metà delle volte (50%) 3 = più della metà delle volte (75%) 4 = quasi sempre o sempre (100%)
Si sente dispiaciuto per il fatto di eiaculare prima di quando lei voglia?	0 = no, per niente 1 = lievemente 2 = moderatamente 3 = molto 4 = estremamente
E' preoccupato che il tempo tipicamente necessario a raggiungere l'eiaculazione lasci la sua partner sessualmente insoddisfatta?	0 = no, per niente 1 = lievemente 2 = moderatamente 3 = molto 4 = estremamente

<=8 assenza di EP
9-10 probabile EP
>=11 EP

Althof SE *et al.* J Sex Med 2014
UPDATE ISSM PE Guidelines

CAUSE DI EP

Cause organiche e iatrogene	Cause non organiche o psicogene
• Genetiche	• Funzionale (educazione, esperienze)
• Neurobiologiche	• Costituzionale (costituzione psicologica)
• Neurologiche (sclerosi multipla, spina bifida, neuropatia periferica, processi espansivi midollari, tumori della corda spinale)	• Indotta dallo stress (acuto o cronico)
• Urologiche (fimosi, frenulo corto, infezioni urogenitali)	• Deficit delle capacità psicosessuali
• Endocrine (ipertiroidismo, ipogonadismo)	
• Iatrogene (anfetamine, agonisti dopaminergici)	
• Assunzione di droghe	

Ministero della Salute

Quaderni del Ministero della Salute

BEHAVIORAL TREATMENTS

"Stop-Start" techniques

"Squeeze" techniques

Sharlip *et al.* J Sex Med 2005
Jannini *et al*. Elsevier Masson 2007
Porst H *et al.* J Sex Med 2011.
Sotomayor M *J Sex Med* 2005, Suppl 2:110-114

✓ Psychologica Intervention

- To help men develop sexual skills that enable them to delay ejaculation while broadening their sexual scripts, **increasing sexual selfconfidence**, and **diminishing performance anxiety.**

- To resolve psychological and interpersonal issues that may have precipitated, maintained, or be the consequence of the PE symptom for the man, partner, or couple.

Miner M. et al. Postgrad Med 2008
Althof SE *et al.* J Sex Med 2014
UPDATE ISSM PE Guidelines

PHARMACOLOGICAL TREATMENT

Topical Local Anesthetics

(lidocaine and/or prilocaine as a cream, gel, or spray)

- The use of topical LA to diminish the sensitivity of the glans penis is the oldest known pharmacological treatment for PE
- Is moderately effective in delaying ejaculation

Porst H et al. An overview of pharmacotherapy in premature ejaculation. J Sex Med 2011.
Althof SE *et al.* J Sex Med 2014
UPDATE ISSM PE Guidelines

PHARMACOLOGICAL TREATMENT

- PDE5-i

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Controversies in Sexual Medicine

The Controversial Role of Phosphodiesterase Type 5 Inhibitors in the Treatment of Premature Ejaculation

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Antonio Aversa, MD, PhD,§ and Michael Perelman, PhD¶

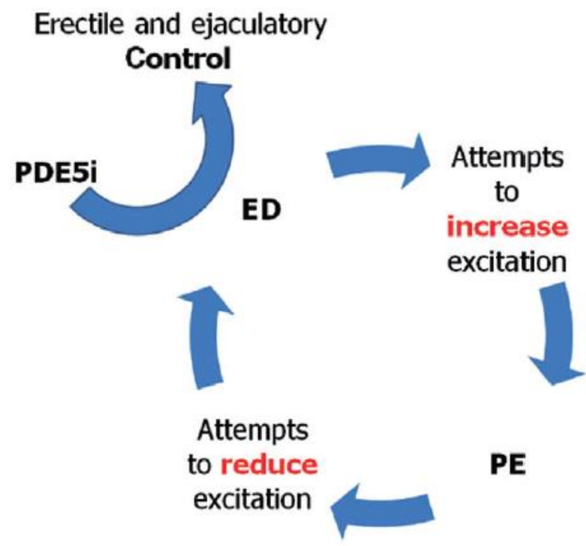


Figure 1 The vicious circle in which premature ejaculation (PE) may generate erectile dysfunction (ED) and vice versa can be destroyed by the use of a phosphodiesterase type 5 inhibitor (PDE5i) (from [2], mod.).

Table 1 Rationale for the use of PDE5i in PE

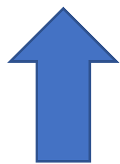
PDE5 plays a role in the physiology of ejaculation.
Men with PE complicated by erectile dysfunction are more than previously suspected.
Control of erection duration implies a better control of ejaculation.
PDE5i may reduce performance anxiety, a major contributor to PE.
PDE5i shorten the refractory time, allowing a faster second intercourse.

PDE5i = phosphodiesterase type 5 inhibitor; PE = premature ejaculation.

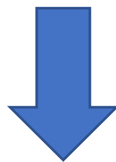
Selective Serotonin Reuptake Inhibitors (SSRI)

DAPOXETINE 30 - 60 mg (1–2 hours before intercourse)

•It is a **rapidacting** and **short half-life** SSRI with a pharmacokinetic profile supporting a role **as an on-demand treatment for PE**



IELT
ejaculatory control
satisfaction



distress

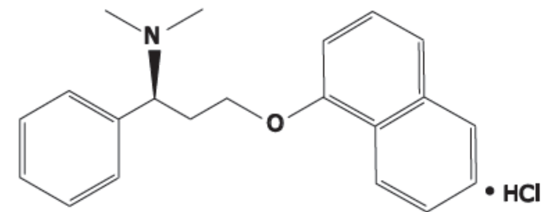


Figure 1. Molecular structure of dapoxetine: (+)-(S)-N,N-dimethyl-(α)-[2(1naphthalenyloxy)ethyl]-benzenemethanamine hydrochloride.

Dapoxetine was comparably effective both in men wit**h LPE** and **APE**
Treatment-related **side effects** were uncommon, dose dependent, and included:

- Nausea
- diarrhea
- Headache
- Dizziness

There is Level 1a evidence to support the efficacy and safety of on-demand dosing of dapoxetine for the treatment of lifelong and APE. (LOE 1a)

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Giuliano F et al.. BJU International 2008.
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Porst H et al. J Sex Med 2011.
Wespes E et al. Guidelines on male sexual dysfunction 2012
Althof SE *et al.* J Sex Med 2014
UPDATE ISSM PE Guidelines

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ORIGINAL ARTICLE

Effects of circumcision on male sexual functions: a systematic review and meta-analysis

Ye Tian[1,*], Wei Liu[2,*], Jian-Zhong Wang[1], Romel Wazir[1], Xuan Yue[1] and Kun-Jie Wang[1]

This meta-analysis was performed to assess sexual functions following adult male circumcision. We searched the Cochrane Central Register of Controlled Trials, PUBMED, EMBASE, the Cochrane Database of Systematic Review and Web of Science from their inception until January 2013 to identify all eligible studies that reported on men's sexual function after circumcision. The Cochrane Collaboration's RevMan 5.2 software was employed for data analysis, and the fixed or the random effect model was selected depending on the proportion of heterogeneity. We identified 10 studies, which described a total of 9317 circumcised and 9423 uncircumcised men who were evaluated for the association of circumcision with male sexual function. There were no significant differences in sexual desire (odds ratio (OR): 0.99; 95% confidence interval (CI): 0.92–1.06), dyspareunia (OR: 1.12; 95% CI: 0.52–2.44), premature ejaculation (OR: 1.13; 95% CI: 0.83–1.54), ejaculation latency time (OR: 1.33; 95% CI: 0.69–1.97), erectile dysfunctions (OR: 0.90; 95% CI: 0.65–1.25) and orgasm difficulties (OR: 0.97; 95% CI: 0.83–1.13). These findings suggest that circumcision is unlikely to adversely affect male sexual functions. However, these results should be evaluated in light of the low quality of the existing evidence and the significant heterogeneity across the various studies. Well-designed and prospective studies are required for a further understanding of this topic.
Asian Journal of Andrology (2013) **15**, 662–666; doi:10.1038/aja.2013.47; published online 10 June 2013

Keywords: complications; male circumcision; review; sexual function

Ulteriori considerazioni

PRESENZA DI DESIDERIO SESSUALE

ATTRAZIONE RECIPROCA TRA I *PARTNER*

MENS SANA* (*LIBERA DA "PENSIERI"*) *IN CORPORE SANO

F. Mazzilli

DISFUNZIONI SESSUALI

DISFUNZIONE ERETTILE

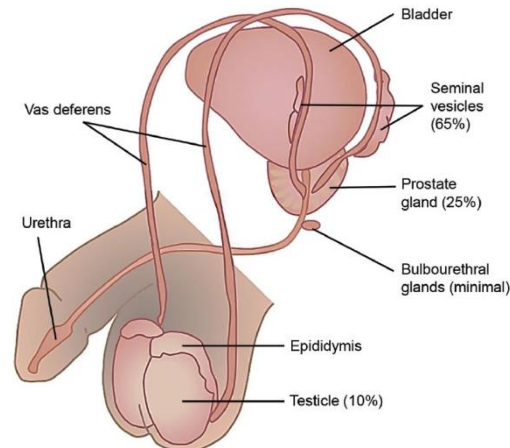
EIACULAZIONE PRECOCE

ALTRE DISFUNZIONI EIACULATORIE

EIACULAZIONE RETROGRADA (ER)

Disfunzione eiaculatoria causata da una incontinenza del collo vescicale e conseguente reflusso del liquido seminale in vescica durante la fase di espulsione.

Rappresenta circa lo 0.3-2% delle cause di infertilità maschile



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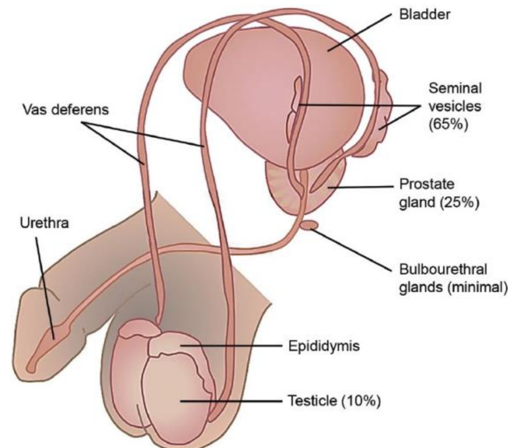
- Vernon M, et al. Fertil Steril 1988;50: 822–4.
- Barazani Y, et al. Asian Journal of Andrology 2012
- Metha A, et al. Fertil Steril. 2015

ANEIACULAZIONE (AE)

Disfunzione eiaculatoria caratterizzata dall'assenza della fase di emissione



Barazan Y et al. AJA 2012

CAUSE AE

Neurologiche: lesioni midollari, della cauda equina.

Chirurgia colon-rettale, lingoadenectomia retroperitoneale

Sclerosi multipla, neuropatia autonomica.

Farmacologiche: antidepressivi, antipsicotici, antipertensivi (alfabloccanti, raro).

PSICOGENA - IDIOPATICA

Parnham and Serefoglu. *Transl Androl Urol* 2016;5(4):592-601

VIBROSTIMOLAZIONE

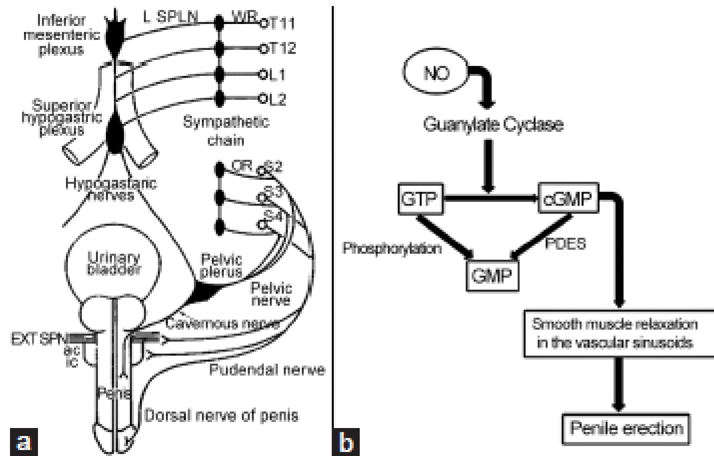


Figure 1: Innervation of the penis and mechanism for erection. (**a**) Sympathetic penile innervation from segments T10-L2 pass via the sympathetic chain, inferior mesenteric and superior hypogastric plexuses to the pelvic plexus via the hypogastric nerve. Parasympathetic penile innervation arises from segments S2-S4 to the pelvic plexus via the pelvic nerve. The pudendal nerve innervates the external sphincter, bulbospongiosus and ischiocavernosus muscles and also provides sensory fibers to the dorsal nerve of the penis. (**b**) Cyclic GMP (cGMP) is responsible for the vascular changes which occur in the corpora cavernosa that result in erection. Cyclic GMP is hydrolyzed by PDE-5 to GMP resulting in loss of penile tumescence. The process is initiated by endogenous nitric oxide (NO) activation of guanylate cyclase which results in increased conversion of GTP to cGMP. The inhibition of PDE-5 results in the maintenance of high levels of cGMP.

Lesioni midollari alte (sopra T10)

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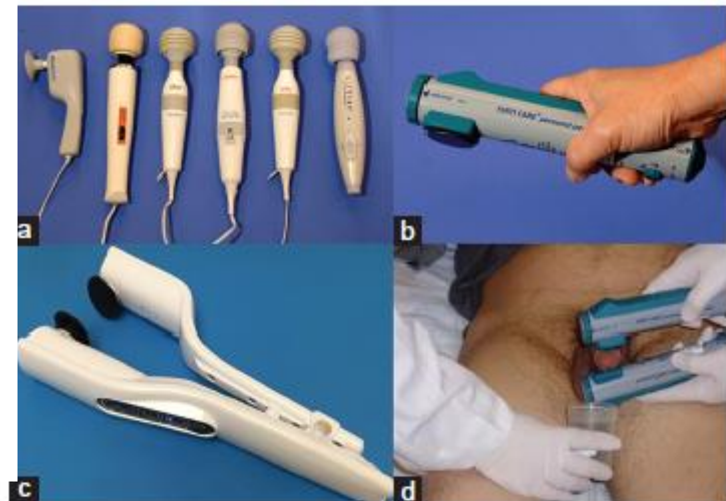
INVITED REVIEW

Male Fertility

Advances in the management of infertility in men with spinal cord injury

Emad Ibrahim[1], Nancy L Brackett[1,2], Charles M Lynne[1,2]



igure 2: Penile vibratory stimulation (PVS) (**a**) various over-the-counter evices, often called wand massagers, have been used for PVS in men with CI. The Personal FertiCare® (**b**) and the Viberect X3® (**c**), are devices that ave been specifically engineered for the purpose of PVS in men with SCI. **l**) The correct placement of two FertiCare devices, which is a recommended ıethod when one device fails to induce ejaculation.

ELETTROEIACULAZIONE

Ejaculatory physiology and pathophysiology: assessment and treatment in male infertility Transl Androl Urol 2014;3(1):41-49

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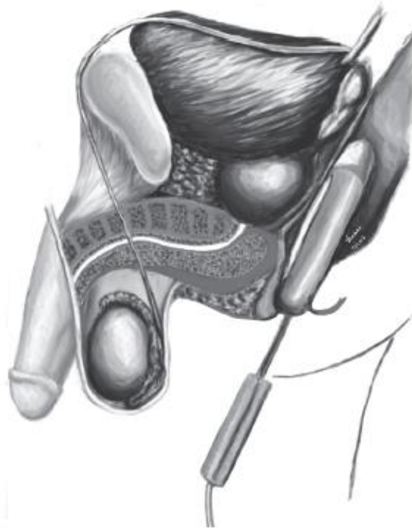

Figure 1 Schematic showing insertion of transrectal probe for electroejaculation (EEJ). The electrodes are oriented towards the prostate and seminal vesicles.

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Figure 3: Electroejaculation machine with an attached rectal probe.