CORRESPONDENCE

Male Sexual Dysfunction: Diagnosis and Treatment From a Sexological and Interdisciplinary Perspective

by Dr. med. Dirk Rösing, Prof. Dr. med. Klaus-Jürgen Klebingat, Dr. med. Hermann J. Berberich, Prof. Dr. med. Hartmut A. G. Bosinski, em. Prof. Dr. med. Kurt Loewit, Prof. Dr. med. Dr. phil. Klaus M. Beier in volume 50/2009

Association With Sleep Apnea

Obstructive sleep apnea in adults is an additional factor for erectile dysfunction that the authors did not include in their review article. An association between the two conditions was suspected (1) as early as in 1981.

If breathing problems arise during the night, erectile dysfunction affects 44% with an apnea index of 5/hour (the apnea index measures the number of episodes without breathing per hour's sleep), 27.9% if the index is 5–10/hour, and 19.6% if the index is more than 15/hour—as shown by a study including 1025 persons. Hypoxia, which occurs often intermittently with sleep apnea, and the ensuing reduction in NO synthase are likely to be important causes of erectile dysfunction (3). In a proportion of patients who receive the usual treatment for sleep apnea—continuous positive airway pressure at night—their erectile dysfunction improves too.

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Dr. med. Holger Hein

Arzt für Innere Medizin, Pneumologie, Allergologie und Schlafmedizin
Bahnhofstr. 9, 21465 Reinbek, Germany
dr.holger.hein@web.de

Absence of Desire

The authors deserve thanks for emphasizing a biopsychosocial approach, which clarifies that erectile dysfunction (ED)—in contrast to what is widely assumed—is not restricted to functional aspects but is a complex problem that requires interdisciplinary treatment. With regard to the impaired appetite (which merited but a brief mention in the article), it should usefully be added that this is an independent pathology, described in the DSM-IV-TR as “hypo-

active sexual desire disorder” (HSDD), which unfortunately thus far has received far too little attention compared with ED. The clinical symptoms of HSDD are characterized by an absence of sexual fantasies and desire, which puts individuals thus affected under great psychological strain. The prevalence of up to 15% comes close to that of ED itself and directly contradicts the myth that men's sexual desire is constant (1, 2). To explore sexual desire diagnostically, the questionnaire of the Sexual Desire Inventory (3) is a useful tool, in order to distinguish HSDD from ED. Since the possible causes that are currently under discussion include factors such as depression, hypogonadism, age, fears and anxieties, and conflicts within the affected man's relationship, it would be highly desirable if in future the existence of HSDD in men were to meet with greater attention in clinical practice as well as the research arena.

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Prof. Dr. med. Markus A. Kuczyk

Dipl.-Psych. Annika Simon

PD Dr. med. Axel Stuart Merseburger

Klinik für Urologie und Urologische Onkologie
Medizinische Hochschule Hannover (MHH)
Carl-Neuberg-Str. 1, 30625 Hannover, Germany
merseburger.axel@mh-hannover.de

Sexual Culture

The authors' interdisciplinary approach and their challenge to consider the different types of sexual disturbances from a biopsychosocial perspective are very welcome. Unfortunately, the importance of the physical examination is neglected; Peyronie's disease is not even mentioned as a pathology (1). Other examples of pathologies that may affect a man's sex life (2) include algopareunia subsequent to scarring, adhesions, inflammations/infections, or trophic disorders in the genital area, or the effects of circumcisions performed for different (e.g. medical, cultural oder religious) reasons.

The authors have missed an opportunity to mention the cultural influences of migrants. Currently, some 7 million foreigners permanently reside in Ger-

many—approx. 10% of the total population. A majority of these maintain their religious beliefs, traditions, and cultures, and many are Muslims. Islam is not a religion that is based on abstinence or asceticism; temporary marriages, some forms of polygamy, and rapid divorces are all permitted. In spite of this, due to historical and cultural traditions, unfaithfulness or sex before marriage among Muslim women are often severely penalized and affect couples' sexual lives (3). Specialists in sexual medicine should therefore possess a certain amount of knowledge about their patients' "sexual culture".

Unfortunately, the authors failed to mention the increasing use of condoms—important in the era of AIDS—and their importance for people's sexual lives and sexuality.

The authors rightly emphasize the importance of taking a sexual history and including both partners; they at least partly try to explain the theory underlying these statements. However, the article barely offers any practical pointers to help doctors with their medical practice. It is thus not surprising—although the authors found this unsatisfactory—that everyday practice focuses on the functional aspects of erectile dysfunction since this approach yields improvements in more than 60% of patients. It remains to be seen whether a therapeutic approach that focuses primarily on the couple and the sexual history can compete in terms of effectiveness.

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PD Dr. med. M.J. Mathers, FEBU

Urologische Gemeinschaftspraxis Remscheid
Kooperationspraxis der Klinik für Urologie und Kinderurologie
Helios-Klinikum
Wuppertal, Universität Witten/Herdecke
Fastenrathstr. 1
42853 Remscheid, Germany
irtima@t-online.de

Prof. Dr. med. T. Klotz, MPH

Klinik für Urologie, Andrologie und Kinderurologie
Am Klinikum Weiden
Söllnerstr. 16
92637 Weiden, Germany
theodor.klotz@kliniken-nordoberpfalz.ag

Sexuality Undergoing Changes

The review article leaves many questions unanswered. Impaired fertility in men is not mentioned at all—sex is not only for recreation but also for procreation. How does the option of having several wives affect sexual

function in men in Islamic countries? An interesting question to consider would be whether polygamy may result in better sexual functioning in men (1)—not least because this would offer advantages in terms of evolutionary genetics.

The authors focus on the Western model of monogamous, heterosexual relationships. It remains unclear what "love" has to do with male—perhaps as opposed to female—sexual function. What about men who are not in a stable relationship? If we assume that virility as a cultural attribute of the male sex is a social construct that is subject to processes of social change (2) then it would perhaps seem logical to also assume that male sexuality does not correspond to postmodern ideas of virility. This may be a possible cause of sexual dysfunction in men that requires not so much couples therapy but rather a firm distancing from clichéd gender typologies. No mention was made of attempting sex with a different partner—perhaps even as an "ex juvantibus" therapeutic approach to certain types of sexual dysfunction. The authors paid only marginal attention to new alternatives that may provide a different experience of sexuality—or, in some men, exclusively enable them to experience sex—such as cybersex. Eroticism and its importance for healthy sexual functioning was another topic that was barely discussed. The secret of couples who have enjoyed exciting sexual lives for many years—which is unlikely without healthy sexual functioning in the male partner—seems to be that they are focused on each other and bound to each other via what might be called mildly perverse consensual staged event (3).

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Dr. med. Dr. rer. nat. Michael G. Haufs

Hoher Heckenweg 147, 48147 Münster, Germany

Christian Gruhn

Königstr. 12, 48143 Münster, Germany

Dr. rer. soc. Pamela Wehling

Stühmerweg 4, 48147 Münster, Germany

In Reply:

We thank your correspondents for their constructive feedback, which shows the importance, as well as the multiple aspects, of the topic of male sexual dysfunction. It was important to us to explain this complexity and to show the associations between biology, psychology, and sociocultural situations. However, it was clear

from the outset that it was not possible to explain every point of interest in great detail; for this reason, some disorders are mentioned only in the form of graphically presented overviews (for example, the induration penis plastica or sexually transmitted infections). We did not mention a possible association between erectile dysfunction and obstructive sleep apnea, but we thank our correspondents for doing so. In the context of this article we did not intend to provide a comprehensive overview of how cultural differences affect sexual experiences and behaviors. We apologize for having created the impression that this is not an important topic in our view and assure our readers that the opposite is the case.

Our article focused in particular on the investigation of possible physical causes for sexual dysfunction; we laid out the multiple therapeutic options in tables and in a figure. We did not intend to provide a new comparison and evaluation of individual therapeutic approaches, because our objective was to make a contribution to improving sexual satisfaction for couples and not the isolated treatment of an individual function. Even though statistics aim to make us believe that this is not so, our case study shows that the reality for many patients is different. Research studies that focus on satisfying basic needs contribute to a complex perspective on the subject and are of use in sexual therapeutic encounters—where the use of medications or aids also has its place. It is by no means a given in clinical medical practice that a sexual history (box) precedes the treatment, but much is attempted “*ex juvantibus*.” We remain critical of the suggestion of one of our correspondents, that changing partners may be the way forward—this cannot really be a medical recommendation in order to find out how sexual functioning is affected. The authors understand sexuality as component of a relationship between two partners; in no culture does sexuality focus merely on functioning because basic needs apply across cultures, and sexuality as body lan-

guage, in addition to the fulfillment of sexual needs, has an important contribution to make in terms of how the other person feels accepted and valued. Unilateral sexual satisfaction at the expense of the other person will always be associated with a change in the couple relationship and thus confront couples with the need to make a pertinent decision. The authors do not see “new alternatives” such as cybersex, as an equivalent for experiencing feelings in a real relationship through a physical connection with a partner and as a substitute for gathering live insights that cannot be replicated in cyberspace. In sexual medical practice, persons present who suffer from their sexual disorder—whatever origin it may have—because they do not feel right, valued, accepted, or approved of, because they do not want to or cannot trust others. It is our responsibility as doctors to be open to these patients—as in all other medical specialties—to help them understand the causes, to raise their awareness of the multifunctionality and multidimensionality of sexuality, in order to improve their satisfaction with their lives in spite of changed or impaired sexual functioning.

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Dr. med. Dirk Rösing

Universitätsklinikum Greifswald
Anstalt öffentlichen Rechts
Klinik und Poliklinik für Urologie
Fleischmannstr. 42–44
17475 Greifswald, Germany
roesing@uni-greifswald.de

Conflict of interest statement

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