Information Snapshot – **Man up** – Managing benign prostatic hyperplasia, erectile dysfunction in general practice

Learning outcomes

- Describe the treatment options for men with ED
- Outline the investigation and medical management of BPH
- Identify a care path for men who present with either ED or BPH

Sexual dysfunction

Healthy sexual function within one's expected norm and desire for sexual activity is an important aspect of sexual health.[1] According to the American Sexual Health Association, sexual function is the ability to experience sexual pleasure and satisfaction when desired. It is an important component of quality of life (QoL) as it is associated with physical and mental wellbeing and relationship satisfaction (if applicable).[2] Sexual function is influenced by a person's biology (physical and physiological), psychology (feelings and thoughts) and society (interpersonal, cultural, literacy and contextual factors).[3] The importance of sexuality varies between people and fluctuates in individuals' lives. It is important to understand the patient's needs and not impose a burden of expectation that the patient does not want. However, as sexuality is often viewed as intercourse, there is room to introduce patients to a broader sexuality involving outercourse, masturbation/self-pleasure and sensual touch. This fits well with ageing, chronic or disabling diseases and disabilities.

Nomenclature is not standardised well in the field of sexuality. 'Sexual problem' is an umbrella term to refer to sexual concerns, sexual difficulties, sexual dysfunctions and sexual disorders. A useful distinction between the two most commonly used terms is a time factor, with a sexual difficulty lasting <6 months and a sexual dysfunction lasting >6 months. In Australia, there are research data on sexual difficulties, but not on sexual dysfunctions, collected from a large national representative sample of approximately 20,000 adult men and women. According to the 2013 Australian Study on Health and Relationships, lack of interest in sex was the single most common sexual difficulty for both men and women.[4]

Sexual dysfunctions have many mediating factors including psychological and sociocultural factors, lifestyle factors and health (especially obesity, sleep disorders, anxiety, depression, chronic disease and side effects of medications).[5] Erectile dysfunction can precede cardiovascular symptoms by 2–3 years and cardiovascular events by 3–5 years.[6],7 Therefore, paying attention to sexual function is relevant to broader health outcomes and an opportunity for aggressive intervention. For optimal management of sexual dysfunctions, biomedical management options are an important therapeutic intervention but cannot serve as a 'stand-alone' intervention.

Sexual dysfunction is considered a medium priority by GPs,1 and sexual dysfunctions are not a common problem managed by Australian GPs.10 Yet, continuity of care in a good and trusting relationship places the GP in an ideal position to initiate a discussion about sexual problems, when relevant, but also to assess and plan the interventions and follow-up needed to ensure that sexual problems are addressed, ameliorated as possible and potentially resolved. GPs can find addressing sexuality issues difficult for many reasons categorised as doctor barriers (lack of knowledge/training), patient barriers (sense of embarrassment), doctor–patient interaction issues (different genders, cultures, ages) and contextual concerns (lack of time)

https://www1.racgp.org.au/ajgp/2020/july/sexual-dysfunctions-and-sex-therapy

Erectile dysfunction

is defined as a man's consistent or recurrent inability to attain and/or maintain penile erection that is sufficient for sexual activity.1 Although a common condition, sexual dysfunction is often neglected in clinical practice. General practitioners (GPs) are instrumental in the early diagnosis and treatment of men with erectile dysfunction. Sexual complaints should be used as a platform to investigate possible risk factors and comorbidities, and as a means to segue into patient education and lifestyle changes. Even when specialist assistance is required, involvement of the GP is crucial for a durable positive outcome. This review will discuss the basics of erectile dysfunction and its management, and focus on the pivotal role of GPs.

Erectile dysfunction is very common and not limited to older peoples. In an Australian study measuring self-reported erectile dysfunction in 108,477 men aged 45 years or older,2 the overall prevalence of erectile dysfunction was 61% (25% with mild erectile dysfunction; 19% with moderate erectile dysfunction; 17% with complete erectile dysfunction). More than 20% of healthy men aged 60–65 years with no risk factors had moderate or complete erectile dysfunction. A similar prevalence of significant erectile dysfunction was found in men with diabetes in their late 40s. In another Australian study of 810 men aged 35–80 years,3 the overall prevalence of erectile dysfunction was 23.3% at baseline. Of the men with normal erectile function at baseline, 31.7% developed erectile dysfunction at five-year follow-up

Erectile dysfunction may be classified as vasculogenic, neurogenic, endocrinological, drug-related, psychogenic or mixed. Commonly, erectile dysfunction is a cause of anxiety and even depression. Risk factors, such as smoking and hypertension, and reversible causes, such as hypogonadism or offending medications, should be addressed. At present, oral pharmacotherapy represents the first-line option for most patients with erectile dysfunction. It is of utmost importance to evaluate and treat comorbidities, such as depression, metabolic syndrome and cardiovascular disease that often accompany erectile dysfunction. Patients will undoubtedly benefit from comprehensive management by a dedicated GP. Occasionally, referral to a urologist, psychologist or sexual health physician may be required.

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Benign prostatic hyperplasia

(BPH) is the most common benign tumour in men. Although men with BPH often need medical or surgical management from a urologist at some point throughout the timeline of their disease, most men are initially assessed and managed by a general practitioner (GP) in the primary healthcare setting. Between 2009 and 2011, BPH was managed by GPs at approximately 228,000 general practice visits per annum in Australia. Several changes in pharmaceutical agents and surgical intervention have occurred over the past decade. As a result, it is imperative that GPs remain up to date with assessment and management of BPH, are aware of new therapies and understand when to refer to a urologist.

It is common for men to present to a general practitioner (GP) with symptoms suggestive of bladder outflow obstruction, which is often due to benign prostatic enlargement (BPE). Benign prostatic hyperplasia (BPH) is the histological cause of BPE, which often results in lower urinary tract symptoms (LUTS) related to voiding, storage or post-micturition.1 Not all LUTS in men are due to BPE, and other causes of voiding dysfunction require exclusion (Table 1).2 Management of LUTS due to BPE depends on symptom severity or complicating factors and includes observation (for men with minimal symptoms), medical therapy, minimally invasive surgical procedures, endoscopic prostatectomy and, occasionally, abdominopelvic surgery for very large prostates. https://www1.racgp.org.au/ajgp/2018/july/benign-prostatic-hyperplasia

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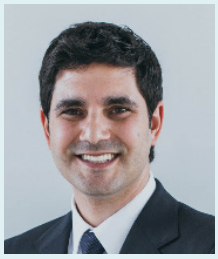

Managing Erectile dysfunction in general practice

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Managing benign prostatic hyperplasia in general practice

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