XLI Reunión MANCHEGO-EXTREMEÑA DE UROLOGÍA

CÁCERES 2018

4 y 5 de Mayo

Síntomas tracto urinario inferior y disfunción sexual

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Conflicto de intereses

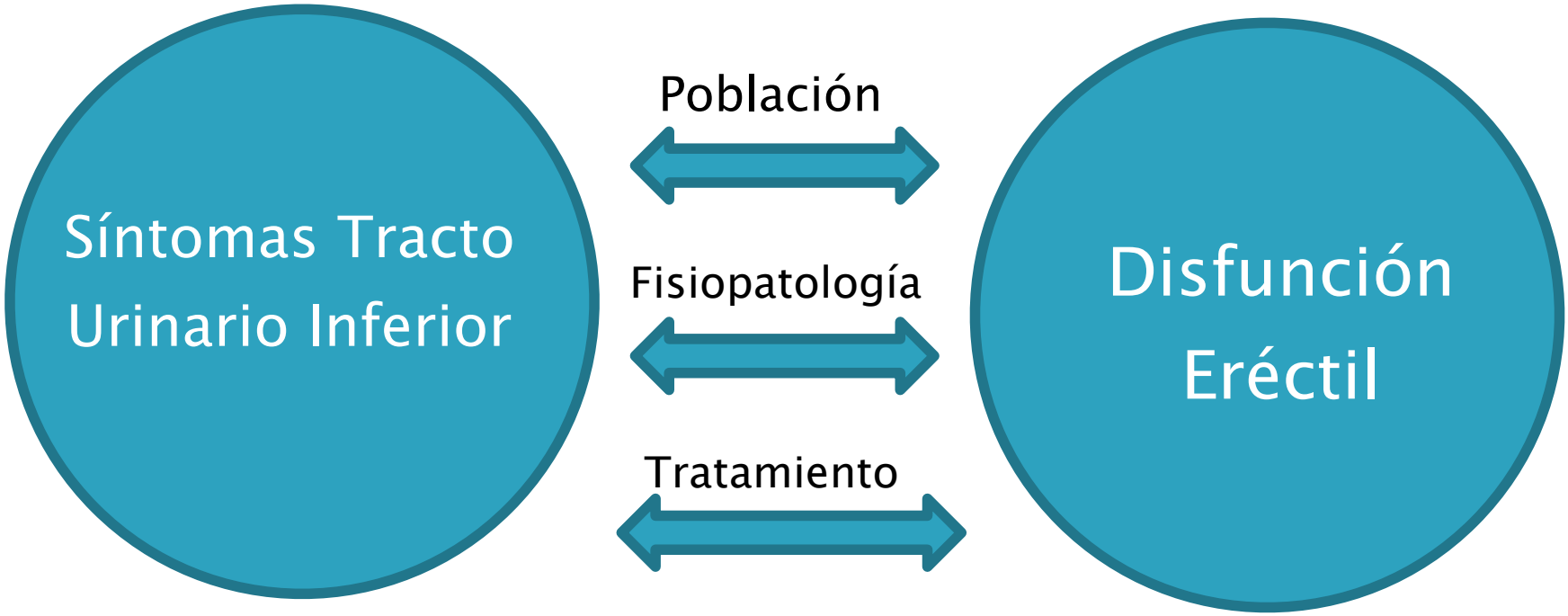
- Comunicación no patrocinada
- Colaboraciones puntuales con Pierre Fabré®, Astellas ®, GSK ®, Almirall ®

Introducción

- La relación entre la HBP y la disfunción sexual está bien establecida y es cada vez más frecuente en la población masculina a medida que envejece
- La disfunción sexual es un complejo fenómeno que no está limitado únicamente a la disfunción eréctil
  - La disfunción sexual puede abarcar los trastornos de eyaculación, la disfunción eréctil, el grado de satisfacción y la pérdida de la lÍbido
- Las consideraciones clínicas en el manejo de la HBP deben incluir la evaluación de la función sexual, la edad del paciente y los efectos de la medicación.

Síntomas Tracto Urinario Inferior

Disfunción Eréctil


Síntomas Tracto Urinario Inferior
Población
Fisiopatología
Tratamiento
Disfunción Eréctil


Síntomas Tracto Urinario Inferior
Disfunción Eréctil

Componentes de la función / disfunción sexual masculina

IH. Overview of Male Sexual Function. Disponible en: http://www.msdmanuals.com/professional/genitourinary-disorders/male-sexual-dysfunction/overview-of-male-sexual-function

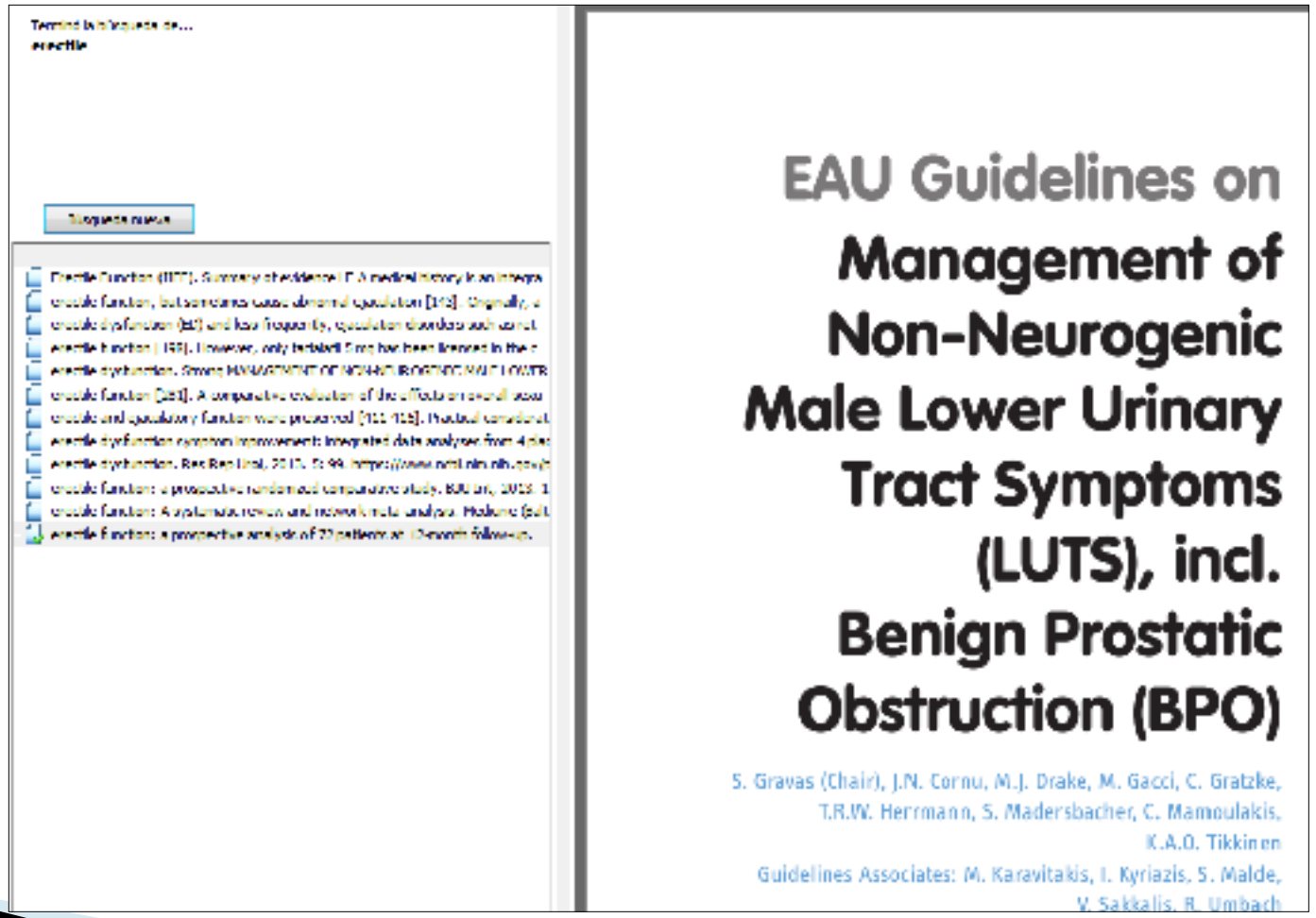
EAU Guidelines on

Management of Non-Neurogenic Male Lower Urinary Tract Symptoms (LUTS), incl. Benign Prostatic Obstruction (BPO)

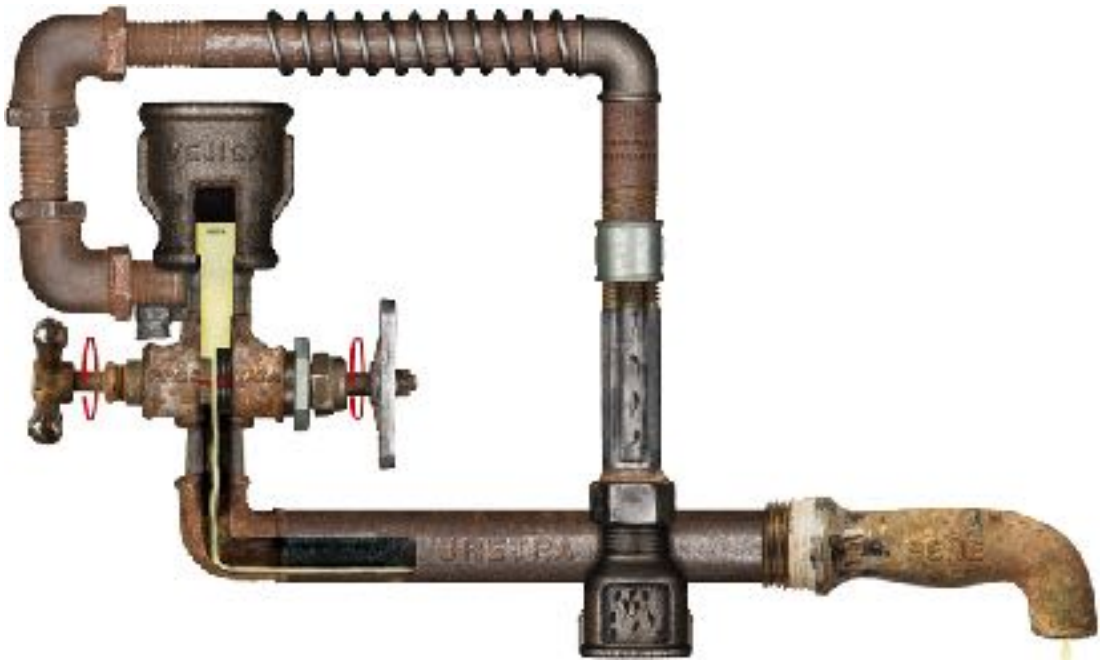
Epidemiological studies have also demonstrated consistent evidence for an association between lower urinary tract symptoms (LUTS)/benign prostatic hyperplasia (BPH) and sexual dysfunction, regardless of age, other comorbidities and various lifestyle factors [50]. The Multinational Survey on the Aging Male (MSAM-7) study - performed in the USA, France, Germany, Italy, Netherlands, Spain, and the UK - systematically investigated the relationship between LUTS and sexual dysfunction in > 12,000 men aged 50-80 years. From the 83% of men who self-reported to be sexually active, the overall prevalence of LUTS was 90%, with the overall prevalence of ED being 49%, and a reported complete absence of erection in 10% of patients. Moreover, the overall prevalence of ejaculatory disorders was 46% [51]. An association between chronic prostatitis/chronic pelvic pain syndrome and ED has also been confirmed [52]. Effects on erectile function vary according to the type of surgery performed in men with LUTS/BPH [53].

EAU Guidelines on

Erectile Dysfunction, Premature Ejaculation, Penile Curvature and Priapism


EAU Guidelines on
Management of Non-Neurogenic Male Lower Urinary Tract Symptoms (LUTS), incl. Benign Prostatic Obstruction (BPO)
S. Gravas (Chair), J.N. Cornu, M.J. Drake, M. Gacci, C. Gratzke, T.R.W. Herrmann, S. Madersbacher, C. Mamoulakis, K.A.O. Tikkinen
Guidelines Associates: M. Karavitakis, I. Kyriazis, S. Malde, V. Sakkalis, R. Umbach

Fisiopatología



EUROPEAN UROLOGY 60 (2011) 809–825

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

European Association of Urology

Collaborative Review – Sexual Medicine – LUTS

Critical Analysis of the Relationship Between Sexual Dysfunctions and Lower Urinary Tract Symptoms Due to Benign Prostatic Hyperplasia

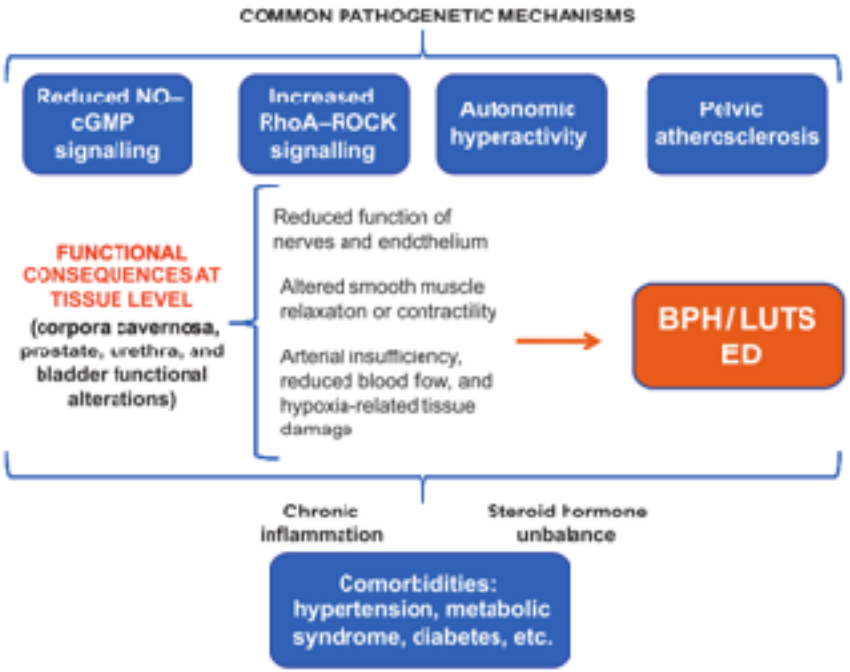


Figure 1 – Schematic representation of the common pathogenetic mechanisms linking lower urinary tract symptoms resulting from benign prostatic hyperplasia and erectile dysfunction.
NO = nitric oxide; cGMP = cyclic guanosine monophosphate; ROCK = Rho-kinase; BPH = benign prostatic hyperplasia; LUTS = lower urinary tract symptoms; ED = erectile dysfunction.

EUROPEAN UROLOGY FOCUS 3 (2017) 352–363

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

Review – Benign Prostatic Hyperplasia

Erectile Dysfunction and Lower Urinary Tract Symptoms

Cosimo De Nunzio[a,*], *Claus G. Roehrborn*[b], *Karl-Erik Andersson*[c], *Kevin T. McVary*[d]

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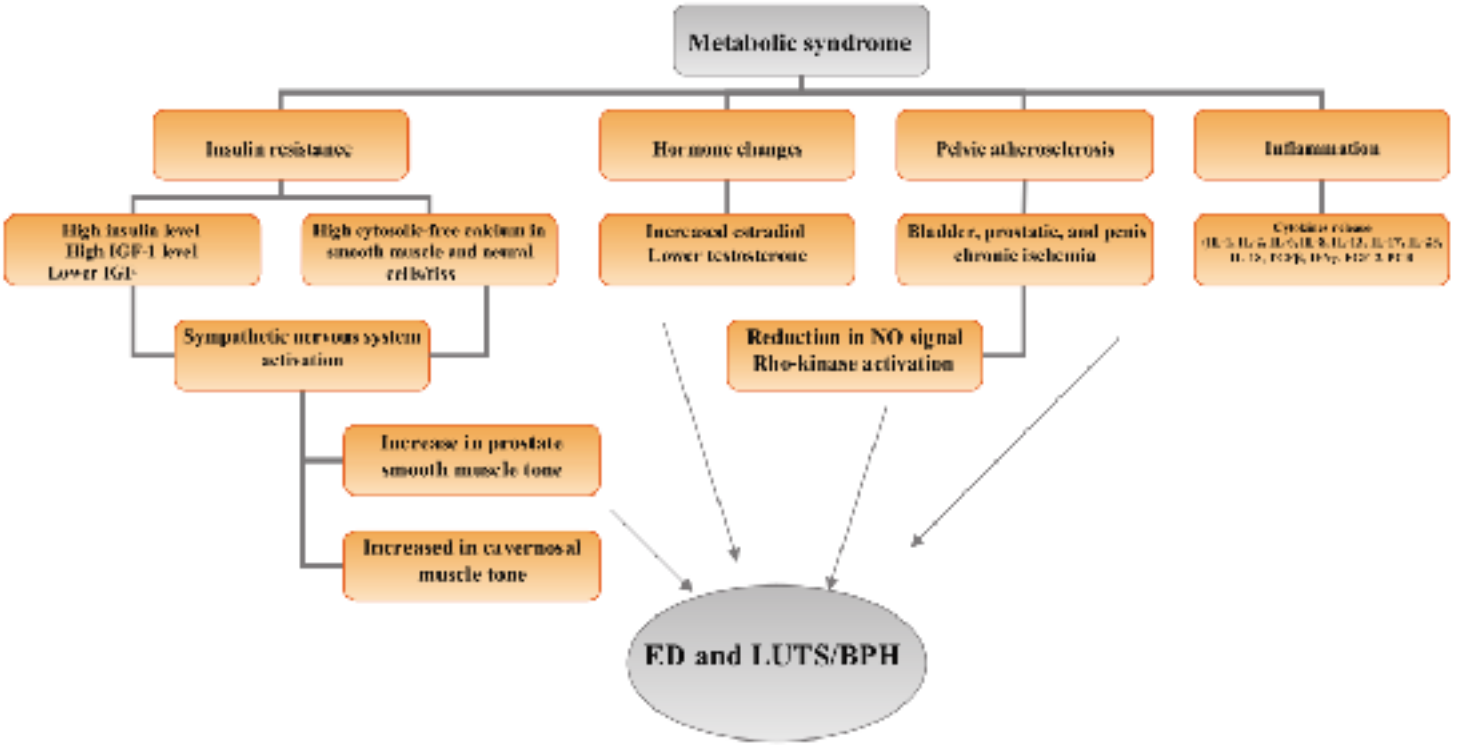

Fig. 4 – Possible biological mechanism for ED and LUTS/BPH in relation to metabolic syndrome. BPH = benign prostatic hyperplasia; ED = erectile dysfunction; FGF = fibroblast growth factor; IFN = interferon; IGF = insulin-like growth factor; IL = interleukin; LUTS = lower urinary tract symptom; PCR = C-reactive protein; TGFβ = transforming growth factor.

Epidemiología

EUROPEAN UROLOGY FOCUS 3 (2017) 352–363

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Review – Benign Prostatic Hyperplasia

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Authors (year)	Study design	Country	Age (yr)	Cohort Size	Outcome/comments
Kupelius et al (1998) [57]	Prospective cohort	Finland	69	155	In LUTS men, 74% had ED
Braun et al (2000) [6]	Cologne male survey	Germany	30–80	4000	LUTSs in 72.2% of patients with ED vs 32.7% without ED; prevalence risk highly significant; odds ratio was 2.11, even after controlling for age
Blanker et al					eater with LUTSs than with
Lehfeld et al					or erectile function
Mercuri et al					ED (OR: 1.83–3.60)
Boyle et al [2					ultiple regression model;
Vallancien et					smoking LUTSs; patients with severe
Rosen et al (2					
Chung et al (2					ly correlated with LUTSs;
Fonhobe et					r age, vascular risk factors
Hansen (2001					erall LUTS prevalence 38%
Elliott et al [2					, depression, hypertension
Teral et al (20					ion coefficient: −0.1) nained after controlling for
McVary (2004					ation with maximum flow
Sak et al (200					nt = −0.15); IPSS could not
Saitō et al (20					ED in a multivariate model
					with OR 2.6–4.4
El Sakka (2005) [67]	Clinic based	Saudi Arabia	54	374	In ED men, 77% have LUTSs; patients with LUTSs are at increased risk of ED; patients with LUTSs have poorer penile vascular parameters
Li et al (2005) [68]	Cross sectional	Asia	50–80	1155	In LUTS men, 75% had ED; OR for ED: 5.17–4 compared with no LUTSs
Rosen et al (2005) [59]	HOPES study and questionnaires	USA	45–78	3881	2% increase in ED risk for one increase in AUASS
Liu et al (2006) [70]	Voluntary screening	Taiwan	60	141	In LUTS men, 67% had ED; OR for ED 3.27 compared with mild LUTSs
Reggio et al (2007) [71]	Prospective screening program	Brazil	58	1267	Patients with LUTSs are at increased risk of ED; RR: 2.73 [2.08–3.57] age adjusted; there is a negative correlation between LUTSs and IIEF (coefficient: −0.13)
Brookes et al (2008) [72]	BACH Study Subset Analysis	UK	30–79	2301	Multivariable regression model of ED found strong association of AUASS and ED independent of age, nocturia, incontinence, and prostatitis emerged factors; no differences found across race or ethnicity
Rhoden et al (2008) [73]	Cross sectional	Brazil	40–81	192	Patients with LUTSs are at increased risk of ED; OR 3.45–3.72, risk for ED
Ikuerowo et al (2008) [74]	Prospective cohort	Nigeria	65	132	In LUTS men, 71% had ED; LUTSs and ED are correlated
Mehrabian et al. (2008) [75]	Prospective	Iran	64	357	In LUTS men, 68% had ED; LUTSs are inversely correlated with ED (coefficient: −0.668); LUTS represents a risk factor for ED in multivariable analysis

Table 1 (Continued)

Authors (year)	Study design	Country	Age (yr)	Cohort Size	Outcome/comments
Rosen et al (2009) [80]	BMI registry	US	64 ± 10	3924	LUTS severity and bother correlated significantly with ED ($R = -0.100$ and -0.072, respectively)
Demir et al (2009) [81]	Prospective, cross sectional	Turkey	60	193	OR for severe LUTSs 2.3 compared with no ED
Jung et al (2009) [82]	Prospective cohort	South Korea	62.04	365	A negative correlation between LUTSs and ED (coefficient = −0.235; $p = 0.001$)
Wong et al. (2010) [83]	Prospective cohort	China	72	1291	Patients with LUTSs are at increased risk of ED (OR = 2.00–4.07); LUTSs were the only independent predictor of ED
Tsai et al (2010) [84]	Prospective cohort	Taiwan	60	339	IPSS ($p < 0.001$ and $p = 0.013$) as significantly associated with ED after controlling other comorbidities; in a further age-adjusted multiple regression analysis, our results showed that irritative symptoms ($p = 0.012$) have a more significant association with ED than obstructive symptoms ($p = 0.128$)
Nasir et al (2011) [85]	Prospective cohort	Pakistan	60	585	There is a negative correlation between LUTSs and ED (coefficient = 0.335, $p = 0.001$)
Lee et al (2013) [86]	Prospective cohort	South Korea	49	2853	A negative correlation exists between LUTSs and ED (correlation coefficient = −0.511, $p = 0.001$)
Akkus et al (2011) [87]	Prospective cohort	Turkey	61	105	IN LUTS men, 40% have ED; no significant correlation between LUTSs and ED
Nakamura et al (2012) [88]	Prospective cohort	Japan	66	220	There is a negative correlation between LUTSs and ED (coefficient = 0.302, $p = 0.001$)
Dubiewicz et al (2012) [89]	Retrospective cohort	Poland	NA	4354	In LUTS men, 80.4% had ED (IIEF < 15)
Song et al (2013) [90]	Cross-sectional study	Korea	64	124	There is a negative correlation between LUTSs and ED (coefficient = 0.260, $p = 0.001$); In patients with DMII
Barbosa et al (2013) [91]	Prospective cohort	Brazil	61	898	In LUTS men, 50% had ED (OR = 1.95 [1.47–2.89])
Fwu et al (2015) [92]	MTOPS study prospective cohort	USA	62	372	Progression of LUTSs does not affect sexual function
Shigehara et al (2014) [93]	Prospective cohort	Japan	65	258	There is a negative correlation between LUTSs and ED (coefficient = 0.331, $p = 0.001$)
Song et al (2014) [94]	Cross sectional study	China	64	1644	There is a negative correlation between LUTSs and ED (coefficient = 0.335, $p = 0.001$)
Gonzalez-Sanchez et al (2016) [95]	MexLUTS epidemiological study	Mexico	43.6	1041	Men with severe LUTSs are at increased risk of ED (HR: 1.530 [1.205–2.206], $p = 0.002$)
Korneyev et al (2016) [96]	Cross sectional	Russia	42	1083	In LUTS men, 76% had ED; OR for ED: 4.80 [3.16–5.03]

AUASS = American Urological Association Symptom Score; BACH = Boston Area Community Health; BPH = benign prostatic hyperplasia; ED = erectile dysfunction; DMII = diabetes mellitus type II; IIEF = International Index of Erectile Function; IPSS = International Prostate Symptom Score; LUTS = lower urinary tract symptom; MTOPS = Medical Therapy of Prostatic Symptoms; NA = not available; PLESS = Proscar Long-term Efficacy and Safety Study; OR = odds ratio; RR = risk ratio.

Tratamiento

Vigilancia/Tratamiento Conservador

- Tanto el tratamiento médico como quirúrgico tiene impacto en la función sexual.
- En pacientes con síntomas leves (IPSS<7) son candidatos a vigilancia.
- El efecto de la vigilancia es variable sobre la

Recommendation	Strength rating
Offer men with mild/moderate symptoms, minimally bothered by their symptoms, watchful waiting.	Strong
Offer men with LUTS lifestyle advice prior to or concurrent with treatment.	Strong

EAU Guidelines 2018

Vigilancia/Tratamiento Conservador

BJU International (2012), 91, 214–218

Sexual function before and after various treatments for symptomatic benign prostatic hyperplasia

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Department of Urology, Laurentius Hospital, Roermond, and *Institute for Health Care Policy and Management, Erasmus University Rotterdam, The Netherlands

Table 1 Questions on sexual function and the distribution of answers (absolute numbers and the percentage of valid answers in parentheses)

Function	*Response*
Libido	
Over the past several months, have you had any interest in sex?	
Yes	441 (68.5)
No	203 (31.5)
Missing	26
Activity	
Over the past several months, have you had any kind of sexual activity (intercourse, masturbation, etc.)?	
Yes	330 (60.0)
No	250 (40.0)
Missing	20
Potency	
Over the past month or so, how often have you been able to have erections when you were sexually stimulated?	
Almost always	198 (30.5)
More than half the time	71 (11.0)
About half the time	52 (8.0)
Less than half the time	48 (7.4)
Rarely	132 (20.4)
Not at all	87 (13.4)
Don't know/had no sexual stimulation	50 (9.3)
Missing	22
Rigidity	
Over the past month or so, how would you rate your erections?	
Firm enough to have intercourse	335 (49.1)
Not firm enough to have intercourse	186 (30.0)
Don't know/had no intercourse	130 (20.9)
Missing	19

Vigilancia/Tratamiento Conservador

BJU International (2001), 87, 208–215

Sexual function before and after various treatments for symptomatic benign prostatic hyperplasia

H. H. J. [illegible]ELD, H. J. STOEVELAAR* and J. McDONNELL*
Department of Urology, Leeuwarden Hospital, Leeuwarden, and *Institute for Health Care Policy and Management, Erasmus University Rotterdam, The Netherlands

Function	*Surgery*	*α-blockers*	*Finasteride*	*Watchful-waiting*	*Total*
Libido					
% normal at baseline*	58	84	78	77	70
% improvement	14	3	8	7	9
% deterioration	7	14	8	7	7
Activity					
% normal at baseline*	52	73	73	68	63
% improvement	12	8	8	10	11
% deterioration	6	5	8	6	6
Erection capacity					
% normal at baseline*	48	66	70	64	59
% improvement	11	9	9	11	11
% deterioration	5	16	15	11	10
Rigidity					
% normal at baseline*	67	67	68	68	67
% improvement	10	13	7	11	10
% deterioration	7	7	–	6	6

*Concerns only patients with complete follow-up data.

Fitoterapia

- La evidencia de respuesta de fitoterapia es limitada.
- Perfil de efectos secundarios es favorable.

Practical considerations: Phytotherapeutic agents are a heterogeneous group and may contain differing concentrations of active ingredients. Hence, meta-analyses may not be justified and results of any analyses have to be interpreted with caution.

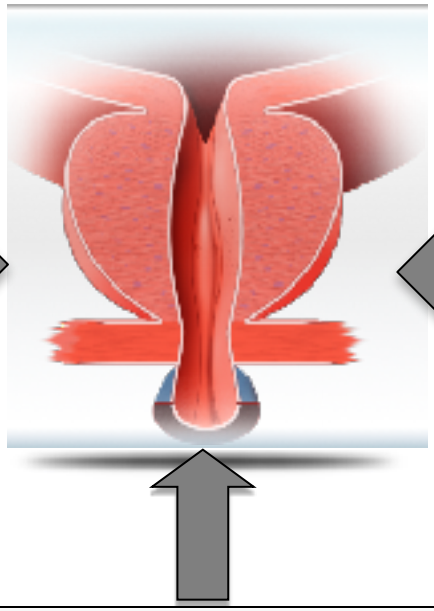
EAU Guidelines 2018

MECANISMO DE ACCIÓN DE SERENOA REPENS

EFECTO ANTIINFLAMATORIO

Disminución FNTα e IL-1β.
Inhibición MCP-1/CCL2 y VCAM-1.

Latil A. BJU Int , (2012)
Vela-Navarrete R. Eur Urol, 44;549-55, (2003)
Paubert-Braquet M Prostaglandins Leukot Essent Fatty Acids 57(3): 299-304. (1997);



EFECTO ANTIANDROGÉNICO

Inhibición no competitiva de la enzima 5-AR tipos I y II.

Bayne C. The Prostate, 40:232-41, (1999)
Di Silverio F. The Prostate, 37:77-83, (1998)
Scaglione F. Pharmacology, 82:270-5,(2008)

EFECTO ANTIPROLIFERATIVO

Inhibición de factores de crecimiento (EGF; b-FGF)

Di Silverio F. The Prostate, 37:77-83, (1998)

European Urology

European Urology 48 (2005) 264–270

BPH/Prostatic Diseases

Evaluation of Male Sexual Function in Patients with Lower Urinary Tract Symptoms (LUTS) Associated with Benign Prostatic Hyperplasia (BPH) Treated with a Phytotherapeutic Agent (Permixon®), Tamsulosin or Finasteride

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[b] Department of Urology, St-Louis Hospital, Paris, France
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Accepted 28 March 2005

Available online 18 April 2005

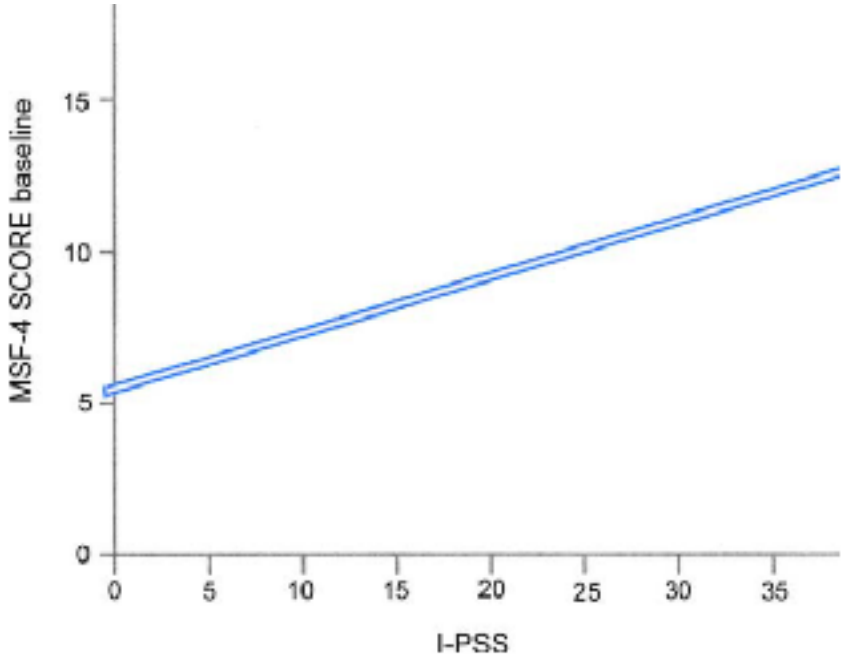

Fig. 1. Correlation between the MSF-4 questionnaire and the baseline I-PSS $r^2 = 0.032$.

European Urology

European Urology 48 (2005) 265–275

BPH/Prostatic Diseases

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[b] Department of Urology, St-Louis Hospital, Paris, France
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Accepted 28 March 2005

Available online 18 April 2005

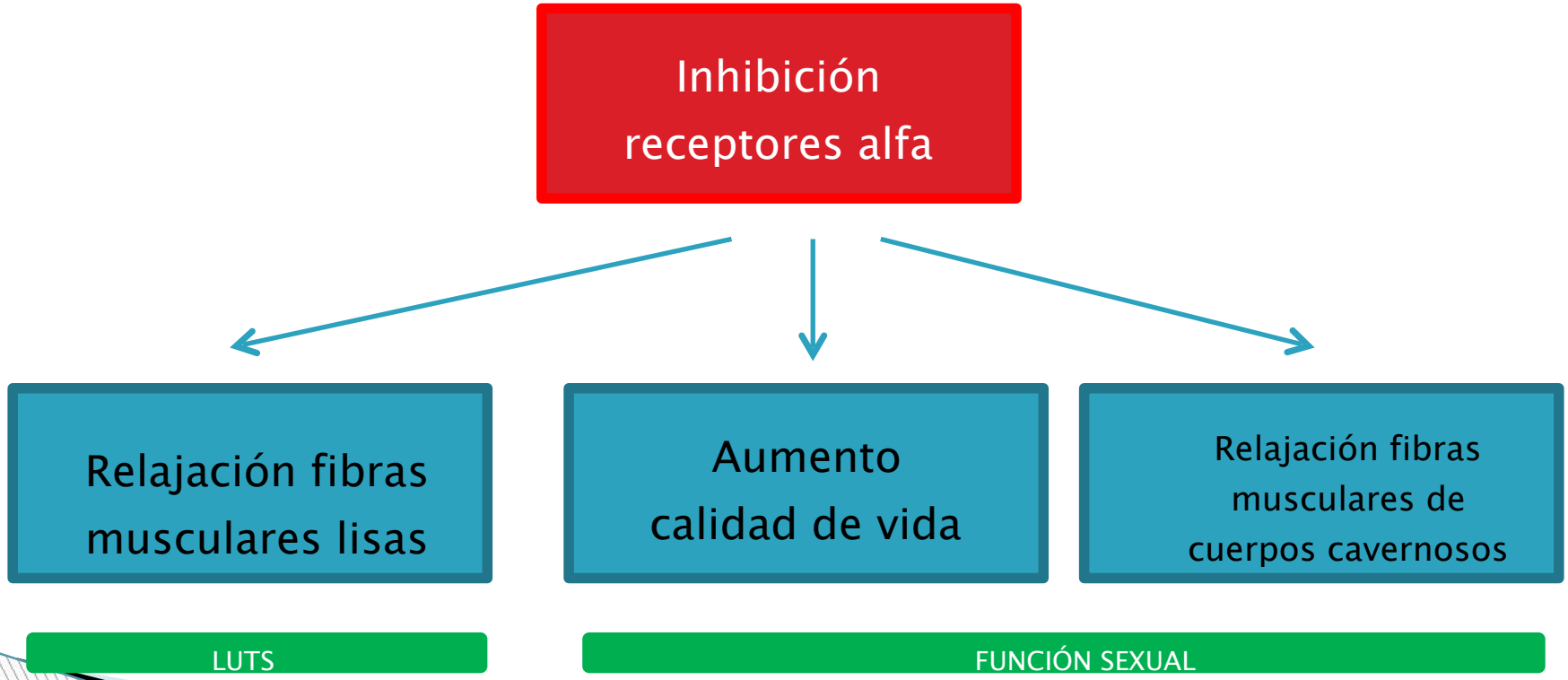
Table 2
Changes in MSF-4 global score at 3 and 6 months of therapy as compared to baseline values

	Permixon (n = 1.609)	Finasteride (n = 545)	Tamsulosin (n = 354)
MSF-4 total score at baseline mean (SD)	8.2 (5.1)	8.5 (5.5)	7.9 (5.1)
Change in MSF-4 total score at 3 months mean (SD)	0.0 (2.8)	+0.5 (3.5)	+0.3 (2.9)
Change in MSF-4 total score at 6 months mean (SD)	−0.2 (3.1)[a]	+0.8 (3.8)	+0.3 (3.4)
% of patients improved at 3 months	30.2%	28.2%	31.0%
% of patients aggravated at 3 months	27.1%	32.0%	39.9%
% of patients stable at 3 months	42.7%	39.8%	29.1%
% of patients improved at 6 months	31.8%[a]	27.5%	34.4%
% of patients aggravated at 6 months	29.5%[a]	38.6%	40.7%
% of patients stable at 6 months	38.7%[a]	33.9%	24.9%

[a] Analysis performed on 902 patients treated with Permixon.

Alfa bloqueantes

- Impacto en la función eréctil y la eyaculación.



-Van Dijk MM, De La Rosette JJ, Michel MC. Effects of alpha 1 adrenoceptor antagonists on male sexual function. Drugs 2006; 66:287-301.
-Lepor H, Williford WO, Barry MJ, Haakenson C, Jones K. The impact of medical therapy on bother due to

Alfa bloqueantes

LEADING ARTICLE

Drugs 2006; 66 (3): 287-30
0012-6667/06/0003-0287/$41.95/0

Effects of α_1-Adrenoceptor Antagonists on Male Sexual Function

Marleen M. van Dijk,[1] *Jean J.M.C.H. de la Rosette*[1] and *Martin C. Michel*[2]

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2 Department of Pharmacology and Pharmacotherapy, Academic Medical Center, University of Amsterdam, Amsterdam, The Netherlands

Alfa bloqueantes

Table I. Effects of α_1-adrenoceptor antagonists o sexual desire

Study type	No. of pts		Decrease in sexual desire (% pts)		Description[a]	Reference
	active treatment	comparator	active treatment	comparator		
Alfuzosin						
RCT	149	154	0.7	0.7	3 × 2.5mg, 12wk	11
RCT	143	154	0.0	0.7	1 × 10mg XL, 12wk	11
RCT	358	344	0.6	1.7	2 × 5mg SR, 6mo, comparator was finasteride (5mg)	12
Doxazosin						
RCT	275	269	3.6	1.9	1 × 1–8mg dose titration, 1y	13
RCT	756	737	1.6	1.4	1 × 1–8mg dose titration, 4.5y. The numbers shown are the rates per 100 person-years of follow-up	14
Tamsulosin						
RCT	381	193	1.0	0.0	1 × 0.4mg MR, pooled analysis of three 12wk European phase III studies including[15]	16
RCT	354	350	1.1	0.3	1 × 0.4mg MR, 1y, comparator was Permixon (320mg)	17
OLS	516		1.2		1 × 0.4mg MR, up to 4y open-label extension of[15,18,19]	20
OLS	949		4.7		Pooled data for 1 × 0.4–0.8mg MR, open-label extension of[15,22] for up to 2y	23
Terazosin						
RCT	305	305	2.6	1.3	1 × 1–10mg dose titration, 1y	24

a. Drug doses refer to the immediate-release formulation of a drug, and 'comparator' refers to placebo, unless otherwise noted.

MR = modified-release formulation; **OLS** = open-label study; **pts** = patients; **RCT** = randomised controlled trial; **SR** = sustained-release formulation; **XL** = extended-release formulation.

Alfa bloqueantes

Table II. Effects of α -adrenoceptor antagonists on erectile function

Study type	No. of patients		Decrease in erectile function (% patients)		Description[a]	Reference
	active treatment	comparator	active treatment	comparator		
Alfuzosin						
RCT	251	267	<1	2.3	3–4 × 2.5mg, 6mo	44
RCT	149	154	0.0	0.7	3 × 2.5mg, 12wk	11
RCT	292	297	0.3	0.0	2 × 5mg SR, 1 and 3mo, pooled data from two studies	45
RCT	143	154	0.0	0.7	1 × 10mg XL, 12wk	11
RCT	176	175	2.8	1.1	1 × 10mg XL, 12wk	46
RCT	177	175	1.1	1.1	1 × 10mg XL, 12wk	46
RCT	154	153	1.3	0.0	1 × 10mg XL, 12wk	47
RCT	153	153	1.3	0.0	1 × 10mg XL, 12wk	47
RCT	124	131	2.4	3.1	3 × 2.5mg, 12wk, comparator was tamsulosin (0.4mg MR)	19
RCT	368	344	2.2	6.7	2 × 5mg SR, 6mo, comparator was finasteride (5mg)	12
RCT	88	88	1.1	0.0	3–4 × 2.5mg dose titration, 14wk, comparator was doxazosin (1–8mg dose titration)	48
OLS	8065		<0.1		3 × 5mg, 3mo, impotence in one patient	49
OLS	8076		1.4		1 × 10mg XL, 1y	50
Doxazosin						
RCT	50	50	0.0	0.0	1 × 1–8mg dose-titration, 14wk	51
RCT	42		9.5		1 × 4mg, 12wk	52
RCT	40		12.5		1 × 8mg, 12wk	53
RCT	275	268	5.8	3.3	1 × 1–8mg dose titration, 1y	13
RCT	750	737	9.6	9.3	1 × 1–8mg dose-titration, 4.5y, the numbers shown are the rates per 100 person-years of follow-up	14
RCT	89	93	0.0	1.1	1 × 1–8mg dose titration, 14wk, comparator was alfuzosin (2–4 × 2.5mg dose titration)	48
OLS	450		2.0		1 × 1–16mg dose titration, 6mo extension of earlier unspecified RCT	53
Tamsulosin						
RCT	361	193	0.8	1.5	1 × 0.4mg MR, pooled analysis of three 12wk European phase III studies including[18]	16
RCT	150	152	4.4	0.0	1 × 0.4mg MR, 12wk	47
RCT	131	124	3.1	2.4	1 × 0.4mg MR, 12wk, comparator was alfuzosin (3 × 2.5mg)	19
RCT	168	204	3.1	3.4	1 × 0.4mg MR, 1y, comparator was finasteride (5mg)	54
OLS	1784		0.6		1 × 0.4mg MR, 6mo	55
OLS	515		5.4		1 × 0.4mg MR, up to 4y open-label extension of[16,18,19]	20

Alfa bloqueantes

Table III. Effects of α_1-adrenoceptor antagonists on ejaculation

Study type	No. of patients		Abnormal ejaculation (% patients)		Description*	Tolerance
	active treatment	comparator	active treatment	comparator		
Alfuzosin						
RCT	149	154	0.0	0.0	3 × 2.5mg, 12wk	11
RCT	143	151	0.0	0.0	1 × 10mg XL, 12wk	11
RCT	176	175	0.6	0.0	1 × 10mg XL, 12wk	46
RCT	177	176	0.6	0.0	1 × 10mg XL, 12wk	46
RCT	151	153	1.3	0.0	1 × 10mg XL, 12wk	47
RCT	158	153	0.0	0.0	1 × 10mg XL, 12wk	47
RCT	124	131	0.0	0.8	3 × 2.5mg, 12wk, comparator was tamsulosin (1 × 0.4 mg MR)	19
RCT	358	341	0.0	1.5	2 × 5mg SR, 6mo, comparator was finasteride (5mg), recorded as ejaculation failure	12
OLS	3036		0.0		2 × 5mg SR, 2mo	49
OLS	311		0.6		1 × 10mg XL, 9mo extension of[11]	21
OLS	3076		0.2		1 × 10mg XL, 1y	60
Doxazosin						
RCT	275	269	0.4	1.5	1 × 1–8mg dose titration, 1y	18
RCT	756	737	1.1	0.8	1 × 1–8mg dose titration, 4.6y. The numbers shown are the rates per 100 person-years of follow-up	14
RCT	40	50	0.0	2.0	1 × 4–8mg GITS dose titration, 8wk, comparator was tamsulosin (1 × 0.4–0.8mg MR dose titration)	72
Tamsulosin						
RCT	35	28	0.0	0.0	1 × 0.2mg MR, 4wk	73
RCT	30	28	0.0	0.0	1 × 0.4mg MR, 4wk	73
RCT	33	28	3.0	0.0	1 × 0.6mg MR, 4wk	73
RCT	881	198	4.5	1.0	1 × 0.4mg MR, pooled analysis of 12wk European phase III studies including[18]	16
RCT	254	254	5.9	0.0	1 × 0.4mg MR, 13wk	21
RCT	248	254	17.7	0.0	1 × 0.8mg MR dose titration, 13wk	21
RCT	248	239	10.9	0.4	1 × 0.4mg MR, 13wk	22
RCT	244	239	18.4	0.4	1 × 0.8mg MR dose titration, 13wk	22
RCT	158	153	3.2	0.0	1 × 0.4mg MR, 12wk	47

Alfa bloqueantes

Table III. Contd

Study type	No. of patients		Abnormal ejaculation (% patients)		Description[a]	Reference
	active treatment	comparator	active treatment	comparator		
RCT	86	90	3.5	0.0	1 × 0.4mg MR, 4wk, study in spinal cord injury	69
RCT	81	90	2.5	0.0	1 × 0.8mg MR dose titration, 4wk, study in spinal cord injury	69
RCT	139	126	10	0.0	1 × 0.4mg MR, 1y double-blind extension of[71]	74
RCT	139	126	26	0.0	1 × 0.8mg MR, 1y double-blind extension of[71]	74
RCT	709	356	3.1	0.3	1 × 0.4mg MR, 12wk	75
RCT	360	356	1.9	0.3	1 × 0.4mg OCAS, 12wk	75
RCT	722	356	5.2	0.3	1 × 0.8mg OCAS, 12wk	75
RCT	131	124	0.9	0.0	1 × 0.4mg MR, 12wk, comparator was alfuzosin (3 × 2.5mg)	19
RCT	50	48	2.0	0.0	1 × 0.4–0.8mg MR dose titration, 8wk, comparator was doxazosin (1 × 4–8mg GITS dose titration)	72
RCT	1032	931	3.7	0.3	1 × 0.4mg MR, 57d, comparator was terazosin (1 × 1–5mg dose titration)	60
RCT	354	350	4.2	0.6	1 × 0.4mg MR, 1y, comparator was saroroa repens (320mg)	17
RCT	196	204	3.1	1.0	1 × 0.4mg MR, 1y, comparator was finasteride (5mg)	64
OLS	1794		1.9		1 × 0.4mg MR, 6mo	53
OLS	516		4.0		1 × 0.4mg MR, up to 4y open-label extension of[18,19,59]	20
OLS	949		30.5		Pooled data for 1 × 0.4–0.8mg MR, open-label extension of[71,72] for up to 2y	23
OLS	178		4.5		1 × 0.4–0.8mg MR, 1y open-label extension of RCT reported in same article	69
Terazosin						
RCT	335	305	0.3	1.3	1 × 1–10mg dose titration, 1y	24
RCT	1053	1031	1.4	0.2	1 × 1–10mg dose titration, 1y	78
RCT	981	1002	0.3	3.7	1 × 1–5mg dose titration, 57d, comparator was tamsulosin (1 × 0.4mg MR)	63

a Drug doses refer to the immediate-release formulation of a drug, 'comparator' refers to placebo, and data are from benign prostatic hyperplasia patients unless otherwise noted.

Alfabloqueantes

EUROPEAN UROLOGY 59 (2011) 342–352

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journal homepage: www.europeanurology.com

Platinum Priority – Benign Prostatic Hyperplasia
Editorial by Giuseppe Morgia on pp. 353–355 of this issue

Silodosin Therapy for Lower Urinary Tract Symptoms in Men with Suspected Benign Prostatic Hyperplasia: Results of an International, Randomized, Double-Blind, Placebo- and Active-Controlled Clinical Trial Performed in Europe

Christopher R. Chapple[a,], Francesco Montorsi[b], Teuvo L.J. Tammela[c], Manfred Wirth[d], Ewert Kaldewijn[e], Eliliberto Fernández Fernández[f], on behalf of the European Silodosin Study Group[†]*

Table 3 – Change in International Prostate Symptom Score storage and voiding subscore

Treatment arm	IPSS storage symptoms		IPSS voiding symptoms	
	Change from baseline	Difference (95% CI) vs placebo	Change from baseline	Difference (95% CI) vs placebo
Silodosin	−2.5	−0.7[‡] (−1.1, −0.2)	−4.5	−1.7[*] (−2.2, −1.1)
Tamsulosin	−2.4	−0.6[†] (−1.1, −0.2)	−4.2	−1.4[*] (−2.0, −0.8)
Placebo	−1.8		−2.9	

CI = confidence interval; IPSS = International Prostate Symptom Score.
[*] $p < 0.001$ versus placebo.
[†] $p = 0.002$ versus placebo.

Alfabloqueantes

Platinum Priority – Benign Prostatic Hyperplasia
Editorial by Giorgio Bianchi on pp. 255–256 of this issue

Silodosin Therapy for Lower Urinary Tract Symptoms in Men with Suspected Benign Prostatic Hyperplasia: Results of an International, Randomized, Double-Blind, Placebo- and Active-Controlled Clinical Trial Performed in Europe

Christopher R. Chapple*, Francesco Montorsi, Tessa J.J. Tammela, Manfred Wirth, Evert Nordenga, Elfriberto Fernández Fernández, Silodosin Study Group

3.4.1. Treatment-emergent adverse events

Overall, the percentage of subjects who reported at least one TEAE was 34.9% (133 of 381) for subjects in the silodosin group, 28.9% (111 of 384) in the tamsulosin group, and 24.2% (46 of 190) in the placebo group (silodosin vs placebo: $p = 0.0094$; silodosin vs tamsulosin: $p = 0.0749$). The most frequently reported TEAEs (>2%) were a reduced or absent ejaculation during orgasm (coded by the Medical Dictionary for Regulatory Activities preferred term as "retrograde ejaculation") and headache. The percentage of subjects reporting AEs coded as "retrograde ejaculation" was 14.2% (54 of 381) in the silodosin treatment group, which was significantly higher compared with 2.1% (8 of 384) and 1.1% (2 of 190) of subjects in the tamsulosin and placebo treatment groups, respectively. The verbatim terms

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- Clásicamente se les ha achacado efectos en la esfera sexual
- Fisiopatología
  - ↓ Dihidrotestosterona
  - ↓ NO y ↓NO sintetasa.
- Datos clásicos:
  - Finasteride:
    - Disf.eréctil 3-16%/Pérdida de líbido 2-10%/Alt.Eyaculación 0-8%
  - Dutasteride(Dut+Tams)
    - Disf.eréctil 6%(7.4)/Pérdida de líbido 2.8%(3.4)/ Alt.Eyaculación 1.1(4.2)%

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- ou[illegible] et al.Longitudinal analysis of sexual function reported by men in the Prostate Cancer Prevention Trial. J Natl Cancer Inst 2007;99:1025-35.

- Roehrborn [illegible]. The effects of dutasteride,tamsulosin and combination therapy on lower urinary tract symptoms in men

Inhibidores 5α-reductasa

original research • nouveautés en recherche

Efficacy and safety of finasteride therapy for benign prostatic hyperplasia: results of a 2-year randomized controlled trial (the PROSPECT Study)

J. Curtis Nickel, MD, FRCSC; Yves Fradet, MD, FRCSC; Rex C. Boake, MD, FRCSC; Peter J. Pommerville, MD, FRCSC; Jean-Paul Perreault, MD, FRCSC; Salim K. Afridi, MD, FRCSC; Mostafa M. Elhilali, MD, FRCSC; and the PROSPECT Study Group*

Table 4: Adverse events related to sexual dysfunction

Adverse event	Group; no. (and %) of patients	
	Finasteride	Placebo
Ejaculation disorder*	24 (7.7)	5 (1.7)
Impotence*	49 (15.8)	19 (6.3)
Libido decreased	31 (10.0)	19 (6.3)

*$p < 0.01$ between groups.

CAN MED ASSOC J • NOV. 1, 1996; 155 (9)

Inhibidores 5α-reductasa

5-Alpha Reductase Inhibitors and Erectile Dysfunction: The Connection

J Sex Med 2008;5:2917–2924

Fikret Erdemir, MD, Andrew Harbin, BA, and Wayne JG Hellstrom, MD

Tulane University-Department of Urology, New Orleans, LA, USA

DOI: 10.1111/j.1743-6109.2008.01001.x

Table 1 The effect of finasteride on sexual function

	Decreased libido rate (%)/placebo	Erectile dysfunction rate (%)/placebo	Ejaculation disorder rate (%)/placebo
Lepor et al.	5.0/1	9.0/5	2.0/1
Marberger et al. [56]	4.0/2.8	6.6/4.7	2.1/0.6
PLESS study	2.6/1.3	5.1/2.2	0.9/0.8
Mondaini et al.*	7.7	9.6	5.7
Stoner	4.3/2.5	5.0/2.0	3.5/1.1
Nickel et al.	10.0/6.3	15.8/6.3	7.7/1.7
Byrnes et al.	3.1/1.2	6.8/3.2	2.3/0.5
Gormley et al.	4.7/1.3	3.4/1.7	4.4/1.7
Zlotta et al.*	—	38.6	—
MTOPS study	2.3/1.4	4.5/3.3	1.7/0.8

*No placebo group.
PLESS = Proscar™ Long Term Efficacy and Safety Study; MTOPS = Medical Therapy of Prostatic Symptoms.

Table 2 The effect of dutasteride on sexual function

	Decreased libido rate (%)/placebo	Erectile dysfunction rate (%)/placebo	Ejaculation disorder rate (%)/placebo
Roehrborn et al.	4.2/2.1	7.3/4.0	2.2/0.8
Andriole et al.	5/1.4	7/1.7	1/0.5
Desgrandchamps et al.*	4	7	<1

*No placebo group.

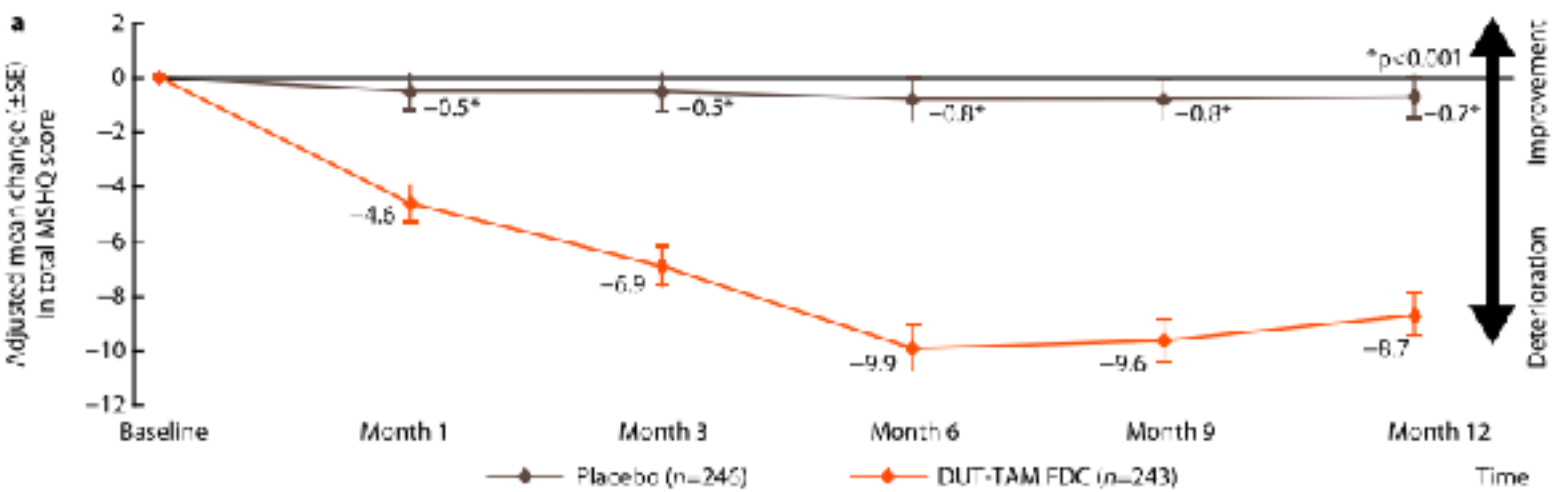
Inhibidores 5α-reductasa

A prospective randomised placebo-controlled study of the impact of dutasteride/tamsulosin combination therapy on sexual function domains in sexually active men with lower urinary tract symptoms (LUTS) secondary to benign prostatic hyperplasia (BPH)

BJU Int 2018; **121**: 647–658

Claus G. Roehrborn[*], Michael J. Manyak[†], Juan Manuel Palacios-Moreno[‡], Timothy H. Wilson[§], Erik P.M. Roos[¶], Javier Cambronero Santos[**], Dimitrios Karanastasis[††], Janet Plastino[‡‡], François Giuliano[§§] and Raymond C. Rosen[¶¶]

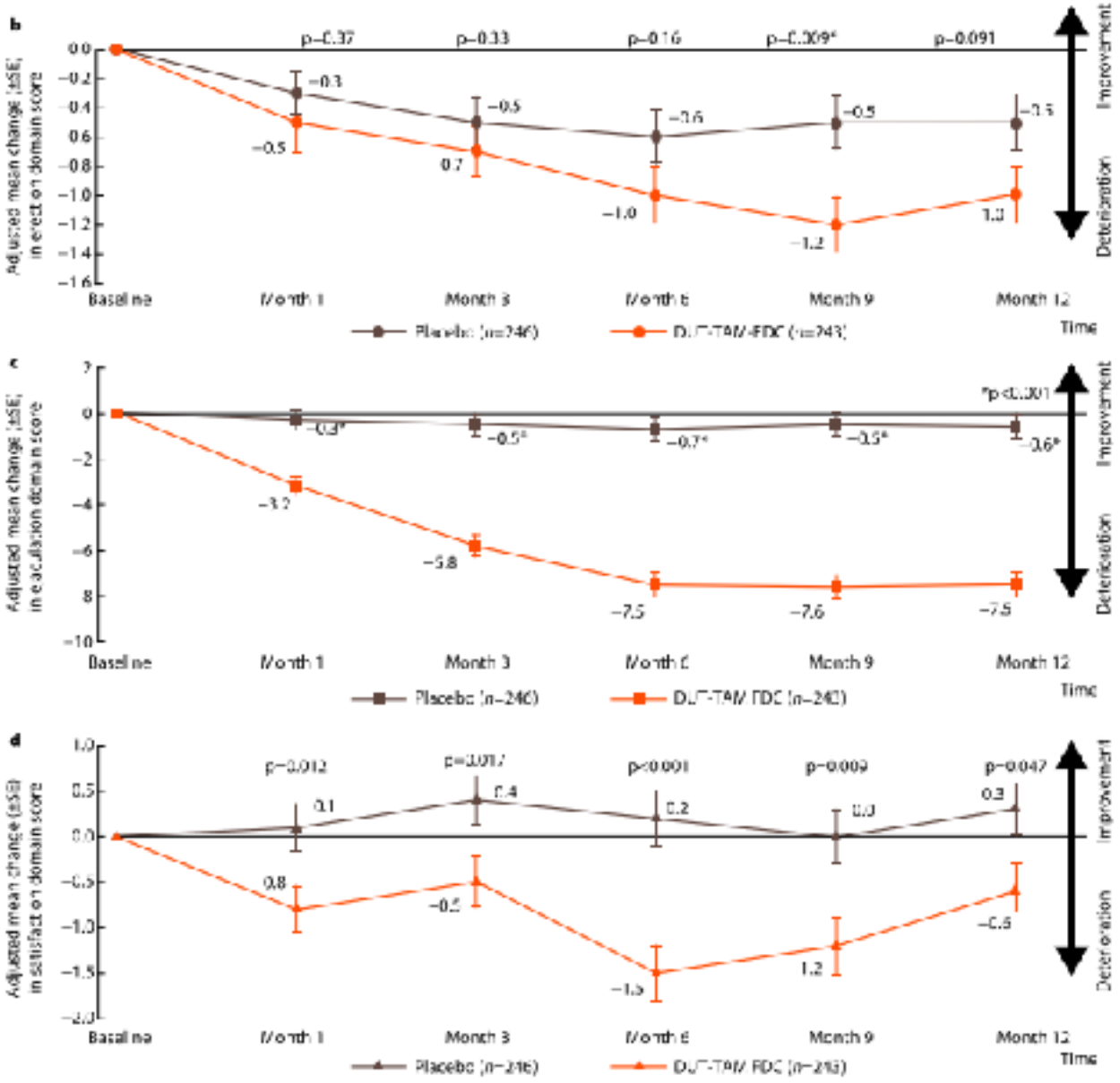
[*]Department of Urology, University of Texas (UT) Southwestern Medical Center, Dallas, TX, USA, [†]GlaxoSmithKline (GSK), Washington, DC, USA, [‡]GSK, Madrid, Spain, [§]PAREXEL International, Durham, NC, USA, [¶]Antonius Ziekenhuis Sneek, Sneek, The Netherlands, [**]Hospital Universitario Infanta Leonor, Madrid, Spain, [††]Urologic Clinic, General Hospital of Athens 'Elpis', Athens, Greece, [‡‡]GSK, Collegeville, PA, USA, [§§]Neuro-Urology R. Poincare Hospital AP-HP, Garches, UMR1179 Inserm-UVSQ-Paris Saclay University, Paris, France, France, and [¶¶]New England Research Institutes, Watertown, MA, USA



Inhibidores 5α-reductasa

A prospective randomised placebo-controlled study of the impact of dutasteride/tamsulosin combination therapy on sexual function domains in sexually active men with lower urinary tract symptoms (LUTS) secondary to benign prostatic hyperplasia (BPH)

Claus G. Roehrborn*, Michael J. Manyak†, Juan Manuel Palacios-Moreno‡, Timothy H. Wilson§, Erik P.M. Roos¶, Javier Cambronero Soriano**, Dimitrios Karanastasis††, Janet Plasilno‡‡, François Giuliano§§ and Raymond C. Rosen¶¶



Inhibidores 5α-reductasa

A prospective randomised placebo-controlled study of the impact of dutasteride/tamsulosin combination therapy on sexual function domains in sexually active men with lower urinary tract symptoms (LUTS) secondary to benign prostatic hyperplasia (BPH)

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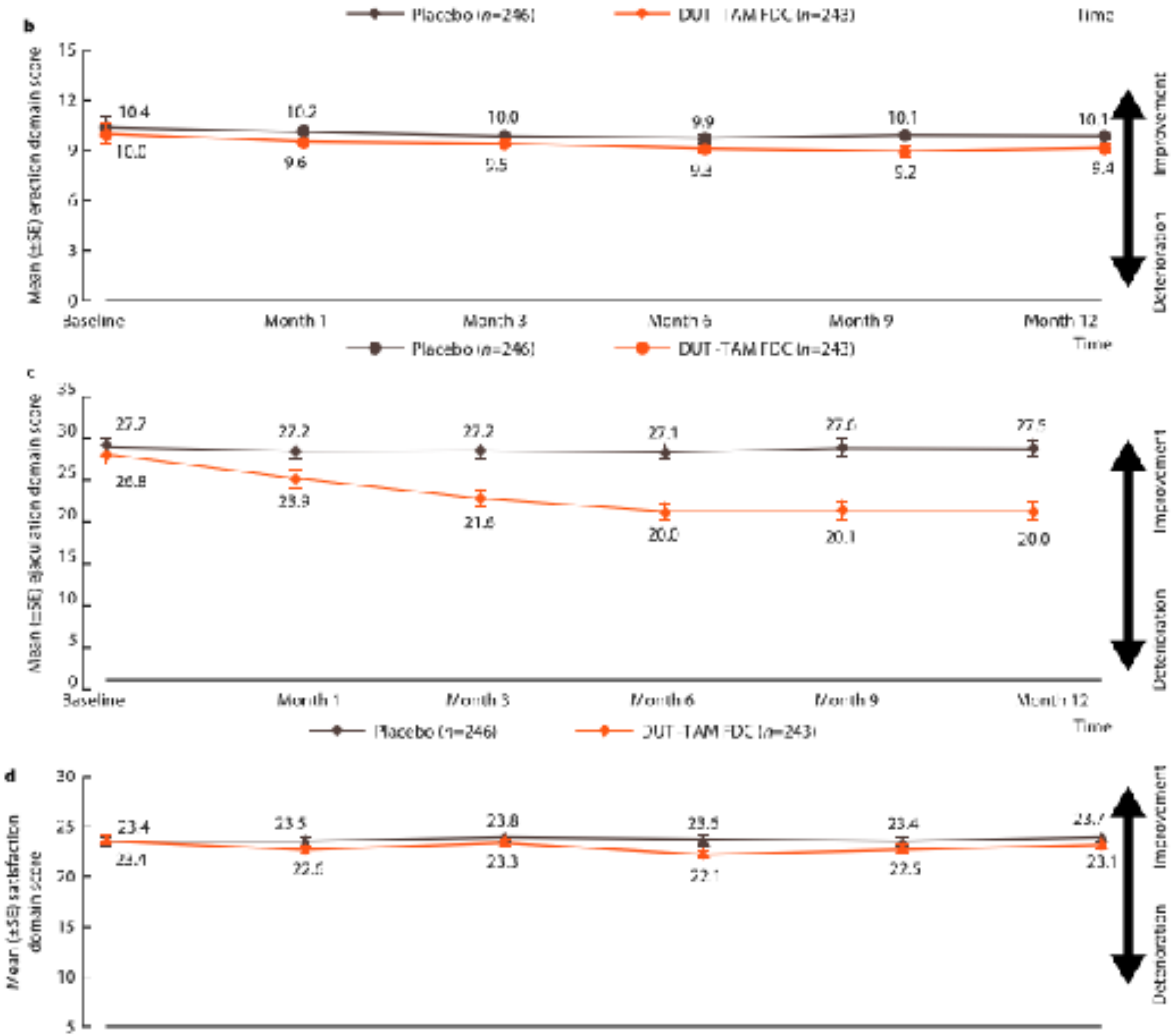

Terapias mínimamente invasivas

- Se incluyen : Termoterapia transuretral con microondas (TUMT), ablación transuretral con aguja (TUNA) y coagulación intersticial con láser (ILC)
- TUMT vs RTU
  - N:1493, RR eyaculación 0.39 /RR erección 0.41
- TUNA
  - Metaanálisis. Disfunción eréctil 0.3%.Eyaculación retrógrada 0.2%
  - TUNA vs RTU: resultados mejores en efectos secundarios “sexuales”.
- ILC
  - Mejoría de los scores “sexuales”, en el brazo de ILC a los 6 meses y 2 años

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Vol. 164, 1256–1261, October 2000
Printed in U.S.A.

IMPACT OF INTERVENTIONAL THERAPY FOR BENIGN PROSTATIC HYPERPLASIA ON QUALITY OF LIFE AND SEXUAL FUNCTION: A PROSPECTIVE STUDY

YOICHI ARAI,* YOSHITAKA AOKI, KAZUTOSHI OKUBO, HIROSHI MAEDA, NAOKI TERADA, YOSUKE MATSUTA, SHINYA MAEKAWA AND KEIJI OGURA

From the Department of Urology, Kuroshio Central Hospital, Kuroshio, Japan

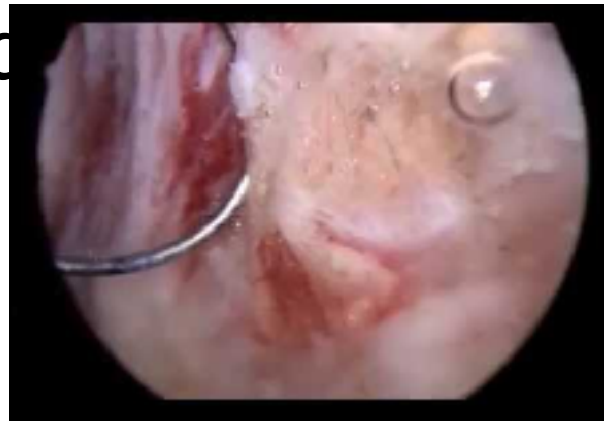
TABLE 3. *Sexual function and impact on sex life*

	Transurethral Resection	Microwave Thermotherapy	Laser Coagulation	Needle Ablation	p Value (ANOVA)
Sexual desire score (0–10):					
Mean baseline (SD)	2.7 (1.8)	3.2 (1.7)	3.3 (2.0)	2.9 (1.9)	0.465
Mean 3 mos. (SD)	2.7 (1.9)	3.3 (1.8)	3.1 (1.9)	3.0 (1.7)	0.646
p Value (t test)	0.921	0.913	0.368	0.923	
No. degree change in sexual desire score 3 mos. (%):					
Decreased by 2 or more	7 (13.7)	3 (9.1)	7 (18.4)	6 (17.1)	
Changed by 1 or less	38 (74.5)	27 (81.8)	28 (73.7)	21 (60.0)	
Increased by 2 or more	6 (11.8)	3 (9.1)	3 (7.9)	8 (22.9)	
Erectile function score (0–10):					
Mean baseline (SD)	3.1 (2.4)	4.2 (2.5)	4.0 (2.4)	3.5 (2.4)	0.183*
Mean 3 mos. (SD)	3.0 (2.6)	4.1 (2.3)	3.7 (2.5)	3.2 (2.2)	0.161*
p Value (t test)	0.831	0.919	0.49	0.363	
No. degree change in erectile function score 3 mos. (%):					
Decreased by 2 or more	13 (26.5)	6 (18.2)	7 (18.4)	7 (20.0)	
Changed by 1 or less	26 (53.1)	22 (66.7)	28 (73.7)	22 (62.9)	
Increased by 2 or more	10 (20.4)	5 (15.2)	3 (7.9)	6 (17.1)	
No. amount ejaculate 3 mos. (%):					0.039†
None	12 (30.8)	6 (19.4)	2 (5.3)	7 (18.9)	
Severely decreased	7 (18.0)	3 (9.7)	7 (18.4)	2 (5.4)	
Moderately decreased	8 (20.5)	7 (22.6)	6 (15.8)	8 (21.6)	
Somewhat decreased	5 (12.8)	3 (9.7)	3 (7.9)	3 (8.1)	
Same	7 (17.9)	12 (38.7)	20 (52.6)	17 (45.9)	
No. impact sex life (%):					0.13‡
Much better	0 (0)	1 (3.1)	3 (7.7)	0 (0)	
Better	8 (17.8)	2 (6.3)	6 (15.4)	7 (18.9)	
Slightly better	2 (4.4)	6 (18.8)	2 (5.1)	3 (8.1)	
Same	21 (46.7)	17 (53.1)	23 (59.0)	20 (54.1)	
Slightly worse	5 (11.1)	3 (9.4)	5 (12.8)	4 (10.8)	
Worse	6 (13.3)	2 (6.3)	0 (0)	3 (8.1)	
Much worse	3 (6.7)	1 (3.1)	0 (0)	0 (0)	

Data not available for some patients.
* Microwave thermotherapy $p < 0.05$ versus resection.
† Laser coagulation $p < 0.01$ versus resection, needle ablation $p < 0.05$ versus resection.
‡ Laser $p < 0.05$ versus resection.

Tratamientos Quirúrgico Estándar

- Gold Standar: RTU de próstata
- Hasta un 13% refieren DE tras RTU próstata.
  - Causa: Neuroapraxia por c
    térmico o lesión capsular



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Resección Transuretral Próstata

Incidence of Erectile Impotence Secondary to Transurethral Resection of Benign Prostatic Hyperplasia, Assessed by Preoperative and Postoperative Snap Gauge Tests

Reto Tscholl, Mario Largo, Ellen Poppinghaus, Franz Recker, Branislav Subotic
From the Department of Surgery, Urological Clinic, Kantonsspital Aarau, Aarau, Switzerland

May 1995 Volume 153, Issue 5, Pages 1491-1493

- Se tratan 98 pacientes
- Se evalúa a la 4a noche:
  - 64 pacientes potentes y 34 pacientes no potentes.
  - Se reevalúa a los 3 meses , 8 pacientes permanecen impotentes.
  - Riesgo de impotencia:
    - 35% INMEDIATA
    - 8% A LOS 3 MESES

ORIGINAL ARTICLE

A Comparison of Transurethral Surgery with Watchful Waiting for Moderate Symptoms of Benign Prostatic Hyperplasia

January 12, 1995
N Engl J Med 1995; 332:75-79
DOI: 10.1056/NEJM199501123320202

John H. Wasson, M.D., Domenic J. Reda, M.S., Reginald C. Bruskewitz, M.D., Jack Elinson, Ph.D., Adam M. Keller, M.P.H., and William G. Henderson, Ph.D. for the Veterans Affairs Cooperative Study Group on Transurethral Resection of the Prostate*

Table 3. Genitourinary Findings and Quality of Life after Three Years of Follow-up.*

Outcome	Surgery	Watchful Waiting	P Value
	mean ±SD		
Genitourinary findings			
Symptom score†			
At 3 years	4.9±4.6	5.1±4.7	
Change from base line	−9.6±5.6	−5.5±5.2	<0.001
Residual urinary volume (ml)			
At 3 years	51±51	72±73	
Change from base line	−60±84	−41±90	0.015
Peak urinary-flow rate (ml/sec)			
At 3 years	17.8±9.1	12.7±7.6	
Change from base line	6.9±9.7	0.4±5.2	<0.001
Quality-of-life scores‡			
Bother from urinary difficulties			
At 3 years	75.7±23.9	59.6±28.3	
Change from base line	33.6±29.4	9.6±29.7	<0.001
Sexual performance			
At 3 years	55.0±26.0	55.6±25.6	
Change from base line	−3.0±27.9	−2.2±26.6	0.920
Activities of daily living			
At 3 years	[illegible]	[illegible]	
Change from base line	19.6±26.5	0.4±30.5	<0.001
General well-being			
At 3 years	76.2±27.8	71.4±31.0	
Change from base line	3.0±25.5	0.1±28.2	0.317
Social activities			
At 3 years	73.3±25.3	72.1±25.5	
Change from base line	−1.6±24.3	−1.7±23.5	0.945

*The average period of follow-up was 2.8 years. Change denotes change from the base-line value. P values are for differences between the two treatment groups with respect to change in genitourinary findings and quality of life.

†On a scale ranging from 0 (least severe symptoms) to 27 (most severe symptoms).

‡On a scale ranging from 0 (greatest impairment) to 100 (least impairment).

European Urology Supplements

European Urology Supplements 2 (2003) 13–20

LUTS and Sexual Dysfunction: Implications for Management of BPH

Jeroen van Moorselaar*

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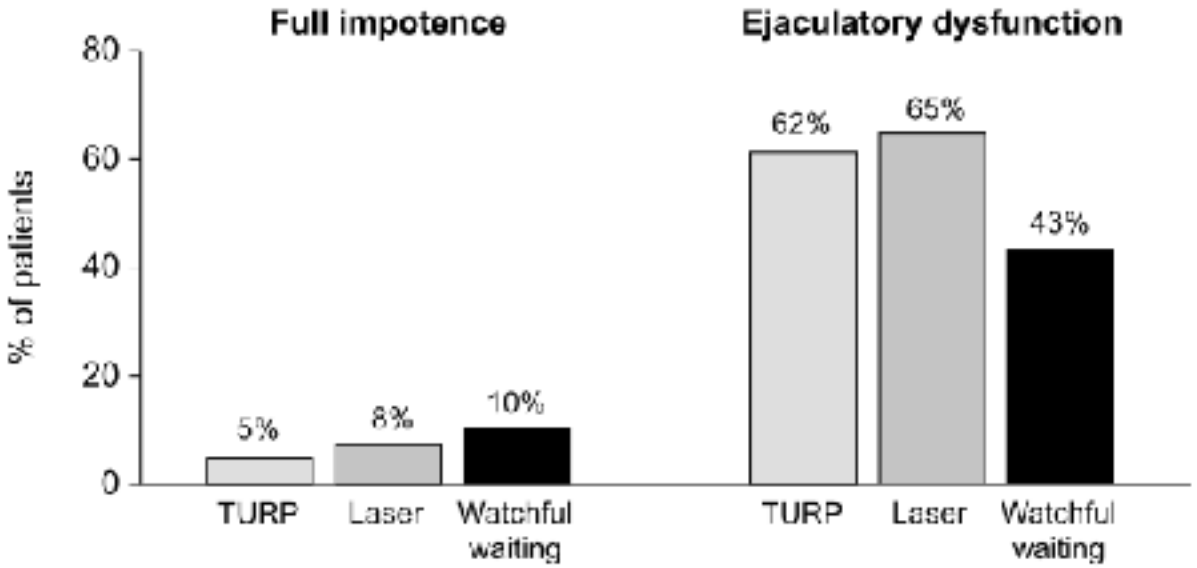


Fig. 2. New cases of impotence and ejaculatory dysfunction at 7.5 months follow-up.

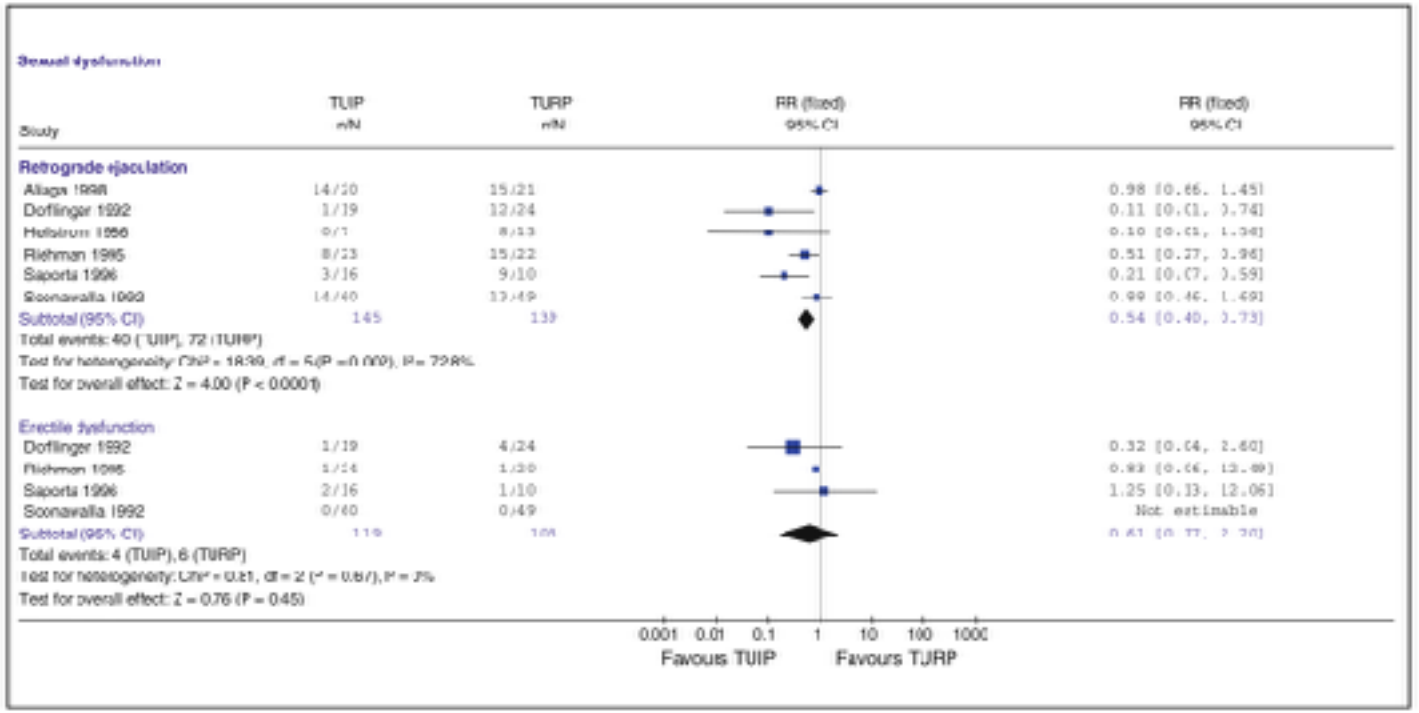
World J Urol (2010) 28:23–32
DOI 10.1007/s00345-009-0456-8

TOPIC PAPER

The clinical effectiveness of transurethral incision of the prostate: a systematic review of randomised controlled trials

Tania Lourenco · Matthew Shaw · Cynthia Fraser · Graeme MacLennan · James N'Dow · Robert Pickard

Sexual dysfunction



Erectile dysfunction after prostatectomy: An evaluation of the risk factors

Mohammad Soleimani, Seyyed Yousef Hosseini, Majid Aliasgari, Farid Dadkhah, Alireza Lashay & Erfan Amini

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Among 184 patients with mild or no ED, 23 (12.5%) showed moderate to severe ED postoperatively. Hypertension, DM, perioperative haemorrhage, higher cardiac index and older age were found to be risk factors for postoperative ED (Table II).

	Al inicio- Prevalencia	Postoperatorio- Nuevos casos
RTU-Próstata	24.6%	13.4%
Adenomectomía	25.9%	11.25%

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Original Article

Changes in Erectile Function after Photoselective Vaporization of the Prostate with a 120-W GreenLight High-Performance System Laser: 2-Year Follow-Up

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Department of Urology, SMG-SNU Boramae Medical Center, Seoul National University College of Medicine, Seoul, Korea

CONCLUSIONS

The erectile function declined in all the groups after PVP, with an especially significant deterioration observed in patients with normal preoperative erectile function. Preoperative BMI was the only independent risk factor for a meaningful decrease in erectile function after PVP.

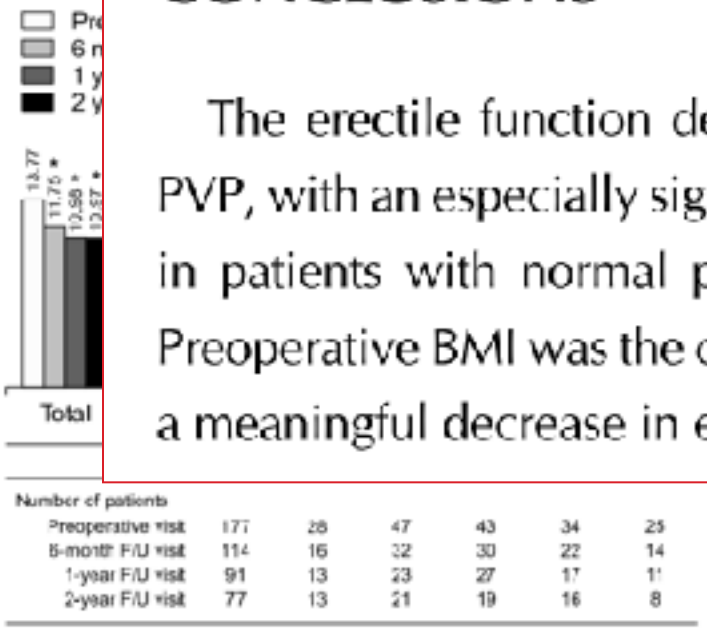

Fig. 2. Change in mean International Index of Erectile Function

Erectile Function
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17–21, n=34],
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Int Urol Nephrol (2013) 45:961–966
DOI 10.1007/s11255-013-0489-9

UROLOGY - ORIGINAL PAPER

The volume of prostate can impact the male sexual function following photoselective vaporization of the prostate: results of a prospective analysis of 128 patients with 2-year follow-up

Zhen Guo · Xunbo Jin

Table 4 Adverse sexual outcomes(score ≤2) in IIEF-5 questionnaires at 6 12 and 24 months

	6 months			12 months			24 months		
	Group I (%)	Group II (%)	*p* value	Group I (%)	Group II (%)	*p* value	Group I (%)	Group II (%)	*p* value
Erectile function *n* (%)	11 (19.0)	32 (45.7)	<0.001	13 (22.4)	36 (51.4)	<0.001	15 (25.8)	46 (65.7)	<0.001
Intercourse satisfied *n* (%)	10 (17.2)	16 (22.9)	0.431	17 (29.3)	24 (34.3)	0.548	22 (37.9)	35 (50.0)	0.172
Orgasmic function *n* (%)	5 (8.6)	9 (12.9)	0.444	7 (12.1)	11 (15.7)	0.554	8 (13.8)	13 (15.6)	0.467
Sexual desire *n* (%)	7 (12.1)	10 (14.3)	0.712	9 (15.5)	11 (15.7)	0.976	10 (17.2)	13 (18.6)	0.845
Overall satisfaction *n* (%)	12 (20.7)	33 (47.1)	0.002	17 (29.3)	38 (54.3)	0.004	20 (34.5)	47 (67.1)	<0.001

2009–2011 were enrolled. We divided all patients into two groups group I (<70 ml, $n = 58$) and group II (≥70 ml, $n = 70$) according to the volume of prostate. Two group patients were assessed by International Index of Erectile Function (IIEF-5) preoperatively and at 1, 3, 6, 12, and 24 months. We measured the IPSS,

Y en mujeres…

THE JOURNAL OF
SEXUAL MEDICINE

Does the Severity of Overactive Bladder Symptoms Correlate With Risk for Female Sexual Dysfunction?

Cássia Raquel Teatin Juliato, MD, PhD,[1] Iane Gleuce Ribeiro Melotti, MD,[2] Luiz Carlos Santos Junior, MSc,[1] Luiz Gustavo Oliveira Brito, MD, PhD,[1] and Cássio Luiz Zanettini Riccetto, MD, PhD[3]

Table 3. Relation between ICIQ-OAB and FSFI in postmenopausal

Table 2. FSFI and ICIQ-OAB scores

	Total (N = 267)	Premeropausal (n = 122)	Postmenopausal (n = 145)	*P* value
ICIQ-OAB	10 ± 3.7	9.7 ± 3.2	10.2 ± 3.2	*P* = .28741
FSFI				
Total	19.2 ± 9.8	23.3 ± 7.7	15.7 ± 9.9	*P* < .0001
Desire	3.1 ± 1.3	3.4 ± 1.3	2.7 ± 1.3	*P* < .0001
Arousal	2.9 ± 1.9	3.7 ± 1.6	2.2 ± 1.9	*P* < .0001
Lubrication	3.3 ± 2.2	4.3 ± 1.7	2.5 ± 2.2	*P* < .0001
Orgasm	2.9 ± 2.1	3.6 ± 1.8	2.2 ± 2.1	*P* < .0001
Satisfaction	3.6 ± 1.7	4.1 ± 1.7	3.2 ± 1.7	*P* < .0001
Pain	3.4 ± 2.2	4.2 ± 1.7	2.8 ± 2.4	*P* < .0001

FSFI = Female Sexual Function Index; ICIQ-OAB = International Consultation on Incontinence Questionnaire Overactive Bladder.

tion on Incontinence Questionnaire Overactive Bladder; r = Spearman correlation coefficient.

Overactive Bladder and Women's Sexual Health: What is the Impact?

Karin S. Coyne, PhD, MPH,* Mary Kay Margolis, MPH, MHA,* Zhanna Jumadilova, MD,† Tamara Bavendam, MD,† Elizabeth Mueller, MD,‡ and Rebecca Rogers, MD§

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DOI: 10.1111/j.1743-6109.2007.00493.x

J Sex Med 2007;4:656–666

Table 3 OAB-q and SQoL-F scores

Mean (SD)	Overall N = 34	Continent N = 11	Incontinent N = 23
OAB-q*			
Symptom bother	56.6 (21.3)	54.3 (18.5)	57.7 (22.8)
Coping	48.0 (29.7)	42.3 (29.9)	50.8 (29.9)
Concern	40.1 (27.6)	41.3 (25.7)	39.5 (29.0)
Sleep	49.5 (32.4)	49.5 (29.1)	49.6 (34.4)
Social interaction	65.3 (24.6)	60.7 (28.4)	67.5 (22.9)
HRQL total	49.6 (25.6)	47.1 (24.7)	50.7 (26.4)
SQoL-F† Total Score	45.6 (24.0) (N = 33)	38.7 (24.9)	49.1 (23.4)

*Higher symptom bother scores indicate greater levels of symptom bother; higher HRQL scores indicate higher levels of HRQL. Both scales 0–100.
†Higher scores indicate higher levels of sexual quality of life on a 1–100 scale.
OAB-q, Overactive Bladder Questionnaire; SQoL-F, Sexual Quality of Life Questionnaire—Female; HRQL, health-related quality of life.

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Table 4 Aspects of sexual health and their impact on women with continent and incontinent OAB

	Continent women	Incontinent women
Sexual desire	• Maintain sexual desire • Frustration associated with pain or discomfort during intercourse, urinary frequency, and urgency	• Decreased sexual desire • Factors: menopause, aging, hysterectomy, fear of odor and/or incontinence, loss of self-confidence, embarrassment
Sexual arousal	• Increased length of time needed for arousal • Factors: tension related to expectation of pain and urgency	• Increased length of time needed for arousal • Factors: fear of incontinence, inability to relax, and interruptions to visit the bathroom to urinate
Vaginal lubrication	• Not a concern	• Not a concern
Orgasm	• Increased length of time to achieve orgasm • Factors: fear and anxiety related to either actual or possible pain or discomfort during intercourse (and resulting inability to relax); and urinary urgency and resulting interruptions to visit the bathroom	• Able to achieve orgasm, but may not allow self to do so • Factors: preventive measure to avoid leaking urine (inability/unwillingness to relax and rushing partner to climax before leaking occurs)
Sexual satisfaction	• Not satisfied • Factors: frustration, pain, discomfort	• Not satisfied • Factors: Lack of orgasm, partner dissatisfaction
Self-image/self-confidence	• Not an issue	• Low self-image and loss of self-confidence • Factors: Feeling of a loss of sexuality, femininity, desirability
Relationship with sexual partner	• Negative impact on relationship • Factors: loss of intimacy, loss of sexual relations, interruptions in intercourse, fear of rejection	• Variable impact on relationship • Factors: acceptance of condition by partner, accommodating nature of partner, fear of rejection by new partner
Coping behaviors	• Employed • Examples: avoidance, massage, "grin and bear it"	• Employed • Examples: masturbation, showering prior to intercourse, having intercourse in the shower, padding the bed with towels or rubber sheets

Overactive Bladder and Women's Sexual Health: What is the Impact?

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DOI: 10.1111/j.1743-6109.2007.00458.x

Sexual Desire—Continent Women

For the most part, continent women maintained their level of sexual desire; however, the frustration associated with pain, frequency, and urgency reduced their initiation of (and response to) sexual intercourse.

> I have the desire for it, but once I start, [it dawns on me] what was I thinking? That is very frustrating because I have always had a really high sex drive.

> When my husband and I try to have sex, it's just sometimes the pressure. [I say], "Oh, just get off of me. It just hurts," and he doesn't know what he's doing wrong, and I don't know how to explain it. It's this huge amount of pressure, or if he goes in a certain position, [I say], "Oh, no way. That hurts so bad. You can't"—and it's just not enjoyable for me.

Sexual Satisfaction—Continent Women

Four continent women were more concerned with their partner's satisfaction than their own; however, the majority of continent women with OAB (N = 8) were not satisfied with their sex life and found it "limiting and frustrating."

> Well, there is no satisfaction.
>
> I am divorced, so that whole husband thing doesn't bother me, I want to satisfy me, and it is just not happening at all.
>
> I enjoy having sex, and I'm not happy that there's something causing me to not enjoy it.

Conclusiones

- Los LUTs por HBP y disfunción eréctil comparten fisiopatología.
- Todos los tratamientos potencialmente puede afectar a función sexual.
- Los riesgos han de ser discutidos con el paciente previo al tratamiento.
- Y el aumento de la calidad de vida tras inicio de tratamiento puede mejorar la función sexual.

MUCHAS GRACIAS

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