

ERECTILE DYSFUNCTION (ED)? – REASONS & POSSIBLE REMEDIES **Compiled by Charles (Chuck) Maack – Prostate Cancer Advocate**

The following is a lengthy compilation of important information regarding Erectile Dysfunction. For those truly interested in this subject, it is my opinion that taking the time to read this entire paper will provide you a more thorough understanding of Erectile Dysfunction, possible remedies, and an importance regarding intimacy you may never had realized.

I was reviewing a “Special Report” from the American Prostate Society published way back in the summer of 1996 regarding male impotence. It appears very little has changed over these subsequent years other than PDE-5 inhibitors coming to the fore. I want to share some of the interesting aspects of that report. As far back as the mid 1980s health care professionals had treated impotence as “all in the mind.” Even the men experiencing this problem came to believe that “if I can get my head straightened out” all would return to normal. Shame and embarrassment were so strong men wouldn’t even discuss this most intimate problem with a doctor. It was a no-win situation made worse by the man’s partner justifiably wondering why she was no longer sexually attractive. Does this sound familiar? The report said back then and holds true today that any man who thinks time and hope will take care of his problem is deluding himself. This is one problem that won’t go away; time just aggravates his situation. I found it interesting that the first step in ending male sexual incapability is to stop thinking of it as “impotence.” “Impotence” means a lack of power and strength, and power and strength have nothing to do with making love. Any man who thinks of himself as “impotent” is not just wrong; he is putting himself down. The more accurate term is “Erectile Dysfunction;” what the condition really is: an inability to attain and maintain an erection sufficient to complete sexual intercourse more than half the time sex is desired. This means rigidity as well as duration. Back in 1996 experts believed more than 30 million men in the U.S. were suffering from erectile dysfunction to some degree. This has unlikely changed. Back then, and I would venture to say even now, one man in two experiences this problem to some degree between the ages of 40 and 70. It is an equal opportunity affliction affecting men of every race, religion, and station in life. Even then it was considered that when those numbers are expanded to include women as partners in sexual relationships, that we begin to understand the enormous impact of erectile dysfunction in the United States. The trigger for penile erection is sexual stimulation reaching the brain. The brain responds to the stimulation by signaling the heart to pump more blood into the penile arteries. These arteries promptly dilate to twice normal size. Blood-flow jumps sixteen times normal. As blood-flow increases in the arteries, it partly blocks the veins

and traps the arterial blood. The two channels of the penis called “Corpus cavernosa” become so full of blood the penis lengthens and can double its cubic size. All of this can take place in a normal man within 60 seconds! This marvelously elaborate system happens, or it doesn’t, depending on the flow of blood. If any part of the process breaks down, getting or keeping an erection becomes impossible. The system can break down from many causes; mental/emotional problems, a new partner, stress, anxiousness, fear of sexual failure, disease involving the blood vessels, hypertension, diabetes, elevated cholesterol, some medications for high blood pressure, diffuse arterial disease (blockages in the small penile arteries), venous leak (though blood flows properly into the corpus cavernosa, the veins are not compressed to hold it where it is needed). Age plays a role since as men get older, the corpus cavernosa can lose their ability to stretch. When this happens, the chambers do not enlarge to accept an increase in blood sufficient to squeeze the veins and hold the blood in place. Other causes: low testosterone, damage to the nerves, muscles, or bones in the groin area, and tobacco. Alcohol’s impact on the libido and sexual capability is well put in the saying “As whiskey make desire go up, ability goes down.” The methods to counter some of these problems are nearly the same today as they were those several years ago. PDE-5 inhibitors were not yet available. Trazadone and Ginseng where sometimes considered as aphrodisiacs that might dilate the penile arteries to an indefinite, varying extent. And then, as now, the use of Muse (not very popular), Vacuum Erection Devices (VEDs), penile injections, and penile implants continue as the few methods to hopefully counter erectile dysfunction. Somewhat a sad commentary that other than PDE-5 inhibitors, nothing has changed. Men experiencing this affliction should be aware that they are not alone. They are rather in company with likely several million other men just here in the United States. And when this occurs and cannot be remedied, I invite your attention to the final paragraph in this paper just prior to the ending disclaimer.

An important paper titled “Persistent Erectile Dysfunction Following Radical Prostatectomy: The Association between Nerve-Sparing Status and the Prevalence and Chronology of Venous Leak” describes reasoning for difficulty regarding erectile function. Certainly worth a read to have some idea why you may be experiencing this difficulty. Go to: www.pubmed.gov then enter 19686421 in the search box).

I also recommend you read the information in this URL regarding penile rehab following surgery:

<http://www.andrologyjournal.org/cgi/rapidpdf/jandrol.108.005835v1>.

In line with the information in the foregoing URL, even prior to, then again following surgical removal of the prostate or complications following radiation therapy, it is important to begin penile rehabilitation.

According to likely the foremost authority on penile rehabilitation, Dr. John Mulhall of Memorial Sloan-Kettering Cancer Center (MSKCC), and contrary to the opinions of some, the Vacuum Erection Device (VED) will not provide appropriate penile rehab. The VED does draw venous blood into the penis but it has no effect on arterial blood. And it is arterial blood that is necessary to oxygenate the tissues in the penis. PDE5 inhibitors (sildenafil/Viagra, Vardenafil/Levitra, or tadalafil/Cialis) provide this function, and this function is enhanced by penile injections. Both the PDE5 inhibitors and penile injections serve to provide increased arterial oxygenation, erection muscle protection, endothelium protection, neuroregeneration, increased prostaglandin secretion, collagen chemical blockage, and preservation of erectile tissue. PDE5 inhibitors are also helpful for vascular health, and the foregoing penile rehab should be practiced for those on androgen deprivation therapy to prevent penile atrophy. Renowned Medical Oncologist Charles E. "Snuffy" Myers explains that it is important that arginine cleave to release nitric oxide in order for arteries going to the penis to relax. Radiation stops the artery wall from making this necessary nitric oxide. The use of PDE5 inhibitors help the arteries relax for access of external nitric oxide. In Dr. Myers case, he personally prefers the prescribing of vardenafil/Levitra at a higher dose to be taken every Monday, Wednesday, and Friday as opposed to a low dose taken daily. He remarks that his patients have improvement over subsequent months of usage. The longer one avoids the use of PDE5 inhibitors and/or penile injections to provide this necessary arterial blood flow into, and oxygenation of, penile tissues, the more difficult it will be to later regain erectile function. Since health insurers often refuse to cover increased use of PDE5 inhibitors, considering such use to be for sexual satisfaction, Dr. Myers remarked that with his providing a letter to insurers explaining that the increased use is not for sexual satisfaction but rather for penile rehabilitation following radiation or surgery, insurers have complied.

A point Dr. Mulhall emphasized is that we men are given all the wrong expectations, and not even explained what all might, or is most likely going to occur when we are treated with surgical removal of the gland or radiation. He remarked that physicians should be forthcoming with a full explanation of what a man can anticipate regarding erectile dysfunction following whatever treatment he is being administered. Rarely are we provided such information, and more often

we are told that "there are several things we can do to help get an erection." The trauma experienced by neurovascular bundles requires appropriate post RP or RT care, and even then can take several months to a few years to reasonable erectile function. And such return depends on pre-treatment function, age, delay in post treatment rehab, and other factors. Younger men may have earlier return of erectile function, whereas the older we get, the longer it may take. Key, again, is beginning penile rehab is early as possible and that can mean beginning daily or very frequent use of PDE5 inhibitors some weeks prior to treatment, then continuing post treatment, with penile injections beginning 4 weeks post-op if the PDE5 inhibitors have not resulted in a natural erection by that time. And keep in mind that this is for penile rehab and not for sexual intercourse in less than six weeks post treatment. In checking my "Saving Your Sex Life" book by Dr. Mulhall, I concluded that as long as a PDE5 inhibitor appears to be resulting in an erection within a couple weeks post-surgery, you won't have to begin penile injection therapy. However, if you are not getting natural or suitable erections with a PDE5 inhibitor by four weeks post-surgery, that would be the time to begin penile injections. And he encourages getting two to three erections every week. If your choice is Cialis, then 5mg is preferred. If taking Viagra and getting a 100mg pill, it should be broken into four pieces with around 25mg to 50mg taken daily. If taking Levitra that comes as a 20mg small pill, try to split in at least two and if possible, four, and take as low dose with 5 or 10mg daily. Dr. Mulhall appears to be more supportive of Viagra or Levitra, and I think this is more because Cialis is a stronger inhibitor and remains in the blood much longer than the other two inhibitors. It appears if taken daily, it could result in a longer lasting erection that could become of some concern if it isn't "receding." in a reasonable time. And I note that if one is taking one of these PDE5 inhibitors, that they skip taking on the day they use penile injection; with much more particular attention in doing so if taking Cialis. He does recommend to take these inhibitors at night. Anyone taking PDE5 inhibitors should check the side effects that one might experience from the medication. Another note is that patients whose treatment has been radiation should take a low dose inhibitor for at least 12 months. He makes note that there is no evidence this is absolutely necessary, but he prefers this be done for more appropriate penile rehabilitation. Recognizing that PDE5 inhibitors can become expensive, and that those with health insurance that covers some oral medication find their insurer will only cover a small number of inhibitors per month, patients may want to consider ordering their Viagra or Levitra from www.alldaychemist.com at a much reduced cost. Also, a prescription is not required and you can order as needed. Patients must recognize that this manufacturer is in India, but if one does some research, we find that a great majority of the drugs provided for sale here in the U.S. at much higher expense are

actually manufactured overseas, with India being one of the primary suppliers. In monitoring the many prostate cancer support lists, many men have reported ordering/purchasing their Viagra and Levitra from this source and noted no difference in effectiveness. So, the choice is yours. Cialis is not available from this source, but can be ordered from another source in India, www.securetabs.com.

Dr. Mulhall explained that it means nothing following RP to hear your physician remark that "all went well" and "I spared the nerve bundles (either both or one side)" or "the nerve bundles looked good." If the nerve bundles experienced damage, and they most likely will from the trauma of surgery or radiation, they can go into a sort of coma for up to 12 months, and it can take another 12 months of recovery.

It is absolutely important to take the time to open the following URL, then click and view video presentations made by Dr. Mulhall at Memorial Sloan Kettering Cancer Center in NYC regarding sexual dysfunction that covers erectile dysfunction, penile rehabilitation, testosterone replacement therapy, and addresses most all sexual concerns addressed by men following surgery or radiation for prostate cancer. If in the presence of others, best to put on earphones then see and hear from likely the most experienced physician in this extensive problem experienced by men:

<http://www.mskcc.org/mskcc/html/94910.cfm>

PC patient and contributor to these support lists, John Mullineaux, provided these remarks: "I am not a doctor. Last year, I was fortunate to hear a presentation by the Director of Men's Sexual Health of a regional medical center (My Note: Dr. Mulhall) in our area. He explained the mechanism of erections and why it is a use it or lose it proposition. Here is what I heard: The outer layer of the two corpora cavernosa is a form of smooth muscle cells. These cells can stretch and expand in both length and width during sexual arousal. They get "exercise" and additional blood supply from our nightly erections. There is an artery that runs down the center of each cavernosa. This supplies the blood flow necessary for an erection. The veins that return that blood run on outside of the smooth muscle tissue with very tiny vessels that enter the cavernosa between the smooth muscle cells. When a man becomes aroused, those nerves that the doc's try and spare send a signal to the arteries to open up. If they do, the penis starts to lengthen and thicken. However, that is only part of the process. As those smooth muscle cells start to expand, they constrict the veins. It is that venous constriction that generates the

penile blood pressure necessary for an erection. After a prostatectomy, if those nerves are traumatized, nightly erections do not occur. Deprived of their exercise and additional blood supply, the theory says those smooth muscle cells begin to develop a plaque like substance that prevents them from stretching and expanding in the future. If this happens to enough of those cells, impotence is the result. Even with injections, the resulting erection will be smaller because some of those cells will not stretch. The speaker's recommendation was men should take daily viagra a month preceding surgery and start injection therapy (but not sexual intercourse) as soon as the catheter is out. The injections only have to produce the lengthening and thickening initially. As healing progresses, the dosage can be increased to produce full erections. He was not convinced of a VED's ability to preserve potency."

I have said in the past and I'll say again that it would behoove both prostate cancer support organizations as well as individuals to consider making a \$149.00 donation to the Prostate Cancer Research Institute (PCRI), and in return for that donation you will receive a set of DVDs that provide each presentation of the several prostate cancer issues reported at the most recent annual PCRI Conference on Prostate Cancer, including the dynamic presentation regarding erectile dysfunction presented by Dr. Mulhall. If interested, go to www.pcri.org. At the very least, one should purchase and thoroughly read the important paperback book by Dr. Mulhall, "Saving Your Sex Life: A Guide For Men With Prostate Cancer." Just go on the internet and type in the subject to find where you can order for under \$15.00 per copy.

To read more about Dr. Mulhall including contact information, please visit:

<http://www.mskcc.org/prg/prg/bios/777.cfm>

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ERECTILE DYSFUNCTION SPECIALISTS

John P. Mulhall, M.D., Memorial Sloan Kettering, NYC, NY. To learn more about this specialist including contact information for an appointment, please visit:

<http://www.mskcc.org/prg/prg/bios/777.cfm>

J. Francois Eid, M.D., 50 East 69th Street, New York, NY 10021, telephone 212-535-6690

<http://www.urologicalcare.com/> (over 3000 implants)

Elias “Jake” Jacobo, M.D., Urology Consultants, 515 West S.R. 434 Suite 302, Longwood, Florida 32750, Tel: Local 407-332-0777 or 1-800-776-8643, Email jakeddoc@aol.com http://www.urologyorlando.com/cv_jacobo.shtml

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OTHER ERECTILE DYSFUNCTION SPECIALISTS (Please note: I have no idea of their expertise)

<http://pcai.pbwiki.com/PCAI%20List%20of%20ED%20Specialists>

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MUSE is occasionally recommended by physicians, but reports I continually read are that not only does it not work very well, but has caused discomfort and even pain to some patients.

Injections certainly work well and do not hurt. Many men reject the idea because they think sticking a needle into their penis would hurt. The needles are very thin and your urologist should provide you a prescription for the mix along with instruction on the appropriate place to inject. The only downside is going through the motions to bring on the erection while the partner is all primed for intercourse. The "upside" (pun intended) is that very good erections result.

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INJECTIONS (PAPAVERINE/BIMIX/TRIMIX)

The following websites describe penile injection therapy for erectile dysfunction:

<http://www.infertility-male.com/erectdys/injxn1.htm>

Patient Guide to Penile Injections:

http://www.ucsfhealth.org/adult/medical_services/urology/male_sexual/injections.html

A prostate cancer survivor who has involved himself in research and study of penile injections and the use of Bimix and Trimix is Michael Holland. He often posts on the pcai@prostatepointers support list in this regard and can be contacted directly for advice and concerns regarding this procedure and appropriate use of the products to be injected. His email address is michaelmaumfh@hotmail.com. If interested in subscribing to the PCAI (Prostate Cancer and Intimacy) support list, here is info:

Prostate Cancer and Intimacy

PCAI is a mailing list for frank and open discussion of the sexual issues surrounding PCa. To subscribe, go to:

<http://www.prostatepointers.org/mailman/listinfo/pcai>

NEW The PCAI Wiki

A collaborative treasure trove of knowledge and help from longtime PCAI subscribers. Please first subscribe to PCAI and then get the wiki URL from the PCAI welcome message.

VACUUM ERECTION DEVICE (VED)

I have observed several exchanges regarding purchasing a Vacuum Erection Device (VED) to help erectile dysfunction issues. Men considering this method of "treatment" should recognize that the VED does NOT aid in penile rehabilitation. It serves no purpose in oxygenating the penis, an effect necessary for penile rehabilitation following surgery or radiation. It does serve to aid in drawing venous blood into the penis that is then hopefully retained in the penis by rubber rings to enable intercourse, but more often than not eventually just does not even serve that purpose very well. Penile injections are much more effective. However, for those interested in purchasing a VED:

Osbon VED info:

<http://www.timmmedical.com/patients/>

Another source is Encore Deluxe VED at <http://tinyurl.com/q7e7st>

You can also find other brands on the internet by entering Vacuum Erection Device in the search box.

As an added bit of info, since "penile shrinking" has also been on support lists recently supposedly occurring because of surgery, Dr. Mulhall says that is rubbish. When the prostate gland is removed, the bladder is stretched down and reconnected to the urethra. The urethra is not a free floating organ. The "shrinkage" is the

result of not following the same directions described above for penile rehabilitation. Doubt the validity of the foregoing? Contact Dr. Mulhall.

For more understanding of Penile Injection for an Erection,

Recommend visiting <https://pcai.pbwiki.com/> then clicking on the folder index "Injections," where Michael Holland has provided the results of his

research and experience.

If not subscribed to pcai@prostatepointers.org, you may have to subscribe before being able to then also subscribe to the pcai.pbwiki site. PCAI is a mailing list for frank and open discussion of the sexual issues surrounding PCa. To subscribe, go to:

<http://www.prostatepointers.org/mailman/listinfo/pcai>.

Information regarding PDE5-inhibiting drugs (Viagra, Levitra, Cialis)

There are now three oral ED drugs: Viagra ([sildenafil](#)) by [Pfizer](#), Levitra ([vardenafil](#)) by [Bayer](#) Pharmaceutical and Glaxo-Smith-Kline-Beecham/Schering Plough, and Cialis ([tadalafil](#)) by Lilly-ICOS.

For all practical purposes, these drugs are the first line of oral [treatment](#) for [males](#) with erectile dysfunction. In certain circumstances in which the males are young, no comorbidities are recognized, and laboratory tests are normal one should look for the etiology of their erectile dysfunction before instituting treatment since the disease process may be more serious than the symptoms, i.e., the ED itself. In some cases, treatment of the primary disease may in fact resolve the [sexual dysfunction](#). However, most men have a cause for their ED as noted by the history and physical examination and the laboratory tests and PDE-5 inhibitors are the first line of choice.

Viagra (Sildenafil)

Discovered by Pfizer, Sildenafil is a potent and selective inhibitor of cGMP-specific phosphodiesterase type 5 (PDE5), which is responsible for

degradation of cGMP in the corpus cavernosum in the penis. This means that, when sildenafil is present in the organism, normal [sexual](#) stimulation leads to increased levels of cGMP in the corpus cavernosum, which leads to better erections. Without [sexual stimulation](#) and no activation of the NO/cGMP system, sildenafil should not cause an erection.

Viagra (Sildenafil) is a member of a family of drugs called PDE5 inhibitors. Viagra was the first PDE5 inhibitor on the market. FDA approved Viagra on March 27, 1998. [Viagra](#)® contains sildenafil citrate packaged as a [pill](#).

Patients receiving sildenafil had a significant improvement in the erectile function

http://www.urotoday.com:80/index.php?option=com_content&task=view_ua&id=2216042

or if won't open, try <http://tinyurl.com/5moca9>

Particular caution should be used when prescribing PDE5 inhibitors for [erectile dysfunction](#) for patients receiving [protease inhibitors](#), including [Reyataz](#). Coadministration of a protease inhibitor with a PDE5 inhibitor is expected to substantially increase the PDE5 inhibitor concentration and may result in an increase in PDE5 inhibitor-associated adverse events, including [hypotension](#), visual changes, and [priapism](#).

PDE5-inhibiting drugs are very effective. PDE5 inhibitor drugs appear to work in men regardless of why they have erectile dysfunction — including vascular [disease](#), nerve problems, and even [psychological](#) causes. PDE5 inhibiting drugs can cause a number of minor [side-effects](#), including [headache](#), lightheadedness, [dizziness](#), flushing, and change in [vision](#). A few men choose not to use one of these drugs because they are bothered by these side-effects.

Studies in vitro have shown that sildenafil is selective for PDE5. Its effect is more potent on PDE5 than on other known phosphodiesterases (10-fold for PDE6, >80-fold for PDE1, >700-fold for PDE2, PDE3, PDE4, PDE7, PDE8, PDE9, PDE10, and PDE11). The approximately 4,000-fold selectivity for PDE5 versus PDE3 is important because PDE3 is involved in control of cardiac contractility. Sildenafil is only about 10-fold as potent for PDE5 compared to PDE6, an enzyme found in the retina that is involved in the

phototransduction pathway of the [retina](#). This lower selectivity is thought to be the basis for abnormalities related to color vision observed with higher doses or plasma levels.

Levitra (vardenafil)

[Levitra](#) was the second oral PDE-5 inhibitor for erectile dysfunction to be [Food and Drug Administration](#) (FDA) approved approximately two years ago. Studies done on Levitra have excluded patients that failed Viagra, and, therefore, the efficacies are somewhat shifted toward the positive. In general, the feeling is that Levitra is more potent and efficient than Viagra as demonstrated by the hard-to-treat groups of [patients](#).

Cialis (tadalafil)

[Cialis](#) has an estimated effective duration of 36 hours; however, there are studies showing high efficacy up to 100 hours. It is not affected by any food whatsoever, and in fact can be taken with pure [fat](#). Viagra, on the other hand, is impeded by any type of food, and Levitra absorption is impeded by a high-fat [diet](#) in which more than 62% of the fat and the [food energy](#) are from fat.

An interesting article regarding PDE-5 efficiency:

Phosphodiesterase Type 5 Inhibitors in the Management of Erectile Dysfunction Secondary to Treatments For Prostate Cancer: Findings from a Cochrane Systematic Review

<http://tinyurl.com/4amxbl>

More good advice from PC survivor/advocate John Mullineaux for those experiencing a problem with their health insurer covering PDE-5 inhibitors:

“My insurance is with CIGNA. My script had been denied as it was considered a "lifestyle" drug.

I wrote the highest level female executive I could find. I told her I thought CIGNA had a problem with "gender parity". I further said I knew CIGNA covered hormone replacement therapy for menopausal females and I didn't see how that was less of a "lifestyle" issue than surgically induced impotence.

It seemed to work as they agreed to cover 8 pills a month.”

Viagra pre & post Surgery/Radiation?

(May 1, 2009) -- Rehabilitation and treatment before and after surgery for prostate cancer can give men a better chance of maintaining erectile function, said [Baylor College of Medicine](#) researchers this week at the [American Urological Association Annual Meeting](#) in Chicago.

"We have shown that treating these men, along with their female partners, before and after surgery significantly improves erectile function."

Two weeks before surgery, patients in Khera's study took Viagra daily. They also received a treatment called medicated urethral system for erection (MUSE) three times a week. See: <http://www.bcm.edu/news/item.cfm?newsID=1403>

Noted Sexual Therapy physician John Mulhall of Memorial Sloan Kettering Cancer Center in NYC remarks: "I would encourage patients to be proactive before surgery or radiation and ask their doctors about rehabilitation and erectile tissue preservation. Before your treatment, set up a plan for how you are going to do rehab. We now start treating patients before surgery and before radiation." See: <http://tinyurl.com/yhv8u9u>

For those of you for whom the foregoing PDE-5 inhibitors fail to work, or if squeamish about injecting medications in the penis, TriMix-gel (TM) is product of TriMix Laboratories LLC. As noted in <http://tinyurl.com/yxl3de> ingredients in TriMix-gel(TM) are FDA approved but TriMix-gel(TM) is a custom compound made in a pharmacy and therefore has not been approved by the FDA for treatment of ED. There is a contact number in the above URL where you can discuss this medication.

Here are ailments identified by Johns Hopkins health alerts that may be contributing to the problem:

Two Studies Link Erectile Dysfunction with Cardiovascular Disease
<http://tinyurl.com/2clr5k>

AND, there is information regarding most any question regarding prostate cancer and its side effects by visiting the Prostate Cancer Research Institute (PCRI) website www.pcri.org then scrolling to “Resources” and then either “PCRI Papers” or “Newsletters.” Here is an article regarding erectile dysfunction:

http://www.prostate-cancer.org/education/sidefx/Auerbach_ErectileDysfunction.html

WHEN ALL ELSE FAILS, AN ERECTILE IMPLANT MAY BE CONSIDERED:

Erectile dysfunction (ED) implants:

You can watch the procedure on-line and find out for yourself exactly what's done. They simply install two inflatable tubes in your penis (that parallel your corpus cavernosum), a pump in your scrotum and a reservoir in your abdomen. The video of the procedure is at:

<http://tinyurl.com/y4cqchf>

Two types of erectile dysfunction penile implants are Titan and Excel. Here is a paper in that regard:

<http://www.garber-online.com/pdf/PenileImplantReview2005.pdf>

You can find more information by searching "Penile Implants" on the internet, and American Medical Systems (AMS), a leading provider of world-class devices and therapies for both male and female pelvic health, announced the launch of a new consumer friendly website at www.EDcure.org designed to help men and their partners learn how penile prosthetic implants can restore sexual function to men suffering with erectile dysfunction (ED).

Obviously it is important that you determine a physician with much experience and expertise in the penile implant procedure.

Comprehensive information regarding penile implants:

<http://tinyurl.com/8jxes3> (If not subscribed, when this opens you can subscribe for free.

A Urologist with experience and special expertise in the installation of penile implants for those willing to travel to get the best in treatment is David R. Paolone, M.D., Assistant Professor of Urology, One South Park Street, Madison, WI 53715, Tel: 608-287-2900, email: david.paolone@uwmf.wisc.edu

The following is a lengthy, but worth reading, article regarding the importance of finding a physician with much expertise in surgically installing a penile implant that will provide an erection suitable for intercourse. I have included this because of the importance that is described:

NEW YORK, NY, USA (Press Release) - March 9, 2009 - After years of testing, Dr. J. Francois Eid, director and founder of Advanced Urological Care in New York City, has refined an innovative "No-Touch" surgical technique that has caused penile implant infection rates to plummet to near zero. Infection rates for the infrequent penile implanter are over TWELVE TIMES as high as Dr. Eid's rate, which is less than 1%. Unlike many infections, which require treatment, healing time, etc., an infected penile prosthesis must be completely removed and replaced. Penile shortening, fibrosis and loss of sensation commonly occur after an infection. Subsequent attempts at re-implantation are extremely difficult with an increased risk of urethral and penile perforation that often requires additional surgery in the future.

For this reason, post-operative infection of a penile prosthesis implant remains one of the most dreaded potential complications of this procedure.

Dr. J. Francois Eid, also a Clinical Associate Professor of Urology at The Weill-Cornell Medical College, has performed more internal penile prosthesis surgeries than anyone in the world. His worldwide reputation for excellence in the treatment of erectile dysfunction (ED) is built on innovations in patient care such as his No-Touch Technique.

Specialized Experience Leads to Breakthrough in Penile Prosthesis Implantation

Doctors that perform fewer than 3 penile implants per year account for 70% of all implants currently inserted in patients in the United States. Dr. Eid attributes his ability to conceptualize, develop, and implement the No-Touch Technique to his extensive experience performing penile implantations, over 300 per year. Despite stringent precautions, many experienced urologist infection rates are 5%, and some institutions are as high as 50%. Dr. Eid's No-Touch success rate speaks for itself, with infection rates near zero.

Dr. Eid's No-Touch Technique

Dr. Eid believes the best way to eliminate infection is through prevention of exposure to bacteria and normal skin flora. Because skin organisms (e.g. staphylococcus epidermis, staphylococcus aureus, candida albicans) cause most infections, Dr. Eid reasons that eliminating direct AND indirect contact (for example, through surgical equipment or gloves) between the prosthesis and the skin will most effectively reduce infection rates. In addition, pre-operative antibiotics and antibiotic coating of the implanted device (the routinely used strategy for eliminating skin bacteria), is ineffective against fungi, such as candida albicans, which account for 10% of post-operative infections. Furthermore, during the surgery, adjustment or even removal and repositioning of the cylinders, pump and/or reservoir is often necessary. When performed without the No-Touch Technique, this results in additional direct contact of the device with skin, thus increasing exposure to skin bacteria and increasing post-operative infection rates.

Experience with Replacements of Infected Penile Prosthesis further supports No-Touch Technique

Salvage procedures, where an infected implant is removed and a new device immediately inserted, have been successful in the past even though the new implant is inserted in an infected tissue bed. Dr. Eid believes that "it is the decrease of total bacterial count and exposure to skin, rather than the complete elimination of bacteria from the procedure, that accounts for the success of penile prosthesis implantation." It is crucial to understand this reality because it gives the implanting physician the tools to further reduce and eliminate infections.

About J. Francois Eid, M.D, and UrologicalCare.com

Dr. Eid is the director and founder of Advanced Urological Care in New York City. He is also a Clinical Associate Professor of Urology at Cornell University. Dr. Eid is one of the foremost specialists in urological prosthetic reconstruction

and performs over 300 internal penile implants per year with zero, or minimal complications. Dr. Eid leads workshops on penile prosthesis surgeries worldwide. More information about Dr. Eid and his expertise with erectile dysfunction treatment, penile prosthesis implantations urinary dysfunction treatment, and ejaculation dysfunction treatment can be found on his website, <http://www.UrologicalCare.com>, or by telephone 212-535-6690.

Some considerations for your partner:

Despite the difficulty you may be experiencing in gaining the return of an erection, it is important that you continue concern for that of your partner. There is no excuse for any man to clam up and come near to shunning his partner because of possibly feeling inadequate because of this hopefully temporary setback. Love and intimacy are more than sexual intercourse. Though sexual intercourse is a comforting and exciting coming together of those who love and care for each other, it is not the entirety of intimacy. Intimacy has so many other acts that express love, care, concern, and need for the other as well as needs of the other. We read recommendations of seeking counseling but that, too, is easier said than accomplished. The questions posed are first, who in the community (pastor, physician, counselor) is experienced in this type of counseling and could adequately address what is occurring sufficiently to understand and want to do something about it? And secondly, likely more important, are you willing to participate in such counseling? When the first question cannot be answered because such professionals are not available, it then becomes paramount that we work with our partner to resolve the intimacy issue in other ways. Obviously those of you caught up in this uncomfortable and for many almost unbearable situation are dealing with much frustration. I wish I had the answer, but I'm only an over eighteen year survivor and over fourteen year androgen deprivation continuing patient myself probably as inadequately addressing this situation as well as I should in my own wonderful marriage continuing since 1954. Here is something that was brought to my attention and is so important and will most certainly help any couple:

In an email, I had remarked "From past experience in reading many such issues between couples, this is a subject that has so many variables that it is difficult to come up with a simple conclusive recommendation. The key word is "communication." With communication and regular discourse between couples, the effects of androgen deprivation therapy are much more easily resolved."

And in regards to that remark, a woman provided likely the best perspective of what the partner/caregiver is experiencing emotionally while trying to comfort and show understanding:

“Sometimes I think that talking is the most evil form of communication there is. We take such comfort in it, yet we can undo everything we've said in one gesture or in one look, or even in one misinterpretation. Show me. Take me outside and let's watch the sunset together. Put your arm around me and pull me to your side for a long hug that tells me I'm treasured. When you wake up in the morning and meet my eyes, smile when you see me there. Surprise me with a picnic you've made for two, or arrange dinner for four with my friends at a cheerful place that won't mind if we linger until closing time. Send me happy-to-be-with-you messages. Join me in the shower and let me wash your back after you've washed mine. Touch me, even if it's just a gentle hand on my shoulder, or on my leg beneath the table. Work your way to "bolder" but ease off at the first sign of resistance. I will do the same, always respecting the signals you give, whether you utter them or not. Show me. Discover me. Rediscover us.

Show me what you are saying is true. Then I'll listen to what you need to say.”

What a powerful rendering regarding what many (most?) of we men fail to recognize; fail to act on! I was so impressed and told her so as did several others. In my reply I added “I still believe communication is vital, but you alluded well that words used in communication and gestures that accompany those words must be considered carefully so that a remark is not perceived as hurtful.” I would encourage all men reading this paper to re-read what this woman provided for our recognition; then take that advice and act on it.

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PLEASE NOTE REGARDING THE FOLLOWING – URO TODAY NO LONGER PROVIDES FREE ACCESS TO THEIR PAPERS, AND SUBSCRIBING IS MUCH TOO EXPENSIVE FOR WE WHO ADVOCATE/MENTOR. I HAVE CONTACTED THE AUTHOR OF THE FOLLOWING SUBJECT TO DETERMINE IF HE CAN PROVIDE A URL WITH DIRECT ACCESS TO HIS IMPORTANT PAPER

“Beyond the Abstract - Androgen deprivation therapy for prostate cancer: Recommendations to improve patient and partner quality of life, by Richard Wassersug, PhD, et al.”

IF HE CAN PROVIDE ME SUCH ACCESS, I WILL AGAIN INCLUDE IT IN THIS PAPER, SINCE, I FOUND IT IMPORTANT ENOUGH TO FORWARD TO EVERY UROLOGIST, RADIATION ONCOLOGIST, AND MEDICAL ONCOLOGIST TO WHICH I HAD EMAIL ADDRESSES. SHOULD YOU GAIN ACCESS TO THIS PAPER, OR RETURN TO THIS PAPER AT A LATER DATE FOR ACCESS, I BELIEVE YOU, TOO, MIGHT CONSIDER DOING THE SAME. OR, ALTERNATIVELY, OPEN AND PRINT THE INFORMATION AND TAKE TO YOUR PHYSICIAN(S) AND SUGGEST THEY READ TO BE BETTER INFORMED.

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or <http://tinyurl.com/2a8mtqg>

The importance in this paper are the issues faced not only by men and their spouses/partners when prescribed ADT, but whenever erectile dysfunction occurs.

In closing, for men and their wives/partners experiencing difficulty with intimacy as the result of treatment, an excellent book is "INTIMACY WITH IMPOTENCE – THE COUPLE’S GUIDE TO BETTER SEX AFTER PROSTATE DISEASE" by Ralph and Barbara Alterowitz, both certified sexuality counselors (AASECT). This book can be purchased at www.renewintimacy.org.”

The following was provided me by a couple with the intent to provide others suggestions towards hopeful enjoyment of intimacy despite erectile issues:

This is for those who may be still wondering what to do after reading the excellent messages that have been posted about ED medications, vacuum devices, injections, and implants. If those methods leave you unsure which way to go, this might help. My wife and I have found that a different approach to intimacy works for us, and I am writing to offer our learning as an alternative to the foregoing techniques.

After my seeds were implanted in Feb of 2007, my sexual abilities were significantly reduced and continued to plummet as time went on. We regard this as a ‘couple problem’, so my wife and I attended a few sexual intimacy seminars,

read some material, and had several great discussions about this. Perhaps the best resource we found was “Intimacy with Impotence”, The Couple’s Guide to Better Sex after Prostate Disease by Ralph and Barbara Alterowitz, distributed by US TOO. We read a few paragraphs out loud then stop to talk about it. A few days later pick it up and read some more then stop and talk again. Continuing in this manner over several weeks, we became better informed about several alternates and about our own intimacy needs and desires.

High on each of our own priority lists is being a good sexual partner to each other. To achieve this, it requires knowing what the other person really wants. Even after over forty years of marriage, I found that my wife’s real desires turned out to be quite different from what I had thought. Her preferences boil down to holding each other, having her hair brushed, and playing with my genitals. We snuggle frequently. About once a week I brush her hair for as long as my arms hold up. She gives me a wonderful genital massage every day using a variety of techniques. We usually spend from ten minutes to an hour doing this just after we wake up and pray together. Sometimes she gets me slippery and takes me over the top while enjoying watching me react to this. Once every six weeks or so we take some ED meds and try traditional intercourse. Sometimes that works sometimes not. If not, it is no big deal, she finishes me off and we end up tired but happy.

We have come to realize that the key factors impacting my ability to have an orgasm are (A) my not worrying about it, (B) taking time to enjoy the passion, and (C) maintaining an erotic atmosphere. It has been fun to explore creative ways to keep the passion high. All this results in both a personal relationship and a sexual satisfaction that exceeds the levels we had before the PC. In addition, our approach doesn’t entail medical risks, pain, inconvenience, or expense. This path has worked well for us, and it is our hope that at least one other couple out there might find our sharing of this useful.

And I hope the following opens the eyes of those of you men who believe an erection is an absolute for sexual pleasure for both you and your partner. This from Virginia E., in a posting to the pcai@prostatecancer.org support list on May 8th, 2011: “Another woman who writes joyfully about sex--in case you haven't read her books--is Erica Jong. I never met her, but I can identify with her. I am her age and went to college in New York at the same time she did and I guess you could say we were shaped by some of the same influences in our generation. We both

grew tired of B.S. and wanted to get to the truth regardless of what other people thought.

I'm reading her most recent book (although another is due to come out in June) "Seducing the Demon". On page 79-80 she writes:

I tried to write about the role of sex in my life in "Fear of Fifty," but I realize now, in my sixties, that I didn't know the half of it. Until you get wise enough (or old enough) to understand sex as a whole-body experience, you know nothing. All my life I had heard about tantric sex and I thought it was utter bullshit...Most of our sexuality is so focused on the stiff prick that we have no idea what to do when that becomes occasionally problematic as it does with age. You can become a Viagra junkie or you can create other ways of making love. The deliciousness of skin, or oral sex, or sex without homage to the divine Lawrentian "phallos" can be a revelation....Whatever breaks our fixation on the genitals and turns us into entire bodies linked to entire minds enhances sex. The best Italian lover I ever had could practically make me come by stroking my neck.

The married poet who shook with fear, then fucked me with a stiff cock, was no sort of lover at all. A lover makes love with words, with stroking, with laughter. ANXIETY RUINS SEX. [emphasis mine because I believe this is the heart of our problem.] Which may be why married people can have great sex--as can longtime lovers--or longtime friends. Music, stroking, scent, poetry--these things are far more important than a stiff prick.

I realized only when my husband had to take heart medication and could not tolerate Viagra that we were able to discover things we never knew before. He could have whole-body orgasm while giving oral sex--his orgasm triggered by mine....When we were able to have genital sex after that, he said, 'It feels so localized compared to before.' Intercourse produces an orgasm in the pelvic area, but other kinds of sex produce it all over the body--and mind."

This was written by someone who faced not prostate cancer but just one of the many other conditions that come with getting older. (In her case, her husband almost died of an aneurysm, as she explains elsewhere). The benefits which come from the need to adjust our sexual attitudes and approach as we grow older or experience injuries can really enhance our sexual lives if we can address them head-on and truthfully rather than fleeing from them or avoiding them. Prostate cancer is one of the most devastating conditions but it isn't the only one that interferes with sex as we have known it. In other words, prostate cancer survivors

aren't as alone as it seems at first. After curing or controlling the disease, life goes on--and our sexual lives can go on--if we let them, if we are willing to fight.”

Virginia provided another important recognition in another post: "I think men equate libido with physical signs they are accustomed to, and when they don't immediately feel and see these signs, they feel depressed, and nothing kills the energy that fuels libido like depression. I think it's even possible that before the spark ignites the unconscious immediately switches it off as a defense against feeling that disappointment of the missing physical response. The unconscious is reasoning, "better to feel nothing than risk failure."

Of course, the only way to counteract this is to break through the unconscious and to redefine failure. This means exploring a new reality, seeking new methods of stimulation to replace those that can no longer be relied on in the interest of preserving life and health.

My explanation is not the only one - in many cases loss of libido is real, and is due to real lack of hormones and nerve connections. But in other cases, it is primarily mental, as in my experiences. Either way, it is possible to find a way to find a path to satisfaction, with courage and perseverance and patience."

Disclaimer: Please recognize that I am not a Medical Doctor. I have been an avid student researching and studying prostate cancer as a survivor and continuing patient since 1992. **The comments or recommendations I make are not intended to be the procedure for you to now follow; rather, they are to be reviewed along with the comments or recommendations of others for your own further research, study, and discussion with the physician providing your prostate cancer care to come to your own, personal conclusion.**