

4.3.5 Haemospermia

The exact incidence and prevalence of haemospermia are difficult to elucidate due to a number of factors including its covert presentation, usually self-limiting nature and patient embarrassment. The symptoms represent 1-1.5% of all urological referrals and occurs in all age groups, with a mean age of 37 years [235, 236]. In a PCa screening study of 26,126 men, aged ≥ 50 years or older than 40 with a history of PCa or of black ethnicity, haemospermia was found in 0.5% on entry to the trial [237].

4.4 Low sexual desire

The global prevalence of low sexual desire in men is 3-28% [210, 238, 239]. Low solitary and dyadic sexual desires have been reported in 68% and 14% of men, respectively [240]. Also, low sexual desire has been observed as a common complaint in gay men, with a prevalence of 19-57% [241, 242]. Despite its relationship with age, low sexual desire has also been reported among young men (18-29 years), with a prevalence of 6-19% [202, 243, 244].

5. MANAGEMENT OF ERECTILE DYSFUNCTION

5.1 Definition and classification

Erectile dysfunction is defined as the persistent inability to attain and maintain an erection sufficient to permit satisfactory sexual performance [245]. Erectile dysfunction may affect psychosocial health and have a significant impact on the QoL of patients and their partner's [197, 246-248]. Erectile dysfunction is commonly classified into three groups based on aetiology: organic, psychogenic and mixed ED. However, this classification should be used with caution as most cases are actually of mixed aetiology. Therefore, it has been suggested to use the terms "primary organic" or "primary psychogenic".

5.2 Risk factors

Erectile dysfunction is a complex medical issue with several known causes, including vascular, hormonal, neurologic, and psychological dysfunctions and is associated with chronic health conditions [249]. An association with numerous risk factors including age, diabetes mellitus, dyslipidaemia, hypertension, CVD, obesity, MetS, hyperhomocysteinemia, lack of exercise, smoking and drug use has been reported [247, 250-261]. In addition, a number of therapeutic agents for CVD have been shown to have a detrimental effect on erectile function (EF), whereas newer drugs have exhibited a neutral or even beneficial effect [253, 262, 263]. Other reported risk factors include atrial fibrillation, hyperthyroidism, vitamin D and folic acid deficiency, hyperuricemia, depression and anxiety disorders, chronic kidney and rheumatic disease, COPD, migraine, inflammatory bowel disease, osteoporosis and sleep disorders [258, 264-277]. In addition, a growing body of evidence has demonstrated an association between the onset of new ED in men who have had COVID-19 [278-281].

Erectile dysfunction is also frequently associated with other urological conditions and procedures including LUTS/BPH and surgery for LUTS/BPH [282-284], chronic pelvic pain syndrome (CPPS) and chronic prostatitis [285], bladder pain syndrome/interstitial cystitis [286], premature ejaculation [287] and urethroplasty surgery for posterior urethral strictures [288].

5.3 Pathophysiology

The pathophysiology of ED may be vasculogenic, neurogenic, anatomical, hormonal, drug-induced and/or psychogenic (Table 5.1) [289]. In most cases, numerous pathophysiological pathways can co-exist and may all negatively impact EF.

Table 5.1: Pathophysiology of ED [289]

Vasculogenic
Recreational habits (i.e., cigarette smoking)
Lack of regular physical exercise
Obesity
Cardiovascular diseases (e.g., hypertension, coronary artery disease, peripheral vasculopathy)
Type 1 and 2 diabetes mellitus; hyperlipidaemia; metabolic syndrome; hyperhomocysteinemia
Major pelvic surgery (e.g., radical prostatectomy) or radiotherapy (pelvis or retroperitoneum)