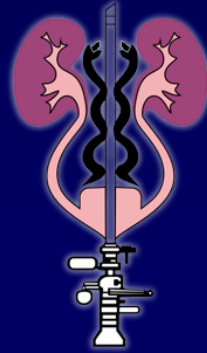




OLGULARLA EREKTİL DİSFONKSİYON



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Guidelines on **Male Sexual Dysfunction:**

Erectile dysfunction and premature ejaculation

K. Hatzimouratidis (Chair), I. Eardley, F. Giuliano,
I. Moncada, A. Salonia

Olgu 1

- 58 y erkek hasta
- 1 yıldır ED, libido +, IIEF 5 =16 (Hafif-orta) IPSS:5/1
- Ağırlığı N↑, 93,7 kg 1.68 cm BKİ:33.2 (şişman orta°)
- HT + 5 yıldır, tiyazid diüretik (spironolakton + hidroklorotiazid 50 mg) ve kalsiyum kanal blokörü (amlodipin 5 mg)
- Sigara + 30 yıldır 1 paket/gün
- Egzersiz yok



Fizik Muayene

- Genitoüriner muayene
 - Peyronie , genital lezyon Ø, RT grade 0.5 benign, testisler N, sekonder s. k .N
- Endokrin n
- Vasküler, femoral alt e. nabazanlar + ama hafif ↓
- Nörolojik N
- Orta derecede obez

FM 2

- KB: 138/86 mmHg
- AC sesleri dođal
- Kalp muayenesi N



LAB

- Hastanın şikayetlerine ve risk faktörlerine
- AKŞ:100 mg/dl
- HbA1c:%4,6
- Lipid profili N
- (Testosteron, PSA, Prolaktin, LH)



Risk Faktörleri

Aterosklerotik damar hastalığı

Yaş

Sigara içimi

HT

Sedanter bir yaşam

(diabet, dislipidemi, metabolik sendrom,
AÜSS)



Bu hastanın ED sorununa yaklaşım nasıl olmalıdır?

Table 2: Cardiac risk stratification (based on 2nd Princeton Consensus [59])

Low-risk category	Intermediate-risk category	High-risk category
Asymptomatic, < 3 risk factors for CAD (excluding sex)	≥ 3 risk factors for CAD (excluding sex)	High-risk arrhythmias
Mild, stable angina (evaluated and/or being treated)	Moderate, stable angina	Unstable or refractory angina
Uncomplicated previous MI	Recent MI (> 2, < 6 weeks)	Recent MI (< 2 weeks)
LVD/CHF (NYHA class I)	LVD/CHF (NYHA class II)	LVD/CHF (NYHA class III/IV)
Post-successful coronary Revascularisation	Non-cardiac sequelae of atherosclerotic disease (e.g., stroke, peripheral vascular disease)	Hypertrophic obstructive and other cardiomyopathies
Controlled hypertension		Uncontrolled hypertension
Mild valvular disease		Moderate-to-severe valvular disease

CAD = coronary artery disease; CHF = congestive heart failure; LVD = left ventricular dysfunction; MI = myocardial infarction; NYHA = New York Heart Association.

- Efor testi
 - İskemi yok
 - Göğüs ağrısı yok
- Seksüel aktivite
 - Düz zeminde 20 dk içinde 1 mil (1.6 km) yürüyüş veya 10 sn içinde 2 katın merdivenini hızlı turmanma
- Seksüel aktivite
 - Bruce treadmill protokolünde 4 dk



Antihipertansif ilaç kullanımı

- ED yapanlar
 - Tiyazid diüretikleri
 - Beta blokürler
 - Reserpin
 - Hidralazin
 - Guanetidin
 - Klonidin
 - Asetazalomid
 - Alfa metil dopa
 - Kalsiyum kanal blokürleri
- ED yapmayanlar
 - Angiotensin dönüştürücü enzim blokürleri
 - Angiotensin reseptör blokürleri

Tedavi

- Sigarayı bırakma
- Kilo verme
- Egzersiz
- Tiyazid diüretik stop yerine angiotensin dönüştürücü enzim inhibitörü (ramipril 5 mg)
- FDE 5i 20 mg tadalafil



Olgu 2



Hasta HD, 72 y E

Gece 4 kez tuvalete kalkma, sık idrara çıkma,
sertleşme sorunu

IPSS:18/3, IIEF-5: 16

İdrar şikayetleri arttıkça ereksiyon zorluğu
da↑

HT + valsartan (diovan) la kontrol altında

Olgu 2

- FM
 - Genitoüriner m: RT grade 1 benign dışında N
 - KB:125/85 stabil
- Lab normal
 - Lipid profili
 - AKŞ
 - Creatinin
 - PSA
 - Testosteron

AÜSS & ED

- Tedavi
- 1. Alfa blokür + PDE 5 İ gerektiğinde
- 2. Tadalafil 5 mg / hergün
- 3. Alfa blokür + tadalafil 5 mg /her gün

- IPSS 18/3 den 12/2
- IIEF 16 ‘dan 23

Guidelines

EAU Guidelines on the Treatment and Follow-up of Non-neurogenic Male Lower Urinary Tract Symptoms Including Benign Prostatic Obstruction

01 Matthias Oelke^a, Alexander Bachmann^b, Aurélien Descazeaud^c, Mark Emberton^d, Stavros Gravas^{e,*}, Martin C. Michel^f, James N'Dow^g, Jørgen Nordling^h, Jean J. de la Rosetteⁱ

Table 4 – Level of evidence and grade of recommendation for the various treatments of male lower urinary tract symptoms and follow-up

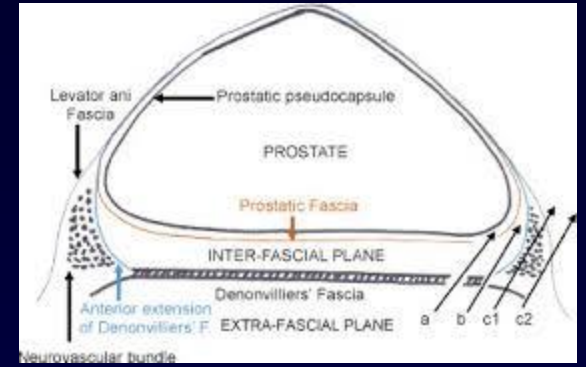
	LE	GR
Conservative treatment: watchful waiting		
Men with mild symptoms are appropriate for watchful waiting.	1b	A
Men with LUTS should always be offered lifestyle advice prior to or concurrent with treatment.	1b	A
Drug treatment:		
1. α_1 -Blockers can be offered to men with moderate-to-severe LUTS.	1a	A
2. 5 α -Reductase inhibitors can be offered to men who have moderate-to-severe LUTS and an enlarged prostate (>40 ml). 5 α -Reductase inhibitors can prevent disease progression with regard to acute urinary retention and need for surgery.	1b	A
3. Muscarinic receptor antagonists may be used in men with moderate-to-severe LUTS who have predominantly bladder storage symptoms. Care is advised in men with BPO.	1b	B
4. Phosphodiesterase type 5 inhibitors reduce moderate-to-severe (storage and voiding) LUTS in men with or without erectile dysfunction. Only tadalafil (5 mg, once daily) has been licensed for the treatment of male LUTS in Europe.	1b	A
5. Vasopressin analogue can be used for the treatment of nocturia due to nocturnal polyuria.	1b	A
6. Combination treatment with an α_1 -blocker together with a 5 α -reductase inhibitor can be offered to men with bothersome moderate-to-severe LUTS, enlarged prostates, and reduced Q _{max} (men likely to develop disease progression).	1b	A
7. Combination treatment with an α_1 -blocker together with a muscarinic receptor antagonist may be used in patients with bothersome moderate-to-severe LUTS if relief of storage symptoms has been insufficient with the monotherapy of either drug. Combination treatment should carefully be prescribed in men who may have BPO.	1b	B
	2b	B

Olgu 3



- HY, 59 y E
- DM + Glifor
- ED sorunu radikal prostatektomi sonrası başlamış
- Prostat adenokarsinom Gleason skor 3+3, PSA:4,9
- 22.02.2013 de RP açık
- Postop PSA:0,001 inkontinans yok
- FM'de özellik yok

RP & ED



- Sinir koruyucu RP sonrası ED %25-75
- Robotik yardımlı=lap RP > açık RP
- Risk faktörleri
 - Hastanın yaşı
 - Cerrahi hacim
 - Sinir-damar paketinin korunması
- Postoperatif rehabilitasyon
- EF düzelmesi 48 ay

RP sonrası PDE5i

- Sildenafil
 - Yanıt %35-75 (sinir koruyucu)
%0-15 (sinir korumasız)
- Tadalafil
 - 20 mg %71 düzelme (plasebo %24)
- Vardenafil
 - 10-20 mg %71-60 düzelme

- Tadalafil 20 mg/gün
- İc caverject 20 mgr (alprostadi)





RESEARCH ARTICLE

Low-intensity extracorporeal shockwave therapy in the treatment of postprostatectomy erectile dysfunction: a pilot study

Anders Frey, Jens Sønksen and Mikkel Fode

Department of Urology, Herlev University Hospital, Copenhagen, Denmark

ABSTRACT

Objective: The objective was to investigate the effect and feasibility of low-intensity extracorporeal shockwave therapy (LI-ESWT) as a treatment for erectile dysfunction (ED) after bilateral nerve-sparing radical prostatectomy (RP). **Materials and methods:** Patients who had undergone robot-assisted bilateral nerve-sparing RP more than a year before entering this pilot study, had no preoperative ED and were suffering from mild to severe postoperative ED were invited to participate. Six treatments were given over a 6 week period, using the Duolith[®] SD1 T-Top machine. The effect of the treatment was evaluated 1 month (t1) and 1 year (t2) after the final treatment. The main outcome measure was changes in the five-item International Index of Erectile Function (IIEF-5) scores. **Results:** Eighteen patients were included in the study. However, two patients breached the protocol and consequently 16 patients were included in the analysis at t1 and 15 patients were included in the analysis at t2. At baseline the median age was 62 years (range 51 to 70 years) and the median time since surgery was 24 months (range 12 to 54 months). The median preoperative IIEF-5 score was 25 (range 22 to 25) and the median baseline IIEF-5 score was 9.5 (range 5 to 20). The median change in IIEF-5 scores was +3.5 (range -1 to 8; $p = 0.0049$) and +1 (range -3 to 14; $p = 0.046$) at t1 and t2, respectively. No severe side-effects were reported.

ARTICLE HISTORY

Received 5 May 2015
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KEYWORDS

Erectile dysfunction, extracorporeal shockwave therapy, radical prostatectomy

Conclusions: LI-ESWT may improve erectile function after bilateral nerve-sparing RP. Based on these results, further studies in patients with ED after nerve-sparing RP are justified.

3A.4.5.3 Shockwave therapy

Recently, the use of low-intensity extracorporeal shock wave therapy (LI-SWT) was proposed as a novel treatment for ED [137]. In the first randomised, double-blind, sham-controlled study, it was demonstrated that LI-SWT had a positive short-term clinical and physiological effect on the EF of men who respond to PDE5Is [138]. Moreover, there are preliminary data showing improvement in penile haemodynamics and endothelial function, as well as IIEF-EF domain score in severe ED patients who are poor responders to PDE5Is [139, 140]. Current data are still limited and clear recommendations cannot be given.

DY-ŞDT

6 hafta haftada 2 kez 3000 şok dalgası

+

Tadalafil 20 mg



- Tedavi
- 1.cerrahiye takiben pro-erektil ilaçlar
- 2.ic enjeksiyon tedavisi
- 3.Üretral mikrosuppozituarlar
- 4.Vakum cihazı
- 5.Düşük yoğunlukta şok dalga tedavisi
- 6.Penil protez

Olgu 4

- 49 y E hasta
- 3 aydır güçsüzlük, halsizlik, libido kaybı ve sertleşme sorunu, sabah ereksiyonlarında azalma
- IIEF-5:12
- FM: özellik yok (testisler hafif atrofik, sekonder seks karakterleri N)
- Öyküde prostat ca unstabil kalp hst yok

- Lab rutinler N,
- Test:total 216 ng/dl(<230 ng/dl)
2.tekrar T:212 ng/dl
- serbest :72 (< 65 pg/dl)
- FSH, LH hafif yüksek, Prolaktin, ferritin N
- Sella MR N

Olgu 4 tanınız nedir?

- Hipogonadizme bađlı ED
 - Ge Bařlayan Hipogonadizm
 - Testosteron yetmezliđi
-
- Bundan sonra ne yapalım ?

Geç başlayan hipogonadizmde

Semptomlar

Libido azalması

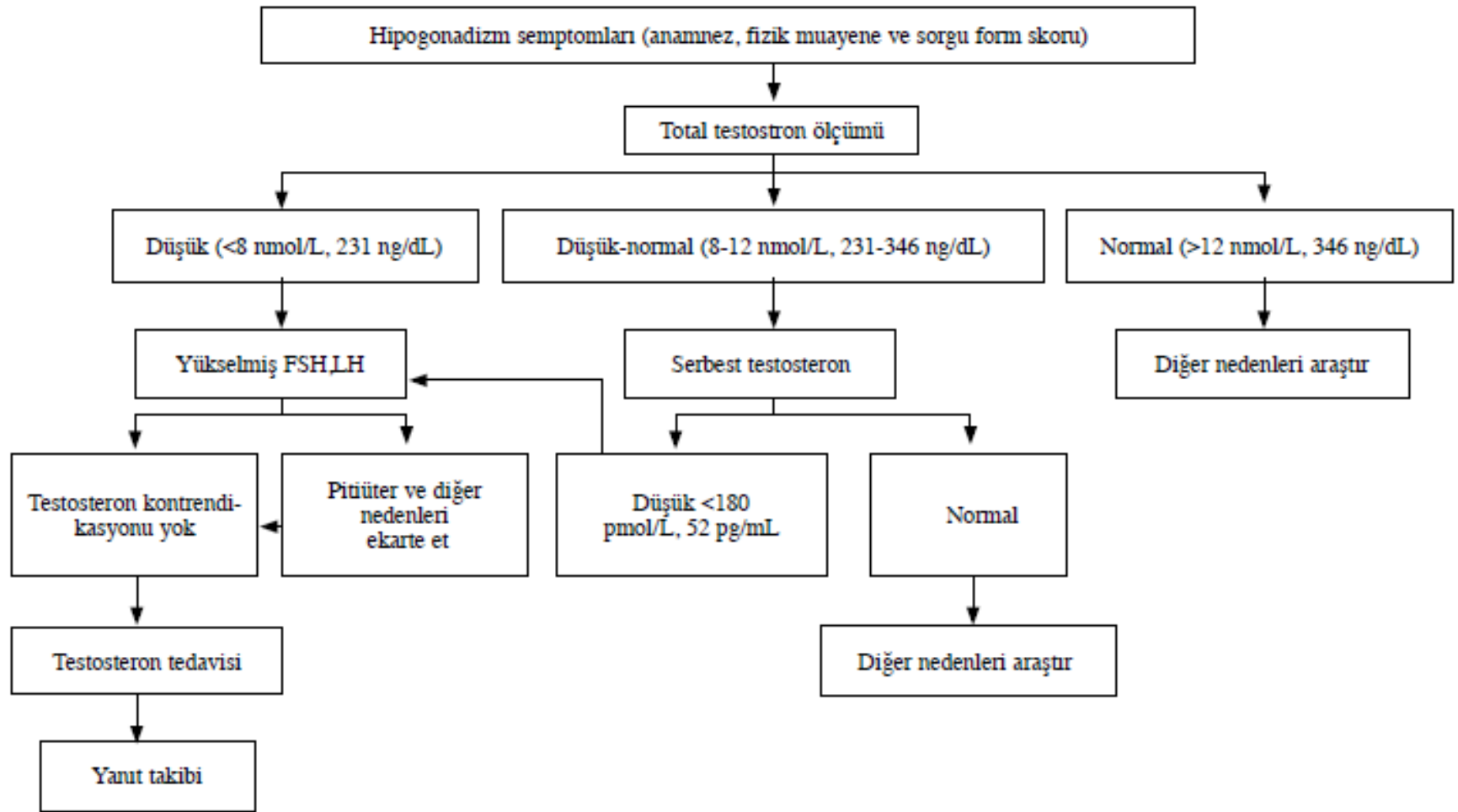
Kas kitle ve gücünde azalma

Kemik mineral dansitesinde azalma ve osteoporoz

Yaşama gücünde azalma

Depresif ruh hali

Vücut yağlanmasında artış



Şekil 1. Yaşlanan erkekte hipogonadizm tanı algoritması

Testosteron yerine koyma tedavisi

- Testosteron tedavisi öncesi
 - RT, serum PSA, Hb, KC fonksiyon testleri, lipid profili

Testosteron Tedavisi Kontrendikasyonları

Prostat kanseri

Meme kanseri

Prostat nodulleri veya sertlik

Açıklanamayan PSA yüksekliği

Eritrositoz (>%50)

Benign prostat hiperplazisi ile birlikte yüksek alt üriner sistem semptomları (IPSS>19)

Stabil olmayankonjestif kalp yetmezliği (Class 3 veya 4)

Ciddi tedavi edilmemiş uyku apnesi sendromu

Testosteron yerine koyma tedavisi

- Parantral
 - Uygulama güçlüğü
 - Ağrı
 - Zamanla yükselen Test ↓
- Oral
 - KC'de toksisite
- Transdermal
 - 50 mg/gün 6 ay
- IIEF 12'den 25'e
- Test 216 ng/dl'den 387 ng/dl
PDE-5 inh eklenmesi?

Teşekkürler

