# key points

SELECTED BY

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**Erectile dysfunction (ED) is the persistent inability to** achieve and maintain an erection sufficient to permit satisfactory sexual performance. Rates of ED increase with age, with an estimated 70% of men aged 70 affected to some extent. ED is a significant predictor of underlying cardiovascular disease and is included in QRISK3.

**In addition to the onset and duration of symptoms,** important points in the history to clarify are: how the patient defines their ED, whether they have ever had erectile function, whether morning erections are preserved, the context of ED and recent sexual history. Men should be asked about symptoms of hypogonadism such as loss of libido or low energy levels. Cardiovascular risk should be evaluated.

**GPs should look for signs of hypogonadism and** examine the external genitalia for any penile or testicular deformity. Examination of lower limb pulses may provide evidence of peripheral vascular disease. If LUTS are elicited during the patient's history a digital rectal examination (DRE) should be performed as part of the man's assessment. NICE guidance also recommends performing a DRE in men with a history of prostate cancer and in men over 50 years of age. BMI, heart rate and BP should be recorded for all patients, and if indicated by the history a cardiovascular or neurological examination may be performed. Initial blood tests should include $HbA_{1c}$ or fasting glucose, a lipid profile and fasting early morning total testosterone.

**Patients should be stratified into cardiovascular risk** categories. Those at high risk should be referred to cardiology before considering any treatment other than lifestyle adaptations. Men with suspected hypogonadism should be referred to endocrinology and counselling should be considered for men with psychosexual dysfunction. Medications known to cause ED should be reviewed and alternative therapy offered if appropriate. Lifestyle advice should include weight loss, smoking cessation, increased exercise and reduced alcohol intake.

**Phosphodiesterase type-5 (PDE-5) inhibitors are** first-line treatment and a trial period of 6 weeks is recommended to assess efficacy. Treatment failure is most commonly due to patients not being educated regarding correct usage. If the first PDE-5 inhibitor is not effective at maximum dosage a change to one of the other PDE-5 inhibitors would be appropriate for a further 6-week trial.

**Men with ED that has not responded to PDE-5 inhibitors** should be referred to a specialist. Vacuum erection devices are an option when PDE-5 inhibitors are ineffective or contraindicated, and in elderly patients where there are concerns about potential side effects or drug interactions. Unless there is a clear reversible organic or psychological cause, men with treatment-refractory ED should be referred to a urologist specialising in andrology, as should those with associated structural penile abnormalities such as Peyronie's disease and all those who develop ED after priapism or genital trauma.