CODEN [USA]: IAJPBB ISSN: 2349-7750

INDO AMERICAN JOURNAL OF
PHARMACEUTICAL SCIENCES

http://doi.org/10.5281/zenodo.2210989

Available online at: http://www.iajps.com ***Review Article***

ERECTILE DYSFUNCTION, TABOO BEHIND ERECTILE DYSFUNCTION AND BREAKING THE ICE OF ERECTILE DYSFUNCTION TABOO

[1]Abdullah Jamal Alomran, [2]Ibrahim Hadi saatyalsroujy, [3]Abdulaziz adnan Kinsara, [4]Abdullah Hadi Saaty, [5]Shady Mohamed Salem

[1]Farwaniyah Hospital, (Kuwait Ministry of Health) Email: dr.ajo13292@gmail.com
[2]King Abdulaziz University Hospital, Email : Ebrahim.alsoruji@yahoo.com
[3]King Abdulaziz University Hospital, Email : Az_kin@outlook.com
[4]King Abdulaziz University Hospital, Email : Saaty.abdullah@yahoo.com
[5] Farwaniyah Hospital (Kuwait Ministry of Health), Email:sh_dy@yahoo.com

Abstract:

Erectile dysfunction is a multidimensional but common male sexual dysfunction that involves an alteration in any of the components of the erectile response and it has been poorly recognized and managed in the past, due to its taboo aspects and erroneous perceptions of its medical significance. With research, improved understanding has guided a practical approach to its diagnosis and treatment. In most presentations, erectile dysfunction has an organic etiology. Likely causes are often discerned from the clinical history and physical examination. Management may be a simple matter of addressing correctable risk factors, or a direct intervention may need to be pursued. Erectile dysfunction taboo is one of the limitation for early diagnosis of erectile dysfunction .

Aim/Objective:To address the importance of erectile dysfunction , why patients with erectile dysfunction don't seek medical advice earlier in course of the disease and what methods medical staff Tried to break the ice with patient sufferers from erectile dysfunction .

Methods : This a review of literature about erectile dysfunction taboo and breaking the ice of erectile dysfunction taboo by using a published researches . Around 14 countries involved in this review of literature addressing the commonest causes of erectile dysfunction taboo and methods to break the ice with erectile dysfunction taboo .

Results :Erectile dysfunction taboo can varies from country to another due to cultural differences , education and socioeconomic states , however, the methods to break the ice are nearly the same .

Conclusion: ED is common yet under-reported, due to the stigma surrounding it.

Corresponding author:
Abdullah Jamal Alomran,
Farwaniyah Hospital,
Kuwait Ministry of Health,
Email: dr.ajo13292@gmail.com

QR code

Please cite this article in press Abdullah Jamal Alomran et al., ***Erectile Dysfunction, Taboo Behind Erectile Dysfunction And Breaking The Ice Of Erectile Dysfunction Taboo.,*** *Indo Am. J. P. Sci, 2018; 05(12).*

INTRODUCTION:

Erectile dysfunction (ED), the second-most common disorder of sexual function in men, is the persistent inability to achieve or maintain an erection adequate for satisfactory sexual activity. Despite its startling prevalence and the undisputed impact that erectile function has on a man's self-esteem and quality of life, ED has remained a largely under-diagnosed disorder [1]. The multi-factorial nature of erectile dysfunction comprises both organic and psychological aspects, but discussing such an issue is not easy, so the assessment and treatment of ED often requires a multidisciplinary approach.

Taking into account the importance of sexual life, Nicolosi[2] collected data from the Global Study of Sexual Attitudes and Behaviours in 2002 that support the assumption that sex is valuable and important to patients, The survey involved over 27,500 individuals in 29 countries and found that, at least in the group aged 40 to 80, approximately 83% of men and 63% of women describe sex as 'extremely', 'very', or 'moderately' important to them.

Perelman[3] conducted a cross-national survey of males aged 25-75 experiencing erectile dysfunction in six countries and concluded that in all countries men agreed that ED was a source of great sadness for themselves and their partners

In this article review, concerned with erectile dysfunction and addressing 16 studies collected from Europe , USA, Asia and Australia , we aim to provide information about the prevalence and under-reporting of ED, the taboos and dilemmas associated with it, the role of education, and ways to break the ice with ED patients, In addition, we address the barriers that prevent patients with ED from seeking medical attention, ways to communicate with them, and the different approaches to ED among countries.

Literature Review

Erectile dysfunction is a important disorder and affects a large section of the population, although it continues to bel under-reported.

Feldman (1994) [4] collected normative data on the prevalence of impotence and its physiological and psychosocial correlates in a general population, using results from the Massachusetts Male Aging Study, a community-based, random-sample observational survey of non-institutionalized men aged 40 to 70 conducted from 1987 to 1989. A self-administered sexual-activity questionnaire was used to characterize erectile potency. The combined rate of minimal, moderate, and complete impotence was 52%. The rate of complete impotence tripled, from 5% to 15% between subjects aged 40 to 70. Subject age was the variable most strongly associated with impotence

Braun (2000)[5] conducted a study to evaluate the epidemiology of male sexuality in Germany using a validated questionnaire on male erectile dysfunction, which was mailed to a representative population sample of 8000 men aged 30-80 in the Cologne urban district. A total of 4883 men replied (a 61.0% response rate). Among respondents, the rate of ED was 19.2%, with a steep age-related increase (2.3±53.4%), The increase was linear in the age groups from 30 to 59 years, while the age groups older than 60 showed an exponential increase in prevalence.

In a study of 741 Danish men aged 18–88, Ventegodt determined that 5.4% of men reported a decreased ability to achieve an erection.

The prevalence of ED remained relatively constant, at about 2% for all age groups up to mid-forties, but jumped to nearly 18% in those aged 58–88. While ED seems to have a significantly negative effect on the quality of life in the younger age groups, this effect diminishes to almost zero in the group aged 58 or above. The study did not ask about difficulties maintaining an erection and thus may have underestimated the overall prevalence of ED. The relative efficacy of questionnaires vs interviews was highlighted in a small but regionally representative group of 51-year-old Danish men.[7] In the questionnaire, 5% of respondents reported experiencing ED more than occasionally (see previous image), and an additional 15% indicated rarely experiencing ED. A subset of 100 men who had not reported ED in the questionnaire, however, were subsequently interviewed by their own physicians: these visits indicated that 7% of them had moderate to severe ED and a further 19% had occasional impairment of erections. In a large-scale Finnish study that combined face-to-face interviews and a questionnaire, 21,996 male respondents aged 18–74 reported an overall 6% prevalence of erection difficulties at least fairly often, while 49% had experienced erection difficulties of any degree during the previous year. Men's erectile ability appeared at its best around the age of 30, with only 1% of men of this age reporting experiencing erectile difficulties fairly often. This rate increased to 32% for men aged 65–74. Similarly, at age 30, 65% of men experienced no erectile difficulty, but this percentage increased to 40% by age 50, 20% at age 70. A total of 15% of men reported having experienced erectile difficulties for an extended period at some point during their life.

This lifetime rate was more than 50% for men aged 70 or older. The survey also asked females about males' erectile disabilities. They tended to report their partners' ED somewhat more frequently, with an overall rate of 9%.

In France, [6], 11% of 1037 men aged 18–70 responded to a self-administered questionnaire that they had experienced ED in at least 50% of their sexual encounters, while an additional 28% indicated that they had erectile difficulties at least occasionally . The prevalence of ED remained relatively constant up to age 40, but increased markedly thereafter, with a prevalence of 67% for any degree of ED among the oldest cohort

In a relatively small-scale study [6] in South Australia, male participants older than 40 were invited to respond to a mailed questionnaire. Of the 392 respondents (53% of the target), 22% indicated experiencing difficulty obtaining an erection, 23% indicated experiencing erections less than half the time when desired, and 26% indicated experiencing erections that were inadequate for intercourse (figure 4). There was a significant correlation of erectile difficulties with age, with reporting of erection difficulties for 7% of the group aged 40–49, 36% of the group aged 60–69, and 92% of the group 80 and older.

Despite the fact that ED is quite common, it is still under-diagnosed.
K. Baldwin[7] studied the incidence of erectile dysfunction and reasons for patient under-reporting using a questionnaire, He asked 500 men older than 50 visiting their urologist's office for problems unrelated to ED whether or not they had any difficulty with their potency. Those who responded positively were then asked to complete a questionnaire to assess their reasons for under-reporting their ED and whether they had previously discussed their sexual function with their primary-care physician. Of 500 men, 218 (44%) reported experiencing some degree of ED. Reasons for their failure to discuss ED with their urologist included: 161 of the 218 (74%) were embarrassed; 27 (12%) felt that ED was a natural part of aging; 20 (9%) were unaware that urologists dealt with ED; and 10 (5%) did not consider the problem worthy of attention. Only 48 of the 218 men with ED reported having previous discussions about it with their primary-care physicians. Of the 170 patients who did not report having such discussions, 140 (82%) reported that they would have liked their primary-care physician to have initiated a discussion of ED during their routine visits. In conclusion, a significant percentage of older men with an unrelated urologic complaint also suffer from some degree of ED and remain undiagnosed unless specifically questioned about it. By far the most common reason for under-reporting ED was patient embarrassment. While urologists can elicit information regarding erectile function with specific questioning, patients appear comfortable and willing to discuss their potency with primary-care physicians.

Asnida Anjang Ab Rahman conducted [8] a cross-sectional research study on help-seeking behaviour amongst 1331 men with ED in a primary-care setting. Questions were asked regarding the presence of erectile problems, help-seeking behaviour and treatments sought. The mean age was 54.7 (±8.3), with a range of 40 to 79 years. Among the subjects, 69.5% had ED; only 54.8%, however, reported having difficulty with erections, which means nearly half of the patients with ED did not seek help. This behaviour might be due to many factors on the part of either the patient or the doctor.[3]

Patrick J. Dimeo studied psychosocial and relationship issues in men with ED. In a cohort study, 31% of men aged 18 to 59 experienced sexual dysfunction, a term comprising eight different sexual problems, including ED (Laumann, Paik, & Rosen, 1999). Approximately 52% of the respondents experienced ED. Dimeo observed that only a few of them went to their doctor for this issue, due to the availability of sildenafil and some psychosocial issues that prevented them from seeking help. These reasons are: (a) a lack of support, (b) fear about or denial of the issue, and (c) self-created barriers, such as embarrassment talking about the issue, fear or loss of self-esteem.

Kai Zhang studied the behaviour of Chinese patients seeking help for ED[9]. Their observational study was conducted using an outpatient clinic-based questionnaire survey of ED patients. From 2008 to 2009, physicians in 10 medical centres in China enrolled 2693 men (aged 25–70) who had been diagnosed with ED. The men were diagnosed based on the International Index of Erectile Function 5 (IIEF-5) questionnaire. The mean age of participants was 43.4 (±5.3 years). In total, 73% of the respondents were younger than 50 years, and 49% had a high household income. A total of 2148 men reported how long had elapsed between noticing ED and their first treatment. The mean interval was 4.3 (± 2.1) months. The distributions of the time intervals were mostly between 4–6 months (33%) or 7–12 months (31%).

Of the respondents, 2577 men noted the sources they

had consulted for their erectile problems; 94% had consulted one or more information sources. Physicians were most often consulted (54%). Other sources were the internet (52%), a friend (34%), one's wife/girlfriend (31%), the media (27%), an assistant in a sexual health shop (19%), a pharmacist (16%), a psychologist (11%) or a family member (5%). The patients first sought help from a physician (23%), the internet (31%), their wife/girlfriend (13%), a friend (11%), the media (9%), an assistant in a sexual health shop (4%), a pharmacist (4%), a psychologist (3%) and a family member (1%). Physicians and the internet were the most consulted sources, and young patients tended to rely more on the internet and consulted more sources.
The researchers found that cultural factors clearly played a role by influencing how comfortable people were discussing sexual problems. Patients in China might think that talking to a partner about their sexual problems might make them appear to lack self-confidence, especially for a man, and that explains why younger Chinese men tend to consult the internet instead of doctors. Finally, the researchers concluded that physicians in China should enhance health education about ED, especially via the internet.

Ömer Gülpinar [10]reported data on the attitudes, beliefs and factors affecting the help-seeking interval amongst Turkish men with ED to determine whether they were different from those previously published in the literature. Of 279 Turkish men complaining of ED and attending a clinic between December 2006 and March 2008 without the need for referral, 202 were interviewed from a standardised questionnaire covering demographic details, relationships, help-seeking intervals and attitudes and beliefs. Participants ranged in age from 20–80, and the mean age of the study population was 50.1 years. More than half (51.8%) of the study participants were employed, and almost one-third (32.5%) had attained only primary school education. Most participants were married. The researchers saw clearly that participants with low household income and education levels had a relatively longer help-seeking interval than the remaining sample. Of the men questioned, 51.8% believed that older people had no sexual desire, and as many as 20.4% said they would consider medication for their ED. Embarrassment was the strongest barrier factor that prevented participants from talking about ED (63%), while the belief that it is a self-limited/non-serious problem accounts for 32%, the belief that the problem is a natural process of aging accounts for 26.7%, and only 6% were uncomfortable talking to their doctor.

S. Humphery [11] sent a postal questionnaire to 218 GPs on the Camden and Islington Health Authority List. The questionnaire collected demographic information on the GPs, including their clinical interests, experience, postgraduate qualifications and views on the clinical importance of sexual dysfunction and their clinical management of the most recent encounter with their patient. The aim of this study was to investigate the role of the GP in the management of problems of sexual dysfunction. A total of 133 GPs responded to the questionnaire. Although only eight had a special interest in sexual health, 41 reported a special interest in mental health and and 50 in women's health. Forty-six had received postgraduate training in taking a sexual history, 45 in the diagnosis of a sexual problem, 49 in the management of sexual dysfunction, 39 in psychosexual counselling and 24 in all four areas. Most GPs (87) categorized sexual dysfunction as medium priority, 25 as high priority and 18 as low priority; three GPs did not respond to this query. Several barriers to the management of sexual dysfunction in general practice were identified. Most doctors identified more than one barrier.

M.F. Abdulmohsen[12] conducted a study testing the knowledge, attitudes and practices (KAP) of physicians towards erectile dysfunction in the eastern province of Saudi Arabia. At a scientific meeting about erectile dysfunction, 159 physicians from both the government and private sectors privately answered a 34-item questionnaire. The mean total KAP score for the group was below the expected standard of 60%. Male physicians scored significantly higher than females. Urologists scored the highest, followed by andrologists. Surprisingly, physicians with higher qualifications scored lower than those with intermediate qualifications and even lower than general practitioners. Those who had practised for at least 10 years scored better than those with less than 10 years practice.

D.S. Solursh and J.L. Ernst[13] studied the human sexuality education of physicians in North American medical schools, Their objective was to assess how well the 125 American and 16 Canadian schools of medicine prepared physicians to diagnose and treat sexual problems. They carried out a prospective cohort study was carried out; the main results were a description of the medical educational experiences, teaching time, specific subject areas, clinical programs, clerkships and continuing education programs in the domain of human sexuality in North American medical schools. The results were as follows. There were 101 survey responses (71.6%) from a potential 141 medical schools (74% of

American and 50% of Canadian medical schools). A total of 84 respondents (83.2%) used a lecture format for sexuality education. A single discipline was used in 32 (31.7%) schools, but a multidisciplinary team was responsible for teaching in 64 (63.4%) schools (five schools failed to respond to the question). The majority (54.1%) of the schools provided between 3 and 10 hours of education. The curriculum of 96 respondents included the causes of sexual dysfunction (94.1%), its treatment (85.2%), sexual orientation (79.2%) and issues of sexuality relating to illness or disability (69.3%). Only 43 (42.6%) schools offered clinical programs that focused on treating patients with sexual problems and dysfunctions, and 56 (55.5%) provided students in their clerkships with supervision in dealing with sexual issues. In conclusion, it may be necessary to expand human sexuality education in medical schools in order to meet public demand for informed health providers.

From June through August 1999, the survey was sent to the existing 125 American and 16 Canadian medical schools. (Follow-up phone calls and e-mails were sent from October 1999 to May 2000.) Numerous calls were sometimes required to find someone who would take responsibility for filling out the questionnaire. In a number of cases, there did not seem to be one person who had an overview of the curriculum. Sometimes there was such a person designated, but they recognized deficiencies in their program, were embarrassed by the prospect of returning a blank survey instrument to us or simply failed to respond, which we determined through follow-up phone calls. Occasionally the failure to respond meant that no human sexuality program existed at a particular school. For example, two schools that did respond admitted they did not devote any time to human sexuality in their training of medical students. A total of 103 responses (including two duplicate responses from the same medical school) were received. Thus, there were 101 valid responses (71.6%) from a potential of 141 medical schools. Of the 101 surveys, 93 (74.4%) of a potential 125 medical schools came from the United States (including two from Puerto Rico), and eight (50%) from 16 medical schools in Canada. Figure 1 shows the geographical distribution of the respondents, which reflects the actual distribution of medical schools in North America.

A Systematic Review of Educational Programs by Coverdale focused on the importance of taking a patient's sexual history[14]. The authors attempted to identify all randomized controlled trials about teaching this topic and reviewed the methods used for teaching and the efficacy of the educational interventions. Of the 11 trials identified, 7 included medical students, 2 included residents, 1 involved community-based physicians, and 1 involved attending physicians, fellows, and residents. The educational interventions and outcome measures were heterogeneous, and the quality of study methodologies varied widely. The authors judged only one study to be of very high quality, although eight studies explicitly mentioned at least one of the following: group differences at baseline, blinding, follow-up, and validated measurement tools. In the highest-quality study, primary care physicians who were mailed educational materials and received an unannounced instructor visit performed better in risk assessment and counselling than did two comparison groups. Evidence also supported the value of interactive workshops over didactic presentations.

E.O. Laumann[15] for the GSSAB Investigators' Group conducted a population-based survey of sexual activity in order to study help-seeking behaviour patterns in mature adults in the United States. Using a random-digit dialled sampling design, computer-assisted telephone interviews were carried out in the US during 2001 and 2002. Respondents were randomly selected by asking for the man or woman in the household between 40 and 80 years of age. Erectile difficulty was the second most common male sexual problem in the US sample, reported by 22.5% of sexually active men. Of the respondents, 45.2% of men did not take any action to address their ED and 21.9% reported talking to a medical doctor about their sexual problems, but overall the majority of men had sought no help from a health professional. Researchers found that talking to a partner was the most common action taken by men with sexual problems, followed by talking to a medical doctor; most of the men, however, did not take any action.
Factors associated with seeking medical help for sexual problems included the belief that decreased sexual ability would significantly affect their own self-esteem. Factors that prevented men from talking about their sexual life or ED were thinking that it was not very serious, waiting for the problem to go away and a belief that ED was a normal part of aging, in 36.3% of men. Thinking that older people no longer want to or have sex had quite a different effect on men, while only 1% thought that talking to doctors about sex was not easy. The researchers also found that doctors in the US rarely asked patients about their sexual health during routine consultations. More than half of the population involved in the study thought that a doctor should routinely ask patients about their sexual function. Finally, researchers concluded that appropriate educational initiatives

aimed at both patients and healthcare professionals may help increase awareness and understanding of sexual health issues and help physicians to identify and overcome the potential barriers that their patients might have.

A study guided by the same concept was conducted in Australia by E.D. Moreira,[16]. A telephone survey was conducted in Australia in 2001 and 2002 with interviews based on a standardised questionnaire. A total of 1500 individuals, including 750 men aged 40–80, completed the survey. Overall, 83% of men had engaged in sexual intercourse during the 12 months preceding the interview and 21% of them had experienced erectile difficulties. Though 21% of the 750 is considered a high percentage, these men rarely sought medical help because they did not perceive these difficulties as serious or sufficiently upsetting.

G. Brock& Moreira Jr, studied sexual activity, the prevalence of sexual difficulties and related help-seeking behaviours amongst mature adults in Canada[17]. This random-digit dialled telephone survey was conducted from 2001 to 2002. Interviews were based on a standardised questionnaire, including demographics, general health, relationships and sexual behaviours, attitudes and beliefs. The survey was completed by a total of 1007 individuals, including 500 men.

This population reported a 16% incidence of erectile difficulties, with more than 75% of men having sought no help for their sexual problem(s) from a health professional. Researchers found that the respondents were not sufficiently bothered by the problem or did not think that it was serious.
Jacques Buvat and Dale Glasser studied sexual activity, the prevalence of sexual problems and related help-seeking behaviour amongst adults in France[18]. A telephone survey was conducted in 2001 and 2002. Interviews were based on a standardised questionnaire including demographic details, overall health, relationships, and sexual behaviours, attitudes and beliefs. A total of 1500 individuals responded, including 750 men. Of the respondents, 81% of men had engaged in sexual intercourse during the 12 months preceding the interview, and 15% of them had experiened ED. The researchers found that only a minority of these individuals had sought medical help for these disorders, largely due to the belief that the problem was not serious, their not being bothered by the problem, and/or lacking awareness about available treatments. Other reasons respondents cited for not consulting a doctor about the sexual problems they had experienced were beliefs that it was a normal part of aging, being comfortable the way he was (87.2%), or believing the problem not to be very serious and waiting to see whether it went away (72.3%). Only 12% were uneasy to talk to doctors about sex, but only 16.7% had attempted to talk to a medical doctor.

Wah-Yun Low [19] conducted research to explore the barriers faced by general practitioners (GPs) in the management of patients with ED. The researchers found that many factors act as barriers, including factors related to doctors, patients, and drugs, among others. For doctors, regarding ED as a 'less important disease' was a major barrier to its treatment and discussion. The lack of time in a busy clinic also made the treatment of ED difficult, and some GPs felt that their lack of training made them uncomfortable treating patients with ED. Patient factors, such as embarrassment in discussing such a sensitive topic, were commonly noted. The patient's age and financial status were also viewed as barriers.
C. Simonelli and F. Tripodi [20] researched the questions that men and women asked a helpline for sexual concerns in the results of an Italian telephone counselling service. The study included selected records of the calls received during the 3-year period between 2006 and 2008 (n = 944). Users were more often male (62.2%) and aged 26–35, who had not sought any previous help. The most frequently reported male sexual difficulties were ED and premature ejaculation. The researchers found an association between desire disorder and ED in men (41.7%). This study provides insight into the importance of telephone counselling.

Hartman and Burkart [21] studied ED in patient–physician communication and investigated which phrasing and communication strategies achieved the highest acceptance from physicians and their patients and were considered the most effective. The researchers found (i) the patient questionnaire found a high level of acceptance, with 54% of discussions of sexual health prompted by it; (ii) the patients' reaction to physicians addressing sexual health concerns was positive in more than two-thirds of the sample and characterized by openness, a willingness to communicate and relief that their sexual problems had been addressed; (iii) from the physicians' perspective, the most favoured communication strategies were a clear signalling of a willingness to talk, and addressing treatment possibilities or signalling that help was available; and (iv) the resulting discussion led to further diagnostic measures in 25% of patients and to further therapeutic measures in 60% of patients.

DISCUSSION:

For most people, sexual expression is an important part of a full and healthy life. World authorities have declared sex to be a basic human right and an integral part of life[22], so a diminished sexual life has a strong effect on one's quality of life. Erectile dysfunction is characterized by a consistent (lasting three months)or recurrent inability to attain and/or maintain penile erection sufficient for sexual performance[1]; it should be considered a disorder based primarily on the patient's complaint. As noted in the article review, a number of studies have observed large variations in the prevalence of ED. To some extent, these differences likely reflect variations in definitions, methodology and study populations; nonetheless, ED his common not only among the elderly population, but among the general population as well.

On the other hand , its highly under-reporting due to many factor including , embarrassment, loss of self-esteem and misunderstanding of the condition, in which patients believe ED [2] in China, the economic status of the patient played a major role. In Malaysia, another factor cited was a lack of time for training in discussion of the issue for busy clinics and doctors at the educational, resident and fellow levels. Finally, the availability of sildenafil plays a role as a barrier; it has been assumed that the availability of convenient treatments affects the diagnosis and treatment rates for ED. Skaer et al [23] reviewed data from the US National Ambulatory Medical Care Survey for the years 1990–1998 and found a significant increase in the rate of physician–patient encounters for 'a complaint (of ED) as a reason for requesting an appointment' and/or 'a diagnosis of ED'. In 1990, there were 17 encounters for a complaint of ED and 15 diagnoses of ED per 1000 US male population. While the number of visits remained relatively stable between 1990 and 1995, in 1996 this increased significantly to 25 encounters per 1000 men for a complaint and 28 per 1000 for a diagnosis of ED. This rate remained constant through 1998. The introduction in 1998 of the PDE-5 inhibitor treatment did not immediately appear to influence the established upward trend in the number of encounters. A look at the prescribing of sildenafil in the same survey, however, showed that only in 41% of patients prescribed sildenafil was a diagnosis of ED recorded, and only in 33% was a complaint of ED given as a reason for the appointment. These facts highlight that there may be an underreporting of ED in the physician files

Despite some common factors and differences across regions, most studies used the same concepts when breaking the ice with ED patients. In the US, Canada, France, Australia and Italy, researchers used the telephone to discuss sexual issues with patients. This technique has the benefit of causing less embarrassment than face-to-face interviews, but may have as a possible unintended consequence misdiagnosis, since ED could be caused by other systematic diseases. Phone interviews also decrease the professionalism of taking the patient's history. In contrast, some countries such as China, the US, Turkey and Malaysia have included studies that use the questioner to discuss sexual issues. This approach may result in a more detailed patient history by decreasing the risk of misunderstanding within the patient-doctor relationship.

Communication skills and education play a major role in approaching a patient with erectile dysfunction. Training courses on ED management, using a combination of tutorials and interactive sessions, constitute an effective way of: (1) providing knowledge, (2) enhancing physicians' communication skills with ED patients and (3) influencing attitudes toward patient-centeredness in sexual issues, as concluded by Athanasiadis et al. in 2006.

A combination of telephone and in-person questioner techniques could help decrease the delay time between the onset of the symptoms and the time of presentation while improving ttraining for doctors to interpret ED in patients. A short patient questionnaire is an excellent aid for patients and physicians in initiating communication on the topic, as concluded by Hartman and Burkart.

The role of awareness is critical in changing misconceptions about ED. Consider the psychological impacts on patients and their partners and the fact that ED could be a sign of an early systematic disease. Devoting more time to each patient and asking appropriate questions about their sexual life, using open-ended questions like 'How is sex going for you lately?' could be helpful in initiating discussion.
Marwick [24] did a survey in 1999 for patients with sexual dysfunction in which he found that patients expect little help from their physicians on the subjet of sexuality, so devoting time to all patients is very important.

How to break the ice with patients could vary from one region to another depending on cultural issues. In some countries patients may benefit from face-to-face interviews, and in others they may rely on different techniques to avoid the embarrassment of

in-person assessments. Asking appropriate questions could help initiate the discussion. Given the sensitivity of the topic, the clinician must be aware of the patient's comfort level. Taking the patient's history provides an opportunity for the physician to initiate patient and partner education about ED and its treatments and to facilitate communication. It also allows the physician to establish rapport with the patient, which assists in treatment. Formal questionnaires may be valuable in this setting by using IIEF, SEP, GAQ, PAIRS, SEAR and EDITS.

CONCLUSION:

ED is common yet under-reported, due to the stigma surrounding it. It negatively affects the psychology of men and their partners, Physicians should continue to improve their communication skills in order to effectively use the multidisciplinary approach to communicating about erectile dysfunction that the sensitive topic so clearly needs.

REFERENCES:

1- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4291852/#ref1
2- Sexual behavior and sexual dysfunctions after age 40: the global study of sexual attitudes and behaviors. https://www.ncbi.nlm.nih.gov/pubmed/15533492
3- perelman et al. 2005 https://www.ncbi.nlm.nih.gov/pubmed/16422872
3- Feldman , McKinlay JB.. Impotence and its medical and psychosocial correlates:results of the Massachusetts Male Aging Study. J Urol
4- Braun (2000) https://www.ncbi.nlm.nih.gov/pubmed/11416833
5- http://www.nature.com/articles/3900949.pdf?origin=publication_detail
6- k.baldwin https://www.ncbi.nlm.nih.gov/pubmed/12789385
7- Asnida Anjang Ab Rahman help-seeking behavior
8- Help-seeking behavior for erectile dysfunction: A clinic-based survey in China https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3901871/
9- https://www.semanticscholar.org/paper/Help-seeking-interval-in-erectile-dysfunction-anal-G%C3%BClpinar-Halilo%C4%9Flu/3091241931c3a0f46f90ba22d3cee3a24b5d9315
10- GPs' views on their management of sexual dysfunction https://academic.oup.com/view-large/11580465
11- Physicians' knowledge, attitude and practice towards erectile dysfunction in Saudi Arabia https://www.researchgate.net/publication/7433362_Physicians%27_knowledge_attitude_and_practice_towards_erectile_dysfunction_in_Saudi_Arabia
12- The human sexuality education of physicians in North American medical school https://pdfs.semanticscholar.org/0b94/1a436347dd6dd083860f4ac82067b7cae9f9.pdf
13- http://journals.lww.com/academicmedicine/abstract/2011/12000/Teaching_Sexual_History_Taking__A_Systematic.29.aspx
14- A population-based survey of sexual activity, sexual problems and associated help-seeking behavior patterns in mature adults in the United States of America https://pdfs.semanticscholar.org/8a70/fd0e46f9862be154de433f1e53ec90f9dbd0.pdf
15- Sexual difficulties and help-seeking among mature adults in Australia: results from the Global Study of Sexual Attitudes and Behaviours https://www.ncbi.nlm.nih.gov/pubmed/18771637
16- http://www.nature.com/articles/ijir20097
17- https://pdfs.semanticscholar.org/3e60/f027285626f20f4af5bb6973c62de0f0432d.pdf
18- http://www.asiaandro.com/archive/1008-682X/6/99.htm
19- https://www.researchgate.net/publication/44586081_What_do_men_and_women_ask_a_helpline_on_sexual_concerns_Results_of_an_Italian_telephone_counselling_service
20- https://www.researchgate.net/publication/6708936_Erectile_Dysfunctions_in_PatientPhysician_Communication_Optimized_Strategies_for_Addressing_Sexual_Issues_and_the_Benefit_of_Using_a_Patient_Questionnaire
21- World Health Organization draft working definition, 2002
22- https://link.springer.com/article/10.2165/00115677-200109010-00004
23- https://jamanetwork.com/journals/jama/article-abstract/1680225