Newsletter

Middle East Society for Sexual Medicine

March 2014
Issue 6

In this issue:

- Erectile dysfunction treatment a lifetime journey and vision to the future
- Practical Recommendations to Work with Couples presenting with “Unconsummated Marriages” in Any Health Care Settings

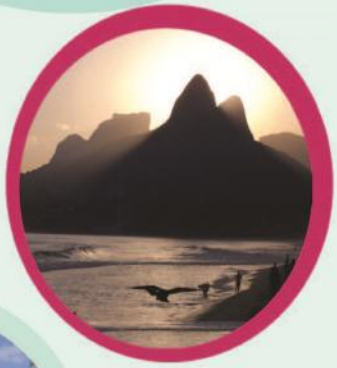
Please visit our website: www.messm.org

16th World Meeting on Sexual Medicine

8 - 12 October 2014 - São Paulo, Brazil

www.issmslams2014.org

See you in São Paulo!



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NEWSLETTER

Middle East Society for Sexual Medicine

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EDITORIAL

Letter from the President

Dear friends and colleagues,

I would like to congratulate the new board of directors for the term 2013-2015. I would also like to thank very much the MESSM members, efficient executive office and the immediate past president and board of directors for their efforts, time and dedication that helped and supported the society very well. I would encourage everyone to participate in the activities of the society such as the MESSM website, MESSM Newsletter, publications in the JSM and participating in the different committees and meeting activities of MESSM.

I would like to thank the immediate Newsletter past editorial board for their achievement during the last couple of years and congratulate the new editorial board and wish them more success in the coming years. This issue of the newsletter is an excellent one and I hope you will enjoy it and will actively participate in the coming issues.

We have already organized the new committees of the MESSM; I encourage everyone to participate in the different committees according to his/her interest. Several scientific activities will be held in the near future. Finally, I would like to extend my great appreciation and warmest thanks to all who attended and helped the success of the 2nd Biennial Meeting of the MESSM, Dubai, U.A.E. from October 31-November 2, 2013.

As president of MESSM I emphasize that members are invited and strongly encouraged to participate and have a role in the society to help make this society a success. We hope that the coming 2 years will carry a lot of good news for patients in the region and be full of achievements to MESSM members.

Ahmed El-Sakka, MD
President MESSM

NEWSLETTER
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EDITORIAL

Letter from the Editor

Dear colleagues,

I would like to welcome you to the 6th Edition of MESSM newsletter. The 5th edition was supposed to be my last one as Chief Editor but it seems that I became addicted to it. I hope I can present new interesting topics in this edition and hope that you enjoy reading it.

In this issue we have two extraordinary review articles. The Famous Dr. Ronald Virag is sharing his lifelong experience in treating erectile dysfunction with us in a must read article. Dr. Sara Nasserzadeh is writing her recommendations in dealing with couples presenting with "Unconsummated Marriage". We also have a bunch of new interesting studies published in different journals as well as case reports that are worth reviewing.

The 2nd Biennial Meeting of MESSM was held in Dubai during October/November, 2013. It was as successful as we wished it to be and we are really proud of it. *Do you want to know more about it?* Then go the meeting report section and join us next time in the 3rd one to share our success.

Last but not least, I want to congratulate the new President of MESSM, ***Dr. Ahmed El-Sakka*** as well as all the ***Board members***. I wish you all the best.

Mohamed Arafa
Chief Editor

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MESSM NEWS

2nd Biennial Meeting of MESSM

The ***2nd Biennial Meeting of MESSM*** was successfully held in Dubai, UAE from 31st October to 2nd November, 2013.

MESSM new board of Directors

MESSM members have elected a new board of directors to carry on the job of maintaining and promoting the society for the next two years. Dr Ahmed El-Sakka is the new President of MESSM.

MESSM Public Website

On September 4th, 2013, the international sexual health day, MESSM launched an Arabic website dedicated for the public www.yoursexualhealth.me.

MESSM FACEBOOK PAGE:

The MESSM Facebook page is now available for all MESSM members and colleagues. Please visit our page and share with us any information that will help improvement of MESSM services in the future.
http://www.facebook.com/pages/Middle-East-Society-for-Sexual-Medicine-MESSM/208135919197719

NEWSLETTER
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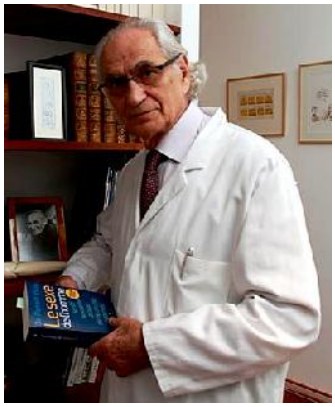
REVIEW ARTICLES

Erectile dysfunction treatment a lifetime journey and vision to the future



Ronald Virag, M.D.

It has been a great honor for me to participate to the 2013 MESMS meeting in Dubai being able to give that lecture on my achievements and vision in erectile dysfunction (ED).

The most frequent question about my career is "How as a cardiovascular surgeon were you interested in ED and decided to dedicate all your professional life to it?

The proper answer is that several facts agglomerate together: Leriche's syndrome, interest in clinical research together with the ambition to go in undiscovered paths and finally the meeting with men enthusiasts to the new field.

1- Premises: from Michal I to Virag's Deep dorsal vein arterializations:

As chief resident (1968-70) in a large CV unit in Paris, I went to operate on many men affected with aorto-iliac obstruction (so called Leriche's syndrome). At that time few surgeons reacted to the patients' claim concerning ED (part of the syndrome). I became interested and started to look at the literature with poor answers. The only available treatments were rigid and implants. A few years later (1975) I read a short notice about an article in the World J. of Surgery concerning direct revascularization of the cavernous bodies (CB) with the epigastric artery. The surgeon was Vaclav Michal (see photo 1) from Chezslovaquia. Michal's thoughts at that moment were that organic ED was quite exclusively an arterial disease. Michal I epigastric to CB shunts had many pitfalls and my understanding was that we were at least on the wrong way. After a careful survey of the literature and study of our cases I felt that we needed a multidisciplinary approach of ED. After the two first international meetings in New York (1978) and in Monte Carlo (1980) I had formed a team to study all the aspects of ED: vascular, neurological, endocrine and of course psychological. We started to work closely with the Danish group headed by Gorm Wagner. (photo 2) The vascular mechanisms of erection and ED were clarified with the evaluation of hemodynamics with ultrasound, artificial erection and cavernosography (photo 2). With the proper engineers adequate tools were developed (photo 3 and 4) and inspired widely what was later done in the US. Results were summarized in 4 categories: normal, arterial, venous or mixed arterial and venous. The arterial group alone was candidate to Michal's technique, and for the two other groups we designed the deep dorsal vein arterialization plus some veins' ligations. Our results concerning 440 cases were studied in 1984 in situ by an American urologist Allan H Bennett. Therefore, the AUA presented me with the Lattimer Lecture in 1985. In the meantime (1981-2) had occurred the first intracavernous injection (ICI) of papaverine (published in 1982 in the Lancet) which open a completely new field in the treatment of ED.

Photo 1: "Vaclav Michal"

Photo 2: "The author with Gorm Wagner"

Photo 3 & 4: "The Rigidimeter"

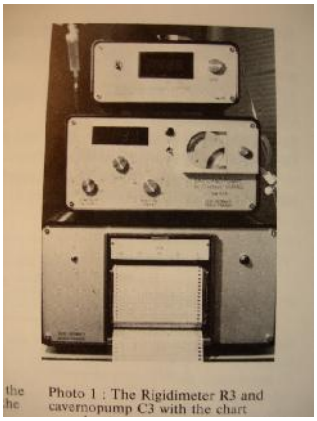


Photo 1 : The Rigidimeter R3 and cavernopump C3 with the chart

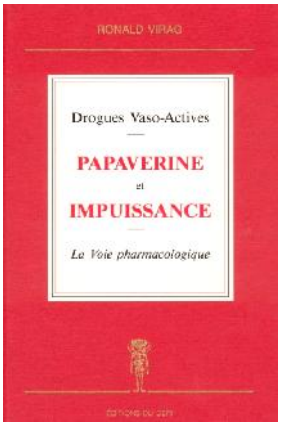
2- From Papaverine to Viagra: the pharmacologic era of ED

The discovery itself was the consequence of an event in the OR during a direct bypass between the epigastric artery and the CB. The donor artery was collapsed. So, I did an injection of papaverine in the vessel already branched to the CB. The man had a very severe arterial disease of his two pudendal arteries. A full erection occurred a few minutes later which lasted for two hours, even after having clamped the donor artery. It became obvious to me that the medication should have provoked such an effect. I decide that the only way to verify the hypothesis was to inject myself with the drug. Same result with a much lower dose. During the next months until the today famous letter to the Lancet, with the help of Gorm Wagner several tests were done using papaverine to enhance ultrasound performance, cavernosography and research. Finally, patients started to be injected with some results which reported in the Lancet and in a more extensive study in a specialized vascular journal.In the meantime an English psychiatrist, Giles Brindley studied on himself the effects of intracavernous phenoxybenzamine. He made a stunning presentation one year later in the 1983 AUA meeting. Then Zorgniotti proposed to mixed papaverine with regitine and on both sides of the Atlantic auto-injections started. Animal research started worldwide especially in Singapore where G. Adaikan who became later president of the ISSM designed very elegant studies with animal and human strips of CB. He came to work with us during one year and we define together the concept of multilevel acting medications reaching to "multimix" mixtures.

The medication containing 5 different compounds as called Ceritine, from CERI, acronyme of Cente for evaluation and research in impotence. Among the studied medications was PGE1 which results were presented in the 1986 ISIR meeting in Prague. Clinical studies were also turned towards epidemiology: in 1985 we published ,again in the Lancet, an article with a provocative title: "Is impotence an arterial disease ?" were it was demonstrated that more arterial risk factors a patient has, more chance his ED has to have an arterial origin. In 1984, with the organization in Paris of the First World Meeting, I have promoted a translational approach of ED: the initial small group of surgeons interested in revascularization of the CB was transformed in a polyvalent association of researchers concerning many specialties: the skeleton of what became nowadays the ISSM and all its local branches. One big issue at that time was the fact that except for the penile implant companies, industry was not interested in this new field. Clinicians were the first promoters until one company Upjohn became aware of the use of PGE1 in ED. The drug had been developed for the very tiny market of pediatric cardiac surgery. And suddenly they had to face a huge and salvage demand for ICI. They were smart and accompanied the demand, developing Caverject, the first marketed compound for ED. All over the world, research spread and especially in the US after the visit we did in 1983 in the Mayo Clinic responding to the invitation of William Furlow. Michal, Wagner and myself brought in that fertile environment all the new ideas which were developed further on. Until 1995 and the launching of the oral PDE5 inhibitors, ED treatments were divided in ICI, implants or vascular surgery, with the support of psychotherapy and or recommendation to change lifestyle: stop smoking, control of cholesterol and sugar level, extra weight loss.

One interesting conclusion of these early years is that the two oldest treatments i.e. implants and ICI are still the more efficacious with the highest level of satisfaction. In 2010, we published the study of a cohort of 542 patients treated with ICI and followed from 10 to 28 years with an average of 14 years.
More than 3 over 4 have still a satisfactory sexual life.

3- ED at the time of PDE5 inhibitors



After the launching of PDE5 inhibitors, namely Viagra in 1995, then Cialis and Levitra, things changed dramatically. First of all the availability of an easy oral treatment pushed many more patients suffering from ED to seek medical support.

The industry put initially a lot of money on research and sponsoring of meetings. But it appeared also that the diagnostic work became scarce with a frequently exclusive prescription of pills. This was encouraged specially among non-specialized doctors by an overestimation of the good results. We demonstrated that the results of sildenafil were specifically dependent of the status of the caverno-venous outflow. More venous leak you have, more failures of sildenafil were observed. In addition to the poor diagnostic work on patients, it appears that research was mainly concentrated in two fields': epidemiology and cellular mechanisms. One has to understand the main focus of the industry sponsoring such research is the development of new oral compounds which is not blameworthy but a bit short. It is the reason why in my clinical research I kept myself concentrated on trying to explain the failures of the oral treatment and focused in trying to overcome them.

Moreover in the last years we had to face two sets of questions even in patients satisfied with their treatments: Doctor should I take this treatment as long as I live? And subsequently are you able to cure me? And even more challenging questions about prevention in an arising ageing population asking to remain sexually active.

<u>Let's see where we go</u>

- Most of the failures of oral iPDE5 are linked to a caverno-venous leak. I recommend to study carefully their cause which might be psychological, hormonal metabolic or anatomic. We have developed two different tests to evaluate the metabolic and the anatomic aspects
- The penile NO release test propose to evaluate the penile endothelium. It is a non-invasive test aimed to measure the dilatation of one of the two deep penile arteries after a 5 minutes ischemia. Changes are evaluated by ultrasonography and an index is then calculated. Low indexes are mostly linked to the presence of arterial risk factors, sometimes unknown. The test may act as preventive in patients with light ED of unknown origin.
- CavernoCTscan is devoted to evaluate patients whose caverno-venous leak does not find other etiology. 3D reconstruction (fig6) permits a classification of the leak and choice for surgery and/or conservative treatments.

What are we personally working on?

- Improvement of the mixture of compounds dedicated to ICI. The ICI treatment is now efficacious in 90% of all cases and safe. All patients carry with the the antidote etilefrine usable without any risk.
- Research is also dedicated to improve the delivery of the medications in the cavernous bodies
- We are currently evaluating two treatments dedicated at the improvement of natural erections. The first one is based on the use of low intensity shock waves as proposed by Vardi. The second one uses autologue cell therapy mixing plasma rich platelets (PRP) mixed with hyaluronic acid.

Targeting the future as a conclusion.

This has been apparently a very long journey (around 40 years), but I feel it very short. My enthusiasm is still there, almost unchanged. Why is it so? Because every morning I awake with a new question about erection and/or ED. This includes so many unsolved items in male sexuality. A such large sample of research's programs. More specifically, gene and cell therapy, tissue engineering are on their way, even if I won't see them myself in day to day practice.

Some days, I am proud to have contributed to have initiated all these tremendous changes but the most I like is when a patient and this is frequent, comes to me and says: "Doctor thanks, you have changed my life"

REVIEW ARTICLES

Practical Recommendations to Work with Couples presenting with "Unconsummated Marriages" in Any Health Care Settings

Sara Nasserzadeh, PhD, DipPST
Accredited Psychosexual Therapist and Couples' Counselor
Private Practice, New York City

The term "unconsummated marriage" (UCM) originally referred to "the failure to perform successful sexual intercourse at the beginning of the marriage". Over the years, working across 22 countries, I came to refine this definition to embody the cultural context of the couple. The working definition that I utilize is "failure to perform successful sexual intercourse within a marital constitution within the time frame that is expected by the couple's cultural context."

Based on my personal clinical observations for over a decade now, by the time a couple decides to see a health care professional in North America or the UK, they fall into three main timeframes:

- Married less than a year (only 10%)
- Married more than 4 years (up to 80%)
- Married more than 10 years (10%)

This ratio is based on my practices in London and New York City, which mainly accommodate couples from the Middle East and South Asia, among other varyied ethnic backgrounds. A practitioner working within a Middle Eastern country (especially Midwives, OBGYNs and Urologists) might see a significantly higher number of couples within the first year of marriage since they would be the first point of contact, and the socio-cultural pressure is much greater to consummate the marriage as soon as the wedding night.
One of the reasons for this earlier health seeking action is the lack of trained and licensed psychosexual therapists within most of the Middle Eastern countries, in addition to the socio-cultural pressure of consummating the marriage within the first year. This timeline may be influenced by the legal system of the country (for example, a couple is eligible for divorce if they could not consummate the marriage within a year – from either the male or the female side) or may be due to the pressure on the couple to start a family. Although there are only fragmented documents on the above-mentioned points, these could prove critically important for colleagues who work with individuals or couples to help them get through their problem. As we all know, the motivation behind the visit to the health care professional indicates the compliance and, ultimately, the outcome of therapy/treatment.

This paper aims to provide some practical recommendations to colleagues working with individuals and couples who present with UCM regardless of the main underlying issue (the male sexual issue or the female).

Moving further from the literal definition of UCM, in most academic settings the term UCM has largely been replaced with the specific underlying issue that the couple presents with (in order of statistical frequency: vaginismus, erectile dysfunction and premature ejaculation). However, as it is still a widely used term for patients, this terminology has been utilized within the context of this practical paper.

There is a good body of literature to examine the predisposing and precipitating factors behind UCM (for examples, please refer to Badran, et al 2006, Abraham, 1956, Michetti, et al. 2014). Most of the contributing factors are known to be of psychogenic origin, due either to socio-cultural pressure on the accomplishments of the wedding night, or the general anxiety the individuals have regarding the initiation of their sexual encounter. These factors are further complicated by the couples' lack of information regarding sexual organs, their function, and ingrained misconceptions regarding what the outcome should be.

Introducing the HAT Model:

The overarching framework this paper would like to propose is the Holistic Assessment and Therapies model (HAT), which considers a bio-psycho-socio-legal assessment of the situation. Furthermore, as the acronym suggests, HAT stands for different roles that a health care professional takes on to address the patients' needs. We can all identify with instances where we only needed to give out information to solve a patient's problem, while at other times we claimed a role of an authority figure to convince the individual/couple that what was suggested (be it a homework or a specific sexual conduct) was to their best interest coming from a place of knowledge and care especially when there was a doubt about the acceptance of the recommended practice by the person's religious beliefs or personal preferences.

Although this approach is likely to be more appealing to colleagues with a psychosocial background, medically-trained professionals could also benefit from this approach by creating a holistic overview regarding the assessment and management process of sexual issues (especially when underlying psychogenic factors are at play).

Utilizing this approach, not only can we accurately diagnose the person presenting the problem (for example, female pain disorder) but we can also go further to examine the dynamic of the relationship (such as fear of intimacy).

PLISSITR Model:

Many medically-trained colleagues work in settings that do not support adequate evaluation time for this holistic assessment; however ,almost everyone will have time to cover the initial steps of the PLISSIT model (Jack Annon, 1976) which has an added element of R (Referral) in the HAT approach. Thus, the whole model is presented as PLISSITR:

- Permission (let the individual and the couple know they are not alone, offer them sympathy and reassurance that this will be resolved, as it has been for many other couples)
- Limited information (using simple props can go a long way in providing education to clients who have never had a systematic and accurate sexuality education)
- Specific suggestions (use of lubricants, specific techniques that might suit a particular couple, changes in lifestyle, etc.)
- Intensive therapy (which could be a referral to a trained psychosexual therapist or, in the absence of such a professional, the use of medical treatment to solve the immediate problem (e.g., medication to help with erectile dysfunction that originated due to anxiety or dyspareunia and may be resolved with local anesthesia, training with dilators, etc.)
- Referral (at this point, the health care professional could use his/her network of referrals to bring in colleagues with complementary expertise to help with the treatment/management of the sexual problem and offer ongoing support to the individual or couple, as needed).

With a focus on providing limited information to individuals and couples (which seems to be the majority of the work with couples presenting with UCM), there are seven things to consider when using educational props:

- Feel comfortable with it (including how it functions)
- Explain why you are using it
- If you don't know the clients/patients well enough – or you suspect that their spiritual/cultural beliefs might contradict the use of specific materials – ask in advance if this form (e.g., picture) will be acceptable to use with them and why it is important to do so
- Consider using specific props/discussion on technique in individual sessions (e.g., perineum massage)
- Take extra care to choose bias-free props (size, color, shape)
- Store with caution
- With more explicit props, utilize a more formal authoritative style
- Use your position as the heath care authority to overcome the clients'/patients' hesitation or shame around being presented with a sexuality-related prop

Main styles of delivering information regarding sexuality:

The four main categories of delivering information – Formal Authority, Demonstrator, Facilitator, Delegator – that were introduced by Fischer and Fischer in 1979 have been adapted in the HAT model to benefit the clients/patients in an accessible, non-offensive, acceptable way. These four styles can be adapted to health care settings and, more specifically, to

psychosexual therapy, and would come together to offer the holistic educational benefits to the clients/patients.

These could be explained as follows:
For teaching sexuality and relationship issues, one can use the formal authority method of instruction, to discuss the importance of the topic one wants to bring up (for example, testicular exam). One could then use the demonstrator style and model the proper way of doing the exam (you can simply use your words, use graphs, pictures or just your hands on a model to demonstrate). Have the client(s) participate in the demonstration by asking questions rather than giving answers. For example, "What are some important things I must remember when I examine myself?"(Answers may include the frequency of the exam, the routine they need to build around it, and any unusual finds.) One could also make suggestions for how to build a routine or where might be best to do the exam, and then facilitate participation by having the client(s) come up with other options that would be suitable for them. When the health care provider asks a client to do an exercise which requires personal adjustments, (s)he may delegate, instructing the client to come to the next lesson with their own list of preferences and how they decided to perform the exercise/exam, etc. In this way, they will be more likely to continue with the exercise. Fischer and Fischer (1979), adapted for Psychosexual Therapy by Nasserzadeh, S. (2013)

Summary

Unconsummated marriage seems to be an overarching terminology that couples use to describe their failure at attempting intercourse with their spouse. Current research from various Middle Eastern countries supports the claim that vaginismus, followed by erectile dysfunction and premature ejaculation, are the main underlying reasons for these failed attempts. As the main predisposing factor noted to be largely psychogenic has been shown to be lack of sexuality education, this paper attempts to provide some practical concepts and recommendations for health care professionals in any setting using the HAT approach to assist them with the provision of necessary information in an accessible, comfortable and acceptable manner.

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HAVE YOU READ THESE PAPERS?

Effect of Repeated Prostate Biopsies on Erectile Function in Men on Active Surveillance for Prostate Cancer

Braun K, Ahallal Y, Sjoberg DD, Ghoneim T, Esteban MD, Mulhall J, Vickers A, Eastham J, Scardino PT, Touijer KA

J Urol 2014; 191(3):744-49

Active surveillance is becoming an increasingly common management strategy for low grade prostate cancer and involves repeat prostate biopsies over time. It has been hypothesized that serial biopsies can lead to reduced erectile function in patients on active surveillance and we explored this hypothesis in a longitudinally followed cohort.

The authors included 342 men who were on active surveillance whose first biopsy occurred between 2000 and 2009. They investigated erectile function using patient reported outcomes, namely the 6 erectile function questions from the IIEF-6 (International Index of Erectile Function).

The median (IQR) patient age in this cohort was 64 years (58–68). Median followup on active surveillance was 3.5 years (2.3–5.0) and the median number of biopsies was 5 (3–6). During the first 4 years on active surveillance erectile function decreased 1.0 point per year (95% CI 0.2, 1.7) on the IIEF-6 (scale 1 to 30). When stratified by comorbidities or number of biopsies the investigators reported an almost identical decrease in erectile function with time. The use of phosphodiesterase-5 inhibitors increased from 5% to 27% from baseline to year 5 on active surveillance.

They concluded that they observed a small decrease in erectile function and an increase in the use of phosphodiesterase-5 inhibitors with time. Although the causes of the changes in erectile function cannot be totally known if it is the effect of multiple biopsies or that of the natural aging process on erectile function in this observational study, the data suggest that active surveillance related biopsies do not have a large impact on erectile function.

Psoriasis and Sexual Behavior in Men: Examination of the National Health and Nutrition Examination Survey (NHANES) in the United States

Armstrong AW, Harskamp CT, Schupp CW

J Sex Med. 2014; 11(2):394-400

Epidemiologic data on sexual behavior in psoriasis patients are lacking. The aim of the present study is to examine and compare the sexual behaviors between men with and without psoriasis in the United States.

The authors analyzed data from the National Health and Nutrition Examination Survey (NHANES) from 2003 to 2006 and 2009 to 2010. Responses from male participants to the dermatology and sexual behavior questionnaires of the NHANES were collated and analyzed. Outcome measures included sexual orientation, age of first sexual encounter, number of oral and non-oral sexual partners, and frequency of unprotected sex.

Among 6,444 U.S. men that responded to the psoriasis question, 170 (2.6%) reported a physician-given diagnosis of psoriasis. Heterosexual men accounted for 95.5% and nonheterosexual men 4.5% of the overall study population. On multivariate analysis, psoriasis was not associated with differences in sexual orientation (odds ratio 1.78, 95% confidence interval [CI] 0.75–4.15). Heterosexual men with psoriasis experienced first sexual encounter at an earlier age than those without psoriasis (weighted difference −0.9 years, P = 0.002). Heterosexual men with psoriasis had significantly fewer female oral sexual partners compared with heterosexual men without psoriasis on multivariate analysis (lifetime partner number: rate ratio [RR] 0.65, 95% CI 0.45–0.95; past-year partner number: RR 0.64, 95% CI 0.42–0.97). No significant differences existed between heterosexual men with and without psoriasis regarding frequency of unprotected sex (RR 0.96, 95% CI 0.85–1.09). Among nonheterosexual men with and without psoriasis, no significant differences existed in age first had sex, number of sexual partners, or frequency of unprotected sex.

The authors concluded that heterosexual men with psoriasis have significantly fewer lifetime female oral sexual partners compared with those without psoriasis. They recommended that dermatologists and other

healthcare providers need to examine the genital region routinely and initiate appropriate therapy to improve patients' sexual health.

Patient Satisfaction with Testosterone Replacement Therapies: The Reasons Behind the Choices

Kovac JR, Rajanahally S, Smith RP, Coward RM, Lamb DJ, Lipshultz LI

J Sex Med. 2014; 11(2):553-62

Testosterone replacement therapy (TRT) for male hypogonadism is rapidly gaining popularity and acceptance. Options include gels, injections, and implantable subcutaneous pellets. The aim of this study was to determine rates of patient satisfaction and reasons for patient preferences in hypogonadal men on TRT.

An anonymous, prospective survey was distributed to men presenting for TRT at an academic urology clinic. The survey was organized into multiple domains including patient satisfaction and treatment motivation.

Average patient age was 49 ± 0.7 years (n = 382). Injectable testosterone was chosen by 53%, gel-based regimens by 31%, and pellets by 17%. Overall, 70% of patients were satisfied with their TRT and 14% reported dissatisfaction. Satisfaction rates were similar between gels (68%), injections (73%), and implantable pellets (70%). Doctor recommendation was the sole significant reason for patients preferring gel-based TRT (66% vs. 37% injection users vs. 31% pellet users). Injectable TRT was favored because of lower cost (35% vs. 21% gel users vs. 19% pellet users). Pellets were favored for ease of use (64% vs. 44% injection users vs. 43% gel users) and convenience (58% vs. 26% injection users vs. 19% gel users). Pellets had increased rates of satisfaction within the first 12 months. Improvements in concentration and mood occurred at higher percentages in satisfied patients.

The authors concluded that patients are satisfied with TRT. Lower costs are important to patients on injections. Convenience and ease of use are central in choosing pellet therapy. Men on TRT should be questioned about mood and concentration because these factors exhibited the greatest improvements in satisfied patients.

Prevention of Recurrent Ischemic Priapism with Ketoconazole: Evolution of a Treatment Protocol and Patient Outcomes

Hoeh MP, Levine LA

J Sex Med 2014; 11(1):197-204

The management of recurrent ischemic priapism (RIP) is not clearly defined. Ketoconazole (KTZ) is used to treat RIP and produces a temporary hypogonadal state to suppress sleep-related erections (SREs), which often evolve into episodes of ischemic priapism in this population. The aim of the present study was to review the authors' experience to prevent RIP using KTZ and present their outcomes using a decreased dose regimen.

A retrospective chart review and phone survey of 17 patients with RIP was performed. KTZ inhibits adrenal and gonadal testosterone production with a half-life of 8 hours. By suppressing testosterone levels, SREs are interrupted. The authors compared their previous protocol of three times daily (TID) KTZ dosing with prednisone for 6 months with their current regimen of initiating KTZ 200 mg TID with prednisone 5 mg daily for 2 weeks and then tapering to KTZ 200 mg nightly for 6 months. The primary outcome was the prevention of RIP using KTZ. Secondary outcomes included side effects secondary to KTZ use and patient satisfaction.

The authors stated that all men experienced daily or almost daily episodes of prolonged, painful erections prior to starting KTZ. The mean number of emergency room (ER) visits per patient prior to starting KTZ was 6.5. No patient required an ER visit for RIP while on KTZ. Sixteen of 17 patients (94%) had complete resolution of priapism while on KTZ with effects noted immediately after starting therapy and no reported sexual side effects attributed to KTZ. One man stopped therapy after 4 days because of nausea/vomiting. Fourteen of 16 men eventually discontinued KTZ after a median duration of 7 months. Twenty-nine percent reported no recurrent priapic episodes after discontinuing. A total of 78.6% had partial or complete resolution of symptoms persisting after KTZ was discontinued with a mean post-treatment follow-up of 36.7 months.

The conclusion was that no reliable effective preventative therapy has been identified for RIP. KTZ appears to be a reasonably effective, safe, and inexpensive treatment to prevent RIP while preserving

sexual function. The authors recommend the tapered dose regimen listed above. After 6 months, they recommend stopping the medication as they have found a majority of patients will not need to resume nightly KTZ.

A clinical study to assess the effectiveness of a hyaluronic acid based procedure for treatment of premature ejaculation

LittaraA, Palmieri B, Rottigni V, Iannitti T

Int J Impot Res 2013; 25:117-120

Premature ejaculation is a sexual debilitating condition affecting a large number of men worldwide and leading to important dysfunctions influencing the patients' affective and emotional life. Hyaluronic acid is a natural and safe compound that has been widely used not only in the aesthetic medicine clinic, but also for treatment of osteoarthritis. The present study shows the effectiveness of a hyaluronic acid-based procedure for treatment of premature ejaculation. The rationale behind this treatment line is that penile augmentation allows a penile volume large enough to prevent premature ejaculation. A hundred and ten male patients were treated with hyaluronic acid injections in the deep dermis of their glans penis to increase the volume and the circumference of their penis to prevent male premature ejaculation and improve the patients' and their partners' sexual satisfaction. The intravaginal ejaculation latency time increased significantly from a baseline value of 88.34±3.14 s to 293.14±8.16 s after 6 months from the procedure. Maximal glandular circumference increased from 98.51±0.71mm to 114.35±0.66mm after 6 months from the procedure. At 6-month follow-up, patients' self-rated satisfaction was 5.3±0.07 (range: 4–6). At the follow-up, partners' self-rated satisfaction was 5.1±0.09 (range: 3–6). The present clinical study showed that hyaluronic acid injection is a promising treatment for premature ejaculation. The effect of the procedure in the long-term follow-up needs to be clarified.

Low Prolactin Is Associated with Sexual Dysfunction and Psychological or Metabolic Disturbances in Middle-Aged and Elderly Men: The European Male Aging Study (EMAS)

Corona G, Wu FW, Rastrelli G, et al.

J Sex Med. 2014; 11(1):240-53

It was previously reported that in male patients consulting for sexual dysfunction, low prolactin (PRL) levels were associated with metabolic syndrome (MetS), arteriogenic erectile dysfunction, and incident major cardiovascular events. The aim of this study is to assess the clinical associations of PRL levels in the European Male Ageing Study (EMAS).

EMAS is a prospective, observational cohort of community-dwelling men aged 40–79 years old (mean age 60 ± 11 years old). PRL was available for 2,948 men. Different parameters were evaluated including the Short Form-36 questionnaire, Becks Depression Inventory, the Adverse Life Events Scale, the Physical Activity Scale for the Elderly, and the EMAS sexual function questionnaire (EMAS-SFQ).

After the adjustment for confounders, PRL levels were inversely related with worsening of sexual function as compared with the previous year, as derived from change in sexual functioning domain of the EMAS-SFQ (adj. $r = -0.043$; $P = 0.029$). The strongest correlation (Wald = 6.840; $P = 0.009$) was observed between lower PRL levels and reduced enjoyment of orgasmic experiences. Furthermore, an inverse relationship between PRL levels and stressful life events or depressive symptoms was observed. Low PRL was also negatively associated with an unhealthy metabolic phenotype as well as with the MetS (Wald = 5.229; $P = 0.022$). In line with these data, low PRL was associated with a lower level of physical activity and feeling unhealthier.

The authors concluded that low PRL is related to several metabolic, psychological, and sexual unhealthy characteristics in European men. Checking PRL might be useful to stratify men for cardiovascular risk and to encourage appropriate lifestyle changes.

Which is guilty in self-induced penile fractures: marital status, culture or geographic region? A case series and literature review

Al Ansari A, Talib RA, Shamsodini A, Hayati A, Canguven O, Al Naimi A

Int J Impot Res 2013; 25: 221-223

Penile fracture is a well-recognized and relatively uncommon clinical entity. It was previously reported that the incidence of penile fracture varies according to various geographic regions. In order to determine whether marital status or culture other than geographic region is involved in the etiology of penile fracture in Qatar, The authors reviewed the charts of 122 men diagnosed with penile fracture retrospectively. Detailed history including cause, symptoms, country of origin and a single-question self-report of erectile dysfunction was used for all cases. Diagnosis of the cases was mainly based on history and physical examination and ultrasonography. Immediate or delayed surgical repair of penile fracture included a degloving circumferential incision and an additional direct incision, if the site of the tear could not be reached via degloving. The patients were evaluated after 1 week and 1, 3, and 6 months follow-up by penile examination, recording complications, and with a single-question self-report questionnaire after 3 and 6 months. The most common cause of penile fracture was manual bending of the erected penis in 66 out of 122 (54.1%) of the studied patients. The authors believe that the prime causes of bending the penis are single status and culture, which are influencing factors irrespective of the geographic distribution.

Sexual dysfunction assessment and hormonal correlations in patients with polycystic ovary syndrome

Ercan CM, Coksuer H, Aydogan U, Alanbay I, Keskin U, Karasahin KE, Baser I

Int J Impot Res 2013; 25:127-132

In this controlled study, the authors aimed to evaluate the sexual dysfunction of patients with polycystic ovary syndrome (PCOS) in comparison to healthy controls. We enrolled 64 sexually active women in our study. The PCOS group consisted of 32 women who met the Rotterdam diagnostic criteria, and the control group was composed of 32 age-matched, healthy females. In addition to the demographic and clinical characteristics of the participants, the hormonal and biochemical parameters were also studied. All patients were invited to fill out the female sexual function index (FSFI) and Beck's Depression Inventory questionnaires. The prevalence of sexual dysfunction in the PCOS group was similar to controls (25% vs 19%; P=0.54). No significant difference was found according to each domain score of FSFI. Significant negative correlations were found between the total FSFI scores of the PCOS group and the total (r=−0.278) and free testosterone (r=−0.493) levels. Although depressive scores of PCOS patients were higher, they did not show greater impaired sexual functions than age-matched controls according to their FSFI scores. Considering the multifactorial state of female sexual dysfunction, further studies are needed to clarify the impact of PCOS upon sexuality.

Reduced Gray Matter Volume and Increased White Matter Fractional Anisotropy in Women with Hypoactive Sexual Desire Disorder

Bloemers J, Scholte HS, Van Rooij K, Goldstein I, Gerritsen J, Olivier B, Tuiten A

J Sex Med. 2014; 11(3):753-67

Models of hypoactive sexual desire disorder (HSDD) imply altered central processing of sexual stimuli. Imaging studies have identified areas which show altered processing as compared with controls, but to date, structural neuroanatomical differences have not been described.

The aim of this study is to investigate differences in brain structure between women with HSDD and women with no history of sexual dysfunction, and to determine sexual behavioral correlates of identified structural deviations.

Sexual functioning and gray matter (GM) and white matter (WM) were assessed in 29 women with HSDD and 16 healthy control subjects of comparable age and socioeconomic status with no history of sexual dysfunction. WM properties were measured using diffusion-weighted imaging and analyzed using fractional anisotropy (FA). GM volume was measured using three-dimensional T1-weighted recordings and analyzed using voxel-based morphometry. Sexual functioning was measured using the Sexual Function Questionnaire.

The Authors found that women with HSDD, as compared with controls, had reduced GM volume in the right insula, bilateral anterior temporal cortices, left occipitotemporal cortex, anterior cingulate gyrus, and right dorsolateral prefrontal cortex. Also, increased WM FA was observed within, amongst others, the bilateral amygdalae. Sexual interest and arousal correlated mostly with GM volume in these regions, whereas orgasm function correlated mostly with WM FA.
Conclusion: HSDD coincides with anatomical differences in the central nervous system, in both GM and WM. The findings suggest that decreased salience attribution to sexual stimuli, decreased perception of bodily responses and sexual emotional stimulus perception, and concomitant altered attentional mechanisms associated with sexual response induction

Female Sexual Dysfunction Among Egyptian Patients with Chronic Hepatitis C

Elshimi E, Morad W, Mohamad NE, Shebl N, Waked I

J Sex Med. 2014; 11(3):768-75

Chronic hepatitis C is associated with many extrahepatic manifestations that impact and impair the quality of life. Hepatitis C virus (HCV) infection has a high prevalence in Egypt and carries with the diagnosis many social impacts and stigmatization correlates that further impair social function. This might negatively impact patients and their sexual function. Sexuality and sexual function have not been studied well in patients with HCV, especially in women. The aim of the study is to investigate sexual dysfunction in Egyptian women with chronic hepatitis C.
This is a non-randomized controlled study where the self-administered Female Sexual Function Index (FSFI) questionnaire was completed by 112 sexually active female patients with chronic hepatitis C without liver cirrhosis prior to initiation of therapy by pegylated interferon and ribavirin. Their results were compared to those of 225 age- and socioeconomic class-matched sexually active healthy females.
The authors found that significantly more patients than controls had questionnaire scores below the threshold of female sexual dysfunction (FSD) (79% vs. 21%,$P < 0.05$), and the mean total score for the patients was significantly lower than that for controls (19.54 ± 6.2 vs. 28.43 ± 4.9 $P < 0.001$). The patients' scores in all domains of the questionnaire were significantly lower than those of the controls.
They concluded that chronic hepatitis C negatively impacts female sexual function, affecting all domains of the sex cycle.

Testosterone Improves Antidepressant-Emergent Loss of Libido in Women: Findings from a Randomized, Double-Blind, Placebo-Controlled Trial

Fooladi E, Bell RJ, Jane F, Robinson PJ, Kulkarni J, Davis SR

J Sex Med. 2014; 11(3):831-9

Female sexual dysfunction is a side effect of selective serotonin reuptake inhibitor (SSRI)/serotonin noradrenalin reuptake inhibitor (SNRI) therapy.
The aim of this study is to investigate the efficacy of transdermal testosterone (TT) as a treatment for SSRI/SNRI-emergent loss of libido.
This was a double-blind, randomized, placebo-controlled study. Forty-four women, aged 35–55 years, on a stable dose of SSRI or SNRI with treatment-emergent loss of libido were randomly allocated to treatment with a TT patch delivering 300 mcg of testosterone/day or an identical placebo patch (Pl) for 12 weeks. The primary outcome measure was the change in the Sabbatsberg Sexual Self-rating Scale (SSS) total score over 12 weeks. The 4-week frequency of Satisfactory Sexual Events (SSEs) and the Female Sexual Distress Scale-Revised (FSDS-R) were also measured.
The authors stated that at baseline, there were no differences between the treatment groups. At week 12, the change in the SSS score did not differ between the two groups. The increase in the 4-week frequency of SSEs was significantly greater for the TT group than for the Pl group (an increase of 2.3 events vs. 0.1, $P = 0.02$). The between-group difference in the change in the FSDS-R score approached statistical significance ($P = 0.06$). The mean total serum testosterone level at 12 weeks in the TT group was 2.1 nmol/L. No women withdrew because of androgenic adverse events.
The conclusion was that transdermal testosterone therapy resulted in a significant increase in the number of SSEs compared with Pl therapy in women with SSRI/SNRI-emergent loss of libido. The lack of improvement in the SSS total score may reflect lack of

sensitivity of this instrument for the measurement of change in sexual function. This provides the first evidence that TT therapy may be a treatment option for women with SSRI/SNRI-emergent loss of libido who need to remain on their antidepressant therapy.

Does vaginal delivery affect postnatal coitus?

Cai L, Zhang B, Lin H, Xing W, Chen J

Int J Impot Res 2013; 26:24–27

The concern that vaginal birth will result in loose vagina and negatively affect their postnatal sexual life is one of the main reasons that many women choose cesarean section. In the present study the authors aimed to implement a new device to measure and compare the intra-vaginal pressures between women who gave vaginal birth and those who had cesarean section, and to evaluate the relationship between sexual function and type of delivery by Female Sexual Function Index (FSFI). A total of 165 women including 88 in the vaginal-delivery group and 77 in the cesarean-delivery group were recruited in the study. Significant differences in intra-vaginal pressures were found between the two groups, and intra-vaginal pressures of vaginal-delivery group were lower than those of cesarean-delivery group. Significant difference was also found in coitus time. However, no significant difference was found regarding sexual satisfaction and sexual function indicated by the FSFI. We concluded that vaginal delivery indeed may result in loose vagina compared with cesarean delivery. However, it did not negatively affect the postnatal sexual function. The author recommended that women should be assured that their sexual functions won't be affected by the types of delivery.

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CASE REPORTS IN SEXUAL MEDICINE

Two Case Presentations of Profound Labial Edema as a Presenting Symptom of Hypermobility-Type Ehlers–Danlos Syndrome

Jill M. Krapf, Andrew T. Goldstein
J Sex Med 2013; 10(9):2347 - 50

Shortened penis post penile prosthesis implantation treated with subcutaneous soft silicone penile implant: case report.

Shirvanian V, Lemperle G, Araujo Pinto C, Elist JJ.
Int J Impot Res 2013; [Ahead of print]

Penile prosthesis surgery for erectile dysfunction has the highest satisfaction rates among all treatment options but is often associated with subjective and objective loss of penile length and girth following surgery. The authors are presenting a novel technique using a subcutaneous soft silicone implant for reversal of penile shortening and narrowing after prosthesis surgery, with additional gains in overall penile length and girth. Nine patients were treated with the insertion of a subcutaneous soft silicone penile implant. All patients had previously reported a loss in penile length (0.5-2 cm), and seven ofnine patients also reported a loss in penile girth (0.5-2.6 cm) after penile prosthesis surgery. During a follow-up period of 4-24 months, penile length and girth measurements showed a mean increase in length of 2.4 cm (±0.75 cm) and a mean increase in girth of 3.4 cm (±0.94 cm). The additional insertion of a subcutaneous soft silicone implant in patients with decreased penile length and girth after penile prosthesis surgery is an effective treatment option that provides reversal of lost penile length and girth.

Reconstructive surgery for female genital mutilation starts sexual functioning in sudanese woman: a case report.

Fazari AB, Berg RC, Mohammed WA, Gailii EB, Elmusharaf K.
J Sex Med 2013;10(11):2861-5

Female genital mutilation (FGM) involves the partial or complete removal of the external female genitalia and/or other injury to the female genital organs whether for cultural or other nontherapeutic reasons. The study aims to describe the method of and findings from reconstructive surgery for FGM victims.
The authors presented a case of a 24-year-old Sudanese female, who had undergone ritual FGM type III as a young girl. She had suffered from a large, vulval mass for the last 6 years and came to the clinic because of apareunia. They performed mass excision and reconstructive surgery of the mutilated genital tissue. The giant mass was successfully removed. Remaining genital tissues were approximated and sutured, with hemostasis assured for the reconstructed organs on each side.
The authors recommended that reconstructive surgery for women who suffer sexual consequences from FGM is feasible, with a high degree of client acceptance and satisfaction. They state that it restores some of women's natural genital anatomy, and offers the potential for improved female sexuality

Unusual complication of male urethral catheterization: intussusception of prepuce into urethral meatus

Amend G, Ghazipura S, Miao Y, Khan SA
IJUN 2014; 8(1):19-21

The authors present a patient who experienced urinary retention with a comorbid phimosis and redundant prepuce, most likely complications of diabetes mellitus. Additionally, they report a rare complication of difficult catheterization, where the prepuce intussuscepted into the urethral meatus. Attempts to change the catheter with poor visualization of the external meatus secondary to diabetic phimosis resulted in telescoping of the prepuce into the urethra. Circumcision and meatotomy of the external meatus alleviated the acute issue and prevented potential problems with future catheterizations
A 78 year old male who had diabetes and a history of difficult catheterizations secondary to diabetic phimosis and redundant prepuce was seen in the emergency department due to the inability to change his Foley catheter. The patient was a nursing home resident, and required chronic catheterization for urinary retention. Physical examination revealed a 5-cm circumferential cystic swelling of the distal shaft of the penis and an inability to retract the prepuce and visualize the glans

penis and external meatus. Attempts to retract the prepuce revealed intussusception of the prepuce into the urethra and a pinhole meatus. Under anaesthesia the prepuce was detached from the urethral meatus, a dorsal slit was performed, and examination of the glans penis was unremarkable. Circumcision and a meatotomy of the external meatus were performed. A Foley catheter was inserted and clear urine drained from the urinary bladder. The catheter balloon was inflated with sterile water.

NEWSLETTER
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March 2014 – Issue 6

An Update of the International Society of Sexual Medicine's Guidelines for the Diagnosis and Treatment of Premature Ejaculation (PE)

Althof SE, McMahon CG, Waldinger MD, Serefoglu EC, Shindel A, Adaikan G, Becher E, Dean J, Giuliano F, Hellstrom WJF, Giraldi A, Glina S, Incrocci L, Jannani E, McCabe M, Parish S, Rowland D, Segraves RT, Sharlip I, Torres LO

ISSM website

Definition of Lifelong & Acquired PE

A male sexual dysfunction characterized by ejaculation which always or nearly always occurs prior to or within about one minute of vaginal penetration, either present from the first sexual experience or following a new bothersome change in ejaculatory latency, and the inability to delay ejaculation on all or nearly all vaginal penetrations, and negative personal consequences, such as distress, bother, frustration and/or the avoidance of sexual intimacy.

Prevalence of PE

Based on these data and the ISSM and DSM-5 definition of PE, in terms of an IELT of about 1 minute, the prevalence of lifelong PE is unlikely to exceed 4% of the general population.

Average Ejaculatory Latency

In multinational studies the median IELT is 5.4 minutes. Median IELT may differ between countries.

Quality of Life

Negative effects on quality of life and interpersonal difficulty related to their PE have been consistently been reported by men and their partners.

Etiology

The etiology of premature ejaculation is not known. To date, no biological factor has been shown to be causative in the majority of men with PE.

Assessment

The committee agreed that there was inadequate evidence to recommend screening or case-finding for PE, either in a general population or in any sub-population. However, it is recommended that men with ED be screened for PE. It is recommended that clinicians utilize the screening questions in Table 3 and that clinicians take a medical and psychosocial history. Since patients self-report is the determining factor in treatment seeking and satisfaction, it has been recommended that self-estimation by the patient and partner of ejaculatory latency be routinely assessed in clinical practice when PE is present. The PEP or IPE are currently the preferred questionnaire measures for assessing PE, particularly in the context of monitoring responsiveness to treatment. For lifelong PE, a physical examination is highly advisable but not mandatory and should be conducted in most if not all patients. For acquired PE a targeted physical examination is mandatory to assess for associated/causal diseases such as ED, thyroid dysfunction or prostatitis

Treatment

There is robust evidence to support the efficacy and safety of on-demand dosing of Dapoxetine for the treatment of lifelong and acquired PE. It has been approved in some countries.

There is robust evidence to support the efficacy and safety of off-label daily dosing of the SSRIs paroxetine sertraline, citalopram, fluoxetine, and the serotonergic tricyclic, clomipramine, and off-label on-demand dosing of clomipramine, paroxetine and sertraline, for the treatment of lifelong and acquired PE.

There is good evidence to support the efficacy and safety of off-label on-demand topical anaesthetics in the treatment of lifelong PE.

There is some evidence to support the efficacy and safety of off-label on-demand or daily dosing of PDE5i's in the treatment of lifelong PE in men with normal erectile function.

Treatment of lifelong PE with PDEi5's in men with normal erectile function is not recommended and further evidence-based research is encouraged to further understand conflicting data.

Tramadol may be an effective option for the treatment of PE. However, it may be considered when other therapies have failed because of the risk of addiction and side effects. It should not be combined with an SSRI because of the risk of serotonin syndrome, a

potentially fatal outcome. Further well-controlled studies are required to assess the efficacy and safety of tramadol in the treatment of PE patients

There is modest evidence supporting the efficacy of psychological/behavioural interventions in the treatment of PE.

Combining pharmacological and psychological /behavioural treatments may be especially useful in men with acquired premature ejaculation where there is a clear psychosocial precipitant or lifelong cases where the individual or couple's responses to PE are likely to interfere in the medical treatment and ultimate success of therapy. Similarly, in men with PE and co-morbid ED, combination therapy may also be helpful to manage the psychosocial aspects of these sexual dysfunctions.

There is reliable evidence to support the treatment of PE and co-morbid ED with ED pharmacotherapy. There is level 3c evidence to support the treatment of PE and comorbid ED with ED pharmacotherapy in combination with PE pharmacotherapy Selective dorsal nerve neurotomy or hyaluronic acid gel glans penis augmentation may be associated with permanent loss of sexual function and is not recommended in the management of PE

Outcome

Treatment outcome can be addressed in one simple, brief and validated question known as the Clinical Global Impression of Change (CGIC). It asks patients, "Compared to before starting treatment, would you describe your premature ejaculation problem as: much worse, worse, slightly worse, no change, slightly better, better, or much better?".

NEWSLETTER
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Meeting Report: The 2nd Biennial Meeting of Middle East Society of Sexual Medicine

Dear Colleagues,

On behalf of the Board Members of Middle East Society for Sexual Medicine (MESSM), I would like to extend our great appreciation and warmest thanks to all who attended and helped the success of the 2nd Biennial Meeting of the MESSM. The meeting took place in the Park Hyatt Hotel, Dubai, U.A.E. from October 31 – November 2, 2013.

125 delegates from 20 countries attended the meeting, from Saudi Arabia (29), UAE (40), Egypt (16), Qatar (9), Lebanon (7), Bahrain (2) and Jordan(4), as well as guests and speakers from other areas (Argentina, Australia, Canada, France, Germany, Netherlands, United Kingdom and United States of America). The attendees represented a variety of medical specialties including Andrologist, Urologists, Psychiatrists, Dermatologists, Gynecologists, and Endocrinologists who are interested in Sexual Medicine.

At the beginning, Dr. Amr El-Meliegy, the immediate past president of the MESSM, announced the beginning of the 2nd Biennial meeting of the MESSM. Dr. Chris McMahon; President of the International Society for Sexual Medicine (ISSM); also welcomed the attendees and emphasized that ISSM strongly supports the Society which was very obvious by the presence of the 5 officers of the ISSM board in the meeting and their participation in the scientific program. Also dr. Abdulqadir Alzarooni President of EUS and Local Chairman of the meeting welcomed the attendees and wished them a successful meeting and a pleasant stay in Dubai.

After the MESSM business meeting/general assembly dr. Ahmed El-Sakka the current president of the MESSM congratulated the new board of directors for the term 2013-2015. Dr. El-Sakka also thanked very much the MESSM members, the efficient executive office and the immediate past president and the board of directors for their efforts, time and dedication that helped and supported the society very well. He encouraged everyone to participate in the activities of the society such as the website, the Newsletter, publications in the JSM and participating in the different committees and meeting activities of the MESSM.

The scientific program was thoroughly formulated by Drs. Hussein Ghanem – Egypt, Raouf Seyam - Saudi Arabiaand members of the scientific committee. The scientific program included several important state of the art lectures, symposia, round tables, videos, podium, posters and others.

Drs. Sara Nasserzadeh – USA, Pierre Assalian – Canada and Rola Yasmine – Lebanon presented several talks in theWorld Association for Sexual Health (WAS) session. In the Emirates Urology Society session Dr Iftikhar A. Jan – UAEpresented Gender assignment issues & outcome of surgery in children with disorders of sex development, and Dr. Manaf Alhashimi – UAE presented Hormonal disorders in male sexual dysfunction. Dr. Ronald Virag presentedErectile dysfunction treatment: a lifetime journey and vision into the future and History and life of Lapeyronie. The Video session demonstrated tips and tricks of various surgical techniques. Revising the venous side of erection byRonald Virag – France; Surgical repair of penile fracture By Ahmed Majzob – Qatar; Dot plication in the management of Peyronies disease by Tariq Hakki – USA; Penile prosthesis implantation in severe diffuse penile corporal fibrosis by Riadh Alzubadi – Qatar; Transient distal penile corporoglanular shunt as an adjunct to aspiration and irrigation procedures in the treatment of early ischemic priapism by Onder Canguven – Qatar ; Circumferential Peyronie's patch excision with semirigid penile prosthesis placement by Tariq Hakki – USA.

In the Androgen replacement therapy in problematic clinical situations session speakers presented Prostate cancer & LUTS by Danny Rabah - Saudi Arabia and Infertility by Amr El-Meliegy - Saudi Arabia. In Penile prosthesis implantation in challenging cases session Wayne Hellstrom - USA presented Salvage implantation for infection - Urinary diversion, posturethroplasty, Tariq Hakki – USA presented Penile prosthesis implantation in patients with penile fibrosis: difficulties and outcome; and Chris McMahon – Australia presented Post-ejaculatory illness syndrome

Lifetime premature ejaculation Hematospermia in Challenging ejaculatory & orgasmic disorders session. In ISSM symposium several talks were presented; Medical treatment of Peyronie's disease - Can we "mend the bend"...? by Chris McMahon – Australia; The link between ED and cardiovascular diseases by Luiz Otavio Torres – Brazil; Impact of BPH surgery on sexual function by Edgardo Becher – Argentina; The Link between male hypogonadism and erectile dysfunction by Wayne Hellstrom – USA. In the Priapism and Peyronie's disease sessionAbdulaziz Baazeem - Saudi Arabia presented Penile curvature: When to operate? and Ahmed El-Sakka – Egyptpresented Priapism: Current management. Aksam Yassin – Germany presented in the Round Table session PDE-5 inhibitors - Where do we stand in 2013, and Amr El-Meliegy - Saudi Arabia presented Cialis once a day, what's beyond ED. In the Egyptian Society of Andrology session Drs Samy Hanafy, Ashraf Hassan, Tarek Anis presented several talks on the subjects of Sexual dysfunction in pregnant female, Endocrine disruptors and Metabolic syndrome.

In the unsatisfied penile prosthesis patient session, why and how to manage? Dr. Said Kattan - Saudi Arabiapresented Why? and Dr. Abdel Rahman Zahran – Egypt presented How to manage? and Dr.Raouf Seyam - Saudi Arabia Presented New developments in ED clinical research.

Throughout the presentations in the MESSM meeting the attendees shared their opinions, studies and knowledge during the discussion of the various issues of sexual medicine which added a true scientific value to the meeting and elaborated the importance of such meetings.

The social program was fascinating where all the participants enjoyed the beautiful sight-seeing in Dubai, specially the view of the Burj Khalifa and the entrancing performance of light, music and water of the "Fountain Dancer".

At the closing ceremony of the 2nd Biennial Meeting of MESSM on the 2nd of November Dr. Ahmed El-Sakka,President of the MESSM, emphasized that all MESSM members are invited and strongly encouraged to participate and have a role in the society to help make this society a success. He also hopes that the coming 2 years will carry a lot of good news for patients in the region and be full of achievements to the MESSM.

Ahmed El-Sakka, MD
President MESSM

EDUCATIONAL CALENDER

2014

29th Annual Congress of the European Association of Urology (EAU)
April 11-15, Stockholm, Sweden
Congress Consultants B.V.
PO Box 30016
6803 AA Arnhem, The Netherlands
Tel +31 (0)26 389 1751
Fax +31 (0)26 389 1752
Mail info@eaustockholm2014.org
Web http://www.eaustockholm2014.org/

Annual Meeting of the American Urological Association (AUA)
May 17-21, Orlando, USA
Headquarters:
1000 Corporate Boulevard
Linthicum, MD 21090
Phone: +1 410-689-3700
Fax: +1 410-689-3800
American Urological Association Government Relations and Advocacy Department:
444 N. Capitol Street, NW, Suite 414
Washington, DC 20001
Phone +1 202-403-8500/Fax +1 202-403-8506
Mail convention@AUAnet.org
Web www.aua2014.org

World Meeting on Sexual Medicine
October 8-12, São Paulo, Brazil
ISSM Executive Office
P.O. Box 94
1520 AB Wormerveer
The Netherlands
Tel +31 75 64 76 372
Fax +31 75 64 76 371
Mail secretariat@issm.info
Web www.issmslams2014.org

ISSWSH 2014 Fall Course
Nov 14, 2014 - Nov 16, 2014, Scottsdale, AZ, USA
ISSWSH Executive Office
PO Box 160, Holly Ridge, NC 28445
Phone: (910) 667 2457
Mail **info@smsna.org**
Web **www.smsna.org**

20th Annual Fall Scientific Meeting Of The Sexual Medicine Society Of North America (SMSNA)
November 20-23, Miami, USA
SMSNA Executive Office
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2015

17th Congress of the European Society for Sexual Medicine (ESSM)
February 5-7, Copenhagen, Denmark
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22882 Barsbuttel,Germany
Tel. +49 40 67 08 820
Fax. +49 40 67 03 283
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Web **www.essm.org**

ISSWSH 2015 Annual Meeting
February 19-22, Austin, USA
ISSWSH Executive Office
PO Box 160, Holly Ridge, NC 28445
Phone: (910) 667 2457
Mail **info@isswsh.org**

4th International Consultation on Sexual Medicine
June 19-21, Madrid, Spain
ISSM Executive Office
P.O. Box 94
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