Approved : Sept 22
For review: Sept 25

GUIDELINES FOR MANAGEMENT OF ERECTILE DYSFUNCTION IN ADULTS ≥ 18 YEARS

INTRODUCTION

This guidance is intended to inform management of erectile dysfunction in primary care and has been developed as a consensus between representatives from primary and secondary care with reference to national guidelines, includingfrom NICE as appropriate. The guidelines are intended to guide clinical management, but every patient should be assessed and managed individually.

These guidelines are not intended to provide a comprehensive overview of ED, but to inform decision making in primary care.

Reference is made to drugs which are, and are not, available on the NoTGNC formulary. Some drugs are only available on a private prescription basis (unless exempt under schedule 2). This has been the case ever since the Department of Health restricted NHS prescribing of phosphodiesterase inhibitorsin 1999 when they were first introduced. With effect from August 1st 2014 theserestrictions have been relaxed for generic sildenafil, but the other drugs are available for the restricted group of patients in accordance with Department of Health regulations or on private prescriptions for patients not covered by the regulations and need to be in line with the local formulary. It is important that different options should be available, but the cost should be made clear to patients.

Please note that vacuum erection devices only need to be replaced when there is mechanical failure.

Referrals

When referral to a secondary care urology clinic is recommended in the guideline, referral for patients to be seen at a local outreach clinic may be preferred. It is anticipated that clinicians in localities where such clinics are available will be aware of them, but further information can be obtained fromNewcastle Urology at the Freeman Hospital.

Guidelines for the investigation and management of men with erectile dysfunction

History
Medical, sexual, psychosocialIllicit drugs, anabolic steroids, smoking, alcohol.
Consider iatrogenic causes e.g. drugs – see appendix 1
Ensure complaint is not premature ejaculation

Examination
BP and BMI Secondary sexual characteristics
Abdomen and genitalia – DRE not necessary (unless associated LUTS)
Lower limb pulses

Investigations to identify any underlying disease:
HbA1c, morning testosterone (between 0800-1100 because of circadian variation), lipid profile
Calculate CV risk and manage as per local guidelines
IIEF questionnaire (see appendix 2)

Management in primary care – for management of patients with underlying health conditions causing ED *(set out in Schedule 2 to the NHS (General Medical Services Contracts) (Prescription of Drugs etc.) Regulations2004)*

Lifestyle changes
Stop smoking, alcohol in moderation, increase exercise, and lose weight (if BMI raised)
Manage underlying cause – diabetes, hypertension, IHD
Oral medication with phosphodiesterase inhibitor, assuming no contraindications (see BNF e.g. regular nitrate use, nicorandil, tamsulosin should not be taken within 6 hours of PD5 inhibitor)

- **FIRST LINE – generic sildenafil 50mg**. If no response to maximum dose (100mg) →
- **SECOND LINE** – tadalafil 10mg as required with max dose 20mg – on formulary)

There is an awareness that other PDE5 inhibitors (e.g. vardenafil, once daily tadalafil) are often prescribed on private prescriptions. It is expected this activity is likely to continue, but this guidance refers to NHS prescribing ONLY.
NB: Sildenafil is also available to buy from Community Pharmacies.

Provide education for using these drugs –

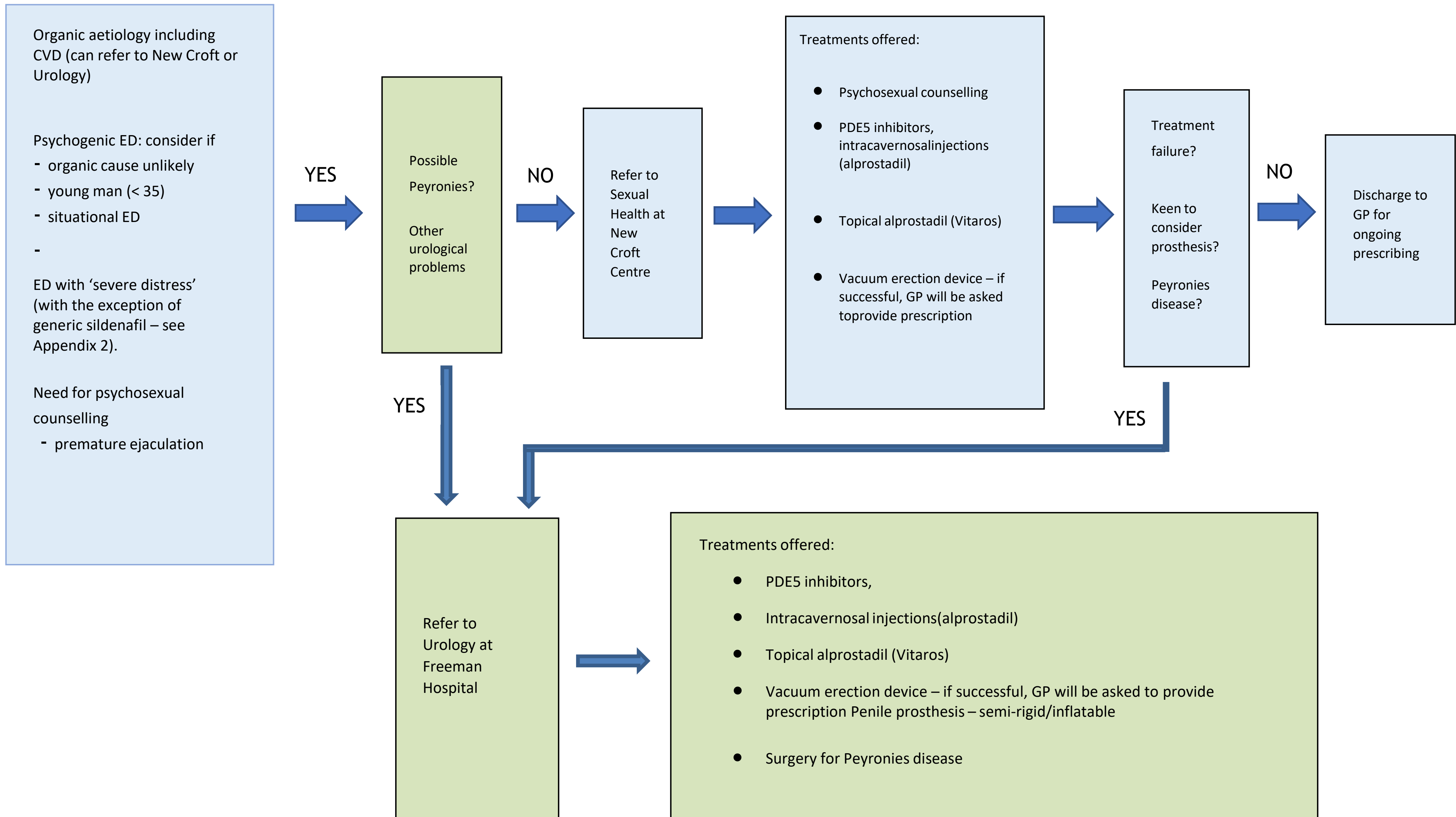
- Delay in onset of action (30 minutes – 2 hours)
- Erotic/sexual stimulation required
- Warn of possible side-effects including headache, flushing (common), visual disturbance, and priapism (very rare) – refer to BNF
- For sildenafil – avoid high fat meals prior to taking the drugs – can delay onset of action

Consider trial of 4 tablets and titrate to maximum dose depending on response. Move on to next tablet or stop if ineffective at maximum dose on at least 6 out of 8 attempts. Generally, research evidence indicates for patients in the 40-60 age range, usage will be one treatment per week (4 per month) for most patients treated for erectile dysfunction.
NB: The Prescriber must endorse the prescription with the reference "SLS".
If PD5 inhibitors are contraindicated or ineffective, consider referral to secondary care for trial of topical alprostadil (green +).

Treatment failure/non-responder (as reported by patient)? Keen to consider further treatment?
REFER TO SECONDARY CARE (ED services available at NUTH (see below), and via urology at Wansbeck and QE Gateshead)

Note: Daily tadalafil (5mg only) is on formulary for the treatment of ED following treatment for prostate cancer only in line with NTAG guidance. This treatment will be initiated by secondary care.

Referral guidelines for men **being referred to NUTH** – access to NewCroft via referral letter **(for Newcastle patients only – block contract)** and Urology via Choose and Book (Surgical Andrology)



APPENDIX 1

DRUGS that may contribute to Erectile dysfunction

CLASS	AGENTS
Diuretics	Thiazides Spironolactone
Antihypertensives	Beta-blockers Verapamil Methyldopa
Cardiac	Digoxin
Antidepressants	Tricyclics MAOIs SSRIs Lithium
H2 antagonists	Cimetidine Ranitidine

APPENDIX 2

Severe distress – the following criteria should be considered:

- Significant disruption to normal social and occupational activities
- Marked effect on mood, behaviour, social and environmental awareness
- Marked effect on interpersonal relationships

With effect from August 1st 2014, the DH has removed the restrictions on genericsildenafil for severe distress and GPs are able to treat these patients in primary care without the need for referral to specialist services.

NB: If there is a lack of success with the first line choice, to access the otherPDE5 inhibitors for severe distress will still require referral for initiation as failure on sildenafil could be due to another cause other than non-response.

APPENDIX 3

The IIEF-5 scoring system

Over the past 6 months:	1	2	3	4	5
How do you rate your confidence that you could get and keep an erection?	Very low	Low	Moderate	High	Very high
When you had erections with sexual stimulation, how often were your erections hard enough for penetration?	Almost never or never	Much less than half the time	About half thetime	Much more than half the time	Almost always or always
During sexual intercourse, how often were you able to maintain your erection after you had penetrated (entered) your partner?	Almost never or never	Much less than half the time	About half thetime	Much more than half the time	Almost always or always
During sexual intercourse how difficult was it to maintain your erection to the completion of intercourse?	Extremely difficult	Very difficult	Difficult	Slightly difficult	Not difficult
When you attempted sexual intercourse, how often was satisfactory for you?	Almost never or never	Much less than half the time	About half thetime	Much more than half the time	Almost always or always
The IIEF-5 score is the sum of questions 1 to 5. The lowest score is 5 and thehighest score is 25. 1-7: Severe ED 8-11: Moderate ED 12-16: Mild-moderate ED 17-21: Mild ED 22-25: No ED					