MEditorial February 2012

"Some 'P's' associated with the Penis"

The *penis* is a fascinating organ, an area of concern and sometimes obsession by its owner. The most common issues are those of function, but a surprising number of men express anxiety over its size. If one searches books on the subject of the penis (e.g., on Amazon's website), one finds that the most requested "literary classics" have titles such as "Huge Penis" or "…The Ultimate Guide for a Longer, Thicker, Stronger Penis". In this regard, low self-esteem for penile size has spawned a sub-industry in urology with penile enhancement surgery. My viewpoint is that unless the penis is truly very small, most men should steer clear of such remedies, which probably create more of the optical illusion of increased length and girth (especially in the flaccid state)—and which can, on occasion, lead to significant complications including infection, scarring, pain, deformity and even poorer function. It is difficult to make men with a poor "body image" happier with surgeries like this. I will rarely refer a man to certain urologists who--by their extra specialty training-- are capable of doing reasonable penile reconstructive surgery on carefully selected individuals.

I have done three penile surgeries in the last few days, and five in the last few weeks. The most unusual was a total penectomy (removal of the entire penis) for an aggressive *penile cancer*. Most penile cancers occur in uncircumcised men and are felt to be more [poor] hygiene-related than foreskin-related, per se. In over twenty years of practice, I have only had to remove the penis in three patients. However, other men have had penile malignancies of lower grade, more akin to other "skin cancers"—these could be dealt with by either excision of the abnormal skin or what is referred to in Dermatology as "MOHS surgery", a type of shaving-of-skin procedure to get down to normal uninvolved tissue. If a lot of skin is actually excised surgically, a skin graft is harvested and sewn into place by the urologist or plastic surgeon.

Abnormalities of *potency* (impotency) or inability to get or hold an erection are very common and probably increase by 10% per decade of life starting in the 40's. We do see rare men in their teens and twenties with issues (often giving a history

of NEVER getting a rigid erection), some of which are due to physical problems regarding blood flow dynamics in the penis. "Venous leak" impotence refers to the inability to maintain high enough pressures (tantamount to rigidity) during sex—due to abnormal veins that are not occluded by the erecting penis and thus allowing blood to exit the penis too quickly, usually an occurrence not seen until after a man ejaculates. We can diagnose this condition using ultrasonic-type tests, but it is questionable whether surgery to repair the "leaky" veins helps or holds up over time—and many young and older men with this particular condition will benefit from oral drugs.

It is often said that impotency has a physical cause in most cases and that sometimes, impotency can be the first "early warning," sign of such diseases as diabetes and coronary artery occlusions. I believe this is true. However, whatever the physical "cause", once a man develops difficulties in this matter, there is always bedroom anxiety and psychological duress that compounds the impotency. In my practice, if I am worried about such "medical condition" associations, I will have the man see his internist/primary care physician about as yet undiagnosed and potentially serious health conditions. I tend to focus on the "practical" of things I know I can do to make the man more potent. Sometimes I will check a testosterone level, but I am not convinced that treatment of a slightly low result will make much of a difference. <u>An extensive "evaluation" with lab and other tests seldom gets the impotent patient to where he wants to be.</u> I have no trouble offering the man with inadequate erections treatment based on his subjective symptoms, something I usually will not do with other urological conditions. Although in the past, various tests of nocturnal erections (a normal event in healthy men) have been used as a proxy for determining physical versus psychological impotence, very few urologists use these anymore. In truth, it is difficult to <u>objectify</u> what is going on in the bedroom!

Oral drugs like Viagra, Levitra, and Cialis (known as *phosphodiesterase inhibitors*), probably work by affecting a cascade of biochemical events leading to relaxation of the spongy tissues inside the corporeal bodies (paired long tubes inside penis accepting blood during sexual excitement). If the spongy erectile tissue is relaxed and not stiff, the chambers can fill with blood and cause rigidity by expanding against the relatively inflexible firm outer wall of these chambers (tunica

albuginea). These drugs help 75% or more of men achieve better erections and have a good safety profile; but should be used in caution in men with serious cardiac disease and cannot be used in those who take nitrates, e.g., nitroglycerine.

Penile self-injections **were a mainstay for treatment of impotence until 1998 (the year that Viagra was approved by FDA). A rigid erection lasting up to 60 minutes can be achieved safely in most men if the dose of drug is properly titrated (always start low!).** ***Papaverine*** **was the original drug that gave way to** ***Prostaglandin E-1*** **(commercial name = Caverject); but now a lot of men have three drug mixes (AKA** ***"triple P"),*** **including the two above penile injection drugs plus** ***Phentolamine*****.**

Aching in the penis, bruising, and scar tissue in the corporeal bodies are the main side effects from penile self-injections--but occasionally one can see a painful prolonged erection lasting well over 4 hours that requires treatment. This condition, called ***priapism*****, is also seen in other men <u>not</u> using injections including those with sickle cell disease, other hematologic disorders, and in some cases those on certain psychiatric medicines. Sudafed available over the counter, as well as the prescription drug terbutaline, can terminate an early priapism. A more severe priapism may require (in an emergency room setting) an "antidote" such as diluted phenylephrine injected irrigated into the penis/with irrigation of the blood sludge out of the corporeal bodies; or even an urgent surgery to "shunt" blood away from the engorged penile corporeal bodies, which--in priapism--are not receiving enough oxygen.**

Penile prostheses **(implants) seem to have had a revival, now that many aging men with increased medical morbidities have developed refractoriness to oral drugs; and either do not respond to penile self-injections or do not want to do them. Bioengineering of both inflatable and rigid implants are better than ever, with a greater than 90% "couple" satisfaction rate. Surgical risks of infection or need to remove/revise the implant are acceptably low. A skilled implanter (such as myself) can usually get you through this with excellent functional and cosmetic results. <u>This is really a good option that should not necessarily be "the impotence treatment of last resort".</u>**

Peyronie's **disease is a condition noted in men of all ages, with a firm plaque involving the erectile tissue. This may come on relatively abruptly and can usually**

be felt by the patient. It causes curvature or an hourglass deformity with erection. Painful erections may go away as the condition stabilizes. Coital trauma may play a role in this condition--but most men I see with this have not had a major traumatic incident with swelling. Some feel Peyronie's is an autoimmune disease where the immune system "makes a mistake" and forms antibodies against "self" tissues. Peyronie's with mild symptoms can and should be watched. For severe symptoms with impotency, a straightening operation with placement of a penile implant may be needed. If potency is preserved and treatment is needed, the use of Vitamin E is often recommended but probably without a sound experimental/clinical basis. Transdermal or injection forms of the cardiovascular drug verapamil can help--but I have not seen great results with this. The drug Trental, also used for some vascular conditions and which has anti-inflammatory properties, is sometimes used; and there are at least anecdotal stories of significant improvement/penile straightening. A vacuum-erection device may play a "non-invasive" role in "physical rehabilitation" of the crooked penis. Surgical straightening procedures can be done for Peyronie's with intact potency--but these are complex and there is sometimes as trade-off between a straighter penis and less rigidity/decreased sensitivity during sex.

I could go on with the "P's"; but I think I will yield to your "Q's".

Dr. Alan Freedman

401 Old Newport Blvd., Suite 101

Newport Beach, CA 92663

Phone: (949) 645-3434

FAX: (949) 645-0277