

A Rational Approach to Sexual Dysfunction

The largest and fastest growing segment of the US population is age 40 years and older. Men in this group are at higher risk for several male-oriented diseases, including erectile dysfunction (ED). As age advances, the risk of vascular disease and diabetes increases. These disorders impair blood flow to the penis and cause ED.

Complete ED is defined as the absolute inability to participate in penetrative relations at any stage. Results from the Massachusetts Male Aging Study of 1300 men between the ages of 40 and 70 years show 52% of men—1 in 2—have some degree of ED.¹ This Special Report supplement to *The American Journal of Managed Care* features interviews with clinical and managed care experts and the proceedings of an educational symposium developed by the University of Kentucky, which was held on April 6, 2000, in Phoenix, Arizona. The goal of the symposium was to provide clinicians with an understanding of treatment options for ED, with an emphasis on emerging therapies, their impact on patient compliance and tolerance, their effectiveness, and contraindication profile.

The first article is based on a presentation by John P. Mulhall, MD, Director of the Center for Male Sexual Health at Loyola University and Assistant Professor for the Loyola University Medical School and the Stritch School of Medicine. Dr. Mulhall reviews the epidemiology and etiology of erectile dysfunction, with a focus on the advantages and risks associated with current treatment modalities. A detailed history and physical examination are essential for

the safe and effective treatment of men with ED.

Dr. Mulhall notes that primary care physicians should be aware that conditions such as diabetes, hypertension, hypercholesterolemia, and coronary heart disease, which they treat on a daily basis, are in fact risk factors for ED. Therefore, it is important for primary care physicians to take a proactive stance in initiating discussion about sexual performance with their patients. In a recent study presented at the May 2000 meeting of the American Urological Association, investigators found nearly half of all men who consult urologists for medical problems also had ED. Moreover, the overwhelming majority of those with ED—82%—would have welcomed a discussion of the problem with their primary care physician—if only the physician had asked.²

In another article, “Access to Innovative Treatment of Erectile Dysfunction: Clinical, Economic, and Quality-of-Life Considerations,” Dr. A. Mark Fendrick of the Consortium for Health Outcomes, Innovation, and Cost-Effectiveness Studies (CHOICES) the University of Michigan School of Public Health and the Division of General Medicine, Department of Internal Medicine, at the University of Michigan School of Medicine, discusses economic considerations surrounding insurance coverage for so-called lifestyle drugs. Dr. Fendrick describes the philosophical and financial barriers that surround access to available therapies. He suggests benefit decisions are founded on a delicate interplay among considerations such as health plan priorities, enrollee preferences, and above all, cost. While con-

sumers generally would prefer access to any intervention that improves quality of life, the more difficult question, Dr. Fendrick notes, is who should pay for that access. Dr. Fendrick concludes that while health plans may question the clinical value of coverage for ED drugs, consumers place a high value on access to all types of prescription drugs in terms of quality of life and overall satisfaction with their health plans.

A commentary by the renowned sex therapist and media personality Ruth K. Westheimer, EdD, warns against a prevailing predisposition to treat ED on a medical level only. Dr. Westheimer stresses the importance of treating relationship issues as well as the physical condition. Dr. Westheimer states the scientific community's emphasis on erection largely ignores the vast spectrum of possibilities that can lead to a satisfying sex life as well as the role of the partner in achieving sexual satisfaction.

In an interview with *The American Journal of Managed Care*, Dr. Mulhall discusses issues surrounding the safe use of ED therapies and the possibility of combining therapies sometime in the future. He also compares a pri-

mary care physician's approach to treatment with that of a specialist, suggesting that patients tend to dictate the intensity of the evaluation of the condition. He observes that primary care physicians infrequently initiate discussions about sexual performance, and they tend not to include the sexual partner in the assessment. Although many cases of ED are best treated by the primary care physician, Dr. Mulhall recommends that follow up be an important component to treatment, but that it is frequently overlooked. He concludes that ED should not be accepted as a condition of aging but should be treated as aggressively as other age-related conditions that affect quality of life such as osteoporosis and arthritis.

In the second interview, James T. Kenney, Jr., RPh, MBA, Pharmacy Operations Manager for Harvard Pilgrim Health Care in Massachusetts, describes managed care considerations when making coverage decisions about ED therapies. Safety, efficacy, and cost are of primary concern, Mr. Kenney says. His particular health plan does not use the "lifestyle" drug classification but applies the same criteria to all drugs. Mr. Kenney also discusses the importance of the drug benefit to members' satisfaction with the health plan.

ACRONYM LIST

The following acronyms appear in the pages of this Special Report supplement:

CAD	Coronary artery disease
cAMP	Cyclic adenosine monophosphate
cGMP	Cyclic guanosine monophosphate
DTC	Direct-to-consumer
ED	Erectile dysfunction
FDA	Food and Drug Administration
GTP	Guanosine triphosphate
HCFA	Health Care Financing Administration
P&T	Pharmacy and therapeutics

...REFERENCES ...

1. Feldman HA, Goldstein I, Hatzichristou DG, Krane RJ, McKinlay JB. Impotence and its medical and psychosocial correlates: Results of the Massachusetts Male Aging Study. *J Urol* 1994;151:54-61.
2. Mulhall JP, Parker M. Evaluation of the consistency of response to intra-urethral prostaglandin (MUSE®) during at-home use. Paper presented at: Annual Meeting of the American Urological Association; June 1998; San Diego, CA. *J Urol* 1998;159:908A. [Abstract]