PAPERS AND SHORT REPORTS

Successful non-invasive management of erectile impotence in diabetic men

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Abstract

The effectiveness of a device designed to overcome erectile impotence was assessed in 10 insulin dependent diabetics with no other cause for their erectile impotence. The 10 men and their partners were instructed how to use the device, which uses suction to induce penile engorgement and maintains erection with a constriction band. After three months they answered a questionnaire about its effectiveness and acceptability, assessing these by visual analogue scales. All the patients achieved lasting erections with the device and gave high mean scores for ease of use, effectiveness, and satisfaction, but three partners refused to complete the questionnaire having failed to come to terms with using the device. One couple stopped using it because of marital disharmony.

This device provides a practical alternative for the treatment of erectile impotence in diabetic men. Unlike invasive treatments, it does not necessitate lengthy assessments of autonomic, endocrine, and erectile function and is safe to use and relatively cheap.

Introduction

Erectile impotence is a common problem among diabetic men.¹ The aetiology is complex, often entailing both organic and psychological factors.² Present management, if attempted, includes assessments of autonomic, endocrine, and erectile function, together with psychological testing. Treatment may include psychosexual counselling and, in some cases, implantation of a penile prosthesis or the use of local intracavernous injections.³⁻⁵

Such assessment is lengthy and often serves only to highlight a patient's inabilities and perceived inadequacies, but it has been necessary because of the invasive nature of the remedies. Recently, devices have been introduced that use suction to induce penile engorgement and maintain erection by a constriction band.⁶ The ErecAid system (Osbon, Augusta, Georgia, United States) works by this process and is being used successfully in the United States to

treat erectile impotence. To assess the potential of this device for treating impotence in diabetic patients, I asked a few patients and their partners to evaluate the effectiveness and acceptability of the ErecAid system.

Patients and methods

Ten insulin dependent diabetic men, median age 55 (range 34-64) and median duration of diabetes 18 years (5-31), were recruited. They had suffered erectile impotence for three years (2-15), having first sought medical help two years (1-15) previously. Treatable organic causes for their impotence were excluded, and none was taking any drugs or suffering from any condition that might predispose to priapism or bruising. They and their partners were carefully instructed, with the help of a video recording, in the use of the ErecAid device (figure). After three months the patients and partners independently assessed the effectiveness and acceptability of ErecAid with questionnaires, giving answers on visual analogue scales, either 0 to 10 or -5 to +5.

ErecAid system: cylinder (with inner sleeve), tubing, and hand pump for inducing penile engorgement; and bands (arrow) or constriction rings for maintaining erection. Adequate lubrication with water based gel or petroleum jelly is essential for the system to work effectively.

Results

All the patients achieved a lasting erection with the device, and none experienced any unpleasant side effects. Some noticed minor discomfort during the first week of use but none thereafter. Most patients commented that adequate lubrication was essential for effective use. Only one couple was not using the device regularly because of marital disharmony.

The table shows the patients' and partners' assessments. Three partners were not willing to complete the questionnaire and were still finding it difficult to come to terms with using the device. Overall reaction varied from the superlative to the satisfied, and in only one case was the relationship not improved. Four of the patients had begun to achieve, but not maintain, erection without the device, and couples were having intercourse an average of six (0-18) times a month.

Discussion

This device provides a practical alternative for the management of erectile impotence in diabetic men. ErecAid is safe, non-invasive, and readily reversible, perhaps making extensive investigation to establish the relative importance of the potential aetiological factors less essential to the management. Psychosexual counselling may still be necessary, as for one of the couples described here, but in general removal of the threat of failure is itself of great therapeutic value.

When explaining the use of the device, I have found it preferable to talk to the couple together, and the system has been most effective when used by those couples prepared to discuss it openly and when the partner has been happy for the device to be incorporated into lovemaking. When inhibitions remained, the system was less successful.

ErecAid may not be used to treat all cases of erectile impotence, but for most couples it is a safe, fairly inexpensive, and simple means of managing impotence, particularly among patients with

Assessment of ErecAid by patients and partners after three months' use. Scores were given on visual analogue scales and are expressed as means (SEM)

	Patients (n=10)	Partners (n=7)
Scale 0 to 10:		
Ease of using device	7.8 (0.6)	7.8 (1.2)
Effectiveness of device	8.5 (0.5)	7.6 (0.6)
Satisfaction with erection	7.5 (0.6)	7.2 (0.8)
Partner's satisfaction	6.2 (1.0)	6.9 (1.3)
Scale -5 to +5:		
Change in overall relationship with partner	2.6 (0.8)	3.0 (0.9)
Change in self esteem	2.1 (0.8)	1.7 (0.8)

diabetes or other organic causes. It may also be a useful adjunct to psychosexual counselling in patients with psychogenic impotence.

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Medical cost of curing childhood acute lymphoblastic leukaemia

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Abstract

Between 1970 and 1979 acute lymphoblastic leukaemia was diagnosed in 378 children at this hospital. The outcome for the 181 survivors was examined six or more years after diagnosis to assess morbidity in an unselected group of long term survivors. One hundred and thirty seven of the survivors were in first remission and probably cured (group I). Forty four (group II) had had one or more relapses, some of whom, who had isolated extramedullary relapses, also have a good chance of cure.

In group I 136 patients had prophylactic cranial or craniospinal irradiation, while patients in group II, in addition to having that treatment, received local testicular (17) or craniospinal radiation (seven) for testicular or central nervous system relapse. Eight had additional prophylactic cranial radiotherapy after bone marrow relapse, and six had total body irradiation before bone

marrow transplantation. The incidence of clinically important growth and endocrine morbidity was 20% in group I and 68% in group II. The morbidity in patients in group I was mainly attributable to early pubertal maturation. In group II 30 patients had growth failure, of whom 19 had gonadal failure from testicular or total body irradiation, 14 had growth hormone deficiency after doses of cranial irradiation of over 2400 cGy, and 10 had spinal growth impairment after craniospinal irradiation. Two also had early pubertal maturation. Five out of six patients who received total body irradiation had multiple endocrine deficiency. Neuropsychological sequelae of treatment were seen in 40 (42%) of 96 schoolchildren in group I and in 12 (38%) of 32 schoolchildren in group II. Postinfective sequelae of treatment were found in patients in both groups.

These results show that the survivors who were in their first remission had a 42% residual morbidity related to treatment compared with an 82% morbidity in the survivors of one or more relapses who had multiple treatments.

Introduction

The number of long term survivors of childhood acute lymphoblastic leukaemia has steadily increased over the past decade. Many of these patients, who are probably "cured," are approaching

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