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Prevalence of erectile dysfunction and its correlates in Egypt: a community-based study

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ABSTRACT

We evaluated the prevalence of erectile dysfunction (ED) in a cross-sectional community-based random sample of Egyptian men. ED was correlated with the socioeconomic status, risk factors and quality of life. Married men in Ismailia province were interviewed at home. Data were processed for 805 men with mean age of 43.58 y (s.d. 11.03). There is a fair correlation between ED and increasing age (P<0.001). Males with complete ED comprised 13.2% of the sample, 26% of men in their 50s, 49% of men in their 60s and 52% of those 70 y or older. The state of better erection correlated fairly with sexual desire and sexual satisfaction (P<0.01). ED was associated with living in rural areas and lower socioeconomic level (P<0.01), with smoking, diabetes, heart disease, hypertension, liver disease, arthritis, peptic ulcer and renal disease (P<0.05). ED was negatively associated with good quality of life (P<0.001). These results indicate that ED is a common problem among married Egyptian men.

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Voiding Dysfunction Associated with "Chronic Bacterial Prostatitis"

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ABSTRACT

The study was done to evaluate flowmetry parameters, bladder capacity and postvoiding residual volume (PVR) in patients with chronic bacterial prostatitis/category II according to the National Institute of Health (NIH) categorization of prostatitis syndromes (CBP/Cat.II).Subjects and Methods: A prospective study of 42 patients with chronic CBP/Cat. II was undertaken. Clinical evaluation and the standard four-glass test with direct microscopy and culture were done for all patients. Flowmetry parameters and PVR were measured. Two groups were compared to the CBP/Cat.II group; a control age matched 42 males without lower urinary tract symptoms and 279 patients with prostatodynia/non-inflammatory chronic pelvic pain (CPP/Cat.IIIB).Results: All the three groups had similar age. The CBP/Cat.II and CPP/Cat.IIIB patients had similar duration of symptoms. In CBP/Cat.II maximum flow rate (Qmax), average flow rate (Qave), and voided volume (Vura) were 12.8±5.9ml/s, 7.4±3.4ml/s, and 238.9±110.8ml. These were significantly less than those for normal controls (21.3±4.2ml/s, 12.2±3.4ml/s, and 381.3±144.4ml). The flowmetry findings in CBP/Cat.II group did not show statistically significant differences from those for CPP/Cat.IIIB group (Qmax, Qave, and Vura were 11.3±5.3ml/s, 6.6±2.0ml/s, and 230.5±88.8ml). In CBP/Cat.II group, patients with Qmax < 15ml/s (25/42) had statistically significant longer duration of symptoms (33.6±19.3 compared to 13.1±6.3 months).Conclusion: In this study, CBP/Cat.II patients had significantly lower flowmetry parameters compared to matched age normals. The flowmetry parameters in this group were found similar to those in a group of CPP/Cat.IIIB patients. Voiding dysfunction in CBP/Cat.II may contribute to the longer duration of symptoms..

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Quantitative and Qualitative Assessment of Flowmetrograms in Patients with Prostatodynia

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ABSTRACT

Prostatodynia (type III–B according to the classification of the National Institute of Diabetes and Digestive and Kidney Diseases) represents a major part of all chronic prostatitis syndromes. Uroflowmetry changes in these patients were rarely described, and discrepancies exist about the prevalence of urodynamic abnormalities. The aim of this study was to describe both qualitative and quantitative flowmetrogram characteristics in these patients.Methods: Two hundred and thirty–eight flowmetrograms from patients diagnosed as having prostatodynia and 71 flowmetrograms from control males with matched age but without lower urinary tract problems were evaluated. Two to three flowmetric analyses were done for each individual, and the best one, i.e., representing the individual's voiding and no artefact (e.g., wag artefact), was chosen. A minimal voided volume of 150 ml was required to be included. Diagnosis of prostatodynia followed the routine criteria. For all patients the postvoiding residual urine was assessed by ultrasound (Bladder Scan). Qualitative study was done according to a classification using flow–time ratio (TQm/T100×100) and flow ratio (Qave/Qmax×100) for continuous flow. Interrupted flow was classified separately. Descriptive statistical analysis was used.Results: The age range was 18–49 (mean ± SD, 34.2±7.8) years. The symptom duration ranged from 3 to 84 (16.5±27.7) months. Out of 238 patients 196 had uninterrupted flow. Thirty–six patients showed interrupted flow due to external sphincter contraction ≤2 s, and 6 patients showed interrupted flow with abdominal muscle straining. Out of the 196 patients, 73 showed Qmax >15 ml/s, and 67 showed a voided volume <200 ml. For this group the Qmax was 13.3±5.3 ml/s, Qave was 7.6±3.0 ml/s, and the mean postvoiding residual urine was 29.9 (range 0–234) ml. Type I flowmetry pattern was present in 39.7%, type II in 38.7%, type III in 5%, type IV in 16%, and type V in 0.5% of the patients with continuous flow (see Patients and Methods). The control group showed a Qmax of 19.5±3.8 ml/s, a Qave of 11.1±2.6 ml/s, a voided volume of 311.9±106.9 ml, and a postvoiding residual urine of 14.3±29.3 ml/s. Pattern I was seen in 89%, pattern II in 8%, and pattern IV in 3% of the controls.Conclusion: Most patients with prostatodynia had abnormal flowmetry parameters, and different patterns were shown, confirming that many have urinary flow disorders. Flowmetry should be part of the prostatodynia patient diagnostic workup, as this might add to the understanding of patient problems and may help in the selection of more appropriate methods in order to define the pathophysiologic basis of the symptoms and to perform treatment accordingly.

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In situ Extracorporeal Shockwave Lithotripsy of Middle and Lower Ureteral Stones: A Boosted, Stentless, Ventral Technique

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ABSTRACT

To assess the outcome of a boosted, stentless, ventral in situ extracorporeal shockwave lithotripsy (ESWL) of middle and lower ureteric stones using a shockwave head from the opposite side of the stone using a Lithostar Siemens lithotriptor for stones larger than average size and of longer duration in place. The purpose was to attain a high clearance rate in a short time thereby avoiding auxiliary procedures. Methods: A prospective study of 132 patients (134 stones) with middle and lower ureteric stones >6 mm in place for more than 2 weeks were treated with a Siemens Lithostar lithotriptor in the prone position with sedoanalgesia on an outpatient basis. No stents were planned ahead of treatment. The shock head from the opposite side of the stone transversing only through the soft tissue of abdomen and pelvis was used routinely. Localization was done using fluoroscopy and snapshots and intravenous contrast was given when needed. The boosted sessions were done on day 1 (S1), day 2 (B1), day 7 (S2) and day 14 (S3) when needed or till adequate fragmentation after any session, even the first one. This procedure was evaluated at the 6th week of management or at adequate fragmentation and clearance if before that time. Results: This study inlcuded 115 males and 17 females with a mean age of 47 ± 15 and 53 ± 11 years. Stone size defined as the longest stone diameter as measured in plain film of the abdomen was 0.75–2.6 cm with a mean of 1.1 cm. All but two stones were successfully fragmented. Only 12% needed interference for developing obstruction and/or complication during the planned treatment. 106 patients needed only S1 or B1, 20 patients needed session 2, 6 patients needed session 3. Clearance was 43% by the 2nd day, 79% by the 7th day, 94% by the 14th day and 98.5% by the end of the 6th week. Conclusion: For larger ureteric stones a boosted stentless ventral shockwave lithotripsy for in situ middle and lower ureteric stones gave good results with short time clearance and without unusual side effects. The ventral application of shockwave from the opposite side was found more convenient with the Siemens Lithostar lithotriptor. We recommend this approach to be the initial procedure for middle and lower ureteric stones when they are larger than average, of longer duration and/or expected to be of harder texture as an outpatient procedure under sedoanalgesia to minimize the need for auxiliary procedures.