Lancashire & South Cumbria Medicines Management Group

Primary Care Management of Erectile Dysfunction

Version 2.0 – May 2021

Introduction

VERSION CONTROL		
1.0	08/10/15	First version agreed at LMMG
1.1	14th April	Updated with tadalafil daily commissioning position
1.2.	26/7/17	Updated to include Invicorp - Reserved for patients not responding or intolerant to Alprostadil, as an option before referral for surgical procedure (section 4.3.3)
2.0	May 2021	Complete review and revision of contents. Pathways condensed and updated. AG.

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Primary Care Management of Erectile Dysfunction

Post radical prostatectomy? → Yes → See page 2

No

Assess patient – consider iatrogenic causes

Priapism? → Yes → Refer – priapism (spontaneous or as a side effect of PDE5 inhibitor therapy), requires an immediate hospital admission.

No

Other criteria necessitating a specialist referral? – see box 1 → Yes → Refer

No

Are PDE5 inhibitors contraindicated? → Yes → Consider a trial of – see page 2:
1. **Vacuum pump***, or
2. **Alprostadil cream –** check local commissioning position

***Please note:** vacuum pumps should only be commenced by non-specialists if they have experience with clinical use

No

1st line – PDE5 inhibitor – generic sildenafil on demand PLUS lifestyle measures

Review response following use of 6 – 8 doses at the maximum tolerated dose

Is the patient satisfied with the therapeutic outcome? → Yes → End of pathway

No

2nd line – PDE5 inhibitor – tadalafil on demand ONLY*

Review response following use of 6 – 8 doses at the maximum tolerated dose

Is the patient satisfied with the therapeutic outcome? → Yes → End of pathway

No

Refer – see box 1

Is the patient satisfied with the therapeutic outcome? → No → Refer

Yes → End of pathway

Box 1: referral criteria

To urology — for young men who have always had erectile dysfunction and for all men with a history of trauma to genital area, pelvis or spine; abnormality of the penis or testicles; or no response to maximum dose of at least two PDE-5 inhibitors. Also consider referral to urology if the man has CVD that makes sexual activity unsafe or contraindicates PDE-5 inhibitor use.

To endocrinology — if hypogonadism is suspected (abnormal serum testosterone).

To mental health services — if an underlying psychogenic cause is suspected or the man has severe mental distress

*Daily tadalafil has a **'Black'** LSCMMG RAG status for use in primary care

Adapted from LSCMMG guideline 'Erectile dysfunction' published October 2015 (updated July 2017), NICE CKS 'Erectile dysfunction' July 2020 [access March 2021] and NICE NG131 'Prostate cancer: diagnosis and management' May 2019 [accessed March 2021]

Primary Care Management of Erectile Dysfunction: Supporting Information

Post radical prostatectomy

Erectile dysfunction is a common complication following prostatectomy due to cavernosal nerve damage, causing hypoxia, apoptosis, venous leak and fibrosis of the corpora cavernosa. Although there is evidence that, following an initial loss of erectile function, spontaneous improvements will occur in a proportion of men without specific intervention, most men who undergo radical treatment for prostate cancer experience erectile dysfunction and this can be a cause of significant distress.

NICE NG131 (Prostate cancer: diagnosis and management) recommends:
Sexual dysfunction

1.3.33 Offer people who have had radical treatment for prostate cancer access to specialist erectile dysfunction services. [2008, amended 2014]

1.3.34 Offer people with prostate cancer who experience loss of erectile function phosphodiesterase type 5 (PDE5) inhibitors to improve their chance of spontaneous erections. [2008]

1.3.35 If PDE5 inhibitors do not restore erectile function or are contraindicated, offer people vacuum devices, intraurethral inserts or penile injections, or penile prostheses as an alternative. [2008]

Within the Lancashire Health Economy, it is recommended that patients are treated with generic sildenafil 1st line post-prostatectomy (unless PDE5 inhibitors are considered inappropriate).

Tadalafil daily is not recommended (Black RAG status), but tadalafil on demand may be used as a 2nd line PDE5 inhibitor (if considered appropriate by specialist erectile dysfunction services).

Alternatives to PDE5 inhibitors

Several treatments for erectile dysfunction are available in secondary care, although none are as convenient or well tolerated as PDE-5 inhibitors.

Vacuum erection devices are recommended as **first-line alternative treatment** in well-informed older men with infrequent sexual intercourse and comorbidity requiring non-invasive, drug-free management of erectile dysfunction. They are reported to be highly effective with variable satisfaction.

Referral to a specialist may be required for assessment and treatment initiation. In this instance the specialist should provide the initial device as cost is included in the treatment tariff.

Choice of Vacuum Pump: Only CE marked devices listed in the Drug Tariff Part IXA are prescribable on NHS prescription.

In the absence of trial data or evidence of individual device effectiveness. Choice should be based on costs and prescriber or organisational satisfaction of the device safety and effectiveness.

Second line treatments include alprostadil, available in the UK as an intracavernous injection (Caverject®, Viridal®), an intraurethral application (MUSE®), and a topical cream (Vitaros®). These can be effective treatments in men with erectile dysfunction following a spinal cord injury or after major pelvic surgery.

Penile prosthesis is a third-line treatment considered for men whose erectile dysfunction has an organic cause and who fail to respond to pharmacotherapy or who prefer a permanent solution to erectile dysfunction.

Primary Care Management of Erectile Dysfunction: Supporting Information

Qualifying for an NHS prescription

Generic sildenafil can be prescribed without restriction on the NHS.

Viagra®, tadalafil (Cialis®), vardenafil (Levitra®), and avanafil (Spedra®) are not prescribable on an NHS prescription except for men who:

- Have diabetes, multiple sclerosis, Parkinson's disease, poliomyelitis, prostate cancer, severe pelvic injury, single-gene neurological disease (for example Huntington's disease), spina bifida, or spinal cord injury.
- Are receiving renal dialysis for renal failure.
- Have had radical pelvic surgery, prostatectomy (including transurethral resection of the prostrate), or a kidney transplant.
- Were receiving Caverject®, Erecnos®, MUSE®, Uprima®, Viagra®, Cialis®, or Viridal® at the expense of the NHS on 14 September 1998.

In addition, specialist centres can prescribe phosphodiesterase-5 (PDE-5) inhibitors on the NHS if the man is 'suffering severe distress as a result of impotence' that causes:

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

Quantity of PDE5 inhibitors to supply on NHS prescription

For most men, as-required treatment with a phosphodiesterase-5 (PDE-5) inhibitor is suitable. The frequency of treatment will need to be considered on an individual basis.

The Health Service Circular: Treatment for impotence recommends one treatment a week on the NHS, based on research evidence that the frequency of sexual intercourse in the 40–60 age range is once a week. However, if the GP considers that more than one treatment a week is appropriate, this can be prescribed on the NHS.

Private prescriptions

For those NHS patients not meeting NHS criteria (excluding those prescribed generic sildenafil) a private prescription should be provided.

These should be free of a prescription writing charge. Repeats can be provided on a private prescription. The cost of the medication will be determined by the dispensing pharmacy.