Erectile function rehabilitation after radical prostatectomy: practice patterns among AUA members.

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Abstract
INTRODUCTION: Despite a growing body of evidence supporting erectile function (EF) rehabilitation after radical prostatectomy (RP), there are no guidelines on this subject.

AIM: To explore EF rehabilitation practice patterns of American Urological Association (AUA) urologists.

METHODS: A 35-question instrument was constructed assessing physician demographics, training, and EF rehabilitation practices after RP, and was e-mailed to AUA members by the AUA Office of Education. Data were acquired by the AUA and analyzed by the investigators.

MAIN OUTCOME MEASURE: Percentage of responders who recommend EF rehabilitation practices following RP, characterization of prevalent rehabilitation practices.

RESULTS: Of the 618 urologists who completed the survey, 71% were in private practice, 28% considered themselves as sexual medicine specialists, although only 4% were fellowship-trained, 43% were urologic oncology specialists (14% fellowship-trained), 86% performed RP, and 86% of responders recommended rehabilitation practices. Being a sexual medicine or a urologic oncology specialist was not predictive of rehabilitation employment. Forty-three percent rehabilitate all patients, 57% only selected patients. Selection for rehabilitation was dependent upon preop EF by 66%, nerve-sparing status by 22%, and age by 5%. Eleven percent started rehab immediately after RP, 97% within 4 months. 24%, 45% and 18% ceased rehab at <12, 12-18, and 18-24 months, respectively. Eighty-nine percent of RP surgeons performed rehabilitation vs. only 66% who do not perform RP (P < 0.0001). Eighty-seven percent prefer phosphodiesterase type 5 inhibitors (PDE5i) as their primary strategy followed (in order) by vacuum erection device (VED), intracavernosal injection (ICI), and urethral suppositories.

CONCLUSIONS: Among the respondents, penile rehabilitation is a common practice. Urologic oncologists and RP surgeons are more likely to use rehabilitation practices. The most commonly employed strategy is regular PDE5i use for 12-18 months after RP.


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