The Prevalence of Bother, Acceptance, and Need for Help in Men with Erectile Dysfunction

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ABSTRACT

Introduction. Apart from knowledge on the prevalence of erectile dysfunction (ED), for clinical reasons it is important to obtain information on concern or bother and need for help. However, information is lacking on men with ED who need help but do not seek medical attention. Thus, this study aimed to assess the distribution of bother, acceptance, and need for help in men with ED, and assess characteristics of patients with ED in need for help but not receiving medical attention for ED.

Methods. A total of 5,721 men aged 18 years and older and registered in 12 general practices in the middle of the Netherlands were sent a questionnaire by mail about sexual problems, ED, need for help, and medical attention. Out of 2,117 questionnaires that were returned, 1,481 were completed on ED, bother, and need for help.

Results. The prevalence of ED (according to World Health Organization definition) in the 1,481 men was 14.2%. Of these men 67.3% were bothered, 68.7% did not accept ED, and 85.3% wanted help. Surprisingly, 41.9% of men who denied a need for help were bothered and 19.4% did not accept ED. Only 10.4% of men with ED received any medical care. Bother in men with ED was related to increasing age (decreasing above 60 years). Compared with men who already received help for ED, men who wanted help but did not receive it more often suffered from diabetes, neurological problems, and various cardiovascular problems. On the other hand, history of myocardial infarction increased the chance of getting adequate medical attention for ED.

Conclusions. The majority of men with ED are concerned or bothered and perceive a need for help. Most of them do not receive any medical attention. These men are characterized by chronic medical conditions, visiting the physician's office regularly for their medical condition.

Key Words. Male Epidemiology; Male Erectile Disorder; Male Risk Factors/Comorbidities

Introduction

Erectile dysfunction (ED) is common among men. Not all men with ED are bothered by their condition [1,2]. Especially, elderly men may regard ED as a natural part of aging [3]. A physician should know not only whether a patient has ED but also whether the patient accepts the condition, or is concerned or bothered by it, and whether he wants to be treated for it. It is unclear whether it is possible to make a relevant selection of patients on the basis of study results about bother (concern), acceptance, and need for help. This kind of information is scarce in spite of many studies on the prevalence of ED in the open population [4,5]. Only a few studies focused on bother and some on both bother and the need for help [2,3,6,7]. According to the literature, only few men with ED seek medical attention. Others perceive the need for help but do not actively seek

medical attention. They seem to expect that the GP will raise the subject of sexual functioning [8–12]. Therefore, it is important that a GP is informed about the characteristics of men with ED who want help but do not receive medical attention as yet. The aim of this study was to

- assess to what extent patients with ED want to be treated for it and to what extent these patients are bothered by it and/or cannot accept their problem; and
- assess the characteristics of patients with ED in need for help but who do not receive medical attention as yet.

Patients and Methods

Patients and methods have been described by de Boer et al. [13]. In the year 2000, a survey on sexual problems and ED, concern, acceptance, perceived need for help, and received medical attention, was sent by mail to 5,721 men registered in 12 general practices in a semiurban area in the center of the Netherlands. Men who were incapable of filling out a questionnaire, because either they were too ill, mentally handicapped, or had insufficient knowledge of the Dutch language, were excluded. A randomly selected group of 500 nonrespondents received a short questionnaire with one question on ED. The study was approved by the Medical Ethics Committee of the University Medical Center Utrecht in Utrecht, the Netherlands.

Assessment of Erectile Dysfunction

The World Health Organization (WHO) defines ED as a continuous or repetitive inability to achieve or maintain an erection sufficient for a satisfying sexual activity [14,15]. We made the WHO definition more specific by adding criteria on duration (more than 3 months) and frequency (more than every now and then). The Enigma questionnaire contained 29 questions on ED. The questions on bother, acceptance for ED, and perceived need for help were scored on a 5-point scale: "none," "minor," "more or less," "much," and "very much." If a man was "(very) much" bothered, or had "very much" not accepted ED, or perceived need for help "(very) much," then he was subsequently catagorized in the group of men with bother, no acceptance for ED, or need for help. Furthermore, the participants were asked if they were being treated and whether they were content with the treatment they received.

Determinants of Sexual Dysfunction

The questionnaire also contained questions on a variety of potential risk factors for ED: age (in years at the moment the participant completed the questionnaire); medical condition (diabetes, hypertension, cardiovascular diseases, neurological diseases, penile disorders, pelvic surgery, pelvic injuries resulting from accidents and/or local irradiation); psychological problems (depression, relational problems, work-related problems, low self-esteem, fear of failure, stress, and surmenage, i.e., overstressed); medication (possibly related to ED); and lifestyle factors (smoking and alcohol consumption). The medication was divided in two groups: allopathic medication, known as related to ED (group 1), and medication not described in the literature as related to ED (group 0). If a participant reported the use of any kind of medication in the "related to ED group of medication," he was categorized in group 1.

Statistical Analysis

Overall prevalence estimates were calculated. Comparisons of potential characteristics between "men with ED in need for help" and "men with ED without need for help," as well as comparisons of characteristics between "men with ED, concerned, perceiving the need for help who did not get medical attention," and "men who were under treatment," were performed by using a univariate model. Results were expressed as odds ratios (OR) with corresponding 95% confidence intervals. All analyses were performed by using SPSS 10.0.

Results

The questionnaire was sent to 5,721 men; 120 men were excluded. A total of 1,481 questionnaires were returned with complete information on bother, acceptance for ED, need for help and treatment for ED; 211 men had ED (14.2%). Figure 1 shows the flow chart of the study population and the nonresponder study.

One hundred eighty men with ED (85.3%) perceived need for help; 142 (67.3%) men with ED reported to be bothered; and 145 (68.7%) did not accept ED. Twenty-two men (10.4%) received treatment. Need for help, acceptance for ED, and bother did not overlap fully.

Figure 2 shows that of the 180 men with ED in need for help, 129 (71.7%) were bothered by ED, 139 men (72.2%) could not accept having ED, and 21 men (11.7%) received treatment. Surprisingly, of the men with ED who perceived no need for

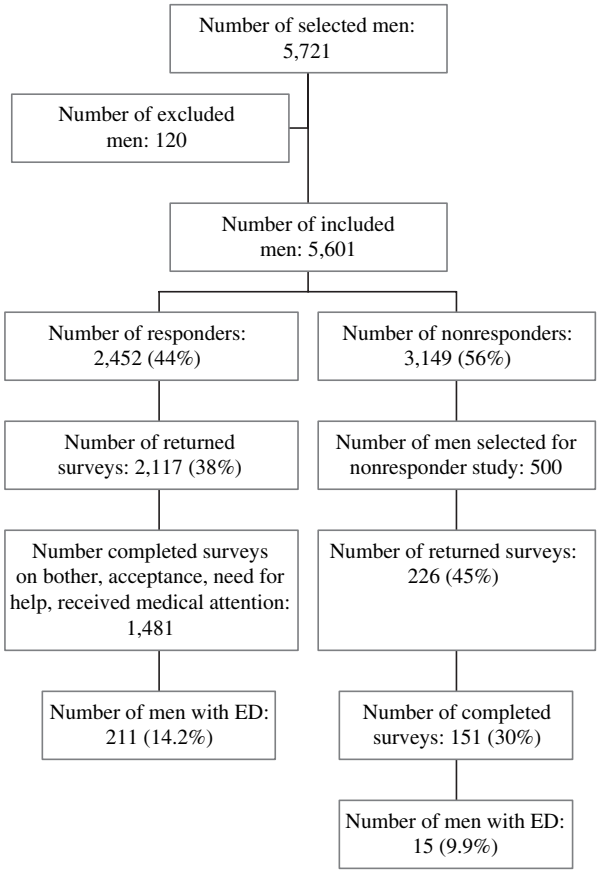


Figure 1 Study flow chart.

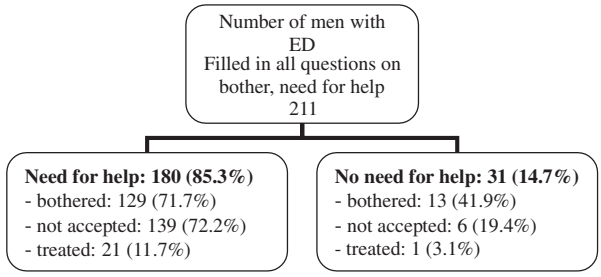
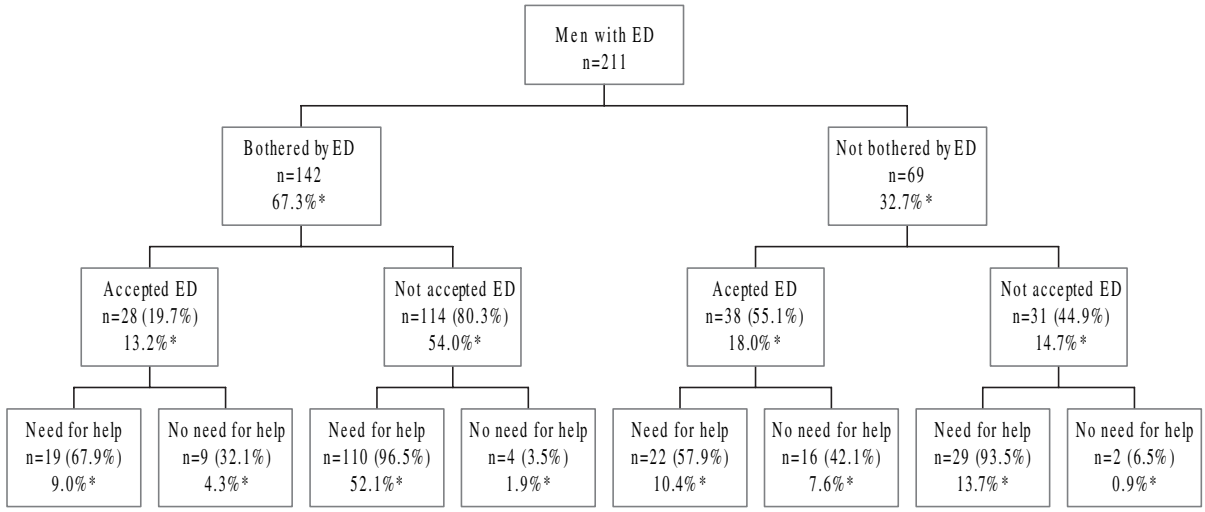


Figure 2 Men with erectile dysfunction (ED): need for help, bother, no acceptance, and treated.

help, 13 (41.9%) were bothered and six (19.4%) could not accept having ED. One man received treatment. In Figure 3 men with ED are subdivided according to the extent of perceived problems. Remarkably, even the majority of men who were not bothered reported need for help.

Need for help was clearly related to age: it is high in men between 31 and 60 years and declines with age (Figure 4). In Table 1 the characteristics of the study population are shown. Determinants of men with ED in need for help who did not receive medical attention, compared with those who received help, were diabetes, various cardiovascular diseases, and neurological problems. Remarkably, a history of myocardial infarction and multiple sclerosis (MS) increased the chance of



*percentage of total group of 211 men with ED

Figure 3 Prevalence of men with erectile dysfunction (ED), bothered by ED, acceptance of ED, and/or need for help.

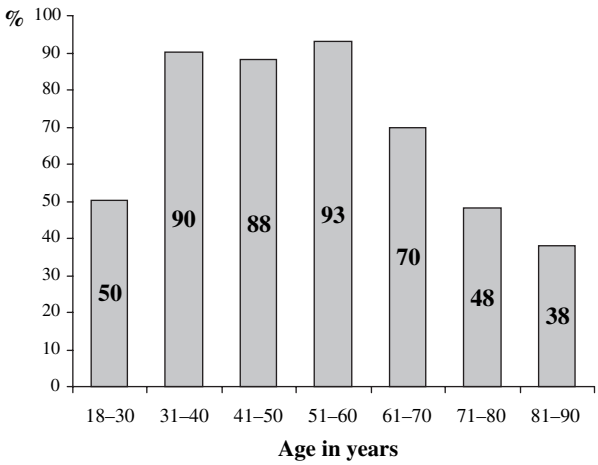


Figure 4 The perceived need for help in men with erectile dysfunction (ED) (%), age related.

receiving adequate medical attention for ED (Table 2).

Discussion

This study showed that the majority (85.3%) of men with ED (according to the WHO definition) perceived need for help. More than two-thirds (67.2%) of men with ED were bothered and could not accept ED. However, only 10.4% received any medical attention at all. Surprisingly, 41.9% of men reporting that they had no need for help were nevertheless concerned about ED. Even the majority of men with ED who were not concerned and accepted having ED still wanted help. Need for help for ED was clearly related to age. When compared with men who did receive medical attention, men with ED in need for medical attention who did not receive any treatment were characterized as having diabetes, neurological problems, and various cardiovascular problems. Men with a history of myocardial infarction and MS were more likely to receive medical attention. All of them visit the GP's office regularly for follow-up treatment of their chronic medical condition.

Some aspects of the study need to be discussed. First, the response rate of the study was 44%. Because we cannot estimate whether there is a difference in information on bother, acceptance, and need for help between responders and non-responders, we cannot in fact indicate what the effect of nonresponse might be on the prevalence rates and risk factor relations. Second, as some men with ED in the responder study did not

Table 1 Characteristics of men with erectile dysfunction

Factor	Number of men	%
Somatic		
Diabetes	23/210	11.0
Hypertension	37/210	17.8
Cardiovascular	21/210	10.0
Myocardial infarction	10/210	4.8
Stroke	7/210	3.3
Other cardiovascular diseases	6/210	2.9
Neurological problems	14/210	6.7
Spinal problems	7/210	3.3
Multiple sclerosis	2/210	1.0
Other central nervous system problems	9/210	4.3
Local disorders	15/210	7.1
Abdominal operations	31/210	14.8
Local irradiation	8/210	3.8
Psychological		
Depression	37/208	17.8
Relational problems	35/208	16.8
Work-related problems	31/208	14.9
Low self-esteem	49/208	23.6
Fear of failure	35/208	16.8
Stress	68/208	32.7
Surmenage (i.e., overstressed)	34/208	16.3
Lifestyle		
Cigarette smoking	61/207	29.5
Alcohol >2x daily	29/209	13.9
Highest education	23/206	11.2
Medication	110/210	52.4

Table 2 Characteristics of men with erectile dysfunction in need for help who did not get medical attention, compared with those men who did get help

Factor	Odds ratio	95% confidence interval
Somatic		
Diabetes	4.14	1.38–12.29
Hypertension	1.59	0.53–4.71
Cardiovascular	2.72	0.84–8.83
Myocardial infarction	0.88	0.83–0.93
Stroke	3.22	0.58–17.77
Other cardiovascular disease	9.53	1.48–61.27
Neurological problems	8.30	2.57–29.01
Spinal problems	12.16	2.51–58.93
Multiple sclerosis	0.88	0.84–0.93
Other central nervous system problems	5.1	1.12–23.14
Local disorders	2.23	0.57–8.74
Abdominal operations	1.15	0.31–4.26
Local irradiation	1.28	0.67–5.43
Psychological		
Depression	1.43	0.48–4.23
Relational problems	1.37	0.46–4.04
Work-related problems	0.80	0.22–2.90
Low self-esteem	1.61	0.60–4.28
Fear of failure	0.50	0.11–2.89
Stress	1.37	0.46–4.04
Surmenage (i.e., overstressed)	1.23	0.41–3.75
Lifestyle		
Cigarette smoking	1.48	0.51–4.27
Alcohol > 2x daily	0.97	0.27–3.56
Highest education	1.37	0.52–3.62

entirely fill out the questionnaire on ED, bother, acceptance, need for help, and received help, the number of men with ED for analysis was reduced to 211 (14.2%, compared with 16.8% of the total responder group). This may have caused selection in the population and consequently may have affected the results. However, in this study nonresponse is an issue only if it is related to higher or lower prevalence of bother, acceptance for ED, and need for help among those who are considered to have ED. Even if nonresponse results in higher prevalence of ED in the population, it will only affect our results if nonreponse differs across the above mentioned categories. In the nonresponder study we found a slightly lower prevalence of ED. Unfortunately, no information on bother, acceptance for ED, and need for help was collected in the nonresponder study. In addition, we found no differences in characteristics between men with ED who completed the questionnaire on bother, acceptance for ED, and need for help, and all 356 men with ED. As a consequence, the number of men with ED in need for help and not receiving any treatment per characteristic was very small and therefore the risk factor analysis was less precise (wider confidence limits).

Second, whether lack of knowledge on the availability of treatment options for ED at the time of the study (2000) may have affected the bother and the acceptance of ED is not clear. The availability of effective oral medication since 1998 and the associated publicity may have influenced acceptance and bother and therefore may have provoked medicalization of ED. On the other hand, availability of oral treatment may have induced awareness of ED and may have awakened repressed bother about ED. Kubin et al. concluded from their study that many men are considerably distressed because of their condition and that the increasing awareness of ED, as well as the availability of noninvasive treatments, probably resulted in a greater proportion of patients seeking treatment who eventually regained a satisfying sex life [12]. In the United States, as well as in the Netherlands, publicity on oral treatment for ED resulted in a growing demand for effective medication.

It is unclear why physicians do not raise the subject of erectile problems with their patients. Probably, ED does not cross their mind, and as patients (even if they need help for ED) do not mention ED either, the subject remains undiscussed. On the other hand, after a myocardial infarction, patients have to follow a rehabilitation program before resuming sexual activity, resulting in regular attention by a physician.

Other studies on ED focusing on bother and need for help showed comparable age-related prevalence of bother and need for help in men with ED and also a considerable lack of treatment [1–3,16,17]. In the Boxmeer study, 64% of men with ED aged 40–49 years reported bother, decreasing to 27% in men with ED aged 70–79 years [3]. In the Cologne study, 35.9% of the men with ED were distressed by having ED and reported to require treatment [7]. This is only half of the percentage of men bothered by ED and in need for help in our study. Apart from differences in assessing bother and need for help and a higher mean age of the study population, we cannot explain these differences, despite that Cologne is situated close to the Netherlands, with inhabitants having more or less the same Northern European cultural background. In the Cologne study, a relevant reason for not seeking treatment were the costs involved, as medical treatment for ED was not reimbursable. In the Krimpen study, Blanker et al. showed that 38% of men with severe ED and only 8% of men with mild ED were bothered [6]. Compared with our study (mean age 48 years), these rates were lower, which may partly be explained by the higher mean age in the Cologne study and the Krimpen study (respectively 52 and 58 years), differences in the method of assessing bother and need for help, and the cultural background of the inhabitants of Krimpen (Protestant). In the Cologne study, a relevant reason for not yet wanting treatment were the costs, as treatment for ED was not reimbursable. In the United Kingdom 64% of men with sexual problems (not only ED) would have liked to receive help [2]. This is less then the percentage of men in need for help in our study. Only 6% actually received any medical attention. A West Australian open population study (men aged 18–91 years, mean age 56 years) indicated that 26% of men with ED had mentioned the problem to their doctor [1]. That percentage is higher than in our study (only 10.4%), but the reasons could not be explained. Hesitation to actually seek help was also mentioned by Solstad, who found that only 6% of men with ED and need for help had the intention to seek help [10]. He found that asking about seeking treatment by questionnaire, resulted in a lower percentage of men seeking help, compared with asking the same question by interview. Our study is based on a questionnaire and thus may underestimate the number of help-seeking behavior. In

a review Kubin showed that up to 70% of men with ED were not treated (more or less corresponding to our results) [12]. Segraves et al. investigated differences in characteristics of men who initially consulted a urologist with a complaint of ED vs. those who visited a sexual dysfunction clinic without being referred. Patients suffering from sexual dysfunction who visited the clinic without being referred were more often Caucasian, more often had psychogenic etiology, were more often of higher socioeconomic class, and responded much better to psychological interventions [17]. We found no differences in social class regarding help-seeking behavior. Whether differences between studies also reflect differences in characteristics, response rates, or cultural factors has not been assessed. In general, however, when compared with the reported need for medical attention, all findings indicate a low prevalence of receiving treatment for ED.

Conclusion

The majority of men with ED are concerned or bothered, do not accept ED, and perceive the need for medical attention. Even most of the men who are not bothered report to have need for help. The majority of these men do not receive any medical attention on ED. They are characterized by chronic diseases, visiting the GP regularly for follow-up treatment of their medical condition. We strongly recommend that GPs ask these patients about their erectile functioning and possible need for help and offer them treatment options if needed. For clinical reasons, questionnaires in studies on the prevalence of ED should contain questions on bother, acceptance, and need for help.

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