



Charles A. Moser, PhD, MD

Guest Editorial

Introducing Sexual Medicine

It is a great honor to be chosen by the editorial board to edit this special edition of *San Francisco Medicine*. My experiences as a sex educator, sex therapist, and sex researcher have been great preparation to promote and explain the importance of sexual health and sexual medicine (the medical aspects of sexual concerns and the sexual aspects of medical concerns) to other physicians as well as patients. Although physicians have always grappled with sexuality, often doing more harm than good, they have been hampered by the absence of a firm scientific foundation, insufficient support from organized medicine, and a dearth of appropriate medical education. Nevertheless, with the growing recognition that many serious medical problems present with sexual symptoms; that many medical and surgical interventions affect our patients' sexuality, that sexual dysfunctions can be treated both medically and psychologically, that different sexual lifestyles are associated with different long-term health problems, and that sexually transmitted infections can be treated successfully, sexuality has become just another aspect of the human condition with which medicine must be concerned.

Most of us grew up in more prudish times and societal conventions have been a barrier to serious study of sexuality. Even now, it is difficult to obtain grant money, find unbiased information, and not be ridiculed for doing sex research. There are many battles ahead, but the tide is changing and serious

discussions of patients' sexual concerns are now common in most physicians' offices.

Sexuality is more than which sexual acts you engage in or with whom. For many people, it encompasses their identity and the essence of their being. For some it is the difference between happiness and despair, between fulfillment and emptiness. While a particular sexual lifestyle can lead to specific medical problems, even being sexual or not can have health consequences (i.e., orgasms can be protective against cardiovascular events)¹.

Physicians interested in this new area have been organizing to promote higher clinical standards, as well as basic and medical research. The new medical specialty of Sexual Medicine is forming; for example, the International Sexual Medicine Society (ISSM) (<http://www.issir.org/>) and the International Society for Study of Women's Sexual Health (<http://www.isswsh.org>), not to mention numerous other but more narrowly focused physician groups, are promoting research and excellence in the clinical practice of sexual medicine. The newly renamed *Journal of Sexual Medicine*, the

official journal of the ISSM (<http://www.blackwellpublishing.com/journal.asp?ref=1743-6095>), joins numerous other scientific journals devoted to the scientific study of sexuality. Articles advising physicians about how to become sexologists and sexual medicine physicians (sexiatrists) are also beginning to appear.²

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A Brief Rationale for *NOT* Scheduling Viagra and Other PDE5 Inhibitors as Controlled Substances

Charles A. Moser, PhD, MD

Dr. Klausner presents a very interesting argument for scheduling sildenafil, vardenafil and tadalafil, the three phosphodiesterase type 5 (PDE5) inhibitors currently available for the treatment of erectile dysfunction. I disagree with his position, and here is a point-by-point response with my rationale for not changing the status of this drug class.

Dr. Klausner suggests that an association exists between participation in unsafe sex and the use of these drugs, leading to a rise in STIs. The studies he cites do show correlation, but not causation, between PDE5 inhibitors and unsafe sex. Dr. Klausner admits that the use (and abuse) of other recreational or disinhibiting substances taken in combination with the PDE5 inhibitors is the real problem. Those other drugs are already scheduled, which does not seem to have diminished access to them. We doubt that scheduling the PDE5 inhibitors will diminish access for those individuals who apparently have little problem in obtaining other scheduled substances. We believe that the effect on STI rates from scheduling these drugs would be minuscule at best.

Dr. Klausner is also concerned about the medical consequences of illicit PDE5

inhibitor use. Although all drugs can have negative effects, there is no indication that individuals using these drugs are clogging the emergency departments or local physician offices with complications from their illicit PDE5 inhibitor use. Although I do not support the use of these drugs without medical supervision, I doubt that the direct negative medical consequences are significant. The problems that arise from the other illicit drug use are much more serious. The desire for PDE5 inhibitors in this population presents another opportunity to reach out to these individuals and should not be ignored.

A positive response from a "friend's" use of a PDE5 inhibitor could lead a patient to request evaluation for his own prescription. At that time, the physician may uncover other medical conditions, psychiatric concerns, as well as use the opportunity to counsel the patient on the dangers of unsafe sex and illicit drugs. Scheduling the drug, thus increasing the penalties for its illicit use, would probably decrease the likelihood that the patient will consult the physician.

Inherent in Dr. Klausner's article is the belief that young men do not have problems with erections. Actually 7 percent of the men between 18 and 29 years of age report difficulty obtaining or

maintaining an erection.¹ Erectile dysfunction in younger men should not be ignored and can be a significant problem for these men. There is also some evidence that one reason that substance abusers use illicit drugs is to self-medicate their own sexual dysfunction.^{2,3} There is no way of knowing how many men with sexual dysfunction self-medicate with illicit drugs and, consequently, how many would avoid illicit drugs if their sexual concerns were treated in a timely factor.

There is a concern that younger men are using these drugs for enhancement—not to treat a "true" dysfunction. In fact, PDE5 inhibitors have little effect on normal men.^{4,6} In reality, the definition of erectile dysfunction is a patient's complaint of difficulty with getting or maintaining an erection. Physicians should not impose their beliefs of what constitutes an acceptable sexual response or what is acceptable sexual behavior on their patients; we have come a long way from denying contraception to unmarried women. In addition, we do not deny weekend athletes NSAIDs, just because they are more functional than someone who is crippled by arthritis.

We are trying to foster an atmosphere where all patients can feel comfortable discussing their sexual concerns. If

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medications and other substance use can be assessed. Use of phosphodiesterase type 5 inhibitors with other substances that may increase untoward effects—like nitrites, either prescribed or recreational, and inhibitors of enzymatic function like protease inhibitors—can be avoided.

The successful scheduling of this class of drugs requires consent of the Department of Health and Human Services. That will not be easy but it is a rational response to reduce the unforeseen public health consequences associated with their abuse while preserving their availability to those in need.

Dr. Klausner is the Deputy Health Officer and Director of the STD Prevention and Control Services at the San Francisco Department of Public Health. The views of Dr. Klausner on this subject are not necessarily the policy views of the SFDPH.

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No to PDE5 Inhibitors as Scheduled Drugs

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patients sense reticence to prescribe these drugs, they may not discuss their sexual concerns with their physicians; we could miss the clinically significant diagnoses associated with sexual dysfunction and the chance to connect with our patients on a deeper level.

Some physicians resist prescribing scheduled drugs, which is the basis for the current campaign to improve the treatment of pain. The scheduling of these drugs may create analogous problems. Concerns about drug-seeking behavior are always an issue with patients taking scheduled drugs. These concerns can add to resistance to prescribing PDE5 inhibitors.

Both physicians and patients have resisted discussing sexual concerns, and these drugs (and sex therapy) are actually underutilized. Scheduling these drugs would be a further impediment to the appropriate treatment of erectile dysfunction. We need to foster an atmosphere of frank and open communication.

Although any drug can be misused or abused, there are at least some men who use the PDE5 inhibitors to maintain erections while using condoms. These men may not technically suffer from erectile dysfunction, because they can function quite well without a condom.

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These drugs, then, can increase adherence to safer sex guidelines and decrease the spread of STIs.

I am sure that Dr. Klausner would agree that we need to prevent the Internet sales of these drugs, limit the self-medication with these drugs, and assure that physicians are diagnosing and treating these problems. The solution to this problem is better education of both physicians and patients, rather than limitations imposed by scheduling these drugs.

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Sexual health is being recognized as an integral part of overall health (see <http://www.paho.org/English/HCP/HCA/PromotionSexualHealth.pdf> and <http://www.surgeongeneral.gov/library/sexualhealth/>), and the concept of sexual rights as human rights is being advanced³. See an excellent example of a Declaration of Sexual Rights adopted by the World Association of Sexology at http://www.worldsexology.org/about_sexualrights.asp.

Physicians are at the forefront of finding new, active and preventive treatments for a variety of sexual concerns. New vaccines for HSV and HPV are in development. We are defining the mechanisms of erection and the pathophysiology of erectile dysfunction, as well as other sexual concerns. We are learning the molecular intricacies of how various sexually transmitted infections are actually transmitted. We are exploring the special health concerns of various sexual lifestyles and how sexuality changes through the lifespan.

The standard of care has progressed so that the sexual concerns of our patients can no longer be ignored. *San Francisco Medicine* has taken up the challenge to assist physicians to educate themselves and provide the resources for that education. I am proud to be part of that process.

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