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Letter to the Editor OMICS International

Erectile Dysfunction: The Problem Hiding Behind Prostate Cancer

Tarik Emre Sener* **and Bahadir Sahin**

Department of Urology, School of Medicine, Marmara University, Istanbul, Turkey

***Corresponding author:** Sener TE, Marmara Universitesi Pendik Egitim ve Arastirma Hastanesi, Uroloji Anabilim Dalı, 4. Kat. Fevzi Cakmak Mah. Muhsin Yazicioglu Cad. Ust Kaynarca, Pendik, Istanbul, Turkiye, Tel: +905337620712; E-mail: dr.emresener@gmail.com

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Letter to Editor

We read with great interest, the article written by Quaresima et al. evaluating the onset of erectile dysfunction (ED) in patients under active surveillance (AS) for low risk prostate cancer. We think that this topic is of huge importance, as ED affects enormously the quality of life in patients who are not under great threat by their primary illness in terms of mortality. Also, when a cancer diagnosis is on the table, many of the complaints that are not directly a cause of mortality are overlooked. Thus, investigating the AS patients for ED carries a significant importance to provide good health care.

Prostate cancer is a major health problem globally with 1,442,460 incident cases in 2013. It is the 8th leading cause of cancer death worldwide as developed countries are affected approximately twice more than developing countries [1]. Life expectancy in men has increase and taken into consideration the higher incidence of prostate cancer in elderly, the overall death from prostate cancer has doubled between 1990 and 2013 according to Dy et al. [1]. However, the mortality rate of untreated low risk prostate cancer with Gleason scores between 5-7 might be as low as 7% [2]. Thus, AS is becoming the way to manage patients with clinically confined, low risk prostate cancer without compromising curative treatment.

A prospective study is what scientific communities need now-a-days and is the appropriate way to investigate AS patients. The purpose of AS is to aim the correct timing for appropriate curative treatment without compromising curative intent, so patient follow-up must be both standardized for a predefined schedule and be individualized for each patient due to different co-morbidities and life-expectancies [3]. One of the largest cohorts with the longest follow-up including 993 patients demonstrated the safety profile of active surveillance as disease-specific survival is 98.1% and 94.3% at 10 and 15 years, respectively [4].

One of the major problems during AS, is the fear of disease progression with general anxiety. According to PRIAS study, this anxiety decreases after 18 months of AS [5]. Considering the co-occurrence of ED with anxiety, ED is rather an early problem of AS and this topic is already covered by Pearce et al. but using different parameters for erectile function assessment [6]. Quaresima et al. preferred the IIEF-5 questionnaire, which provided high sensitivity and specificity and is recommended by the European Association of Urology (EAU) Male Sexual Dysfunction Guidelines [7,8].

High body mass index, diabetes, hypertension and age have been pointed out as contributors to ED onset by the authors which is followed by their comment that a larger cohort is needed to support these findings. However, these factors have already been mentioned as risk factors by Pearle et al. as well as in the EAU Guidelines on Erectile Dysfunction [6,7].

In these contexts, we think the article by Quaresima et al. carries great importance regarding the approach towards patients that will undergo AS. Recognizing those AS patients under risk for ED can change our practice towards ameliorating our diagnostic and therapeutic approaches in terms of erectile function. The potential improvement in ED would decrease anxiety and ensure patients' well-being.

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