

Cardiovascular risk evaluation for all men should include assessment of sexual function

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Assessment of sexual function should be incorporated into cardiovascular risk evaluation for all men, regardless of the presence or absence of known cardiovascular disease, according to Dr. Ajay Nehra, lead author of a report by the Princeton Consensus (Expert Panel) Conference, a collaboration of 22 international, multispecialty researchers. Nehra is vice chairperson, professor and director of Men's Health in the Department of Urology at Rush University Medical Center in Chicago.

Erectile dysfunction (ED) is a red flag in [younger men](#), less than 55 years of age for future cardiac morbidity or mortality – death or disease – for cardiovascular disease (CVD). In some patients, the time window between onset of ED and a [cardiovascular event](#) may be two to five years.

"Any man with ED should be considered at a substantially higher increase [cardiovascular risk](#) until further testing can be done," said Nehra. "Erectile dysfunction often occurs in the presence of silent, non-symptomatic cardiovascular disease; and hence this is an opportunity for cardiovascular risk reduction."

The panel recommends that younger men, more than 30 years old who experience ED receive a thorough, non invasive cardiovascular disease evaluation. As the consensus panel considers all men with ED who are older than 30 to be at increased CVD risk, a thorough noninvasive and, when indicated, invasive evaluation of CVD status is recommended.

They found that younger men who experienced ED were twice as likely to develop cardiovascular disease than men without ED. The highest risk for cardiovascular disease was in younger men.

While controversial, the consensus panel also recommended that testosterone levels be measured in all men diagnosed with organic ED due to an accumulation of recent studies that link low testosterone to ED, CVD and [cardiovascular mortality](#).

"Testosterone levels should be routinely measured. Men with testosterone levels less than 230 have higher risk for all cause and cardiovascular mortality," said Nehra. In population based studies of 500 or more patients, low [testosterone levels](#) have increased mortality level.

These and other recommendations for controlling ED and CVD emerged from the Princeton III Meeting on Cardiometabolic Risks and Sexual Health, held in 2010, that were reported in the August 2012 issue of the *Mayo Clinic Proceedings*.

The purpose of the Princeton III meeting was to find an approach for optimizing [sexual function](#) and preserving cardiovascular health in men with known CVD. The conference updated findings from the Princeton I and Princeton II meetings, held in 2000 and 2005, respectively.

"The conference focused on the predictive value of vascular erectile dysfunction in assigning cardiovascular risk in men of all ages, the objective being development of a primary approach to cardiovascular risk assessment in younger men with erectile dysfunction and no cardiovascular disease," Nehra said.

The panel's approach broadens the use of the 2010 American College of Cardiology/American Heart Association guideline for assessment of cardiovascular risk in asymptomatic adults to address an at-risk

population that the guideline does not mention – men with ED. Even long-term observational studies, such as the well-known Framingham Heart Study, include few data from patients younger than 40 years.

"Experts have been considering the connection between erectile dysfunction and [cardiovascular disease](#) for a while," said Nehra. "Recent data and publications about the connection have become more consistent in linking the two."

There is a growing body of scientific evidence that ED is a particular precursor of CVD in men younger than 40. One study found that men 40 to 49 years of age with ED had a 50-fold higher incidence of new-onset coronary artery disease than those without ED.

In light of this evidence, the panel recommended that the cardiovascular evaluation include an assessment of important indicators of risk that can be seen in certain blood and urine tests, patient and family history and a review of lifestyle factors. Such an evaluation will help stratify the patient's CV risk and guide the next steps in evaluation and treatment.

"That means that doctors treating men for [erectile dysfunction](#) can play a critical role in helping monitor and start reducing a patient's cardiovascular risk, even when the patient has no symptoms," said Nehra.

The new recommendations also emphasize using exercise ability before prescribing treatment for ED to ensure that each man's cardiovascular health is consistent with the physical demands of sexual activity, especially for those who have been identified as having a high risk for CVD.

The panel encouraged a collaborative approach to management of men's sexual function and cardiovascular risk, incorporating general, urologic,

endocrine and cardiologic expertise. Scientific evidence suggests that a comprehensive approach to cardiovascular risk reduction will improve overall vascular health, including sexual function, the report said.

The Princeton III panel also strongly urges physicians to inquire about ED symptoms in all men older than 30 years of age with CVD risk factors. "Identification of ED, particularly in [men](#) younger than 60, represents an important first step toward CVD detection and reduction," the panel concluded.

Provided by Rush University Medical Center

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