

## Dr. Al Shaiji and Dr. Brock's rebuttal

**D**r. Lee makes his points in a succinct and eloquent fashion but, in essence, supports the basic thrust of our point of view.

Dr. Lee cites a recent report by Teloken and colleagues,<sup>1</sup> in which key sexual medicine specialists across 41 countries were questioned. More than 80% recommended penile rehabilitation for their patients. In fact, when these same specialists were asked if they would institute a program for themselves following a radical prostatectomy (RP), more than 90% responded positively. In our view, this favourable response from experts who know the medical literature and have vast clinical experience with couples following prostate cancer therapy adds credence to the value in these initiatives, rather than discounts them!

Also among Dr. Lee's key commentaries is that there is a clear need for additional research and clinical studies to determine which agent, dosing regimen and timing best optimizes the rehabilitative strategies. We agree that further studies are needed. Additionally, we concur with Dr. Lee that studies of men with unilateral cavernous nerve-sparing RP and men with pre-existing erectile dysfunction need to be performed.

We do not agree with Dr. Lee that unmet expectations or treatment cost are factors that limit the value of a rehabilitative approach.

We believe that the scientific evidence strongly supports improved quality-of-life end points among those patients and partners who enter a rehabilitation program.<sup>2</sup> In fact, the couples who enter into these programs generally have greater access to health care information and treatment alternatives, and are encouraged to restart intimacy with their partners at an earlier time point than cohorts not offered similar care. Like most therapeutic approaches, penile rehabilitation is not

appropriate for **all** men undergoing radical prostate cancer therapy, but needs to be individualized to the specific patient, partner and their specific goals. I do tell **all** of my patients interested in optimizing their posttreatment erectile function that the overwhelming weight of basic scientific evidence supports a beneficial effect of phosphodiesterase-5 inhibitors on cavernous smooth muscle and that many clinical trials support these effects in men.

Few areas of clinical medicine provide clear and absolute standards for therapy. The skilled clinician needs to balance safety, efficacy, cost and clinical benefit when choosing any therapeutic approach. In our view, penile rehabilitation is in its infancy. We are armed with results from early trials in some subpopulations of men, evaluating a paradigm that has shown great promise in the laboratory, with animal models and with human volunteers, but many unanswered questions remain. The real issue for our patients is, do we hold off therapy and wait until all the data are in and risk cavernous fibrosis, apoptosis and irreversible erectile dysfunction, or initiate treatment now, understanding we have an incomplete data set. At the University of Western Ontario, most of our patients choose to start therapy now while we wait for those studies to be completed.

This article has been peer reviewed.

**Competing interests:** None declared.

### References

1. Teloken PE, Mesquita GG de, Montorsi F, et al. Post radical prostatectomy pharmacological penile rehabilitation: current practice status. *J Sex Med* 2006;3(suppl 5):394.
2. Mulhall JP. Penile rehabilitation following radical prostatectomy. *Curr Opin Urol* 2008;18:613-20.