A "shocking" word

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The treatment of erectile dysfunction (ED) has changed since I entered practice in 1984. Initially thought to be primarily psychogenic in nature, the introduction of vasoactive agents revolutionized the field and introduced a generation to intracorporal injection therapy in the late 1980s. I still remember attending a lecture at the American Urological Association's annual meeting where the presenter discussed self-injection with papaverine, then displayed a penis that had been artificially erect from an earlier papaverine injection. This ushered in a number of agents for penile self-injection. We would teach men in small groups. Because of the time it took to teach and the efforts to keep our patients on track, we charged a fee of $150, considered a large sum in 1990. I still charge patients to learn intracavernous injections (ICI); my nurse of 25 years leads the workshops. It takes about 45 minutes and often a number of followup phone calls and emails to get our patients comfortable with the dose and technique.

Over the last year, I have seen several young patients who have had shock wave therapy for their ED. While the efficacy of low-intensity shock wave therapy (LISWT) is still in question, it has already been commercialized and considerable money has been invested in clinics that offer this option. Unfortunately, the old saying, "When you're a hammer, everything looks like a nail," applies to these facilities. Not one of the dozen LISWT failures I've seen would meet the inclusion criteria for successful treatment, as outlined by the few clinical trials with positive outcomes. Add to this the outlay of up to $5000 for some of the treatment schedules and you have a large cohort of vulnerable patients that have been taken advantage by the purveyors of this therapy.

Who is offering LISWT? In my region, there are a few clinics run by a retired dentist and a practicing chiropractor — not your typical ED professionals, but they may have educated themselves. If the patients I've seen who have had treatment represent an example of their knowledge base, then it would suggest that the primary indication for shock wave therapy is the ability to pay for treatment. If urologists *are* involved, they are not part of the clinical assessment.

Why haven't urologists embraced this treatment? I think a review of the data would answer that question. It isn't ready for prime time and needs further study. What can be done to protect patients from healthcare professionals who offer this treatment to the vulnerable? While it is not our nature to interfere with other practices, should we speak out if we know that patients are being scammed?

Should I report the shock wave clinics to our College? No one is being injured. Patients leave the clinic a bit poorer and a little more frustrated. I'd be interested in the experience other urologists have had with this technology. Feel free to email CUAJ at journal@cua.org.

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