Dysfonction érectile : point de vue de l'angiologie

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Formation continue RHNe

12 mars 2026

UNIVERSITÉ DE GENÈVE
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Aucun conflit d’intérêt

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Au programme

- Un peu d’épidémiologie
- Anatomie pénienne et physiologie de l’érection
- Dysfonction érectile et maladies cardio-vasculaires
- Approche clinique initiale
- Traitements courants
- Investigations approfondies
- Traitements alternatifs
- Interventions et chirurgies
- Conclusions

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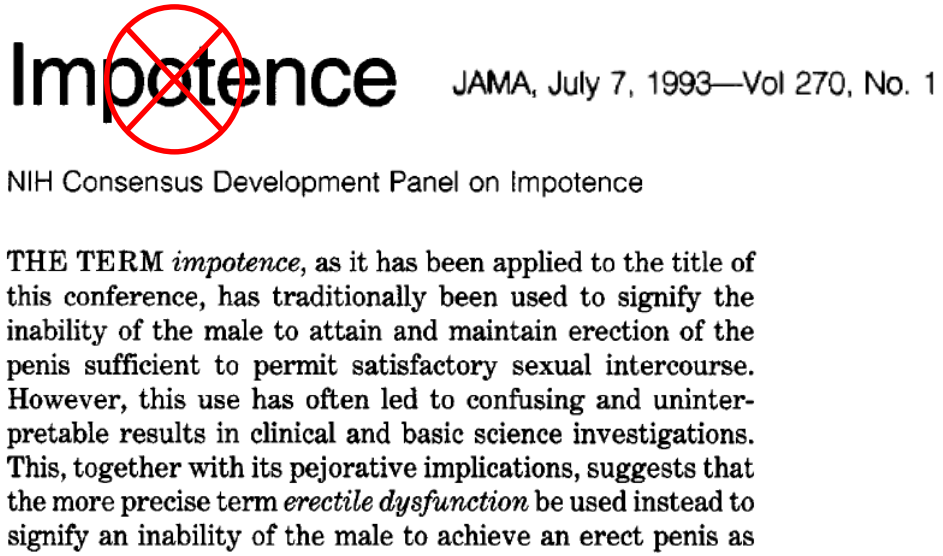
C’est quoi la dysfonction érectile ?



Impotence

JAMA, July 7, 1993—Vol 270, No. 1

NIH Consensus Development Panel on Impotence

THE TERM *impotence*, as it has been applied to the title of this conference, has traditionally been used to signify the inability of the male to attain and maintain erection of the penis sufficient to permit satisfactory sexual intercourse. However, this use has often led to confusing and uninterpretable results in clinical and basic science investigations. This, together with its pejorative implications, suggests that the more precise term *erectile dysfunction* be used instead to signify an inability of the male to achieve an erect penis as

Incapacité permanente ou partielle d’obtenir ou de maintenir une rigidité pénienne suffisante pour permettre une activité sexuelle satisfaisante.

NIH Consensus Development Panel on Impotence. JAMA. 1993 July 7;270(1):83–90. PMID: 8510302
European Association of Urology Guidelines on Male Sexual and Reproductive Health: 2025 Update Eur Urol. 2025 Jul; PMID: 40340108.

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Est-ce fréquent ?

1994	Feldman *et al.* [3] **MMAS*	1,290 men; random population sample (United States)	40%	40-70	Self-administered questionnaire	Overall, 52% of men had ED 17.2% of men had minimal ED 25.2% of men had moderate ED 9.6% of men had complete ED	Age
2000	Braun *et al.* [10] (COLOGNE Study)	8,000 men	56%	30-80	Self-administered questionnaire by mail (Cologne ED Questionnaire)	Prevalence of ED was 19.2%	Age, Hypertension, Diabetes, Pelvic surgery, LUTS
2010	Corona *et al.* [33]	3,369 men; random population study (Europe: Italy, Belgium, United Kingdom, Spain, Poland, Hungary, Estonia)	40%	40-80	Self-administered questionnaire	Overall, 30% of men had ED 6% ED in men aged 40–49 years 19% ED in men aged 50–59 years 38% ED in men aged 60–69 years 64% ED in men ≥ 70 years	Age, Depression, LUTS, Cardiovascular disease, Diabetes, Obesity

Incidence estimée à environ 2%

Méthodologies et populations étudiées différentes

Epidemiology of erectile dysfunction: results of the 'Cologne Male Survey'. Int J Impot Res. 2000 Dec PMID: 11416833.

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Et chez les plus jeunes ?

Table 1 Descriptive statistics in ≤40 years old and >40 years old ED patients (No. = 439)

	Patients ≤40 years	Patients >40 years	*P* value*
No. of patients (%)	114 (25.9)	325 (74.1)	
Age (years; mean [SD])	32.4 (6.0)	57.1 (9.7)	<0.001
Range	17–40	41–77	
CCI (No. [%])			<0.001 (χ^2, 39.12)
0	103 (90.4)	189 (58.3)	
1	6 (5.3)	62 (19)	
2+	5 (4.4)	74 (22.7)	
BMI (kg/m²; mean [SD])	25.1 (4.1)	26.4 (3.7)	0.005
BMI (NIH classification) (No. [%])			0.002 (χ^2, 15.20)
<18.5	1 (0.9)	0 (0)	
Sexual orientation (No. [%])			
Heterosexual	109 (95.6)	322 (99.1)	
Homosexual	5 (4.4)	3 (0.9)	
Relationship status (No. [%])			<0.001 (χ^2, 27.51)
Stable sexual relationship ≥6 months	81 (71.4)	303 (93.2)	
No stable sexual relationship	33 (28.6)	22 (6.8)	
Educational status (No. [%])			0.05 (χ^2, 9.30)
Elementary school	0 (0)	22 (6.8)	
Secondary school	20 (17.5)	64 (19.7)	
High school	51 (44.7)	141 (43.4)	
University degree	43 (37.7)	98 (30.2)	
Concomitant sexual complaints (No. [%])			
PE	14 (12.4)	20 (6.2)	0.03 (χ^2, 4.55)
Low libido	10 (8.8)	23 (7.1)	0.55 (χ^2, 0.35)
Peyronie's disease	5 (4.4)	37 (11.4)	0.03 (χ^2, 4.78)

Keys: SD = standard deviation; CCI = Charlson Comorbidity Index; BMI = body mass index; NIH = National Institutes of Health; MeTs = metabolic syndrome; tT = total testosterone; PE = premature ejaculation
*P value according to χ^2 test or two-tailed independent t-test, as indicated

Table 3 IIEF-domain scores and rates of ED severity in ≤40 years old and > years old ED patients (No. = 439)

IIEF-domains (mean [SD])	Patients ≤40 years	Patients >40 years	*P* value*
IIEF-EF	12.77 (8.7)	14.67 (8.4)	0.23
Moderate ED	21 (18.8)	48 (14.9)	
Severe ED	56 (48.8)	132 (40.6)	

Keys: IIEF = International Index of Erectile Function; EF = Erectile Function domain; IS = intercourse satisfaction domain; OF = orgasmic function domain; SD = sexual desire domain; OS: overall satisfaction domain; ED = erectile dysfunction
*P value according to two-tailed Student's t-test or χ^2 test, as indicated
†ED severity was categorized according to the classification suggested by Cappelleri et al. [23].

2021	Calzo *et al.* [37]	2,660 sexually active men (USA)	Not reported	18-31	Self-administered questionnaire (IIEF-5)	Prevalence of mild ED was 11.3% and moderate-to-severe ED was 2.9%	Demographic (age; marital status) Metabolic (body mass index; waist circumference; history of diabetes, hypertension, hypercholesterolaemia) Mental health (depression, anxiety, antidepressant, tranquiliser use)

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Facteurs de risque

Conclusion: The review provides summary estimates for 37 risk factors and 28 treatments. Meta-analyses of risk factors often did not control for important confounders, and meta-analyses of randomized trials were not exclusive to double-blinded trials, active placebo controls, or tests of long-term effects. We recommend further meta-analyses that eliminate lower quality studies and further primary research on behavioral and combined treatments. **Allen MS, Walter EE. Erectile Dysfunction: An Umbrella Review of Meta-Analyses of Risk-Factors, Treatment, and Prevalence Outcomes. J Sex Med 2019;16:531–541.**

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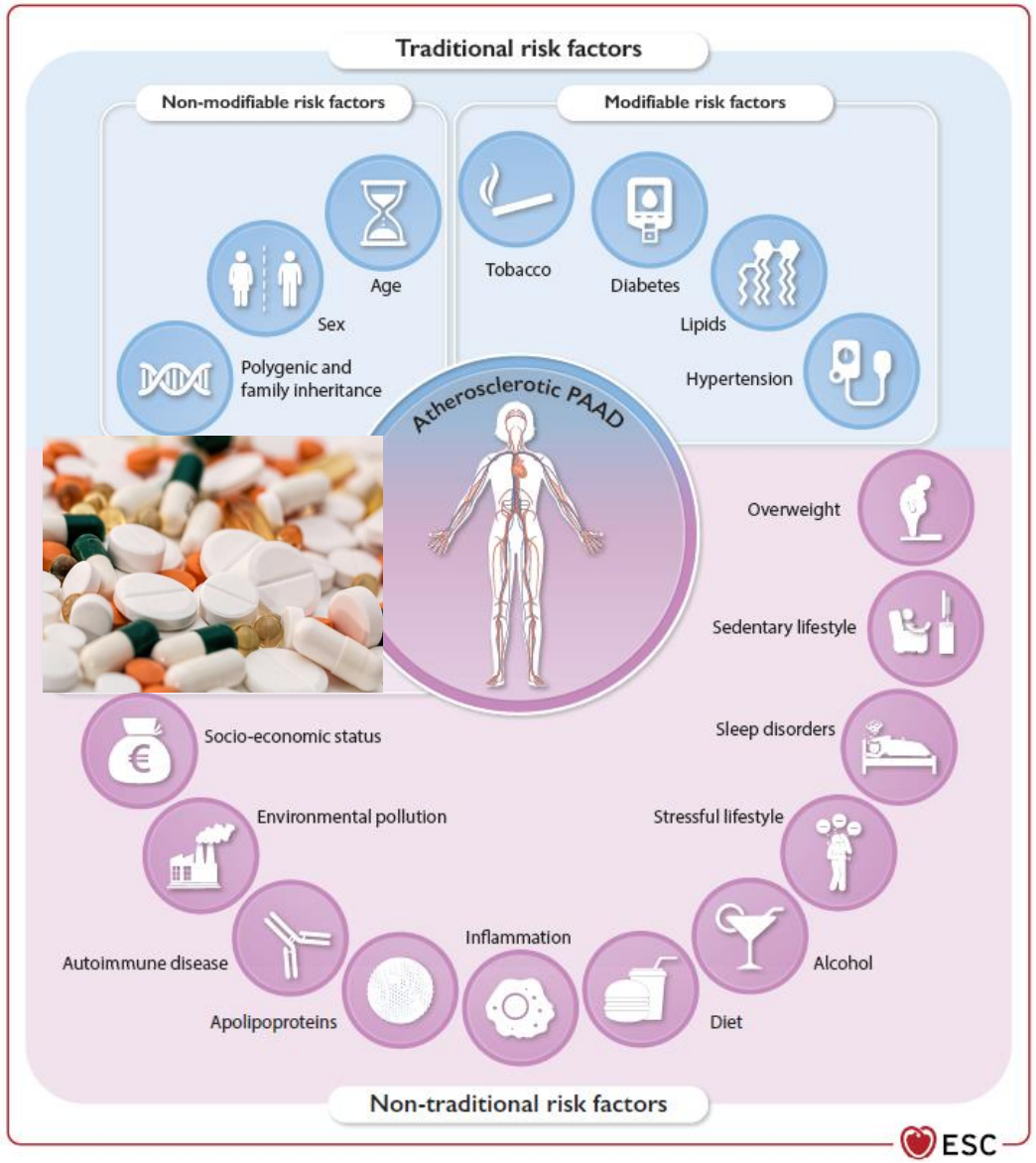

Guidelines for the management of peripheral arterial and aortic diseases. Eur Heart J. 2024 PMID: 39210722.

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Somatique ou psychogène ?

Received: 29 January 2022 | Revised: 3 May 2022 | Accepted: 24 May 2022

DOI: 10.1111/andr.13212

ORIGINAL ARTICLE

ANDROLOGY WILEY

Primary organic versus primary psychogenic erectile dysfunction: Findings from a real-life cross-sectional study

Origine principalement somatiques > principalement psychogène

- 1/9 purement psychogène
- Patient principalement > 40 ans
- CAVE bcp de biais de sélection

Panel 1: **Main organic causes of erectile dysfunction**

Neurogenic

- Central (cerebral or spinal cord): for example, cerebral insult, multiple sclerosis, and spinal cord injury
- Peripheral: afferent (sensory neuropathy, eg, diabetes mellitus and polyneuropathy of various other causes)
- Efferent (autonomic neuropathy or after radical pelvic surgery)

Endocrinological

- Diabetes mellitus, hypogonadism, and hyperprolactinaemia

Vasculogenic

- Arterial: macro or micro angiopathy (eg, atherosclerosis and trauma)
- Venous: failure of the corporal veno-occlusive mechanism
- Sinusoidal: failure to relax (eg, fibrosis)

Drug-induced depression

- Drugs: for example, some antihypertensives, antidepressants, antiandrogens, and major tranquillisers
- Cigarette smoking, alcoholism, and recreational drug use (eg, marijuana and heroin)

Systemic diseases and general ill health

- For example, liver, renal, respiratory, and cardiovascular disease

Local penile(cavernous) factors

- For example, cavernous fibrosis after priapism or due to other reasons, Peyronie's disease, and penile fracture

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Shamloul R, Ghanem H. Erectile dysfunction. Lancet. 2013 Jan. Epub 2012 Oct 5. PMID: 2304

Similaire chez les < 40 ans ?

- Etiologie globalement similaires
- Psychogène > somatique ?
  - Tendance à pensez cela
  - Difficile de donner des chiffres précis
  - Dépendant également de la tranche d'âge
  - Les origines vasculaires ne sont pas rares

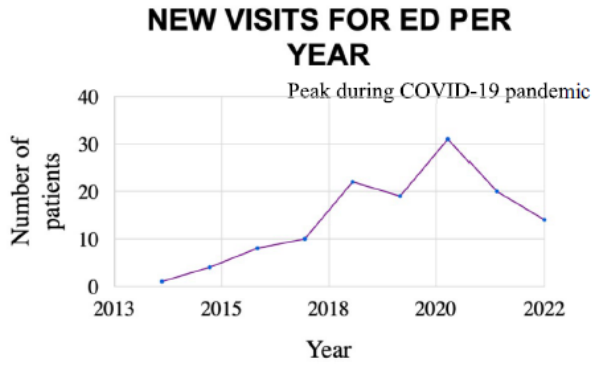

Fig. 1 Number of patients presenting to our large pediatric urology practice over the last 10 years

Conclusions: ED in young men is an increasingly common condition. A careful diagnostic evaluation should focus on the identification of any underlying etiology to ensure appropriate management of patients. **Nguyen HMT, Gabrielson AT, Hellstrom WJG. Erectile Dysfunction in Young Men—A Review of the Prevalence and Risk Factors. Sex Med Rev 2017;5:508–520.**

Key Words: Erectile Dysfunction; Young Men; Risk Factors; Prevalence; Treatment

Pantazis A, Franco I, Gitlin J. Erectile Dysfunction in Adolescents and Young Adults. Curr Urol Rep. 2024 Sep;25(9):225-232. PMID: 38922362.

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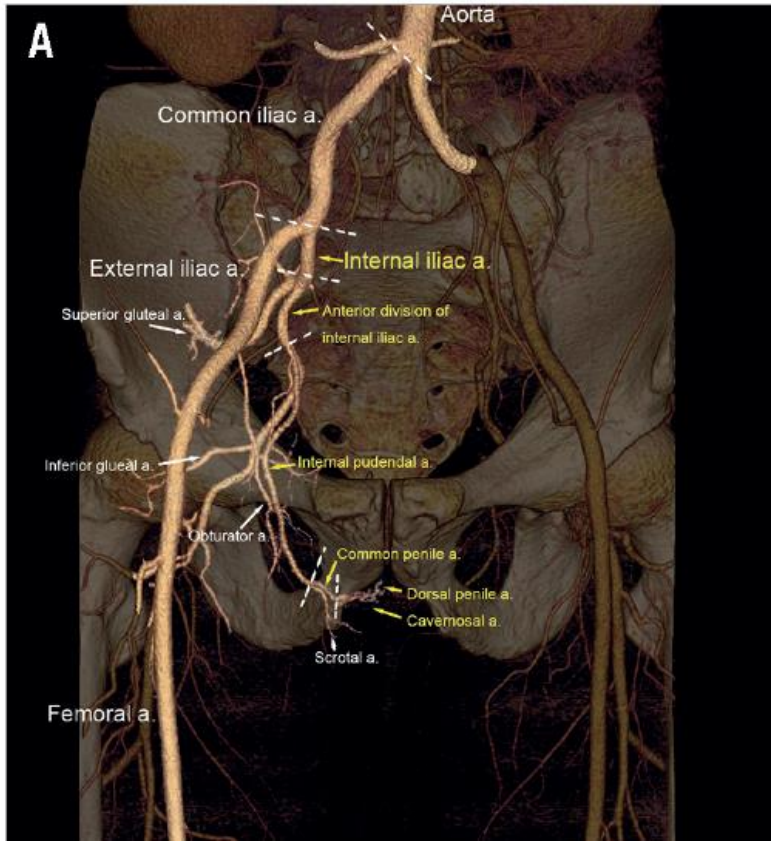
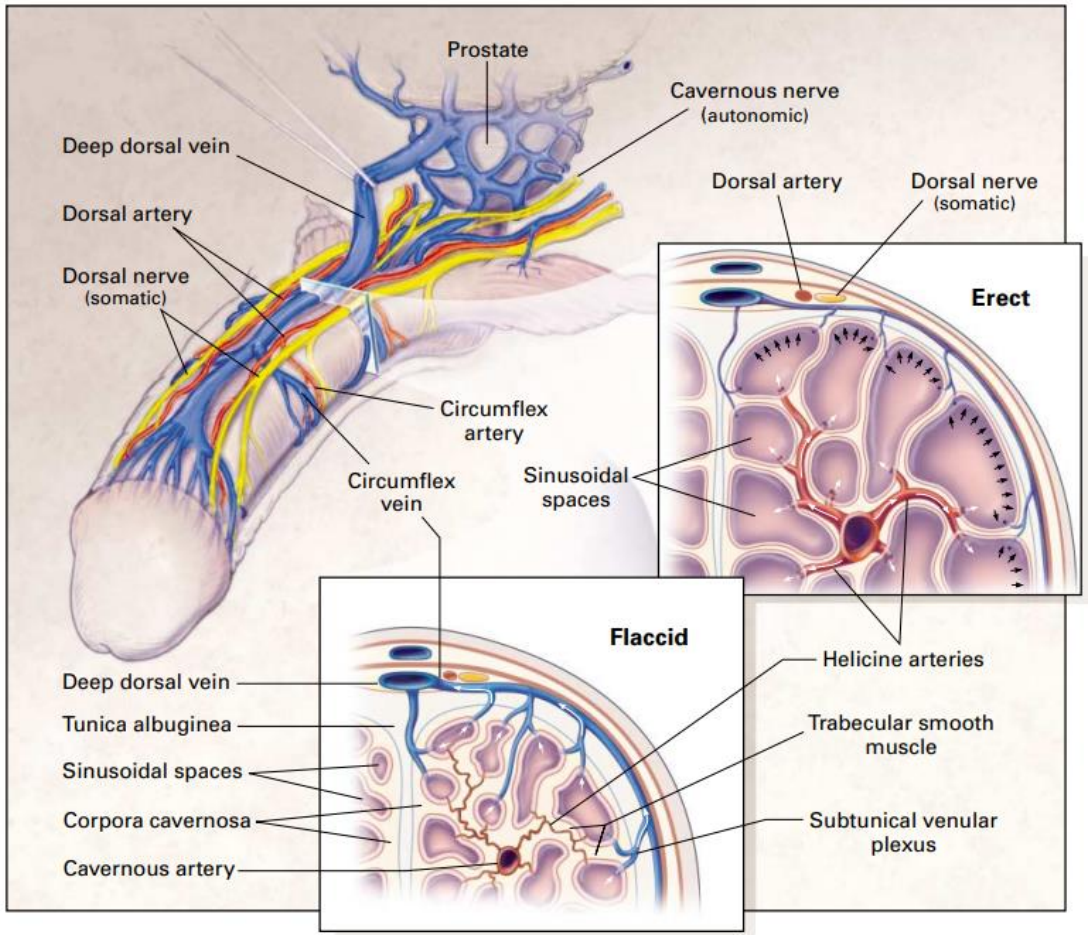
Rappels anatomiques





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Lue TF. Erectile dysfunction. N Engl J Med. 2000 Jun PMID: 10853004.

Wang TD et al. Safety and six-month durability of angioplasty for isolated penile artery stenoses in patients with erectile dysfunction: a first-in-man study. EuroIntervention. 2014 May.

Physiologie de l'érection

L'érection est un phénomène neurovasculaire complexe.

Au repos

- tonus sympathique prédomine
- contraction des CML
- Faible apport sanguin

Initiation érection par stimuli érogène (visuel, tactile, auditif, olfactif ou imaginatif)

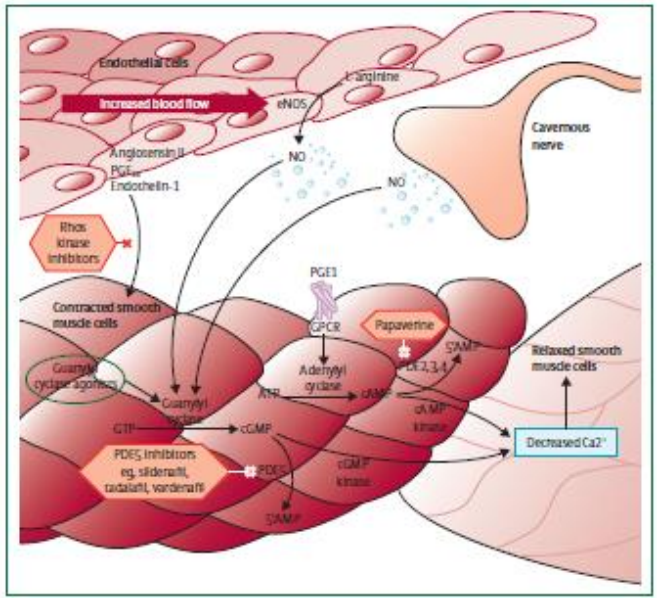
- Réponse cérébrale complexe
- Activation fibre parasympathique issues du plexus pelvien
- Libération de NO → diffuse dans les CML → relaxation (augmentation GMPc diminution Ca2+ intracel) → afflux massif de sang dans les espaces sinusoïdaux

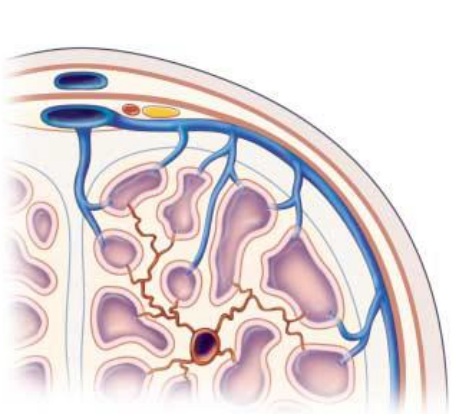
Maintien de la rigidité

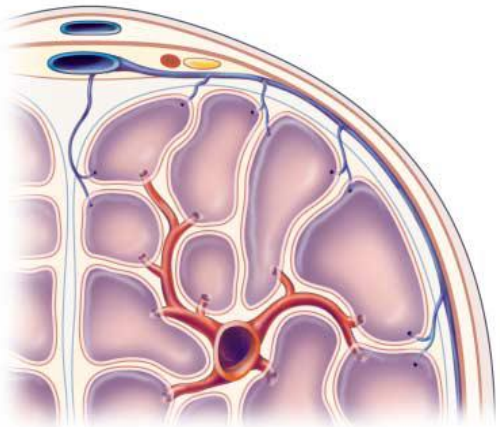
- Remplissage des sinus caverneux → compression des veines contre la tunique albuginée → diminution drainage veineux

Fin de l'érection par la reprise de l'activité sympathique

- Dégradation GMPc par la PDE5







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Dysfonction érectile et maladies cardio-vasculaires

Début du 20ème siècle René Leriche	• atteinte aorto-iliaque
1985 Virag	• présence plus fréquente de tabac, diabète et/ou HCT
2005 Prostate Cancer Prevention Trial (suivi de 9457 hommes)	• DE significativement associée à un risque accru d'événement CV (IM) • DE précédait souvent l'IM de plusieurs années
2006 COBRA trial (étude observationnelle sur 245 hommes)	• DE plus élevée chez les patients atteints pluritronculaire • DE apparaissant jusqu'à 3 ans avant le diagnostic de coronaropathie

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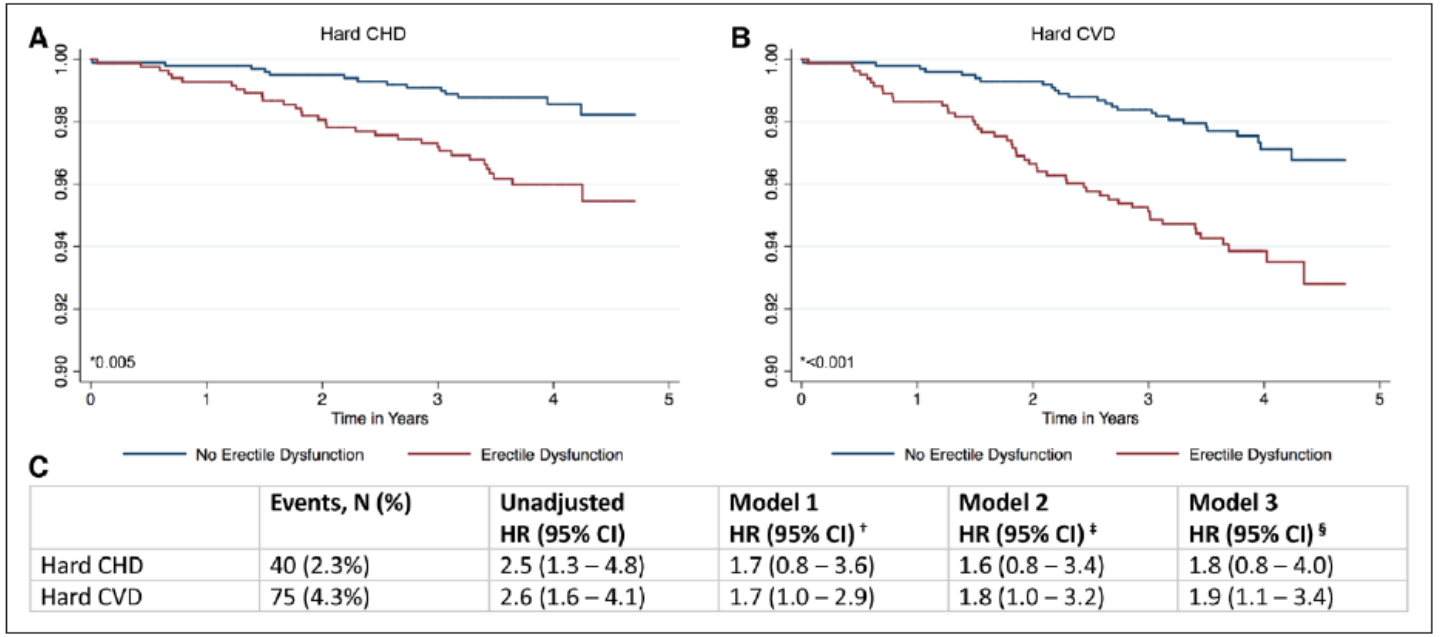
The Multi-Ethnic Study of Atherosclerosis

- Cohorte américaine
- Commence au début des années 2000
- Inclusion questionnaire DE à partir de 2010
- 1757 participants
- Suivi pendant 3,8 ans
- Patient avec DE 2x plus de risque cardio-vasculaire



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	Events, N (%)	Unadjusted HR (95% CI)	Model 1 HR (95% CI) †	Model 2 HR (95% CI) ‡	Model 3 HR (95% CI) §
Hard CHD	40 (2.3%)	2.5 (1.3 – 4.8)	1.7 (0.8 – 3.6)	1.6 (0.8 – 3.4)	1.8 (0.8 – 4.0)
Hard CVD	75 (4.3%)	2.6 (1.6 – 4.1)	1.7 (1.0 – 2.9)	1.8 (1.0 – 3.2)	1.9 (1.1 – 3.4)

Figure. Association between ED and incident CHD and CVD hard events among 1757 male MESA participants.
A and **B**, Kaplan-Meier cumulative survival function curves for hard CHD and CVD events by ED status. **C**, Cox proportional hazard ratios (95% CIs) of hard CHD and CVD events by ED status. **P* value by log-rank testing. †Model 1 adjusted for age, race/ethnicity and education. ‡Model 2 adjusted for model 1 + smoking status, diabetes mellitus, family history of CHD, total/HDL cholesterol ratio, systolic blood pressure, antihypertensive medication use, and lipid-lowering medication use. §Model 3 adjusted for model 2 + depression and β-blocker use. CHD indicates coronary heart disease; CI, confidence interval; CVD, cardiovascular disease; ED, erectile dysfunction; HDL, high-density lipoprotein; and HR, hazard ratio.

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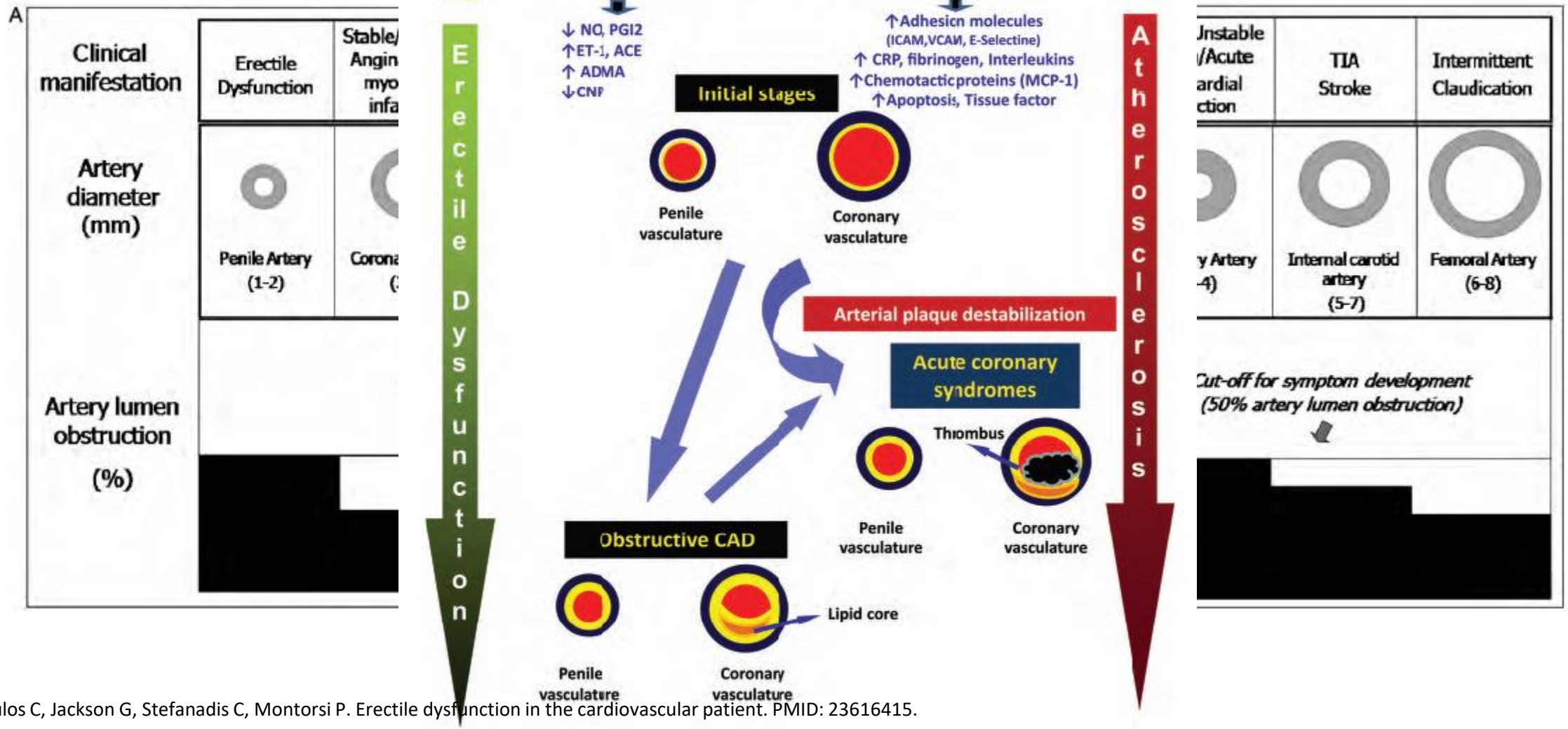

Vlachopoulos C, Jackson G, Stefanadis C, Montorsi P. Erectile dysfunction in the cardiovascular patient. PMID: 23616415.

Santé sexuelle dans l'évaluation cardiovasculaire

8. Mental health in specific populations and situations

8.1. Sex and gender differences in mental health and cardiovascular disease

ESC European Society of Cardiology
European Heart Journal (2025) **00**, 1–70
https://doi.org/10.1093/eurheartj/ehaf191

ESC GUIDELINES

2025 ESC Clinical Consensus Statement on mental health and cardiovascular disease: developed under the auspices of the ESC Clinical Practice Guidelines Committee

In men, erectile dysfunction has not only been shown to be a consequence of CVD, it is also a risk marker for future CVD.[513] A recent meta-analysis demonstrated that sexual dysfunction is also a predictor of future CVD in women.[514]

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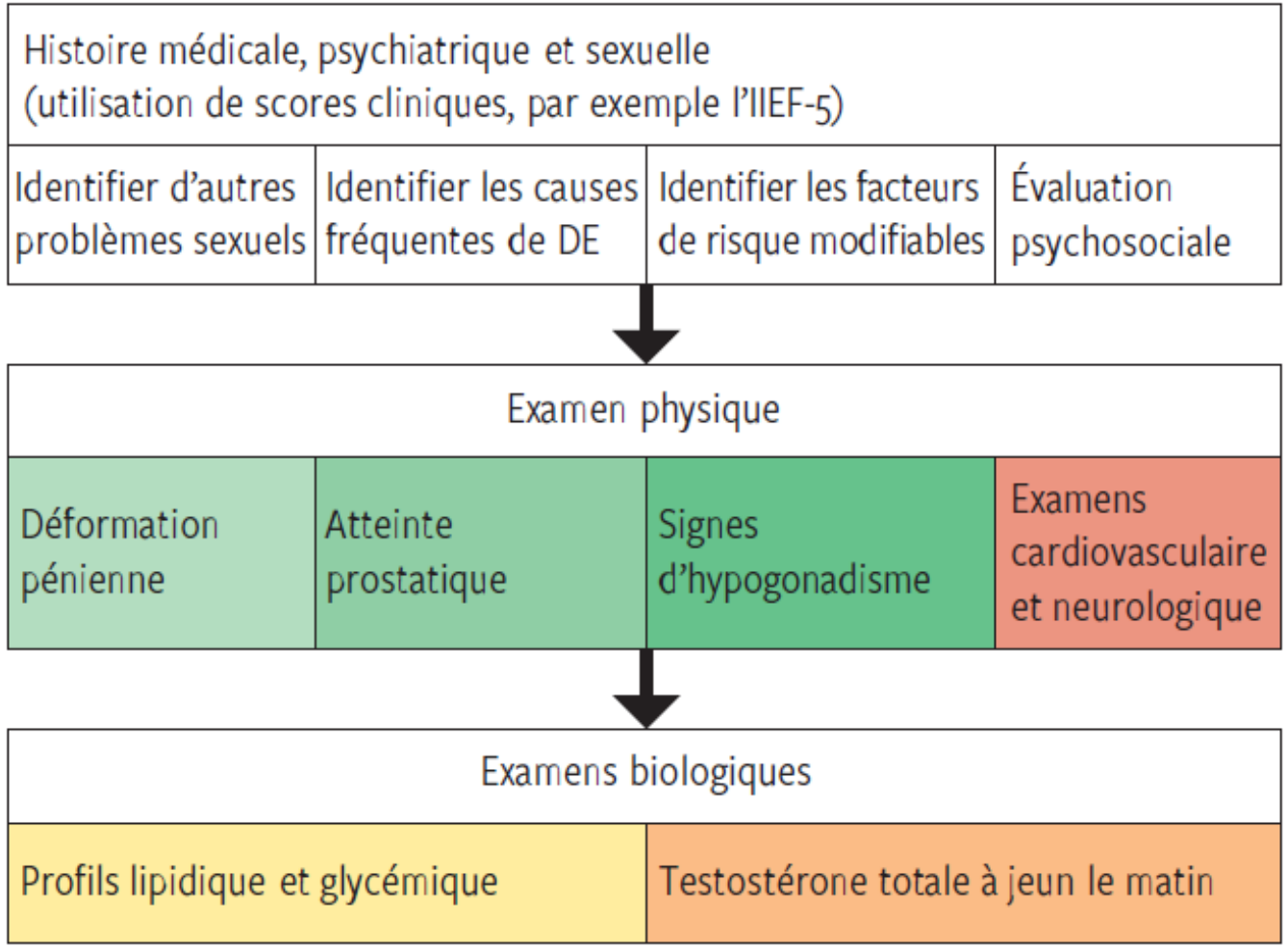
Comment l'aborder dans un 1er temps ?

- Identifier le problème sexuel, rechercher les facteurs contributifs potentiels et clarifier avec le patient et sa/son partenaire les objectifs.
- Si DE suspectée utiliser un questionnaire clinique validé (IIEF ou IIEF-5) pour objectiver la DE et la quantifier.
- Rechercher les facteurs de risque et les possibles étiologies sous-jacentes.
- Examen clinique inspection pénis, testicules, prostate, mesurer la FC, TA et BMI
- Examen biologique



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Exemple de l'IIEF-5 et de l'EHS

	Question	Response (eg. ☒) 1	2	3	4	5
1	How do you rate your **confidence** that you could get and keep an erection?	Very low ☐	Low ☐	Moderate ☐	High ☐	Very high ☐
2	When you had erections with sexual stimulation, **how often** were your erections hard enough for penetration?	Never or almost never ☐	A few times ☐	Sometimes ☐	Most times ☐	Almost always or always ☐
3	During sexual intercourse, **how often** were you able to maintain your erection after you had penetrated (entered) your partner?	Never or almost never ☐	A few times ☐	Sometimes ☐	Most times ☐	Almost always or always ☐
4	During sexual intercourse, **how difficult** was it to maintain your erection to completion of intercourse?	Extremely difficult ☐	Very difficult ☐	Difficult ☐	Slightly difficult ☐	Not difficult ☐
5	When you attempted sexual intercourse, **how often** was it satisfactory for you?	Never or almost never ☐	A few times ☐	Sometimes ☐	Most times ☐	Almost always or always ☐

Score	Interpretation
22-25	No erectile dysfunction
17-21	Mild erectile dysfunction
12-16	Mild to moderate erectile dysfunction
8-11	Moderate erectile dysfunction
5-7	Severe erectile dysfunction

Table 2 Erection Hardness Score.

0	Penis does not enlarge
1	Penis is larger, but not hard
2	Penis is hard, but not hard enough for penetration
3	Penis is hard enough for penetration, but not completely hard
4	Penis is completely hard and fully rigid

Evaluation du risque cardio-vasculaires

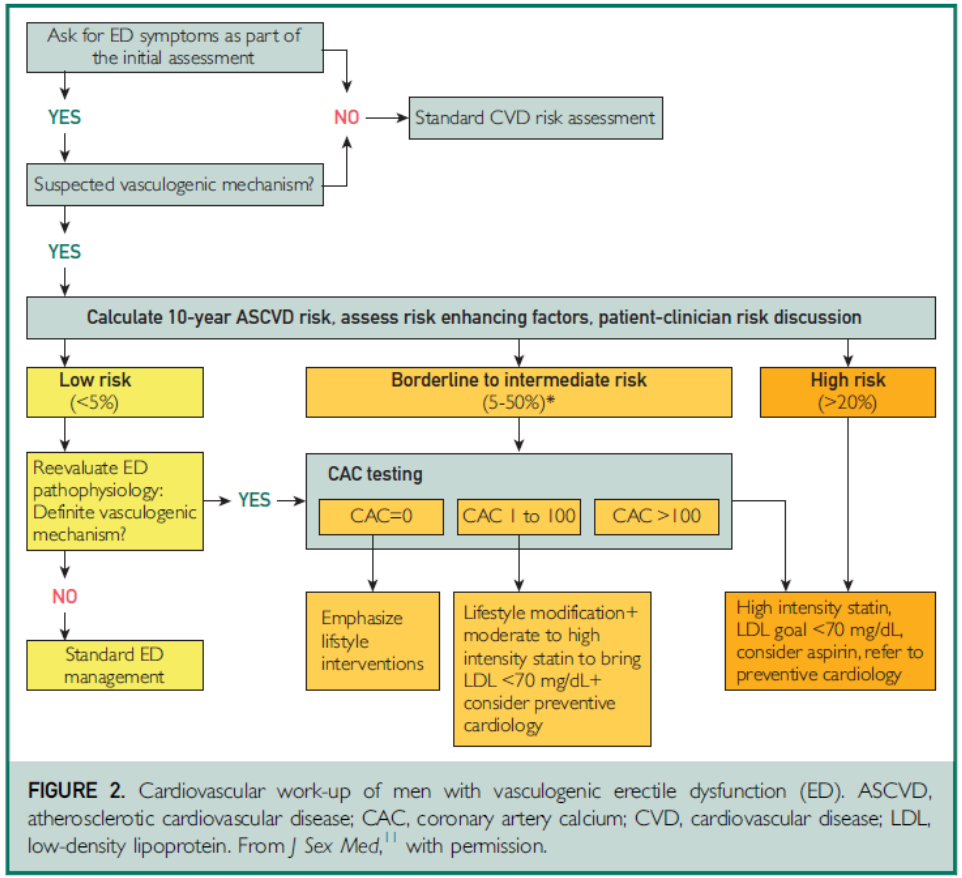

FIGURE 2. Cardiovascular work-up of men with vasculogenic erectile dysfunction (ED). ASCVD, atherosclerotic cardiovascular disease; CAC, coronary artery calcium; CVD, cardiovascular disease; LDL, low-density lipoprotein. From *J Sex Med*,[11] with permission.

Mayo Clin Proc. ■ September 2024;99(9):1500-1517 ■ https://doi.org/10.1016/j.mayocp.2024.06.002
www.mayoclinicproceedings.org

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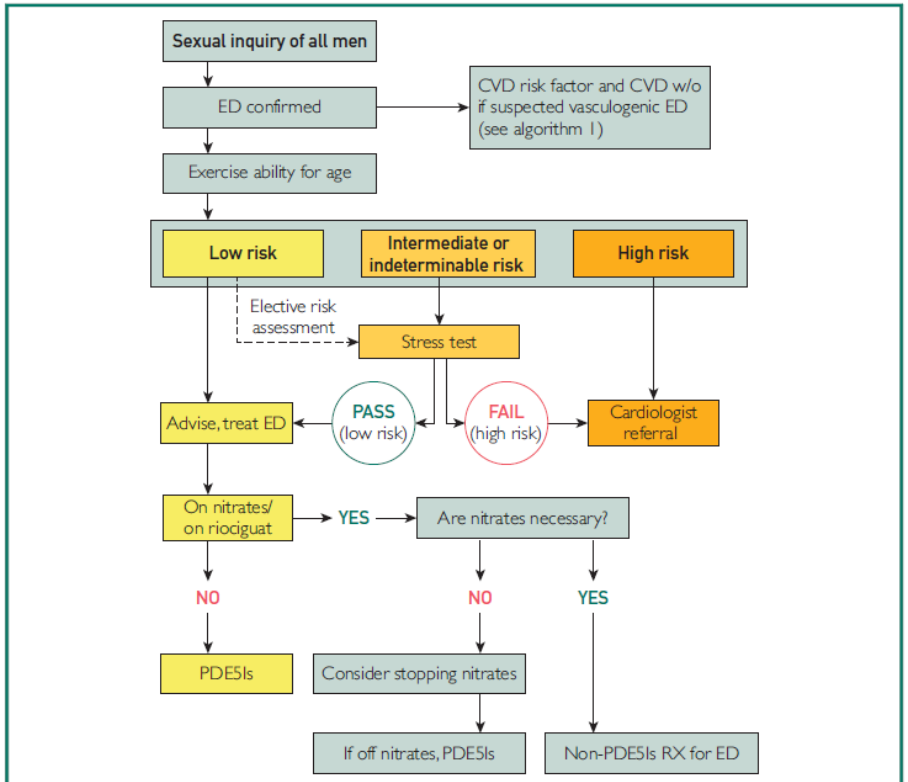

FIGURE 3. Management of erectile dysfunction (ED) in men with cardiovascular disease (CVD). PDE5Is, phosphodiesterase type 5 inhibitors; RX, medical prescription. From *J Sex Med*,[11] with permission.

Mayo Clin Proc. ■ September 2024;99(9):1500-1517 ■ https://doi.org/10.1016/j.mayocp.2024.06.002
www.mayoclinicproceedings.org

Initier une prise en charge

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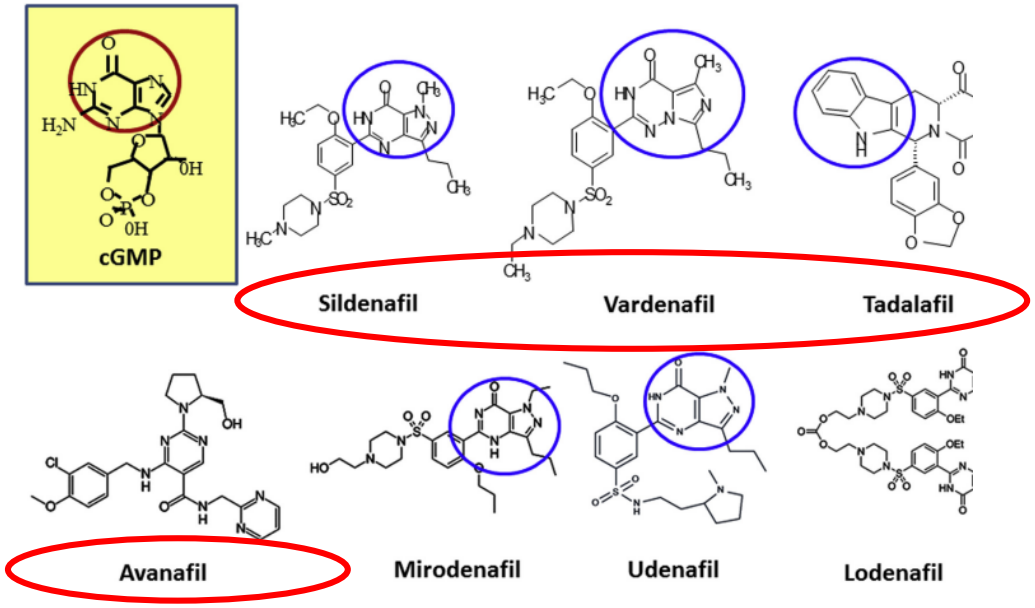
Traitements médicamenteux



Contre-indication :

- Utilisation de dérivés nitrés ou stimulateur de la guanylate cyclase (riociguat)
- ATCD récent d'IM, AVC, angor instable, IC non compensée, NOIAA
- Certaines maladies héréditaires de la rétine (rétinite pigmentaire).

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Traitements oral à la demande

Sildenafil :

- 25, 50 ou 100 mg en comprimé
- 25, 50, 75 ou 100 mg en orodispersible
- Fenêtre thérapeutique de 30-60 min à 12 heures

Tadalafil :

- 10 ou 20 mg en comprimé
- Fenêtre thérapeutique de 30 minutes à 36 heures

Vardenafil :

- 5, 10 ou 20 mg en comprimé
- Existe forme orodispersible aux USA

Avanfil :

- 50, 100 et 200mg en comprimé
- Efficacité similaire aux 3 autres.

Table 5.4: Common adverse events of the four PDE5Is currently EMA-approved to treat ED*

Adverse event	Sildenafil	Tadalafil	Vardenafil	Avanafil, 200mg
Headache	12.8%	14.5%	16%	9.3%
Flushing	10.4%	4.1%	12%	3.7%
Dyspepsia	4.6%	12.3%	4%	uncommon
Nasal congestion	1.1%	4.3%	10%	1.9%
Dizziness	1.2%	2.3%	2%	0.6%
Abnormal vision	1.9%		< 2%	None
Back pain		6.5%		< 2%
Myalgia		5.7%		< 2%

** Adapted from EMA statements on product characteristics.*

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Traitement oral en continu

Tadalafil uniquement

- Posologie de 2,5 ou 5 mg 1x/jour
- Possibilité de combiner avec une prise à la demande

Option pour :

- Les non répondeurs au traitement à la demande seule
- Chez > 40 ans avec DE et IU basse récidivante/HBP

Effet placebo ?

JAMA Network | Open

Original Investigation | Urology

Placebo Responses Among Men With Erectile Dysfunction Enrolled in Phosphodiesterase 5 Inhibitor Trials

A Systematic Review and Meta-analysis

Alexander Stridh, MSc; Moa Pontén, MSc; Stefan Arver, MD, PhD; Irving Kirsch, PhD; Christoph Abé, PhD; Karin B. Jensen, PhD

RESULTS A total of 63 studies that included 12 564 men (mean [SD] age, 55 [7] years; age range, 36-68 years) were included. Erectile function was significantly improved among participants in the placebo arm, with a small to moderate effect size (Hedges *g* [SE], 0.35 [0.03]; *P* < .001). Placebo effect size was larger among participants with ED associated with posttraumatic stress disorder (Hedges *g* [SE], 0.78 [0.32]; *P* = .02) compared with the overall analysis. No significant difference was found between placebo and PDE5Is for ED after prostate surgery or radiotherapy (Hedges *g* [SE], 0.30 [0.17]; *P* = .08).

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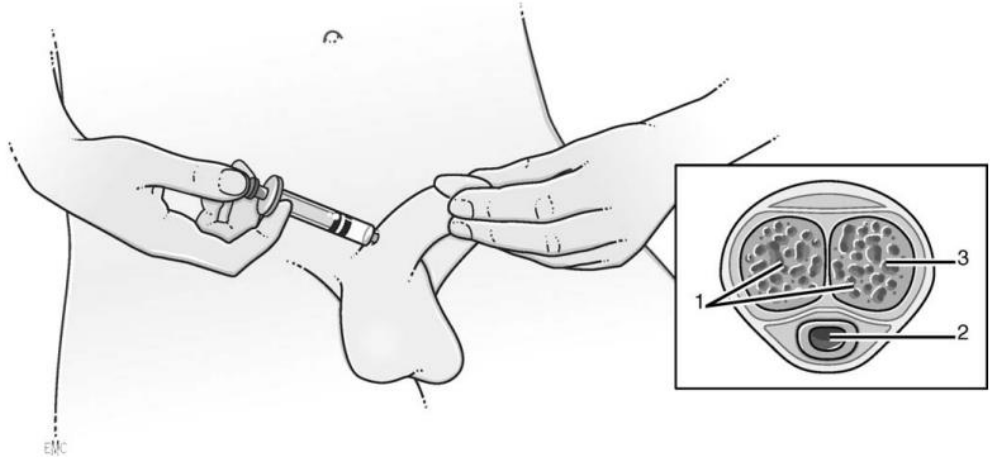
Injections intracaverneuses et application topiques



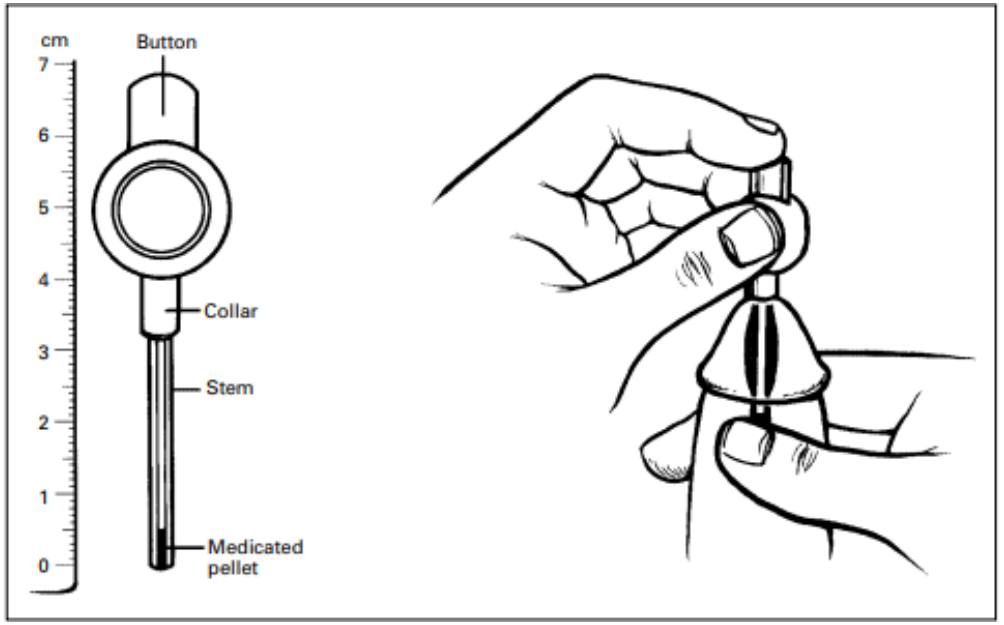
Injection intracaverneuse (IIC)

- Alprostadil apparu avant même les formes orales
- Existe d'autres molécules (seules ou combinées)
- Taux de succès intéressant selon les études

- limitation :
  - Apprentissage de l'auto-injection
  - Les risques (priapisme, douleur, fibrose)

Application topique ou intra-urétrales

- Topique
  - Une ECR montre une amélioration des IIEF mais < aux IIC.
- MUSE (Medicated Urethral System for Erection)
  - Bien tolérée, parfois même préférée par les patients
  - Option complémentaire si auto-injection pas réalisable.



Impotence : erectile dysfonction T. Lebret et al. 2004

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Autres approches thérapeutiques

Mécanique ou physique :

- Pompe à vide
  - Résultats intéressants chez les patients diabétiques ou âgées
  - CAVE lésions cutanées ou douleurs par l'utilisation répétée
  - Pertinent si fréquence sexuelle faible
- Ondes de choc extracorporelles de faible intensité
  - Essaie qui montre une amélioration des scores IIEF
  - Hétérogénéité des protocoles tailles souvent limitées des études
  - EAU propose cette approche chez patients vasculaires non répondants aux IPDE5
  - Pas prit en charge par la LAMAL

Autres :

- Injection intracaverneuse de plasma riche en plaquettes
- Neurotoxine botulinique A
- Injection intracaverneuse de cellule souche

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Poursuites des investigations

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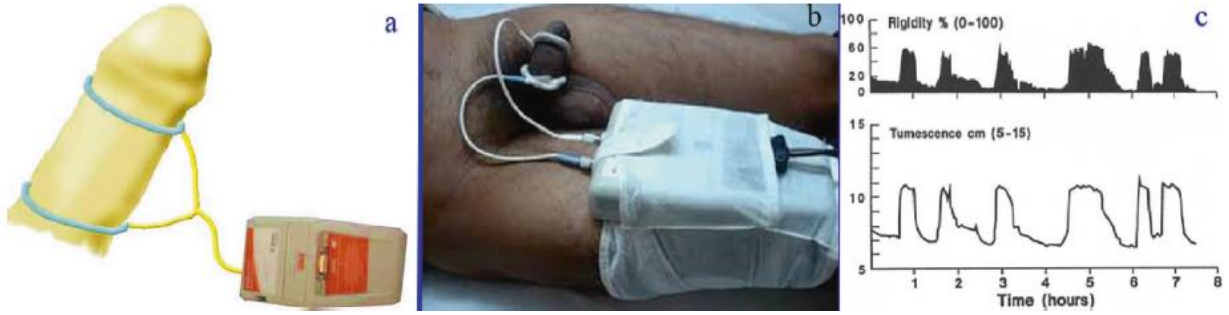
Nocturnal Penile Tumescence and Rigidity test (NPTR)

- Mesure du nombre, de la tumescence, la rigidité et la durée de l'érection.
- Approche pour différencier de manière objective une origine somatique ou psychogène.
- Selon EAU doit être fait à 2 reprises, au moins 60% de rigidité et ≥ 10 minutes.



Limitations :

- Corrélation entre érection et rapport sexuel achevé ?
- Corrélation entre rigidité axiale et radiale ?
- Facteurs confondants (âge, situations, troubles du sommeil)

Qin F, Gao L, Qian S, Fu F, Yang Y, Yuan J. Advantages and limitations of sleep-related erection and rigidity monitoring: a review. Int J Impot Res. 2018 PM : 29 555
European Association of Urology Guidelines on Male Sexual and Reproductive Health: 2025 Update Eur Urol. 2025 Jul; PMID: 40340108.
The Role of Nocturnal Penile Tumescence and Rigidity (NPTR) Monitoring in the Diagnosis of Psychogenic Erectile Dysfunction: A Review. Sex Med Rev. 2019 Jul PMID:

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Le pharmaco-écho-doppler pénien (PEDP)

Examen de 2ème intention

- Forte suspicion d'une origine vasculaire
- Echec traitement médicamenteux initiaux.

Conditions :

- Patient bien informé.
- Cliniciens expérimentés.
- Pièce calme et tempérée.

Matériel :

- Echo-Doppler linéaire à haute fréquence (7,5-12 MHz), sonde à basse fréquence à disposition (exploration axe aorto-iliaques)
- Matériel pour injection intrecaverneuse

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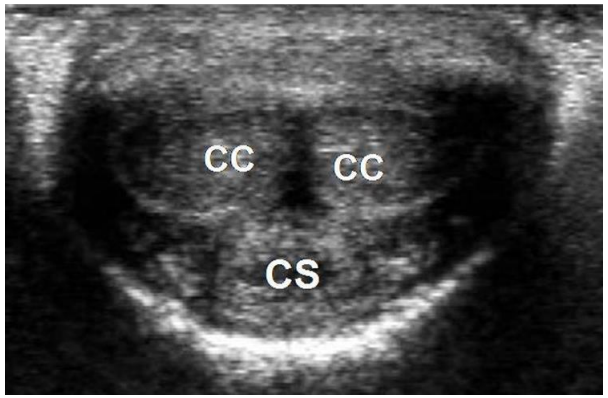
Pratique du PEDP

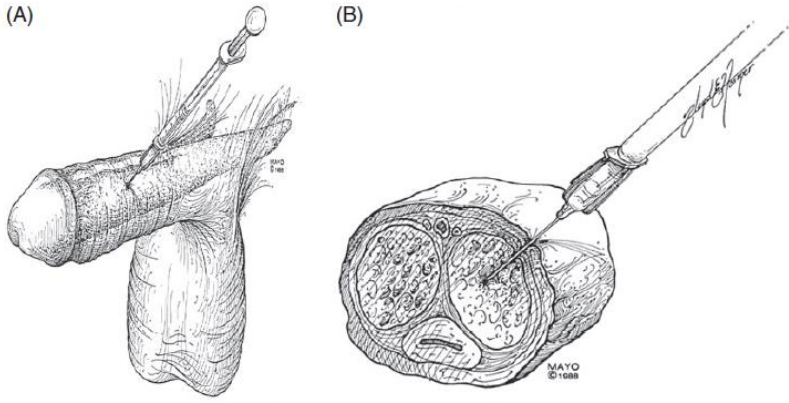
Echo-Doppler à l'état flasque :

- Analyse des structures
- Présence d'anomalies, épaississements, calcifications et/ou autre



Echo-Doppler après injection intracaverneuse (IIC) d'une molécule érectrice

- Alprostadil
- Papaverine
- Phentolamine



Echo-Doppler artériel complet (aorto-pelvien +/- MI si nécessaire)

Intracavernosal Injection for the Diagnosis, Evaluation, and Treatment of Erectile Dysfunction: A Review. Sex Med Rev. 2015 Mar PMID: 27784568.

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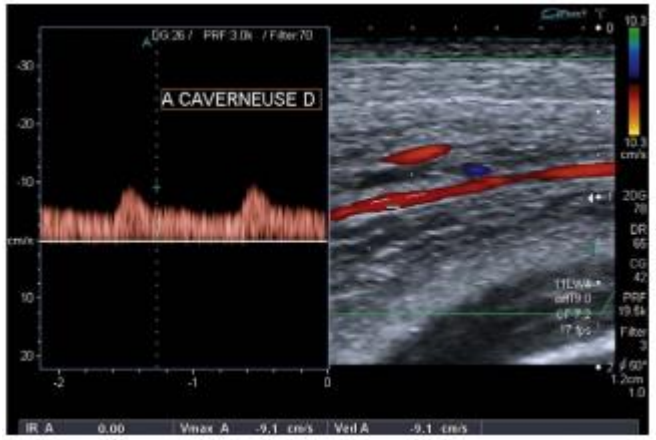
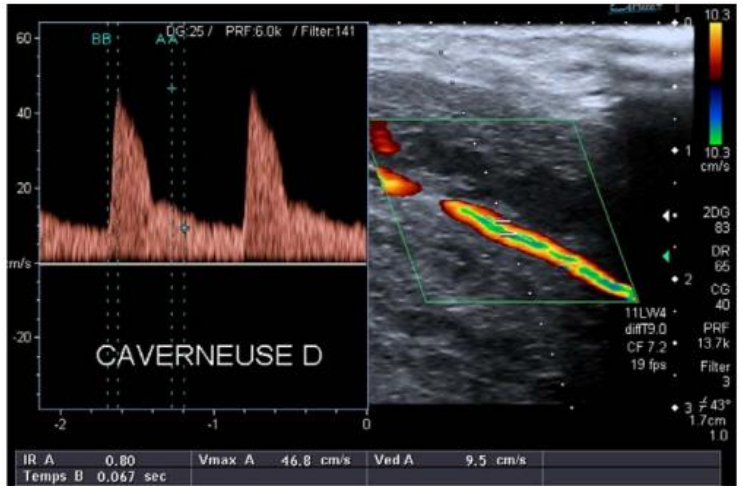
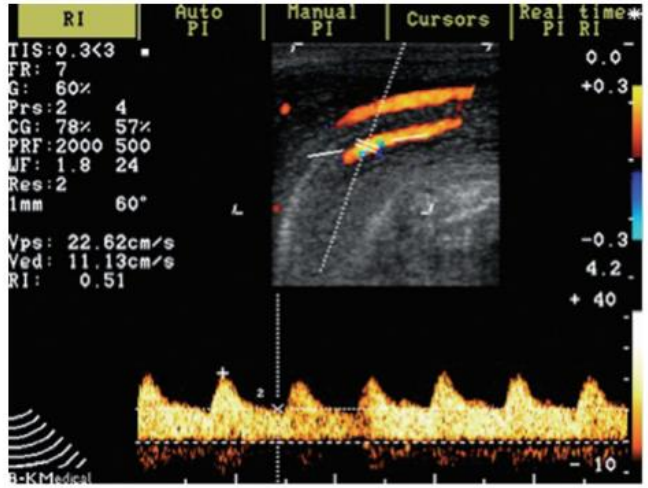
Critères hémodynamiques







	Non vasculaire	Artériel	Veineux	Borderline	Mixte
PVS	≥ 30 cm/sec	< 25 cm/sec	≥ 30 cm/sec	25-30 cm/sec	< 25cm/sec
IR	> 0.8		< 0.6	0.6-0.8	< 0.6
VTD	< 3 cm/sec	< 3 cm/sec	≥ 6 cm/sec	3-6 cm/sec	> 6 cm/sec
TM	< 100 ms	> 100 ms			

Sikka Sc et al. Standardization of vascular assessment of erectile dysfunction: standard operating procedures for duplex ultrasound. J Sex Med. 2013 Jan
Bonnin C et al. Le pharmaco-écho-doppler pénien : quel rôle dans la prise en charge d'une dysfonction érectile ? J Mal Vasc. 2011 Feb

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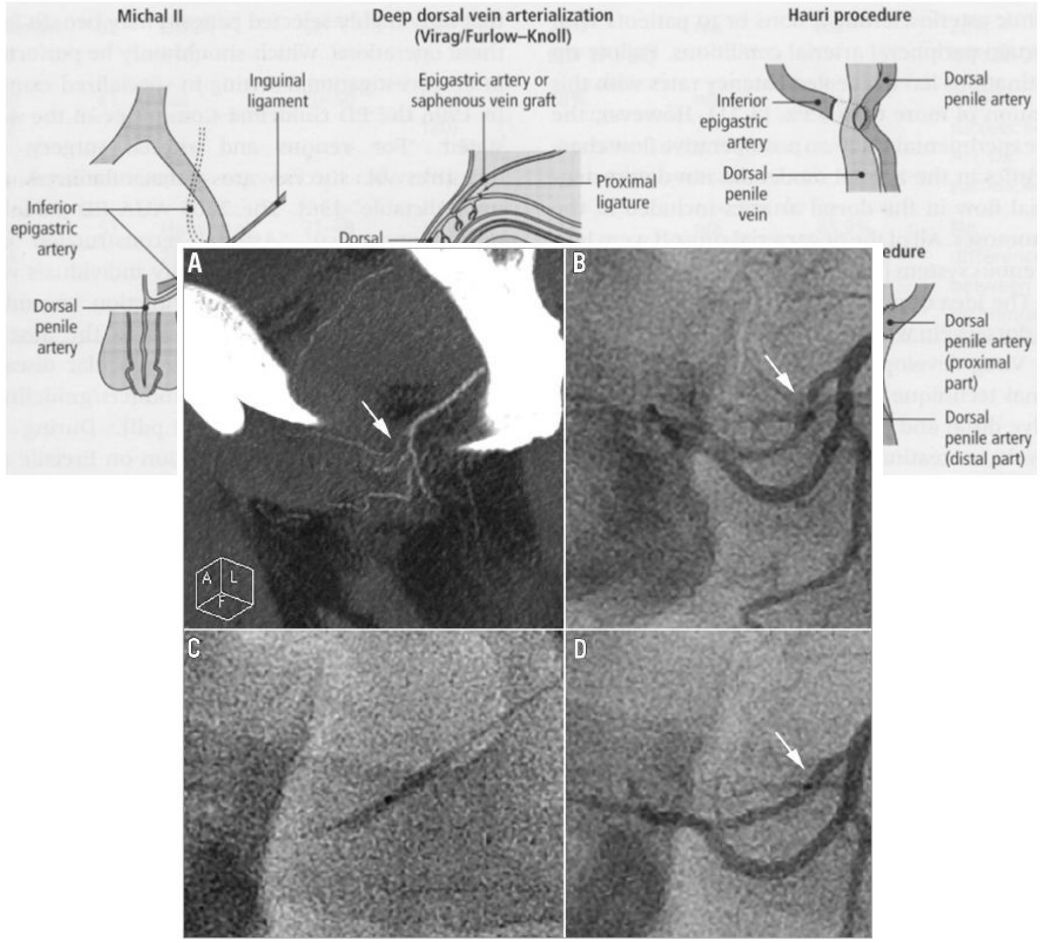
Approches interventionnelles artérielles



- Revascularisations chirurgicales :
  - anastomose de l'artère épigastrique inférieure aux corps caverneux ou aux artères dorsales
- progressivement abandonnées
  - Risques de priapisme à haut débit
  - Fibrose
  - Taux de succès limités.

Revascularisations endovasculaires, artères iliaques internes, pudendales ou péniennes :

- alternative moins invasive
- bons résultats pour les lésions proximales.
- Plus hétérogènes pour les atteintes distales

Sohn M et al. Standard Operating Procedures for Vascular Surgery in Erectile Dysfunction: Revascularization and Venous Procedures. The Journal of Sexual Medicine. 2013 Jan 1;10(1):172–179.
Doppalapudi SK et al. Endovascular Therapy for Vasculogenic Erectile Dysfunction: A Systematic Review and Meta-Analysis of Arterial and Venous Therapies. J Vasc Interv Rad. 20

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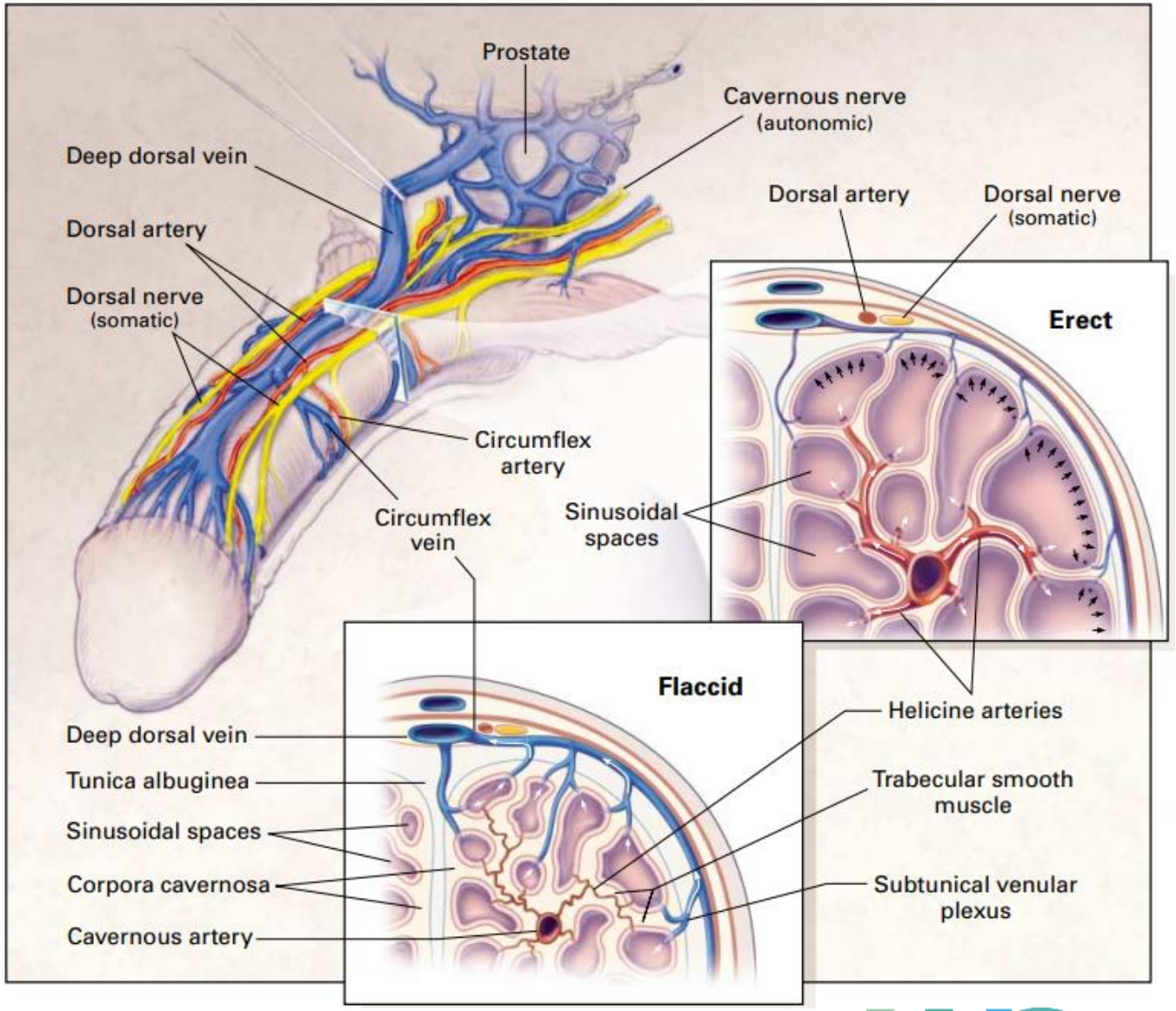
Fuite veineuse?



Lue TF. Erectile dysfunction. N Engl J Med. 2000 Jun PMID: 10853004

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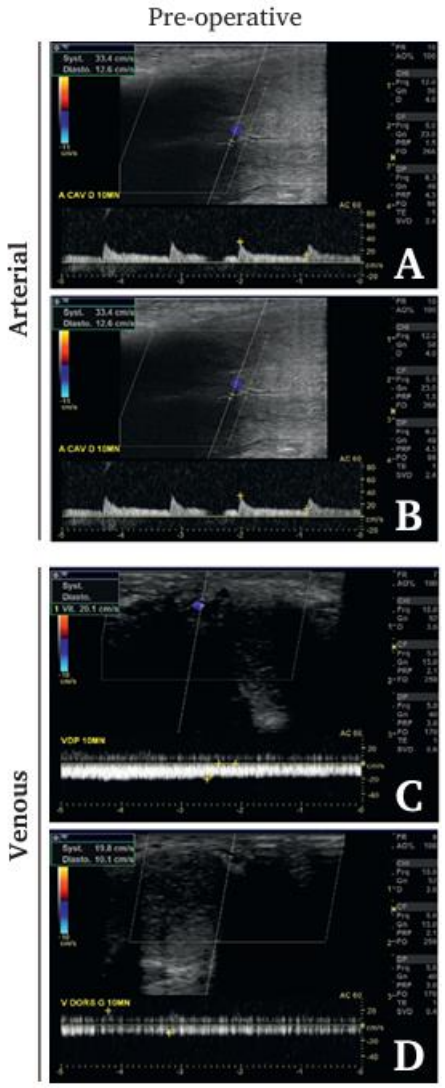
Approches interventionnelles veineuses

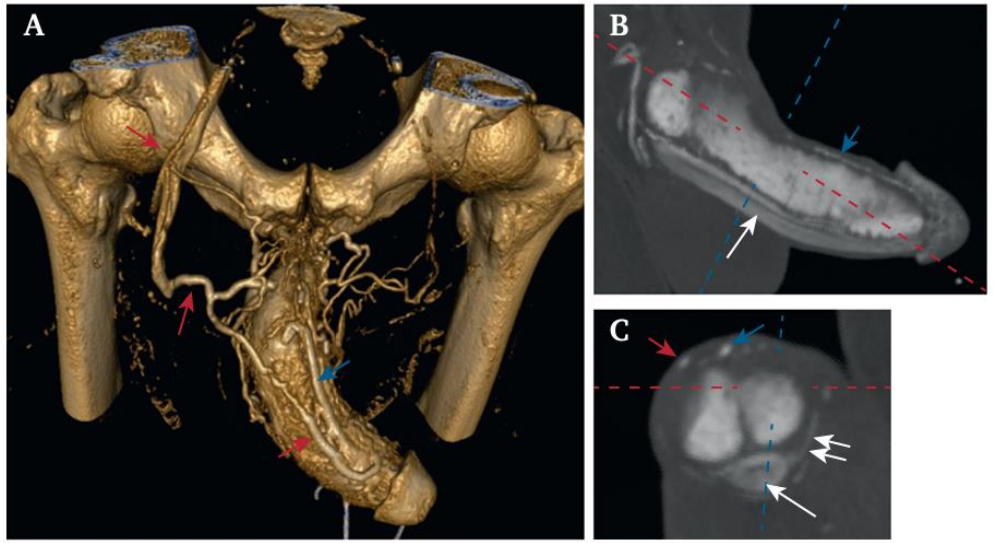


Miscellaneous

Eur J Vasc Endovasc Surg (2021) 61, 510–517

EJVES Open Access

Erectile Dysfunction Resistant to Medical Treatment Caused by Cavernovenous Leakage: An Innovative Surgical Approach Combining Pre-operative Work Up, Embolisation, and Open Surgery



procedure. Accordingly, the primary success rate (EHS $\geq$ 3, sexual intercourse with penetration possible, no vascular re-operation, no implant) was 73% (n = 33). The secondary success rate was 82% (n = 37, including patients with vascular re-intervention). Including the three patients who had received a penile prosthesis, 40 patients (89%) were able to achieve sexual intercourse with penetration, whereas before surgery, 41 (91%) were unable to perform penetration, despite any medication.

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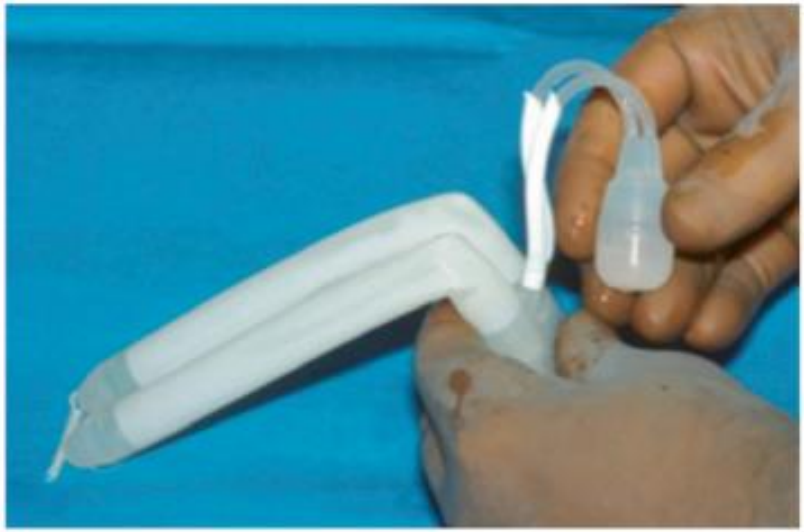
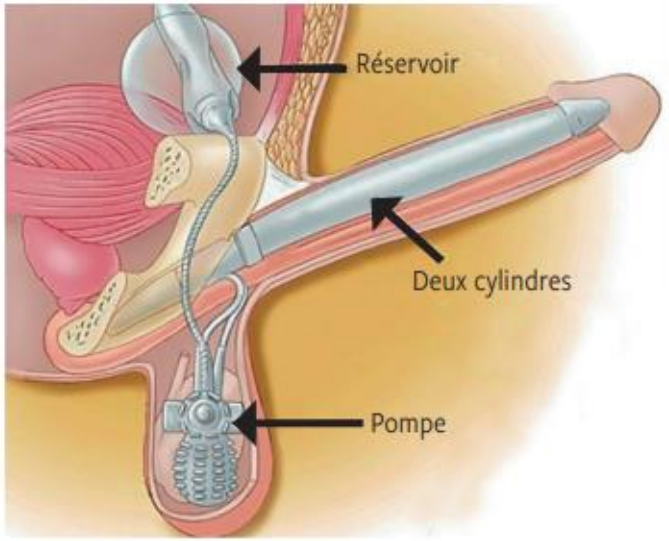
Les implants péniens d'érection

- En cas d'échec des différents traitements
- Option définitive
- Peut-être semi-rigide ou gonflable
- Risque chirurgicaux
- Taux de satisfaction élevés
- Bonne longévité (moyenne de 12.5 ans)





Chevallier D, Faix A, Bettocchi C, Djinovic R, Ralph D. Place des implants péniens d'érection dans le traitement de la dysfonction érectile : le point en 2020 PMID: 32186797.

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Take home message

- La dysfonction érectile est fréquente
- L'origine vasculaire est la cause principale des étiologies somatiques
- La prise en charge des FRCV est essentielle
- Le pharmaco-écho-doppler pénien est un bon outil pour orienter le diagnostic et la prise en charge
- Les inhibiteurs de la phosphodiestérase sont toujours d'actualité
- Des approches interventionnelles plus invasives sont possibles mais faut bien évaluer le risque/bénéfice
- La prothèse pénienne est toujours une option en cas d'échec

Merci pour votre attention

Questions ?