Erectile Disorder

Code: 302.72 (F52.21)

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Diagnostic Criteria 302.72 (F52.21)

A. At least one of the three following symptoms must be experienced on almost all or all (approximately 75%–100%) occasions of sexual activity (in identified situational contexts or, if generalized, in all contexts):
1. Marked difficulty in obtaining an erection during sexual activity.
2. Marked difficulty in maintaining an erection until the completion of sexual activity.
3. Marked decrease in erectile rigidity.
B. The symptoms in Criterion A have persisted for a minimum duration of approximately 6 months.
C. The symptoms in Criterion A cause clinically significant distress in the individual.
D. The sexual dysfunction is not better explained by a nonsexual mental disorder or as a consequence of severe relationship distress or other significant stressors and is not attributable to the effects of a substance/medication or another medical condition.

Specify whether:
Lifelong: The disturbance has been present since the individual became sexually active.
Acquired: The disturbance began after a period of relatively normal sexual function.
Specify whether:
Generalized: Not limited to certain types of stimulation, situations, or partners.
Situational: Only occurs with certain types of stimulation, situations, or partners.
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Specify current severity:
Mild: Evidence of mild distress over the symptoms in Criterion A.
Moderate: Evidence of moderate distress over the symptoms in Criterion A.
Severe: Evidence of severe or extreme distress over the symptoms in Criterion A.

Diagnostic Features

The essential feature of erectile disorder is the repeated failure to obtain or maintain erections during partnered sexual activities (Criterion A). A careful sexual history is necessary to ascertain that the problem has been present for a significant duration of time (i.e., at least approximately 6 months) and occurs on the majority of sexual occasions (i.e., at least 75% of the time). Symptoms may occur only in specific situations involving certain types of stimulation or partners, or they may occur in a generalized manner in all types of situations, stimulation, or partners.

Associated Features Supporting Diagnosis

Many men with erectile disorder may have low self-esteem, low self-confidence, and a decreased sense of masculinity, and may experience depressed affect. Fear and/or avoidance of future sexual encounters may occur. Decreased sexual satisfaction and reduced sexual desire in the individual's partner are common.
In addition to the subtypes "lifelong/acquired" and "generalized/situational," the following five factors must be considered during assessment and diagnosis of erectile disorder given that they may be relevant to etiology and/or treatment: 1) partner factors (e.g., partner's sexual problems, partner's health status); 2) relationship factors (e.g., poor communication, discrepancies in desire for sexual activity); 3) individual vulnerability factors (e.g., poor body image, history of sexual or emotional abuse), psychiatric comorbidity (e.g., depression, anxiety), or stressors (e.g., job loss, bereavement); 4) cultural/religious factors (e.g., inhibitions related to prohibitions against sexual activity; attitudes toward sexuality); and 5) medical factors relevant to prognosis, course, or treatment. Each of these factors may contribute differently to the presenting symptoms of different men with this disorder.

Prevalence

The prevalence of lifelong versus acquired erectile disorder is unknown. There is a strong age-related increase in both prevalence and incidence of problems with erection, particularly after age 50 years. Approximately 13%–21% of men ages 40–80 years complain of occasional problems with erections. Approximately 2% of men younger than age 40–50 years complain of frequent problems with erections, whereas 40%–50% of men older than 60–70 years may have significant problems with erections. About 20% of men fear erectile problems on their first sexual experience, whereas approximately 8% experienced erectile problems that hindered penetration during their first sexual experience.

Development and Course

Erectile failure on first sexual attempt has been found to be related to having sex with a previously unknown partner, concomitant use of drugs or alcohol, not wanting to have sex, and peer pressure. There is minimal evidence regarding the persistence of such problems after the first attempt. It is assumed that most of these problems spontaneously remit without professional intervention, but some men may continue to have episodic problems. In contrast, acquired erectile disorder is often associated with biological factors such as diabetes and cardiovascular disease. Acquired erectile disorder is likely to be persistent in most men.
The natural history of lifelong erectile disorder is unknown. Clinical observation supports the association of lifelong erectile disorder with psychological factors that are self-
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limiting or responsive to psychological interventions, whereas, as noted above, acquired erectile disorder is more likely to be related to biological factors and to be persistent. The incidence of erectile disorder increases with age. A minority of men diagnosed as having moderate erectile failure may experience spontaneous remission of symptoms without medical intervention. Distress associated with erectile disorder is lower in older men as compared with younger men.

Risk and Prognostic Factors

Temperamental. Neurotic personality traits may be associated with erectile problems in college students, and submissive personality traits may be associated with erectile problems in men age 40 years and older. Alexithymia (i.e., deficits in cognitive processing of emotions) is common in men diagnosed with "psychogenic" erectile dysfunction. Erectile problems are common in men diagnosed with depression and posttraumatic stress disorder.
Course modifiers. Risk factors for acquired erectile disorder include age, smoking tobacco, lack of physical exercise, diabetes, and decreased desire.

Culture-Related Diagnostic Issues

Complaints of erectile disorder have been found to vary across countries. It is unclear to what extent these differences represent differences in cultural expectations as opposed to genuine differences in the frequency of erectile failure.

Diagnostic Markers

Nocturnal penile tumescence testing and measured erectile turgidity during sleep can be employed to help differentiate organic from psychogenic erectile problems on the assumption that adequate erections during rapid eye movement sleep indicate a psychological etiology to the problem. A number of other diagnostic procedures may be employed depending on the clinician's assessment of their relevance given the individual's age, comorbid medical problems, and clinical presentation. Doppler ultrasonography and intravascular injection of vasoactive drugs, as well as invasive diagnostic procedures such as dynamic infusion cavernosography, can be used to assess vascular integrity. Pudendal nerve conduction studies, including somatosensory evoked potentials, can be employed when a peripheral neuropathy is suspected. In men also complaining of decreased sexual desire, serum bioavailable or free testosterone is frequently assessed to determine if the difficulty is secondary to endocrinological factors. Thyroid function may also be assessed. Determination of fasting serum glucose is useful to screen for the presence of diabetes mellitus. The assessment of serum lipids is important, as erectile disorder in men 40 years and older is predictive of the future risk of coronary artery disease.

Functional Consequences of Erectile Disorder

Erectile disorder can interfere with fertility and produce both individual and interpersonal distress. Fear and/or avoidance of sexual encounters may interfere with the ability to develop intimate relationships.

Differential Diagnosis

Nonsexual mental disorders. Major depressive disorder and erectile disorder are closely associated, and erectile disorder accompanying severe depressive disorder may occur.
Normal erectile function. The differential should include consideration of normal erectile function in men with excessive expectations.
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Substance/medication use. Another major differential diagnosis is whether the erectile problem is secondary to substance/medication use. An onset that coincides with the beginning of substance/medication use and that dissipates with discontinuation of the substance/medication or dose reduction is suggestive of a substance/medication-induced sexual dysfunction.
Another medical condition. The most difficult aspect of the differential diagnosis of erectile disorder is ruling out erectile problems that are fully explained by medical factors. Such cases would not receive a diagnosis of a mental disorder. The distinction between erectile disorder as a mental disorder and erectile dysfunction as the result of another medical condition is usually unclear, and many cases will have complex, interactive biological and psychiatric etiologies. If the individual is older than 40–50 years and/or has concomitant medical problems, the differential diagnosis should include medical etiologies, especially vascular disease. The presence of an organic disease known to cause erectile problems does not confirm a causal relation. For example, a man with diabetes mellitus can develop erectile disorder in response to psychological stress. In general, erectile dysfunction due to organic factors is generalized and gradual in onset. An exception would be erectile problems after traumatic injury to the nervous innervation of the genital organs (e.g., spinal cord injury). Erectile problems that are situational and inconsistent and that have an acute onset after a stressful life event are most often due to psychological events. An age of less than 40 years is also suggestive of a psychological etiology to the difficulty.
Other sexual dysfunctions. Erectile disorder may coexist with premature (early) ejaculation and male hypoactive sexual desire disorder.

Comorbidity

Erectile disorder can be comorbid with other sexual diagnoses, such as premature (early) ejaculation and male hypoactive sexual desire disorder, as well as with anxiety and depressive disorders. Erectile disorder is common in men with lower urinary tract symptoms related to prostatic hypertrophy. Erectile disorder may be comorbid with dyslipidemia, cardiovascular disease, hypogonadism, multiple sclerosis, diabetes mellitus, and other diseases that interfere with the vascular, neurological, or endocrine function necessary for normal erectile function.
Relationship to International Classification of Diseases
Erectile response is coded as failure of genital response in ICD-10 (F2.2).