COMPREHENSIVE ENDOCRINE & UROLOGY SPECIALISTS

1580 Medical Plaza, Suite 400 | Seattle, WA 98101

Phone: (206) 555-0287 | Fax: (206) 555-0288

MULTIDISCIPLINARY CONSULTATION REPORT

Patient Name: Anderson, Michael T.

Date of Birth: 06/08/1961 (Age: 64)

MRN: CEUS-582947

Date of Service: October 3, 2025

Primary Care: Dr. Patricia Lee, MD

Consulting Providers: Dr. James Morrison (Urology), Dr. Sarah Chen (Endocrinology)

CHIEF COMPLAINT

Progressive erectile dysfunction over 3 years, refractory to multiple treatment modalities

HISTORY OF PRESENT ILLNESS

Mr. Anderson is a 64-year-old male with a complex medical history presenting for multidisciplinary evaluation of severe erectile dysfunction that has progressively worsened over the past 36 months. Patient reports initially gradual onset with intermittent difficulties achieving adequate erections, which has progressed to complete inability to achieve or maintain erections sufficient for intercourse over the past 12 months.

The patient has undergone extensive evaluation and treatment attempts across multiple specialties:

Treatment Timeline (2023-2025):

Phase 1 (Early 2023): Initial evaluation revealed borderline low testosterone. Started testosterone replacement therapy (AndroGel 1.62%, 40.5mg daily). Partial improvement noted initially but erectile function remained suboptimal.

Phase 2 (Mid 2023): Added sildenafil 50mg with dose titration to 100mg. Minimal response even at maximum dose. Switched to tadalafil 20mg - similarly ineffective.

Phase 3 (Late 2023): Trial of vardenafil 20mg without improvement. Referred to endocrinology for comprehensive hormonal evaluation.

Phase 4 (Early 2024): Penile Doppler ultrasound revealed significant arterial insufficiency. Vascular surgery consultation obtained. Patient not candidate for vascular surgery due to diffuse small vessel disease.

Phase 5 (Mid 2024): Initiated intracavernosal injection therapy (alprostadil 20mcg). Patient achieved partial erections but insufficient rigidity for penetration even with dose escalation to 40mcg. Combination therapy (alprostadil + phentolamine) attempted without adequate response.

> **Phase 6 (Late 2024-2025):** Trial of vacuum erection device with constriction ring. Patient found device difficult to use and results unsatisfactory. Psychological evaluation performed to rule out contributing factors.

PAST MEDICAL HISTORY

- **Type 2 Diabetes Mellitus** - diagnosed 2008, complicated by peripheral neuropathy and early nephropathy. Current HbA1c 7.4%
- **Peripheral Vascular Disease** - diffuse small vessel disease documented on multiple vascular studies
- **Diabetic Peripheral Neuropathy** - confirmed by EMG/NCV studies showing sensory and motor involvement
- **Hypertension** - well controlled on dual therapy
- **Hyperlipidemia** - on statin therapy
- **Chronic Kidney Disease Stage 2** - secondary to diabetic nephropathy, stable
- **Obstructive Sleep Apnea** - compliant with CPAP therapy
- **Secondary Hypogonadism** - on testosterone replacement

MEDICATIONS

- Metformin 1000mg twice daily
- Insulin glargine 32 units at bedtime
- Lisinopril 20mg daily
- Amlodipine 10mg daily
- Atorvastatin 80mg daily
- Aspirin 81mg daily
- Gabapentin 300mg three times daily (for neuropathy)
- AndroGel 1.62% 40.5mg daily

SOCIAL HISTORY

Married for 35 years, monogamous relationship. Former smoker (quit 15 years ago, 20 pack-year history). Minimal alcohol use. Works as financial consultant. Patient reports significant relationship strain due to erectile dysfunction despite supportive partner.

PHYSICAL EXAMINATION

Vital Signs: BP 126/74, HR 68, Temp 98.2°F, Weight 212 lbs (BMI 29.8), O2 Sat 97% on RA

General: Well-developed male, appears stated age, no acute distress

Cardiovascular: Regular rhythm, no murmurs, diminished peripheral pulses bilaterally

Genitourinary: Normal external male genitalia, testes normal size and consistency bilaterally, no plaques or deformities of penis

Neurological: Decreased vibration sense in lower extremities, absent ankle reflexes bilaterally, decreased pinprick sensation in stocking distribution consistent with peripheral neuropathy. Reduced genital sensation noted on examination.

DIAGNOSTIC STUDIES & LABORATORY RESULTS

Study/Test	Date	Results	Interpretation
Penile Doppler Ultrasound	02/14/2024	PSV: Right 16 cm/sec, Left 14 cm/sec; EDV: 6 cm/sec bilaterally	Severe arterial insufficiency; inadequate venous occlusion
Testosterone, Total (AM)	01/15/2023	248 ng/dL	Low (prior to TRT)
Testosterone, Total (AM)	09/10/2025	487 ng/dL	Normal (on TRT)
Free Testosterone	09/10/2025	9.8 pg/mL	Normal
LH	01/15/2023	3.2 mIU/mL	Low-normal with low testosterone (secondary hypogonadism)
Prolactin	01/15/2023	8.4 ng/mL	Normal
TSH	09/10/2025	2.1 mIU/L	Normal
HbA1c	09/10/2025	7.4%	Suboptimal control
EMG/NCV Studies	06/18/2024	Decreased sensory and motor nerve conduction velocities	Consistent with diabetic peripheral neuropathy
Nocturnal Penile Tumescence	08/22/2025	Absent nocturnal erections over 3 nights	Confirms organic etiology
Psychological Evaluation	07/30/2025	No primary psychiatric disorder identified	Reactive anxiety to erectile dysfunction; psychogenic component not primary

MULTIDISCIPLINARY ASSESSMENT

Urological Assessment (Dr. Morrison):

Patient presents with severe multifactorial organic erectile dysfunction. Primary etiologies include:

- **Vasculogenic:** Severe arterial insufficiency documented on Doppler studies with peak systolic velocities well below normal threshold. Venous occlusive dysfunction also present. Secondary to diabetic microangiopathy and peripheral vascular disease.

- **Neurogenic:** Diabetic peripheral neuropathy affecting both autonomic and sensory pathways critical for erectile function. Confirmed by EMG/NCV studies and clinical examination.
- **Endocrine:** History of hypogonadism, now adequately treated with testosterone replacement.

Patient has exhaustively pursued conservative management without success over 24-month period. He is not a candidate for vascular surgery. The combination of severe vascular disease and neuropathy makes him unlikely to respond to any further non-surgical interventions.

Endocrine Assessment (Dr. Chen):

Patient's secondary hypogonadism has been adequately addressed with testosterone replacement therapy. Current testosterone levels are within normal physiologic range. While hypogonadism was a contributing factor, the persistent erectile dysfunction despite normalized testosterone levels indicates that vascular and neurogenic factors are the predominant causes. No additional endocrine abnormalities identified that would contribute to erectile dysfunction.

DIAGNOSIS

Primary: Erectile dysfunction, multifactorial organic etiology (ICD-10: N52.01, N52.03)

- Vasculogenic erectile dysfunction due to diabetic microangiopathy
- Neurogenic erectile dysfunction due to diabetic peripheral neuropathy
- Secondary hypogonadism (treated)

Contributing Conditions: Type 2 diabetes mellitus with complications, peripheral vascular disease, chronic kidney disease

PHYSICIAN ASSESSMENT AND RECOMMENDATION

This is a complex case of multifactorial organic erectile dysfunction in a 64-year-old male with multiple comorbidities. The patient has undergone comprehensive evaluation by urology, endocrinology, and psychology, with extensive diagnostic testing confirming organic etiology involving both vascular and neurogenic pathways.

Over a 24-month period, the patient has systematically failed all appropriate conservative treatment modalities including:

- Testosterone replacement therapy with normalization of levels
- Three different PDE-5 inhibitors at maximum doses

- Intracavernosal injection therapy with dose escalation and combination therapy
- Vacuum erection device

Nocturnal penile tumescence testing confirms complete absence of nocturnal erections, supporting organic rather than psychogenic etiology. Psychological evaluation ruled out primary psychiatric contribution, with noted anxiety being reactive and secondary to the erectile dysfunction itself.

Given the failure of comprehensive conservative management, documented organic pathology, and significant impact on quality of life, patient is an appropriate candidate for penile prosthesis implantation. We recommend three-piece inflatable penile prosthesis as definitive treatment.

Patient has been extensively counseled regarding the procedure, including risks of infection, mechanical failure, erosion, need for future revisions, and the permanent nature of the implant. He demonstrates excellent understanding and has realistic expectations regarding outcomes. His comorbid conditions including diabetes have been discussed, and he understands the increased perioperative risks. Optimization of glycemic control is underway in preparation for surgery.

_____

James Morrison, MD, FACS
Board Certified Urologist
WA License #: UR-38492
Date: October 3, 2025

_____

Sarah Chen, MD, FACE
Board Certified Endocrinologist
WA License #: EN-29483
Date: October 3, 2025