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Letter to the Editor

Re: Efficacy of tadalafil treatment in erectile dysfunction in patients receiving dutasteride treatment: A prospective nonrandomized comparative study

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Apart from erectile dysfunction treatment, phosphodiesterase-5 inhibitors are being commonly used in the treatment of lower urinary tract symptoms (LUTS) that are secondary to benign enlargement of prostate. This study demonstrated the beneficial effects of tadalafil treatment in terms of improvement in erection and probably LUTS.[1,2] The pharmacology of LUTS aims to address obstructive and storage symptoms. The available medical treatment options include α1-adrenergic blocker, antimuscarinics, β3 agonist, 5α-reductase inhibitors, and phosphodiesterase-5 inhibitors. For obstructive symptoms, α1-blockers or PDE5 inhibitors provide immediate relief, whereas 5α-reductase inhibitors may take 3–6 months to provide symptomatic relief, and 5α-reductase inhibitors reduces prostatic growth, which reduces the prostate volume by 25%–50% by 6 months.[3] For storage/voiding symptoms, the mainstay of treatment includes antimuscarinics and β3-adrenoceptor agonists. In this study, it is not clear why α1-adrenoceptors blockers were not used with 5α reductase inhibitors for quick relief of symptoms. The medications used for LUTS affect sexual function, which includes erection, ejaculation, orgasm/climax, and libido. In combat study, sexual dysfunctions were more with combination therapy and the same trend was noted for erectile dysfunction; 9% of the patients who received combination therapy (Tamsulosin plus dutasteride) had erectile dysfunction, whereas 5% of the patients who received only Tamsulosin had erectile dysfunction.[4] In this study, the authors could have used Male Sexual Health Questionnaire, which covers erection, ejaculation, and satisfaction, instead of the International Index of Erectile Function, which only covers erection.[5] Phosphodiesterase-5 inhibitors were found to improve erectile function as a side effect in a trial testing its efficacy in the treatment of angina pectoris in 1994, and in 2003, FDA approved its use for erectile dysfunction and eventually for LUTS. In the study design, it is not clear how authors categorized the patients of same age groups who have erectile dysfunction but do not have LUTS; was it only on the basis of previous history or International Prostate Symptom Score (IPSS) and uroflowmetry parameters? Uroflowmetry and IPSS could have been used in the groups both before and after treatment. Moreover, the status of sexual activity and availability of partners before enrolling subjects are lacking. In this study, authors must state the duration of treatment after which analysis was performed.

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