

those who did not respond ( $p=0.060$ ). Neither the Likert Pain Score nor the Chronic Orchialgia Index Score showed a significant difference between those who responded to SCB and those who did not. In those who responded to SCB, 60% described their pain as constant compared to 37% of those who did not respond to SCB ( $p=0.025$ ). Only 14% of patients who did not respond to SCB responded to neuromodulating medications while 55% of patients who responded to SCB also responded to these medications. Table 1 summarizes other potential predictive factors for those who respond to SCB for management of their ICO, most not showing a significant difference between cohorts.

**CONCLUSIONS:** These findings suggest that when evaluating patients for a SCB for the successful management of their ICO, it is important to understand the characteristics of their pain as well as the previous treatment methods that proved effective.

Table 1: Predictive Factors and Response to Spermatic Cord Block

		Responded to SCB N=26 (%)	No Response to SCB N=26 (%)	$\chi^2$	p-value
Pain Characteristics	Intermittent	10 (38.5)	12 (46.2)	0.32	0.5745
	Constant	15 (57.7)	7 (26.9)	5.04	0.0247
	Radiates	12 (46.2)	16 (61.5)	1.24	0.2658
	Dull	10 (38.5)	6 (23.1)	1.44	0.2294
	Achy	7 (26.9)	4 (15.4)	1.04	0.3084
	Sharp/Stabbing	12 (46.2)	6 (23.1)	3.06	0.0803
	Other Symptoms	7 (26.9)	7 (26.9)	0.00	1.000
Medical History	History of Vasectomy	7 (26.9)	8 (30.7)	0.09	0.7595
	Other Urological Condition	14 (53.8)	13 (50.0)	0.08	0.7814
Social History	Alcohol Use at First Encounter	12* (60.0)	13** (59.1)	0.004	0.9522
	Tobacco Use at First Encounter	5 (19.2)	5*** (20.0)	0.005	0.9449
Physical Exam	Tenderness to Palpation	16 (61.5)	20 (76.9)	1.44	0.2294
Response to Previous Management	Conservative Measurements	3* (21.4)	2** (16.7)	0.09	0.7587
	Oral Neuromodulating Pain Medications	6*** (54.5)	2* (14.3)	4.59	0.0322

\*N20, \*\*N=22, \*\*\*N=25, + N=14, ++N=12, +++N=11.

**Source of Funding:** None

## MP47-10

### SEEING VASECTOMY THROUGH A DIFFERENT LENS: UTILIZING VIRTUAL REALITY TO ENHANCE VASECTOMY COMFORT AND REDUCE ANXIETY IN SINGLE-CENTER, RANDOMIZED, OPEN-LABEL CLINICAL TRIAL

Jason Codrington, Farhan Qureshi, Aymara Evans, Farah Rahman, Max Sandler, Ranjith Ramasamy, Miami, FL; Nicholas A. Deebel\*, Winston-Salem, NC

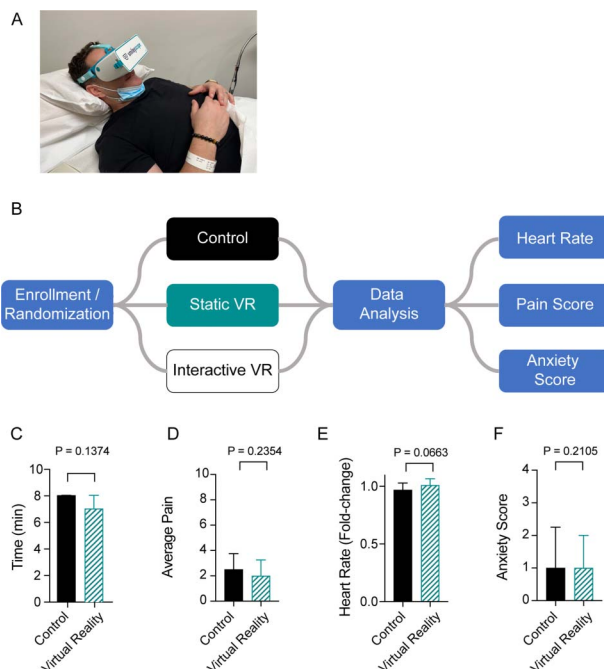
**INTRODUCTION AND OBJECTIVE:** Vasectomy is a widely practiced method for male sterilization, performed around 33 million times globally each year. While generally safe, concerns about pain and anxiety can deter potential patients from an in-office procedure. Research on VR headsets during vasectomy is limited. In an ongoing single-center, randomized clinical trial, we present interim data on the SmileyScope VR device's effectiveness in reducing anxiety and pain during in-office vasectomy under local anesthesia. The main objective of this study is to assess how virtual reality (VR) devices can reduce

anxiety and pain during in-office vasectomy under local anesthesia. Additionally, we aim to compare the effectiveness of interactive VR, where patients can control the experience, with static VR, which lacks patient control.

**METHODS:** Patients scheduled for in-office vasectomy with a single urologist at the University of Miami were enrolled. Patients were randomly assigned to one of three groups: the control group receiving standard in-office vasectomy without a VR headset, the static VR intervention group, or the interactive VR intervention group. The primary outcome measures included patient-reported pain and anxiety levels before and after the procedure, along with heart rate measurements recorded utilizing a FitBit Versa 3 wearable device.

**RESULTS:** Interim analysis of this ongoing study includes data from a total of 107 men. 37 men were in the control group, 34 in the static VR arm, and 36 in the interactive VR arm. There was no observed difference in subjective pain scores ( $p=0.2354$ ), pre-procedure anxiety ( $p=0.2105$ ), or heart rate variability during the procedure ( $p=0.0663$ ).

**CONCLUSIONS:** Initial results from our ongoing randomized clinical trial indicate that although the use of VR headsets during in-office vasectomy is safe and feasible, there is no statistically significant difference in pre-procedure anxiety, heart rate variability or subjective pain.



**Source of Funding:** This trial was supported by the National Institutes of Health National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) grant R01DK130991-0. The sponsor has no direct role in the study. Virtual Reality Headsets were provided by SmileyScopeTM

## MP47-11

### PHARMACOLOGICAL MANAGEMENT OF PREMATURE EJACULATION: A SYSTEMATIC REVIEW AND BAYESIAN NETWORK META-ANALYSIS

David E. Hinojosa-Gonzalez, Gal Saffati\*, Shane Kronstedt, Troy La, Nicole Wright, John Donato, Nelson Mills, Mohit Khera, Houston, TX

**INTRODUCTION AND OBJECTIVE:** Premature ejaculation (PE) is defined as concurrent brief ejaculatory time, loss of control, and related psychological distress to the patient and/or partner. While PE is one of the most prevalent male sexual dysfunctions, its management remains highly variable with a plethora of pharmacological options at

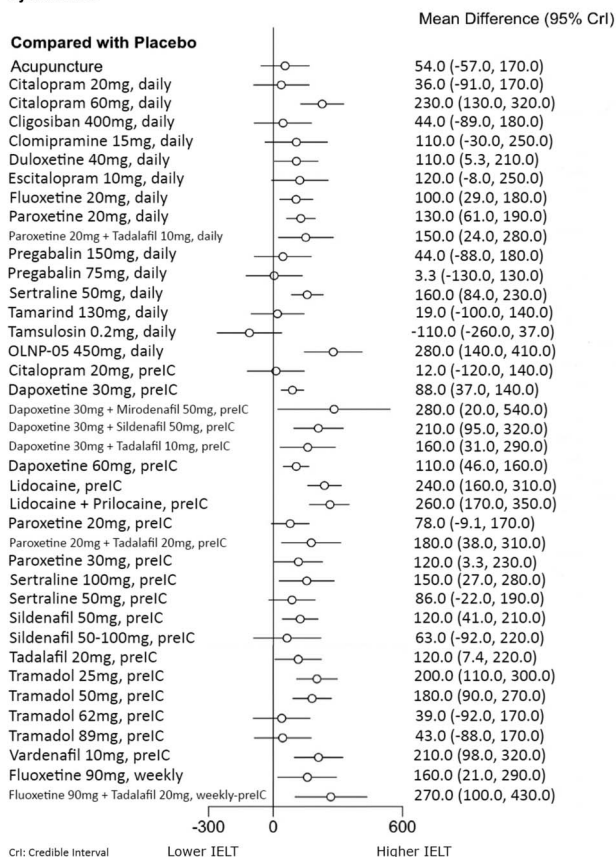
the urologist's disposal. Thus, we sought to comprehensively compare the efficacy of drugs and dosing regimens used in the treatment of PE.

**METHODS:** In May 2023, a systematic review was performed to identify randomized controlled trials (RCTs) evaluating pharmacologic treatments in patients with PE. Included studies reported intravaginal ejaculatory latency time (IELT). Data was extracted independently by two authors and used to build a network model used to run 200,000 markov chain monte carlo iterations with samplings every 10 iterations in R. Studies were grouped by drug, dose and timing of the medication. The results are presented as mean difference (MD) with 95% credible intervals.

**RESULTS:** We included 41 studies involving 9,025 patients that examined the effectiveness of pharmacological treatments for PE and reported IELT. Overall, the highest MD compared to placebo was with pre-intercourse dapoxetine 30 mg+mirodenafil 50 mg (MD 280.0 [23.0, 400.0]) and with the investigational drug named OLNP-05 (MD 280.0 [140.0, 410.0]). Interestingly, lower doses of pre-intercourse tramadol (25 mg and 50 mg) also demonstrated a significant increase in IELT compared to a placebo, but this effect was not observed with higher doses (62 mg and 89 mg). Additionally, pre-intercourse lidocaine, either alone or in combination with prilocaine, led to significantly higher IELT compared to a placebo, with MD values of 240.0 [160.0, 310.0] and 260.0 [170.0, 350.0], respectively. Furthermore, there was a general trend showing higher IELT in pre-intercourse medications compared to daily medications, when compared to a placebo. Results are shown in Figure 1.

**CONCLUSIONS:** In conclusion, our results show that pre-intercourse therapies appear to correlate with the highest MD in IELT compared to placebo. Knowledge from this study will aid the urologist in selecting pharmacological treatments most likely to benefit patients with PE.

**Figure 1. Forest plot of relative effectiveness of interventions for premature ejaculation**



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## MP47-12

### CORRELATION BETWEEN COMORBIDITIES AND THE RESPONSE OF ERECTILE DYSFUNCTION (ED) TO LOW-INTENSITY EXTRACORPOREAL SHOCK WAVE THERAPY (LI-ESWT): A PROSPECTIVE STUDY

Luigi Quaresima, Civitanova Marche, Italy; Daniela Fasanella\*, L'Aquila, Italy; Luciana Mariani, Willy Giannubilo, Civitanova Marche, Italy

**INTRODUCTION AND OBJECTIVE:** Low-intensity extracorporeal shock wave therapy (LI-ESWT) has been used for the treatment of Erectile Dysfunction (ED), in particular for mild ED or for patients who are poorly responsive to oral therapy. Unfortunately, LI-ESWT, which consists of a cycle of treatments of at least 10 sessions, whose cost is at the patient's charge, is burdened by a failure rate that is far from negligible. The purpose of our study is to identify the factors that predispose to the response of LI-ESWT.

**METHODS:** 115 patients with mild to moderate ED were treated from February 2021 to February 2023. All patients were stratified by age, BMI (normal weight, overweight, obese), and comorbidities (smoking, compensated or decompensated diabetes mellitus, controlled or not controlled hypertension) and were evaluated before and 2 weeks after the end of the course of treatment with questionnaire International Index of Erectile Function short version (IIEF-5). The study excluded patients who had previously performed unsuccessful drug therapy. Patients with iatrogenic or post-trauma ED were also excluded. The patients underwent a cycle of 10 sessions of focal LI-ESWT with an electro-pneumatic device with 1.1 Bar pressure with 4000 strokes per session with 4 Hz frequency.

**RESULTS:** 115 patients with an average age of 63 years (56-70) met the study criteria. Of these, 71 showed an increase in the questionnaire score: these patients with an average pre-treatment IIEF-5 score of 19/25, had an average post-treatment IIEF-5 score of 22/25. The percentage of patients with a valid erection recovery was 61%. This percentage was lower in the subcategories of obese patients, smokers, with not well-compensated diabetes, with not well-controlled hypertension, with percentages of 11.3, 15.5, 12.7, and 11.3 % respectively ( $p < 0.05$ ). No association was found with age, overweight, compensated diabetes or well-controlled hypertension ( $p > 0.05$ ).

**CONCLUSIONS:** Age, overweight (not obesity), well-compensated diabetes, or well-controlled hypertension do not affect the recovery of a valid erection with the LI-ESWT. On the contrary, smokers or patients with poorly controlled diabetes, not controlled hypertension, or with obesity show a less than average response to treatment and should be directed toward other therapies.

	Total	No improve	Improve
	n=115	n=44	n=71
Age, mean±SD	63.3±7.1	62.1±6.7	64.1±7.3
BMI, n(%)			
Normal	40(34.8%)	16(36.4%)	24(33.8%)
Overweight	45(39.1%)	6(13.6%)	39(54.9%)
Obese	30(26.1%)	22(50.0%)	8(11.3%)
Smoker, n(%)	31(27.0%)	20(45.5%)	11(15.5%)
Diabetes, n(%)			
No	46(40.0%)	8(18.2%)	38(53.5%)
Yes, compensated	42(36.5%)	18(40.9%)	24(33.8%)
Yes, Not compensated	27(23.5%)	18(40.9%)	9(12.7%)
Hypertension, n(%)			
No	41(35.7%)	11(25.0%)	30(42.2%)
Yes, controlled	52(45.2%)	19(43.2%)	33(46.5%)
Yes, Not controlled	22(19.1%)	14(31.8%)	8(11.3%)

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