IP10-07

OXYTOCIN FOR MALE ORGASMIC DISORDER: FACT OR FICTION?

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INTRODUCTION AND OBJECTIVE: There is a lack of FDA approved medications and standardized treatments for male orgasmic disorder. Current options include off label use and compounded medications. Efficacy of these medications is poorly studied. One option is intranasal oxytocin, which has been associated with physiologic surges during ejaculation and arousal. We sought to characterize the real-world effectiveness of intranasal oxytocin.

METHODS: Our male sexual function database was queried for a diagnosis of male orgasmic disorder. Patient demographics, co-morbidities, associated diagnoses, medications, treatments and effectiveness were analyzed. All patients in our practice are offered a stepwise treatment regimen for orgasmic disorder. This starts with vibratory stimulation, followed by oxytocin, bupropion, and cabergoline, and finally bremelanotide and flibanserin. Effectiveness was determined by a>50% improved ability to achieve orgasm or a>50% improved estimated time to orgasm. Exclusions included untreated hypogonadism or untreated erectile dysfunction.

RESULTS: 138 patients with male orgasmic disorder were identified. Average age was 53 years old (range 14 – 89; Sd 17). 9.4% (13/138) of patients elected to use intranasal oxytocin. Common associated diagnoses included erectile dysfunction (92%), hypogonadism (46%), and treatment for a psychiatric disorder (54%). One patient had complete resolution of his orgasmic disorder, two had a partial response (<50% improvement in orgasm), and 10 patients either had no response or failed to follow up.

CONCLUSIONS: Intranasal oxytocin failed to significantly improve orgasmic disorder in the majority of men in our cohort. Male orgasmic disorder remains a difficult to treat condition. A significant proportion of patients with orgasmic disorder are co-morbid with erectile dysfunction and a psychiatric diagnosis, most commonly major depressive disorder. Oxytocin should not be considered first line treatment in this patient population. Future research on the treatment of male orgasmic disorder would likely benefit from a focus on off label use of FDA approved female hypoactive sexual desire disorder medications bremelanotide or flibanserin, which might offer more promise.

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IP10-08

SUPERSELECTIVE TRANSCATHETER EMBOLIZATION IN HIGH-FLOW PRIAPISM: RESULTS FROM A MULTICENTER ANALYSIS

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INTRODUCTION AND OBJECTIVE: High-flow priapism is a rare condition characterized by unregulated arterial inflow into the penis due to a fistula between penile arteries and cavernous sinusoids. The goal of treatment is to interrupt the blood flow through the fistula. Conservative treatments have low success rates, as spontaneous fistula closure is uncommon. The first-line active treatment is superselective transcatheter embolization, which can be performed using temporary or permanent agents such as microcoils, ethylene-vinyl alcohol copolymer (PVA), and N-butyl-cyanoacrylate (NBCA). Literature on this topic is limited, with only small series and short-term follow-up. This study presents the outcomes from a multi-institutional series of patients who underwent angiographic treatment for high-flow priapism.

METHODS: We included all patients treated with superselective arterial embolization for high-flow priapism at two tertiary referral centers between January 2002 and September 2024. Demographic, epidemiological, and procedural data were collected. Procedural success was defined as the angiographic resolution of the fistula after embolization. At the last follow-up, all patients were reassessed using the International Index of Erectile Function-5 (IIEF-5), the Erection Hardness Score (EHS), and satisfaction surveys related to the procedure.

RESULTS: During the study period, 22 patients with a median age of 33 years (IQR: 24–40) underwent angiographic treatment for high-flow priapism. In 12 cases (54.5%), the fistula was located on the left, in 8 cases (36.4%) on the right, and in 2 cases (9.1%) bilaterally. Seventeen patients underwent superselective arterial embolization with permanent occlusive agents (7 PVA, 6 microcoils, 4 with both PVA and microcoils), while 3 patients were treated with absorbable agents (2 Spongostan, 1 cyanoacrylate surgical glue), and 2 patients received a combination of both absorbable and permanent agents. All procedures were technically successful, and no postoperative complications were reported. The median follow-up was 74 months (IQR: 48.5–183.5). At the last follow-up, no recurrences were observed, the median IIEF-5 score was 22 (IQR: 20–25), and the median EHS was 4 (IQR: 3–4). The satisfaction rate with the procedure outcomes was 91%.

CONCLUSIONS: Superselective transcatheter arterial embolization is an effective and safe treatment for high-flow priapism. Both permanent and absorbable agents are effective and do not lead to long-term impairment of erectile function or other complications.

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IP10-09

PREDICTORS OF CLOMIPHENE CITRATE RESPONSE IN THE TREATMENT OF MEN WITH TESTOSTERONE DEFICIENCY

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INTRODUCTION AND OBJECTIVE: Clomiphene citrate (CC) has proven efficacy in managing testosterone deficiency (TD) in men. This study aimed to identify predictors of a clinically meaningful response in serum total testosterone (TT) levels when using CC as treatment.

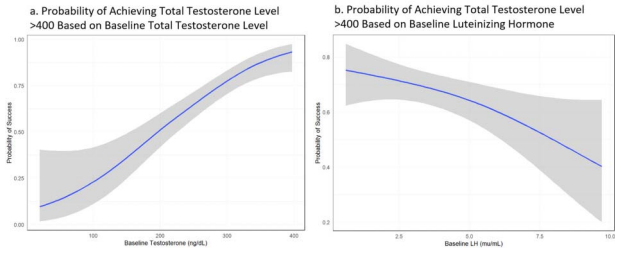
METHODS: This study included symptomatic men with (i) low TT (≤300 ng/dL) (ii) or borderline TT (≤400 ng/dL) with signs of TD such as low bone density or new discovery of elevated HbA1c. Two morning TT measurements were measured using liquid chromatography-mass spectrometry. Initial CC dose was 25 mg every other day (QOD). Follow-up labs were obtained 3-12 weeks after initiation. Adequate response was defined as an on-treatment TT level≥400 ng/dL. CC was increased to 50 mg QOD in those with poor response. No response within 12 weeks or a switch to alternate therapy prior to response was considered treatment failure. A secondary analysis was performed with adequate response being defined as a rise in TT>200 ng/dL from baseline. Multivariable logistic regression was used to identify predictors of treatment success including age, comorbidities, smoking status, baseline TT and LH, concurrent anastrozole, prior androgen deprivation, prior chemotherapy, prior radiation, and prior radical prostatectomy.

RESULTS: 292 men met the inclusion criteria for this study with a median age of 60 (IQR 50,66) years. 52 patients met criteria but were excluded due to lack of compliance for post-treatment lab work. Comorbidities: 18% diabetes, 46% hyperlipidemia, 44% hypertension, 41% had radical prostatectomy, 12% pelvic radiotherapy, and 5% prior androgen deprivation therapy. Median baseline TT was 264 (IQR 219, 314) ng/dL and luteinizing hormone (LH) was 3.5 (IQR 2.6, 5.1) mU/mL. 67% (CI 61-72%) responded with an on-treatment TT>400 ng/dL. 49% (CI 43%-55%) had a response of>200 ng/dL above baseline. On multivariate models, baseline TT (OR 1.18, CI 1.13-1.25, p<0.001) and baseline LH (OR 0.53, CI 0.63-0.90, p=0.003) were predictive of an on-treatment TT>400 ng/dL. Baseline LH remained negatively predictive when response was defined as a rise>200 ng/dL above baseline. The figure graphically represents

multivariate models for the probability of success based on baseline TT and LH.

CONCLUSIONS: In men with TD, lower LH levels and higher TT levels were a predictors of CC response. Clinicians can incorporate this into their treatment discussions with patients with TD.

Figure. Probability of Response Based on Baseline Total Testosterone and Luteinizing Hormone Using Generalized Additive Logistic Models



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IP10-10

THE IMPACT OF PENILE REHABILITATION (PR) TIMING ON ERECTILE FUNCTION RECOVERY (EFR) OUTCOMES 2 YEARS AFTER RADICAL PROSTATECTOMY (RP)

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INTRODUCTION AND OBJECTIVE: While controversial, PR is purported to optimize EFR after RP. We aim to define the impact of early versus delayed PR on EFR at 2 years after RP.

METHODS: This study includes men with normal baseline erectile function (EF), who underwent bilateral or unilateral nerve-sparing (NS) surgery and completed follow-up for 2 years post-surgery. Those receiving radiotherapy or androgen deprivation were excluded. International Index of Erectile Function – Erectile Function Domain (IIEF-EFD) was used to assess EF; normal baseline EF and EFR both defined as≥24; severe erectile dysfunction (ED) ≤10. Nerve Sparing Score (NSS) graded NS 1-4 (1=complete NS; 4=full resection); NS surgery defined as NSS≤2 on one or both sides. For PR, men initiated daily low-dose PDE5 inhibitor supplemented with a full dose of PDE5i at least once a week; goal of≥2 penetration hardness erections a week. Intracavernosal injections were started for PDE5i non-responders. Preoperative PR (PPR) started prior to RP; early PR (EPR) started 0-3 months post-op; delayed PR (DPR) started>3 months after surgery. Demographics, comorbidities, and hormone profiles were assessed. Low testosterone defined as≤300 ng/dL. EFR was compared between PPR, EPR and DPR. Multivariable models were used to define predictors of EFR at 24m post-RP. Variables included patient age, comorbidity status, PR timing, Bilateral NS, and PDE5I exposure.

RESULTS: 1042 men were evaluated with a median age of 60 (IQR 55, 65) years. 26% had obstructive sleep apnea, 9% had diabetes, 41% had≥2 vascular comorbidities, 26% had low T, and 35% were former or current smokers. 80% had bilateral, and 20% had unilateral NS surgery. PPR was undertaken by 17%, EPR 36%, and DPR 46%. At 24m post-RP, the median IIEF-EFD score overall was 19 (IQR 8, 27), with those having PPR 23 (14, 29), EPR 20(7, 28) and DPR 16 (7,25) (p<0.001). Comparing PPR, EPR, and DPR, the earlier intervention was associated with significantly higher EFR rates (PPR 50%, EPR 42%, DPR 28%, p<0.001) and significantly lower severe ED rates (PPR 18%, EPR 32%, DPR 35%, p<0.001). Patient age, PR timing, and bilateral NS surgery were predictors for functional erections. Age and bilateral NS surgery were predictors for severe ED (Table 1).

CONCLUSIONS: The PR Timing on EFR after surgery is critical. PPR and EPR predict better EFR outcomes compared to DPR 2 years post-RP.

Table 1. Predictors of Functional Erections and Severe Erectile Dysfunction

	EFR (IIEF-EFD ≥24)			SEVERE ED (IIEF-EFD ≤10)		
	OR	CI	p-value	OR	CI	p-value
Age (per decade increase)	0.71	0.58-0.86	**<0.001**	1.73	1.40-2.13	**<0.001**
Early RP (PPR/EPR vs DPR)	1.82	1.40-2.37	**<0.001**	0.78	0.60-1.03	0.079
NS Surgery (Bilateral, yes)	1.94	1.36-2.77	**<0.001**	0.60	0.43-0.82	**0.002**

EFR = Erectile function recovery, IIEF-EFD = International Index of Erectile Function Erectile Function Domain, ED = Erectile dysfunction, PPR = Preoperative penile rehabilitation, EPR = Early penile rehabilitation, NS = Nerve-sparing, OR = Odds ratio, CI = Confidence interval

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IP10-11

PRELIMINARY ASSESSMENT OF GLP-1 RECEPTOR AGONISTS ON TESTOSTERONE LEVELS, ERECTILE FUNCTION, AND METABOLIC OUTCOMES IN MEN WITH OBESITY OR TYPE 2 DIABETES

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INTRODUCTION AND OBJECTIVE: Glucagon-like peptide-1 receptor agonists (GLP-1 RAs) have benefits in glycemic control and weight reduction. Emerging research also suggests benefits in male reproductive health, including improvements in testosterone (T) levels and erectile function. However, new studies highlight that GLP-1 RAs may induce significant loss of lean body mass, or sarcopenia. Given that T can support muscle maintenance, our study seeks to explore the interplay between GLP-1 therapy and T levels, as well as provide preliminary insights into their impact on sexual function.

METHODS: A retrospective chart review was conducted on 53 male patients prescribed GLP-1 RAs for type 2 diabetes (T2DM) or obesity. Data collected included demographics, smoking status, indications for GLP-1 RA, hypogonadism diagnosis, T replacement therapy usage, erectile dysfunction medication use, weight, BMI, HbA1c, and total and free T (pre- and post-therapy). Analyses were performed with SPSS 29 (IBM Corp., Armonk, NY).

RESULTS: Results are summarized in Table 1. The mean baseline BMI was 35.56, with 64% of patients with obesity. The mean baseline HbA1c was 6.43, with 36% with prediabetes and 40% with T2DM. Patients showed a mean increase of 111 ng/dL in total T. A paired t-test comparing pre- and post-testosterone levels showed a statistically significant improvement (t=−2.19, p=0.048). The mean SHIM score increased by 2.4; however, individual patient scores demonstrated variability. The Wilcoxon signed-rank test for SHIM scores yielded no significant difference pre- and post-therapy (W=10.5, p=0.42). Regression analysis revealed no significant relationship between weight change and testosterone levels (R-squared = 0.000, p=0.969), with a regression coefficient of -0.1020.

CONCLUSIONS: GLP-1 RA therapy is associated with significant increases in T among men with obesity or T2DM. The lack of a significant association between weight loss and T change suggests that the underlying mechanisms may be independent of weight loss. While preliminary data showed improvements in erectile function, additional data will be necessary to determine whether these trends will achieve clinical or statistical significance. Given emerging data on sarcopenia and GLP-1 RAs, future studies should investigate the potential role of combined GLP-1 and testosterone therapies to optimize outcomes in body composition, metabolic control, and sexual health.

Table 1. Impact of GLP-1 Receptor Agonist Therapy on Testosterone Levels, Sexual Health, and Metabolic Parameters in Men with Obesity or Type 2 Diabetes: Summary statistics

Parameter	Pre-T Total (ng/dL)	Post-T Total (ng/dL)	Change in T Total (ng/dL)	Pre-SHIM Score	Post-SHIM Score	Change in SHIM Score	Weight Change (%)	HbA1c Change (%)
Patients included	14	14	14	5	5	5	25	25
Mean	247	358	111	12.4	14.8	2.4	-6.3	-0.8
Median	219	348	129	8	16	1	-5.1	-0.3
Range	82–436	129–757	-83 – +611	5–24	4–23	-4 – +10	-29.2 – +8.1	-2.5 – +0.2

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