The objectives of this study were to determine if central obesity as measured by waist circumference (WC) is a risk factor in metabolic dysfunction, which includes hypertension, dyslipidaemia and type 2 diabetes (DM2); and to test the hypothesis that central obesity and WC are associated with and predictive of the severity of voiding dysfunction.

Men aged ≥40 years with moderate or severe lower urinary tract symptoms (LUTS; International Prostate Symptom Score [IPSS] ≥8) with no previous treatment were included for study. Subjects were divided into three groups according to WC (<90, 90–99 and ≥100cm). Baseline parameters including IPSS, prostate volume, serum prostate-specific antigen (PSA), presence of erectile dysfunction (ED) and ejaculatory dysfunction, and the prevalence of hypertension, coronary artery disease and DM2 were compared among the three WC categories. The association between WC and all parameters assessed was tested using multivariate logistic regression analysis.

In conclusion, increased WC is associated with worsened voiding. There was a significantly increased prevalence of components of the metabolic syndrome in patients with higher WC. Obese men, in particular those with other features of the metabolic syndrome, are at increased risk of male pelvic dysfunction and can be easily recognised by measurement of WC.


In men, stored energy tends to reside within the abdomen. Patients with DM2 or metabolic syndrome typically have visceral obesity, which, along with insulin resistance, is becoming increasingly recognised as an important risk factor for cardiovascular disease. Visceral adipose tissue is now established as a metabolically active organ, which is thought to contribute to vascular disease by secreting a range of cytokines and other pro-inflammatory mediators.

Furthermore, a number of additional, novel risk factors have been linked to insulin resistance and the metabolic syndrome, including inflammatory markers (IL-6, TNF-alfa, CRP, adiponectin) and thrombotic factors (PAI-1, fibrinogen). The generation of inflammatory cytokines from visceral adipose tissue is likely to be an important contributor to the pro-inflammatory state and endothelial dysfunction. Increased insulin levels lead to hypertension caused by sodium retention, and the typical dyslipidaemia includes low high-density lipoprotein cholesterol and high triglycerides.

These proven links with vascular disease and urological symptoms provide the clinician with opportunities to identify important men’s health issues, which are often missed or present too late, because men do not talk about them.

For the urologist and generalist, there are opportunities during the consultation with men who are overweight, presenting with LUTS or ED to consider the presence of underlying metabolic syndrome and its components. There also should be a reminder on the template to enquire about LUTS and ED in men who are overweight and to think about measuring testosterone, which is also often reduced in this situation.

A lifestyle programme to include weight loss, diet and exercise, combined with therapies to address cardiovascular risk factors, offers benefits for both the cardiovascular and urological problems these men face. Additional benefits could include improved joint health, less depression and increased self-esteem. Let’s get these men to a better PLACE!

**PREDICTING ERECTILE FUNCTION AFTER RADICAL PROSTATECTOMY**

The objectives of this study were to identify the reported rates of potency after prostatectomy in the recent literature for men without preoperative ED and to develop a statistical model for predicting the expected potency after prostatectomy.

A Medline search was conducted with the keywords ‘potency’ and ‘prostatectomy’ from 2003 to 2009. In total, 33 studies in the English language reporting pre- and postoperative erectile function were identified. Data from studies reporting outcome after open, laparoscopic and robot-assisted prostatectomy were analysed separately. Only data obtained from potent men before surgery were included in the analysis.

In potent men before surgery, the main predictors of post-treatment erectile function were age and time after treatment. The cumulative range of potency rates at 48 months for all ages (45–75 years) was 49–74 per cent for open, 58–74 per cent for laparoscopic and 60–100 per cent for robotic prostatectomy. The predicted outcome differed by type of operation and patient age.

In conclusion, men aged <60 years have a significant likelihood of regaining erectile function after radical prostatectomy. The reported statistical model provides a reliable estimation of erectile function outcome after prostatectomy for men with localised prostate cancer and intact erectile function.

**MESSAGE FOR THE CLINIC**

Thirty-seven thousand men will be diagnosed with prostate cancer this year. Many of these men will be treated with curative intent with surgery or radiotherapy. This paper reviews 33 studies of erectile function before and after radical prostatectomy. The main predictors of outcome were age and time after treatment and the conclusion was that men less than 60 years of age are likely to regain erectile function if they are potent preoperatively. Return of function is gradual and can take up to four years. The outcome appeared to be better with the robotic technique, but selection bias may have been a confounding factor.

Disappointingly, sexual function is not reliably addressed during consultations with prostate cancer patients in either urological or oncological clinics. Forbat et al. observed 60 such consultations: sexual function was discussed infrequently and involvement of the partner was minimal. There was limited opportunity to discuss sexual functioning.

Primary care can fill this gap and take the opportunity to enquire about the importance of sexual functioning to both the man and his partner. The authors point out that early intervention appears beneficial.

A detailed evaluation of current sexual function should be performed, involving the partner, starting preoperatively soon after the diagnosis is confirmed. An erection preservation programme and any continence issues should be discussed, involving the partner, soon after surgical intervention.

There are six components to early intervention: phosphodiesterase type 5 (PDE5) inhibitors (daily), pelvic floor exercises, use of a vacuum device, starting after four to six weeks postoperatively, consider intraurethral pellets (MUSE) and intracorporeal injections (Caverject or Invicorp) if necessary. Daily exercise such as a brisk walk is important and should be encouraged for three months. Penile prostheses are an option if all else fails.

NICE recommends that healthcare professionals should ensure that men and their partners have early and ongoing access to specialist ED services. Men with prostate cancer who experience loss of erectile function should be offered PDE5 inhibitors to improve their chance of spontaneous erections. If PDE5 inhibitors fail to restore erectile function or are contraindicated, men should be offered vacuum devices, intraurethral inserts or penile injections, or penile prostheses as an alternative.