

# Erectile impotence precipitated by organic factors and perpetuated by performance anxiety

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A survey of 72 men with erectile impotence showed that for 14 the onset had been concurrent with the start of a temporary physical disability (in 8), temporary exposure to a chemical agent in doses thought to be significant (in 4) or the return of sexual opportunity after a long period of celibacy or near-celibacy (in 2 older men). After elimination of that possible cause the impotence had persisted owing to anxiety about sexual performance. In another 6 of the 72 there were persistent nonpsychic causes for the impotence. Thus, in 28% of the men surveyed the precipitating cause of erectile impotence was organic. A large proportion of the cases of erectile impotence precipitated by a temporary nonpsychic factor could probably have been prevented with appropriate professional advice — for example, at the time an antihypertensive drug capable of causing the dysfunction was first prescribed.

Une enquête réalisée chez 72 hommes ayant une incapacité de l'érection a révélé que chez 14 d'entre eux le début avait coïncidé avec l'apparition d'une incapacité physique temporaire (chez 8), une exposition temporaire à des agents chimiques à doses considérées comme significatives (chez 4) ou l'occasion d'une relation sexuelle possible après une longue période de célibat ou de quasi-celibat (chez 2 hommes âgés). Après disparition de la cause possible l'impotence avait persisté due à l'anxiété concernant la performance sexuelle. Chez six autres patients du groupe étudié il existait des causes non psychiques persistantes à l'impotence. En conséquence, pour 28% des hommes étudiés le facteur déclenchant de l'incapacité de l'érection était organique. Une forte proportion des cas d'impotences précipités par des facteurs non psychiques temporaires auraient probablement pu être évitée avec les conseils professionnels appropriés — par exemple, au moment où un antihypertenseur capable de causer de l'impotence fut prescrit pour la première fois.

Most men have had erectile impotence on some occasion, but they usually consider it of no consequence. Anxiety and embarrassment, however, will make the episode significant to them.

The immediate cause of a first significant episode of erectile impotence can be stress, fatigue, or an interpersonal conflict or intrapsychic problem generating, for example, anxiety, depression or anger.<sup>1,2</sup> It can also be a

physical or chemical disturbance interfering with body function. A long period of little or no sexual activity is another cause, especially among men over 50 years of age. Kolodny and colleagues<sup>3</sup> have called this form of impotence — or, more specifically, that occurring in conjunction with a lengthy and eventually fatal illness of the wife — the “widower's syndrome”. They suggest that the underlying dynamics are different if impotence is experienced after divorce, but we see no reason for making this distinction if the divorce involved a long period of little or no sexual activity. We shall use the term “widower's syndrome” when the first episode of impotence is thought to be the physiologic (as opposed to psychologic) result of prolonged sexual inactivity in an older man. Return to sexual activity could soon restore potency, but rapid loss of sexual self-confidence all too often intervenes.

“Performance anxiety” usually develops after several clustered episodes of erectile impotence, regardless of the initial cause. Ignorance of that cause greatly increases the fear of failure.

The blocking effect of performance anxiety often perpetuates the erectile difficulty even after the initial cause of the dysfunction is no longer operative. Kolodny and colleagues<sup>3</sup> were referring to this phenomenon when they pointed out that sexual difficulties may persist on a psychogenic basis even when the primary organic cause is discovered and successfully treated. Because this phenomenon and its implications are not widely enough recognized by physicians and others providing sex counselling services, we present a study of 14 men who remained impotent after the possible initial organic cause of temporary erectile dysfunction was eliminated, as well as 6 men for whom the possible initial organic cause was persisting at the time of our assessment.

## Patients and methods

Like Masters and Johnson,<sup>1</sup> we define erectile impotence as failure to obtain or maintain sufficient penile tumescence for coitus in at least 25% of opportunities. The term is not synonymous with an absence of erections. Between July 1976 and February 1981, 72 men with this complaint and the female sexual partners of 53 of them were assessed. For 20 of the men the medical history indicated approximate concurrence of the first significant episode of erectile impotence and the onset of a physical disorder, use of a chemical agent or, for older men, return of sexual opportunity after a long period of celibacy or near-celibacy. These 20 men were selected for this report.

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The initial assessment of each of the 20 men, which lasted at least an hour, was devoted to eliciting the man's sexual, social and medical histories. For 16 of the 20, additional historical information was obtained from the sexual partner. A complete physical examination was then performed. For 7 of the 20 men conjoint sex therapy with the partner provided additional relevant data.

## Results

Table I lists the possible initial physical and chemical causes of erectile impotence in the 20 men. In two instances the need for the man to continue indefinitely taking a medication other than the antihypertensive originally prescribed but also capable of causing impotence led to uncertainty about whether the chemical cause was persistent.

We believe that a nonpsychic event concurrent with the onset of impotence was the precipitating cause of erectile dysfunction in most of the 20 men. For some (e.g., patients 3 and 4) the cause listed in Table I was considered not to have been the immediate cause but, rather, to have set the stage for a psychogenic mechanism that rapidly became operative. In many instances there were probably contributing causes, such as diabetes mellitus, vascular insufficiency or neuropathy, which tend to produce gradually progressive disability. Performance anxiety followed the initial erectile failure in most cases and doubtless limited the capacity for sexual arousal thereafter.

Table I—Possible initial causes, temporary (T) or persistent (P), of erectile impotence in 20 men

Patient no.	Age (yr)	Possible cause	Duration of impotence (yr)
1	57	Genital disease	
2	34	Peyronie's disease (P) Acute prostatitis (T)	¾ 1¼
3	33	Genital surgery	
4	55	Vasectomy (leading to scrotal hematoma?) (T) Circumcision (leading to altered penile sensation) (T)	1 2
5	50	Neurologic disease	
6	59	Hemianesthesia (S3-4), cause unknown (P) Multiple sclerosis (T)	1 7
7	19	Neurologic injury	
8	35	Spinal cord (T10-L2) (P)	5
9	47	Spinal cord (T11-12), partial (T) Intercostal neuralgia (T6-9) since rib fractures (P)	1½ 1¼
10	58	Other disease	
11	53	Myocardial infarction (T) Bleeding peptic ulcer (T)	5 8
12	28	Other injury	
13	58	Multiple fractures (T) Prolonged lack of sexual activity (T)	6 ½
14	62	Prolonged lack of sexual activity (T)	½
15	21	Chemical agent(s)	
16	59	Alcohol (T) Antihypertensive drug (T)	¾ 3
17	58	Spironolactone, hydrochlorothiazide, imipramine (T)	4
18	46	Hydrochlorothiazide (T?)	2½
19	59	Methyldopa, furosemide, digoxin (P?)	8
20	48	Methyldopa, propranolol, hydrochlorothiazide (P?)	5

Among the 14 men in whom the possible initial cause was eliminated, that factor was the only relevant initial one, organic or psychogenic, for patients 2, 15 and 16. Although patients 12, 17 and 18 showed various degrees of psychologic abnormality, the listed cause was believed to have been the precipitating factor in each instance. Diabetes could have been a contributing factor for patients 3, 4, 6 and 10, although the association of diabetes with impotence does not necessarily imply cause and effect.<sup>4</sup>

Masters and Johnson<sup>1</sup> have pointed out that almost any physical dysfunction that reduces the body's metabolic efficiency below acceptable levels can result in erectile incompetence. Patients 10, 11 and 12 were recovering from miscellaneous acute illnesses when their erectile dysfunction first occurred, but an etiologic association cannot be proved.

The emotionally stable individual who is fully informed about the consequences of vasectomy and who makes no unusual demands on himself during convalescence need have little concern about impotence as a complication. We believe that patient 3 made unusual demands on himself by masturbating several times to produce semen for sperm counts during the first two postoperative weeks.

From patient 4's history (especially the sequence of events described by the wife) we traced his sexual difficulties back to his first coital encounters after circumcision, when he ejaculated prematurely. Subsequently he experienced erectile dysfunction. Premature ejaculation occasionally occurs following circumcision, but usually just for the first few weeks or months.<sup>5</sup> In patient 4 the loss of ejaculatory control may have generated sufficient anxiety to precipitate psychogenic impotence.

## Illustrative case report

Patient 16 failed to obtain an erection during sexual encounters in the 3 months that he was taking an unidentified antihypertensive medication. His physician had not mentioned the possibility of this side effect, and the patient found the dysfunction both puzzling and upsetting. When he stopped taking the medication his blood pressure remained essentially normal, and his capacity for obtaining an erection improved. However, tumescence usually faded when he was applying a condom or attempting intromission. Physical examination revealed no cause for impotence. Although he had been informed that not taking the medication should allow return of potency, he could not overcome the established fear of erectile failure. He continues to harbour resentment that he was not warned about the possibility of impotence when the antihypertensive drug was prescribed.

## Discussion

Kolodny and colleagues<sup>3</sup> have estimated that approximately 10% to 15% of impotence is primarily organic, and Lief<sup>6</sup> has remarked on the failure of some professionals to distinguish between immediate and long-range causes of impotence. The clinician must search in each

case for all possible causes, whether persistent or temporarily present and now eliminated. Among the 72 patients we assessed in the study period the initial cause of impotence was nonpsychogenic in 28% but was persistent in only 8%. All too often one cannot confidently weigh each factor uncovered.<sup>1</sup> Had it been possible to do so for diabetes and other contributing physical and chemical factors the total percentage of cases with nonpsychogenic initial causes might have been higher.

Our findings show that in specific situations provision of relevant information could have prevented erectile impotence. Too many men are unaware that their sexual desire and capability may well be reduced during certain chronic illnesses or convalescence from acute illness, surgery or injury. Physicians can caution men against unrealistic expectations when they resume intercourse — or, indeed, masturbation — in these circumstances and thereby reduce the likelihood that performance anxiety will be generated. Once established, performance fear is sometimes refractory to the most skilful psychotherapeutic effort.

Antihypertensive agents probably head the list of drugs with a potential for causing impotence, especially

if one considers the frequency with which they are used.<sup>7</sup> Physicians should not avoid telling patients about erectile impotence as a possible side effect when prescribing an antihypertensive capable of causing this dysfunction in, say, 5% of users. Patient 16's experience illustrates what can happen when they do. We recommend the approach suggested by Kolodny and colleagues.<sup>7</sup> They mention the possibility of impotence and follow with a statement of this type: "If this problem occurs with you, just let me know and we can easily make an adjustment in your medication to restore things to normal." Sexual problems should be asked about at each follow-up visit.

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## Acute renal failure secondary to bilateral ureteric obstruction: review of 50 cases

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The records of 50 patients with acute renal failure secondary to bilateral ureteric obstruction were reviewed. An underlying malignant disorder was the cause of the obstruction in 38 of the patients and had not previously been diagnosed in almost half of them. Carcinomas of the cervix and prostate were the most frequent malignant disorders, and aggressive management resulted in good survival rates. Similarly, the outcome for patients with benign bilateral ureteric obstruction, usually caused by retroperitoneal fibrosis, was good with proper management.

On a étudié les dossiers de 50 patients ayant une insuffisance rénale aiguë consécutive à une obstruction bilatérale des uretères. Chez 38 de ces patients une atteinte maligne profonde était responsable de

l'obstruction, et elle n'avait pas été préalablement diagnostiquée dans près de la moitié des cas. Les cancers du col et de la prostate étaient les affections malignes les plus fréquentes, et un traitement agressif a permis de bons taux de survie. De même, avec le traitement approprié le résultat pour des patients ayant une obstruction bilatérale bénigne des uretères, causée habituellement par une fibrose rétropéritonéale, était bon.

Acute renal failure secondary to bilateral ureteric obstruction is not uncommon. Recent publications have emphasized the frequency of advanced underlying malignant disorders and have concentrated on the indications and rationale for palliative urinary diversion in such situations.<sup>1-5</sup>

There has been a tendency to overlook the fact that the cause of the obstruction is often unknown at the time of presentation and that the cause is often proven to be benign. We therefore undertook a study to review our experience with the underlying disease, its management and the prognosis in a large group of patients.

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Presented at a meeting of the Canadian Urological Association and the British Association of Urological Surgeons, Montreal, June 22-23, 1981

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