There are other options

Your February issue contains a statement[1] from The Heart and Stroke Foundation of Canada and the Canadian Cardiovascular Society about "Using sildenafil for patients with cardiovascular disease." I have a number of concerns about it.

First, in the opening paragraph it says that "Penile erection… is essential to men's enjoyment of orgasm during sexual intercourse." While it is true that an erection is required for sexual intercourse, the enjoyment of orgasm requires neither sexual intercourse nor erection.

The patient-directed approach to managing erectile dysfunction recognizes sexual activity without intercourse as a feasible and satisfying option for some couples. The statement goes on to suggest that "If nitrate therapy is essential, other types of therapy for erectile dysfunction should be considered" but again fails to mention that there are options beyond erection enhancement. While this might seem like a small point, it is an important one. The goal of therapy, to restore a couple's intimacy, necessitates a variety of approaches. If sexual intercourse is "off the menu" for whatever reason, couples still need to know that other types of sexual activity are available and acceptable to consenting adults.

On a related note, I have seen cardiac patients taking drugs, such as amiodarone, who request sildenafil and have no other apparent contraindications to its use. Sildenafil blocks only the phosphodiesterase 5 enzyme (PDE-5) receptor found primarily in the penis, and amiodarone's affinity lies with the PDE-3 receptors present mainly in cardiac tissue. Combining the two, in theory, should be no problem, therefore. There are, however, no studies of patients given both drugs, to my knowledge. I caution physicians against combining the two until specific data are available. I expected the *Compendium of Pharmaceuticals and Specialties* to at least note the potential for adverse drug interaction, but I have not seen it mentioned or discussed anywhere in the literature. Incidentally, aminophylline is another PDE inhibitor that could theoretically interact with sildenafil. Granted, it is used less frequently than it once was, but a considerable number of patients are still taking it.

Third, patients with New York Heart Association class IV heart disease are listed in the article under the "maybe sildenafil" category, but these patients have a high likelihood of needing nitrates, which are now considered first-choice drugs in emergency treatment of acute pulmonary edema, to which these patients are particularly prone. I do not think it wise to risk using sildenafil under these circumstances.

The prospect of revitalized erection has caused some to throw caution to the wind. As physicians we should set a slightly higher standard. Sildenafil is a useful drug and generally safe, but we must remember that other options might be more appropriate in certain situations.

—Barry Rich, MD
Vancouver, BC
by e-mail

Reference

1. Heart and Stroke Foundation of Canada, Canadian Cardiovascular Society. Managing sexual dysfuction. Using sildenafil for patients with cardiovascular disease. *Can Fam Physician* 2000;46:393 (Eng), 398 (Fr).

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Response

I thank Dr Rich for his letter.

I agree that an erection is not needed to experience sexual pleasure and that many men can enjoy orgasm without a full erection or sexual intercourse. A goal of reducing performance anxiety for men with a psychogenic component to their erectile dysfunction is to have them (and their partners) focus on noncoital sexual activity. Many couples are still very sexual without having intercourse. This can be due to many issues, medical, psychological, and relational for either partner. Physicians have a powerful role in supporting patients' exploration of the "sexual smorgasbord" and alternatives

when, as Dr Rich puts it, sexual intercourse is "off the menu."

Penis-in-vagina intercourse and orgasm through sexual intercourse alone is, however, difficult to achieve without an erection. This is the point of the statement in trying to help guide medical management for men dealing with physical causes of erectile dysfunction that are associated with cardiac disease. For much of non–coronary artery heart disease (such as hypertension and atrial fibrillation), sildenafil is considered safe. It would be doing our patients a disservice if we denied them a therapeutic option because of a misperception of risk.

If a man has *ever* used nitrates or is carrying prophylactic nitroglycerin, he should *never* take sildenafil. For men who fall in the third category of "maybe," such as those taking medications, such as amiodarone, or having a grade IV ventricle, treatment with sildenafil truly needs to be individualized. Potentially causing fatal hypotension needs to be weighed against reducing sexual anxiety of both men and their partners. As I pointed out in my accompanying editorial,[1] even with end-stage heart disease, sex remains an important concern for most men. At this point, a conversation between patient, cardiologist, and family physician would be fitting to weigh the benefits as well as the risks. Sometimes, helping couples explore other options than medication-induced sexual intercourse is the appropriate treatment.

The goal of treating sexual concerns is to help individuals and couples improve their emotional and physical intimacy, independent of their capacity for sexual intercourse. There is a four-letter word for intercourse: it is called "talk." Helping couples discuss their sexual concerns together and with their physicians can best lead to integration of appropriate psychological and medical therapies.

—Stephen Holzapfel, MD, CCFP, FCFP
Director, Sexual Medicine
Counselling Unit
Sunnybrook and Women's
College Health Sciences Centre
University of Toronto, Ont

Reference

1. Holzapfel S. Viagra and broken hearts [editorial]. *Can Fam Physician* 2000;46:257-9 (Eng), 267-9 (Fr).

Anecdotal evidence "impressive"

I am always interested in reading "Prescrire: Evidence-based drug reviews," and having read the one[1] in the February issue on olanzapine, I wish to mention an adverse drug reaction that occurred to a patient of mine taking olanzapine.

After several months of receiving 5 mg bid, this 49-year-old woman complained of muscle cramps in her neck, shoulders, and thighs. The medical student who examined her recommended a creatinine phosphokinase test be done. The result was 1572 U/L. The symptoms subsided, and her creatinine phosphokinase levels returned to normal 2 weeks after olanzapine was discontinued—admittedly anecdotal evidence but impressive, nevertheless.

—Ralph Scandiffio, MD, CCFP
Gloucester, Ont
by e-mail

Reference

1. Prescrire. Evidence-based drug reviews. Olanzapine. Keep an eye on this neuroleptic. *Can Fam Physician* 2000;46:321-6 (Eng), 330-6 (Fr).

Family physicians and maternity care

The March issue featured two papers[1,2] looking at the role of family physicians in maternity care. Using different types of data, both Kaczorowski and Levitt (administrative data) and Reid et al (survey data) paint a consistent picture of decreasing involvement of our colleagues in maternity care. The patterns are consistent over time with the slope of the decrease in involvement varying from province to province.

Despite this distressing trend and the paragraph entitled "Potential crisis" in Reid et al's paper, a subsequent paragraph states: "All these signs are encouraging for the future.... The CFPC will have to continue to work with other organizations to prevent the potential crisis...."

I suggest the crisis is already upon us. The trends are clear. The crisis is not the absence of family medicine from the maternity suite but the trend that will lead to this absence. I do not share Reid et al's optimism about the future or their confidence in the ability of the College of Family Physicians of Canada (CFPC) to reverse the trend.