differentially affect health-related QoL outcomes. Urinary control and sexual function were better after EBRT, although bilateral nerve-sparing (NS) surgery diminished these differences among potent men undergoing RP. BT caused more obstructive and irritative symptoms, and both forms of radiation caused more bowel dysfunction. These results may inform medical decision-making for men with localized prostate cancer [3].

In their longitudinal study, Pinkawa and coauthors [4] confirmed the common belief that if one waits long enough, the percentages of men developing erectile dysfunction following EBRT will reach similar values as after NSRP [5]. Unfortunately, the study misses the sexologic perspective. It seems to me that the authors have collected data on sexual functioning of their patients without taking active care of their sexual health. This aspect is the more disappointing because it is well established that sexologic counselling is an important determinator of regaining postoperative sexual functioning [6]. It leaves me with the hope that this study will stimulate the radiotherapy community to design and apply sexologic support programmes for their patients.

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DOI: 10.1016/j.eururo.2008.03.027

DOI of original article: 10.1016/j.eururo.2008.03.026

Editorial Comment on: Erectile Dysfunction After External Beam Radiotherapy for Prostate Cancer

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Erectile dysfunction (ED) represents a common sequela following external beam radiotherapy (EBRT) for prostate cancer [1–3]. However, despite its significant impact on quality of life, only a few studies have assessed the rate and the determinants of ED after EBRT [2,3].

In the study by Pinkawa et al [4], 123 patients treated with EBRT for cT1–3N0M0 prostate cancer not receiving any antiandrogen treatment were evaluated. Patient sexual function was evaluated up to 22 mo after EBRT by means of the Expanded Prostate Cancer Index Composite (EPIC) questionnaire. Important data can be derived from this study. First, this study represents one of the few prospective assessments of erectile function after EBRT. Second, this study reinforces previous evidence reporting a progressive decline of erectile function after EBRT [2,3]. Third, the importance of patients' stratification according to preoperative erectile function has been clearly shown. A significant positive correlation has indeed been found between preoperative and postoperative sexual function. Despite these advantages, the study is limited by important methodologic biases. The major limitation stems from lack of a stringent definition of posttreatment ED. The authors indeed used different definitions in the assessment of posttreatment ED. These were separately tested in univariable and multivariable logistic regression models. However, these definitions were strongly influenced by subjective patient self-assessment (ie, loss of nightly erections). This bias could have been avoided by clearly categorizing erectile function on the basis of different scores, such as those derived by the internationally known International Index of Erectile Function. Further-

more, as for radical prostatectomy, pretreatment erectile function was a major determinant of posttreatment erectile status. Indeed, 70% of the patients with ''at least poor'' pretreatment erectile ability ($n = 96$) retained this ability 1 yr after treatment. However, how did the authors define ''at least poor'' ability''? Can it be considered an objective and reliable assessment of erectile function? I doubt it. Moreover, if a correlation between preoperative and postoperative erectile function was found, this should have been confirmed by multivariable analyses, after accounting for other key variables associated with erectile function recovery after treatment (ie, age, comorbidities). However, this has not been done by Pinkawa et al [4]. Finally, we should also consider that erectile function recovery after primary treatment for prostate cancer is strictly related to the time of erectile status assessment [5]. However, in the study by Pinkawa et al [4], patients were not assessed at the same time after EBRT (range of evaluation: 12–22 mo after EBRT). Therefore, a time to event analysis (namely, Cox regression) would have been more appropriate for posttreatment erectile function predictions.

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DOI: 10.1016/j.eururo.2008.03.028

DOI of original article: 10.1016/j.eururo.2008.03.026