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REVIEW ARTICLE

Narrative-based sexual medicine. A collection of patients' stories and clinical cases to better understand the management of erectile dysfunction with type 5 phosphodiesterase inhibitors in the real life

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ABSTRACT

Introduction: Narrative-based medicine (NBM) integrates patient stories with the clinician's perspective and scientific evidence to personalize care. This approach is particularly well suited to sexual medicine. Sexual dysfunctions — especially erectile dysfunction (ED) — are highly multifaceted conditions in which individual histories and couple dynamics substantially influence diagnosis and treatment. Traditional evidence-based tools may fail to capture this complexity, as sexual symptoms emerge from the interplay of several connected systems.

Findings: This narrative review presents a series of realistic clinical vignettes illustrating the challenges of ED management within contemporary Italian sexual medicine, using the multidisciplinary Italian Society of Andrology and Sexual Medicine (SIAMS) guidelines as a normative framework. Each vignette is accompanied by scientific commentary grounded on evidence provided by the SIAMS guidelines. ED is framed as a sentinel symptom of systemic health, as postulated by the Systems Sexology which offer integrative models connecting the prescription of virtuous lifestyles with the type 5 phosphodiesterase inhibitors (PDE5i).

Conclusion: This perspective underscores the inadequacy of simplistic "symptom–pill" approaches and highlights the need for personalized, multidimensional care, including alternative pharmaceutical formulations of PDE5i, such as the orodispersible film, that may enhance discretion, acceptability, and adherence.

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Introduction

The "narrative-based medicine" (NBM) refers to a medical approach and an educational tool that integrates patient stories and experiences with the doctor's perceptions in the light of scientific evidence to personalize the treatment pathway [1].

The characteristics of sexual medicine, a discipline that connects basic research knowledge with clinical medicine, along with surgical and psychological expertise, make NBM particularly well-suited to this young science [2].

Sexual dysfunctions are, in fact, extremely multifaceted, and individual cluster of symptoms and of unique personal histories which play a dramatic role in both diagnosis and management. In particular, the characteristic of human sexuality to unfold within couples, not necessarily stable ones, constitutes a further complicating mechanism for clinical reasoning. Since Masters & Johnson [3], we learned not to consider the individual as the true and only dysfunctional patient, but rather to interpret sexual symptoms as the result – not always predictable with the evidence-based medicine (EBM) tools – of the multiplication of the perspective of one member of the couple with that of the other. This multiplication can generate what we have called, for example, Couplepause or Doublepause, when the sexual silence of one partner is silently echoed by the sexual silence of the other, amplifying the dyadic sexual dysfunction [4–6]. Another

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paradigm representing the role of the couple in generating sexual dysfunction is the Inferto-sex syndrome, i.e. the sexual consequences of infertility or of fertility search and the fertility consequences of the sexual dysfunctions of one of two members of the couple [7,8].

On these bases, systems sexology (SS) has been recently proposed as an extension of the biopsychosocial model, integrating biological, psychological, experiential, and societal determinants within a systems-medicine framework [9]. While the biopsychosocial model emphasizes multidimensional assessment, SS further incorporates chronic inflammation (producing endothelial dysfunction, affecting nitric oxide signaling, and generation oxidative stress), lifestyle-related noncommunicable diseases, and environmental determinants as interacting networks influencing sexual symptoms [10], avoiding the typical body/mind dualism of the majorities of the BPS approaches [11].

For this reason, we present here a series of patient stories, beginning with the longest and most complex, which summarizes many of the most challenging aspects of a physician treating the most common cause of sexual medicine consultations: erectile dysfunction (ED) [12]. Note that the clinical vignettes are representative of the clinical real life in Italy, a scientific environment particularly fruitful in the field of sexual medicine [13]. For this reason, the guidelines on the ED management recently produced by the Italian Society of Andrology and Sexual Medicine (SIAMS) will be used as a normative path [14]. These guidelines have also the merit to be the unique truly multidisciplinary document, having been signed and endorsed together with SIAMS, by the Italian Society of Endocrinology, the Association of Clinical Endocrinologists, the Italian Society of Diabetology, the Association of Clinical Diabetologists, the Italian Society of Internal Medicine, the Italian Society of Obesity, the Italian Society of Metabolism, Diabetes and Obesity, the Italian National Association of Hospital Clinical Cardiologists, the Italian Society of Interventional Cardiology, and the Italian Society of Psychopathology.

All the cases presented here are exemplary clinical histories extrapolated from real life and experience in the field of medical sexology and andrology. To preserve the patients' privacy. several personal characteristics have been transformed. The cases represent, in fact, composite clinical scenarios derived from routine practice. For rigorous scientific data, randomized controlled trials (RCTs), meta-analyzes, and guidelines from scientific societies are available. We will use these EBM data to comment on our modified cases, which closely correspond to reality and our clinical experience. A clinical and bibliographic comment is proposed at the end of each clinical vignette based on the scientific production of the Chair of Endocrinology and Medical Sexology (ENDOSEX) of the University of Rome Tor Vergata, Italy. The purpose of this narrative review is, in fact, to tell various patient stories, to listen the “real” voices and thoughts of the people attending a sexual medicine office, combining clinical data from several cases occurring in our daily life. The aim of this narrative review based on the authors' experience is to help the health care providers (HCPs), especially young people at the beginning of their clinical life, recognize the hidden needs of patients with ED, offering them the best integrated treatment in its most modern formulations and thus ensuring full therapeutic adherence.

Clinical cases

Case 1. Carlo, a prototype of erectile dysfunction

Carlo is a Senator of the Republic and is now 67 years old. He carries the burden of 25 kilos of excess fat, which he blames on the excellent refreshment bar in Palazzo Madama, the seat of the Italian Senate. He has always smoked a pack of cigarettes a day. As many politicians, Carlo is often busy meeting people, traveling, or attending conferences: there is little time for physical activity, which is mostly limited to a brief walk from his *pied-à-terre* to Palazzo Madama when in Rome. Carlo has always had a complex sex life: he's had affairs with many women, unbeknownst to his wife, with whom, without too much trauma and with the complicity of a somewhat premature menopause, he was in a sexual truce. They hadn't made love in a while. Carlo was one of the first users, almost thirty years ago, of the legendary *Blue Pill*. He even went to buy it in the little independent Republic of San Marino (the oldest in the world), when it wasn't yet sold in Italian pharmacies. Alcohol, smoking, obesity, a sedentary lifestyle, and stress had made him a classic ED patient: well before he turned fifty, his erections had begun to fade, and he often lost them during penetration.

Perhaps the urologist who first prescribed the pill hadn't done his job properly: instead of encouraging Carlo to change his lifestyle by losing weight, eliminating alcohol and smoking, and exercising regularly, he opted for the shortcut of the pill. Certainly, this way, the hands of the sexual clock were moving backward: perfect erections, at the right time, of the ideal duration. But failing to change his lifestyle, despite having brilliantly solved the problem (in the meantime, he had also added a little cocaine, but it was a short-lived passion), caused Carlo to have a heart attack. And he was lucky to have taken sildenafil which was, in fact, originally synthesized to protect the coronary arteries and it is currently used in appropriately selected patients not receiving nitrates [15], despite the (false) reports circulating in the media. However, like all drugs in this family, it is contraindicated in patients whose cardiovascular system is so compromised that they are unable to engage in sexual activity or who are taking other cardioprotective drugs for angina, such as nitrates. In this case, the effects would be cumulative, thus risking collapse. Carlo's heart attack was likely less serious than it could have been, thanks to the little but measurable cardioprotective effect of chronic use of sildenafil and other phosphodiesterase type 5 inhibitor (PDE5i). In any case, a coronary stent allowed our representative of the people and his coronary arteries to survive the changing political fortunes unscathed, alas without the Senator significantly changing his unhealthy habits. Indeed, new sexual opportunities convinced him to ask his doctor about switching to tadalafil, the active ingredient in the *Weekend Pill*, so named for its ability to last well beyond the 12 hours promised by sildenafil. Carlo took tadalafil on Tuesday late mornings, as soon as he arrived in Rome, to allow the drug to work in time for the evening (like a diesel engine, it takes a long time to "get going" but works longer than other pills), when he would have his first sexual encounter. Precisely because he didn't always need such a long-acting pill, Carlo alternated between his old gasoline-powered car (metaphorically, sildenafil) and his diesel-powered one, tadalafil.

He took the prescribed pills, but "Something was missing," Carlo said to himself.

It happened on a Friday. The Senate vote had dragged on, and Carlo didn't have time to change in his small Roman *pied-à-terre* before catching the last plane home. On Sunday morning, tragedy struck. His wife, emptying his pockets to put away his formal double-breasted suit, found the recognizable blue lozenge-shaped pill – Viagra, or sildenafil – and a handful of equally recognizable yellow drop-shaped medicines – Cialis, or tadalafil. The equation was clear: "If you don't have sex with me and you take these pills, it means you're having other affairs. We're getting divorced. And right away." Carlo soon found himself out of the house and with much less money in his bank account. But his political fortunes, and his fortunes as a seducer, weren't so greatly shaken. His newfound freedom, on the contrary, allowed him to begin a new Roman relationship with an ambitious, much younger woman, deeply in love. This time, as soon as the relationship was well established, and on the specialist's advice, the Senator decided to talk to his new flame about using love pills. And she, furious, replied: "So I'm not enough for you? So I don't excite you enough? But what if I'm 30 years younger than you and people turn around in the street when I pass by? Don't you know this stuff is bad for you? Don't you realize it's like making love to a robot?" Poor Carlo tried to convince the girl to come talk to the doctor, who would explain that they certainly weren't harmful, that he needed these pills, and that they didn't detract from her sex appeal; in fact, they would never work without the right amount of compelling sexual desire. In short, Carlo found himself alone again.

That's what Carlo was missing. Discretion! Privacy! Portability! How many partners of ED patients view love pills as rivals? In short, despite the extensive educational and media efforts that all experts have undertaken over the past few decades, too many women still fear love pills, and too many men still view them as a wound, a breach of their own fragile masculine identity, and are ashamed of it. One of the most daunting challenges an andrologist faces is determining, before prescribing, whether their patient's partner can be an ally in the therapeutic process or, conversely, a saboteur, an enemy of ED medications.

Meanwhile, someone had come up with the idea of "disguising" sex pills, making them unrecognizable and thus respecting the desire for discretion. A well-established and particularly powerful PDE5i with rapid onset of action, sildenafil, was taken and transformed into an orodispersible film (ODF, naturally, patients began calling it the "love film") that dissolves instantly on the tongue, completely without water, leaving breath smelling of mint. Sildenafil formulated as ODF represented, in

this case, a practical option to address the patient's concerns regarding discretion and portability: action perceived as particularly rapid and pharmacological potency enclosed in an unrecognizable little thin light-red film, approximately 24 mm wide and 32 mm long Carlo learned to keep the small film in his wallet and place it on his tongue like a perfectly innocent mint, in a gesture devoid of any particular visibility and certainly not medically connoted, whenever his partner (he's no longer able to bond with anyone, and claims he's fine with it) hints at the desire to make love. In a short time, an hour at most, but even just 25 minutes if he's fasting, the sildenafil ODF 50 mg dissolved in the mouth reaches its target, inhibiting the PDE5 enzyme. Once the inhibition is overcome, the natural erection, sustained by our Senator's unrepentant desire, manifests fully and steadily, for the entire time necessary for perfect lovemaking. And this happens for a duration compatible with satisfactory sexual activity, without either partner noticing.

Carlo's story could have been a parable of the expected behavior of a classic ED patient: consulting a doctor without hesitation for a diagnosis that takes into account the patient's clinical, relational, and psychological needs, modifying one's lifestyle and eliminating stress or its after-effects where possible, perhaps with the help of a brief course of psychosexual counseling, if not psychotherapy, and forgetting forever the most aggressive public enemies of male sexual potency at all ages: cigarettes, alcohol abuse, a sedentary lifestyle, animal fats, large binges, and short and troubled sleep.

In the story we've told, that's not how it went. Carlo pays for the consequences, endures the risks, and will forever be dependent on medication. But it could have been worse: just thirty years ago, Carlo would have been condemned to sexual silence, suffering from total ED, or forced to undergo painful, intimacy-destroying injections in his penis or a complex surgical procedure to implant a penile prosthesis. This is also why Her Majesty the Queen of England graciously granted knighthood to Simon Campbell, the chemist who, by pure chance, discovered that the blue pill not only protected the coronary arteries a little but also restored sexual happiness to legions of men and, therefore, couples. We suspect that the Honorable Senator Carlo would have wanted he would have gladly sent a telegram of congratulations to Dr. Campbell if experience had not taught him the importance of discretion.

COMMENT

This story represents a paradigm of how lifestyle may induce ED on one side and NCDs in the other [10]. The inability of several patients to modify their daily habit should not prevent the doctor from using the ED symptom as a lever for prevention through better adherence to prescriptions. However, it is also very important to listen to the patient's real needs: in this case, these are represented not only by the effectiveness of the treatment, but also by its discreet characteristics, a topic considered particularly sensitive by many patients. INTIMA is a new, well validated psychometric tool able to assess the patient-perceived perceived "Viagra jealousy" and to predict the risks of involving or not the partner in ED treatment and to identify optimal strategies for better adherence and outcomes [16]. This questionnaire, unfortunately, was not used because not available at the time of this story. Had it been used, it would have signaled with a red light the attitude of the patient's partners towards pharmacological treatments for ED.

Case 2 – The man who hid his fatigue

Marco, a 35-year-old accountant from Florence, booked an appointment with an endocrinologist for what he described as "a strange need to pee all night." He insisted his main problem was nocturnal polyuria, something he blamed on "maybe my kidneys." Despite his basic renal function tests being normal, his general practitioner insisted for him to consult an endocrinologist for the suspicion of diabetes insipidus.

All the other basic blood tests were normal, including complete renal function. Hormonal evaluation was almost entirely unremarkable, beside total testosterone being 10.5 nmol/L, low enough to raise questions but not enough to explain everything.

During the consultation, the endocrinologist noticed Marco carefully avoiding any discussion related to sexuality. When gently asked about energy levels, mood, and libido, Marco minimized everything – "I'm just tired, like everyone else." Only when the doctor explicitly asked about erections did Marco briefly admit that he had been experiencing erectile dysfunction (ED) for more than a year but had never spoken about it "because it felt embarrassing and not important enough."

Given the combination of fatigue, poor sleep, and nocturnal symptoms, the endocrinologist suggested screening for obstructive sleep apnea (OSA) – a possibility Marco had never considered. Overnight polysomnography revealed moderate OSA with significant nocturnal desaturation.

Within weeks of starting CPAP therapy, Marco's nocturia resolved almost completely, his daytime energy improved, and, much to his surprise, his erections returned without medication. He told the endocrinologist: "I thought the problem was my kidney… I didn't realize it was my breathing."

COMMENT

ED had been the hidden symptom, the one he was ashamed to disclose, yet it was the clue that led to the real diagnosis. According to the SIAMS guidelines on ED management, chronic pulmonary obstructive disease (COPD), a major NCD, is the third leading cause of death globally but also associated with an ED reported prevalence ranging from 72 to 87% of cases [14]. However, while the Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Lung Disease (GOLD) guidelines recommend the assessment of the state of sexual activity in chronic obstructive pulmonary disease men, they do not contain any suggestion on how to evaluate or manage the problem [17].

Case 3 – The graduate who blamed his laptopb

Luca, 27, had just finished his master's degree in engineering in Turin. He arrived at the clinic with a flushed expression, saying he had been unable to maintain an erection for the last four months. He attributed everything to "working too much on the laptop" and sitting for hours, convinced that poor posture was the main culprit.

When Luca entered the clinic, the doctor noticed him before he even sat down. His posture was tight and inward, shoulders curled slightly forward, as if he were trying to make himself smaller. He held his backpack against his chest, gripping the straps with both hands. He avoided eye contact at first, glancing instead at the certificates on the wall, the window, the floor – anywhere except at the doctor. When he finally sat, he chose the very edge of the chair, back straight, legs pulled close, as though he might spring up at any moment.

The doctor had seen this posture before: the posture of a young man terrified of being judged, ashamed of asking for help, rehearsing in his mind how to explain something he did not want to say out loud. His breathing was shallow, his fingers fidgeted constantly, and even the way he crossed and uncrossed his legs betrayed unease. Before the consultation even began, the doctor understood this would require gentleness: slow questions, long pauses, and a space in which Luca could feel safe enough to speak honestly about something he had been hiding even from himself.

The truth, indeed, emerged slowly. Luca had recently ended a long-term relationship and had been consuming pornography excessively during the period that followed. Sexual encounters with a new partner suddenly felt intimidating, and erections vanished as soon as intimacy became real.

Hormonal tests were normal. No metabolic comorbidities. But his anxiety levels were extreme, and he described feeling "disconnected" from real intimacy.

Luca received a combination of psychological support, sexual therapy, and a short trial of PDE5i helped him regain confidence. Since he was anxious about the discreetness and the discreet portability of the drug, sildenafil was selected in the ODF pharmaceutical form.

When he returned months later, he said: "I thought I had broken myself. Turns out I just needed to relearn who I was."

COMMENT

The story of Luca is a typical representation of ED with a major component due to anxiety. The association of talking therapy with drug was particularly efficacious. However, a key hidden point was related to need of Luca to count on discreet formulation offering an unique benefit to patients with ED by improving their acceptance and compliance and respecting their privacy and the need for a discreet treatment, with a perceived short onset of action [18]. In this case, the late T_{max} of tadalafil would have produced frustrations and more anxiety [19]. This pharmacokinetic parameter is, in fact, much shorter in sildenafil, vardenafil, and avanafil with respect of tadalafil [14]. Furthermore, the ODF formulation

may further increase the perception of short onset of action, particularly in fasting conditions. In several cases, this characteristics better met the patient's expectations. [18]

Case 4 – The banker with silent diabetes

Alberto, a 49-year-old bank manager from Milan, requested "the strongest pill available" because he no longer responded to maximum-dosage vardenafil, a PDE5i with a good pharmacological efficacy.

He insisted the problem was strictly mechanical: "Give me something stronger. Everything else is fine."

In the attempts to give a comprehensive evaluation of his condition, the doctor prescribed him some routine glucometabolic and hormonal tests.

His fasting glucose was 146 mg/dL. HbA1c: 8.2%. He had undiagnosed type 2 diabetes, likely for years. Diabetic neuropathy and endothelial dysfunction were already present. Instead of escalating medication, the endocrinologist started him on lifestyle interventions, antidiabetic medication, and a more powerful PDE5i, such as sildenafil citrate. Six months later, both his glycemic control and erections improved.

Alberto later admitted: "ED forced me to check what I didn't want to check."

COMMENT

Comparative studies using objective measurements – such as the dynamic echo-color doppler ultrasound (CDU) evaluation of the penile flows – have proven that the most powerful treatment from a vascular perspective is sildenafil, the drug selected for this patient [20]. This evidence is particularly important. In fact, although operator-dependent, dynamic CDU with prostaglandin injection has been proven to be a safe and efficacious diagnostic technique to evaluate the vasculogenic ED [21]. Notably, sildenafil has been also found to have a specific ability to ameliorate the endothelial health [22,23]. Finally, since the value of dual-energy computed tomography (DE-CT) angiography has been recently compared to that of the CDU [24], this unbiased, safe evaluation of the vascular status of the penile bed in patients with ED could become in the future another tool to evaluate the efficacy of PDE5i [25].

Case 5 – The thyroid mask

Gianni, 54, a police officer from Southern Italy, came to the clinic convinced he had "low testosterone." For six months he had suffered from progressive ED. He felt otherwise fine - no weight loss, no palpitations, no tremors. Just ED.

Routine blood tests told a different story. Instead of low testosterone, the lab reported a total testosterone above 52 nmol/L, surprisingly high for his age. The endocrinologist ordered other tests, which showed a markedly elevated SHBG (132 nmol/L), which explained the paradoxically high total testosterone, and a significantly reduced calculated free testosterone (277.4 pmol/L), consistent with the patient's symptoms. Thyroid functions tests showed a suppressed TSH < 0.005 mIU/L, with elevated fT4 and fT3, revealing that Gianni was in marked hyperthyroidism. The extraordinarily high testosterone was almost certainly explained by increased sex hormone binding globulin (SHBG), a common biochemical effect of thyrotoxicosis that raises total testosterone while leaving bioavailable fractions unchanged.

A neck ultrasound revealed a longstanding multinodular goiter he had always ignored. After discussion with the surgical team, Gianni underwent thyroidectomy. Post-operatively, thyroid levels normalized, SHBG dropped, and testosterone returned to physiological ranges. Within a few months, his erectile function gradually improved without the need for specific symptomatic treatments.

At follow-up, he said: "If I hadn't had ED, I would never have checked my thyroid. I thought everything was normal."

His case became an example for medical students: ED was not the disease, but a symptom pushing a good clinician to look deeper.

COMMENT

It is very important to check for all possible treatable risk factors leading to ED or comorbid with them. Hyperthyroidism is one of them, as it has been demonstrated to induce premature ejaculation (which was not the case here), hypoactive sexual desire disorder, and ED [26]. Notably, in this case, it was not needed to add a symptomatic treatment of ED, nor a testosterone supplementation, to the thyreostatic drug [27].

Case 6 – The law student who collapsed under expectations

Valerio, 23, was in his third year of law school in Rome. He arrived at the clinic whispering, barely audible, embarrassed even to sit in the waiting room.

He had been experiencing ED for three months, tracing its origin to the night before an important exam: "Something snapped. Since then, nothing works anymore."

As the doctor listened, it became clear that Valerio lived under relentless pressure to excel. His parents were both lawyers, each with strong expectations about his academic performance. Intimacy had become part of that same system of evaluation – another arena in which he felt he had to "perform" perfectly. Whenever he approached a partner, his body froze. Desire was overshadowed by fear. Anticipatory anxiety became a self-fulfilling prophecy.

His physical and laboratory examinations were completely normal: no hormonal abnormalities, no metabolic issues, no medication side effects. What emerged instead was strong anticipatory anxiety, compounded by perfectionism. The doctor suggested psychotherapy to help Valerio reframe intimacy as connection rather than evaluation. To support the process and interrupt the cycle of fear, the doctor also prescribed on-demand generic tadalafil 5 mg, a low-dose medication taken before sexual activity.

Valerio was initially hesitant – he feared it meant he was "failing even more."The doctor reassured him: "This isn't a crutch. It's a tool. Something to help your body remember what it can already do." However, the choice for the generic, the low dose, the lack of good counseling from the doctor, the on-demand prescription, which does not meet the daily use established for the 5 mg dose, prevented the patient to assume the drug. A typical case of lack of adherence.

A second opinion doctor associated a deep counseling with the prescription of branded sildenafil ODF 50 mg. In this case the compliance of the patient was excellent. In particular, he said: "this formulation meets my needs and expectations. I feel stronger now and more reassured."

The impact was gradual but unmistakable. The medication allowed his body to respond when his mind was still learning to trust itself again. Positive experiences rebuilt confidence, and confidence softened anxiety. Within months, Valerio began reducing the number of assumptions of ODF as therapy took effect, and his erections became reliable without pharmacological support.

At his final follow-up, he summarized everything in a quiet, almost surprised tone: "For the first time… sex isn't an exam. It's just me."

COMMENT

The SIAMS document is the first guideline mentioning ODF because this formulation, in addition to the benefit of all orodispersible formulations, enhances bioavailability [18,28]. "Moreover – SIAMS writes – the ODF formulation respects the need for privacy felt to be essential by several patients for a perfect compliance with the ED oral treatments" [14]. In the juvenile setting, the stigma of being prescribed with a PDE5i could be even deeper and more impacting that that one occurring in more mature populations. For this reason, the respect of privacy granted by a "non-pill" formulation which masks the pill under the film assumed without water is currently having a strong favor from the Italian patients.

Case 7 – The young couple who never talked

Simone, 22, came with his girlfriend Marta, both visibly uncomfortable. They had been together for four years, and Simone had never had a full erection during partnered sex.

He feared this meant he was "defective." She feared he did not find her attractive.

When Simone and Marta first entered the consultation room, they sat close together but without touching – two parallel lines, near but not connected. At first glance they appeared a solid couple, four years of shared history, a familiar rhythm in the way they looked at each other before speaking. But it took the doctor less than five minutes to notice that something fundamental was missing. As the discussion moved gently toward intimacy, their miscommunication revealed itself not in what they said, but in what they did not. For instance, when the doctor asked Simone what he thought Marta enjoyed during sex, he hesitated, looked at her briefly, then shrugged. Marta did the same when the doctor asked about Simone's preferences. Their answers were vague, cautious, as if they were trying not to say the wrong thing. They weren't hiding secrets – they simply did not know.

Even simple questions highlighted the gap. “Do you ever talk about what you like or don't like?” the doctor asked.

They both shook their heads, almost embarrassed. “Have you ever asked each other what feels good, or what makes you anxious?.”

Another shared silence, heavier this time.

It became clear that Simone believed Marta expected a certain kind of performance he felt unable to provide, while Marta believed Simone's hesitations meant she was not attractive enough. Each had built a narrative in their own head, and each was completely wrong about the other. The doctor realized that the ED was not the problem, rather it was the consequence of years of unspoken fears, gentle assumptions, and a mutual reluctance to be vulnerable. What struck the doctor most was how much love was in the room, yet how little they had ever allowed that love to guide them into an honest conversation.

When the medical sexologist suggested starting with simple communication exercises – questions to ask each other at home, small truths to share without judgment – they both nodded with a mix of relief and apprehension. For the first time, they turned toward each other rather than away.

Later, when they returned for follow-up, the doctor could immediately see something had changed. They sat closer, shoulders touching lightly, and the tension that once lived between them had dissolved into something gentler, something cooperative. It was not a pill that had repaired their intimacy, but the realization that after four years together, they had finally begun to truly meet.

Their last session ended with Marta saying: “We didn't need a pill. We needed a conversation.”

Discussion

As per the SIAMS guidelines, in the Recommendation # 23 it is recommended considering anxiety and depression as independent predictors of ED and its severity, while the Recommendation #25 recommends considering relational and marital factors as major risk factors for developing and maintaining ED [14].

Case 8 – The man with the missing libido

Miguel, a 43-year-old chef working in Rome, reported “total loss of libido,” followed by ED. He was convinced that working late hours and stress were to blame.

The urologist asked him to perform a Rigiscan to determine whether his problem was organic or “psychogenic,” as he wrote in the request. The results were inconclusive, as he had three nocturnal erections of acceptable duration, but never achieved the 100% of hardness.

But his history hinted at something else: profound fatigue, recent weight gain, cold intolerance, a depressive trait. The thyroidal nuance convinced the doctor to test hormones. Tests confirmed severe hypothyroidism (TSH > 20 mIU/L, decreased fT3 and fT4). After having excluded other hormonal deficiencies and starting levothyroxine, both libido and erectile function progressively normalized.

He joked during the final visit: “I thought I needed a pill. Turns out I needed a thyroid.”

COMMENT

The use of the Rigiscan as unique tool to establish the organic or non-organic (a term much more correct than that of « psychogenic») nature of ED is not anymore considered a gold diagnostic standard due to the high cost and low sensitivity and specificity [29]. Moreover, the SIAMS guidelines suggest to check thyroid function in patients with a clinical picture, as that one described here, suggesting a thyroid involvement in the sexual symptom [14].

Case 9 – The subclinical cyclist

Jeroen, 33, a Dutch software engineer living in Milan, had cycled to the clinic – of course. He cycled everywhere.

He complained of intermittent ED and occasional penile numbness. “I can penetrate – he said – but with an erection which is not 100%, and this very boring to me: I am also afraid that my partner also is feeling the same.” Analytical, rational, he had already ruled out psychological factors and wanted “evidence-based answers.”

His exams were unremarkable. Instead, a focused history showed he padded his bike seat improperly and rode long distances with an aggressive aerodynamic posture. Urological exam and nerve testing suggest an initial perineal nerve compression, a possible risk among long-distance cyclists.

After 3 months of a physical and psychological rehabilitation run with 50 mg of sildenafil ODF every other day, switching seat type, altering posture, and reducing weekly mileage, symptoms improved dramatically.

He later said: "I thought cycling made me healthy… apparently not that healthy."

COMMENT

The role of heavy biking in producing ED is still under debate. Aerobic sports are beneficial for the endothelium, particularly for that of the corpora cavernosa. However, in some cases of heavy off-road cycling training, using inappropriate saddles, a sort of pincer movement between the bicycle seat and the hipbones joined by the pubic symphysis can reduce blood flow to the penis or nerve conduction in the reflex arc used to achieve and maintain an erection [30]. In Jeroen's case, this could be a contributing factor, producing not clinical ED, but rather a subclinical form [31]. Erectile dysfunction, in fact, is clinically defined as "the chronic inability to achieve and/or maintain an erection for satisfactory sexual activity" [32]. But in the case we are describing, the loss of erection is only partial and fails to prevent penetration. Therefore, it cannot properly be considered a case of ED [25]. On the contrary, it perfectly meets the major and minor criteria for subclinical ED (SED), a condition which may work as a precursor to clinical ED and that must be treated with counseling, change in the lifestyles, and in selected case with a PDE5i, such as sildenafil 50 mg ODF, to interrupt the vicious cycle of anxiety and the anticipation of failure [33].

Case 10 – The man who mistook depression for ED

Antonio, 46, entered the clinic looking exhausted in a way that went beyond poor sleep. He moved slowly, and when he sat down, he kept his jacket on, gripping the sleeves as though he needed the pressure to stay present.

He opened the consultation with a simple sentence: "My erections aren't working anymore." He said it flatly, almost mechanically, like someone reporting a technical malfunction rather than a human experience.

As the doctor began asking questions, something became immediately apparent: Antonio answered everything about his erections quickly and superficially, but hesitated whenever the conversation touched other areas of his life.

The doctor asked about libido. A long pause. "I don't know. I don't feel much of anything these days." Sleep? He sighed. "Two, maybe three hours a night… on a good week." Appetite? He shrugged: "Foods taste like almost the same. Not much appetite recently". Energy? He gave a small, defeated smile: "What energy?."

His wife had encouraged him to come, saying he "wasn't himself anymore." Antonio dismissed that with irritation. "She exaggerates. I'm just stressed."

But the doctor noticed more subtle clues: the way Antonio kept avoiding eye contact, the monotone voice, the slowed speech, the way he described his days as identical, numbing, empty. Even the way he sat suggested something deeper than sexual dysfunction.

When the doctor gently explored his emotional state, Antonio's composure cracked for the first time.

He looked down. His eyes watered. "I… don't feel joy. Not at work, not at home. Not even with my kids. I thought it was just exhaustion."

A validated questionnaire was administered, revealing severe depressive symptoms. His hormonal tests, glucose, thyroid function, all came back normal. There was no apparent organic cause for his ED.

The real diagnosis was major depressive disorder, with ED as a secondary manifestation. When the doctor explained this, Antonio seemed almost relieved.

The psychiatrist decided to delay antidepressant therapy, starting just with psychological support. The first improvements were subtle: a little more sleep, fewer mornings filled with dread, a return of small pleasures.

His sexual function recovered gradually, paralleling his emotional healing, helped by a PDE5i used on demand.

Months later, Antonio reflected on the journey: "The ED was the only part I could see… but the depression was what was drowning me."

COMMENT

According to the SIAMS guidelines, in the Recommendation #24, it is advised to consider "intrapsychic factors as major risk factors for developing and maintaining ED" [14]. Furthermore, it is advocated, when treating anxiety or depressive disorders, to prescribe psychotropic drugs with a lower risk of worsening ED [34].

Case 11 – The silent heart warning

Paolo, 62, a retired train conductor, complained of a gradual decline in erectile function. He dismissed it as "normal ageing" and requested "a stronger pill."

But his history suggested something more ominous: mild exertional fatigue, shortness of breath when climbing stairs, and occasional chest tightness.

An ECG revealed ischemic changes: subtle ST-segment depressions that Paolo had never noticed because he rarely allowed himself to slow down long enough to feel his own body. Further cardiology evaluation, including stress testing and coronary angiography, confirmed significant coronary artery disease. What struck the team was the timeline, being the vascular impairment affecting penile arteries manifesting long before the larger coronary vessels became symptomatic.

ED had been his earliest symptom, months before any cardiac event. It was the quiet whisper of endothelial dysfunction, a warning signal he had ignored until it forced him into medical care.

After successful revascularization, the improvement surprised even him. His energy returned, his breathing eased, and his erections, once dismissed as "ageing," recovered far more than he had expected. It became clear that treating his heart had also restored a piece of his identity he thought was gone for good. However, during sexual activity the erectile function was not fully achieved.

At the final visit, when he said: "The heart was asking for help. The ED made me listen," he received from the andrologist sildenafil 50 mg ODF on demand with the agreement of the cardiologist. This surprised the general practitioner, who tried to convince the patient not to assume the drug considered, she said, "very dangerous for the heart." However, upon the reassurance of the two specialists, Paolo used the drug resuming a quiet but satisfactory and regular sexual activity, which increased his self-esteem very much.

COMMENT

The story of Paolo is a paradigm of the false, but tremendously popular in the general population (and unfortunately also among HCPs), assumption that PDE5i are not indicated in cardiovascular patients and that they can worsen the cardiac performance. However, the pro-erectile sildenafil has been serendipitously discovered in the search of a new cardioprotective treatment and plenty of evidence support the idea that these drugs maintain a measurable cardiovascular protection [15].

Case 12 – The musician lost on tour

Elliot, 29, a guitarist touring across Europe, walked into the clinic while performing in town. He described himself as "exhausted, wired, and unable to perform – sexually, I mean."

His schedule was chaotic: late-night concerts, alcohol, erratic sleep, and frequent travel. He reported sudden-onset ED and "no sexual desire whatsoever," which frightened him.

When Elliot finally agreed to undergo testing, his basic labs were largely unremarkable. What stood out was the four-point salivary cortisol profile the doctor ordered specifically because of his disordered lifestyle. Instead of the typical steep morning peak followed by a gradual decline, Elliot's curve was flattened and disordered: a blunted morning cortisol and elevated evening values, the classic fingerprint of chronic sleep disruption and circadian strain.

It was the physiological mirror of his touring life: late nights, erratic meals, adrenaline surges, and stretches of insomnia stitched together with energy drinks and hotel room naps. His body no longer knew when it was supposed to be awake, let alone when it was supposed to be intimate.

The musician was also used to buy counterfeit PDE5i to support his weak erection. The output of this self-treatment was totally unpredictable, exactly as his lifestyle.

The diagnosis was not mysterious anymore: circadian dysregulation with stress-related sexual dysfunction. By restructuring his tour schedule, enforcing protected sleep windows, reducing alcohol and stimulants, and practicing wind-down techniques, his cortisol rhythm gradually normalized. As it did, his libido resurfaced, and erections began returning with reassuring consistency, without the need to buy dangerous "drugs" on the Internet.

He later joked on that: "So it's not that I don't want sex, it's that my body doesn't know what time it is."

COMMENT

PDE5i are within the most counterfeit drugs, and their illegal market is unfortunately expanding. Governments and regulatory agencies tried several strategies to reduce the risks for the exposed patients. However, the majority of them did not reach the goal. One of the most efficacious, however, has been found in the ODF technology, which is too expensive for counterfeiters [35].

Case 13 – The post-SSRI sexual dysfunction

Gabriele, 26, had been prescribed an SSRI one year earlier for debilitating anxiety. The medication helped him almost immediately: the panic attacks stopped, his breathing steadied, and his life regained a sense of order. When his mental health stabilized, he and his psychiatrist agreed to gradually discontinue the SSRI. But soon after stopping the therapy, his erections weakened. At first he dismissed it as stress, or fatigue. Only when he attempted sexual activity with his partner did he realize that arousal felt different – muted, distant, as if filtered through a layer of cotton.

His psychiatrist reassured him initially: "It's common. It will improve."

But it did not. Even after waiting a few months, the sexual numbness persisted.

He described it haltingly to the doctor: "It's not just erections. It's like my body doesn't feel pleasure the same way… like someone turned the volume down."

Yet, months after full withdrawal, the sexual symptoms remained unchanged.

Morning erections were absent. Sexual thoughts triggered no physical response. His genital sensitivity was significantly reduced. This persistence, despite cessation of the drug and resolution of anxiety, pointed towards a troubling, though still poorly understood, entity: Post-SSRI Sexual Dysfunction (PSSD).

His medical work-up indeed was normal, and the contrast between his restored mental serenity and his persistent sexual blunting was striking. Treatment then focused on four pillars: psychoeducation, helping him understand he was not imagining the symptoms; behavioral and sensory retraining to enhance genital–brain signaling; trial of PDE5i (vardenafil 20 mg, on demand, assumed 1 hour before the intercourse), which improved rigidity but not sensation; close psychiatric follow-up, ensuring no re-emergence of anxiety or depression.

Recovery was slow and uneven. Some mornings brought slight tumescence; some encounters triggered faint arousal.

At a follow-up three months later, he said: "It's not perfect, but something is waking up again. At least I don't feel numb anymore."

The doctor knew that cases like his were complex – not hopeless, not irreversible, but requiring patience, validation, and a multidisciplinary approach.

COMMENT

The PSSD is a complex, almost unknown, but destructive condition where the most characterizing symptom is a peripheral (but also central) anhedonia, i.e. inability to read sex, sexual pleasure, orgasms as pleasurable and rewarding, associated with several other sexual symptoms, such as reduced libido, ED or SED [36]. These insidious and dramatically prolonged, even after dismission, side effects of antidepressants might be frequently underestimated during common clinical practice, especially by nonpsychiatrists [37]. No one therapy has been found able to cure the PSSD, which could be supported by PDE5i, waiting for the spontaneous resolution of the sexual symptomatology.

Case 14 – The elderly gentleman with a new love

Giovanni, 74, widowed for ten years, had recently started dating a woman from his choir group. He arrived at the clinic dressed elegantly, shyly explaining that he had erection difficulties "after many years of inactivity."

His cardiovascular status and metabolic profile were surprisingly good for his age. His blood pressure was well controlled without medication, his fasting glucose normal, and his lipid profile enviable. The only issue that emerged was the predictable age-related endothelial decline as revealed by the dynamic penile ultrasound, showing a suboptimal response and a gradual loss of vascular responsiveness that affects most men long before they are willing to talk about it.

The doctor explained that nothing was "wrong" with him, his body was simply following the natural trajectory of ageing. Giovanni listened carefully, relief softening the lines on his face. For years he had feared that intimacy at his age was something forbidden by biology, rather than something simply needing a little support.

A low-dose PDE5i (sildenafil 25 mg on demand, 1 hour before the intercourse) was prescribed, not as a miracle cure but as a gentle boost to the vascular system he had kept remarkably healthy. The response was almost immediate. Within a few attempts, rigidity and confidence returned, not exaggerated, not youthful, but sufficient, dignified, reassuring. Since the partner was well supported by the gynecologist in her post-menopausal sexual life, the couple was considered well treated for its Couplepause.

More than the erections, what mattered was how he felt afterward. He told the doctor at his follow-up visit: "It wasn't about being young again. It was about feeling allowed to be alive again."

COMMENT

Couplepause and its derivate Doublepause (which could be applied also to non-heterosexual couples) are new complementary paradigms that effectively address the sexual health needs of aging couples, taking into account physical, psychological, cultural, social, and dyadic-related factors. The message carried by the Doublepause/Couplepause is that even a successful treatment of one member of the aging couple without considering the sexual health of the other member will produce a final therapeutic failure [5,6]. On the contrary, the HCP could "«use» the more motivated member of the couple to increase the adherence of the other to the needed changes in the lifestyle. This virtuous couple has been named «anti-inflammatory»" because of its ability to face subacute inflammation, leading to both NCDs and sexual dysfunctions in general and ED in particular [38].

Case 15 – The chef who forgot to rest

Mateo, 45, an Argentine chef running a busy restaurant in town, worked for 14-hour days.

He reported ED and near-constant fatigue. His diet consisted of coffee, cigarettes, and occasional bites of whatever dish he was preparing. Tests showed prediabetes, high triglycerides, and borderline low testosterone, classic signs of metabolic stress.

"Cooking for others was easy", he said. "Cooking a healthier life for myself… that was the hard part". However, he was successful in changing his habit. Lifestyle modification was tough in the restaurant world, but with structured support, he slowly improved. His energy returned first, then his libido, but not his erections during sexual activity. He was prescribed with a PDE5i, but keeping them in the clothes or in the pocket (he didn't want to communicate the treatment with the younger wife Marcela) produced a particular anxiety. He told the doctor: "Look, in my kitchen the temperature is sometimes even more than 40 °C and I cannot leave the medicine at home, or she will discover my little secret".

The doctor took seriously the patient's need and prescribed sildenafil ODF 50 mg, the unique formulation which has been found stable at 60 °C for the three weeks of the experimental setting.

The reassured Mateo is now using the drug, but the doctor predicted him that, if the adherence to the correct lifestyle (he lost 4 kilos just with a healthy diet) continues over the time, he will not need the PDE5i anymore in the near future.

COMMENT

Smoking, unhealthy diet, sedentary life, and alcohol and drug abuse are producing a chronic subclinical inflammation and oxidative stress to all tissues and in particular to the genital endothelium [39–41]. All guidelines agree that the first therapeutical intervention in ED is the modification of the wrong lifestyles [14]. In refractory patients, the prescription of the PDE5i, in particular the ODF formulation which warrants improved ease of intake, taste, portability, storage, and compliance among ED patients, making it the potential most preferred formulation and drug of choice [18], could be negotiated with the patient adopting correct lifestyles.

Case 16 – The body builder

Federico, a 38-year-old body builder, came to the clinic for erectile function complaints. He was well known in his local gym. Strong, disciplined, obsessively focused on improving his personal best. When he walked into the clinic, he carried himself with the confidence of someone used to pushing through discomfort, but his voice betrayed him:

"My erections… they're just not there anymore".

At first, he blamed stress from training. He insisted he was "just tired," that weight-lifting competitions preparation was demanding but manageable. Yet the doctor noticed the clues immediately: a slightly flushed complexion, prominent acne along the jawline, small testicles on examination, and an irritability that simmered beneath his polished athletic *façade*.

Federico avoided eye contact when asked about supplements.

"Yes, protein. Creatine sometimes".
"And anything else?".

A pause.

"No… nothing…"

The hormonal panel told a different story. Total testosterone was very high (67.6 nmol/L), with undetectable FSH and LH, suppressed SHBG, mildly elevated estradiol, slightly abnormal liver enzymes and unfavorable lipid profile. These results painted a classic picture: exogenous synthetic androgen use plus testosterone, with pituitary suppression.

When gently confronted, Federico's *façade* cracked. He admitted he had begun using anabolic steroids – first low doses, then stacking them – after a disappointing result in a regional competition. He rationalized it as "temporary," just to break a plateau. But soon the muscle gains, the confidence, the competitive edge became addictive. Stopping terrified him, yet continuing was destroying his sexual function.

"I didn't think it would happen so fast" he said.

"Nobody tells you steroids take your erections before they take your health".

The doctor explained the pathophysiology: how supraphysiological androgens shut down the hypothalamic–pituitary–testicular axis, leading to testicular atrophy, suppressed spermatogenesis, and often severe ED. Federico sat silently, absorbing the weight of it.

The rehabilitation plan required immediate cessation of all anabolic agents, careful monitoring of liver and metabolic parameters, structured psychological support to address performance obsession and strict follow-up, as recovery could take months.

The first weeks were brutal. Withdrawal from androgens left him fatigued, irritable, insecure. His sexual function initially worsened. He admitted to feeling "like a balloon deflating."

But gradually, with medical guidance, LH and FSH began to reappear in his labs. Endogenous testosterone rose slowly. Morning erections returned sporadically at first, then more consistently. He arrived at one follow-up visit with an expression of cautious relief: "It's not perfect yet… but it's coming back. I'm coming back."

He reduced his training volume, abandoned the belief that performance was his only identity, and rediscovered the joy of exercising without chemical shortcuts.

The doctor later reflected on his case as a reminder: ED is not the symptom of weakness – but the body's final plea to stop a path of self-destruction.

COMMENT

The perception of ED in young generations is peculiar. They are very much afraid of it, having a predominant model in the unrealistic erection of pornography, an attitude exacerbated by the recent pandemic [42]. Moreover, the majority of doctors believe erroneously that the youth age is not compatible with erectile failure unless a major psychological problem is present. More research is needed, in fact, to better explore the clinical characteristics of organic juvenile ED.

Discussion and conclusion

Sexual medicine is a young discipline generated by marriage of the anecdotal knowledge of psychology and psychosexology with the hard evidence typical of medical (endocrinology, internal medicine, psychiatry) and surgical (gynecology and urology) sciences. This unique and extraordinary wedding has not been without difficulties, shocks, and conflicts, still not entirely resolved [2]. In any case, the matrimonial product of conception – SM – as happens with every branch of medicine, retains its nature as art and mastery, being its practicing complex and quite operator- and experience-dependent [43]. In fact, there are many aspects of sexual medicine that have not been tested (or cannot be tested) in RCTs, nor are easily amenable to positive research. What produces a real expert in SM is certainly education (still lacking in most of the universities) [44], but also the years of humble clinical experience, constant ability of self-reflection and coping with personal beliefs about sexual ethics, striving for non-judgmental and empathetic patient-centered care, and the acquisition of cumulative wisdom in human sexual health.

The goal to reach the best clinical practice in SM is indeed a combination of EBM and anecdotes and clinical stories told by experts who have dedicated their entire lives to this charming field of science. Like all anecdotes, they only reveal a small part of medical art and cannot, nor should, be generalized. However, they can be valuable in breaking away from a dangerous and pointless reliance on guidelines alone, not always signed by proven experts in the field, but by panels selected based on geopolitical considerations. While technological advances and artificial intelligence may support clinical decision-making, they cannot replace the relational and interpretative dimensions inherent to sexual medicine [45].

All these considerations seems dramatically suitable for ED, which is a complex and multifaceted symptom that reflects most systemic and organ dysfunctions, particularly the five most common causes of morbidity and mortality in developed regions: cardiovascular diseases, metabolic diseases, oncological diseases, respiratory diseases, and psychiatric diseases, particularly mood disorders, but at the same time dramatically impacts on the other member of the couple, which amplifies who in turn dramatically experiences the ED symptom and returns it amplified, as the Doublepause paradigm demonstrates [6]. What is the common factor among all these pathological conditions we presented here? Most of the clinical cases we've described illustrate this: the lowest common denominator is inflammation. The characteristic chronic, low-grade inflammation is the central, underlying driver for ED and, at the same time, for most NCDs, acting as a key link between unhealthy lifestyle factors (smoking, addiction to drugs, wrong diet, physical inactivity, alcohol abuse, stress, poor sleep) and disease development, often alongside oxidative stress and immune system dysregulation, necessitating behavioral changes for prevention and management [39].

The discipline handling the sexual effects of the "dark triad" of wrong lifestyle/inflammation-oxidative stress/NCDs is the mentioned SS, which is a modern approach, exquisitely interdisciplinary in its vocation, that uses data from various sources, including genetics, lifestyle, and environment, to develop personalized sexual treatments and predict sexual symptom and disease outcomes [10]. It integrates the classic BPS model [46] by examining the environment, the history and the traditions, the society, the political and economic choices and the *Zeitgeist* as producers of health or diseases, as well as the complex, large-scale datasets using computational models and simulations to gain a holistic understanding of human physiology and disease. This enables early detection of illnesses, tailored therapies, and the optimization of wellness for individuals and communities. The SS is an evolution of the BPS model, and uses the same approach to understand sexual symptoms and syndromes, considered as typical topics of the social and internal medicine [9].

But the lesson of the SS gives more even more insights. The particular physiology of human sexuality during evolution and the peculiar architecture of the organs used for sex in our species transform ED (but also sexual desire disorders, female hypolubrication, and even reproduction itself) into a highly sensitive predictor of the individual's health, as well as – with some extents – that of society itself [47]. The meaning of the "canary in the coal mine" metaphor lies precisely in the sexual symptom's ability to anticipate, even by many years, the clinical onset of NCDs. It is, in fact, like the famous canary that miners took with them into the mines because it was more sensitive than humans to gas leaks, it would faint prematurely, warning the miners to change their route while there was still time [48].

All these reasons help us better understand the clinical cases presented here as realistic representations of our clinical experience. At the same time, we hope that the new approach of the Narrative-

based Sexual Medicine presented here may help the doctor to recognize that careful listening the patient's stories (and that of the couple, when possible), in the light of the EBM, is the unique possible strategy in the field of human sexuality. It appears in fact mandatory to give up psychological reductionism ("it's all in your mind"), which is not tenable anymore. At the same time, the pivotal message of these clinical cases here described is that the oversimplified model of the medical reductionism: "Doctor, I'm impotent"/"Take this pill" can no longer be applied in the vast majority of cases treated by the contemporary HCP [49]. Finally, the time has come to also renounce the Manichean reductionism of the mind-body dualism that still pervades most guidelines [9,11]. By rejecting these three reductionisms: psychological, medical, and Manichean, the sexual medicine expert must, in fact, aim to make the diagnosis and to manage ED by recognizing the pathophysiological role of one or more of the four systems described by the SS paradigm: the system of the mind (with intrapsychic and relational issues), the system of experience (education, religion, sexual history, etc.), the system of society (political and economic choices that produce health or illness), and the system of the body in its various functions and dysfunctions.

Despite their clinical efficacy and safety profile, the dropout rate of traditional PDE5i is up to 50% [50]. This is due to a combination of wrong expectations, incorrect information, presence of comorbidities, marital and intrapsychic factors, as well as unmet needs [51,52]. Hence, HCPs dealing with subjects seeking medical care for ED should be aware that a tailored therapy should be based on adequate counseling and understanding the patients' needs, which are the cornerstone for the success of any sexual treatment. In the future, more robust data with respect to those currently available may suggest the association of PDE5i with external shockwave therapy for severe vasculogenic ED [53].

The new ODF 50 mg formulation of sildenafil, one the most powerful PDE5i, with its unique characteristics (Strength and Safety, Portability, Convenience, Respect for privacy, Ease of use, Patient-perceived as Fast acting) is a typical product of the SS, generating a personalized medical treatment of ED to motivate the patient to both the therapeutical adherence and to the needed shift to more virtuous lifestyles.

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