Erectile Dysfunction
BioBalance Podcast — Dr. Kathy Maupin and Brett Newcomb
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Dr. Kathy Maupin: This is the BioBalance Health podcast episode 23. I'm Dr. Kathy Maupin, founder and Medical Director of BioBalance Health and an anti-aging physician as well as an OBGYN. With me today is Brett Newcomb he is a presenter, a trainer, a marriage counselor and therapist, and he also was a history teacher. We're just going to tell one more thing about you every time you come on.

Brett Newcomb: Alright.

KM: Today we're talking about E.D. or Erectile Dysfunction. Which, if you turn any television on you can see all the non-facts or too much information for your children.

BN: I see those all the time. I love the one where the guy is out in the yard with the football and he's throwing it at the tire swing and it goes right though the tire after he takes the pill.

KM: Yes, they have a lot of that. You know advertising is an amazing thing.

BN: The symbolism, the psychology of advertising is a fascinating study in its own right.

KM: It is because no one is going to get that except for the people that should.

BN: Exactly. Which is why they put them on mainstream television.

KM: But E.D. has now become an acronym that people actually say in their households which is something they didn't do 5 years ago. And it has actually become of more interest because we, the baby boomers, are now getting older and since I have the anti-aging practice this is common.

BN: Well you have major public figures come out and say "I suffer from E.D." or "I use this E.D. medicine" or "I talked to my doctor about E.D." So it becomes less taboo and less sort of "under the cover" to talk about it.

KM: Which in many ways is great, but I'm not sure we need that many commercials about it. Because it's not as you said when we were having our discussion about this, it's not just taking a blue pill.

BN: No, it isn't.

KM: Because it's so much more than that to try to reverse E.D. It's something that I deal with every day. It is hormonal; you have to replace testosterone. It is emotional

because people have stage fright. Once they are back, they can actually get an erection, then emotionally they are afraid. It is stage fright. So often times I have to talk to my patients about that, and their wives because their wives are saying "You can't do this" You know, that makes it worse. So it's that as well and that's your area.

BN: Right.

KM: It also involves the other hormones in your body. You have to have your thyroid working properly. Neurologically, you have to have your nerves working properly. And diabetes impairs erectile dysfunction. No matter how much testosterone I give, if diabetes has affected the vessels than that's very difficult to treat. And then lastly, blood flow. If you have E.D. it is a heralding sign not only that your testosterone is low but you could be ready to have a heart attack.

BN: It is a vascular problem.

KM: Because the vessels in the pelvis go, and that's one of the things I'm concerned about the most. Because I don't want someone to have a vascular event, a stroke or a heart attack. But I need to remember this sign is one of those things not just another symptom.

BN: Well you need to remember and they need to know.

KM: Yes.

BN: It is much too simplistic an answer to say "well just take this pill". And sometimes for men it is a difficult discussion to have because the size and prowess of their erections, the functionality of themselves sexually. I mean I've had men come in, in sessions over the last 30 years, who brag and self define "They call me Rod. I can go for an hour without . . " and I ask "and what's important about that?" And their chest puffs just out, and their shoulders go back and they're proud. And that diminishes.

KM: Well they haven't gotten proud by themselves. Women have made them proud about this, they've complimented them. It's a two way street.

BN: It is, but the point I was making is that if their identity becomes defined by that limited part of reality and then something happens to that part of reality then they're going to suffer anxiety and they're going to suffer depression. They're going to suffer anger and often then get medicines for depression and anxiety, it's a vicious cycle.

KM: And then depressive medicines are one of the medicines that causes them to lose their sexual drive and it also causes them to have trouble ejaculating. So even if they do perform a little bit than all the Prozacs of the world and everything like it cause them to have trouble with their ejaculation.

BN: So I'm still not any better in my ability to function but I'm less anxious about it.

KM: Right. So I don't care anymore. And you know there's something to be said for anti-depressants. But for this particular problem they don't really help. For premature ejaculation they actually help. But not for this particular problem which is much more pervasive.

BN: But for premature ejaculation also cognitive behavioral training helps. There are psychological approaches to it and medical approaches to it.

KM: So what's an example of that?

BN: You practice mental arousal, you practice withdrawal to stretch that time limit, you practice being focused on what you're doing and pulling back from that and thinking about something else so that you don't.

KM: Doing calculus in your head.

BN: Again, the research shows that both the male and female contribute to that process very often. So if the female is resistant, or if she's too dry and it's too painful for her, you have to look at the whole complex and you have to get both parties involved. But for a lot of guys who have those issues of premature ejaculation, it can be a physiological issue and anti-depressants can help and some other treatments can help, but it can also be a thought stopping skill that you have to learn, which we use with people who are obsessive compulsive. You have to stop that thought. When you obsess all day about 'did I turn off the coffee pot', 'did I lock the front door' and you go back and check, you go back and check, you go back and check. It's that sort of thing. Once a guy decides, or knows, that he has premature ejaculation or that he doesn't have a good erection, he's dead in the water. His ability to distract himself from that and just let nature take it's course and let his body work is impaired because his psychology starts weighing him down.

KM: I have a couple that came to mind that are just, they're hilarious. They're darling. they both come to see me, they are in their late 60's and they both had their testosterone replaced. She is up and at em' ready to roll all the time. And he was still having problems with great testosterone levels. Really everything was perfect physiologically. So I sat them down and I started talking, and she was talking over him and talking for him and she was being deprecating. And I finally said, "Hang on just a second". And I talked to him alone and I said "You're getting stage fright, aren't you? I mean for a long time you haven't been able to do this and now you have the ability but now you're afraid. You're afraid of failure." So I talked to the wife about it, and she's delightful, she would have done anything to make this better.

BN: And probably didn't know she was being cruel and deprecating.

KM: She didn't. She had no idea. She thought she was being funny.

BN: Trying to be funny to make light of a very serious and scary proposition.

KM: Right. well we don't get so upset about 'well you didn't have an orgasm – so what I'll just have one next time'. Men are really upset about not being able to have an erection or ejaculation.

BN: And that kind of criticism, even teasing criticism, can be emasculating.

KM: It is emasculating.

BN: The ability to function just withers.

KM: And no matter what your testosterone level is or how healthy you are or how much you work out, it isn't going to work.

BN: Scorn is not an arousal tool.

KM: No, it is not. But some of us don't know when we're doing that and just have to be aware of it and if our heart's good, meaning if we have a good heart meaning not like pumping, but if we have a good heart and we want the relationship to work then we will do anything to make that work.

BN: Which goes back to caring, and awareness, and communication.

KM: And having it me be a couple deal.

KM: So, the minute he was given permission to give it a shot without being scorned, now they sit in my waiting room. . .

BN: And smile.

KM: No! They're very vociferous. They talk all about it and they tell all my other patients that are younger, usually, than them, (especially new patients), and they tell them all about their sex life which is really cute and actually great marketing for me. But now he has no fear and he just smiles.

BN: So you should just rent them to come and sit in your waiting room.

KM: I should. But, they're very busy people, they travel all over the world. So they're very happy and it is a complete change in their lives.

BN: We're getting lost from something that I wanted to stay focused on. You were talking about the other issues that may be involved with E.D. We talked about premature ejaculation as a concern.

KM: That's the opposite problem.

BN: Right, but in other conversations you have talked about diminished thyroid production, and you have talked about diabetes and obesity. Do these things play into this at all?

KM: Yes. Thyroid functions just like testosterone. If it's not functioning then none of the other hormones are working and your enzyme systems aren't working if you have a low thyroid. So all the enzyme systems that work in your brain and all over your body and every cell don't work if your temperature is low and low thyroid makes your temperature below 98. I try to get all of my patients thyroids back in order and do basal temperatures and try to get their temperature up.

BN: So 98 degrees is sort of the required incubator for the enzyme process.

KM: For all the enzymes to work. It's very hard to be sexually competent and healthy without having your thyroid work and having everything be warm enough to work. So that's one thing.

BN: So your core temperature has to be around 98 for this to work.

KM: Yes and you'd be surprised how many people are never 98 have never been 98 because their thyroid has always hypo-functioned. It's not always about the numbers on the lab test. Now diabetes. . .

BN: You know I don't know that, until I talked to you, that any doctor had ever asked me about that.

KM: I think it's probably an old fashioned thing. It is something that I picked up back in medical school when tests were hard to do and took a long time coming back, I started doing that and pulse rates. Pulse rates drop down, blood pressure drops, and generally, not always, (especially in young people), your core temperature drops if you have a low thyroid. Besides the fact that your hair is falling out, you've gained weight, your skin is dry, the outside of your eyebrows fall out. All of those things mean hypothyroidism. But really the concern is not your hair or your eyebrows. For your health or your sex life, it is the warmth of your body so that everything will work. That's key. Diabetes is key because diabetes affects all the small vessels in your body. When your blood sugar is off, then all the blood vessels are damaged. And they're blocked off. So when you block off all the vessels that are around your pelvis, that go to the pelvis, there's a lot of little vessels that go to the penis and you need to have them competent. You cannot get an erection if all those tiny little vessels have been damaged by high glucose levels. So I try to pull people back from the edge if they're almost diabetic, or early diabetic. I try to bring them back and have them lose weight.

BN: What's the process then when guys can't get an erection and they use a shot directly in the penis? Or they use a vacuum pump to force an erection? How does that work?

KM: Those don't work very well if you have diabetes. Because you can't get the blood flow. And the pills don't work that well because that depends on drawing the blood to the pelvis.

BN: You have to force the blood flow to that region and if those vascular elements are compromised than the blood can't flow to that region.

KM: Right. None of those things work very well if your vessels are already damaged by diabetes or if you have atherosclerosis and they've clotted off. What happens is your vessels get thinner and thinner, narrower, as they fill with atherosclerosis. The wall of the vessel becomes much smaller.

BN: The wall of the vessel gets thinner?

KM: No the wall gets thicker the opening gets smaller. And they don't respond to dilation messages, they're just very rigid. Both high cholesterol and inflammation together cause that and then diabetes is a whole different mechanism with high blood sugar just damaging the vessels going to the pelvis and lower extremities. So, that's the role of [diabetes}. I was going to talk about high blood pressure but what's the other thing you asked about?

BN: Well thyroid, obesity, high blood pressure

KM: Obesity, I'm sorry. Obesity is something that sooner or later is going to lead to diabetes so I usually put people on a low carb. diet, exercise program, give them help if they need it with medication that will help them lose weight. Because diabetes, excuse me, I mean obesity can actually cause a physical problem in terms of just not being able to get to one another.

BN: Unless you're very creative.

KM: And they have devices that they use to actually be able to get in proximity with one another. Because sometimes the fat is in the way and if they can't get their weight off very fast in the interim they use these devices.

BN: So do you have a definition or does medicine generally say 'okay, at this point what you're dealing with is erectile dysfunction'? Because it is possible for men to have an orgasm without having an erection and it is possible for a man to be sexually satisfied without having an orgasm.

KM: True.

BN: So if a man came in and said "This is happening sometimes; should I be worried? Do I have a problem?" How would you medically respond to him?

KM: Medicine describes E.D. It is a symptom. It is erectile dysfunction. It just means that the penis is not erect or is poorly erect or is not what it used to be.

BN: So it's more of a self diagnosed complaint? If I come in and say I'm not happy with that.

KM: Well I'm not going to make you show me. It's not that kind of thing.

BN: No, no, no, no. And I'm not talking; I'm certainly not talking about me. But if a man comes in and says I'm not happy with the way this is all working, then you treat it as a self defined condition.

KM: The first step for medicine is always the symptom. If the symptom is the erectile dysfunction. The diagnosis of the erectile dysfunction can be thyroid, low testosterone is the most common.

BN: Blood pressure, depression medicine.

KM: And it's low blood pressure that causes E.D.

BN: Low blood pressure? Now that's interesting.

KM: Because if you don't have enough blood pressure to get to your pelvis, than you're not going to have an erection. One of things I do after I get someone's hormones back, if they're still not functional, (of course I do all of the hormones and make sure that they are all functioning before we go to the next step); if I do all of the hormones and it's still happening. Then generally I look at the drugs at the same time. If they are on anti-depressants then they're not going to have the desire and they also are going to have problems with ejaculation.

BN: Okay.

KM: Okay.

BN: Totally off the wall question: Ben Franklin used to stand on his head to urinate because he had kidney stones, and it would fall away.

KM: Oh goodness, I didn't know that.

BN: So if a man had these issues, would standing on his head be helpful?

KM: I don't know. I have no idea, but just as a guess, probably not.

BN: No, because it is harder for the heart.

KM: It would be harder to get the blood flow to the [affected area].

BN: Yes, it would be harder for the heart to pump up hill. Exactly. You won the prize, you got the answer right. You were always a good student weren't you?

KM: Yes, I was always able to jump to conclusions well. So we've gone through pretty much what my work up is except the medications. The next thing is, many men are on something called Lisinopril. Lisinopril has the number one side effect as impotence. So why men are put on Lisinopril in the beginning unless it's a last ditch effort to control

blood pressure, I don't know. The best available blood pressure medicine that does not drop your pelvic blood pressure, that decreases blood pressure throughout body but doesn't drop your pelvic blood pressure lower than it should be for an erection, is Benicar. And Benicar is an angiotensin 2 receptor blocker.

BN: Those are all ace inhibitors. Both Lisinopril and Benicar.

KM: No.

BN: No? Lisinopril is an ace inhibitor and Benicar is not?

KM: Benicar is not. It is an angiotensin.

BN: And that's why it avoids the side effects.

KM: Right, and beta blockers are really bad, like Methyldopa or Aldomet. Those actually cause trouble with the vessels. They dilate and then they just stay dilated and the blood pressure goes down too low and the heart beats go down, (it decreases the heart rate). Often times, that is going to decrease flow and you are just not going to be successful. If you are on blood pressure medicine and if it is possible to put you on Benicar then right now that's the best thing we've got because it does not have a side effect of E.D.

BN: If they are having these erectile issues and they're on an ace inhibitor or a beta blocker you would encourage them to discuss with their doctor whether or not they can be safely transferred to Benicar. I think that's an important information to get out there.

KM: Yes, that's absolutely correct. It is. And diuretics, even though they are necessary often to control salt in our diet because it's everywhere, also has an impact on our pelvic blood pressure. If you need to have a diuretic then we try to keep you on the lowest level possible. Because we may impair your function just by giving you the hydrochlorothiazide or whatever you have.

BN: But isn't that generally true for all medicines you want to keep them on the lowest metabolically successful rate that works.

KM: That works. Yes. It's not true for testosterone. We try to get that back to normally young and healthy.

BN: Yes, you have to get that above 400.

KM: And actually we probably need to have that a little higher than that when we get older for the men. Not meaning we, you.

BN: So if our listeners are up for more on the topic of E.D. they should contact you?

KM: Oh, I'm not done yet, I'm not done yet.

BN: What else do you have to say?

KM: The next thing is if I give them all these things and I change their medications and they still have this issue than I usually try one of the E.D. drugs. If that is not completely successful, I send them to a vascular surgeon to look at the vessels in their pelvis.

BN: And what does a vascular surgeon do? How do they do that?

KM: They do an ultrasound, generally, usually.

BN: Oh good, they don't have to open it up?

KM: No. Non-invasive. They look at the femoral arteries and see what the flow is like. And then they can usually tell what the flow is above that. Often times, if the flow is bad in your femoral arteries, (that's where it comes out to your leg) then they go backwards and they do an arteriogram of the pelvis and then they can tell if there's a compromise there and if there is, something really has to happen for cholesterol. And I'm not a fan of anti-cholesterol drugs because it lowers testosterone but in that case you have to decrease inflammation and you have to decrease cholesterol, you have to manage diet, and you have to give a medication for cholesterol, if that's the case. And they may even need something else.

BN: So it's a real complex chemistry set problem.

KM: It us, and a vascular surgeon will look at the pelvis there and say "ah, we need to look at your heart." So you may be referred for a heart work up too, an extensive one. Not just like "get on the treadmill". But a more extensive heart work up if that's the case in your pelvis. These are things that it is not just a symptom that's a pain in the butt. It is actually a sign of other things. If we go through this and take my patients and then find the ones that don't respond to this treatment.

BN: So you would say E.D. is not just about sex.

KM: No, it is not. No, it is not.

BN: At all.

KM: And the other thing I wanted to tell our listeners is that the first thing that comes back when your E.D. is fixed and your testosterone level is adequate is that you get morning erections. I never understood that was such a big deal until I started talking to men about them. Because that is the first sign that they are normal. And that's like, okay, it's starting to come back. And that usually tells you that all systems are go.

BN: Okay, good. That's important information as well.

KM: Now, I'm done. I'm finished.

BN: Alright.

KM: You can reach us for any questions. You can email us at biobalancehealth.com, we have a place for contact. Or you can call my office for an appointment 314-993-0963. Or you can read my blog at drkathymaupin.com. This is the end of our 23rd, (I can't believe that),

BN: Yes, that's amazing.

KM: Our 23rd podcast. Thank you Brett.

BN: Thank you.

KM: I'm Dr. Kathy Maupin.