COMPARISON OF BIOTHESIOMETRY AND NEURO-UROPHYSIOLOGICAL INVESTIGATIONS FOR THE CLINICAL EVALUATION OF PATIENTS WITH ERECTILE DYSFUNCTION

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ABSTRACT

Penile erection is a complex physiological response that depends upon the integration of neurological, vascular and hormonal mechanisms. The neurological processes responsible for penile erection originate in the central nervous system through integration of sexual stimuli (tactile, audio-visual, gustatory and olfactory), and through mechanical and reflexogenic stimulation of the genital organs. Several studies have directly or indirectly demonstrated the importance of penile sensory input for sexual function. Herbert showed that sexual activity and ejaculation in the rhesus monkey are dependent upon dorsal penile nerve function.1 Newman found a correlation between ejaculation in the rhesus monkey and erectile function.2 The disadvantage of this procedure is that it requires expensive electronic monitoring equipment and that it requires expensive electronic monitoring equipment.3 Several diagnostic tests have the disadvantage of complexity, invasiveness and time consumption. In our study both methods were compared in 31 impotent patients. The results showed that penile glans biothesiometry yields consistent results when measurements are repeated during 1 session. However, no relationship was found between the outcome of penile glans biothesiometry and neuro-urophysiological tests of the dorsal penile nerve, which is probably due to the fact that vibration is not an adequate stimulus to the skin of the penile glans that contains free nerve endings (that is pain receptors) only, and hardly any vibration receptors. We conclude that biothesiometric investigation of penile glans innervation is unsuited for the evaluation of penile innervation and cannot replace neuro-urophysiological tests.

KEY WORDS: neurophysiology, penis, penile erection, impotence, evoked potentials

From each patient we obtained a detailed history focusing on factors associated with neurogenic erectile dysfunction, such as pelvic surgery, alcohol abuse, diabetes mellitus as well as medication and intoxications. Furthermore, we measured height and weight to calculate body mass index. Extensive neurological testing of each patient consisted of biothesiometry followed by neuro-urophysiological investigations. Each patient was tested during 1 session to avoid time related variations. Before the investigation patients were informed about both procedures and from all patients written informed consent was obtained.

During the investigations each patient was in the supine position in a room with a constant temperature of 25°C. A commercially available biothesiometer was used. Vibratory stimuli were given through a 1 cm wide tactor at a fixed frequency of 120 cycles per minute with variable amplitude. Amplitude adaption is possible by turning a control knob. Electromagnetic energy is transformed into vibratory motion of the tactor, which is placed on the skin. Vibration amplitude is linearly related to the applied voltage. For statistical analysis the applied voltages, which can range from 0 to 50 volts, were recorded.

To avoid adaptation the tactor should be at rest when it is placed on the site selected for analysis. On every test site a clear noticeable stimulus was given so patients would know what type of stimulus to which they were supposed to respond. After this initial stimulation the apparatus was turned to zero. The amplitude was increased stepwise with increments of 1 to 2 volts, and the patient was told to respond with a clear “yes” when he first perceived the vibration, at which point he was supposed to respond again with a clear...
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RESULTS

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Table 1 indicates the age dependency of biothesiometric parameters. There was a statistically significant increase in ankle vibratory threshold in older patients (r = 0.38, p = 0.003). Fair correlation between patient age and index finger measurements was found (r = 0.29, p = 0.07). There was no significant correlation between patient age and biothesiometric data derived from the glans penis (r = 0.17, p = 0.19).

Comparison of biothesiometric and neuro-urophysiological data showed fair correlation between tibial evoked potential latency and ankle vibratory threshold (r = 0.28, p = 0.03). Comparison of pudendal evoked potential latency and penile vibratory threshold showed no significant correlation (r = 0.11, p = 0.39), as did comparison of bulbocavernosus reflex latency and penile vibratory threshold (r = 0.20, p = 0.12).

DISCUSSION

We compared the results of 2 testing modalities for the evaluation of peripheral nerve function. Biothesiometry, an inexpensive and simple method for the determination of vibratory thresholds of any area of the body surface, was compared with neuro-urophysiological tests. For the former test, vibratory stimuli were applied to the index finger of the dominant hand, glans penis and medial malleolus of the ankle of the right foot. For the latter test, latencies of tibial and pudendal evoked potential as well as bulbocavernous reflexes were measured.

The value of neuro-urophysiological tests for the diagnosis of neurogenic erectile dysfunction has been proved in many studies.1-3,11-15 One study showed aged-dependent pudendal nerve neuropathy in clinically unsuspected patients with erectile dysfunction.9 That study proved that repeatability and reproducibility of neuro-urophysiological investigations are excellent. Combination of the test results of pudendal evoked potential and bulbocavernosus reflex latency measurements allows for differentiation between peripheral and central pudendal nerve neuropathy. The combination of an abnormal pudendal evoked response with a normal bulbocavernous reflex is compatible with central neuropathy, whereas an abnormal bulbocavernous reflex together with a normal pudendal evoked potential latency suggests peripheral or sacral neuropathy.10

Although neurophysiological tests are undoubtedly valid, some questions must be raised concerning the value of biothesiometry. In the literature the topic of intra-individual variation of biothesiometric data has been discussed extensively. Aaserud et al.,14 and Fagius and Wahren15 demonstrated a marked inter-individual and intra-individual variation in vibration sensitivity threshold measurements. Both studies concluded that repeatability, meaning within 1 session, and reproducibility, meaning at different occasions, of biothesiometric measurements are questionable. In our study, when

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**Table 2: Biothesiometric data**

<table>
<thead>
<tr>
<th>Pts.</th>
<th>Volts</th>
<th>Mean ± SD (range)</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finger</td>
<td>31</td>
<td>5.5 ± 2.6 (1.0–11.0)</td>
<td>5.0</td>
</tr>
<tr>
<td>Penis</td>
<td>31</td>
<td>21.2 ± 15.0 (9.5–no response*)</td>
<td>16.7</td>
</tr>
<tr>
<td>Ankle</td>
<td>31</td>
<td>28.4 ± 14.8 (5.3–no response*)</td>
<td>18.8</td>
</tr>
</tbody>
</table>

* No response is set at 55.0 volts.
we assessed only intra-individual repeatability of biothesiometric measurements, we found that it was good. The coefficients of replication reliability for the index finger, glans penis and ankle were 0.99, 0.98 and 0.99, respectively. Reproducibility of biothesiometry, however, was not investigated in our study but it is judged to be poor by the aforementioned studies. This poor reproducibility of biothesiometry is attributed to methodological problems, such as varying pressure exerted on the hand-held probe, variation in the exact locus that is stimulated at different moments, and psychological variability in alertness and attentiveness.

We found fair correlation between ankle vibratory threshold and tibial evoked potential latency ($r = 0.28$), which was to be expected regarding neuroanatomy of the sensory portion of the posterior tibial nerve that consists mainly of large diameter myelinated fibers with gnostic (vibration, touch) sensory properties. Direct electrical stimulation, as in tibial evoked potential measurement, and indirect vibratory stimulation via vibration sensors, as in ankle biothesiometry, are adequate stimuli for the posterior tibial nerve. Both techniques investigate the same sensory modality and neuroanatomical tracts. Therefore, we were likely to find a correlation between the outcome of both investigations.

On the other hand, there was no significant correlation between penile vibratory threshold and pudendal evoked potential or bulbocavernous reflex latency ($r = 0.11$ and 0.20, respectively). This lack of correlation between penile biothesiometry and neuro-urophysiological measurements of the dorsal penile nerve (pudendal evoked potential and bulbocavernous reflex) can be explained by the fact that both tests investigate distinct parts of penile innervation. In an anatomical study of the innervation of the human glans penis, Halata and Munger found the most numerous nerve terminals to be free nerve endings (Aδ or C type). The unique corpuscular receptors of the glans penis, the so-called genital end bulbs, proved to be numerously coiled free nerve endings. From a neurophysiological viewpoint, these genital end bulbs, proved to be numerously coiled free nerve endings.

The finding that biothesiometry is an unsuitable investigative tool for the assessment of penile glans innervation is further corroborated by the fact that the penile vibratory threshold did not correlate with patient age ($p = 0.19$), whereas for the other measurements (index finger and ankle) an age dependency was found. The latter finding is in accordance with the results of Aaserud et al, who demonstrated a clear age-related increase in vibration thresholds of the knuckle of the second metacarpophalangeal joint and of the medial malleolus. In a similar study of the penile shaft, Rowland et al found a good correlation between vibrotactile threshold and patient age. The main and important difference between their study and ours was the location of stimulation. Rowland et al stimulated the ventral penile shaft, whereas we stimulated the penile glans.

### TABLE 2. Age dependency of biothesiometry

<table>
<thead>
<tr>
<th>No. Pts.</th>
<th>Median Volts</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>17–46</td>
</tr>
<tr>
<td>10</td>
<td>47–55</td>
</tr>
<tr>
<td>10</td>
<td>56–71</td>
</tr>
<tr>
<td>Index Finger</td>
<td>5.3</td>
</tr>
<tr>
<td>Glans Penis</td>
<td>4.3</td>
</tr>
<tr>
<td>Ankle</td>
<td>6.9</td>
</tr>
</tbody>
</table>

From our study it must be concluded that penile glans biothesiometry and neuro-urophysiological studies of the dorsal penile nerve investigate different sensory modalities, with the latter covering the larger part and yielding the more consistent results. Therefore, we conclude that penile glans biothesiometry cannot replace laborious studies, such as somatosensory evoked potentials and sacral reflex latency measurements. Whether biothesiometric investigation of the penile shaft might prove useful as an office test should be a subject for further research.

The issue of the clinical use of neurological investigations (either evoked potential studies or biothesiometry) in the diagnostic evaluation of erectile dysfunction needs some further comment. Our previous studies have shown that the outcome of neuro-urophysiological investigations correlates well with the clinical presentation and pathogenesis of erectile dysfunction. These studies also have an important impact on our understanding of the etiology of male impotence. Neuro-urophysiological investigations can be beneficial to the clinician in many ways. These tests can be helpful in establishing a differential diagnosis, and an abnormal test can determine those patients who need special precautions with respect to the dose of intracavernous pharmacological agents. The diagnosis of a somatic cause for the erectile dysfunction can help a patient and partner to accept the problem more easily. The proof of neurogenic impotence can predict the possible success of other therapies. When laborious or invasive therapies, such as psychotherapy or penile revascularization, are planned a thorough neuro-urophysiological evaluation is indispensable because these therapies should not be performed in patients with combined neurogenic and psychogenic/vasculogenic impotence. On the other hand, however, it is important to state that neuro-urophysiological tests, including biothesiometry, have no therapeutic implication per se. The finding of neurogenic impotence has no therapeutic consequences to date. It can only keep physicians and patients from embarking on therapeutic strategies that are bound to fail. In conclusion, our bias is that a comprehensive neuro-urophysiological investigation should not be replaced by simple biothesiometry and that the test should be done within the context of special scientific protocols or whenever elucidation of a certain individual problem is warranted, either by the physician or patient.

### REFERENCES

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