Comment on: Adipokines, Hormonal Parameters, and Cardiovascular Risk Factors: Similarities and Differences Between Patients with Erectile Dysfunction of Arteriogenic and Nonarteriogenic Origin

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In our study [1], we found that leptin level resulted higher in the serum of patients with arteriogenic erectile dysfunction (A-ED) in comparison to patients with non-arteriogenic erectile dysfunction (NA-ED). Leptin has pro-inflammatory properties and it increases proportionally to the degree of adiposity. In A-ED, we also found a significant increase of asymmetrical dimethylarginine (ADMA) [2]. One cause of this increase could be a reduced activity of dimethylarginine dimethylaminohydrolase (DDAH) whose activity may be inhibited by traditional (diabetes, smoking) and non-traditional (inflammation, estrogen deficiency, insulin resistance) risk factors, and finally by oxidative stress. In another study [3] it has been found that reactive oxygen metabolite (ROS) concentrations were higher and total antioxidant status (TAS) lower in A-ED patients in comparison to NA-ED patients and in controls.

In conclusion, the effect of adipokines on ED could be caused by nitric oxide synthase (NOS) inhibition due to an ADMA increase as a consequence of the reduced activity of DDAH. This reduction is correlated to many causes, several of them under the control of leptin to adiponectin ratio (L/A).

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References

1 Dozio E, Barassi A, Dogliotti G, Malavazos AE, Colpi GM, D'Eril GV, Corsi MM. Adipokines, hormonal parameters and cardiovascular risk factors: Similarities and differences between patients with erectile dysfunction of arteriogenic and nonarteriogenic origin. J Sex Med 2012;9:2370–7.
2 Paroni R, Barassi A, Ciociola F, Dozio E, Finati E, Fermo I, Ghilardi F, Colpi GM, Corsi MM, Melzi d'Eril GV. Asymmetric dimethylarginine (ADMA), symmetric dimethylarginine (SDMA) and L-arginine in patients with arteriogenic and non-arteriogenic erectile dysfunction. Int J Androl 2012;35:660–7.
3 Barassi A, Colpi GM, Piediferro G, Dogliotti G, D'Eril GV, Corsi MM. Oxidative stress and antioxidant status in patients with erectile dysfunction. J Sex Med 2009;6:2820–5.

Faulty Analysis Leads to Erroneous Conclusions

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I read with some concern the report by Rodriguez-Diaz CE et al. in "More than Foreskin: Circumcision Status, History of HIV/STI, and Sexual Risk in a Clinic-Based Sample of Men in Puerto Rico" [1]. The authors conducted a large random survey of men in an STI/HIV clinic waiting room in San Juan, Puerto Rico, and measured self-reported circumcision status, various demographic and sexual risk behaviors and history of STI/HIV infection. While the intent and survey methods of the authors' study were laudable the methods of analysis and interpretation of the results left a lot to be desired. Nearly a quarter of the sample were men who have sex with men and an unknown proportion had a history of injection drug use, two well-known routes of acquisition of HIV

infection that would not be expected to be associated with protection of HIV infection by circumcision. Furthermore, the authors found that twice as many circumcised men (43.8%) reported receptive anal intercourse as uncircumcised men (20.4%), yet in their multivariable model they failed to control for that critical sexual risk behavior—the authors only controlled for place of birth and education level. Based on the author's analytic model, they report that male circumcision increased the likelihood of having HIV infection ($P = 0.027$) with no reported measure showing the strength of that association. Given the increased risk behaviors in circumcised men (receptive anal intercourse in particular) it is no surprise that men who had increased sexual risk for HIV infection had increased odds of infection. The finding of increased odds of infection among circumcised men is likely erroneous due to confounding. The authors should have controlled for confounding by stratifying—separating those who reported receptive anal intercourse (or same-sex male sexual behavior) from those who did not. At the minimum they should have included same-sex behavior status in their multivariable model.

The failure to address confounding leads the authors to false conclusions. The authors state the findings from their study suggest that circumcision may not confer sufficient protective benefit in their setting. While perhaps an accurate statement, based on the biological understanding that foreskin removal reduces HIV entry into the penis, no reader would expect male circumcision to protect all those at risk of HIV infection including women, injection drug users, and those who engage in receptive anal intercourse [2]. The authors do a disservice to the epidemiologic study of the role of circumcision in the prevention of HIV infection and STIs by performing an incomplete and faulty analysis of their data.

The recent endorsement of newborn circumcision by the American Academy of Pediatrics is an evidence-based policy recognizing the clear benefits of medical male circumcision for male sexual and reproductive health [3]. Strong consideration should be given toward the implementation of newborn circumcision as a sexual and reproductive health promotion strategy in the Caribbean.

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Conflict of Interest: None.

References

1 Rodriguez-Diaz CE, Clatts MC, Jovet-Toledo GG, Vargas-Molina RL, Goldsamt LA, García H. More than foreskin: Circumcision status, history of HIV/STI, and sexual risk in a clinic-based sample of men in Puerto Rico. J Sex Med 2012 Aug 15 [Epub ahead of print] doi: 10.1111/j.1743-6109.2012.02871.x.
2 Tobian AA, Gray RH. The medical benefits of male circumcision. JAMA 2011;306:1479–80. PubMed PMID: 21972310.
3 Task Force on Circumcision. Circumcision policy statement. Pediatrics 2012;130:585–6.

Insecure Attachment is Related to More Anal Sex and Vibrator Orgasm but Less Vaginal Orgasm

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Stefanou and McCabe [1] offer a welcome review of the connection between adult attachment styles (secure, as contrasted with anxious or avoidant attachment; presumably reflecting the effects of early childhood experience) and sexual behaviors. We wish to correct some of their errors and omissions from their presentation of our *JSM* report [2] on attachment and women's orgasmic responses.

They reported in their text that our study: (i) "focused on sexual satisfaction"; (ii) "began recruitment at [age] 15+"; (iii) had results mediated by sexual communication; (iv) "did not specify sexual orientation"; (v) "did not measure relationship duration"; and (vi) had a final sample over 200. All these statements are wrong (the latter three are contradicted by the correct information in their tables).

Although they correctly reported that we found that anxious attachment was associated with "less vaginal orgasms," and that "avoidant attachment had a nonsignificant trend toward being related to less vaginal orgasms," they neglected to report that we also found that: (i) both anxious and avoidant attachment were associated with higher frequency of vibrator orgasms; (ii) anxious attachment was associated with higher frequency of anal sex and solitary clitoral masturbation orgasms; and (iii) neither anxious nor avoidant attachment was associated with lifetime number of penile–vaginal intercourse (PVI) partners.

We also found that anxious and avoidant attachment correlated significantly with each other, as well as with immature psychological defense mechanisms. Immature defenses might offer a more detailed description of emotional functioning (also related to early childhood experience). Previous research in several countries found that immature defenses are associated with less vaginal orgasm likelihood, more clitoral masturbation during PVI, and more noncoital sex, including masturbation, anal sex, and vibrator orgasms [3–7], findings that were replicated in our *JSM* article on attachment [2].

They stated of all the studies reviewed that given the nature of self-report, social desirability responding (and recall bias) might have limited the reliability, but neglected to note that we used a measure of social desirability responding, and in multivariate analyses found that it was not a significant predictor of anxious or avoidant attachment.

They also stated that Brassard et al. [8] "found that anxiously attached individuals had higher rates of sexual intercourse, possibly to establish intense closeness and reduce insecurities." However, that study found no main effects of anxious attachment and PVI frequency. Brassard et al. did find interaction effects between partners attachment styles, such that if the woman was anxious and the man avoidant, there were lower rates of PVI, and if both partners were anxious there were higher rates of PVI.

We discussed how the choice of using a nonliving object (vibrator) for orgasm would be consistent with disturbed attachment. We also discussed the consonance of our results with earlier studies finding that PVI and the orgasm it directly produces are associated with indices of greater sexual satisfaction, and physical and mental health [9–11], but other sexual behaviors and orgasm