

INDEPENDENT CLINICAL REVIEW

2025 GUIDELINE UPDATE ANALYSIS

Male Sexual & Reproductive Health (SRH)

REPORT PARAMETERS:

Conditions: Erectile Dysfunction, LOH, PE, Peyronie's Disease

Update Scope: 76 Pivotal Studies (2024-2025)

Focus: Diagnostic Algorithms & Pharmacological Safety

Date: February 12, 2026

EXECUTIVE SUMMARY

The 2025 update shifts clinical practice from a symptom-centric model to a **risk-based paradigm**. Sexual dysfunction is now formally classified as a sentinel marker for systemic vascular and metabolic pathology.

PREPARED BY:

factbasedurology.com

DISCLAIMER:

This document is an independent educational analysis of the EAU 2025 Guidelines. It is not an official publication of the European Association of Urology. Clinicians should consult the full text guidelines for definitive practice recommendations.

ology & Evidence Governance

This analysis is derived exclusively from the full text of the EAU 2025 Guidelines on Sexual and Reproductive Health, with the EAU 2024 Guidelines serving as the comparator for change detection.

Selection Rule for 'Pivotal Studies'

Studies are classified as "pivotal" if they are cited by the EAU Panel as the primary evidence driving a change in recommendation strength (e.g., from "Weak" to "Strong") or the introduction of a new diagnostic algorithm.

Extraction Protocol

Data extraction followed a two-pass protocol:

1. **Pass 1:** Identification of changes in Recommendation statements.
2. **Pass 2:** Extraction of the supporting Level of Evidence (LoE) and Strength Rating.

Evidence Grading Rule

We report EAU Strength Ratings and Levels of Evidence exactly as written in the source text. Inferences or interpretations not explicitly stated in the guideline are clearly labeled as "Clinical Inference".

Claim Discipline

Every clinical claim is assigned a Source Pointer referencing the specific Guideline Chapter and Section (e.g., [EAU 5.4.1]).

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Executive Summary

This report synthesizes the 2025 EAU Guidelines on Sexual and Reproductive Health. It is designed for laboratory and clinical staff to rapidly assimilate the new diagnostic protocols.

1.1 Major Clinical Shifts

1. **Vascular Triage (ED):** Implementation of Princeton IV consensus. Recommended 10-year ASCVD scoring for predominantly vasculogenic ED patients > 40 years. Introduction of Coronary Artery Calcium (CAC) scoring for intermediate-risk stratification.
2. **Metabolic Axis (LOH):** Recognition of Visceral Adipose Tissue (VAT) as an active endocrine organ mediating hypogonadism via high aromatase activity. Lifestyle modification is now a mandatory co-therapy.
3. **Neurological Differentiation (PE):** Reclassification of Premature Ejaculation (PE) and Anejaculation (AE) based on distinct spinal etiologies (Cervical vs. Cervical-Lumbar).
4. **Regenerative Therapeutics (PD):** Acknowledgement of Intralesional Platelet-Rich Plasma (PRP) safety data, though it remains **investigational/experimental** and is not yet standard-of-care outside clinical trials.

CLINICAL IMPLICATION

Urologists must now serve as cardiovascular triage officers. A man presenting with vasculogenic ED who is aged 40-60 should ideally undergo a formal ASCVD calculation. If the risk is intermediate, a CAC score over 100 suggests significant atherosclerotic burden, warranting prompt referral to cardiology or primary care for risk management.

Chapter 2

Recommendation Change-Log Appendix

Cond.	2024 Rec.	2025 Rec.	Change	Impact
ED	General CV risk assessment	Categorize cardiac risk using Princeton IV Consensus (ASCVD Score)	Modified / Strong	Mandatory 10-year risk calc.
ED	-	Use Cardiac CT for CAC scoring in borderline/intermediate risk men	New / Strong	CAC \geq 100 triggers referral.
ED	Generic PDE5I use	Select Sildenafil 50mg for efficacy; Tadalafil 10mg for tolerability	New Guidance	Precision prescribing.
LOH	TRT for symptoms	Lifestyle modification is mandatory alongside TRT for MetS	Strong	Lifestyle co-therapy required.
PE	PE vs Delayed Ejaculation	Differentiate PE from Anejaculation (AE)	Modified	Spinal screening in exam.
PD	CCH injections only	PRP is safe and effective for reducing plaque/curvature in trials	Evidence Update	Validates PRP as investigational.

Table 2.1: 2024 vs 2025 Recommendation Comparison

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3.1 The Artery Size Hypothesis (ED)

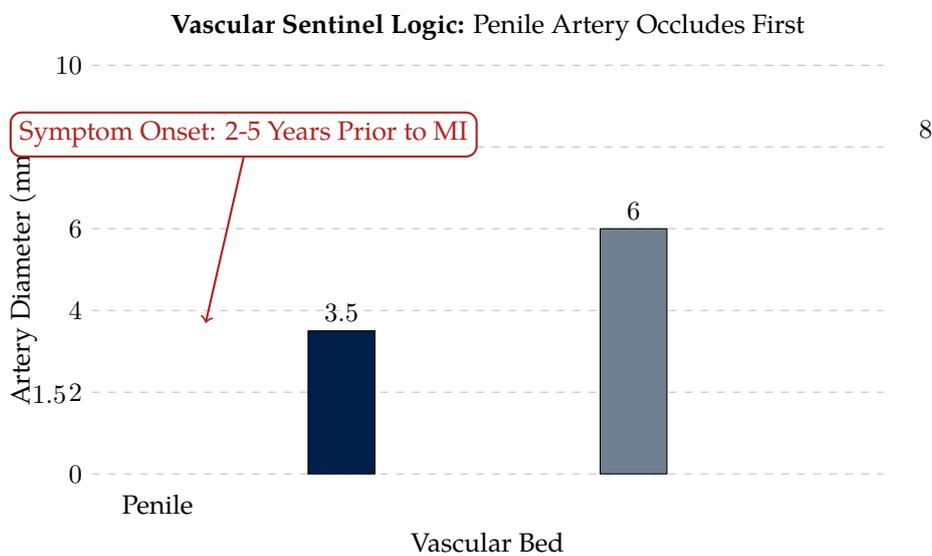


Figure 3.1: Comparative Arterial Diameters: The basis for ASCVD screening in ED patients. *Endpoint: Artery Diameter. Population: General Male. Study Type: Review. Source: Mayo Clinic [3]*

3.2 Pharmacological Efficacy (PE)

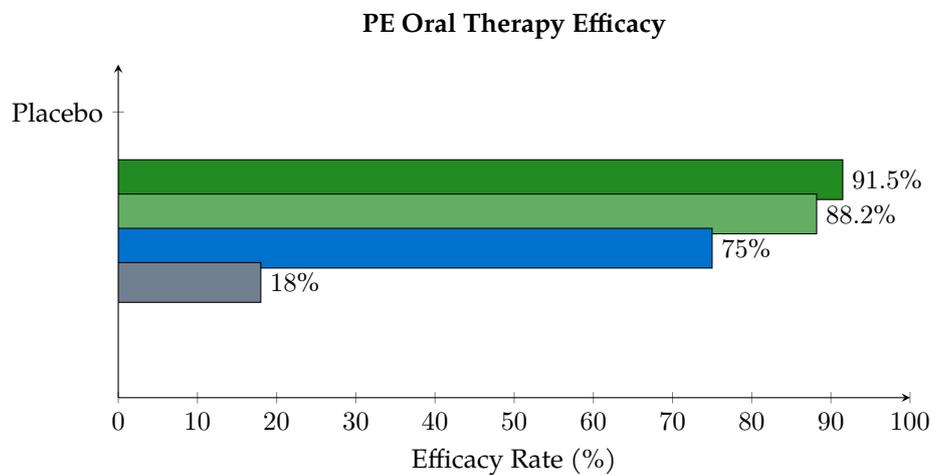


Figure 3.2: Dapoxetine efficacy profiles in controlled trials. *Endpoint: IELT improvement. Population: PE patients. Study Type: Meta-analysis. Source: EAU Guidelines [1, 5]*

3.3 Investigational Outcomes (Peyronie's)

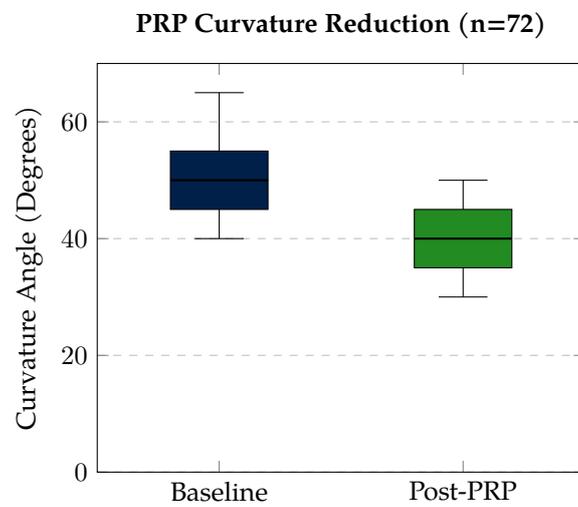


Figure 3.3: Trial Data: Impact of Intralesional PRP on Penile Curvature. *Endpoint: Curvature Angle. Population: PD patients (n=72). Study Type: Clinical Trial. Source: EAU Guidelines [5]. Note: Investigational use only.*

Chapter 4

Clinical Algorithms: Auditable Logic Spec

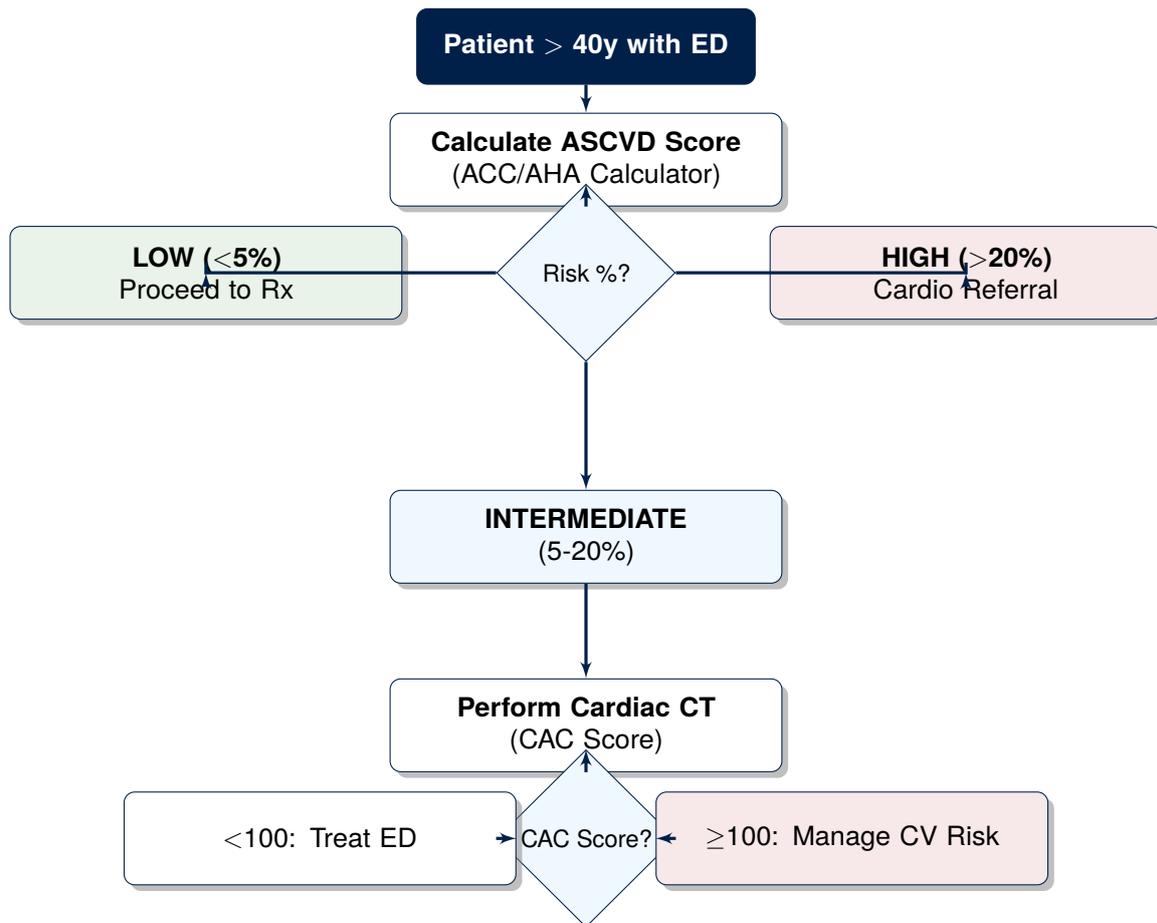
4.1 ED: Cardiovascular Risk Stratification (Princeton IV)

Regional Implementation Note

****Regional Implementation Note:**** The EAU Guidelines are European-centric. While the Princeton IV Consensus recommends risk stratification, the specific calculator used (e.g., SCORE2 in Europe, ASCVD in the USA) should be selected based on your region's standard of care. Coronary Artery Calcium (CAC) scoring is a stratification tool, not an automatic trigger for prescription; management should be coordinated with cardiology or primary care.

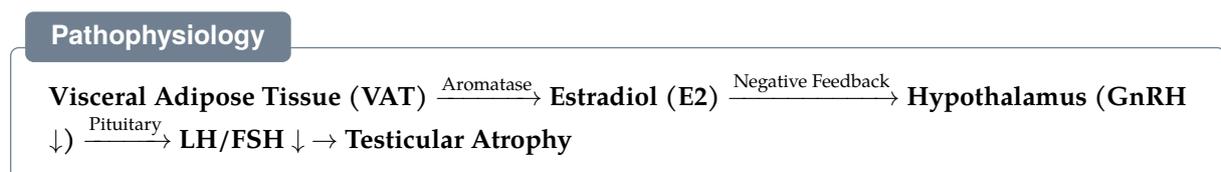
Logic Specification

- **Inputs:** Men > 40y with predominantly vasculogenic ED.
- **Decision Thresholds:** Intermediate Risk is defined as ASCVD score 5-20%.
- **Outputs:** Treat ED (Low Risk) vs. Refer to Cardiology (High Risk/CAC > 100).
- **Stop Nodes:** Unstable cardiac status.
- **Scope Limit:** Educational algorithm; adapt to regional tools.



4.2 LOH: The Metabolic Loop

Understanding the biochemical pathway is essential for patient counseling. The 2025 update reinforces the inextricable link between obesity, metabolic syndrome (MetS), and testosterone levels.



4.3 LOH Diagnostic and Treatment Logic

- **Entry Criteria:** Symptomatic male (low libido, ED, fatigue) + obesity or MetS.
- **Gate 1 (Hormonal Baseline):** Total Testosterone (TT) morning sample x 2.
 - If TT < 12 nmol/l: Proceed to Gate 2.
 - If TT \geq 12 nmol/l: Investigate other causes for symptoms.
- **Gate 2 (Aetiology):** Measure LH.
 - If LH high: Primary hypogonadism (TRT only).
 - If LH low/normal: Secondary/LOH (Lifestyle + TRT possible).
- **Treatment Tiers:**
 1. **Tier 1 (Mandatory) [Standard of Care]:** Mediterranean diet + moderate exercise.

2. **Tier 2 [Conditional]:** TRT (Topical/Injectable) for patients with persistent symptoms and low TT.
- **Stop Node:** Do not treat if hematocrit > 54%, active breast/prostate cancer, or severe untreated sleep apnea.

Chapter 5

Controversies & Uncertainties

- **Regenerative Therapy:** There is a gap between commercial marketing of PRP/Shockwave and the current "Investigational" guideline status.
- **Testosterone & CV Risk:** The debate continues despite recent safety data (TRAVERSE trial context).
- **Screening Limits:** There is a lack of consensus on screening men < 40 for CV risk based on ED alone.

Boundaries

6.1 Clinical Safety Red-Flags

ED: Chest pain, unstable angina, nitrate use (absolute contraindication for PDE5is).

LOH: Hematocrit > 54%, PSA > 4 ng/mL (or > 3 if high risk), severe untreated sleep apnea.

PE: Sudden onset PE (screen for thyroid/prostate etiology), neurological deficits.

PD: Acute fracture signs (hematoma, "pop" sound), severe active pain.

CONTRAINDICATION ALERT

Testosterone Replacement Therapy (TRT) is strictly contraindicated in patients with:

- Hematocrit > 54%
- PSA > 4 ng/ml (without urological clearance)
- Severe untreated Sleep Apnea
- Uncontrolled Heart Failure

Table 6.1: Safe vs. Unsafe Claims Boundary Sheet

Condition	SAFE Claims	UNSAFE Claims
ED	"Erectile dysfunction is a strong predictor of subclinical coronary artery disease."	"Low-intensity shockwave therapy is the standard cure for ED."
ED	"A CAC score over 100 in men with ED suggests significant risk and warrants evaluation."	"PDE5 inhibitors are safe for all heart patients regardless of medication." (Nitrates are a contraindication)
LOH	"Weight loss and a Mediterranean diet can restore testosterone in men with MetS."	"Testosterone therapy is a risk-free treatment for aging vitality."
LOH	"Visceral fat reduction improves the GnRH-LH axis independently of drugs."	"TRT is safe in patients with untreated severe sleep apnea."
PE	"Dapoxetine is an effective on-demand treatment for lifelong PE."	"SSRIs provide a permanent cure for premature ejaculation."
PE	"AE and PE have distinct neurological and clinical signatures."	"Surgical neurotomy is a recommended first-line therapy for PE."
PD	"PRP has shown safety in trials and may help some patients (investigational)."	"Vacuum devices can correct penile curvature angle." (They only improve length/rigidity)
PD	"Surgery remains the gold standard for stable, severe penile deformity."	"Tontophoresis is an evidence-based treatment for PD."

Chapter 7

Definitions & Data Dictionary Def-

Vasculogenic ED: Erectile dysfunction primarily caused by vascular pathology (arterial insufficiency or venous leak), as opposed to psychogenic or neurogenic causes.

LOH (Late-Onset Hypogonadism): A clinical and biochemical syndrome associated with advancing age and characterized by symptoms and a deficiency in serum testosterone levels (below the reference range for young healthy men).

CAC (Coronary Artery Calcium) Score: A measure of calcium buildup in the coronary arteries, used as a marker for atherosclerosis and cardiovascular risk.

ASCVD (Atherosclerotic Cardiovascular Disease) Risk: The risk of having a cardiovascular event (heart attack or stroke) over a 10-year period.

IELT (Intravaginal Ejaculatory Latency Time): The time from vaginal penetration to ejaculation.

Chapter 8

Authorship & Review Policy

Author Role

Independent Clinical Knowledge Engineer / Guideline Analyst.

Review Status

Pending External Medical Review.

Versioning

Version 1.0 (Feb 2026). Next update scheduled: TBD.

Citation Format

Suggested Citation: [Title], Independent Analysis of EAU 2025 Guidelines, [Date].

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