Recommendations from the EAU Sexual and Reproductive Health Guidelines Panel applicable during the COVID-19 pandemic

General Statement				
Management (diagnosis, treatment and follow up) of Sexual Health/Erectile Dysfunction in the COVID-19 period is of low priority, with the exception of the following recommendations.				
Diagnosis				
Priority Category	**LOW PRIORITY**	**INTERMEDIATE PRIORITY**	**HIGH PRIORITY**	**EMERGENCY**
Definition	Clinical harm very unlikely if postponed 6 months	Clinical harm possible if postponed 3-4 months but unlikely	Clinical harm very likely if postponed > 6 weeks	Life threatening situation
COVID-recommendations				
Evaluation of late-onset hypogonadism (LOH)		All diagnosis of LOH except for testosterone therapy trial which is low priority.		
Erectile dysfunction			• Medical and psychosexual history (use of validated instruments, e.g. IIEF). • Take a comprehensive medical and sexual history in every patient presenting for erectile dysfunction (ED). Consider psychosexual development, including life stressors, cultural aspects, and cognitive/thinking style of the patient regarding their sexual performance.	
Evaluation of male infertility		• Investigate both partners simultaneously to categorise the cause of infertility. • Include a parallel assessment of the fertility		A multidisciplinary team discussion concerning invasive diagnostic modalities (e.g., US-guided testis biopsy with frozen

		status, including ovarian reserve, of the female partner during the diagnosis and management of the infertile male, since this might determine decision making in terms of timing and therapeutic strategies (e.g., assisted reproductive technology (ART) versus surgical intervention). • Perform semen analyses according to the WHO Laboratory Manual for the Examination and Processing of Human Semen (5th edn) indications and reference criteria. • Perform scrotal ultrasound (US) in patients with infertility, as there is a higher risk of testis cancer.		section versus radical orchidectomy versus surveillance) should be considered in infertile men with US-detected indeterminate testicular lesions, especially if additional risk factors for malignancy are present.
Low Sexual Desire			Perform the diagnosis and classification of low sexual desire based on medical and sexual history, which could include validated questionnaires.	
Treatment				
Priority Category	**LOW PRIORITY**	**INTERMEDIATE PRIORITY**	**HIGH PRIORITY**	**EMERGENCY**
Definition	Clinical harm very unlikely if postponed 6 months	Clinical harm possible if postponed 3-4 months but unlikely	Clinical harm very likely if postponed > 6 weeks	Life threatening situation

COVID-recommendations				
Late-onset hypogonadism			• Use conventional medical therapies for treating severe depressive symptoms and osteoporosis. • Do not use testosterone therapy to improve body composition, reduce weight and benefit cardio-metabolic profile. • Do not use testosterone therapy for improving cognition vitality and physical strength in aging men.	
Late-onset hypogonadism choice of treatment		• Treat, when indicated, organic causes of hypogonadism (e.g., pituitary masses, hyperprolactinaemia, etc). • Improve lifestyle and reduce weight (e.g., obesity); withdraw, when possible, concomitant drugs which can impair testosterone production; treat comorbidities before starting testosterone therapy. • Select the testosterone preparation in a joint decision process, only with a fully informed patient.		
Erectile dysfunction		• Assess all patients for inadequate/incorrect information about the	Discuss with patients undergoing radical prostatectomy (any technique)	

		mechanism of action and the ways in which drugs should be taken, as they are the main causes of a lack of response to phosphodiesterase type 5 inhibitors (PDE5Is.) • Treat a curable cause of ED first, when found. • Use PDE5Is as first-line therapeutic options. • Pro-erectile treatments should start at the earliest opportunity after radical prostatectomy/ pelvic surgery and other curative treatments for prostate cancer.	about the risk of sexual changes other than ED, including libido reduction, changes in orgasm, anejaculation, Peyronie's like disease and penile size changes.	
Recurrent haemospermia		Men > 40 years of age with persistent haemospermia should be screened for prostate cancer.		
Peyronie's disease		• Offer conservative treatment to patients not fit for surgery or when surgery is not acceptable to the patient. • Discuss with patients all the available treatment options and expected results before starting any treatment. • Nonsteroidal anti-inflammatory drugs (NSAIDs) can be used to treat penile pain in the acute phase of PD. • Phosphodiesterase type 5 inhibitors can be used to treat	Do not offer oral treatment with vitamin E, potassium para-aminobenzoate (potaba), tamoxifen, pentoxifiline, colchicine and acetyl esters of carnitine to treat Peyronie's disease.	

		concomitant ED or if the deformity results in difficulty in penetrative intercourse in order to optimise penetration.		
Cryptorchidism		Men with unilateral undescended testis and normal hormonal function/spermatogenesis should be offered orchidectomy.		
Germ cell malignancy and testicular microcalcification			• Men with testicular microcalcification should learn to perform self-examination even without additional risk factors, as this may result in early detection of testicular germ cell tumour. • Sperm cryopreservation should be performed prior to planned orchidectomy, since men with testis cancer may have significant semen abnormalities (including azoospermia). • Men with testis cancer and azoospermia or severe abnormalities in their semen parameters may be offered onco-testicular sperm extraction at the time of radical orchidectomy.	If there are suspicious findings on physical examination or ultrasound in patients with testicular microcalcification with associated lesions, perform inguinal surgical exploration with testicular biopsy or offer orchidectomy after multidisciplinary meeting and discussion with the patient.
Hormonal Therapy		• Hypogonadotropic hypogonadism (secondary hypogonadism), including		Do not use testosterone therapy for the treatment of male infertility.

		congenital causes, should be treated with combined human chorionic gonadotropin (hCG) and follicle stimulating hormone (FSH) (recombinant FSH; highly purified FSH) or pulsed Gonadotropin releasing hormone (GnRH) via pump therapy to stimulate spermatogenesis. • In men with hypogonadotropic hypogonadism, induce spermatogenesis by an effective drug therapy (hCG; human menopausal gonadotropins; recombinant FSH; highly purified FSH). • In the presence of hyperprolactinaemia dopamine agonist therapy may improve spermatogenesis.		
Male fertility surgery	All elective surgical sperm retrieval and fertility procedures should be cancelled until further notice.		Women who have limited ovarian reserve or are of advanced maternal age, a delay in fertility intervention may result in significantly poorer outcomes and a full discussion with the couple needs to take place highlighting this.	
Sperm cryopreservation	Sperm banking: Low Priority			Prior to planned

in men with testis cancer since they may have significant semen abnormalities (including azoospermia).	(in patients receiving adjuvant treatment, but should be performed before any gonadotoxic or ablative therapy. There is currently no evidence for vertical transmission of COVID 19. However, patients may be offered testing at their discretion at the time of performing standard serology (ie HIV/Hepatitis testing) prior to sperm cryopreservation.			orchidectomy.
Onco-testicular sperm extraction in men with testis cancer and azoospermia or severe abnormalities in their semen parameters				At the time of radical orchidectomy.
Follow up				
Priority Category	**LOW PRIORITY**	**INTERMEDIATE PRIORITY**	**HIGH PRIORITY**	**EMERGENCY**
Definition	Clinical harm very unlikely if postponed 6 months	Clinical harm possible if postponed 3-4 months but unlikely	Clinical harm very likely if postponed > 6 weeks	Life threatening situation
COVID-recommendations				
Late-onset hypogonadism			• Assess for cardiovascular risk factors before commencing testosterone therapy. • Assess men with known cardiovascular disease (CVD) for cardiovascular symptoms before testosterone therapy and with close clinical	

			assessment and evaluation during treatment. • Treat men with hypogonadism and pre-existing CVD, venous-thromboembolism or chronic cardiac failure, who require testosterone therapy with caution, by careful clinical monitoring and regular measurement of haematocrit (not exceeding 54%) and testosterone levels. • Exclude a family history of venous-thromboembolism before commencing testosterone therapy. • Monitor testosterone, haematocrit at three, six and twelve months after testosterone therapy initiation, and thereafter annually. A haematocrit more than 54% should require testosterone therapy withdrawal and phlebotomy. Reintroduce a lower dose once the haematocrit has normalised and consider switching to topical testosterone therapy at testosterone	

			preparations.	