

## Erectile Dysfunction in A Middle Aged Man 6 Years After Bariatric Surgery: A Case Report

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**Abstract :** Introduction: Morbid obesity has been successfully treated with bariatric surgery for over 60 years. Although operative procedures have improved and associated complications have reduced substantially, surgery still carries the risk of post-operative malabsorption, malnutrition and a range of gastrointestinal disorders. Overweight by itself can impair libido in both sexes and cause erectile dysfunction in males by inducing a state of hypogonadotropic hypogonadism, proportional to the degree of obesity. Impact of weight reduction on libido and sexual activity remains controversial, however it is broadly accepted that weight loss improves sexual drive. Zinc deficiency, subsequent to malabsorption, may lead to impaired testosterone synthesis in men while excessive and/or rapid weight loss in females may result in reversible amenorrhoea leading to sub-fertility. Methods: We describe a 37 year old male, 6 years post Roux-en-Y gastric bypass surgery, who presented with erectile dysfunction, loss of libido, worsening fatigue and generalized weakness for 4 months. He also complained of constipation and frequent muscle cramps but denied having headache, vomiting or visual disturbances. Patient had lost 38 kg of body weight post gastric bypass surgery over four years {135kg (BMI 42.6 kg/m<sup>2</sup>) to 97 kg (BMI 30.6 kg/m<sup>2</sup>)} and the weight had been stable for past two years. He had no recognised co-morbidities at the time of the surgery and noted marked improvement in general wellbeing, physical fitness and psychological confidence post surgery, up until four months before presentation. Clinical examination revealed dry pale skin with normal body hair distribution, no thyroid nodules or goitre, normal size testicles and normal neurological examination with no visual field defects or diplopia. He had low serum testosterone, follicular stimulating hormone (FSH), luteinizing hormone (LH), T3, T4, thyroid stimulating hormone (TSH), insulin like growth factor 1 (IGF-1) and 24-hour urine cortisol levels. Serum cortisol demonstrated an appropriate rise to ACTH stimulation test but growth hormone (GH) failed increase on insulin tolerance test. Other biochemical and haematological studies were normal, except for low zinc and folate with minimally raised liver enzymes. MRI scan of the head confirmed a solid pituitary mass with no mass effect on optic chiasm. Results: In this patient clinical, biochemical and radiological findings were consistent with anterior pituitary dysfunction. However, there were no features of raised intracranial pressure or neurological compromise. He was commenced on appropriate hormone replacement therapy and referred for neurosurgical evaluation. Patient reported marked improvement in his symptoms, specially libido and erectile dysfunction, on subsequent follow up visits. Conclusion: Sexual dysfunction coupled with non specific constitutional symptoms has multiple aetiologies. Clinical symptoms out of proportion to nutritional deficiencies post bariatric surgery should be thoroughly investigated. Close long term follow up is crucial for overall success.

**Keywords :** obesity, bariatric surgery, erectile dysfunction, loss of libido

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