events appears to be 1 and 8% of patients, respectively, although individual studies have reported higher incidence rates.[3] Patients performing self-injection of intracavernous alprostadil should be instructed to seek medical attention if an erection persists for >4 hours, since physical damage to the penis may ensue if priapism persists for ≥6 hours.[3]

In addition to local effects of intracavernous alprostadil, there have been a few reports of systemic adverse events, such as syncope.[3]

Prescribing and formulary considerations

Intracavernous alprostadil represents an effective option for many men with erectile dysfunction.[3]

Compared with other agents that have been administered by intracavernous injection, alprostadil appears to be at least as effective or superior in efficacy.[3] In addition, it appears to be generally well tolerated, although penile pain may be troublesome. Thus, it should be considered for addition to formulary lists at centres that manage patients with erectile dysfunction. However, it appears prudent to evaluate noninvasive forms of management for erectile dysfunction before considering prescribing intracavernous alprostadil (see *Patient care guidelines*).

When prescribing intracavernous alprostadil for patients with erectile dysfunction, it is important that:

- patients have the first injection performed by medical personnel
- patients receive adequate training and education regarding the technique of self-injection
- recommended maximum frequencies of injection are not exceeded (i.e. 1 per 24-hour period and 3 per week)
- doses are titrated to the optimal response (an erection sufficient for sexual intercourse lasting <1 hour)
- patients know to seek medical attention before attempting dose adjustment and in the event of an erection lasting >4 hours.[3]

Patients with a history of haemoglobinopathy, bleeding diathesis, Peyronie's disease or idiopathic priapism should be excluded from treatment.[1] In addition, patients with poor manual dexterity, poor visual acuity, a condition that would be adversely affected by transient hypotension or a serious psychiatric disorder are generally not suitable for this treatment.[1]

It has been suggested that using combinations of drugs at relatively low doses may be at least as effective and better tolerated than using higher doses of drugs as monotherapy.[1] However, in contrast to alprostadil monotherapy, combination regimens are not commercially available for intracavernous injection.

Patients who have failed to respond to noninvasive methods and who are either unsuitable for, or refuse treatment with, alprostadil may consider alternative invasive approaches (see *Patient care guidelines*).

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Erratum

In the article 'Cabergoline: a long-acting alternative to bromocriptine' [Drug Ther Perspect 1995 Sep 4; 6(5): 1-5], the usual dosage of cabergoline for the inhibition of established lactation in the *Differential features* table should be 0.25mg bid for 2 days, and the response rate for bromocriptine in hyperprolactinaemia should be 52 to 90%.

In addition, the second sentence in the first paragraph of the Prescribing and formulary considerations section should read '. . . and a simple 1- to 2-day treatment regimen.'

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