These preliminary observations are quite provocative and if confirmed, indicate that inherited forms of MC hypertension are surprisingly common. In this therapeutic trial using spironolactone to block the MC receptor, 84% of the patients responded with a fall in BP. Many had previously been poorly controlled requiring 2 or more antihypertensives. We have interpreted this response to indicate MC hypersecretion, an idea which is supported by finding raised aldosterone levels in 4 of the 8 normokalemic patients randomly admitted for study. Furthermore, BP control was achieved only in one of the 4 with normal aldosterone: as the responder (patient 11) had undetectable levels during steroid suppression a diagnosis of FH1 seems likely. As might be expected, all the patients with a raised aldosterone responded to medical therapy.[2] Of the 14 patients so far admitted, 3 had non MC induced hypertension, and the remainder a presumptive diagnosis of FH2 (4 patients), FHI (2 patients), based on steroid suppression data, HRFH (4 patients) and one a Conn's tumor. The latter was removed during laparoscopic surgery and has resulted in normal aldosterone levels and BP control. The patient's father, mother and sister, now deceased, were all hypertensive as is his only brother suggesting the possibility of familial Conn's syndrome. We hope to obtain an adrenal CT scan from the brother shortly. Computerized tomography scans were normal in the 4 patients with HRFH, and as yet we have no explanation for their raised renin values.[4] A secondary increase resulting from hypertensive kidney damage seems unlikely as all had normal creatinine levels (50, 57, 58 and 41 μmol/L) and only mild to moderate hypertension.[5] Family screening is underway to document whether or not they have familial hyperreninemic MC excess. These findings indicate that the prevalence of MC induced disease may be much higher than previously suspected. In evolutionary terms, this makes sense as the ability to retain salt in extreme climates might be expected to have a definite survival advantage. We conclude that patients with familial disease should undergo a therapeutic trial of an MC receptor blocking drug, before embarking on expensive endocrine investigations. The advent of a new MC receptor blocking agent not affecting the estrogen receptor is awaited with interest.[2] The fact that we identified responders from 3 continents also argues that MC induced hypertension is worldwide and not just a Middle Eastern problem. The identification of increasing numbers of patients with primary hyperaldosteronism, in the United States, Europe, Australia and elsewhere and the realization that many of them are normokalemic at presentation[2] suggests to us that the so called "primary" or "idiopathic" disease may in fact be FH2 in disguise.

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The penile support. *A new method for the treatment of impotence (erectile dysfunction)*

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The penile support (PS) is a newly designed instrument to treat the erectile failure, it is indicated for the treatment of all cases of psychological impotence caused or accompanied by weakness of erection in which the fear of failure (vicious-cycle effect) is preponderant and inaccessible to psychological treatment and it does not make sense to waste time with fruitless procedures and to put off a helpful form of treatment for so long that the patients detrimental auto-suggestion have becomes enhanced and fixed, thereby considerably impairing the prognosis. For approximately 2 years, 21 cases of psychological impotent males were treated by the PS, the success rate was more than 80%. According to the review articles obtained from the medline there was no previous similar method. I recommended the PS method for the treatment of psychological erectile dysfunction. Erectile failure is one of the most rewarding of all sexual problems to treat.[1] Impotence is the inability to obtain or maintain an erection of sufficient firmness to permit coitus to be initiated or completed, and can be classified as either primary or secondary. The male with primary impotence has never been able to have intercourse, whereas the male with secondary impotence is experiencing erectile dysfunction after a previous period of normal function.[2] Impairment of erection may result from a variety of organic and psychogenic disorders but in the majority of cases of erectile dysfunction the cause is usually multifactorial.[3] Psychological factors have a role to play in every case of erectile failure whatever the cause, such factors are not always deep in origin and can often be

Table 1 - The n of patients with impotence and the percentage of each obtained groups (N=21).

Type of impotence	Cured		Improved		Uncured or undecided	
	n	(%)	n	(%)	n	(%)
Primary (N=9)	5	(55.5)	2	(22.2)	2	(22.2)
Secondary (N=12)	9	(75)	1	(8.3)	2	(16.6)
Total	**14**	**(66.7)**	**3**	**(14.2)**	**4**	**(19.1)**

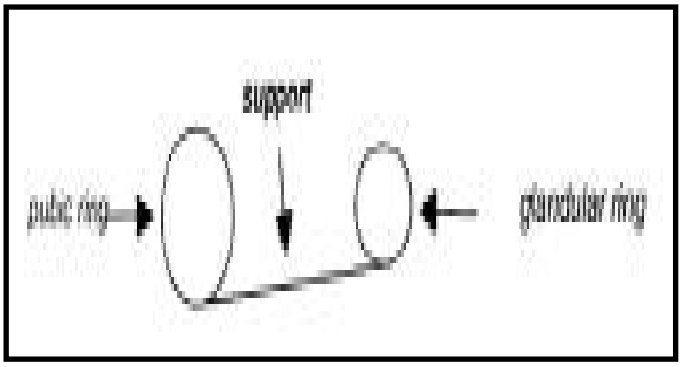

Figure 1 - The penile support.

discovered easily by looking into the current situation without delving into early childhood experience. Ignorance, cultural taboos and myths, and poor communication are the most common factors in causation. The problem is usually maintained by a vicious circle of failing, leading to fear of failure and then leading to more failure. Reversing the causative factors and breaking the circle need more than sensitive handling.[1] Patients with organic impotence, psychotherapy is often beneficial in alleviating concomitant psychogenic factors that limit the success of medical and surgical therapy.[4] Minimal vascular insufficiency, as in mild diabetes, hypertension, or mere old age, may not be enough in itself to cause erectile difficulty, but if psychological factors were added, erection may start to fail and the psychological factors are usually predominant.[5]

Between July 1997 to March 1999, 21 cases of impotent males attending a private clinic in Basrah, Southern Iraq, were included in this prospective study, all of them were complaining from impotence of psychological type caused by different psychological causes. Informative data sheets including a details regarding the medical and sexual history was obtained from each patient in the first visit with complete physical and genital examination and some investigations excluded the organic causes of impotence (according to the individual case). In the 2nd visit, a details regarding the action and usage of the PS was explained to the patient and taking the measurements of the penile size of each patient (length and circumference). In the 3rd visit, each patient received their own PS, the technique and instructions about the treatment had been explained to the patient, and the patients seen weekly for follow-up until improvement. The PS, regarding its description, an instrument supporting the penis during intercourse, it will be remove from the penis after finishing the intercourse, it can be used many times daily. Structurally it is consist of a splint supporting the underside of the penis and formed at each end in the shape of a ring, the pubic ring rests upon the symphysis while the opposite glandular ring grips the sulcus glandes, so that the glans remains beyond the glandular ring during the intercourse **(Figure 1)**. In the following statistics, I understand by "cured" those patients in whom complete capacity has been attained or re-attained, by "improved" those patients who have been enabled or enabled again to perform coitus regularly, with orgasm, emission and satisfaction to the female partner but only through the help of PS and by "uncured" or "undecided" are those cases who did not succeed at all or who withdrew from treatment and have not been heard of since. Twenty-one cases of impotence caused by different psychological causes have been treated by the PS, the results shown in **Table 1.** The average duration of treatment of 17 cases (cured and improved) was 13 weeks. The age distribution ranged from 22-71 years.

Statistical evidence concerning the results of treatment of impotence is very difficult to come by, as the impotent patient is inclined to break off his treatment before it is finished, the final result is often unknown. Yet the disappearance of the patient does not necessarily mean a bad result, on the contrary when he experiences his first successes, his self-confidence tends to grow immediately and immensely. He wants to carry on independently, and to forget his former pitiable condition as completely as quickly as possible, he will not be heard of again. The PS can only, in its treatment course, produce an "erect penis" but will not repair bad or hostile marriages, so it must be dealing with problems in the relationship which might be the main cause of impotence. The chief advantage of the PS is that the patient need not to pay any attention to the presence of the degree of erection, and can perform intercourse with out any regard to it, so that the patient will be able at any time (regardless of erection) to accomplish coitus without risk of failure (namely break the vicious cycle effect) therefore, the PS treatment can be used for different types of psychological impotence such as widowers impotence, temporary impotence (for example wedding night impotence), involutional impotence, impotence due to premature ejaculation,

sinlge man impotence, handicapped impotent patient, impotence caused by iatrogenic causes, and postsurgical impotence (for example anal surgery and following prostatectomy). Also the PS can be used for those patients with organic impotence in case when the patients's wife want to get pregnant instead of the usage of the artificial insemination method but the patients's seminal fluid should be normal, due to PS design permit the ejaculate to drawn out in contrast to the vacuum constriction device which cause dry ejaculate. The PS as an apparatus is well adapted to anatomical conditions, it form a firm unity with the penis, it is light in weight, simple in structure and easily cleaned. It is easily to put on and off and cause no pain or inconvenience for both partners. The failure of PS treatment does not occur if the patient is sufficiently instructed regarding the technique of treatment, except when the female partner refuse co-operation.

In conclusion, psychogenic impotence may be one of the easiest or the most difficult conditions which a physician is called up on treatment, and by the help of the PS treatment, we can reduce the number of cases of impotency, even those cases that extremely resistant to any methods of psychotherapeutic approach. However, it should keep in mind that if the PS method used as "primary" and prescribed without a complete and skillful consideration of all the factors involved; the number of therapeutic failures would be added to rather than reduced, so it is important to point out that the mechanical treatment of psychogenic impotence must be regarded as an ancillary method only, and thus psychological considerations must take first place. However, it is important to view that the use of PS to the patient as one that accurate psychophysiologic intervention and appropriate psychotherapeutic techniques, rather than as a simple mechanical treatment.

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Erratum

In manuscript "Variants in origin of the left circumflex coronary artery with angiography", Saudi Medical Journal 2002; Vol. 23 (11) 1390-1393, the authors listed should have appeared as: ***Ayfer Mavi,*** *PhD,* ***Alper Sercelik,*** *MD,* ***Resat Ayalp,*** *MD,* ***Turan Pestemalci,*** *MD,* ***Talantbek Batyraliev,*** *MD,* ***Erdem Gumusburun,*** *PhD.*