Author Year; Country Dates included in the review Total sample size Level of evidence Type of study Score	**Methods Databases**	**Outcomes**
Consortium for Spinal Cord Medicine 2010; USA Reviewed published and unpublished articles between Jan 1995 and Sept 2007 N=145 **Level of evidence:** Methdological quality assessed using criteria from the Centre for Evidence-based Medicine in Oxford **Type of studies:** RCTs assessed using the Jadad Quality Score Assessment AMSTAR=5	**Method:** Searched for all articles describing sexual and reproductive health in people with SCI. Reviews and meta-analyses were excluded, as were studies with a paediatric population. Only English studies were considered. **Databases:** Medline, PreMedline, Cinahl, SocioFile, PsycInfo, and Cochrane Library.	A panel of experts reviewed the literature and created a clinical practice guideline to provide information for SCI clinicians, individuals with SCI and their partners. Some important points include: • understanding the importance of sexuality and reproduction to the individual, and conveying the appropriate information in a timely manner • obtain a sexual history and assessment • provide information on sexual education and on maintaining sexual well-being • discuss with the individual any relevant physical and practical considerations (bladder/bowel, skin care, secondary medical complications, optimal position for sexual activity) • discuss the effect of injury on sexual function, responsiveness and expression with the individual with SCI and their partner; and • discuss dysfunction and fertility issues as needed.
Davidson et al. 2016 Canada Systematic Review AMSTAR= 5 N=29	**Methods:** The first search used two sets of key words including ‘‘sexuality, orgasm, ejaculation, sexual arousal, and masturbation’’ and ‘‘cardiovascular measures, blood pressure, arterial pressure, cardiovascular, and hypertension.” The search was limited to the English language published articles from 1948-2012 to source original articles, practice guidelines, and review articles. 11 studies for able-bodied persons met the criteria and 18 studies for SCI patients met inclusion criteria, making 29 articles in total. **Databases:** Embase, PubMed and Medline	1. In able-bodied persons, sexual activity resulted in modest increases in systolic blood pressure peaking at orgasm (males of 163mm Hg and females of 142mm Hg) and returning to baseline shortly afterward. 2. In persons with SCI, results varied from minimal changes to significant elevations in systolic blood pressure because of episodes of autonomic dysreflexia, especially in those with high thoracic and cervical lesions. 3. Peak systolic blood pressure in these individuals was measured to be as high as 325mm Hg. In the SCI population, more intense stimuli (including penile vibrostimulation and electroejaculation) tended to result in a greater increase in systolic blood pressure compared with self-stimulation. 4. Studies that used continuous versus intermittent monitoring were more likely to report greater changes in systolic blood pressure. 5. In able-bodied persons, sexual activity results in modest increases in blood pressure.

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		6. In those with SCI, intense stimulation and higher injury levels result in a higher likelihood of autonomic dysreflexia and elevated blood pressure. 7. Because of rapid changes in blood pressure, continuous monitoring is more advantageous than intermittent measurement, because the latter may miss peak values.
Lombardi et al. 2015 Italy Systematic Review AMSTAR = N=12	Review study. **Method:** A MEDLINE search was done to retrieve relevant papers published in English from 1999 to 2014. Papers of interest were all ED interventions for humans other than oral phosphodiesterase type 5 inhibitors (PDE5Is). **Databases:** MEDLINE – PubMed, Embase and OVID.	1. Twelve studies were selected. One article documented that 76% of subjects reached satisfactory sexual intercourse (SI) using intracavernosal injection of vasoactive medications (papaverine and prostaglandin E1). One study regarding perineal training showed a significant increase ($P<0.05$) in penile tumescence in 10 individuals with preserved sacral segment. Two studies reported contrasting results on erectile function (EF) using various dosages of oral fampridine (25-40 mg). Furthermore, 95.1% of patients on fampridine 25 mg experienced drawbacks. Disappointing findings were found with intraurethral alprostadil (125-1000 μg) and sublingual apomorphine 3 mg. Two studies concerning penile prosthesis reported valid SI more than 75% of the time with a mean follow-up of 11 years, although around 15% of individuals showed side effects. As for surgical treatments, 88% of males submitted to Brindley sacral anterior root stimulator after sacral dorsal rhizotomy achieved valid erection up to 8 years following the procedure. Three studies documented the impact of definitive sacral neuromodulation implant (Medtronic, Minneapolis, MN, USA) also on EF. After surgery, 20-37.5% of patients with ED recovered normal EF. 2. CONCLUSIONS: 3. Data are scant on the efficacy of ED treatments for SCL subjects who did not respond to PDE5Is. Further research should investigate the effects of any SCL treatments even when they are not strictly used for neurogenic sexual dysfunction.
Courtois et al. 2012; Canada Reviewed published articles from 1948 to 2011	**Method:** search using autonomic dysreflexia (AD) and spinal cord injury (SCI) to find literature on the acute or prophylactic treatment of AD in the context of sexual activities; included all levels of evidence (randomized placebo control	***1.*** 37 papers on the specific treatment of autonomic dysreflexia (AD) showed nifedipine, prazosin, captopril and clonidine are candidates in the context of sexual

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N=37 **Level of evidence:** methodological quality not assessed **Type of studies:** Not described AMSTAR=2	studies, case reports, literature reviews) and all years of publication; articles were read to assess whether they mentioned only a procedural management of AD or whether they specifically investigated a treatment of AD. **Databases:** MEDLINE.	activities; sildenafil and prostaglandins have given inconclusive results. ***2.*** Prazosin has an initial hypotensive effect therefore treatment should begin 12h before intercourse. This makes it less ideal for spontaneous sexual activities. ***3.*** Nifedipine remains the most widely studied and significant treatment of AD whether in acute or prophylactic conditions. ***4.*** Recent concerns suggest increased cardiovascular risks with sublingual nifedipine in non-SCI populations, but negative long-term effects have not been reported in the SCI population.