CHAPTER 10

EJACULATION/ORGASM DISORDERS

Three disorders of ejaculation/orgasm are most common in primary care: Premature Ejaculation [PE], Delayed Ejaculation/ Orgasm [DE/O], and Retrograde Ejaculation [RE]. Three others are found infrequently: Anejaculation, Painful Ejaculation, and Anorgasmic Ejaculation. The six conditions are discussed in order of frequency.

PREMATURE EJACULATION

Time and time again premature ejaculators of many years' standing not only lose confidence in their own sexual performance but also, unable to respond positively while questioning their own masculinity, terminate their sexual functioning with secondary impotence. This stage of functional involution is, of course, the crowning blow to husband and wife as individuals and usually to the marital relationship.

MASTERS & JOHNSON, 1970[1]

The Problem

A couple in their late 20s and married for three years was concerned about the man's ejaculation. For religious reasons, they had not attempted intercourse before marriage. Since they were married, he regularly ejaculated before attempts at vaginal entry. As a result, their union had not been "consummated." Her sexual desire diminished considerably over the three years of their marriage. Apart from embarrassment and diminished sexual pleasure that they both experienced, they wanted to have children and for her to become pregnant in the "natural way." Ejaculating quickly was not a new problem for him. Since the first time he attempted intercourse at the age of 14, he was unable to accomplish vaginal entry except on one occasion, and, then, he ejaculated in a matter of seconds. Since the "squeeze technique" described by Masters & Johnson[1] was tried and found not helpful, the couple felt desperate and anticipated separation and divorce if another way to help them could not be found.

A couple in their mid-50s and married for 25 years was seen because of erectile and ejaculation problems. Sexual difficulties began about five years before and were gradually becoming worse. The husband was aware of the association between sexual dysfunctions and diabetes (a disease with which he lived in the previous 20

years) but until recently had not volunteered information to his physician about his sexual difficulties. He believed that the onset of his (generalized) erectile problems preceded his ejaculation difficulty by about one year. He described ejaculating rapidly after a frantic process of gaining vaginal entry and before any softening of his erection made continued containment impossible.

Terminology

Patients often use the word "come" to describe an ejaculation/orgasm and "Premature Ejaculation" when this process happens too quickly. When the term, *Premature Ejaculation* (PE), is used by health professionals, some consider it to be pejorative and value laden. Preferring a more descriptive term, McCarthy has suggested *Early Ejaculation* as an alternative[2] (p. 144). Others have also used the term, *Rapid Ejaculation*.[3,4] These terms indicate that speed of ejaculation is on a continuum from slow to fast rather than a normal/abnormal dichotomy. For reasons of consistency with DSM-IV[5] and DSM-IV-PC[6] nomenclature, as well as the inclusion of the concept of control in the definition (see immediately below), the term, *Premature Ejaculation*, will be used in this chapter.

Definition

Definition problems abound in attempts to clarify PE. Does one use a time element? (Critics say that no one carries a stopwatch to bed.) Or is it better to specify the number of movements or thrusts? (One might legitimately ask: just what is the "correct" number?) Should one follow the Masters and Johnson suggestion that the woman be "satisfied" 50% of the time when intercourse occurs?[1] (p. 92) (On the presumption that "satisfaction" means "orgasm," of what relevance is the Masters and Johnson definition to a man who is having intercourse with a woman who comes to orgasm only with direct clitoral stimulation and not with intercourse?)

Usually no one debates the issue of the definition of prematurity when a heterosexual man ejaculates before, during, or immediately after vaginal entry. Definition problems arise with lengthening of the amount of time after penetration. It is conceivable that two syndromes exist: (1) ejaculation before, during, or immediately after vaginal entry and (2) ejaculation after vaginal entry but with little or no control over the timing. It may be that the former has "premature ejaculation" and the latter is simply quite fast and would be reasonably described as having "rapid ejaculation."

Grenier and Byers suggest a different way of considering the definition of PE: there should be two criteria for the diagnosis. One is based on the extent of voluntary control experienced by the man and the other is based on "latency," or the amount of time from vaginal entry to ejaculation.[3]

Does PE apply to men who are sexually active with other men? The literature is unclear on this subject. Masters and Johnson found that PE "rarely represents a serious problem to interacting male homosexuals . . . [since] . . . neither man is dependent upon the other's ejaculatory control to achieve sexual satisfaction"[7] (p. 239). However,

another study declared that 19% of a convenience sample of 197 gay men reported "ejaculating too soon/too quickly."[8]

If the definition of PE includes only the speed of ejaculation, the definition doubtless applies to men sexually active with other men. However, if the definition also includes control, the answer is not so clear. It might depend on the kind of sexual practices between the two men. For example, some men might ejaculate rapidly and out of control during anal intercourse but rapidly and in control with mutual masturbation.

Classification

DSM-IV-PC summarizes the criteria for the diagnosis of PE as follows: "Persistent or recurrent ejaculation with minimal stimulation before, on, or shortly after penetration and before the person wishes it, causing marked distress or interpersonal difficulty."[6] (This statement introduces a subjective element by using the phrase "wishes it"). The clinician is further instructed to " . . . take into account factors that affect the duration of the sexual excitement phase, such as age, novelty of the sexual partner or situation,

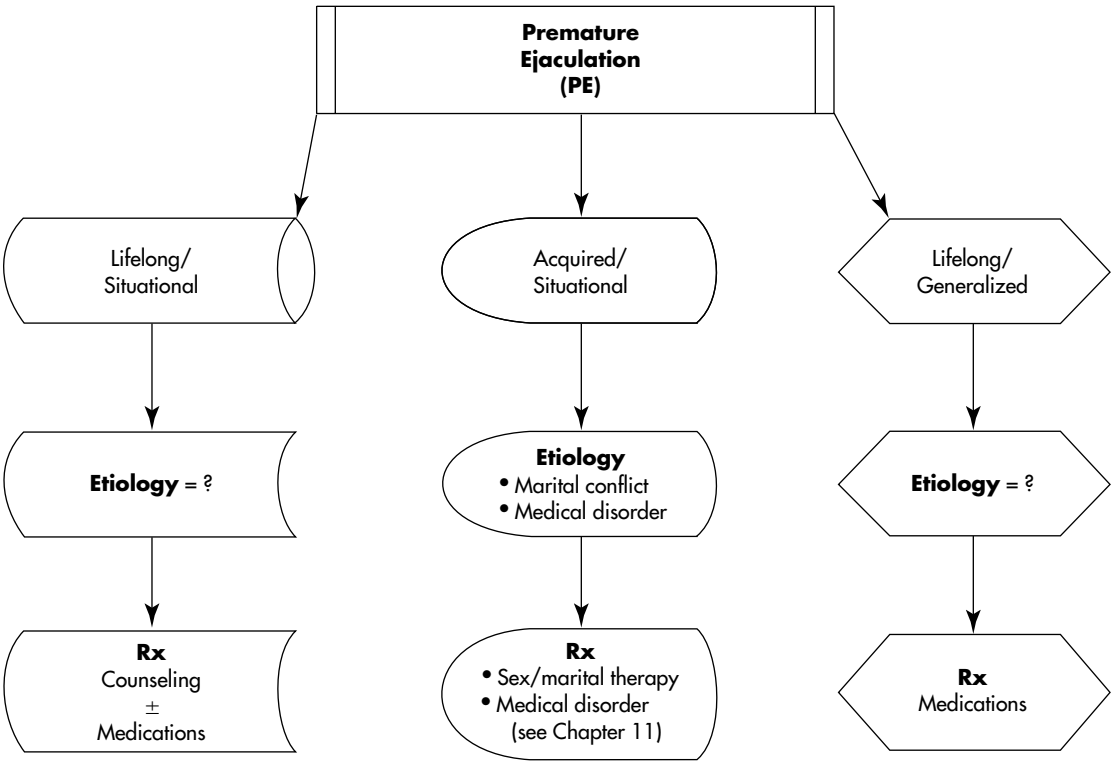

Figure 10-1 Assessment of premature ejaculation.

and frequency of sexual activity." As with other sexual dysfunctions, clinicians are also asked to specify if the problem is lifelong or acquired, or situational or generalized. The assessment of premature ejaculation is outlined in Figure 10-1

Description

The majority of men who ask for assistance describe a lifelong pattern of ejaculating quickly and without any control in attempts at intercourse. This process usually contrasts with ejaculation with masturbation, the timing of which is described as entirely in their control.

History reveals increasing concern about ejaculation in intercourse after an initial period in which the man seemed unaware of possible dissatisfaction of previous sexual partners ("no one ever said anything"). His sexual activities tend to focus on intercourse. On a time scale, the man often ejaculates within seconds after vaginal entry. While ejaculation is pleasurable, the total sexual experience is anything but, since it is filled with worry and trepidation about 'the same thing taking place that occurred the last time.' Various attempts at controlling ejaculation (including distracting oneself by nonsexual thoughts or masturbating before a sexual encounter) have been tried and found wanting. The patient is apologetic to his partner and privately self-deprecatory. The current partner is often angry because her sexual arousal is repeatedly interrupted. Her interest in sexual activities may decline. Sometimes a woman in this situation believes that the man deliberately chooses not to control the timing of his ejaculation. Resulting intra- and interpersonal tensions can be substantial.

Some men describe difficulties with the timing of ejaculation of relatively recent onset and after a lengthy period in which this was not considered to be a problem by him or his partner(s). The distinction between this acquired form and its lifelong counterpart is important from etiological and therapeutic viewpoints.

Epidemiology

Some information about "normal" latency was provided by Kinsey and his colleagues in their survey of men in the general population[9] (pp. 579-581). While they did not seem to consider PE to be a disorder, curiosity about speed of ejaculation (rather than definition of the problem) resulted in them asking about ejaculation latency (that is, the estimated average time for ejaculation to occur after vaginal entry). The time was two minutes for about three fourths of the men studied.

Question: "During the last 12 months has there ever been a period of several months or more when you came to a climax too quickly?" Twenty-nine percent of the men surveyed answered, "Yes." (This is, by far, the most common sexual complaint of the men surveyed.)

Laumann and his colleagues asked those who were surveyed: "during the last 12 months has there ever been a period of several months or more when you came to a climax too quickly?"[10] pp.368-375) Twenty-nine percent of the men answered "yes"—the most common sexual complaint, by far, of the men surveyed. Positive answers were greatest in men who were under the age of 40 and over the age of 54, married and divorced (compared to those who had never married), less educated (i.e., received less than high school education), black, in poor health, and unhappy.

PE has varied from 15% to 46% of presenting complaints at sexual problem clinics in a review of studies completed between 1970 and 1988.[11] Furthermore, for unknown reasons, PE may be decreasing over time as the principal sexual concern of men who appear at the clinics.

The acquired form of PE (sometimes referred to as "secondary") is characterized by: (1) an older man, (2) a briefer interval of time existing between beginning of the difficulty and seeking professional assistance, and (3) erectile difficulties preceding the onset.[12]

Etiology

The variety of psychologically and biologically based etiological hypotheses for PE have been thoroughly reviewed[3] and include the following:

1. Psychodynamic theories (excessive narcissism or a virulent dislike of women)
2. Early experience (conditioning based on haste and nervousness)
3. Anxiety (causing activation of the sympathetic nervous system or distraction from worry resulting in lack of awareness of sensations premonitory to ejaculation)
4. Low frequency of sexual activity
5. Not using techniques that other men have learned to control the timing of ejaculation
6. Not considering rapidity of ejaculation to be a disorder, since it is a superior trait from an evolutionary viewpoint
7. Easier arousal
8. Greater sensitivity to penile stimulation
9. Malfunctioning of the normal ejaculatory reflex[3]

Many men (perhaps most) who ejaculate unpredictably with a partner are able to control the timing of their ejaculation when masturbating.

Theories about PE represent etiological speculations concerning men who are otherwise healthy. However, PE has also been reported in association with trauma to the sympathetic nervous system during surgery for aortic aneurysm, pelvic fracture, prostatitis, urethritis[4] and neurological diseases such as multiple sclerosis[2] (p. 148).

While the presence of anxiety often seems to be associated with PE, the direction of the relationship (cause or effect) is unclear. What is striking, however, is the fact that many men (perhaps most) who ejaculate unpredictably with a partner are able to control the timing of their ejaculation when masturbating. (A few men who appear to be otherwise healthy ejaculate spontaneously and without control in the presence of any kind of sexual stimulation.) Assuming a relationship between anxiety and ejaculatory control, anxiety is helpful as an explanation for the occurrence of PE only in relation to intercourse (since men are considerably less anxious when masturbating[13]).

Speed of ejaculation was compared in premature and nonpremature ejaculating men when masturbating. Assessment of latency to ejaculation showed that when at home the men with PE ejaculated in about half the time as their conterparts (three minutes versus six minutes).

One of the more compelling hypotheses for PE is that it "may be, at least in part, the result of a physiologically determined hypersensitivity to sexual stimulation," that is, PE may be a reflection of a lower ejaculatory threshold. In a study that adds support to this idea, speed of ejaculation was compared in premature and nonpremature ejaculating men when masturbating. Assessment of latency to ejaculation showed that when at home the men with PE ejaculated in about half the time as their counterparts (three minutes versus six minutes).[11] The authors of this study suggest a diathesis-stress model in which "some individuals with a particularly strong

somatic vulnerability may require little, if any, anxiety in order to manifest their low orgastic threshold."

Investigation into the etiology of the acquired form of PE suggests separation into two groups: (1) one in which the patients had a "demonstrable organic cause" (e.g., erectile dysfunction as a result of diabetes) and (2) one in which the men were involved in disturbed relationships.[12]

Investigation

History

The history is the key to the diagnosis of PE in a man who is otherwise healthy. While history can be obtained from the man alone, the effect of this syndrome on both sexual partners is best gauged by talking directly with each. Issues to inquire about and suggested descriptive questions (asked of heterosexual men, although easily adapted to gay men as well) include:

1. Duration of ejaculatory difficulty (see Chapter 4, "lifelong versus acquired")

Suggested Question: **HAS EJACULATING QUICKLY ALWAYS BEEN A PROBLEM FOR YOU OR WAS THERE A PERIOD OF TIME WHEN THIS DID NOT OCCUR?"**

2. Subjective feeling before ejaculation (see Chapter 4, "generalized versus situational")

Suggested Question: "**IF YOU COMPARE YOUR EJACULATION WHEN HAVING INTERCOURSE TO MASTURBATING, HOW MUCH WARNING DO YOU HAVE THAT EJACULATION IS ABOUT TO OCCUR IN EACH SITUATION?"**

3. Timing of ejaculation (see Chapter 4, "description")

Suggested Question: "**DO YOU EJACULATE BEFORE, DURING, OR AFTER VAGINAL ENTRY?"**

4. Speed of ejaculation (see Chapter 4, "description")

Question if Answer is "After": "**ON THE BASIS OF TIME, HOW LONG DOES IT TAKE YOU TO EJACULATE AFTER ENTRY?"**

Additional Question: "**ON THE BASIS OF NUMBERS OF MOVEMENTS OR THRUSTS, HOW MANY OCCUR BEFORE YOU EJACULATE?"**

5. Methods used to control ejaculation (see Chapter 4, "description")

Suggested Question: "**HAVE YOU TRIED TO CONTROL THE TIMING OF YOUR EJACULATION?"**

If the Answer is "Yes," Follow-up Suggested Question: "**WHAT METHODS HAVE YOU USED TO DO THIS?"**

Additional Question: "**FOR EXAMPLE, MANY MEN STOP MOVING (OR USE CONDOMS, ANESTHETIC CREAMS OR OILS, OR THINK OF SOMETHING NONSEXUAL) IN AN ATTEMPT TO PREVENT THEMSELVES FROM GETTING CLOSE. IS THAT SOMETHING YOU'VE TRIED TO DO?**"

6. Subjective feeling of orgasm (see Chapter 4, "description")

Suggested Question: "**ALTHOUGH ORGASM IS DIFFICULT TO DESCRIBE, CAN YOU EXPLAIN WHAT IT FEELS LIKE WHEN YOU EJACULATE?**"

Additional Possible Question: "**IS IT A PLEASANT OR UNPLEASANT EXPERIENCE FOR YOU?**"

7. Description of emission (see Chapter 4, "description")

Suggested Question: "**MEN USUALLY EXPERIENCE REPEATED OR RHYTHMIC CONTRACTIONS WHEN THEY EJACULATE SO THAT THE SEMEN COMES OUT IN SPURTS. DO YOU NOTICE THESE CONTRACTIONS WHEN YOU EJACULATE?**"

Additional Suggested Question: "**WHEN EJACULATION OCCURS, DOES THE SEMEN COME OUT IN SPURTS OR DOES IT DRIBBLE OUT?**"

(Comment: There is less force to ejaculation when there is some obstruction [e.g., prostatic hypertrophy or urethral stricture] neurological disorder, and in the aging process[14] [pp. 257-259].)

8. Psychological accompaniment (see Chapter 4, "patient and partner's reaction to problem")

Suggested Question: "**WHEN YOU HAVE TROUBLE WITH EJACULATION, WHAT'S GOING THROUGH YOUR MIND?**"

Additional Question: "**WHAT DOES YOUR WIFE (PARTNER) THINK?**"

Given the prevalence of lifelong Premature Ejaculation, the focus on history-taking as the principal diagnostic technique, the etiological concentration on the present rather than the past, and the usefulness of some brief approaches, treatment of this disorder is well within the purview of primary care.

Physical and laboratory examinations

In otherwise healthy men, these investigations add little useful information.

Treatment

Given the substantial frequency of lifelong Premature Ejaculation in the community, the focus on history-taking as the principal diagnostic technique, the etiological concentration on the present rather than the past, and the usefulness of some brief approaches, treatment of this disorder is well within the purview of primary care.

Masters and Johnson described a talk-oriented treatment method for PE that provides an "overall failure rate" of 2.7%[1] (pp. 92-115 and 367). Perhaps as a result of the reported benefits, little else was suggested therapeutically for some time after. Others also reported positive effects after treatment but when long-term follow-up studies

were done considerably less robust results were found. A three-year follow-up study (for example) reported dramatic changes at the end of treatment for PE in the duration of intercourse. However, pretreatment levels returned after three years.[15] (Interestingly, significant improvements in the duration of *foreplay* reported at the end of treatment were found in this study to have persisted at follow-up.)

Counseling and medications are presently the mainstays of treatment for lifelong PE. Obviously, drug prescription is available only to physicians. However, cooperative relationships between all professionals in the health care system increasingly reflect changes toward improvement in the quality of patient care.

Pharmacotherapy

Evidence for the utility of drug treatment of PE is increasing. In case reports and single blind studies, psychotropic drugs are noted to interfere with ejaculation as a side effect.[16] Some investigators reason that this observation could be turned to advantage, suggesting that a side effect is not necessarily an *adverse* effect. The antidepressants paroxetine,[17] sertraline,[18] and clomipramine[4] have undergone double-blind testing for their usefulness in the treatment of PE (often in smaller doses than that used in the treatment of depression). (Paroxetine [Paxil] and sertraline [Zoloft] are selective serotonin reuptake inhibitors [SSRIs], and clomipramine [Anafranil] is a chemical hybrid of a tricyclic and SSRI).

Waldinger and his colleagues conducted a double-blind, randomized, placebo-controlled study of paroxetine (40 mg/day for five of the six weeks of the study [higher than what is usually prescribed in treating depression]) in the treatment of PE in 17 men.[17] Patients and partners were questioned separately. The improvement was described as dramatic and began in the first days of treatment (suggesting that the effect was not a result of diminished psychopathology). No anticholinergic side effects (a possible problem with clomipramine, depending on the dose) or effect on erection function was reported.

Mendels and his colleagues randomly assigned 52 heterosexual males to an eight week study of either sertraline or a placebo administered in a double-blind fashion.[18] The drug was given daily and the dose varied from 50 to 200 mg, depending on the beneficial response and adverse experiences of the patient. Sertraline was judged to be significantly better than placebo in (1) prolongation of time to ejaculation and (2) number of successful attempts at intercourse.

Althof and his colleagues completed a double-blind placebo-controlled crossover trial of clomipramine in a group of 15 otherwise healthy men with lifelong PE who were also married or cohabiting with a woman for at least six months.[4] Partners participated in the study. Results of the study are as follows:

1. Mean ejaculatory latency increased almost threefold at a dose of 25 mg/day and over five-fold at the other studied dose of 50 mg/day
2. Both partners reported statistically significant greater levels of sexual satisfaction
3. Some of the women who reported never previously experiencing orgasm with intercourse became coitally orgasmic
4. Over half of the 10 women who previously reported orgasm during intercourse indicated that it now happened more frequently

5. The men reported greater emotional and relationship satisfaction

However, when the drug was discontinued, sexual function returned to the level that existed before the study.

The use of clomipramine on an "as needed" basis was examined[19] in another study. Using a double-blind, placebo-controlled, crossover design, eight men with PE, six men with PE and erectile dysfunction, and eight control men were studied. Partners did not participate in the study. Subjects took 26 mg of clomipramine or placebo 12 to 24 hours before anticipated sexual activity. In contrast to the marked beneficial effect in the men with "primary" (i.e., lifelong) PE, the authors report that the drug was not useful in men who had PE and erectile dysfunction. This result affirms the importance of subclassification.

A 28-year-old man and his 32-year-old wife were seen because of his difficulty with regular ejaculation before vaginal entry. This pattern of ejaculation had existed since the beginning of his attempts at intercourse as a teenager. His wife was becoming sexually disinterested and questioned her commitment to the relationship, particularly because "the biological clock was ticking" and she wanted to begin a family. The couple had undergone a Masters and Johnson-type of treatment program about one year earlier and found that the initial gains were short-lived.[1] A one-visit assessment was conducted with them together, and clomipramine was prescribed. The couple was seen again two weeks later, when substantial improvement was reported in the following:

- His ejaculation latency
- Their sexual relationship
- Other aspects of their life as a couple

Much to the wife's pleasure, she became pregnant within two months of the first visit. The man was seen for a third time alone because the wife was unable to accompany him for the visit. He reported continued improvement in sexual and nonsexual areas of their life. Telephone contact was periodically maintained for the purpose of medication refills.

In a review of pharmacologic studies into the treatment of PE, Althof asks the following serious questions.[4]

1. Should drugs be the first line of treatment?
2. How should drugs be used? (daily? the day of intercourse? a duration of weeks? months? lifetime?)
3. What are the indications and contraindications? (Used only in the lifelong form? The acquired form? Prescribed only for men who do not ejaculate before, during, or immediately after entry but want to "last longer?")

4. What should be the relationship between drug treatment and psychotherapy?

Althof concludes that all of these questions require empirical research and are therefore difficult to answer at the present time. Some of these questions are considered below, and the information given is based more on clinical judgment and experience than research data.

Should drugs be the first line of treatment? Drugs may well be used immediately, as follows:

- A man who persistently ejaculates in an uncontrolled manner with any form of sexual stimulation and particularly before vaginal entry
- A couple when talk-oriented treatment methods are not helpful
- Many single men without partners
- When talking to a couple is unproductive even if a couple relationship exists (e.g., in the case of a couple raised in a culture where gender roles dictate that the woman is subservient to the man and both subscribe to this philosophy—a situation that is functionally the same as talking with the man by himself)

How should drugs be used? Daily and ad hoc (e.g., clomipramine four hours before intercourse is expected to occur) administration methods have been found helpful.

What are the contraindications? There are two reasons why drug treatment should not be used in men who have the acquired form of PE based on relationship discord. First, PE in this situation is clearly symptomatic and it makes little sense to treat the symptom and not the "disease" (i.e., the relationship discord). Second, the problem of PE may well be reversed with attention given to the disrupted relationship. Furthermore, in acquired PE associated with erectile problems, clomipramine treatment has been shown to be ineffective.[17] On the subject of contraindications, Althof also counseled that considerable caution be exercised in response to requests from men who want "boundless intercourse or designer orgasmic capabilities."[4]

What should be the relationship between drug therapy and psychotherapy? Althof states that there should not be an either/or attitude to the use of these treatment methods and that both may be desirable or necessary.[4] "The two treatment approaches are not to be compared solely in terms of economics or ejaculatory latency. Psychotherapy educates, clarifies, and often addresses other issues not perceived when the diagnosis was originally made." Indeed, if the physician's approach to medications is such that psychotherapy is *not* used in conjunction, then, by experience so far, the man is implicitly being told that he must take this medication for, perhaps, a lifetime. The implications of such a treatment decision are substantial, especially given that many of the men presenting with the lifelong and situational form of PE are young and in the early stages of their sexual experience.

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Counseling

The talking part of the treatment of someone with PE includes at least four components:

- Information
- Specific techniques
- Adaptation
- Attention to psychological issues

Some are easily incorporated into primary care practice.

INFORMATION

PE-related self-help books seem to be particularly useful in providing two elements of counseling[20-22]:

- Information (in this instance about men and sexual issues)
- Specific advice (in this example about controlling ejaculation)

The extent to which these two elements are therapeutically helpful is unclear, since men who benefit greatly from such books would not be likely to seek assistance from health professionals. Judging by the reaction of patients to whom such books are suggested, many find the content to be at least informative and reassuring and some follow the specific treatment methods suggested. Apart from specific issues around ejaculation control, Zilbergeld, in particular, interests male readers when discussing the powerful and influential sexual "myths" that so often determine how men think and behave sexually—in their own eyes and in those of their sexual partners.[20,22] This is "sex education" as it should be, that is, the description of body parts and their function and the discussion of sex-related aspects of human relationships. Kaplan's book includes information about PE and specific techniques for ejaculatory control (see immediately below).[21]

SPECIFIC TECHNIQUES

A second element in counseling, more applicable to couples, is directed at specific techniques to control the speed of ejaculation. Two approaches were described in the past: "stop-start"[23] and the "squeeze technique"[1] (pp. 102-104). The stop-start technique is more popular among sex therapists because it is easier for health professionals to explain and for patients to use. The stop-start approach involves an exercise in "communication" and comprises at least four steps:

1. Both partners initially agree not to attempt intercourse on at least several occasions (this is essential)
2. The woman stimulates the man's erect penis until he is close to ejaculation at which point he signals her to stop
3. This happens three or four times on any one sexual occasion before he eventually ejaculates
4. The couple then integrates this into intercourse experiences with frequent "pauses"

ADAPTATION

An additional facet of counseling, also more directed to couples, is incorporated into the concept of adaptation. Even if little change develops in the timing or speed of ejaculation as a result of talking forms of treatment, a considerable shift may occur in the sexual experiences of the couple such that the timing of the man's ejaculation becomes a lesser or even nonissue. For example, if the usual "order" of sexual events is such that the man ejaculates before his partner is stimulated, this process can be altered so that attention is given to the woman's satisfaction and (possibly) orgasm, before or after vaginal entry occurs. The notion of adaptation is consistent with some results found at follow-up, namely that treatment of PE may change aspects of foreplay rather than ejaculatory control.[12]

PSYCHOLOGICAL ISSUES

Ignoring concurrent psychological issues in the counseling process decreases the potential for a good outcome.

A couple in their late 30s, married for 15 years, was referred because the man regularly ejaculated immediately after vaginal entry, a pattern that existed throughout all of his life. In the process of initially talking with both (together and separately) it became clear that she was angry and "at the end of (her) rope." She was seriously considering separation for sexual and nonsexual reasons. Sexually, her level of interest was similar to her husband's (i.e., substantial) but her sexual arousal was interrupted continually by his ejaculation. She was orgasmic with direct clitoral stimulation before intercourse but this was irregular and unpredictable. Her animosity toward her husband about nonsexual concerns related to his inclination to continually avoid talking about contentious issues (including their sexual troubles). It was evident that simply delaying his ejaculation by using pharmacotherapy would not circumvent the discord between the two. Thus deliberate decision was made to treat this couple using traditional counseling methods.

Psychological issues may be particularly important in the solo male. A man might ask for solo treatment for several reasons:

1. He may not have a partner
2. Confidentiality and trust issues may prevent the involvement of a new partner
3. A partner may be unwilling or unable to participate in the process (this is less frequent than many men report)

In such circumstances, it is usually best to explain that although much can be accomplished diagnostically in seeing him alone, the absence of a sexual partner is often therapeutically limiting. Some aspects of the multifaceted treatment approach described above can be applied to the solo male, including the provision of information and learning specific techniques such as stop-start while masturbating.

When the limitations of solo (versus couple) treatment are discussed, clinicians frequently meet with a "catch-22" response in which the man says that the very existence of this problem prevents establishment of a relationship. He is, in effect, saying that speed of ejaculation is a determining force in relationships between men and women—a suggestion that (to say the least) not everyone supports. The fact that a partner is not present to possibly refute this argument puts the health professional in the difficult position of presenting a different point of view to the patient and potentially disrupting the professional relationship in the process. Psychotherapy might be helpful to the extent that the man is prepared to examine *all* aspects of a failed relationship, sexual and otherwise.

Indications for Referral for Consultation or Continuing Care by a Specialist

1. Consultation with a physician is required when pharmacotherapy is considered and the health professional is trained in a different discipline.
2. In the acquired form of PE associated with relationship discord, the ejaculation issue is likely symptomatic and treatment would involve relationship therapy—a process that is best undertaken on a continuing care basis by those in the health care system with clinical experience in this area, that is, mental health professionals.
3. In the acquired form of PE associated with an erectile disorder, managing both problems may be complex. Therefore referral to a sex-specialist for continuing care may be necessary.
4. Care of the solo man, beyond the use of drugs, often presents a dilemma. Men who are unwilling to use pharmacotherapy or who continue to have inter- or intrapersonal difficulty despite slower ejaculation are best seen for continuing care by a mental health professional who is comfortable with sexual issues.
5. Unsuccessful treatment at the primary care level should result in referral to a sex-specialist, at least for consultation, and possibly for continuing care.

Summary

Premature Ejaculation (PE) in heterosexual men is difficult to define precisely except in situations where ejaculation occurs persistently before, during, or immediately after vaginal entry. Control over the process of ejaculation appears to be a significant element in the definition, as well as the duration of time between vaginal entry and ejaculation. Most men with this disorder describe a lifelong pattern. "Coming to a climax too quickly" was the most common sexual complaint registered by men in a substantial survey of sexual behavior. An unreplicated study suggests an appealing hypothesis for the etiology of the lifelong form of PE, namely, that it is partly related to a "physiologically determined hypersensitivity to sexual stimulation." The acquired form seems to be the result of relationship discord or medical illness. The focus of investigation into the lifelong form of PE is particularly on history-taking (rather than physical examination or laboratory studies). Counseling and medications are the mainstays of treatment of this disorder. The latter has demonstrated great value, although many details concerning drug treatment have yet to be elaborated.

Long term follow-up studies of counseling alone show modest results. The potential value of combining the two treatment forms has not been investigated. Intuitively, medications may be considered a short-term intervention, and psychotherapy may be included toward the long-term goal of permanent change. Referral for consultation with a physician is required when drug therapy is undertaken by a health professional from another discipline. Referral for continuing care is particularly reasonable in the acquired form of PE and when slowing of ejaculation in a man seen alone has resulted in limited success in allowing him to develop intimate relationships.

DELAYED EJACULATION/ORGASM

Terminology

This syndrome has been variously called:

- Ejaculatory Incompetence[1]
- Retarded Ejaculation[24]
- Male Orgasm Disorder[5,6]

An evident problem with the terms is the confusion about whether this is a disorder of ejaculation, of orgasm, or both. These two phenomena are separate from a neurophysiological viewpoint although usually tightly interwoven. The separateness is evident in the normal development of preadolescent boys who are able to come to orgasm but who cannot ejaculate because the mechanism is not fully developed. The term, *Delayed Ejaculation/Orgasm* (DE/O), is preferred because it is entirely descriptive and DE/O refers to a delay in both ejaculation *and* orgasm.

Definition

Defining DE/O presents problems similar to PE, namely, the question of how much time constitutes a delay? In one form, the definition of time is not a problem, since the man can ejaculate without difficulty when alone (without any delay), but usually not at all when with a partner. When ejaculation is truly delayed, it is slow in *all* situations—regardless of the sexual activity and the nature of the partnership. In fact, ejaculation/orgasm may be so delayed that the person stops trying. In either case (delayed or absent) the definition is usually provided by the patient as he, for example, compares his present experience to that of the past or receives complaints from a sexual partner who may become vaginally uncomfortable because of a lengthy period of intercourse.

Classification

In DSM-IV-PC, orgasm difficulties for men and women are classified similarly[6] (p. 117). "Male Orgasmic Disorder" is defined as: persistent or recurrent delay in, or absence of, orgasm after a normal sexual excitement phase. This can be present in all situations, or present only in specific settings, and causes marked distress or interpersonal difficulty. Additional clinical information is provided: "In diagnosing Orgasmic Disorder, the clinician should also take into account the person's age and sexual expe-

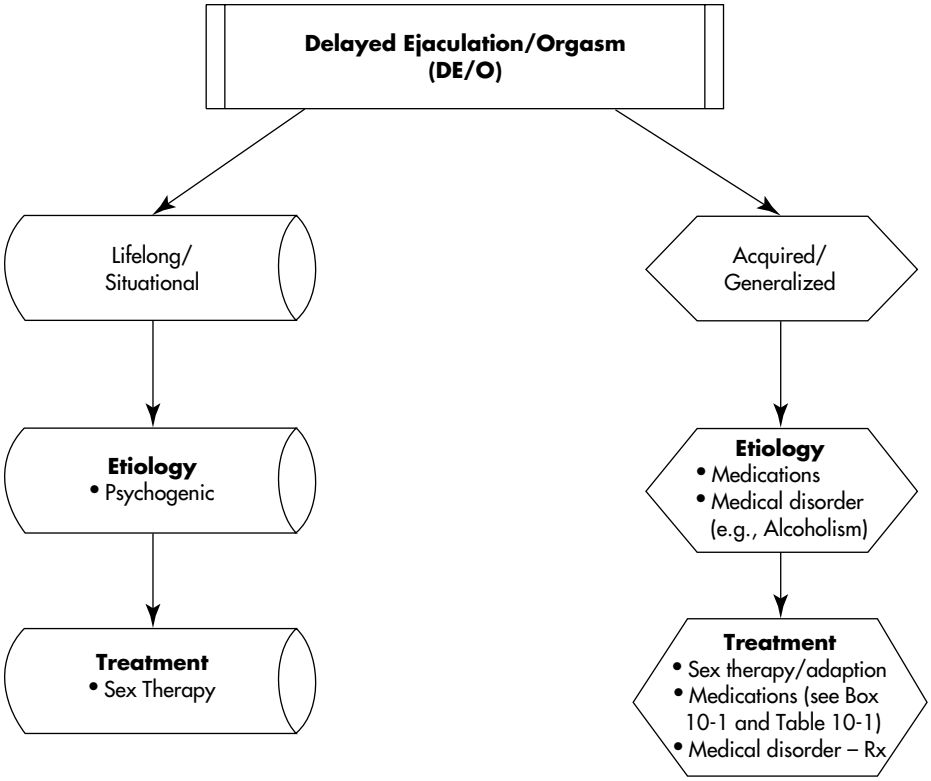

Figure 10-2 Assessment of delayed ejaculation/orgasm.

rience. . . . In the most common form of Male Orgasmic Disorder, a male cannot reach orgasm during intercourse, although he can ejaculate with a partner's manual or oral stimulation. Some males. . . . can reach coital orgasm but only after very prolonged and intense noncoital stimulation. Some can ejaculate only from masturbation. When a man has hidden his lack of coital orgasm from his sexual partner, the couple may present with infertility of unknown cause." Determining the subclassification as lifelong or acquired, generalized or situational can be crucial to determining etiology and treatment.

The assessment of Delayed Ejaculation/Orgasm is outlined in Figure 10-2.

Description

DE/O presents clinically in one of two forms:

- Situational
- Generalized

When situational, the problem is usually lifelong rather than acquired. When generalized, it is much more likely to be acquired.

In the situational form, the history is usually one of ejaculation without difficulty when alone but inability to ejaculate with partners generally or during a specific sexual

activity, typically intercourse. The request for assistance often can be traced to the partner and characteristically results from vaginal discomfort, concerns about reproduction, or both. Sometimes the man describes a method of masturbation that is difficult to transfer to sexual activity with a partner (e.g., rubbing his penis against a firm surface rather than using his hand).

Two gay men in their 20s were seen because one was unable to ejaculate in the presence of the other while having no such difficulty when masturbating alone. Strains in their relationship became apparent when the sexually functional partner let it be known that he considered his partner's inability to ejaculate to be a form of rejection. History revealed that the man with DE/O experienced this pattern of ejaculation in previous brief sexual relationships as well as the three he considered long-term. Treatment using the approach described by Masters and Johnson was unsuccessful at reversing the pattern[1] (pp. 129-133). One-year follow-up revealed that the relationship had dissolved.

In the generalized form (lifelong or acquired), history reveals that the man is experiencing substantial delay or absence of ejaculation/orgasm in all circumstances. Typically, the history is brief and clearly indicates that this is acquired and dates from the onset of the use of a particular medication (see "Etiology" below in this chapter). Occasionally this may be life long. Cultural or religious beliefs may also be a critical factor.

On some occasions, the history reveals a hybrid form, that is, one that has characteristics of both syndromes. Ejaculation is possible but only during masturbation. When ejaculation does occur in such circumstances, vigorous and lengthy penile stimulation is usually required—much more so than can be provided by vaginal intercourse.

A 35-year-old single man described an inability to ejaculate with a partner in spite of intercourse lasting up to one hour. Women partners initially enjoyed the experience and would find themselves repeatedly orgasmic. However, this attitude was soon replaced by one of impatience as the pleasure was superseded by the vaginal discomfort accompanying the long duration of intercourse. He described being able to ejaculate only with masturbation in a process that required about 15 minutes and great physical exertion in which he "worked" so hard he would sweat. He forcefully rubbed his penis against a hard surface while fantasizing about himself dressed as a woman.

In the Lauman study,[10] 8% of men reported being "unable to orgasm." (The investigators did not apparently distinguish between ejaculation/orgasm that was delayed and that which was entirely absent.)

Epidemiology

In the Laumann study, 8% of men reported being "unable to orgasm"[10](pp. 370-374). (The investigators did not apparently distinguish between ejaculation/orgasm that was delayed and that which was entirely absent.) The age category in which this syndrome was reported with greatest frequency was the 50 to 54 year old group (14%). Inability to come to orgasm was also reported more commonly in "Asian/Pacific Islander" men (19%), as well as those who were poorly educated (13%—less than high school), and financially poor (16%). As with other dysfunctions, the percentages of affected men increased with diminished health (18% of those whose health was "fair") and happiness (23% of men who were "unhappy most times").

"Male Orgasm Disorder" accounted for 3% to 8% of cases presenting for treatment in a review of clinical studies.[11]

Etiology

In the situational and hybrid forms, it is evident that specific sexual and/or psychosocial factors are central to etiological speculations[25] (pp.179-185); [1](p. 126). Theories include:

1. That some men are highly reactive genitally
2. That some men are fearful of dangers associated with ejaculation
3. An inhibition reflex
4. Religious orthodoxy
5. Male fear of pregnancy
6. Sexual interest in other men
7. A psychologically traumatic event

All drugs approved for treatment of depression or obsessive-compulsive disorder in the United States with the exception of nefazodone and bupropion are reported to be associated wih ejaculatory or orgasmic difficulty.[26]

In the acquired and generalized form, there is often a history of recent use of a medication that is known to interfere with ejaculation/orgasm (see Appendix V) or the presence of a neurological disorder such as multiple sclerosis.

"All of the drugs approved for the treatment of depression or the treatment of obsessive-compulsive disorder in the United States, with the exception of nefazodone and bupropion, have been reported to be associated with ejaculatory or orgasmic difficulty."[26] Prevalence figures for any one of the drugs varies as a result of different sources (manufacturer or published report) or variations in methodology (spontaneous reports or direct inquiry). Ejaculatory problems (delay or inhibition) have been reported in patients taking the following drugs:

- Imipramine (30%)
- Phenelzine (40%)
- Clomipramine (96%)
- Fluoxetine (24% to 75%)
- Sertraline (16%)
- Paroxetine (13%)
- Venlafaxine (12%)

Some antihypertensive drugs also interfere with ejaculation/orgasm. One of the problems in investigating the extent of this problem is that hypertension can cause sexual

difficulties apart from the drugs used in its treatment. "Ejaculatory dysfunction" was not found at all in two studies that included normotensives, but was associated with 7% to 17% of untreated, and 26% to 30% of treated patients[27] (p. 204). Antihypertensive drugs that can cause sexual difficulties were reviewed[27]: and, in relation to delayed ejaculation, specifically included the following:

- Reserpine (p. 216)
- Methyldopa (p. 219)
- Guanethidine (p. 224)
- Alpha$_1$ blockers (p. 235)
- Alpha$_2$ agonists (p. 237)
- Calcium channel blockers (p. 245)

Notably missing from this list were the following:

- Diuretics (p. 210)
- Beta-blockers (p. 227)
- ACE inhibitors (p. 242)

Investigation

History

1. Duration (see Chapter 4, "lifelong versus acquired")

Suggested Question: "**HAS EJACULATION DIFFICULTY BEEN A PROBLEM ALL YOUR LIFE OR IS IT A PROBLEM THAT DEVELOPED RECENTLY?**"

2. Ejaculation with a partner (see Chapter 4, "generalized versus situational")

Suggested Question: "**DO YOU EJACULATE AT ALL NOW WHEN YOU ARE WITH A PARTNER?**"

Additional Question if the Answer is "No": "**HAVE YOU EVER EJACULATED WITH A PARTNER?**"

Additional Question if the Answer to Either Previous Question is "Yes": "**WHAT KIND OF SEXUAL ACTIVITY RESULTED IN YOUR EJACULATION (E.G., INTERCOURSE OR ORAL STIMULATION)?**"

3. Ejaculation with masturbation (see Chapter 4, "generalized versus situational")

Suggested Question: "**DO YOU EJACULATE NOW WHEN YOU MASTURBATE?**"

Additional Question if the Answer is "No": "**HAVE YOU EVER EJACULATED WHEN YOU MASTURBATED?**"

4. Feeling prior to ejaculation/orgasm (see Chapter 4, "description")

Suggested Question: "**DO YOU SOMETIMES FEEL THAT YOU ARE CLOSE TO EJACULATION/ ORGASM BUT THEN THE FEELING DISAPPEARS?**"

Additional Question: "**WHEN WITH A PARTNER, DO YOU EVER PRETEND THAT YOU HAVE COME TO ORGASM?**"

Physical and Laboratory Examinations

In an otherwise healthy man, no particular physical or laboratory examinations are required.

Treatment

In the care of men with the situational form of DE/O, reported series are few. Masters and Johnson described their treatment format and their five-year follow-up of 17 men and reported a treatment failure rate of 17.6%[1] (pp. 116-136, p.357). Another three-year follow-up study in the United States described the treatment of five men[15] who reported themselves as:

Three men	Improved
One man	The same
One man	Worse

Men with DE/O usually do not ask for treatment until they are pressured into it by a sexual partner. By then, many sexual experiences may have taken place, resulting in a firmly established pattern of ejaculation that may be difficult to change.

A one to six year follow-up study conducted in the United Kingdom described two cases of "ejaculatory failure" and reported that in one there was no change, and in the other, the problem was resolved although still experienced.[28] No other case studies involving large numbers of patients have been published.

On the basis of impression rather than data, the occasional man with DE/O asks for care in his teens, and soon after intercourse experiences have begun. Such men may be amenable to the reassurance and provision of information that often comes with history-taking alone. The health professional might be justifiably optimistic about the result in such circumstances. Unfortunately, in most instances, men with DE/O do not ask for treatment until years later when they are pressured into it by a sexual partner. By that time, many sexual experiences have taken place (either alone or with partners) with a particular method of ejaculation, a pattern that may have become crystallized and difficult to change.

In the generalized form of DE/O, and when there is reason to suspect the use of a medication in the etiology, the following treatment "strategies" are suggested:

1. Maintain dosage of the medication and wait for tolerance to develop
2. Reducing the dosage
3. Change the regimen (e.g., the use of a "drug holiday")[29]
4. Change to an alternative medication (e.g., when the sexual side effects of sertraline and nefazodone were compared in the treatment of depression, nefazodone was said to have no inhibitory effects on ejaculation)[30]
5. Administer a second medication to counter the sexual side-effect of the first (see immediately below)[26]

Box 10-1 Strategies in Treating Delayed Ejaculation/Orgasm due to Antidepressant Drugs

1. Wait for tolerance to develop
2. Decrease dosage
3. Change regimen (e.g., "drug holiday")
4. Use alternate drugs
5. Use additional drugs ("antidotes")

Table 10-1 Drug Treatment of Delayed Ejaculation/Orgasm Due to Antidepressant Medications

DRUG	DOSAGE
Bethanecol	10-20 mg 1-2 hours pre IC
Cyproheptadine	4-8 mg 1-2 hours pre IC
Yohimbine	5.4-10.8 mg as needed
Amantadine	100-400 mg as needed
Bupropion	75 mg per day
Penoline	18.75 mg per day
Methylphenidate	5-25 mg as needed
Dextroamphetamine	5 mg sublingual 1 hr pre sex activity
Nefazodone	150 mg 1 hour pre IC

IC, Intercourse

Two potential problems exist when using other medications at the same time: the clinician must ensure that the second medication does not counteract the *therapeutic* impact of the first, and sexual spontaneity inevitably diminishes somewhat when planning precedes the sexual event (although often an exaggerated patient concern).

Segraves described seven medications that have been used in an effort to control the sexual side-effects of antidepressants (mostly SSRIs): bethanechol, cyproheptadine, yohimbine, amantadine, bupropion, dextroamphetamine, and penoline.[26] Methylphenidate has been suggested[31] also, as well as intermittent nefazodone[32] (Box 10-1 and Table 10-1).

Since outcome research has not subclassified patients, one can only provide clinical impressions about the generalized and lifelong form of DE/O. Given that biological factors likely explain the etiology, helping the patient adapt through the provision of information seems the optimal approach.

Indications for Referral for Consultation or Continuing Care by a Specialist

1. Situational DE/O: If this pattern of ejaculation has existed for some years, referral for sex therapy for the purpose of continuing care may be most beneficial
2. Acquired and generalized DE/O: where medications seem etiologically significant but the symptom has not altered with the strategies outlined in Box 10-1, it is reasonable to ask for advice (consultation) from a physician who has expertise in the use of the particular class of drugs.
3. Lifelong and generalized DE/O: if the provision of information and reassurance about the likely positive outcome proves insufficient, referral to a sex therapist for continuing care is the next logical step

Summary

Delayed Ejaculation usually represents a disorder (delay or absence) of both ejaculation and orgasm, hence the use of the abbreviation, "DE/O." The disorder appears in two forms:

- Situational, in that the man can come to ejaculation/orgasm without problem when alone but has great difficulty when a partner is present
- Generalized in the sense that the man has difficulty under all circumstances (with a partner or when alone with masturbation)

While unusual, the problem of delayed ejaculation is by no means rare (8% of men in one community survey indicated inability "to orgasm"). Etiologies are as follows:

1. The situational form includes significant psychosocial factors
2. The lifelong and generalized form includes biological factors that have not yet been defined
3. The acquired and generalized form can usually be explained by the use of medications (especially medications used in Psychiatry and in the control of hypertension) or the onset of a neurological disorder

The effects of treatment in the situational form seem better when the duration of the problem is brief. Several approaches are suggested for the generalized and acquired form where the etiology is related to medications. Treatment for the lifelong and generalized form can generally be undertaken initially on a primary care level through the provision of information and reassurance. Men with the acquired and generalized form who have never ejaculated in the waking state require care from a specialist.

RETROGRADE EJACULATION

Definition

Retrograde ejaculation (RE) "is the propulsion of seminal fluid from the posterior urethra into the bladder".[33] What is usually referred to as "ejaculation" actually comprises three separate events[34] (p. 423):

- First, "emission"

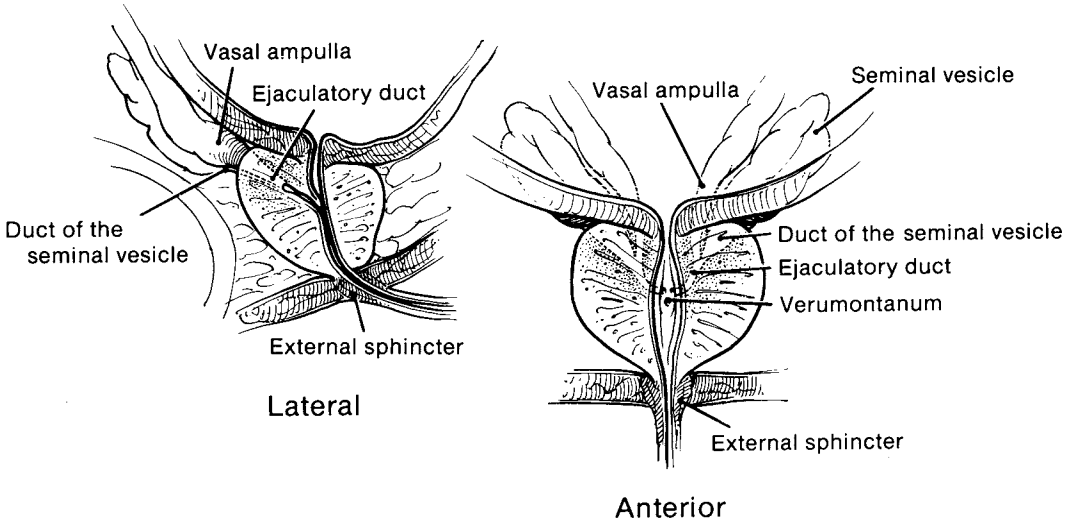

Figure 10-3 Anatomy of male accessory sex organs. (From Shaban SF, Seaman EK, Lipshultz LI: Treatment of abnormalities of ejaculation. In Lipshultz LI, Howards SS (editors): *Infertility in the male,* ed 3, St. Louis, 1997, Mosby.)

- Second, closure of the "bladder neck"
- Third, "ejaculation"

Emission involves the deposition of seminal fluid from the vas deferens, the seminal vesicles, and prostate gland into the posterior urethra. Ejaculation refers to the expulsion of semen from the penis, which, in turn, requires simultaneous closure of the muscular valve at the junction between the urethra and bladder (the bladder "neck"). This blockage prevents the semen from traveling backward into the bladder instead of going forward out the end of a man's penis. The expulsion of semen (true ejaculation) also involves intermittent relaxation of the "external sphincter"; there are three to seven contractions about 0.8 seconds apart (see Figure 10-3).

The final portion of this process comprises rhythmic contractions of the bulbospongiosus and ischiocavernosus muscles, resulting in forward movement of seminal fluid through the anterior urethra and emerging from the penile meatus. Orgasm is considered a cerebral event that occurs together with emission or ejaculation and associated with unknown physiological mechanisms[35] (p. 155).

Emission and bladder neck closure appear to be predominantly under the control of the sympathetic portion of the autonomic nervous system, and the expulsion of semen is predominately under the influence of the somatic nervous system[35] (pp. 165-166). "Any interference (anatomical, traumatic, neurogenic or drug-induced) with (the integrity of these systems) may result in abnormal function of the internal sphincter of the urethra, and favor retrograde ejaculation (RE) as the path of least resistance".[36]

Etiology

One way of considering etiological factors in RE is to separate them into (1) ones that disrupt the anatomy of the sphincter at the bladder neck and (2) ones that interfere with this sphincter's function[37] (p. 383). The best example of an anatomical disruption of this sphincter is a transurethral prostatectomy (TURP). Examples of factors that interfere with function of this sphincter include the following:

1. Retroperitoneal lymph node dissection (RPLND) or total lymphadenectomy in the treatment of some testicular cancers
2. Diabetes
3. Abdominopelvic surgery
4. Spinal cord injury

Some medications can induce a pharmacologic "sympathectomy" resulting in failure of emission and/or bladder neck closure (see Appendix V). These drugs[34] (p. 427) include the following antipsychotics (e.g., chlorpromazine and Haldol), antidepressants (e.g., amitriptyline and SSRIs), antihypertensives (e.g., guanethidine, diuretics and prazosin), and others (including alcohol).

Epidemiology

RE seems to be common as a complication of TURP but the actual frequency is not entirely clear. In one study of men before and after surgery, 24% who had no presurgical difficulty with ejaculation answered "yes" to the following question after surgery: "Do you have difficulty with getting the sperm out?"[38] However, 37% of the men who had no presurgical difficulty also said that they had no ejaculatory problem afterward.

Most men who develop RE as a consequence of TURP accept this situation and do not ask for treatment. When care is required (usually because of infertility), RE is best managed by physicians. The focus of infertility treatment is on attempting to induce antegrade ejaculation by increasing sympathetic tone at the bladder neck or diminishing parasympathetic activity.[33]

Given the frequency with which RE seems to occur as a result of TURP, the aging of the population (assuming TURP continues to be medically popular as a treatment of benign prostatic hypertrophy) might well result in an increase in the prevalence of RE.

RE seems to be infrequent as a cause of infertility in men (up to 2%)[37] (p. 383).

Investigation

History reveals that the patient reports not ejaculating while (in the majority of cases) continuing to experience orgasm ("dry orgasm"). The definitive diagnosis is made by laboratory examination of the man's urine immediatly after orgasm, and finding spermatozoa in the sample.

Treatment

Most men who develop RE as a consequence of TURP accept this situation and do not ask for treatment. When care is required (usually because of infertility), RE is best managed by physicians. The focus of infertility treatment is on attempting to induce antegrade ejaculation by increasing sympathetic tone at the bladder neck or diminishing parasympathetic activity.[33] Alpha-adrenergic agents are commonly used to enhance

sympathetic tone. In a detailed study of one patient who stopped ejaculating as a result of lymphadenectomy, four such drugs were used[39] and all seemed equally efficacious:

1. Dextroamphetamine sulphate, 5 mg four times daily
2. Ephedrine, 25 mg four times daily
3. Phenylpropanolamine, 75 mg twice daily
4. Pseudoephedrine, 60 mg four times daily

The study concluded that long-term treatment was consistently more effective than a single dose. Elliott (personal communication, 1997) found that in patients who have RE as a result of a spinal injury the effects of pseudoephedrine, in particular, can diminish if used continuously for more than four days, and that it may be more useful to use it on an "as needed" basis Anticholinergics have also been used successfully (brompheniramine 8 mg twice daily) and imipramine (25 to 50 mg daily). Surgery has also been suggested.[33]

When antegrade ejaculation can not be restored the treatment of infertility involves inseminating the woman with sperm cells taken from the urine by the process of centrifugation. In one group of eight patients with RE, the combination of alkalinization of the urine, immediate removal of sperm cells from the urine, and the implementation of artificial insemination techniques resulted in a "fecundity rate" of 45%[40] (p. 440).

When psychological concerns exist, they often relate to surprise and apprehension if, for example, a patient who has undergone a TURP was not forewarned about not seeing semen when he ejaculates. Psychological concerns may also be about other accompanying factors such as the possible presence of erectile or orgasmic difficulties and infertility. These other issues can have powerful repercussions.

Indications for Referral for Consultation or Continuing Care by a Specialist

As an isolated issue, RE does not appear to be a cause of further sexual difficulties. To the extent that sexual concerns are related to information, primary care treatment is usually sufficient. Consultation with a sexual medicine specialist may be useful in instances when RE is associated with other sexual difficulties. When infertility concerns result from RE (generally younger men of reproductive age who have experienced retroperitoneal lymph node dissection or total lymphadenectomy for the treatment of testicular cancer), continuing care should be undertaken by an expert physician.

Summary

Retrograde ejaculation (RE) is usually reported by a man as an orgasm without the associated emergence of semen ("dry orgasm"). Semen travels "backward" into the bladder and the definitive diagnosis can be made by the finding of spermatozoa in the urine. The most common cause of RE is the TURP procedure for benign prostatic hypertrophy. For most men, information is the only treatment needed. When fertility is a concern, medical treatment focus is on the attempt to enhance sympathetic tone at the bladder neck by using alpha-adrenergic agents or diminishing parasympathetic activity. Specialist care is required only in those instances where there are associated sexual difficulties or concerns about infertility.

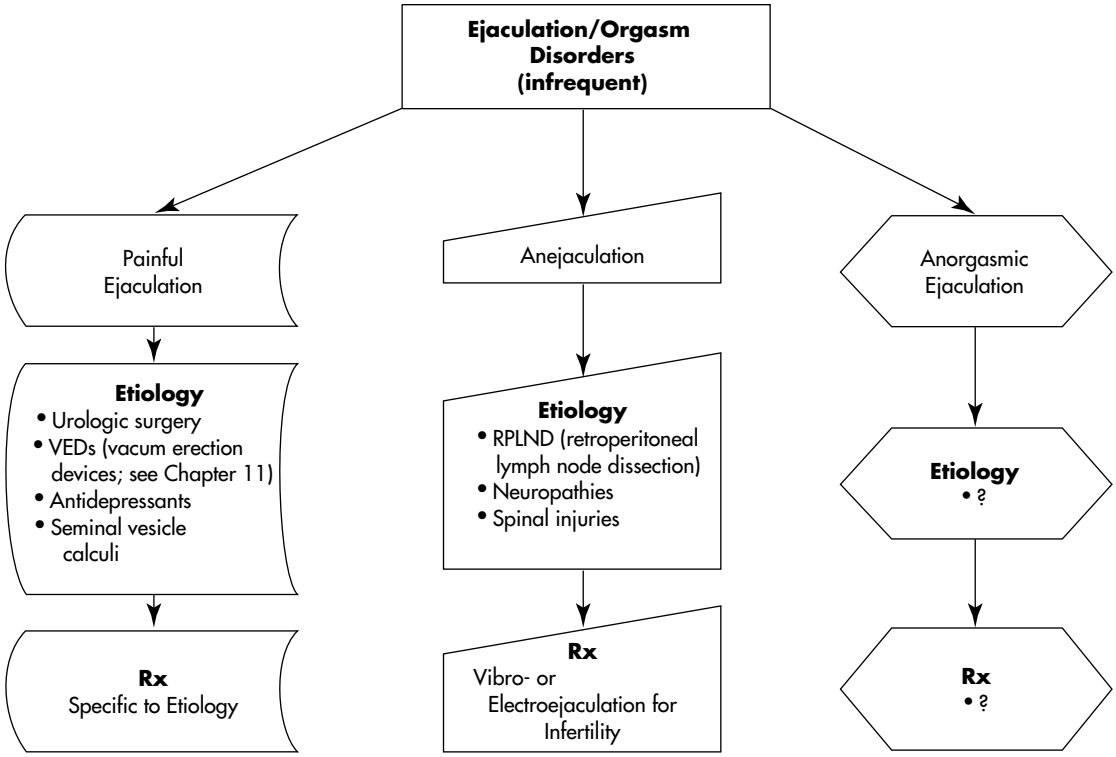

Figure 10-4 Assessment of infrequent ejaculation/orgasm disorders.

INFREQUENT EJACULATION/ORGASM DISORDERS

Infrequent ejaculation/orgasm disorders include painful ejaculation, anejaculation and anorgasmic ejaculation. The assessment of infrequent ejaculation/orgasm disorders is outlined in Figure 10-4.

Reports of genital pain associated with ejaculation are uncommon. The following four causes are known:

1. Some of the tricyclic antidepressants (amoxapine [related to loxapine], imipramine, desipramine, clomipramine)[41,42]
2. Seminal vesicle calculi[43]
3. Urological surgery
4. Vacuum erection devices (VEDs)

The first two explanations may not be immediately apparent. When associated with tricyclic antidepressants, ejaculatory pain is dose-related so that it diminishes when the dose is decreased and disappears when the medication is discontinued.[42]

The absence of ejaculation, or anejaculation (antegrade or retrograde), occurs as a result of peripheral sympathetic neuropathy[44] (pp. 404-6). It occurs in men with spinal

cord injury, men who had retroperitoneal lymph node dissection (RPLND) for testicular cancer, and in neuropathies such as those seen in multiple sclerosis and diabetes. Diagnosis is based on the absence of seminal fluid in postejaculatory urine to eliminate the possibility of RE. Emission/ejaculation and subsequent pregnancy can result from the use of specialized procedures such as vibratory stimulation or electroejaculation.[45]

Ejaculation without orgasm is quite unusual judging from the literature and clinical experience. The etiology is unknown.

A 47-year-old man was seen with the complaint of ejaculating without the sensation of orgasm. He vividly recalled the powerful feeling of orgasm in the past and hoped that it would return. The sensation of orgasm tapered during the past three years so that it was virtually absent at the present time—regardless if he ejaculated with masturbation or with a partner. He had previously been married for 12 years and had experienced premature ejaculation throughout all of the marriage. In four of the seven years after his divorce, his sexual experiences with other women were described with relish, particularly since he was then free of any ejaculatory difficulty. His general health was unimpaired, his sexual desire was as strong as ever, and he never experienced any erectile difficulties. When seen one year after his initial consultation, the problem had not changed.

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