Ejaculatory Disorders

HEALTHY MALE
ANDROLOGY AUSTRALIA

1. Premature Ejaculation (PE)

- The most common ejaculatory disorder
- Ejaculation that occurs sooner than desired
- Primary (lifelong) PE
  - patient has never had control of ejaculation
  - disorder of lower set point for ejaculatory control
  - unlikely to diagnose an underlying disease
- Secondary (acquired) PE
  - patient was previously able to control ejaculation
  - most commonly associated with erectile dysfunction (ED)
- Definition (ISSM, 2014):
  - an intravaginal ejaculatory latency time (IELT) of less than about 1 minute (lifelong) or about 3 minutes (acquired), and
  - an inability to delay ejaculation on nearly all occasions, and
  - negative personal consequences such as distress.
- Primary (lifelong) PE tends to present in men in their 20s and 30s; secondary (acquired) PE tends to present in older age groups

Clinical notes: PE is a self reported diagnosis, and can be based on sexual history alone.

The GP's role

- GPs are typically the first point of contact for men with a disorder of ejaculation
- The GP's role in management of PE includes diagnosis, treatment and referral
- Offer brief counselling and education as part of routine management

How do I approach the topic?

- "Many men experience sexual difficulties. If you have any difficulties, I am happy to discuss them."

Diagnosis

Medical history

Sexual history

- Establish presenting complaint (i.e. linked with ED)
- Intravaginal ejaculatory latency time
- Onset and duration of PE
- Previous sexual function
- History of sexual relationships
- Perceived degree of ejaculatory control
- Degree of patient/partner distress
- Determine if fertility is an issue

Medical

- General medical history
- Medications (prescription and non prescription)
- Trauma (urogenital, neurological, surgical)
- Prostatitis or hyperthyroidism (uncommonly associated)

Psychological

- Depression
- Anxiety
- Stressors
- Taboos or beliefs about sex (religious, cultural)

Physical examination

- General examination
- Genito-urinary: penile and testicular
  - rectal examination (if PE occurs with painful ejaculation)
- Neurological assessment of genital area and lower limb

Refer to Clinical Summary Guide 1: Step-by-Step Male Genital Examination

Management

Treatment

Treatment decision-making should consider:

- Aetiology
- Patient needs and preferences
- The impact of the disorder on the patient and his partner
- Whether fertility is an issue.

Management of PE is guided by the underlying cause.

Primary PE:

- 1st line: SSRI, reducing penile sensation, e.g. using topical penile anaesthetic sprays (only use with a condom)
- 2nd line: Behavioural techniques, counselling
- Most men require ongoing treatment to maintain normal function.

Secondary PE

- Secondary to ED: Manage the primary cause or
- 1st line: Behavioural techniques, counselling
- 2nd line: SSRI, reducing penile sensation, PDE5 inhibitors
- Many men return to normal function following treatment

Treatment options

Erectile dysfunction (ED) treatment

- If PE is associated with ED, treat the primary cause (e.g. PDE5 inhibitors)

Behavioural techniques

- 'Stop-start' and 'squeeze' techniques, extended foreplay, pre-intercourse masturbation, cognitive distractions, alternate sexual positions, interval sex and increased frequency of sex
- Techniques are difficult to maintain long-term

Psychosexual counselling

- Address the issue that has created the anxiety or psychogenic cause
- Address methods to improve ejaculatory control. Therapy options include meditation/relaxation, hypnotherapy and neuro-biofeedback

Oral pharmacotherapy

A common side-effect of some selective serotonin reuptake inhibitors (SSRI) and tricyclic antidepressants is delayed ejaculation. SSRIs are commonly prescribed for PE; except for Priligy®, all other SSRIs are used off-label for treating PE. Common dosing regimens are:

- **Dapoxetine hydrochloride (Priligy®):** a short-acting on-demand SSRI,the only SSRI approved for treatment of PE in Australia; 30 mg taken 1-3 hours before intercourse
- **Fluoxetine hydrochloride:** 20 mg/day
- **Paroxetine hydrochloride:** 20 mg/day. Some patients find 10mg effective; 40 mg is rarely required. Pre-intercourse dosing regime is generally not effective
- **Sertraline hydrochloride:** 50 mg/day or 100 mg/day is usually effective. 200 mg/day is rarely required. Pre-intercourse dosing regime is generally not effective
- **Clomipramine hydrochloride*:** 25-50 mg/day or 25 mg 4-24 hrs pre-intercourse

*** Suggest 25 mg on a Friday night for a weekend of benefit (long acting)**

PDE-5 Inhibitors: e.g. Sildenafil (Viagra®: 50-100 mg), 30-60 minutes pre-intercourse if PE is related to ED.

'Start low and titrate slow'. Trial for 3-6 months and then slowly titrate down to cessation. If PE reoccurs, trial drug again. If one drug is not effective, trial another.

Reducing penile sensation

- **Topical applications:** Local anesthetic gels/creams can diminish sensitivity and delay ejaculation. Excess use can be associated with a loss of pleasure, orgasm and erection. Apply 30 minutes prior to intercourse to prevent trans-vaginal absorption. Use a condom if intercourse occurs sooner
- **Lignocaine spray:** 10% ('Stud' 100 Desensitising spray for men; this should be used with a condom to prevent numbing of partner's genitalia)
- **Condoms:** Using condoms can diminish sensitivity and delay ejaculation, especially condoms containing anaesthetic

Clinical notes: combination treatment can be used.

Specialist referral

For general assessment refer to a specialist (GP, endocrinologist or urologist) who has an interest in sexual medicine.

Refer to a urologist: If suspicion of lower urinary tract disease

Refer to an endocrinologist: If a hormonal problem is diagnosed

Refer to counsellor, psychologist, psychiatrist or sexual therapist: For issues of a psychosexual nature

Refer to fertility specialist: If fertility is an issue

2. Other ejaculatory disorders

- Spectrum of disorders including delayed ejaculation, anorgasmia, retrograde ejaculation, anejaculation and painful ejaculation
- Can result from a disrupted mechanism of ejaculation (emission, ejaculation and orgasm)
- Disorders of ejaculation are uncommon, but are important to manage when fertility is an issue
- Etiology of ejaculatory dysfunction are numerous and multifactorial, and include psychogenic, congenital, anatomic causes, neurogenic causes, infectious, endocrinological and secondary to medications (antihypertensive, psychiatric (SSRIs), α-blocker)

Delayed ejaculation / no orgasm

Delayed ejaculation

- Delayed ejaculation occurs when an 'abnormal' or 'excessive' amount of stimulation is required to achieve orgasm with ejaculation
- Often occurs with concomitant illness
- Associated with ageing
- Can be associated with idiosyncratic masturbatory style (psychosexual)

Investigation	Treatment
Testosterone levels	**Aetiological treatment:** Management of underlying condition or concomitant illness e.g. androgen deficiency **Medication modification:** consider alternative agent or 'drug holiday' from causal agent **Psychosexual counselling**

Anorgasmia

- Anorgasmia is the inability to reach orgasm
- Some men experience nocturnal or spontaneous ejaculation
- Aetiology is usually psychological

Investigation	Treatment
Testosterone levels	**Psychosexual counselling** **Medication modification:** consider alternative agent or 'drug holiday' from causal agent **Pharmacotherapy:** Pheniramine maleate, decongestant medication such as Sudafed® or antihistamines such as Periactin® may help but have a low success rate.

Orgasm with no ejaculation

Retrograde "dry" ejaculation

- Retrograde ejaculation occurs when semen passes backwards through the bladder neck into the bladder. Little or no semen is discharged from the penis during ejaculation
- Causes include prostate surgery, diabetes
- Patients experience a normal or decreased orgasmic sensation
- The first urination after sex looks cloudy as semen mixes into urine

Investigation	Treatment
Post-ejaculatory urinalysis - presence of sperm and fructose	**Counselling:** to normalise the condition **Pharmacotherapy:** possible restoration of antegrade ejaculation and natural conception; note that pharmacotherapy may not be successful - Imipramine hydrochloride (10 mg, 25 mg tablets) 25-75 mg three times daily - Pheniramine maleate (50 mg tablet) 50 mg every second day - Decongestant medication such as Sudafed®; antihistamines such as Periactin® **Medication modification:** consider alternative agent or 'drug holiday' from causal agent **Behavioural techniques:** The patient may also be encouraged to ejaculate when his bladder is full, to increase bladder neck closure **Vibrostimulation, electroejaculation, or sperm recovery from post-ejaculatory urine:** Can be used when other treatments are not effective, to retrieve sperm for assisted reproductive techniques (ART)

Anejaculation

- Anejaculation is the complete absence of ejaculation, due to a failure of semen emission from the prostate and seminal ducts into the urethra
- Anejaculation is usually associated with normal orgasmic sensation

Investigation	Treatment
Testosterone levels Post-ejaculatory urinalysis - absence of sperm and fructose Ultrasound of seminal vesicles and post ejaculatory ducts (usually via the rectum)	**Counselling:** to normalise the condition **Medication modification:** consider alternative agent or 'drug holiday' from causal agent **Vibrostimulation or electroejaculation:** Used when other treatments are not effective, to retrieve sperm for ART **Pharmacotherapy:** Pheniramine maleate, decongestant medication such as Sudafed® or antihistamines such as Periactin® may help but have a low success rate

Painful ejaculation

- Painful ejaculation is an acquired condition where painful sensations are felt in the perineum or urethra and urethral meatus
- Multiple causes e.g. ejaculatory duct obstruction, post-prostatitis, urethritis, autonomic nerve dysfunction

Investigation	Treatment
Urine analysis (first pass urine- chlamydia & gonorrhoea urine PCR test; midstream urine MC&S) Cultures of semen (MC&S) Cystoscopy	**Aetiological treatment (e.g. infections-prostatitis, urethritis):** Implement disease specific treatment **Behavioural techniques:** If no physiological process identified. Use of relaxation techniques (i.e. ejaculation in conditions when muscles can be relaxed), use of fantasy for distraction **Psychosexual counselling**

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