



Ejaculatory Disorders

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 premature ejaculation (PE) includes diagnosis, treatment and referral.
- Offer brief counselling and education as part of routine management.

How to approach the topic with patients

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

Overview

- Ejaculatory disorders include premature ejaculation, delayed ejaculation, anorgasmia, retrograde ejaculation, anejaculation and painful ejaculation.
- Ejaculatory disorders 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.
- Etiologies 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).

Premature ejaculation

- The most common ejaculatory disorder¹.
- 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).
- Definition²:
 - An intravaginal ejaculatory latency time (IELT) of less than about 1 minute (lifelong) or about 3 minutes (acquired)
 - An inability to delay ejaculation on nearly all occasions
 - Negative personal consequences such as distress.
- Primary (lifelong) PE is present from the first sexual experience; secondary (acquired) PE represents a significant reduction in latency time occurring later in life, after initially having an acceptable IELT.

Clinical notes

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

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 and/or counselling.
- Most men require ongoing treatment to maintain normal function.

Secondary PE

- Secondary to ED: Manage the primary cause.
- 1st line: Behavioural techniques and/or counselling.
- 2nd line: SSRI, reducing penile sensation and/or 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 dapoxetine hydrochloride, all other SSRIs are used off-label for treating PE. Common dosing regimens are:

- **Dapoxetine hydrochloride:** 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 10 mg 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 (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:** 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.
- Combination treatment can be used.

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.

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).

Treatment³

- **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.
- Testosterone levels.

Anorgasmia (no orgasm)

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

Treatment⁴

- Psychosexual counselling
- **Medication modification:** Consider alternative agent or 'drug holiday' from causal agent.
- **Pharmacotherapy:** Pheniramine maleate, pseudoephedrine or cyproheptadine may help but have a low success rate.
- Testosterone levels.

Retrograde "dry" ejaculation (orgasm with no 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 and diabetes.
- Patients experience a normal or decreased orgasmic sensation.
- The first urination after sex looks cloudy as semen mixes into urine.

Treatment⁵

- **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 pseudoephedrine; antihistamines such as cyproheptadine.
- **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).
- **Post-ejaculatory urinalysis** — presence of sperm and fructose.

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.

Treatment⁵

- 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: Dopamine receptor agonists, serotonin antagonists, oxytocin and drugs that increase noradrenaline.
- Testosterone levels.
- Post-ejaculatory urinalysis — absence of sperm and fructose.
- MRI or ultrasound of seminal vesicles and post ejaculatory ducts (usually via the rectum).

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 and autonomic nerve dysfunction).

Investigation

Treatment

- Aetiological treatment (e.g. infections-prostatitis, urethritis): Implement disease specific treatment.
- Behavioural techniques: If no physiological process identified. Use of relaxation techniques (e.g. ejaculation in conditions when muscles can be relaxed), use of fantasy for distraction.
- Psychosexual counselling.
- Transurethral resection of the ejaculatory duct.
- Urine analysis (first pass urine – chlamydia & gonorrhoea urine PCR test; midstream urine MC&S).
- Cultures of semen (MC&S).
- Cystoscopy.
- Consider imaging (MRI and transrectal ultrasound) to assess for ejaculatory duct obstruction.

References

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5. Otani, 2019. Clinical review of ejaculatory dysfunction. *Reproductive Medicine and Biology*