Sexual dysfunction in men

Low sex drive

MKN–10: ***Lack or loss of sexual desire***

Low sexual appetite is a rare disorder in men (unlike women). As a **primary** disorder, it occurs in hypogonadism with absent or weakened androgen production. These patients are usually also affected by typical disorders of sexual physical development. Therapy must be appropriate for the underlying disorder.

Most low sex drive conditions are secondary in nature. Their main characteristic is depression. Bad mood may not always be easy to detect. Low activity of dopaminergic regulation and a high level of prolactin are common causes of reduced sexual appetite. Hyperprolactinemia can be caused by psychological stress or physical ilness. It may be related to the administration of medications (psychopharmaceuticals). Extremely high levels of prolactin are often caused by a pituitary adenoma (prolactinoma).

Some apparently not sexually active men have other than typically heterosexual interests. These are realized outside of heterosexual partner relationships. The majority of such patients we examined were homosexual men. However, there are also pedophiles, fetishists and transvestites or transsexuals. Therefore, the attempt of sexually deviant men to compensate for their problem by getting married is not always successful

Erectile dysfunction

- MKN–10: ***Failure of genital response***

In clinical practice, the most common sexual dysfunction is insufficient rigidity of the genital organ. The vast majority of men will encounter this problem at least at some point in their lives. We consider clinically relevant sexual dysfunction when an erection repeatedly does not reach the level that would be sufficient to satisfactorily connect the genitals.

Occurence

The incidence of erectile dysfunction increases with age, especially in men over forty. In the popular Massachusetts study of aging men aged 40-70 years, the lifetime prevalence of erectile dysfunction was greater than 52%.

Different types

Erectile dysfunction can be isolated. Then it is only a problem of stiffness (or rather "hardness") of the genital organ. All other sexual functions proceed reliably. In most cases, we note a combination of erection disorders with other sexual dysfunctions. Especially with reduced sexual appetite, reduced excitability or premature ejaculation.

We distinguish erectile dysfunction:

1. **complete**
2. **incomplete**

In a **complete** disorder, the hardness of the genital organ is insufficient in all circumstances. Thus, spontaneous erections (nocturnal and morning erections) and masturbatory erections and erections induced by non-coital stimulation are insufficient.

Incomplete erectile dysfunction is much more common in clinical practice. Problems with insufficient hardness of erection occur in these patients only sometimes and in some situations. There are difficulties with erection during coitus, but spontaneous and masturbatory erections are not significantly impaired. Even in this category, however, organic causes cannot be ruled out without further examination. While there is usually no doubt about the organic nature of complete erectile dysfunction, incomplete dysfunctions are typically multifactorial in nature. Biological, psychological, partner and social influences intertwine with them.

The distinction between **primary** and **secondary** erectile dysfunction is of great importance. The primary disorder occurs from the very beginning of sexual life. If it is not a simple debut failure of a transient nature, it has a worse prognosis than disorders of a secondary nature

The following table shows indicative discriminating characteristics of "organic" and "psychogenic" erectile dysfunction:

	organic	psychogenic
Sudden onset	–	+
Creeping start	+	–
Disturbance instability	–	+
Age over 30 years	+	–
Psychopathology	+	+
Partnership conflicts	+	+

It is clear from the table that psychopathological symptoms or partner conflicts in themselves do not mean that erectile dysfunction is "functional". A thorough sexual history as well as a physical examination are necessary to determine adequate therapy. In the first phase, the nature of the disorder must first be thoroughly described. Also, a single man can fully explore his erection abilities. Erections at night, in the morning and especially erections during masturbation are an important guide here.

Treatment

Psychotherapy

Psychotherapy is used in the treatment of erectile dysfunction. It is especially important for incomplete and combined disorders. Classical couple sex therapy is not always necessary. Sometimes a rational and explanatory approach with the man himself is enough.

Pharmacotherapy

Dopaminergic preparations (ergoline preparations, bromocriptine, apomorphine, yohimbine) increase sexual activity through a central effect

Vasodilatation drugs can be tried wherever we suspect an arterial lesion. Stimulants do not have a peripheral beneficial effect on erection. However, they can improve the mood and, by increasing the level of alertness, also increase the sexual entrepreneurship of the patients.

Phosphodiesterase 5 (PDE 5) inhibitors potentiate the effect of nitric oxide in the axillary bodies of the penis (sildenafil, vardenafil, tadalafil). Acts in the axis: L-arginine/NO/guanylate cyclase/cGMP. These are medications that improve erectile dysfunction in up to 80% of cases. They marked a significant advance in the treatment of these disorders

Traditionally, **androgens** have been administered to men with erectile dysfunction. There is no doubt about the activating effect of exogenous testosterone on the sexual activity of hypogonadal men.

Intracavernous application of vasoactive substances: After applying an effective dose of papaverine, phentolamine, prostaglandin E1 (alprostadil), or their mixture into the hollow shaft of the penis, an erection occurs in a healthy man. An erection induced in this way starts within a few minutes after administration and wears off in 1-2 hours. If even a high dose of vasodilators fails to induce a firm erection, then it is a serious vascular lesion, usually not only of an arterial nature, but also with a venous component. The main risk of this procedure is a prolonged erection. Every application of vasoactive substances into the corpora cavernosa therefore requires good availability of qualified urological care in case of prolonged erection (pripaism). Autoinjection therapy can sometimes be considered for men with erectile dysfunction. During this, the patient injects a predetermined dose of vasoactive substance into the cavernous bodies of the penis at home and performs sexual intercourse with this enhanced erection.

Penile endoprosthesis

Finally, it is possible to solve otherwise uncontrollable erectile dysfunction by **implanting penile endoprostheses**. These are silicone fillings that are implanted into the cavernous bodies of the penis. There are semi-rigid simple systems. However, inflatable endoprostheses have also been constructed, equipped with a complicated hydraulic system, which allows external manipulations to induce rigidity and extend it as needed

Premature ejaculation

The category *ejaculatio praecox* includes a wide range of short duration of intercourse, which cannot be unreservedly understood as sexual dysfunction.

Precipitous ejaculation is an undoubted defect of sexual physiology. In this condition, the semen is ejected sometimes before ejaculation (ejaculatio ante portas), sometimes when the penis is inserted into the vagina or after several copulatory movements. In order for this dysfunction to be fully expressed, rapid ejaculation must occur during frequent intercourse (at least several times a week or daily), and during repeated sexual intercourse. Most of these men come for a sexological examination at a young age, under 30 years. According to ICD-10,

premature ejaculation is defined as “the inability to delay ejaculation sufficiently to allow sexual satisfaction to occur. Ejaculation occurs before or within 15 seconds after intercourse begins". What is important is what the ICD-10 states in the description, namely that "The problem is not the result of a long-term lack of sexual activity".

Mostly it is a **primary** matter. The condition fluctuates depending on how successful intercourse is. A lot depends on partner relationships. There are tolerant women who don't mind a short connection. They settle for non-coital intercourse as the main source of their sexual satisfaction. However, there are women with a high level of expectation that can stress men with premature ejaculation. The most typical is a situation in which a man has premature ejaculation mainly because he does not have intercourse regularly. The woman then does not agree to more frequent intercourse, because it is so short that "it is not worth it". And the vicious circle closes

The basic **therapeutic** measure is the adjustment of the partner's sexual relations. There is no improvement in premature ejaculation without regular intercourse with a frequency that corresponds to the spontaneous needs of the patient.

In recent years, **the squeeze technique** has often been used as part of sex therapy for dysfunctional partners. It is a maneuver well known since ancient times. It consists in the fact that a strong squeeze of the glans (even painful) stops the development of the ejaculation reflex. The purpose of these exercises is to teach the man to tolerate a high level of sexual arousal without ejaculation. An indisputable advantage of couple training treatment is the emphasis on non-coital sexual activities. Sometimes practicing the sexual satisfaction of the woman with non-coital techniques helps to reduce the emotional tension of the couple. Local anesthetics can be used as supportive therapy for premature ejaculation. Some psychotropic drugs also prolong ejaculation latency (clomipramine, SSRI antidepressants).

Orgasm disorders in men

Anorgasmia

- MKN–10: ***Dysfunctional orgasm***

The term means the inability to experience orgasm. In completely expressed cases, the patient is unable to achieve orgasm either through sexual intercourse, or non-coital stimulation, or masturbation. Even these men ejaculate more or less regularly. However, this only happens during the night hours. Most true anorgasmias in men are **primary** in nature. Secondary anorgasmia occurs very rarely. The sovereign **treatment** of anorgasmia is exercise therapy, possibly with the use of a vibrator or other masturbation device. In terms of differential diagnosis, true anorgasmia must be distinguished from coital anorgasmia (when a man is able to orgasm only non-coitally or by masturbation).

Orgasmus retardatus (delayed orgasm)

- MKN–10: ***„Dysfunctional orgasm“ F52.3***

In this sexual dysfunction, a man exhibits an abnormally long orgasmic latency. Long and intense stimulation is required to induce orgasm. Such men are characterized by an unusually long duration of intercourse. Sometimes they reach orgasm only after tens of minutes or more than an hour of copulation. Under physiological circumstances, abnormal ejaculatory latency can also occur in healthy men during successive sexual intercourses. We evaluate such a condition as dysfunction if it occurs after adequate sexual abstinence and if it causes negative experiences in the patient. Sometimes men in involution complain of a delayed orgasm when their physical condition makes it difficult for them to complete intercourse.

True delayed orgasm is an **idiopathic** dysfunction and is constitutional in nature. However, secondary disorders of this type also occur. The reasons can be different. For example, a decrease in sexual arousal in secondary hypogonadism, genital innervation disorder in peripheral neuropathy or systemic neurological disease. Delayed orgasm can also be caused by the administration of psychotropic drugs (neuroleptics, antidepressants).

Therapy for delayed orgasm is difficult when it comes to primary constitutional dysfunction. The supreme means of achieving orgasm here is intense non-coital stimulation, possibly enhanced by the use of an intensively working vibrator.

Anejaculation during orgasm („dry orgasm“)

Dry orgasm is a sexual dysfunction that has become more common in the last decade. Conditions after injuries and surgical interventions, as well as more frequent administration of hypotensive drugs and psychotropic drugs, contribute to the increased incidence

A dry orgasm has two possible underlying causes. The first is **retrograde ejaculation**. During expulsion, the ejaculate is not pushed out of the urethra, but into the bladder. This happens most often with vegetative neuropathies (diabetes and other causes).

The second possible cause of dry orgasm is true anejaculation. In this disorder, an orgasm does occur, but the semen is not expelled into the urethra. It is a blockade of the sympathetic innervation of the first phase of the ejaculation process (emission). The cause may be pharmacological blockade of innervation due to sympatholytic drugs. The most common cause is the administration of hypotensive drugs (e.g. guanethidine) and psychotropic

drugs (neuroleptics, some antidepressants). Blockage of ejaculation can also be caused by peripheral vegetative neuropathy in diabetes and other underlying diseases, or spinal cord injury (trauma, retroperitoneal surgery, or systemic neurological disease). Loss of ejaculation also occurs after radical prostatectomies, where the cause is the anatomical destruction of the main source of seminal fluid, i.e. the seminal vesicles and the prostate, as well as the loss of communication between the vas deferens and the urethra. Anejaculation during orgasm is by no means a cause for major concern. Sex life goes on in the usual way. Only in certain etiological moments can the erection be disturbed.

Priapism

We refer to **priapism** as a long-lasting and spontaneously unrelenting erection, which is usually significantly painful. The main risk of this condition is hypoxic fibrosis of the corpora cavernosa with subsequent irreversible erectile dysfunction. In diagnosis, a physical examination is used, when the penis is in rigid tumescence, but the glans penis is soft.

We distinguish two types of priapism:

- low-flow (ischemic) − based on venous occlusion, there is insufficient supply of oxygenated blood and ischemic damage to the cavernous bodies occurs;
- high-flow (non-ischemic) − excessive supply of arterial blood, does not lead to damage to the cavernous bodies.

Etiology

The most common cause of priapism is the intracavernous application of drugs such as PGE1 in the treatment of erectile dysfunction. All conditions with increased blood coagulation are predisposed to the development of priapism. A known predisposing factor is sickle cell disease, leukemia, and thromboembolic disease. Among medications, neuroleptics, especially phenothiazine series and tricyclic antidepressants, increase the likelihood of priapism. Occurs in traumatic spinal cord lesions. Priapism (and abdominal breathing) in an unconscious patient indicates spinal cord injury.

High-flow priapism occurs in pelvic injuries where the arterio-cavernous junction is formed.

Therapy

As part of first aid, the penis is cooled. The treatment of priapism is a puncture of both corpora cavernosa with a wider needle and aspiration of blood, which is then sent for a blood gas examination to distinguish the type of priapism. In case of insufficient detumescence, it is possible to repeatedly rinse with 1-2 ml of physiological solution or diluted noradrenaline. If even then the effect is not sufficient, we proceed to create a spongio-cavernous junction. We introduce a needle through the glans penis into the corpus cavernosum so that the blood can drain through the corpus spongiosum. The last option is a surgical connection between the saphenous vein and the corpus cavernosum.

The treatment of non-ischemic priapism is embolization of the branches of the pudendal artery.

This condition must be distinguished from a simple prolonged erection. With priapism, hypoxia of the cavernous bodies develops on the basis of reduced perfusion, and the condition is significantly painful. Prolonged erection, on the other hand, is painless and does not cause hypoxia of the corpora cavernosa.

Links

External links

- Priapismus (Czech wikipedia)
- Priapism (English wikipedia)

Source

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AMBLER, Zdeněk. *Klinická neurologie: část obecná. 2008. 976 s. + errata (1 l.)-.* - edition. Triton, 2008. ISBN 9788073871574.

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