

# Assessing orgasmic and ejaculatory problems in clinical practice

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**ABSTRACT** Orgasmic or ejaculatory disorders affect a greater segment of the population than typically realized, and are more prevalent than erectile dysfunction. Unlike the increased visibility of treatments for erectile dysfunction, ejaculatory disorders are a largely overlooked and underreported area of male sexual functioning; they clearly need to be addressed within the primary care office. Differentiating whether the concern is functional, neurologic, or anatomic is necessary, as it allows for the formulation of an investigative and treatment strategy. Ejaculatory problems of a functional nature are the main complaints seen in the primary care setting. For orgasmic or ejaculatory difficulties with anatomic or neurologic etiologies, treatment includes adapting or overcoming the additional organic pathology with various medical or operative options. Such complaints may often require referral to a specialist.

## Practice Tips

- | Inquire about the entirety of the patient's sexual response, not just the presenting complaint—you could miss an important clue to the diagnosis.
- | Determine whether the difficulty is situational or generalized and if it worsens with particular sexual acts.
- | During the physical exam look for systemic signs of hypogonadism, neurologic changes in sensation to the genitalia or genital reflexes, and signs of peripheral neuropathy.

When a patient presents to you with a suspected ejaculatory or orgasmic disorder, or when you take the sexual history, a direct line of questioning must be pursued. In addition to clarifying the patient's chief complaint, you should also inquire about the effect of this complaint on the entirety of his sexual response and sexual self-view. A comfortable assessment will be comprised of direct and inclusive, yet sensitive, questions that will examine all aspects of the patient's sexual functioning. You could use the following questions as a starting point in assessing any patient with ejaculatory or orgasmic complaint:

- Is this complaint interfering negatively with your sexual experience? That is, is your ejaculation difficulty interfering with your sexual satisfaction, your relationships, and/or your quality of life?
- Is infertility a problem, and if it is, do you think your ejaculatory concern is a contributing factor?
- Do you experience pain, blood, or other medical concerns with the process of ejaculation?

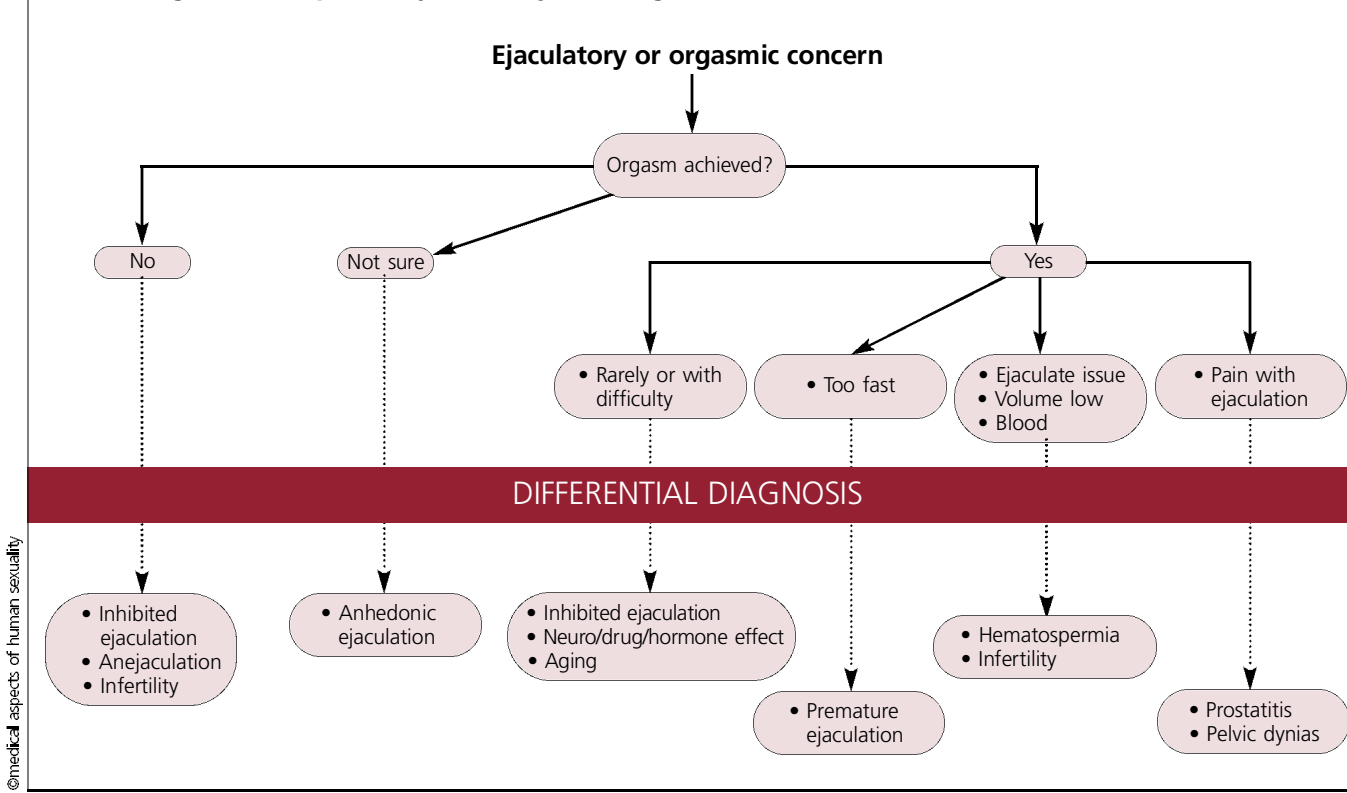
The answers to these questions will help identify the cause of your patient's distress and clarify his chief complaint. A patient may present with normal antegrade ejaculation, but he is distraught because he is ejaculating too quickly, which is significantly interfering with his or his partner's

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**FIGURE** Diagnostic steps for ejaculatory and orgasmic concerns



©medical aspects of human sexuality

sexual pleasure. Another patient may present with infertility because he has little or no antegrade ejaculate, yet he does not complain of sexual dissatisfaction, because his erections and orgasms are fine. Other patients may have pain with ejaculation and/or notice abnormalities in the ejaculate and become worried—this pain or anxiety can, in turn, interfere with sexual enjoyment or performance. Be clear which area, or combination of areas, is your patient’s main issue before moving on—it will make the assessment easier and more beneficial for both you and your patient.

### Evaluate your patient’s complaint carefully

Patients may not only have difficulty articulating their concerns about orgasm or ejaculation, or both, but may even misleadingly present with secondary erectile dysfunction (ED) or sexual disinterest. The importance of taking a proper and complete sexual history becomes particularly crucial at this point in order to properly assess the primary problem and to avoid going down the wrong therapeutic track. For example, some men with premature ejaculation know they cannot maintain their erection

during intercourse, and may mistake normal detumescence secondary to ejaculation as ED; however, it would be inappropriate to treat them for ED. Therefore, when presented by a patient complaining of ED, you must be sure to inquire about the entirety of his sexual response so you do not miss the correct diagnosis. You could ask, “Do you have any concerns about the speed of ejaculation, if it is too slow or fast, or about the amount or color of the semen itself?”

### Classify the complaint

The next task is to clarify and classify the chief complaint in the same fashion as you would clarify any sexual concern.<sup>1</sup> Keep in mind the basic diagnostic steps (Figure), which will help you direct your questioning. Be sure to distinguish if this is an ejaculatory problem, orgasmic concern, or both. Patients find the distinctions between orgasmic and ejaculatory concerns confusing, so do not assume they know the difference.

Provide your patient with simple definitions of ejaculation and orgasm—especially if the patient uses language such as “when I come.” Ask, “Do you reach a point where

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**TABLE 1** Assessment of functional ejaculatory disorders

	Premature ejaculation	Inhibited ejaculation
<b>Psychosocial issues</b>	Lack of sexual knowledge Sexual inexperience <sup>1</sup> Unrealistic expectations Anxiety Change of health status of either partner <sup>1</sup> Lack of accommodation to high arousal	Lack of confidence Lack of inhibitory release
<b>Physiological etiologies</b>	Penile hypersensitivity Lower spinal cord lesions <sup>2</sup> (rare) Stroke or brain injury Acute prostatitis Decreased orgasmic threshold	Older age Low androgen states Diabetes Multiple sclerosis Penile hyposensitivity Central nervous system injury Peripheral nerve injury
<b>Drug-induced</b>	Sympathomimetics	Psychotropic drugs Antihypertensives

1. Levine SB. *Sexual Life: A Clinician's Guide*. New York: Plenum Press, 1992.  
2. Kuhr CS.<sup>2</sup>

you are very highly aroused and fluid comes out of the end of your penis? Do you experience a very pleasant feeling of sexual release at any time?”

Once the chief concern has been elicited, you must get a more detailed description of the problem, which will assist in categorizing the condition as situational or generalized. The key question is whether or not orgasm is being reached and if so, what is the main issue for the patient. Additional questions are necessary to clarify the exact nature of the problem.

**Additional questions**

**Duration.** Inquire how long the problem has been present? Did it start abruptly or was the onset gradual?

**Situational or generalized.** Is the difficulty always present, or only sometimes? In other words, does the patient have this concern in every situation or only in certain situations—with a partner, alone during attempts at masturbation, during the day and/or at

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night? Depending on the problem, you may ask whether the problem improves or worsens with particular sexual acts, such as manual, oral, or intercourse stimulation.

**Entirety of sexual response.** What is the rest of the patient’s sexual response—desire, erection, freedom from sexual pain?

**Reaction.** How has the patient’s partner reacted to the problem? Are his/her reactions positive, negative, supportive, blaming?

**Effect.** What is the effect of the problem on the sexual relationship—sexual frequency, overall affection?

**Motivation.** How motivated is the man, and his partner, to continue with investigations, therapy, or referral?

**Physical examination**

A physical exam must be performed to rule out obvious anatomic and organic factors. Carefully examine the abdomen and genitalia for size and firmness of the testicles, presence of spermatic cord structures, normal penile foreskin retractability, and prostate conditions. Look for systemic signs of hypogonadism. Neurologic changes in sensation to the genitalia or genital reflexes, such as the bulbocavernosus reflex, will signify intact somatic but not autonomic nerves. Intact pinprick sensation to the glans penis and voluntary anal contraction demonstrate the potential for normal genital orgasmic sensation. Look for other signs of peripheral neuropathy or general cardiovascular compromise that may signify a neu-

rologic or endocrine condition (ie, diabetes) that cause known ejaculatory problems.

**Laboratory testing**

In the field of ejaculatory disorders, laboratory investigations are generally limited except for those involving ejaculatory pain and infertility. Ejaculatory pain must be investigated as there is usually an infectious (ie, prostatitis) or obstructive (ie, stricture, stones) cause. Infertility secondary to ejaculatory difficulties requires assessment of semen volume, if any, and semen quality of any antegrade or retrograde ejaculate. You can assess retrograde ejaculation by looking for the presence of spermatozoa in

**TABLE 2** Examples of sexual consequences of neurologic conditions

	Erection	Ejaculation	Orgasm	Fertility issues
<b>Diabetes</b>	>50% will have ED	None to progressive loss of antegrade fluid	Intensity may be altered: ability may diminish with neuropathy	Usually retrograde ejaculation
<b>Multiple sclerosis</b>	Daytime ED Nocturnal erections may be preserved	Delayed May be loss of urine at orgasm	Intensity may diminish and duration shorten	Diminished volume Retrograde ejaculation Anejaculation
<b>Spinal cord injury: Upper cord</b>	Reflex erections to touch	Variable: anejaculation common	Rare	May require sperm retrieval techniques
<b>Spinal cord injury: Lower cord</b>	Mental erections	Incomplete lesions have a better chance: variable May be spontaneous to erotic thought	Incomplete lesions have a better chance	May require assistance May be retrograde
<b>Central brain injury/problem</b>	Affected negatively	Often delayed	Usually decreased, but may have increased drive (and need for orgasmic release)	May require assisted methods
<b>Radical prostatectomy</b>	Global ED common	No ejaculate (structures removed)	Orgasm remains but may be altered	Have to obtain spermatozoa from distal structures
<b>Retroperitoneal lymph node dissection</b>	Normal erection	Loss of seminal emission	Present and unchanged	Retrograde or no antegrade ejaculation

ED=erectile dysfunction

the urine, which should be obtained after masturbation to orgasm. Serum hormone and follicle-stimulating hormone levels may also be obtained if you suspect hypogonadism, hyperprolactinemia, or other infertility issues.

### Putting the clinical information together

**Functional difficulties.** The most common ejaculatory disorders seen in primary care are functional disorders. The most prevalent, premature ejaculation, is best assessed using the biopsychosocial model as the lack of control over the reflex can be from biological causes (ie, enhanced sympathetic response) or psychosocial issues (ie, performance anxiety, low sexual self-esteem). Inhibited ejaculation is more rare (Table 1). Most of these functional difficulties have to do with the brain–genitalia connection and the ability to remove the tonic inhibition (orgasmic threshold).

**Premature ejaculation, the most prevalent concern, is best assessed by using the biopsychosocial model, as the lack of control over the reflex can be the result of biological causes or psychosocial issues.**

Clinically, there is either poor control—premature ejaculation—or over-suppression—inhibited ejaculation—of the cerebral inhibition.

Particular medical conditions may also affect functional ejaculation; for example, neurologic problems and low androgen levels delay ejaculation, make orgasm difficult to achieve, or alter the intensity of orgasm. However, injury to the lower thoracic, lumbar, or sacral cord can cause spontaneous ejaculation or orgasm in some cases.<sup>2</sup>

### Neurologic Etiologies.

Neurologic problems may cause other symptoms as well as disturbances in the ejaculation and orgasmic mechanisms (Table 2). Neurologic alterations in either the central nervous system or the peripheral nervous system result in disruptions of the ejaculatory pathways and orgasmic and ejaculatory reflex abnormalities. Central nervous system problems usually result in diminution of the ejac-

ulatory or orgasmic process, but can also lower the orgasmic threshold in rare cases.

Seminal emission is a sympathetic nervous system response: propulsatile ejaculation is a parasympathetic and somatic response. Erection is also a parasympathetic response. Therefore, medications and peripheral nerve function alterations affecting these various parts of the mechanism will result in a spectrum of abnormalities from not ejaculating at all to ejaculating abnormal seminal volumes. However, because ejaculation is primarily a sympathetic event, adrenergic or anticholinergic medications can enhance ejaculation by sensitizing the nerve endings involved in seminal emission, including closure of the bladder neck.<sup>3</sup> For example, some men may experience accelerated ejaculation with the use of sympathomimetic cold medications (eg, pseudoephedrine decongestant); therapeutically, this can also be used to enhance antegrade ejaculation in some men with inadequate closure of the bladder neck.

Alternately, those medications that slow down the ejaculatory response may cause delayed ejaculation, or be used therapeutically to treat premature ejaculation. For example, medications that increase the concentrations of the sexually negative neurotransmitter serotonin at key synapses (ie, serotonin reuptake inhibitors [SSRIs]), are known to delay ejaculation.

**Anatomic causes.** Congenital causes of ejaculatory dysfunction include incomplete or altered embryologic development of epididymis, vas deferens, prostate, ejaculatory ducts, penis, and/or urethra (hypospadias, epispadias, and bladder exstrophy).<sup>3</sup> Acquired causes include those secondary to surgery that interfere with the

anatomy or the nervous control of the ejaculatory system, those stemming from infective consequences—prostatitis causing ejaculatory pain, postinfective obstruction—and obstruction by stones in the genitourinary system, and from tumor invasion or cancer therapy. These abnormalities of ejaculatory function usually present as infertility. However, ejaculatory symptoms such as pain or hematospermia should always be investigated.

### Conclusion

It may be difficult and embarrassing for a patient to initiate discussion of an ejaculatory or orgasmic problem. Therefore, every effort should be made to assess your patient's concern thoroughly and sensitively. A full sexual history, along with a medical history and physical exam, is essential in order not to miss reversible and etiological factors that will dictate further investigations and therapy. 

### Acknowledgment

This approach for sexual history-taking is based on the teachings of Dr George Szasz, Professor Emeritus, Department of Psychiatry, Division of Sexual Medicine, University of British Columbia.

### References

1. Basson R. Eliciting the sexual concerns of your patient in primary care: taking the sexual history, part 1. *Med Asp Human Sex* 1(1): 13–18, 2000.
2. Kuhr CS, Heiman J, Cardenas D, et al. Premature emission after spinal cord injury. *J Urol* 153: 429–431, 1995.
3. Hendry WF. Causes and treatments of ejaculatory disorders. In: Carson CC, Kirby RS, Goldstein I, eds. *Textbook of Erectile Dysfunction*. Virginia: Oxford, 1999, pp 569–582