



# The Truth About Male Sexual Dysfunction



By Michael C. Stephensen, MD, CCFP

## In this article:

Advances in sexual medicine are some of the factors influencing cultural attitudes towards sex. The advent of the oral contraceptive pill and effective oral treatment for erectile dysfunction has allowed people more freedom to express their sexuality. Recently, sexual medicine has begun to find its way into medical education programs.

1. What is male sexual dysfunction and what tests can be done to determine its presence?
2. What causes erectile dysfunction?
3. What contributes to decreased libido in men?
4. How is rapid ejaculation treated?

## What is male sexual dysfunction?

The primary male sexual dysfunctions include erectile dysfunction, inhibited or absent libido, premature ejaculation, and retarded ejaculation/anorgasmia. Problems no less disturbing, but perhaps less common, would include pain with sexual activity, anxiety or panic associated with sexual activity, hyperactive sexual desire, paraphilias, voyeurism, exhibitionism and sexual addiction.

## What role do relationships play?

People with relationship problems often present to the family physician's office believing they

are suffering from sexual dysfunction. In general, it is difficult to treat a sexual problem in a dysfunctional relationship. Patients often believe that the sexual dysfunction is the cause of the relationship discord. Experience would suggest that, in many cases, the relationship problems are contributing to the sexual dysfunction.

## What tools are used to investigate the problem?

In sexual medicine, the patient's history is usually the most important investigative tool available. Several authors have written in detail about sexual history taking.

# Male Sexual Dysfunction

## Practice Pointer

To learn more about taking a detailed sexual history, refer to:

- *Sexual Desire Disorders: Dysfunctional Regulation of Sexual Motivation* by Helen Singer Kaplan (Taylor & Francis Inc., 1989).
- *Sexual Medicine in Primary Care* by William L. Maurice (Mosby-Year Book, 1998).

The “ten-minute sexual history” technique was designed and perfected for family physicians by Drs. Basson, Elliott, and Ward (Table 1). Naturally, any positive responses need more in-depth assessment.

## What are the key history features that are sometimes missed?

When taking a full sexual history, some questions can be difficult to ask. However, if they go unasked, important information may be missed. These questions need not always be asked in the first visit and, in most cases, not in front of the patient’s partner.



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Table 1

### The ten-minute sexual history

Clarify the chief complaint. Does “I can’t get it up,” really mean erectile dysfunction?

Is the onset gradual or sudden, remote or recent?

Is the problem situational or generalised (with partners, self-stimulation, morning erections, etc.)?

Get a description and explore the details.

How is the rest of the sexual response?

How is the partner’s sexual function?

How has the couple reacted to the problem and what is the state of the relationship?

Are the patient and partner motivated and are goals realistic?

Adapted from: Course material designed by Dr. Richard Ward, Dr. Rosemary Basson, and Dr. Stacy Elliott

Getting the patient’s permission before asking difficult questions and giving permission not to answer them all is very reasonable. Important questions include:

- Do you have any homosexual thoughts, fantasies, or tendencies?
- Is your relationship monogamous?
- Do you suffer from any substance abuse?
- Do you have a history of physical, psychological, or sexual abuse?
- Is there anxiety or pain associated with your sexual activity?
- Are you taking any herbal products?
- Are there fertility issues involved?

# Male Sexual Dysfunction

Table 2

## Non-oral therapies for erectile dysfunction

Sexual therapy

Medicated urethral system for erection

Intracavernosal injections

- Alprostadil
- Phentolamine (bimix)
- Papaverine (trimix)

Vacuum constrictive device

Penile prosthesis implant

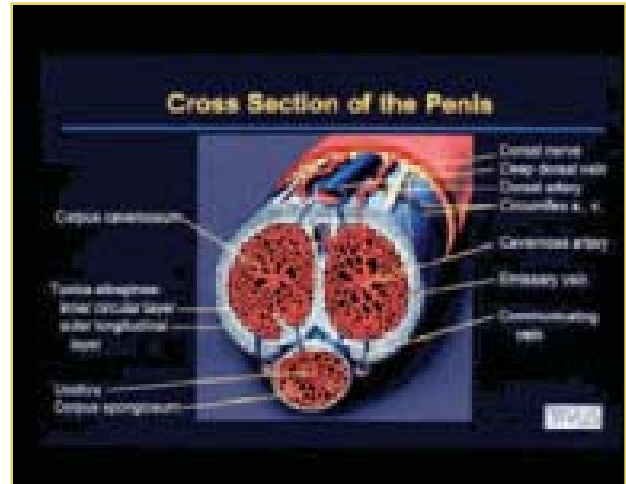


Figure 1. Cross-section of a penis

## Erectile dysfunction

In recent years we have learned that erectile dysfunction is common. New understanding of the physiology of the erection has led to improved treatment for erectile dysfunction.

In the right hormonal milieu and with adequate stimulation, via the nervous system, smooth muscle tissue in the penile corpus cavernosum relaxes. This lowers vascular resistance, allows blood to fill the corpus, and leads to an erection. Outflow of the blood from the penis is reduced significantly, allowing the erection to be maintained. Difficulties in any of the above areas can lead to erectile dysfunction.

With the advent of highly effective oral therapies, reliance on less effective oral therapies and more intrusive non-oral therapies is diminished.

Pommerville recently published a comprehensive review of emerging therapies for erectile dysfunction. In this article, he contrasted sildenafil, tadalafil, and vardenafil.<sup>1</sup> The three phosphodiesterase-5 (PDE-5) inhibitors are roughly equiva-

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# Male Sexual Dysfunction

Table 3

## Less common causes for inhibited libido in men

- |   |   |
|---|---|
| • Substance abuse                         | • Adjustment disorder                     |
| • Iatrogenic (medication)                 | • Multiple Sclerosis                      |
| • Sleep apnea                             | • Congestive heart failure                |
| • Acute or chronic pain                   | • Gender dysphoria                        |
| • Chronic fatigue                         | • Cancer/chemotherapy                     |
| • Hypothyroidism                          | • Parkinson's disease                     |
| • Secondary to another dysfunction        | • Chronic renal failure                   |
| • Secondary to partner sexual dysfunction | • Alzheimer's disease                     |
| • Cerebral vascular accident              | • Lack of available time/hectic lifestyle |

lent in efficacy when compared across all populations, but differences in pharmacodynamics and pharmacokinetics will result in specific preferences among physicians and patients.

Novel treatments on the horizon include apo-

## Practice Pointer

Summary of writings on rapid ejaculation:

1. There is little or no voluntary control over ejaculation speed.
2. It is a problem that causes distress for the man and the couple.

morphine and topical alprostadil. Apomorphine is a dopamine agonist and, unlike PDE-5 inhibitors, works centrally to initiate an erection. Topical alprostadil, with its absorption enhancer, will absorb through the skin to the corpora cavernosa.

Non-oral therapies still have an important place in the treatment of erectile dysfunction (Table 2). Some patients are not able to take PDE-5 inhibitors due to possible interference with nitrates, and yet others prefer a non-medicinal approach. For many patients who wish to remain sexual, the damage done to erectile systems is beyond what can be overcome by oral therapies. Oral therapies are clearly preferred by patients, but in the right patients, non-oral therapies can also be very effective. Some patients will benefit from sex therapy.

An excellent resource for Canadian primary-care physicians is the Canadian Urological Association's Erectile Dysfunction Practice Guideline, which gives a primary-care perspective.

## What contributes to inhibited libido?

Inhibited or absent libido in men can be challenging to treat because some of the causes are not readily apparent and others are not well accepted by the patients themselves. The scope of this topic is too broad for a general article on male sexual dysfunction. Generally, treatment is aimed at the underlying cause.

The common causes of inhibited libido include, depression, relationship dysfunction, and androgen deficiency. Less common causes are listed in Table 3.

# Male Sexual Dysfunction

## Point of View

In my experience, despite a full discussion of options, the majority of patients prefer a pharmacologic treatment. Selective serotonin reuptake inhibitors have been shown in many studies to be very effective. In some studies, sildenafil has been shown to be effective, suggesting either a previously unknown mechanism of rapid ejaculation or, more likely, a subgroup of rapid ejaculators who “let go” early because of fears they will lose their erections.<sup>8</sup>

Some patients find that methods to decrease sensitivity are helpful. Local anesthetic creams have been shown to be effective despite the concerns of some about decreasing enjoyment.<sup>9</sup>

Condoms have also been used. Some younger men find ejaculating prior to intercourse can occasionally be helpful.

## Rapid ejaculation

Rapid ejaculation is a common sexual dysfunction. The number of American men affected ranges from 15% to 20%. In the 18 to 59 age group, 39% of men are affected.<sup>2,3</sup>

Many attempts have been made at defining rapid ejaculation. These writings can all be summarised in two important statements:

1. There is little or no voluntary control over ejaculation speed; and
2. It is a problem that causes distress for the man and the couple.

There is much debate about the cause of rapid ejaculation. Some believe it is a learned behaviour, while others believe there is a possible genetic component. Undoubtedly, there is some truth to both nature and nurture theories. Men with a hardwired disposition to ejaculate quickly, who compound this



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# Male Sexual Dysfunction

tendency with reward and other learning principles, may be the ones showing up in our offices in the most trouble. Screponi et al, have shown chronic prostatitis can be a common cause.<sup>4</sup>

Waldinger reviewed literature from 1887 to 2001 and concluded that the evidence supported a neurobiologic (serotonergic) cause rather than a psychologic one.<sup>5</sup> He said the mechanism for rapid ejaculation is transmitted genetically. Given the original purpose of ejaculation, procreation, it may be that a rapid ejaculator is not disordered, but rather, simply efficient.

## How is it treated?

The learned and/or psychologic component that causes rapid ejaculation can be retrained. In her book, *How to Overcome Premature Ejaculation*, Helen Singer Kaplan wrote that 99% of rapid ejaculation is psychogenic and that 90% of males to whom this occurs could easily learn to control the tendency.<sup>6</sup> The method taught in this book is effective, but prone to relapse. Zilbergeld also covers the behavioural method in his book, *The New Male Sexuality*.<sup>7</sup>

## What medications are to be avoided?

Generally, stimulant medications [e.g., methylphenidate, Ma Huang (a Chinese herb), ephedrine, phenylpropanolamine, pseudoephedrine, phenylephrine] will tend to increase the speed of ejaculation.

***15% to 20% of American men are affected by premature ejaculation. In the 18 to 59 age group, 39% of men are affected.***

## Take-home message

- The primary male sexual dysfunctions include, erectile dysfunction, inhibited libido, premature ejaculation, and retarded ejaculation.
- Sexual history is probably the most important investigative tool available.
- Erectile dysfunction can be treated with both oral medications, such as phosphodiesterase-5 inhibitors, and non-oral therapies, such as sex therapy. Erectile dysfunction can also be a marker for vascular disease.
- The common causes of inhibited libido are depression, relationship dysfunction, and androgen deficiency.
- Some researchers argue that premature ejaculation is a learned behaviour which can be “unlearned” through psychotherapy. Others say it may also have a genetic link.

## What tests should be considered for each problem?

If a patient has premature global erectile dysfunction, one may consider screening for undetected vascular disease and risk factors. Erectile dysfunction is a marker for vascular disease. Fasting blood sugar, cholesterol, and a complete blood cell count can be considered. If sexual libido is affected, consider checking serum testosterone, sex hormone-binding globulin and thyroid-stimulating hormone. If testosterone is low, rule out a pituitary cause and check prolactin, follicle-stimulating hormone, and luteinising hormone. More intensive tests, such as Doppler ultrasound of the penile arteries and nocturnal penile tumescence, are rarely indicated.

# Male Sexual Dysfunction

## How common is male sexual dysfunction?

Many of the various disorders that fall under the heading of male sexual dysfunction are common. These disorders have a significant impact on the quality of life of men. In most cases the treatment of these disorders by family physicians is appropriate. [CME](#)

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### Suggested Readings

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# The truth about Male Sexual Dysfunction

## 1. What is male sexual dysfunction?

The primary male sexual dysfunctions include erectile dysfunction, inhibited or absent libido, premature ejaculation, and retarded ejaculation/anorgasmia.

## 2. How common is male sexual dysfunction?

All of the various disorders that fall under the heading of male sexual dysfunction are common. These disorders have a significant impact on the quality of life of men. In most cases, the treatment of these disorders by family physicians is appropriate.

## 3. What is the most important investigative tool?

Sexual history is probably the most important investigative tool available.

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By Michael C. Stephensen, MD, CCFP

## 4. How can erectile dysfunction be treated?

Erectile dysfunction can be treated with both oral medications, such as phosphodiesterase-5 inhibitors, and non-oral therapies, such as sex therapy. Erectile dysfunction can also be a marker for vascular disease.

## 5. What are the common causes of inhibited libido?

The common causes of inhibited libido are depression, relationship dysfunction, and androgen deficiency.

For an in-depth article on male sexual dysfunction, please go to page 115.