

Orgasmic Pain following RP or RT

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It appears that orgasmic/ejaculation pain following surgical removal or radiation of the prostate gland, is not uncommon. For those using a Vacuum Erection Device (VED), orgasmic/ejaculation pain may result if the ring is too tight.

In a study of 239 patients, 22% had no change in orgasm intensity, 37% reported a complete absence of orgasm, 37% had decreased orgasm intensity and 4% reported a more intense orgasm after RP than before. Pain during orgasm (dysorgasmia) occurred in 14% of the patients; in these respondents the pain reportedly occurred always (with every orgasm) in 33%, frequently in 13%, occasionally in 35%, and rarely in 19%. Most patients (55%) had orgasm-associated pain for <1 min.

In a questionnaire-based study conducted by one of the top specialists in Male Sexual & Reproductive Medicine, Dr. John Mulhall, 380 men who underwent RP were questioned regarding postoperative orgasm quality and the presence of pain with orgasm (dysorgasmia), 22% of men had some degree of orgasmic pain interfering with sexual relations.

The alpha-blocking medication tamsulosin (Flomax) is known to provide orgasmic/ejaculation relief for many.

From: <http://tinyurl.com/yj2wl6z>

The Utility of Tamsulosin in the Management of Orgasm-Associated Pain: A Pilot Analysis

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Abstract

Introduction:

Orgasmic pain is an infrequently reported but distressing problem for the patients who experience it. No consensus exists as to its etiology however bladder neck/pelvic floor spasm may play a role. This analysis was conducted to assess the effect of the alpha-blocking medication, tamsulosin on post-orgasmic pain.

Methods:

In a prospective, non-placebo controlled study, patients with orgasmic pain were interviewed and administered tamsulosin 0.4 mg po qhs for at least 4 weeks. Outcome measures included libido, pain and continence and these were evaluated using the International Index of Erectile Function (IIEF), a visual analog scale (VAS) for pain and an incontinence scale respectively pre and post treatment. Patients were separated into groups based on etiology of the problem (radical prostatectomy, radiation therapy, and other) for statistical analysis.

Results:

98 patients were enrolled. Pain was located predominantly in the penis (72%), with other sites including testis, rectum and abdomen. Most patients (52%) experienced pain for less than 5 minutes post-orgasm. 76/98 (77%) patients reported significant improvement in pain (≥ 2 points on pain VAS) and 12/98 (12%) noted complete resolution of their pain. The VAS for pain reflected a statistically significant decrease in pain for all groups in response to tamsulosin treatment. The entire group had a decrease of 2.7 points between pre and post-treatment phases. The IIEF libido domain increased significantly (mean of 2.4 points) for all treatment groups.

Conclusion:

Tamsulosin decreases orgasmic pain intensity in patients with orgasmic pain. These data support the hypothesis that orgasmic pain is related to bladder neck and/or pelvic floor muscle spasm.

From: <http://tinyurl.com/ykur5xg>

Dysorgasmia

The occurrence of postorgasm-associated pain, referred to as dysorgasmia, has received little attention in the literature. As a result, very little is known about its incidence in the general population. Although believed to be generally uncommon, there is evidence that men who have undergone a prostatectomy or pelvic radiation and young men suffering from chronic pelvic pain disorder experience high rates

of dysorgasmia. Barnas and co-workers published data from a series of 239 patients who underwent radical prostatectomy and found that 33 (14%) complained of postorgasm-related pain.

In 1997, Goriunov and colleagues found that 188 (23%) of 818 men surveyed following treatment for benign prostatic hyperplasia (BPH) reported dysorgasmia. The etiology of this disorder is not well understood; however, Barnas and associates have recently argued that dysorgasmia may be associated with pelvic floor muscle or bladder neck spasm. These authors point out that no current electromyographic data are available to support this hypothesis, and that this postulate was based on clinical observations that young men with chronic orchalgia associated with chronic pelvic pain disorder frequently experienced pain during ejaculation and orgasm.

These researchers support their argument with the results from a non-placebo controlled trial of the α -blocker tamsulosin (Flomax, Boehringer Ingelheim). This α -blocker is specific to the smooth muscle tissues of the prostate and bladder, and has been proven to alleviate pain associated with treatments affecting the prostate. In their study, 98 men who complained of dysorgasmia were instructed to use oral tamsulosin 0.4 mg at bedtime, for at least 4 weeks. There was a statistically significant reduction in pain, with 77% reporting improvement and 13% indicating complete resolution of their pain. This is currently the only empirically supported treatment for this disorder in the literature.

CONCLUSION

For men, orgasmic disorders include premature ejaculation, retarded orgasm, anorgasmia, and dysorgasmia. Although researchers have made important advances in the understanding and treatment of orgasmic disorders, there still is much work to be done in delineating their nature and finding effective treatments. Defining the nature of orgasm and of these orgasmic disorders is important, as this phase of the sexual response cycle has implications for a patient's quality of life and relationship satisfaction.