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Management of Psychogenic Anejaculation

Androlog Summary

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Note: Postings to *Androlog* have been edited before publication.

Clinicians involved in the management of male infertility occasionally encounter a patient who can not produce a semen specimen for analysis or for use in intrauterine insemination (IUI). In some cases, the patient is unable to ejaculate during intercourse as well. Such a patient is described in this edition of *From Androlog.* Dr. Lonny Green describes the patient and enquires about the use of electroejaculation (EEJ). The members of Androlog provide useful information and advice.

> I recently met a healthy 29-year-old man with a normal, 30-year-old woman partner. The patient is unable to ejaculate around the time of his wife's ovulation, nor can he ejaculate in order to provide a semen specimen for analysis, although the presence of sperm in one postcoital test was confirmed by a reproductive endocrinologist. The patient's erectile function is not an issue. I have recommended the couple consult a sex therapist, but in the meantime, the patient's wife wants to know whether her husband would be a candidate for EEJ. Does anyone have experience using EEJ in a similar situation, or in any other case involving a neurologically intact man?

Dr. Peter Kolettis, from Birmingham, Alabama, suggests vibratory stimulation as a solution to this situation:

> I would first try vibratory stimulation because it is simpler and less invasive, and it can be performed in the office or at home. EEJ requires general anesthesia.

Reinforcing the use of vibratory stimulation, Dr. Arnold Belker, from Louisville, Kentucky, submits the following:

> Use of vibratory stimulation of the penis to stimulate ejaculation would be much more practical in a neurologically intact man because it does not require anesthesia and it can be performed in the office. Vibratory stimulation should produce an ejaculate in a patient such as the one described by Dr. Green.

Dr. Dana Ohl, who practices in Ann Arbor, Michigan, and who has long been recognized as a leader in this area of clinical practice, provides information on the use of EEJ and suggests that Dr. Green consider sperm extraction:

> EEJ can certainly be used in a neurologically intact man. It can also be used in men who have a neurological problem, but who also have enough intact sensation to make it painful, but EEJ requires either spinal or general anesthesia (Stewart and Ohl, 1989; Ohl et al, 1991; Gerig et al, 1997).
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> However, our article, published last December (Ohl et al, 2001), in which we examined >700 cycles of EEJ and assisted reproductive technology, suggests that if general anesthesia is required in order to perform EEJ, then it is usually more cost-effective to perform in vitro fertilization (IVF) rather than IUI. We currently recommend testicular sperm extraction and IVF/intracytoplasmic sperm injection for these patients, and thus avoid general anesthesia and EEJ altogether. In distinction to this patient population, IUI coupled with EEJ or penile vibratory stimulation is cost-effective in patients with spinal cord injury who do not require anesthesia.

Dr. Richard Berger, corresponding from Seattle, Washington, makes a number of good points, including a reminder to make certain that a female infertility factor does not need to be addressed:

> I agree that vibratory stimulation is the first option. If the patient still cannot ejaculate at ovulation, then it might be worthwhile to consider sample cryopreservation. Sex therapy may also help the patient ejaculate intravaginally by gradual desensitization. Another option is open microsurgical vasal aspiration. I have performed the procedure up to 6 times on a single vas without it scarring shut (Berger et al, 1986). Dr. Green should also make sure the patient's wife receives a full evaluation. I performed EEJ on an anejaculatory man after node dissection only to discover that his wife had a problem that precluded success.

Dr. Michael Perelman, from New York City, provides additional information regarding the potential benefit of sex therapy and makes a compelling case that such therapy can provide lasting benefit to couples for fertility and an overall better quality of life.

> I congratulate Dr. Green for referring his patient to a sex therapist. For those who are interested, I refer them to an article (Perelman, 2002) outlining a case that was similar to Dr. Green's, in which a patient presented with an initial complaint of erectile dysfunction and retarded ejaculation. The patient telephoned me last week, 2 years later, to let me know that his wife was again pregnant, for a second time, via coitus.
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> Practicing in New York City has afforded me the opportunity to treat more than 125 men with retarded ejaculation, including 3 men who were completely anorgasmic, and whose wives were artificially inseminated after the men underwent EEJ. New York

City has a large population, and a disproportionately large number of ultraorthodox Jews, some of whom take seriously the talmudic injunction against ''spilling seed'' and who have avoided premarital sexual activity. The result, for a small percentage yet a sizable number of these men, is complete anorgasmia, frequently complicated by erectile dysfunction.

One of the men I have treated (to his delight as well as my own), who, like the others, was anorgasmic but neurologically intact, has subsequently fathered 3 children over the last 6 years via coitus! I have not treated him in more than 5 years, but he leaves periodic birth announcements in my voice mail box as well as in that of his urologist.

Dr. Green should sympathetically encourage optimism and patience in his patient's wife. While the patient may be a candidate for EEJ, it should not be the first treatment of choice. Dr. Green's decision to refer his patient to a sex therapist was a wise one. While vibratory stimulation is less intrusive and might result in a semen sample, it is unlikely that this is the most appropriate first step for the couple, viewing their life as a whole. Obviously, the sex therapy must be time-limited given the age of the patient's wife and her concomitant declining fertility, but that does not mean a rush to judgment is necessary. These situations are somewhat rare, but it is very important to handle them correctly in terms of future quality of life, independent of fertility.

Dr. Ganesan Adaikan, contributing from Singapore, further discusses sex therapy, and opines that EEJ is not a viable option at this stage:

Dr. Green's patient appears to be experiencing psychogenic (situational) anejaculation. Because the patient's physiology of ejaculation is intact, behavioral therapy involving sensate focus exercises, masturbation technique, and counseling may help. Some men who are unable to masturbate and ejaculate at the masturbatorium in the fertility clinic may find it easier to ejaculate at home and rush the specimen to the clinic. Some patients have collected specimens from coitus interruptus, and I have had 1 or 2 patients who managed to swiftly collect part of a wet dream specimen.

For some men, the pressure from a wife to conceive creates a great deal of anxiety, which leads either to erectile dysfunction or to anejaculation during ovulation. Both spouses may benefit from counseling to make love rather than to make a baby. Perhaps the patient may ejaculate intravaginally if his wife does not reveal the time of ovulation.

I agree that use of vibrator should be tried, but EEJ should not be an option at this stage.

Finally, Dr. Nancy Brackett, from Miami, Florida, describes the use of EEJ in such individuals, indicating that decreased semen quality might be expected:

Dr. Hovav in Israel has had experience with these patients (Hovav et al, 1996, 1998, 1999, 2000, 2001, 2002). Dr. Hovav has used EEJ to retrieve semen, but has found that semen quality is somewhat compromised.

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