

ORGASMIC FUNCTION AFTER SURGERY PRESERVATION & RECOVERY

Assist. Prof. Dr. Nicolae CRISAN

The prevalence and nature of orgasmic dysfunction after radical prostatectomy

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2004 BJU INTERNATIONAL | 94, 603-605

- The rate of RP in men aged < 55 years has increased over the past decade

MEN'S ORGASM



WOMEN'S ORGASM



We Know Memes

male
orgasm

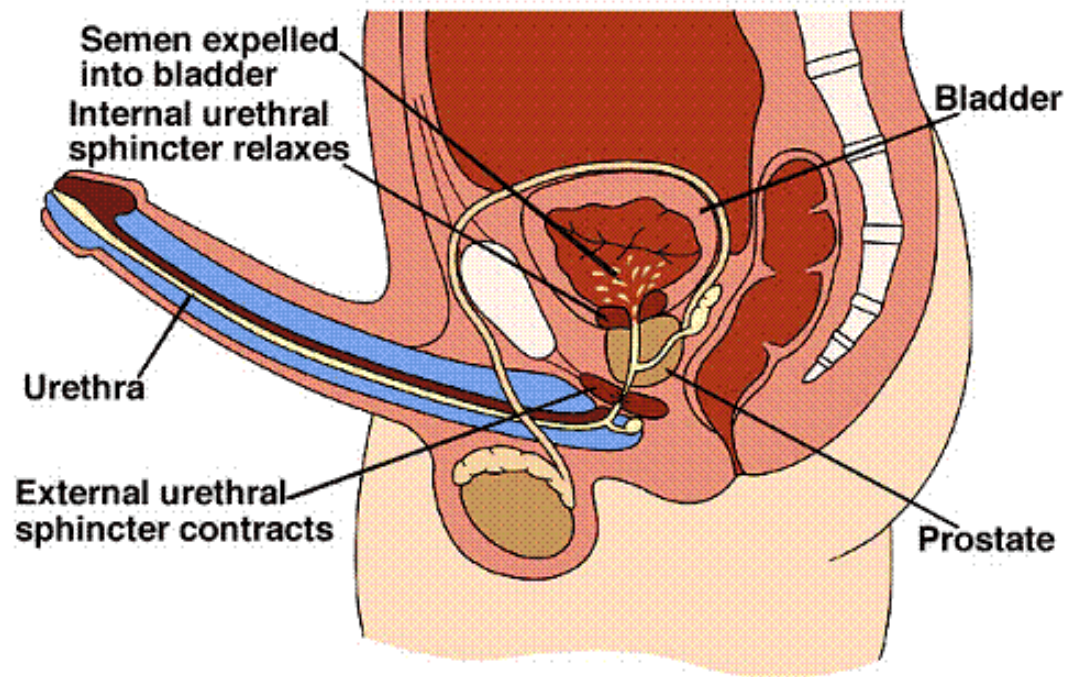


female
orgasm

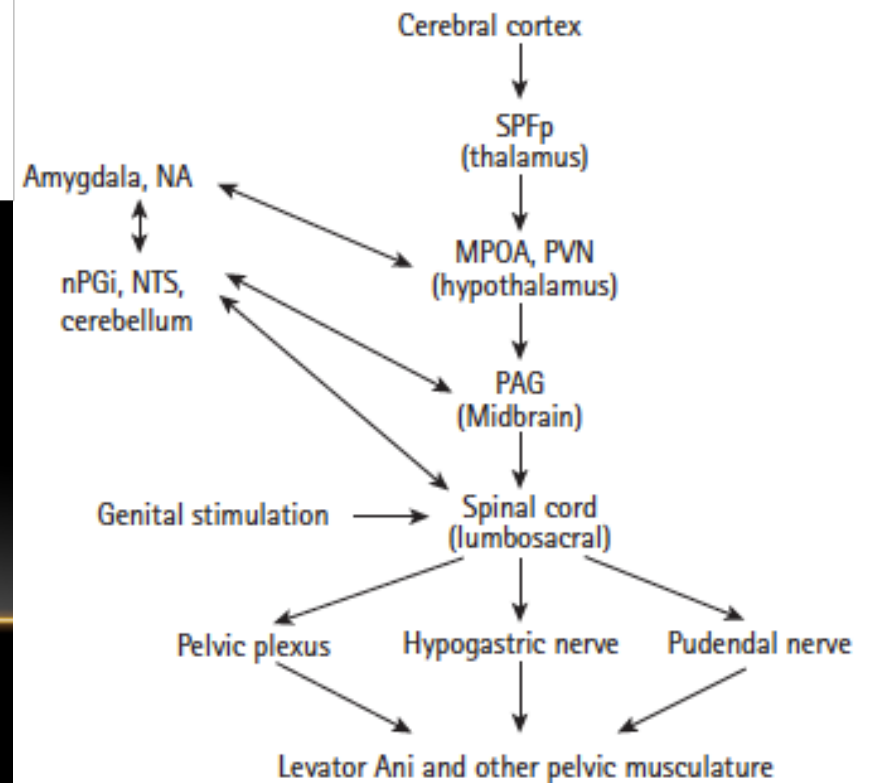


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Retrograde Ejaculation



Combined physiological changes and pleasure that occurs coincident with ejaculation in men

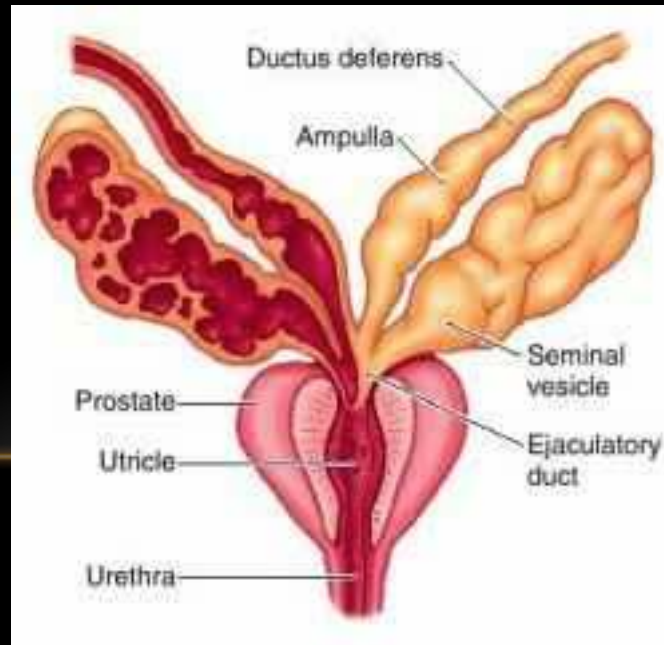


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- Radical prostatectomy = 'dry orgasm'



ORGASMIC DYSFUNCTION POST-RP

- absence of orgasm (anorgasmia)
- painful orgasm (dysorgasmia)
- urine loss during orgasm (climacturia)



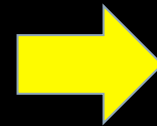
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Sexual dysfunction

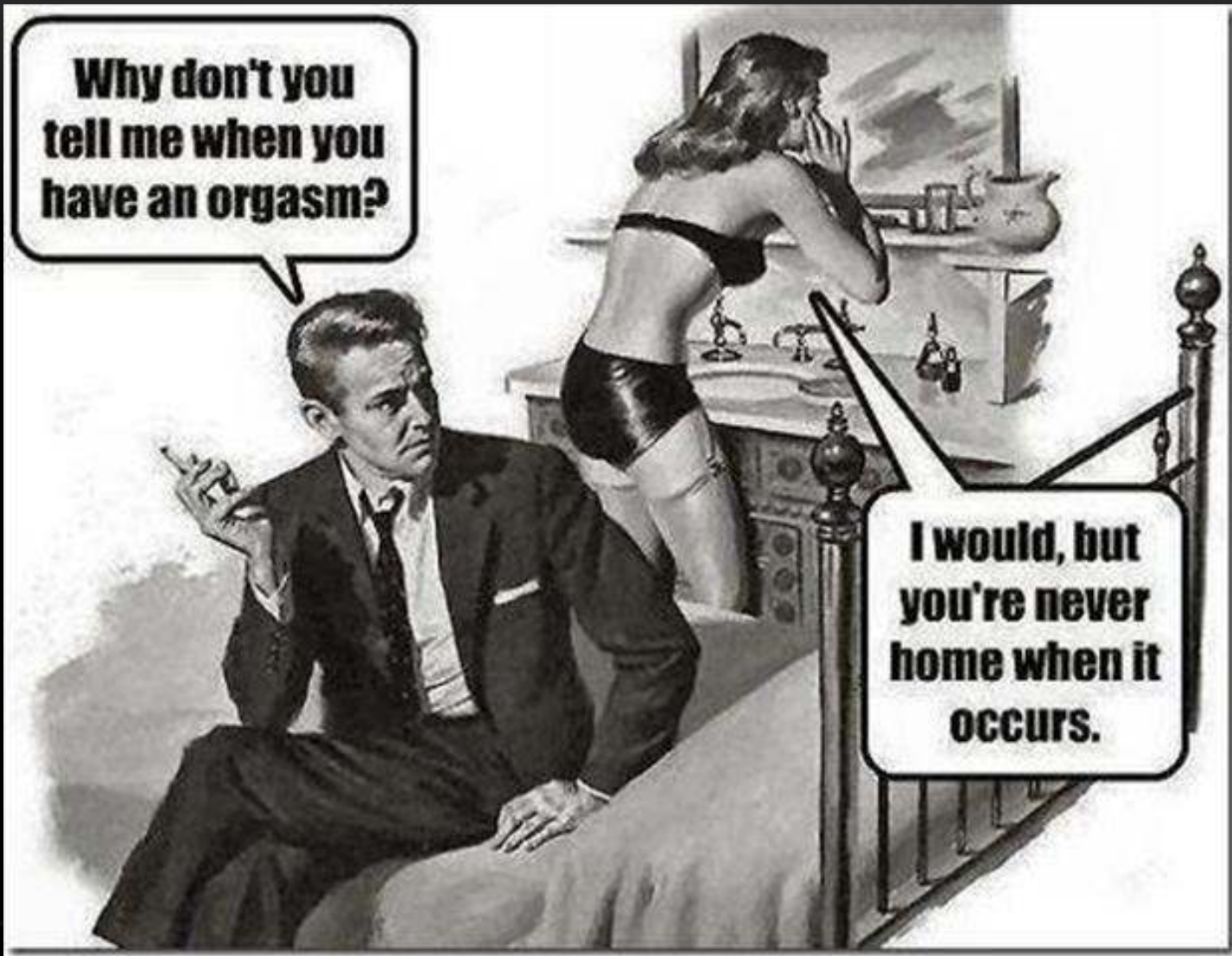
- decreased orgasm intensity
- lack of orgasm
- pain during orgasm



- reduction in quality of life
- loss of self-esteem
- loss of self-confidence
- discord in relationships
 - marital satisfaction
 - stability
 - happiness

ORGASMIC DYSFUNCTION POST-RP

- **absence of orgasm (anorgasmia)**
- **painful orgasm (dysorgasmia)**
- **urine loss during orgasm (climacturia)**



**Why don't you
tell me when you
have an orgasm?**

**I would, but
you're never
home when it
occurs.**

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- **37% reported a complete absence of orgasm**
- **37% had decreased orgasm intensity**
- **22% of patients had no change in orgasm intensity**
- **4% reported more intense orgasm after RP than before**

ORGASMIC DYSFUNCTION POST-RP

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- painful orgasm (dysorgasmia)
- urine loss during orgasm (climacturia)

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- **The cause of dysorgasmia**
 - **spasm of the vesico-urethral anastomosis**
 - **pelvic floor musculature dystonia**

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- Pain during orgasm (dysorgasmia) – 14%
 - penis (63%)
 - abdomen (9%)
 - rectum (24%)
 - other areas (4%)
- pain was reported
 - always 33%
 - frequently in 13%,
 - occasionally in 35%
 - rarely in 19%

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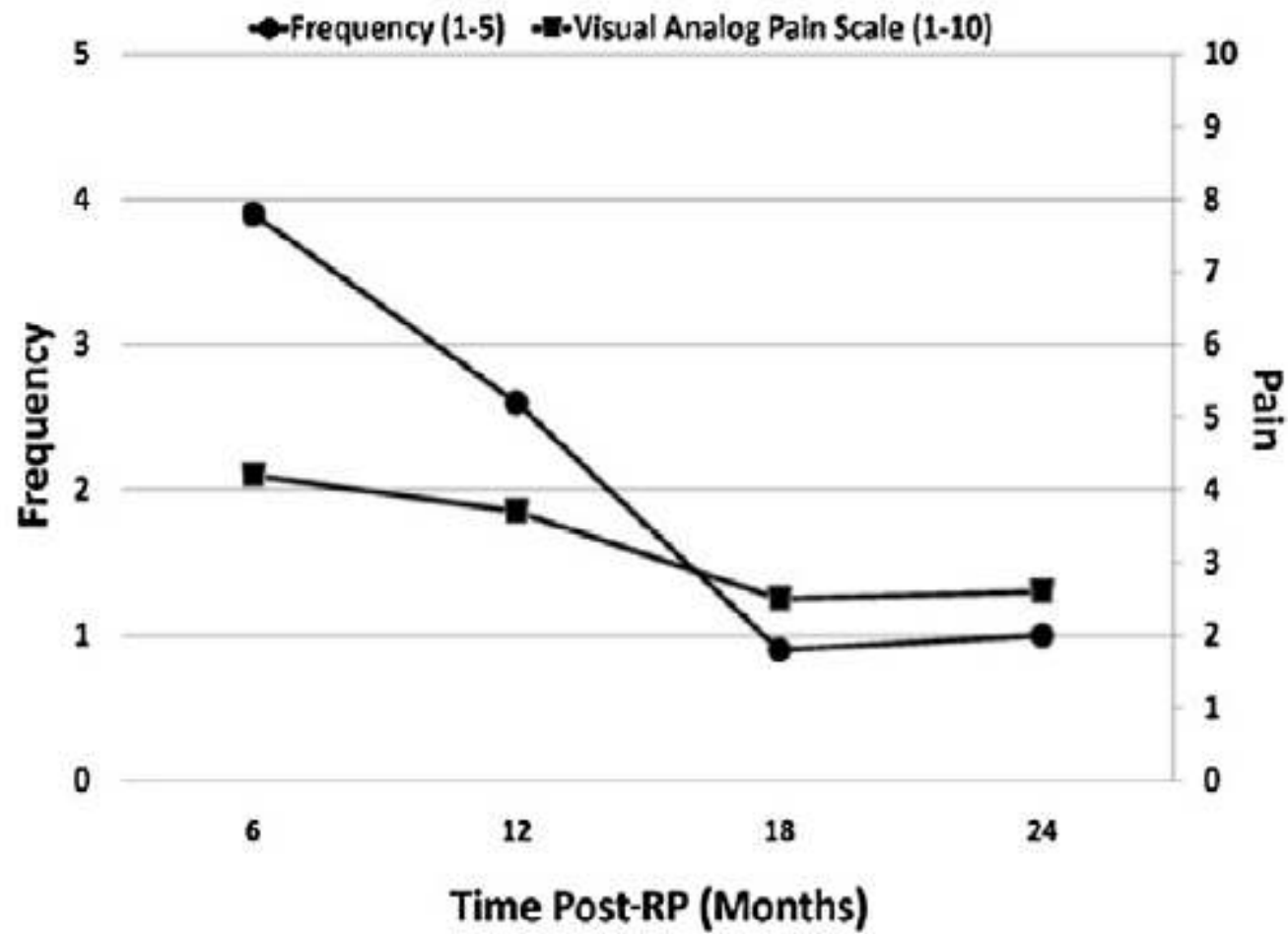
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- 55% pain for < 1 min
- a third reported pain for 1–5 min
- 12 % pain of >5 min
- only 2.5% of patients complained of pain lasting >1 h

The Evolution of Orgasmic Pain (Dysorgasmia) Following Radical Prostatectomy

Kazuhito Matsushita, MD, Raanan Tal, MD, and John P. Mulhall, MD

J Sex Med 2012;9:1454–1458



ORGASMIC DYSFUNCTION POST-RP

- absence of orgasm (anorgasmia)
- painful orgasm (dysorgasmia)
- urine loss during orgasm (climacturia)

ORGASM ASSOCIATED INCONTINENCE (CLIMACTURIA)

- **Causes:**
 - anatomical differences of sphincteric/membranous urethra
 - surgeon ability to preserve urethral length
 - damage of the autonomic nerves
- always in 16%,
- occasionally in 44%
- rarely in 33%
- never in 7%



preservation & recovery

TABLE 3 Postoperative sexual function outcomes with relation to nerve sparing

	BNS (N = 301), n/N (%)	UNS (N = 56), n/N (%)	NNS* (N = 51), n/N (%)	P value
Orgasmic outcomes				<0.001
Postoperative orgasm present	273/301 (90.7)	46/56 (82.1)	31/51 (60.8)	
Have same orgasm	257/301 (85.4)	42/56 (75)	28/51 (54.9)	
Diminished orgasm	12/301 (4)	2/56 (3.5)	2/51 (3.9)	
Better orgasm	3/301 (1)	1/56 (1.8)	1/51 (2)	
Early orgasm	1/301 (0.3)	1/56 (1.8)	0	
Postoperative orgasm absent	28/301 (9.3)	10/56 (17.9)	20/51 (39.2)	
Potency outcomes				<0.001
Postoperative potent	261/301 (86.7)	40/56 (71.4)	31/51 (60.8)	
Postoperative potent if age ≤60 years	152/168 (90.5)	22/30 (73.3)	16/26 (61.5)	

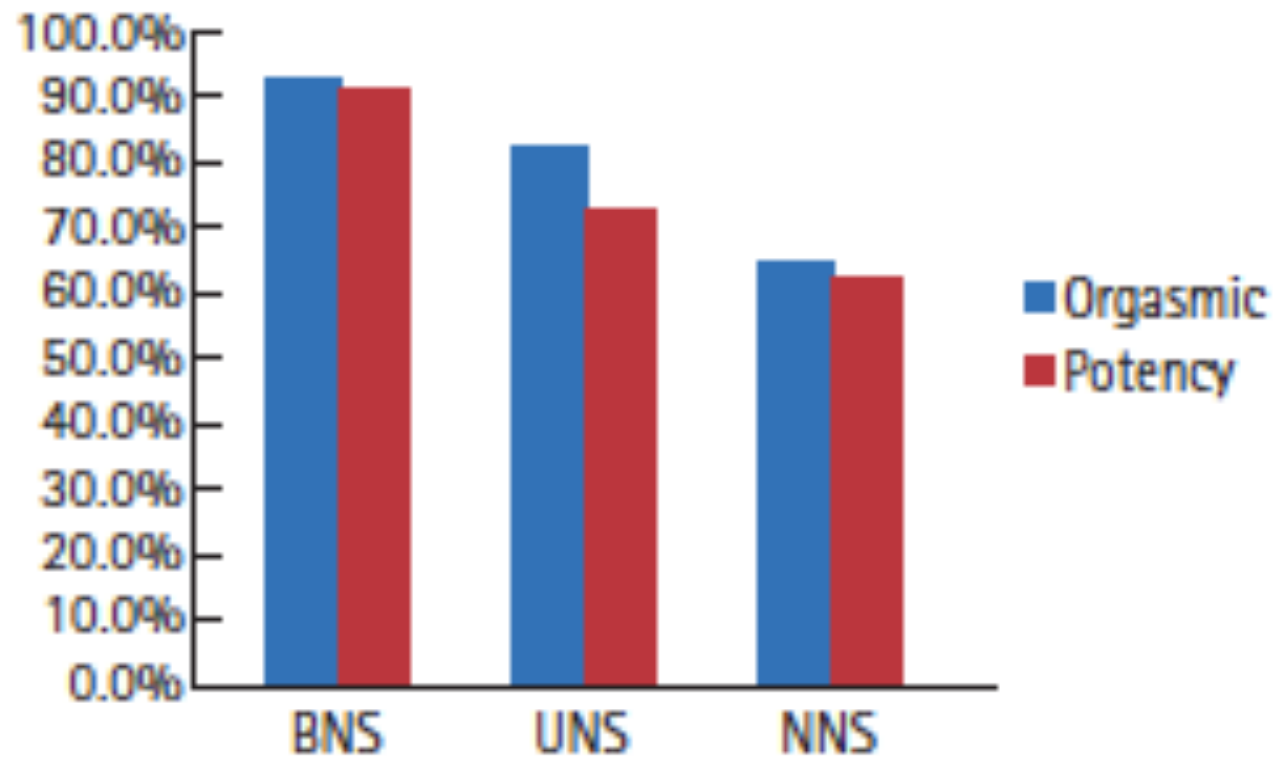
BNS, bilateral nerve sparing; UNS, unilateral nerve sparing; NNS, non-nerve sparing.

*Includes patients with incremental nerve sparing and nerve reconstruction.

Nerve sparing can preserve orgasmic function in most men after robotic-assisted laparoscopic radical prostatectomy

Ashutosh Tewari, Sonal Grover, Prasanna Sooriakumaran, Abhishek Srivastava, Sandhya Rao, Amit Gupta, Robert Gray, Robert Leung and Darius A. Paduch*

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Radical Prostatectomy, Sparing of the Seminal Vesicles, and Painful Orgasm

Andrea Mogorovich, MD,^{*a} Andreas E. Nilsson, MD,^{†a} Stavros I. Tyrantzis, MD, PhD, FEBU,^{‡a} Stefan Carlsson, MD, PhD,[†] Martin Jonsson, MD,[†] Leif Haendler, MD,[†] Tommy Nyberg, MSc,[‡] Gunnar Steineck, MD, PhD,^{‡a} and N. Peter Wiklund, MD, PhD^{†a}

J Sex Med 2013;10:1417–1423

Variable		No. painful orgasm/total no.
SV-sparing	Bilateral removal	6/67 (9)
	Unilateral sparing	11/91 (12)
	Bilateral sparing	30/144 (21)
Nerve-sparing technique	Interfascial	20/146 (14)
	Intrafascial	15/84 (18)
	Extrafascial	
Bladder neck dissection	Non-bladder neck sparing	11/72 (15)
	Bladder neck sparing	39/234 (17)

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- **Tamsulosin for dysorgasmia**
 - **77% reported an improvement in pain**
 - **8% complete resolution of their pain**
- **Phosphodiesterase type 5 inhibitor**

CONCLUSIONS

- **Dysorgasmia decreases in frequency and degree over time after RP**
 - **Preservation**
 - **SV sparing ?**
 - **Nerve sparing**
 - **Recovery**
 - **Tamsulosin**
 - **5 PDE inhibitors**
-

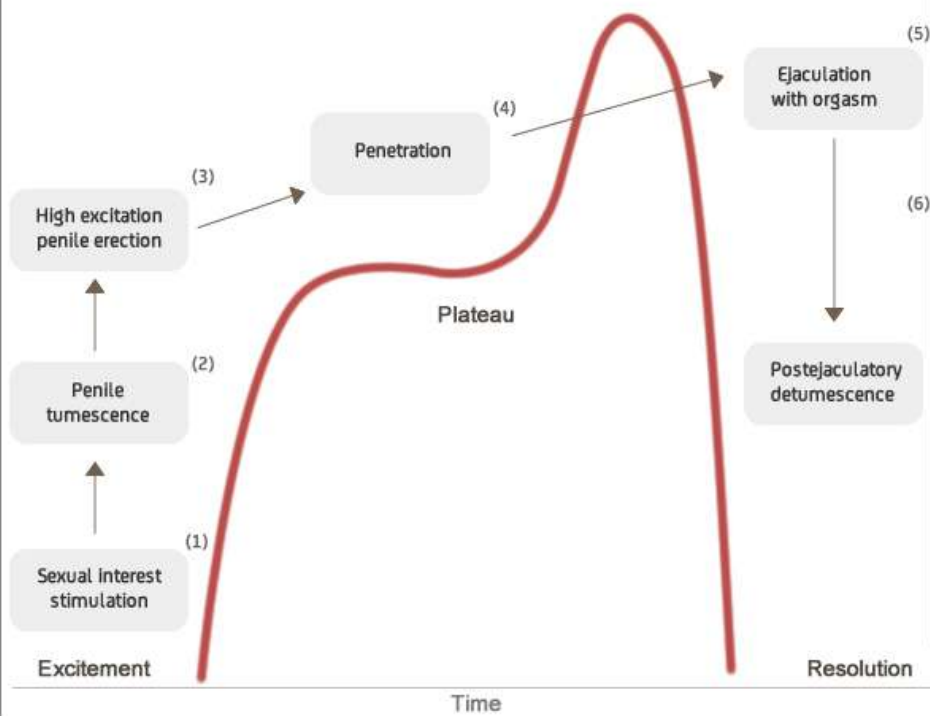


- Orgasm is associated with a series of
- regular sphincteric contractions of the
- bulbocavernosus muscle with an abrupt
- onset and termination [8] . While subjective
- perception of orgasm is associated with
- the contraction of the bulbocavernosus
- muscle, and orgasm typically occurs with
- ejaculation, neurophysiologically, orgasm
- and ejaculation are regulated by different
- neurotransmitters. Ejaculation is not
- necessary for orgasm as is evident in men
- who have undergone prostatectomy but
- who have normal orgasm [9] . What is
- known is that orgasm is mediated by
- complex interactions between autonomic
- and somatic nervous systems in conjunction
- with spinal cord circuits and higher brain

- centres [10] (Fig. 1). Arousal, defined as a
- progressive increase in the sensation of
- pleasure, results in progressive changes in
- neurotransmitters. Once the threshold level
- for orgasm is achieved an intense sensation
- of pleasure follows. The main regions
- involved in the feeling of reward that forms
- the subjective orgasmic response are the
- cortex, subparafascicular thalamic nucleus,
- amygdala and nucleus accumbens); the
- other regions illustrated in Fig. 1 are
- responsible mostly for the physical event of
- ejaculation. The pelvic (inferior hypogastric)
- plexus and pudendal and hypogastric nerves
- relay the afferent and efferent information
- during orgasm [10]

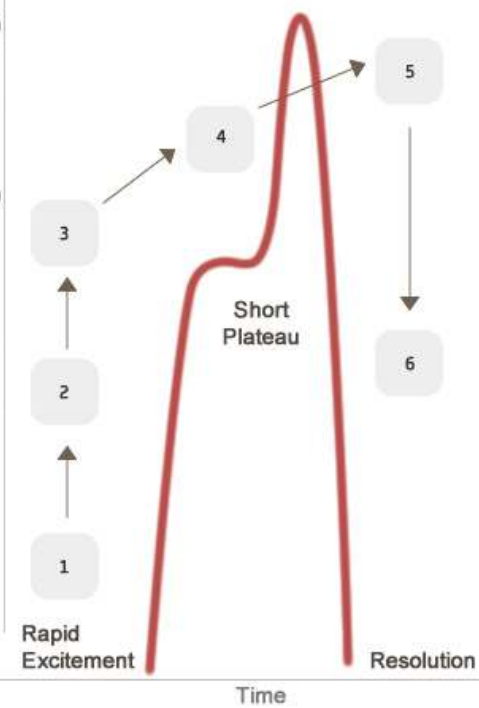
- Normal integration of
- tactile, olfactory, visual and auditory sexual
- cues during arousal is necessary for orgasm
- to occur, but it is unclear to what extent the
- afferent signalling from the pelvic muscles
- and open nerve endings on the penis
- contribute to progression of arousal and
- orgasm. The fact that some men can achieve
- orgasm without tactile stimulation to the
- genital region (through auditory or visual
- cues) clearly indicates that orgasm is at
- least partly central and not a purely
- peripheral event.

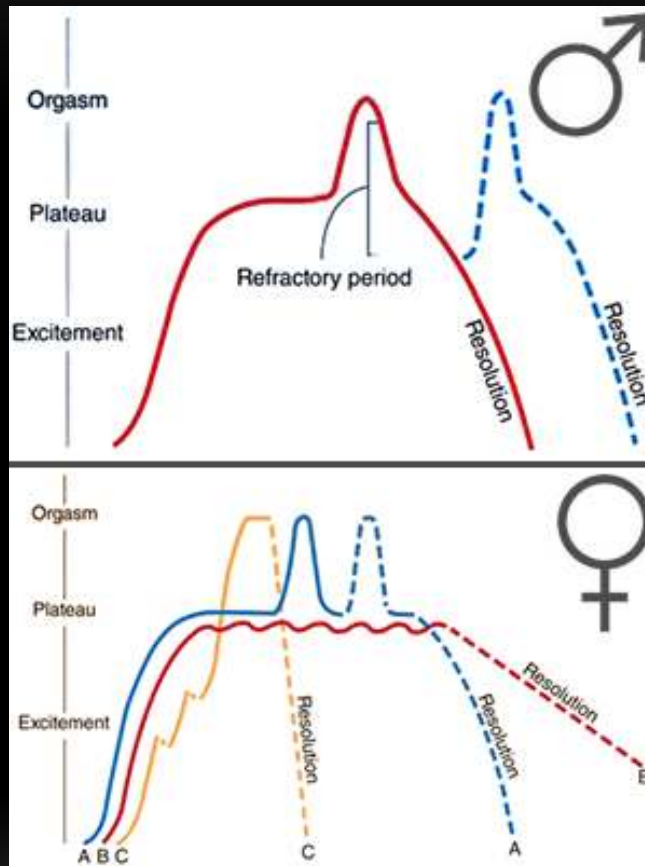
Normal ejaculation



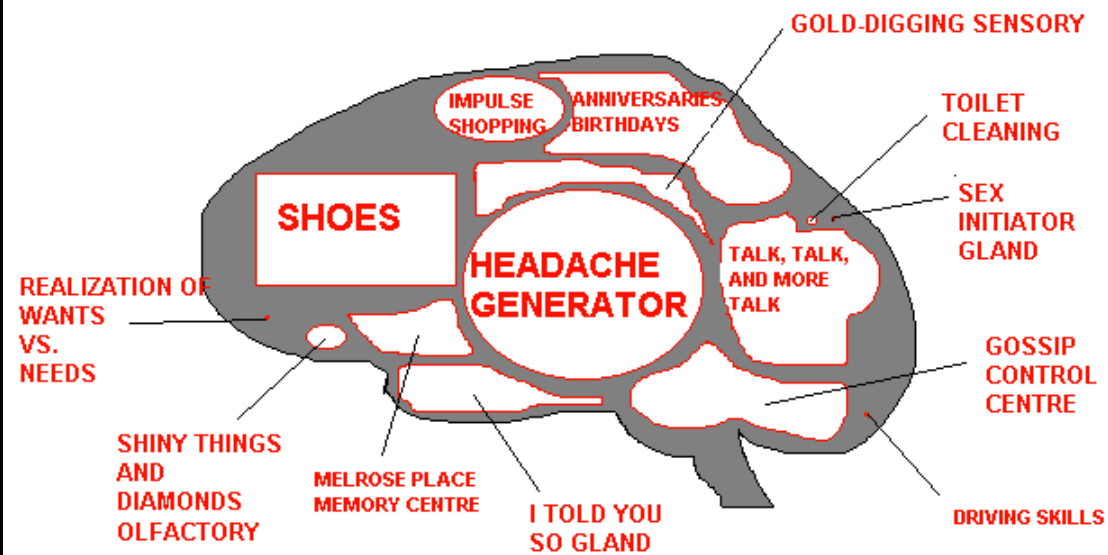
Premature ejaculation

Rapid ejaculation with orgasm





THE FEMALE BRAIN



FOOTNOTE: The "Put Oil into the Car" and "Be Quite During the Game" glands are active only when the "SHINY THINGS AND DIAMONDS" OLFatory has been satisfied or when there is a shoe sale.



Orgasmic Dysfunction After Open Radical Prostatectomy: Clinical Correlates and Prognostic Factors

Yvette Dubbelman, MD,* Mark Wildhagen, PhD,[†] Frits Schröder, PhD, MD,[†] Chris Bangma, PhD, MD,[†] and Gert Dohle, PhD, MD[†]

J Sex Med 2010;7:1216–1223

Table 2 Sexual evaluation after radical retropubic prostatectomy in preoperatively potent and sexual active men according to type of surgery

Parameter	Postoperative	Total group (%)	BNS (%)	UNS (%)	NNS (%)	<i>P</i> value
Sexual active (N = 596)	Yes	401 (67.3%)	186 (74.7%)	118 (67.8%)	97 (56.1%)	<0.0001
	No	195	63	56	76	
Spontaneous erections (N = 698)	Yes	205 (29.4%)	119 (41.9%)	55 (27.8%)	31 (14.4%)	<0.0001
	No	493	165	143	185	
Sexual interest (N = 425)	Yes	413 (97.2%)	191 (99.0%)	120 (96.8%)	102 (94.4%)	0.072
	No	12	2	4	6	
Orgasmic function (N = 458)	Yes	306 (66.8%)	141 (73.4%)	90 (70.9%)	75 (54.0%)	0.001
	No	152	51	37	64	