

DISTÚRBIOS EJACULATÓRIOS NÃO NEGLIGENCIÁVEIS

Sofia Santos Lopes

- Consulta Andrologia CHBM
- Fellow European Board of Sexual Medicine
- Fellow European Board of Urology

**7^{os} ENCONTROS
DE ANDROLOGIA**

REABILITAÇÃO EM ANDROLOGIA
E MEDICINA SEXUAL

AUDITÓRIO DO HOSPITAL
DE S^{TO} ANDRÉ - LEIRIA

16.11.2019

Imagem: Ad Médic



Secretariado Científico: Sociedade Portuguesa de Andrologia, Medicina Sexual e Reprodução
Inscrições em: spandro.sec@gmail.com

ORGANIZAÇÃO





Premature Ejaculation: 2020 Update

Giorgio Ivan Russo¹ · Ege Can Serefoglu²

© Springer Science+Business Media, LLC, part of Springer Nature 2019

Abstract

Purpose of Review Premature ejaculation (PE) is one of the most common forms of male sexual disorder. There are still different opinions and point of view regarding its definition, classification, prevalence, pathophysiology and treatment alternatives. For these reasons, we aim to recap the recently accumulated data on definition, classification, pathophysiology and treatment alternatives of PE. The literature pertaining to PE has been reviewed by the authors. All the related articles were critically analyzed and examined. Levels of evidence (Les) and grades of recommendation (Grs) are provided based on a thorough analysis of the literature and consensus.

Recent Findings After the initial evidence-based definition developed for lifelong PE, the International Society for Sexual Medicine (ISSM) advertised another unified definition for lifelong and acquired PE and confirmed the time criterion for the diagnosis of PE. The ISSM has also acknowledged the presence of the two more PE subtypes (variable and subjective PE) underlining the fact that more research is required to develop an evidence-based definition of these sexual problems. Although the pathophysiology of these four PE syndromes has not been completely elucidated yet, pharmacotherapy must be considered the treatment of choice for lifelong PE patients whereas treating the underlying pathology must be the initial goal for patients with acquired PE. To treat PE, we can use daily or on-demand use of SSRIs, on-demand use of topical anaesthetics, on-demand tramadol or phosphodiesterase type-5 inhibitors. Psychotherapy can be offered to patients who describe variable and subjective PE.

Summary Despite the recent progress reached in the field of PE, there are on-going debates regarding the definition, classification, pathophysiology and treatment of this common problem. Future clinical trials must be performed to understand the actual aetiology of the four PE syndromes and develop more effective and safe treatment alternatives.

Keywords Premature ejaculation · Definition · Classification · Genetics · Drug treatment · Epidemiology

Introduction

Premature ejaculation (PE) is one of the most common male sexual complaints [1, 2] (two level 3 studies). As the first report on this sexual problem was published over 100 years ago [3], there are still different points of view and opinions regarding its definition, classification, prevalence,

pathophysiology and treatment alternatives [4]. These different views are mainly arising from the historical psychological theories, which are formulated before the area of evidence-based medical research. Moreover, different perspectives on the interpretation of the validity and reliability of the methods, designs and data of the new studies resulted in disagreements between researchers. A Dutch group has introduced intravaginal ejaculatory latency time (IELT) as the objective measurement for PE studies [4–8], whereas endocrinological (testosterone and prolactin) data have mainly been derived from an Italian group [9, 10, 11, 12], and twin studies have been performed only by a Finnish group [13–16]. Although these recent data have resulted in the development of evidence-based PE definitions and guidelines [17–20], there is a continuous discussion on what ought to be considered PE and what biological, endocrinological, somatic and genetic factors play role in its aetiology.

This article is part of the Topical Collection on *Urology, Gynecology, and Endocrinology*

✉ Ege Can Serefoglu
egecanserefoglu@hotmail.com

¹ Urology Section, Department of Surgery, University of Catania, Catania, Italy

² Department of Urology, Biruni University, School of Medicine, Istanbul, Turkey



EJACULAÇÃO



Table 16a.1 The three stages of normal ejaculation

Emission	Triggered by activation of the sympathetic spinal cord center (T10–L2) upon increasing sexual stimuli Peristaltic contraction of epididymis and vas deferens with progressive transport of sperm. Contraction of seminal vesicles and prostate with excretion of seminal fluid and emptying of the seminal fluid into the posterior urethra. Ejaculatory sensation resulting from distension of posterior urethra and increasing pressure.
Ejection	Triggered by the parasympathetic and somatic (pudendal nerve) spinal reflex center (S2–S4). Rhythmic contractions of bulbocavernous/pelvic floor muscles with synchronization of bladder neck closure and relaxation of external urinary sphincter.
Orgasm	Processing of sensory and somato-motoric sensations/feelings originating from the internal genitals, urethra and pelvic floor muscle contractions.

EJACULAÇÃO – EMISSÃO

Secreção de fluídos seminais pelas glândulas sexuais acessórias

- **parassimpático**

Contração tracto seminal (epididimo – próstata)

- **simpático**

Transporte do fluido seminal » uretra posterior

- **simpático**

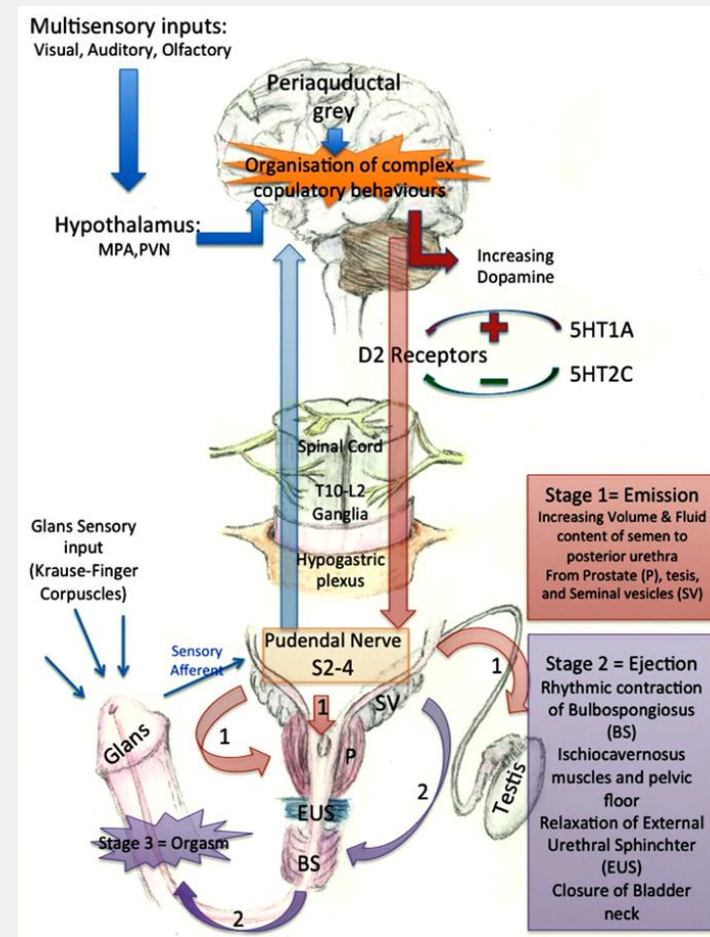
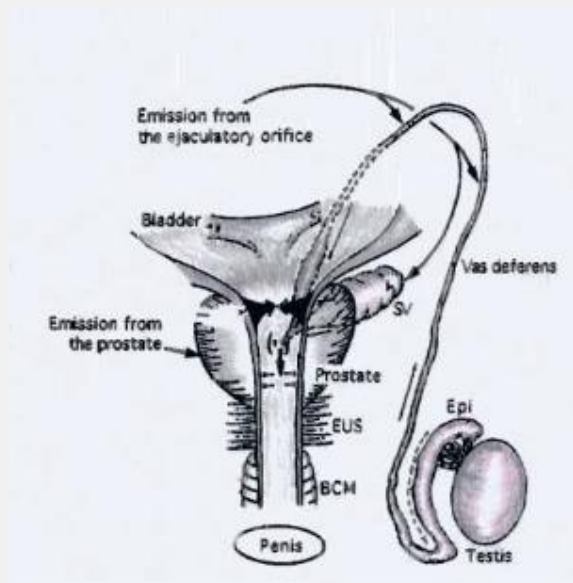
Encerramento colo vesical e elevação Verum

- **Simpático**

Nervos hipogástricos e pélvicos

- **simpático**
- **parassimpático**

- ↑ **Pressão uretra posterior** » *Sensação de ejaculação iminente*



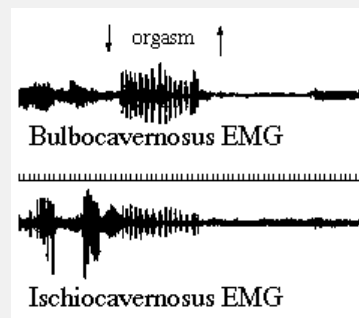
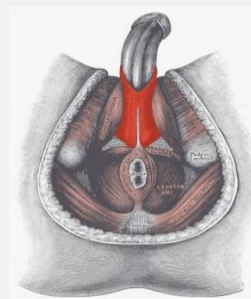
EJACULAÇÃO – EXPULSÃO

Encerramento colo vesical

- **simpático**

Contração bulboesponjoso: **somático**

Contração isquiocavernoso: **somático**



Contrações rítmicas do m. estriado do períneo

- **Expulsão** esperma

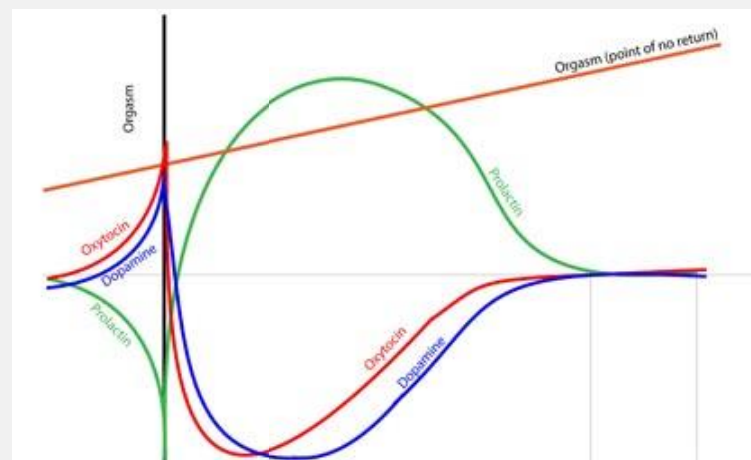
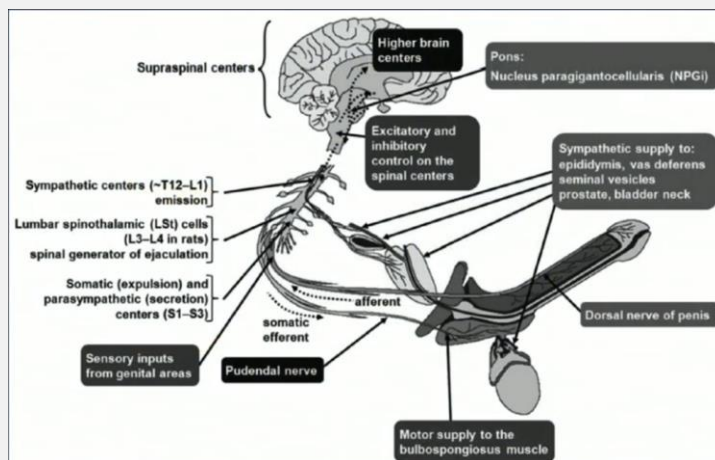


Nervos hipogástricos e pudendo

- **simpático**
- **somático**

EJACULAÇÃO - ORGASMO

- Concomitantemente com fase emissão – orgasmo
- Interpretação **cerebral**
- **Sensação de prazer** sentida na região pélvica e/ou no corpo e/ou nas vísceras abdominais aquando da ejaculação
- Em **indivíduos saudáveis**, a ejaculação promove o **orgasmo**, no entanto existe orgasmo sem ejaculação

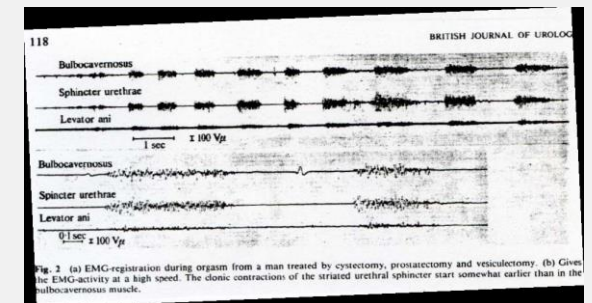


The Effect on Erection and Orgasm of Cystectomy, Prostatectomy and Vesiculectomy for Cancer of the Bladder: A Clinical and Electromyographic Study

B. BERGMAN, S. NILSSON and I. PETERSÉN

Departments of Urology and Clinical Neurophysiology, Sahlgren Hospital, University of Göteborg, Göteborg, Sweden

- **Forty-three men** who had been subjected to cystectomy and concomitant prostatectomy, vesiculectomy and urethrectomy were interviewed about their pre-operative and post-operative sexual activities at a mean of 3 (range 1 to 8) years after operation. **Twenty-eight of the 38 men (74%)** who had been sexually active continued to have some form of sexual activity, **21 of them achieving orgasm**. Only **3 men had penile erection**; 2 of them had been subjected to prostatectomy and 1 to prostatic resection. One of these men treated by prostatectomy had also had urethrectomy.
- Electromyographic registration from the striated external urethral sphincter, the bulbocavernosus muscle and the levator ani muscle showed normal duration of muscular contractions and length of interval between contractions after operation. The pattern of impulses during organs did not differ from that of normal men.



DISTÚRBIOS EJACULATORIOS CLASSIFICAÇÃO – ICSM 2015

- 1. Premature ejaculation: classified into lifelong and acquired;
- 2. Primary delayed ejaculation;
- 3. Acquired delayed ejaculation;
- 4. Retrograde ejaculation;
- 5. **Anejaculation** (antegrade ejaculation is impossible);
- 6. Anhedonic ejaculation (non-enjoyable ejaculation);
- 7. **Anorgasmia** (orgasmic disorder);
- 8. Hypohedonic orgasm (low-enjoyable orgasm);
- 9. **Painful ejaculation or orgasm** (pain during ejaculation, orgasmo pain);
- 10. Postorgasmic illness syndrome (postejaculation fatigue).





Orgasmic Dysfunction after Radical Prostatectomy

Paolo Capogrosso^{1,2}, Eugenio Ventimiglia^{1,2}, Walter Cazzaniga^{1,2}, Francesco Montorsi^{1,2}, Andrea Salonia^{1,2}

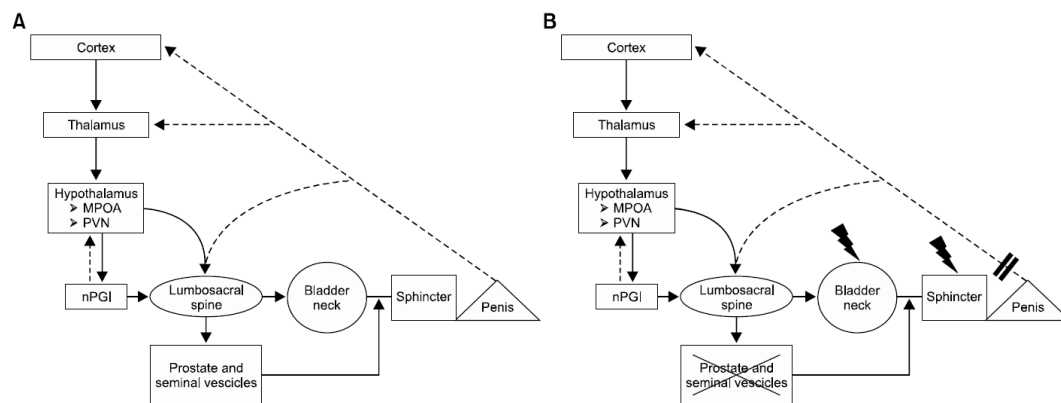


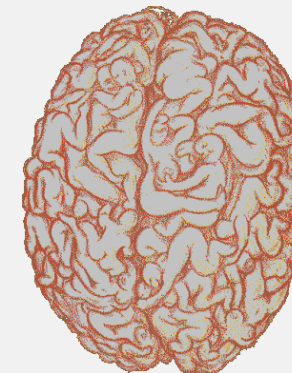
Fig. 1. (A) Physiology of orgasm and ejaculation. (B) Orgasmic alterations after radical prostatectomy. MPOA: medial preoptic area, PVN: paraventricular thalamic nucleus, nPGI: paraventricular nucleus.

- Anejaculação
- Lesão colo vesical
- Lesão fibras simpático – responsáveis contração colo vesical e relaxamento esfínter externo



Orgasmic Dysfunction after Radical Prostatectomy

Paolo Capogrosso^{1,2}, Eugenio Ventimiglia^{1,2}, Walter Cazzaniga^{1,2}, Francesco Montorsi^{1,2}, Andrea Salonia^{1,2}



DISORGASMIA

- Espasmos musculares/distonia colo vesical e do p.pélvico – baseado em estudos com alfa-bloq.
- Técn. Cirúrgica poupadora VS significativamente associada a a disorgasmia – contracção tecido seminal restante

ANORGASMIA

- Disrupção mec. ejaculatório » anejaculação
- DE pós-op:
 - ↓ Estimulação n. dorsal pénis
 - ↓ Estimulo sensorial aferente
- Perturbação Psicológica
 - ↓ Masculinidade

DISORGASMIA

Table 2. Studies reporting the prevalence of painful orgasm after radical prostatectomy

Study (author)	Case	Study design	Patient characteristic	Tool for the assessment of OF	Rate of painful orgasm	Predictor of painful orgasm
Koeman et al [24]	14 ORP	Prospective study	Median age, 65 yr FU not specified	Non-validated self-administered questionnaire	14%	-
Barnas et al [27]	239 ORP	Prospective study	Mean age, 62 yr Mean FU, 39.5 mo	Non-validated self-administered questionnaire	Overall 14% 63% in penis 9% in abdomen 24% in rectum 4% in other areas	-
Nilsson et al [28]	691 ORP/RARP	Prospective study	Median age, 63 yr Postoperatively sexually active Median FU, 2.2 yr	Non-validated questionnaire	17.9%	-
Matsushita et al [33]	702 RP	Prospective study	Mean age, 64 yr Median FU, 2.2 mo	Non-validated questionnaire	Overall 12% Within patients reporting pain: 72% at 12 mo of FU 26% at 18 mo of FU 7% at 24 mo of FU	Nerve-sparing status was not associated
Mogorovich et al [20]	613 ORP 221 RARP	Retrospective analysis	Median age, 65 yr Able to have orgasm Median FU, 2.3 mo	Non-validated self-administered questionnaire	18%	Seminal vesicle-sparing technique
Tewari et al [34]	408 RARP	Prospective study	Median age, 60 yr Preoperatively sexually active Mean FU, 36 mo	Non-validated self-administered questionnaire	3.2%	-
Frey et al [30]	256 RP	Retrospective analysis	Median age, 64 yr Postoperatively sexually active Median FU, 17 mo	Non-validated self-administered questionnaire	Overall 9% 6% lasting 0~1 min 2% lasting 1~5 min 2% lasting >10 min	-
Capogrosso et al [31]	395 ORP 354 RARP	Prospective comparison	Mean age, 61.5 yr Preoperatively sexually active	Non-validated self-administered questionnaire	3 mo of FU 9.5%	RARP patients showed lower rates of PO

OF: orgasmic function, ORP: open radical prostatectomy, RARP: robot-assisted radical prostatectomy, RP: radical prostatectomy, FU: follow-up, PO: painful orgasm.

ANORGASMIA

Table 3. Studies reporting the prevalence of altered orgasmic sensation after radical prostatectomy

Study (author)	Case	Study design	Patient characteristic	Tool for the assessment of OF	Rate of altered orgasmic sensation	Predictor of altered orgasmic sensation
Koeman et al [24]	14 ORP	Prospective study	Median age, 65 yr FU not specified	Non-validated self-administered questionnaire	50% weakened orgasm	-
Helgason et al [36]	342 PCa patients (22 RP)	Prospective study	Median age, 72 yr	Non-validated self-administered questionnaire	14/20 (70.0%) decreased orgasmic pleasure	-
Hollenbeck et al [37]	671 ORP	Retrospective analysis	FU of 4~52 mo	Expanded Prostate Cancer Index Composite questionnaire	Anorgasmia in patients aged < 58 yr 16% after BNS-RP 32% after UNS-RP 33% after NNS-RP	Age <u>Nerve-sparing</u> Prostate weight < 59 g
Barnas et al [27]	239 ORP	Prospective study	Mean age, 62 yr Mean FU, 39.5 mo	Non-validated self-administered questionnaire	37% anorgasmia 37% decreased orgasmic pleasure	-
Dubbelman et al [38]	458 ORP	Prospective study	Mean age, 63 yr	Non-validated self-administered questionnaire	33.2% impaired orgasmic function	<u>Age</u> <u>Nerve-sparing</u>
Salonia et al [35]	334 ORP	Retrospective analysis	Mean age, 61.8 yr Preoperatively sexually active Bilateral nerve-sparing	International Index of Erectile Function questionnaire	International Index of Erectile Function: <u>OF score linearly increased through follow-up</u>	Age International Index of Erectile Function: <u>Erectile Function domain score</u>
Tewari et al [34]	408 RARP	Prospective study	Median age, 60 yr Preoperatively sexually active Mean FU, 36 mo	Non-validated self-administered questionnaire	Rates of anorgasmia: BNS: 9.3% UNS: 17.9% NNS: 39.2%	Age Nerve-sparing
Messaoudi et al [23]	50 LRP 9 PRP 4 RARP	Prospective study	Mean age, 63.9 yr Postoperatively sexually active Median FU, 26.8 mo	Non-validated self-administered questionnaire	77.8% decreased orgasmic pleasure 39.7% anorgasmia	-
Frey et al [30]	256 RP	Retrospective analysis	Median age, 64 yr Postoperatively sexually active Median FU, 17 mo	Non-validated self-administered questionnaire	60% decreased orgasm intensity 5% anorgasmia	UI

OF: orgasmic function, ORP: open radical prostatectomy, PCa: prostate cancer, RP: radical prostatectomy, RARP: robot-assisted radical prostatectomy, LRP: laparoscopic radical prostatectomy, PRP: perineal radical prostatectomy, FU: follow-up, BNS: bilateral nerve-sparing, UNS: unilateral nerve-sparing, NNS: non-nerve-sparing, UI: urinary incontinence.

The prevalence and nature of orgasmic dysfunction after radical prostatectomy

JENNIFER L. BARNAS, STEVEN PIERPAOLI*, PATRICIA LADD*,
ROLANDO VALENZUELA*, NADID AVIV*, MARILYN PARKER*,
W. BEDFORD WATERS*, ROBERT C. FLANIGAN* and JOHN P. MULHALL

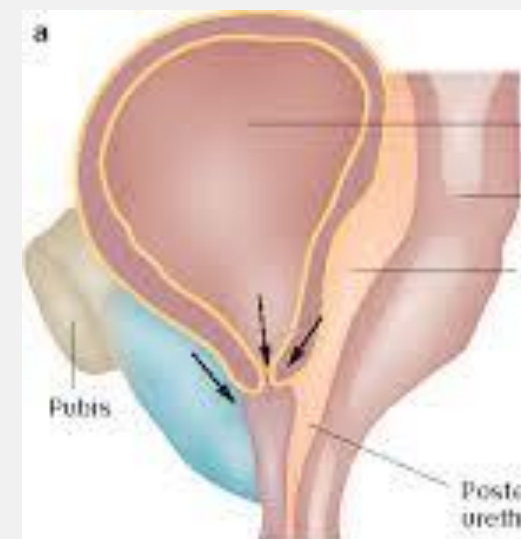
BJU INTERNATIONAL 2004; 94, 603-605

239 patients following RP:

- 37% complete absence of orgasm
- 22% no change in orgasm intensity
- 37% decreased orgasm intensity
- **4% reported a more intense orgasm**

- 14% Dysorgasmia:
 - primary location - penis (63%), abdomen (9%), rectum (24%), other (4%)
 - always (with every orgasm) in 33%, frequently in 13%, occasionally in 35%, and rarely in 19%.

- The cause of dysorgasmia is not well understood; we postulate that the **physiological bladder neck closure that occurs during orgasm** in these men **translates into spasm of the vesico-urethral anastomosis, or pelvic floor musculature dystonia**, after RP
- The muscle spasm concept is supported by our experience with the **amelioration of dysorgasmia** using the a-blocker tamsulosin.



Sexual Rehabilitation and Cancer Survivorship: A State of Art Review of Current Literature and Management Strategies in Male Sexual Dysfunction Among Prostate Cancer Survivors

Eric Chung, FRACS* and Gerald Brock, FRCSC†

J Sex Med 2013;10(suppl 1):102–111

Table 1 Various forms of male sexual dysfunction following prostate cancer treatment

1. Penile deformities
 - a. Penile length loss
 - b. Penile curvature
2. Erectile dysfunction
3. Sexual desire and mental health
 - a. Hypoactive sexual desire
 - b. Depression, anxiety and/or frustration with sexual function
4. Ejaculatory and orgasmic dysfunctions
 - a. Decreased ejaculation or anejaculation
 - b. Climacturia
 - c. Decreased orgasm or anorgasmia
 - d. Dysorgasmia
5. Partner sexual relationship and dynamics
 - a. Changes in sexual intimacy and satisfaction
 - b. Marital distress

- Both ejaculatory and orgasmic dysfunctions usually go hand-in-hand as **disruption (removal in RP) or dysfunction (fibrosis in radiation therapy)** of the ejaculatory apparatus (prostate, seminal vesicles, and ejaculatory ducts) may explain any eventual orgasm impairment.
- Schover et al. [49] found that approximately 65% of men who underwent **RP or radiation therapy** reported a problem with their Orgasms:
 - **31%** who no longer tried to reach orgasm
 - **28%** with orgasm that were disappointingly weak
- Huyghe et al. [50] found that after **low dose seed brachytherapy** :
 - **84.9%** of men with maintained ejaculatory function reported a **reduced volume of ejaculate -18.7% dry ejaculation** compared with 26.9% before ($P < 0.001$)
 - **30.3%** of the patients experienced **painful ejaculation** compared with 12.9% before ($P = 0.001$), with more patients who experienced late/difficult or weak orgasms ($P = 0.001$).

EJACULATORY FUNCTION AFTER PERMANENT ¹²⁵I PROSTATE BRACHYTHERAPY
FOR LOCALIZED PROSTATE CANCER

Int. J. Radiation Oncology Biol. Phys., Vol. 74, No. 1, pp. 126-132, 2009

Table 4. Ejaculation and orgasm before and after PB for overall population and those with preimplant IIEF score >12

Variable	Overall population		IIEF ≥12	
	Before PB	After PB	Before PB	After PB
Total	241	198	216	120
Ejaculation				
Never	18 (7.5)	37 (18.7)	13 (6.0)	14 (11.7)
Sometimes	57 (23.6)	81 (40.9)	40 (18.5)	42 (35.0)
Always	166 (68.9)	80 (40.4)	163 (75.5)	64 (53.3)
Ejaculate volume				
Absent	7 (2.9)	32 (16.2)	4 (1.8)	12 (10)
Diminished	63 (26.1)	141 (71.2)	46 (21.3)	86 (71.7)
Unchanged	165 (68.5)	24 (12.1)	160 (74.1)	21 (17.5)
Increased	6 (2.5)	1 (0.5)	6 (2.8)	1 (0.8)
Dry ejaculation	0	37 (18.7)	0	12 (10)
Pain				
Never	210 (87.1)	138 (69.7)	189 (87.5)	85 (70.8)
Sometimes	30 (12.5)	40 (20.2)	26 (12.0)	24 (20.0)
Often	1 (0.4)	20 (10.1)	1 (0.5)	11 (9.2)
Orgasm				
Absent	3 (1.2)	19 (9.6)	—	3 (2.5)
Premature	102 (42.3)	57 (28.8)	89 (41.2)	34 (28.3)
Difficult	30 (12.5)	55 (27.8)	22 (10.2)	28 (23.3)
Intense	97 (40.3)	34 (17.2)	96 (44.4)	32 (26.7)
Weak	9 (3.7)	33 (16.6)	9 (4.2)	23 (19.2)
Consistency				
Bloody	4 (1.6)	10 (5.1)	4 (1.8)	7 (5.83)
Liquid	4 (1.6)	4 (2.0)	2 (1)	1 (0.83)
Agglutinated	4 (1.6)	3 (1.5)	3 (1.4)	3 (2.5)
Colored	—	1 (0.5)	—	1 (0.83)
Normal	229 (95.1)	180 (90.9)	207 (95.8)	108 (90.0)

Abbreviations as in Table 3.

Prevalence and Predicting Factors for Commonly Neglected Sexual Side Effects to External-Beam Radiation Therapy for Prostate Cancer

Anders Frey, MD,¹ Christian Pedersen, MD,³ Henriette Lindberg, MD, PhD,² Rasmus Bisbjerg, MD,¹ Jens Sørensen, MD, DMSci,¹ and Mikkel Fode, MD, PhD, FEMSM^{1,3}

J Sex Med 2017;■:1–8

- 199 doentes – RTE 78Gy sem Bloqueio Hormonal activo
- 24% Anorgasmia; 44% diminuição intensidade orgasmo
- 11% Anejaculação
- 15% Disorgasmia
- Maior tempo follow-up associado a maior frequência das alterações

TERAPÊUTICA?



The prevalence and nature of orgasmic dysfunction after radical prostatectomy

JENNIFER L. BARNAS, STEVEN PIERPAOLI*, PATRICIA LADD*,
ROLANDO VALENZUELA*, NADID AVIV*, MARILYN PARKER*,
W. BEDFORD WATERS*, ROBERT C. FLANIGAN* and JOHN P. MULHALL

Orgasmic Dysfunction after Radical Prostatectomy

Paolo Capogrosso^{1,2}, Eugenio Ventimiglia^{1,2}, Walter Cazzaniga^{1,2}, Francesco Montorsi

- OF progressively ameliorates over a 48-mo postoperative follow-up
- Scientific literature completely **lacks rigorous trials** aimed at assessing potential treatments for **orgasm-associated pain after RP**

- Amelioration of dysorgasmia using the α -blocker tamsulosin.
- Of 98 patients, 77% reported an improvement in pain and 8% complete resolution of their pain using oral tamsulosin at 0.4 mg/day

- **We are still far from being able to suggest satisfactory treatments for either PO or postoperative anorgasmia.**

PAPEL DA FISIOTERAPIA?

Pelvic Floor Involvement in Male and Female Sexual Dysfunction and the Role of Pelvic Floor Rehabilitation in Treatment: A Literature Review

Talli Yehuda Rosenbaum, BS, PT

J Sex Med 2007;4:4-13

- Papel do pavimento pélvico na Ejaculação e Orgasmo
- Controlo p.pélvico pode ser útil na DE e PE
- Sem dados noutras disfunções ejaculatórias

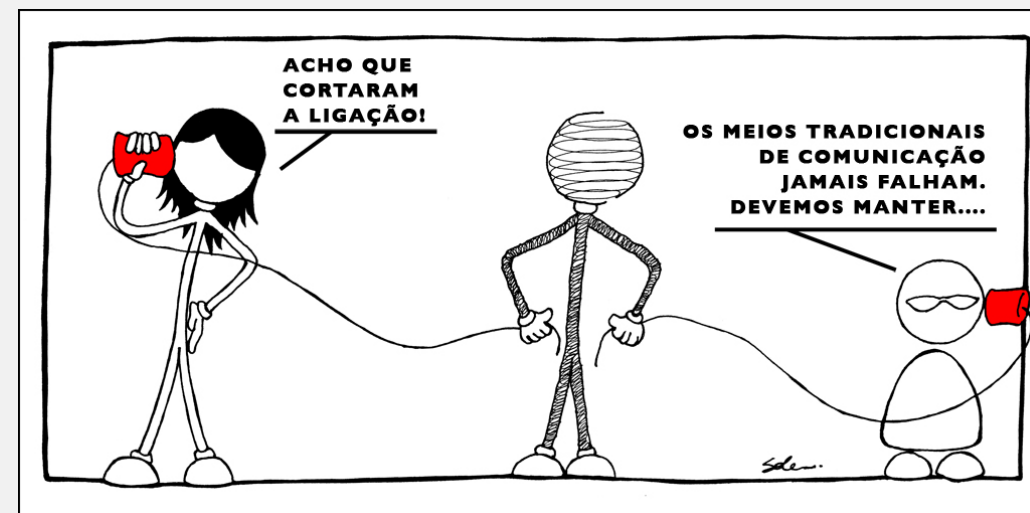
Ejaculation is controlled by the sympathetic nervous system. The proposed mechanism whereby active pelvic floor muscle control may delay its onset may be related to inhibition of the ejaculation reflex through intentional relaxation of the bulbocavernous and ischiocavernous muscles active during arousal. This may be facilitated by “releasing” the levator ani muscles through an active relaxation of the pelvic floor muscles with avoidance of valsalva. This is a learned technique, which may be mastered using pelvic floor biofeedback. Pelvic floor exercise and biofeedback for the treatment of both ED and premature ejaculation (PE) have been reported on in the literature.

A survey of patient expectations regarding sexual function following radical prostatectomy

Serkan Deveci^{*†}, Geoffrey T. Gotto^{*}, Byron Alex^{*}, Keith O'Brien^{*} and John P. Mulhall^{*}

BJU Int 2016; 118: 641-645

- 336 doentes
- 50% doentes não sabiam que prostatectomia estava associada a :
 - Anejaculação
 - Alt. orgasmo, disorgasmia ou climatúria
- Alguns doentes e médicos desconheciam que era possível orgasmo sem ejaculação



Crawford et al. [15] reported a disparity in physician and patient recall of discussions surrounding treatment options and outcomes after a diagnosis of prostate cancer. All of the physicians surveyed claimed to always discuss treatment-related side-effects, whereas only 16% of patients recalled being provided with such information. Additionally, all of

Preparing Patients and Partners for Recovery From the Side Effects of Prostate Cancer Surgery: A Group Approach

Kellie Paich, Rodney Dunn, Ted Skolarus, James Montie, Brent Hollenbeck,
Ganesh Palapattu, David Wood Jr., Staci Mitchell, Victor Hola, Kim Erickson,
Jennifer Shifferd, and Daniela Wittmann

OBJECTIVE	To evaluate the acceptance and knowledge attained in a preoperative psychoeducational group seminar for patients and partners. Education before radical prostatectomy (RP) helps patients set appropriate expectations for functional recovery. We hypothesized that the seminar would be acceptable and would facilitate learning.
MATERIALS AND METHODS	Men scheduled for RP from March 1, 2012, to July 31, 2013, were eligible, and partners were invited. The 2.5-hour interactive seminar included multidisciplinary presentations about surgery-related urinary and sexual outcomes, rehabilitation, and couples' work toward recovering sexual intimacy. A satisfaction and knowledge survey was administered immediately afterward. We analyzed demographic and satisfaction data with descriptive statistics and evaluated congruence of patients' and partners' knowledge responses using nonparametric statistics.
RESULTS	Of 618 patients scheduled, 426 patients and 342 partners attended; 323 couples provided complete data. Over 90% of participants found the seminar informative and 74% found a group setting comfortable; 84% found travel to the seminar burdensome. Most patients and partners (84% and 90%, respectively) expected some urinary incontinence and understood rehabilitation strategies to regain bladder control; 84% of patients and 78% of partners expected postsurgery sexual activity to be different and 73% of patients and 65% of partners expected surgery to make erections worse. Couples were incongruent regarding frequency of incontinence, likelihood of erectile dysfunction, and sex being different after surgery: patients were more realistic.
CONCLUSION	A preoperative psychoeducational group seminar on the recovery from RP side effects promotes realistic expectations and is acceptable to patients and partners. Incongruent couples may need further instruction after surgery. Web-based methodology could improve access and should be studied in future research. UROLOGY ■■■: ■■■–■■■, 2015. © 2015 Elsevier Inc.

- Médico + Enfermeiro +
Fisioterapeuta + Psicólogo/ Sexólogo
- Apresentação tema
- Discussão após

Support Care Cancer
DOI 10.1007/s00520-014-2244-x

ORIGINAL ARTICLE

Exploring the role of the partner in couples' sexual recovery after surgery for prostate cancer

Daniela Wittmann · Marsha Carolan · Barbara Given ·
Ted A. Skolarus · Lawrence An · Ganesh Palapattu ·
James E. Montie

Received: 8 January 2014 / Accepted: 31 March 2014
© Springer-Verlag Berlin Heidelberg 2014

Abstract

Background Prostate cancer survivors' post-surgery sexual problems are well documented and long lasting. Partners' distress in this context leads to psychological morbidity which is poorly understood. Given the prevalence of prostate cancer diagnoses in older men, partners' distress represents a public health concern. This study elucidates an important aspect of partners' distress which has hitherto been undocumented. It can lead to further research and health-care provisions that will support couples in prostate cancer survivorship towards improved mental health and health outcomes.

Purpose Partner sexual function has been viewed as a factor in men's erectile function recovery after prostatectomy for

prostate cancer. However, patients' and partners' perceptions on the role of the partner in couples' sexual recovery has not been studied. We wanted to understand those perceptions and to see whether their perceptions were congruent.

Methods Men and partners were recruited from a previous study and interviewed separately about the role of the partner. Interview transcripts were analyzed using grounded theory with the help of NVivo software.

Results Ten men and nine partners participated; most were more than 1 year past surgery. Men were 62, and partners were 58 years old on average. Nine men had erectile dysfunction. Six female partners were post-menopausal, and a participating male partner had post-prostatectomy erectile dysfunction. Men and partners agreed that partners provide emotional and logistical support. Both perceived the partner's own sexual interest, not function, as critical to the couple's sexual recovery. Some men felt pressured by partners' initiative, feeling insecure about sexual performance. Men were unaware of partners' sexual needs or needs for support. Partners expressed those needs but were unsure of what kind of support they needed.

Conclusion Partners' sexual and support needs during couples' sexual recovery after prostatectomy should be acknowledged and addressed as a legitimate aspect of research and care for men recovering from prostatectomy.

D. Wittmann · T. A. Skolarus · G. Palapattu · J. E. Montie
Department of Urology, University of Michigan, North Campus
Research Complex Building 16, 2800 Plymouth Road, Ann Arbor,
MI 48109-2800, USA

D. Wittmann (✉)
School of Social Work, University of Michigan, Ann Arbor, MI,
USA
e-mail: dwittman@med.umich.edu

M. Carolan
Department of Human Development and Family Study, Michigan
State University, East Lansing, MI, USA

sexual repertoire, although some reported more foreplay. Acceptance of ED was easier for the partners than for the patients, as has been shown in other research [20]. The ability to adopt "flexible coping" [30] and develop a sexual relationship based on the man's diminished erectile function led some couples to even more intimate sexual relationships than they had prior to surgery.

Partners have a critical role in the sexual recovery of the couple after surgery for prostate cancer. Their needs and challenges are not well understood, and their post-menopausal sexual viability has been misunderstood. Preventing partners from becoming burdened by their dual role as caregivers and sexual partners should be included in interventions designed to help couples recover sexual intima-



Platinum Priority – Collaborative Review – Sexual Medicine
Editorial by Dimitris Hatzichristou on pp. 287–289 of this issue

Prevention and Management of Postprostatectomy Sexual Dysfunctions Part 2: Recovery and Preservation of Erectile Function, Sexual Desire, and Orgasmic Function

Andrea Salonia^{a,*}, Arthur L. Burnett^b, Markus Graefen^c, Kostas Hatzimouratidis^d,
Francesco Montorsi^a, John P. Mulhall^e, Christian Stief^f

- Absence of orgasm, decreased orgasm intensity, dysorgasmia, and climacturia may make a man feel uncomfortable or ashamed and cause **psychological distress** potentially resulting in a loss of self-confidence and self-esteem, avoidance of sexual contact with discord in relationships, and a reduction of HRQoL
- Importance of **counseling** patients both preoperatively and postoperatively to reduce the risk of complete sexual avoidance, which—as we extensively discussed—may result in serious damage to the structure of the penis and negatively affect a patient’s psychological and emotional state.
- **Psychological and sexual counseling** is of major importance to **improve any rehabilitation and treatment of postoperative EF, SD, and OF impairment**

TERAPIA SEXUAL

- *Good-Enough Sex model*
- Abordagem centrada no casal, orientada para o prazer e que vê a sexualidade como flexível e variável
- Afastar aspectos do modelo tradicional: controlo total, previsibilidade, ereção automática e coito perfeito
- Valorização intimidade e erotismo
- Aceitar cenários eróticos e não “intercoital”

Men, Intimacy, and Eroticism - McCarthy e Thestrup (2009)



Telemedicine and prostate cancer survivorship: a narrative review

Nnenaya Q. Agochukwu^{1,2}, Ted A. Skolarus^{1,2,3}, Daniela Wittmann^{1,2}

¹Department of Urology, University of Michigan Health System, Ann Arbor, MI, USA; ²Dow Division of Health Services Research, University of Michigan, Ann Arbor, MI, USA; ³VA HSR&D Center for Clinical Management Research, VA Ann Arbor Healthcare System, Ann Arbor, MI, USA

Contributions: (I) Conception and design: All authors; (II) Administrative support: All authors; (III) Provision of study material or patients: None; (IV) Collection and assembly of data: All authors; (V) Data analysis and interpretation: All authors; (VI) Manuscript writing: All authors; (VII) Final approval of manuscript: All authors.

Correspondence to: Daniela Wittmann, PhD, MSW, Department of Urology, University of Michigan, Ann Arbor, MI, USA. Email: dwittman@med.umich.edu

Abstract: Prostate cancer survivors have unique needs that encompass diagnosis and treatment-related side effects. The provision of services for prostate cancer survivors is often limited by resources, time constraints in traditional clinic visits, payment, and patient and provider comfort with discussion of sensitive topics including sexual and urinary health, both of which are largely impacted by treatment. Telemedicine, the remote delivery of health care services using telephone, mobile, web, and video platforms, allows for potential cost savings, in addition to ease and comfort as patients can engage in telemedicine-based resources in the comfort of their homes. Furthermore, survivors prefer to seek information online making telemedicine approaches for prostate cancer survivorship care an ideal combination. A majority of the telemedicine-based interventions used the web, followed by telephone, mobile, and video platforms. In limited studies, telemedicine delivery of survivorship care has equal efficacy to traditional care delivery. In addition, although older patients did not use the Internet regularly, they were willing to adapt to Internet usage if it had the potential to increase their quality of life. Telemedicine delivery of prostate cancer survivorship care is acceptable, feasible, cost-effective, and potentially preferred by prostate cancer survivors. Additionally, it emphasizes knowledge, self-management and self-monitoring serving to increase self-efficacy. This specialized care allows for greater access and reaches a wider catchment area compared to traditional clinic visits. This is especially important as the number of prostate cancer survivors increases and healthcare systems incorporate alternatives to traditional in-person care.

Keywords: Prostate cancer survivorship; telemedicine; mhealth; chealth

Received: 23 June 2018; Accepted: 07 September 2018; Published: 08 October 2018.

doi: 10.21037/mhealth.2018.09.08

View this article at: <http://dx.doi.org/10.21037/mhealth.2018.09.08>

- Apelativo para homens que não se sentem confortáveis abordar o tema
- Sem barreira distância
- Menos custos
- Informação validade

DISTÚRBIOS EJACULATORIOS NÃO NEGLIGENCIÁVEIS

- Pouca informação disponível!
- Questionar para além da disfunção erétil
- Explicar sempre as alterações expectáveis, de forma clara
- Envolver o casal
- Referenciar para Sexologia quando necessário

A DOUTORA NUNCA
ME PERGUNTA NADA
SOBRE A MINHA VIDA...
NEM SOBRE OS MEUS
PAIS, NEM SOBRE A
MINHA MULHER, OS
FILHOS, O EMPREGO...

EU SOU UMA
PSIQUIATRA,
QUERIDO.
NÃO SOU UMA
PORTEIRA.



Obrigada!