Ability to Reach Orgasm in Patients With Prostate Cancer Treated With Robot-assisted Laparoscopic Prostatectomy

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OBJECTIVES To study the ability to reach orgasm after robot-assisted laparoscopic prostatectomy (RALP) in relation to demographic, cancer-related, and surgical variables, and the use of erectile aids.

METHODS In this cross-sectional study at a mean of 3 years after RALP at Oslo University Hospital, 982 men were invited to complete a mailed questionnaire, and 777 responded. Respondents who reported postoperative radiotherapy or hormone treatment, or did not report on orgasm were omitted, leaving 609 patients for analysis. Ability to reach orgasm was rated on 1 question from The Expanded Prostate Cancer Index Composite 26-item version, and dichotomized into "good" or "poor."

RESULTS Overall, 27% of the men reported good ability to reach orgasm: 22% among those did not use erectile aids and 34% among those did ($P = .001$). Univariate analysis of men with good versus poor ability to reach orgasm showed many significant differences. In multivariate analysis, being older, having a reduced physical quality of life, and erectile dysfunction were significantly associated with poor ability to reach orgasm. Erectile dysfunction showed an odds ratio of 4.86 for poor orgasmic ability. The 48% of men who used erectile aids had significantly better orgasmic ability than the nonusers.

CONCLUSION In our sample, 27% had good ability to reach orgasm at a mean of 3 years after RALP. Poor orgasmic ability was associated with being older, poor erectile function, and a reduced physical quality of life. Using erectile aids increased the rate of good ability to reach orgasm.

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Orgasm is a pleasurable experience that is an integrated part of the ejaculatory process in men.[1] It is the result of interplay between physiological and psychological elements. Approximately 9% of men from northern Europe self-reported an inability to reach orgasm in a population-based study.[1] Such inability was associated with erectile dysfunction in 55% of the men, and lack of orgasm was also significantly associated with short-term relationships, antidepressant medication, lack of sexual interest, and an inability to "let go" during sex.[1]

Because the prostate gland and seminal vesicles are removed in radical prostatectomy (RP), the emission and ejection phases of the ejaculatory process are lost. RP also frequently disturbs the orgasmic phase.[2] After RP, 35-75% of men report anorgasmia, decreased orgasmic intensity, dysorgasmia, climacturia, or pain at orgasm.[3-8] Such negative orgasmic changes are significantly associated with increasing age, low education, preoperative problems with erection and orgasm, lack of nerve sparing, urinary leakage, and nonuse of erectile aids.[3-8] However, these findings are based on few studies, often with small samples using various methods for evaluation of the orgasmic changes.[3-8] Nearly all published studies consist of either open RP or a mixture of open RP and robot-assisted laparoscopic prostatectomy (RALP) samples.[4-8] In addition, differences in sampling and follow-up times exist in these samples.

Given this background, the aim of the present study was to explore demographic, cancer-related, and surgical variables as well as the use of erectile aids in relation to the ability to reach orgasm in a single institutional sample in which all men underwent RALP, mainly performed by 2 surgeons.

METHODS

Setting and Patients

Between January 1, 2005, and August 31, 2010, 988 men underwent RALP as their primary treatment for prostate

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cancer at the Norwegian Radium Hospital within the Oslo University Hospital. By March 2011, 6 men had died, and a follow-up questionnaire was mailed to the remaining 982 patients, of whom 777 (79%) responded. An attrition analysis between these men and the 205 nonrespondents showed no significant differences in cancer-related and operative variables, but the nonrespondents were younger and had a higher Clavien sum score for operative complications, as reported previously.[9] Among the responders, 159 (20%) were omitted because they had received post-RALP radiotherapy or hormone treatments, leaving 618 patients. Nine patients did not complete the orgasm item in the questionnaire, so 609 patients were included in the analyses.

Questionnaire Scales and Variables

The Expanded Prostate Cancer Index Composite 26-item version (EPIC-26) is a well-established instrument for subjective measurements of function and bother over the previous 4 weeks in relation to treatment for prostate cancer.[10] The EPIC-26 contains 1 item on orgasm: "How would you grade your ability to reach orgasm?" with the response alternatives: "very poor," "poor," "fair," "good," and "very good." In line with Le et al,[7] we dichotomized the responses into "poor ability" ("very poor," "poor," and "fair") and "good ability to reach orgasm" ("good" and "very good").

Following the literature,[11] *erectile function* "firm enough for intercourse" was defined as "sufficient erection" and the other response alternatives were defined as "erectile dysfunction." The response alternatives "total lack of control" and "frequent leakage" were defined as "urinary leakage" based on the question: "How would you describe your urinary control?" Climacturia, intensity of orgasm, or quantitative measure of orgasm quality were not covered by the EPIC-26. A psychometric study of the Norwegian version of the EPIC-26 is under way.

Use of Erectile Aids. Before rating the sexuality section of the EPIC-26, the patients stated whether they had used erectile aids for the previous 4 weeks, and if so, what forms: phosphodiesterase 5-inhibitors (PDE5is), penile cavernous injections, vacuum pumps, or transurethral administration of prostaglandin E1. If the participants reported no use of erectile aids, they scored the EPIC-26 sexuality items on erectile aids as negative, and if they used such aids, they scored them as positive. Participants who completed both versions were defined as *intermittent users*, and because we lacked further specifications, these users were merged with the regular users in the analyses.

The Short Form 12 is a commonly used self-rating scale for health-related quality of life (HRQoL) based on 12 items covering 8 dimensions that are summarized as the physical and mental composite summary scores.[12] A mean score of 50 and standard deviation of ±10 was observed in the general Norwegian population in an international validation study.[13]

The Hospital Anxiety and Depression Scale (HADS) is a commonly used questionnaire and consists of 14 items: 7 on the depression (HADS-D) and 7 on the anxiety (HADS-A) subscales.[14] Each item is scored on a 4-point scale from 0 (not present) to 3 (considerable), so the total ranges of the HADS-A and HADS-D subscales were from 0 to 21. Good psychometric properties of the Norwegian version have been demonstrated.[15]

Other Questionnaire Variables

Non-paired relationship consisted of men not married or cohabiting. *Nonworking status* concerned men who were without paid work or pensioned as opposed to those who either had paid work or were self-employed. *Low level of education* was defined as ≤12 school years completed versus high-school level (>12 years). Presence of *cardiovascular comorbidity* was defined as a report of previous stroke(s), diabetes, or hypertension. Relapse of prostate cancer after RALP-associated radiotherapy or hormone treatment was self-reported by the patients. The body mass index (BMI) was calculated in kg/m^2.

Medical Data

Information on *nerve-sparing procedures* was extracted from the operative notes and was coded as none, unilateral, or bilateral. From the fresh prostatectomy specimens, the *prostate volume* was determined by experienced urologic pathologists. The *preoperative risk groups* were defined according to D'Amico et al.[16]

Aftercare

All patients had 1 control outpatient appointment with their surgeons at 6 weeks after RALP, and were later followed up by their regular general practitioners. At the control appointment, all patients were offered sexual guidance. Data on the numbers of patients who had such guidance or any intervention concerning orgasmic dysfunction are lacking, but according to the surgeons, the proportion was low. In Norway, the National Health Insurance covers the cost of all erectile aids except PDE5is, and both urologists and general practitioners can prescribe such aids.

Statistical Analysis

Descriptive statistics were calculated using chi-squared tests for categorical variables and independent sample Student's *t*-tests for continuous variables. In cases of skewed distributions, nonparametric tests were used. Associations between the ability to reach orgasm and erectile function were calculated using Spearman's correlation coefficient, rho. Univariate and multivariable logistic regression analyses with relevant independent variables and poor ability to reach orgasm as the dependent variable were performed. The strength of association is described as ORs with 95% confidence intervals (CIs). Adjustment for potential confounders of orgasmic ability was made by multivariable logistic regression analyses. The level of significance was set at $P < .05$, and all tests were 2 sided. Data analyses were performed with IBM SPSS version 20.0 for Windows (IBM Corp., Armonk, NY).

Ethics

The study was approved by the Regional Committee for Medical and Health Science Research of South-East Norway

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