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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 ($\geq$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.

Keywords: Orgasm; Pain; Alpha-blocker; Tamsulosin

1. Introduction

Sexual dysfunction is a distressing problem for men who suffer from it. It is a condition which negatively impacts quality of life and relationships [1,2]. Post-orgasmic pain (dysorgasmia or orgasmalgia) represents a subcategory of sexual dysfunction that has received little attention in the medical literature [3]. No uniform theory exists pertaining to the etiology of this problem in men, however it is our belief that pelvic floor muscle and/or bladder neck spasm are key to the development of this condition. In our practice it has been recognized that dysorgasmia is not an uncommon complaint of patients who have undergone prostatectomy [3–5], have been exposed to pelvic radiation [6,7] and in young men diagnosed with chronic pelvic pain disorder [8].

Tamsulosin is a prostate specific alpha-adrenergic receptor (alpha$_{1D}$) blocker usually prescribed to alleviate lower urinary tract symptoms related to benign prostatic hyperplasia [9]. Tamsulosin acts via smooth muscle relaxation of the bladder neck and prostate resulting in reduced bladder outlet obstruction, a decrease in symptom scores and improvement in urine flow rates [10]. Case reports have also suggested tamsulosin to be effective in alleviating painful ejaculation in clinically depressed patients [11] and a randomized, placebo-controlled, multi-center clinical trial

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studying the efficacy of tamsulosin in treating patients with chronic prostatitis/chronic pelvic pain has demonstrated improvement in pain using tamsulosin [8].

Given the aforementioned postulated theory for the genesis of dysorgasmia and the uroselective nature of tamsulosin, it was selected as a potential therapeutic candidate for male dysorgasmia. The absence of information on dysorgasmia in men prompted this study in which patients admitting to complaints of pain at orgasm underwent alpha-blocker therapy to define the impact of this treatment on pain.

2. Methods

2.1. Study population

Patients presenting with sexual dysfunction were asked about orgasmic pain at the time of their interview. If they admitted to this problem, they were counseled regarding the rationale and nature of this study. Patients were subdivided into three groups based upon the etiology of their dysorgasmia: radical prostatectomy (RP), pelvic radiation therapy (RT), and a general group unrelated to the other two etiologies. Patients were excluded at baseline if they had been using alpha-blocker therapy for any reason, had a history of another chronic pain disorder or were using any therapy for chronic pelvic pain disorders such as central analgesic agents.

2.2. Medical treatment

Patients meeting inclusion and exclusion criteria and who agreed to participate and signed the informed consent were instructed to use tamsulosin 0.4 mg po qhs for at least 4 weeks. No placebo arm was included in this proof-of-concept study.

2.3. Outcome assessment

At baseline and at a time point at least one month after the commencement of medical therapy, patients completed three inventories (i) the international index of erectile function (IIEF), (ii) a visual analog scale (VAS) for pain, and (iii) an incontinence scale. The IIEF is a 15-question validated inventory, which has 5 domains, erectile function, libido, orgasmic function, sexual satisfaction and overall satisfaction. The questionnaire addresses the patient's sexual function over the 4-week period prior to completing the inventory. The primary domain of interest in this analysis was the libido domain. This domain is composed of questions 9 and 10 and its maximum score is 10. Each question is scored on a Likert scale (maximum score of 5), with higher scores indicating better function. The VAS used was a standard 1–10 scale with a score of 10 representing the worst pain. The incontinence scale used graded the level of incontinence between 1–10, a score of 10 representing constant urinary leakage and 1 representing perfect urinary continence.

2.4. Statistical analysis

Scores for all three scales were compared between pre and post-treatment time periods using a 2-tailed Student's *t*-test.

3. Results

Ninety-eight patients were enrolled in the study. The mean age was 48 ± 18 years. Hypertension was found in 24%, dyslipidemia in 12% and diabetes in 11%. Thirty-five percent had undergone RP and 16% had RT. The mean duration post-RP and RT was 6 ± 2 and 12 ± 7 months respectively. The mean interval between completion of the pre- and post-tamsulosin treatment questionnaires was 1.2 ± 1.5 (0.5–3.2) months.

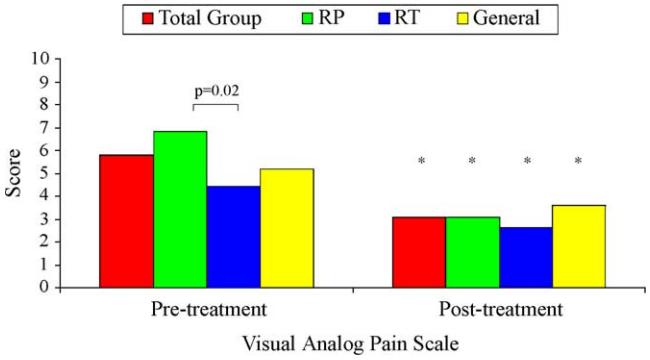

Fig. 1. Visual analog pain scale before after following tamsulosin treatment. At baseline the pain in the radical prostatectomy group was more severe than in radiation therapy group. All post-treatment values were statistically significantly lower than the pre-treatment values for each group.

Pain was located in the penis (72%), testis (12%), rectum (8%), or abdomen (4%). Most patients (52%) experienced pain for a duration of 1 to 5 minutes post-orgasm. Pain lasted less than a minute in 32%, but more than five minutes in 12%. Four percent of men experienced pain for longer than 15 minutes. 76/98 (77%) patients reported improvement in pain and 12/98 (13%) 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 (Fig. 1). The entire group had a decrease of 2.7 points between pre and post-treatment phases (5.8 to 3.1). Of note, at baseline, the group with the greatest pain level (on VAS) was the post-RP group (6.8 at baseline

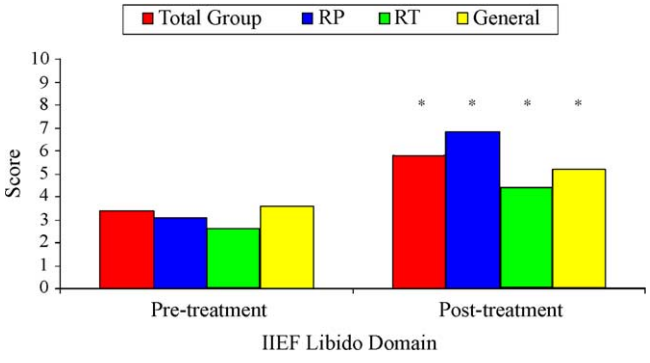

Fig. 2. IIEF libido domain scores before after tamsulosin treatment. All post-treatment values were statistically significantly greater than the pre-treatment values for each group.