Journal of Health Science 5 (2017) 166-171
doi: 10.17265/2328-7136/2017.04.002

Male Sexual Pain Disorders: New Approach

Giorgio Del Noce[1, 2], Vilma Duretto[2], Rosa Bochicchio[2], Francesca Ragni[3]and Giovanni Cociglio[2]

1. Promea Day Surgery-14, via Menabrea-Turin 10126, Italy

2. SSSC (Scuola Superiore di Sessuologia Clinica), Turin 10128, Italy

3. Department of Urology, University of Turin School of Medicine 10043, Italy

Abstract: There are several kinds of male genital pain which can cause mental suffering. Usually, they emerge during ordinary urological or andrological examinations. These distresses, sine materia, can be divided into different types. The first type, that is the most frequent one, mainly affects the testicles; usually, this kind of distress lasts a lifetime and it is often associated with surgery and/or frequent examinations to the genitals during childhood. The second type encompasses cases of real penodynia: the patients express their discomfort especially uncovering the glans and, for this reason, this action is never done. This distress is not always referred to as pain, but more often as “bothersome”. Sexual intercourses are permitted. Often the patients undergo a circumcision that usually has a complicated postoperative course. The males of the third type correspond to the women suffering from “vaginismus”. The patients do not even tolerate the approach of the hand to the penis and they make the same actions and the same movements as the vaginismic women. The patients are unable to have sex. This phenomenon is rare. The fourth type is numerous and may be defined as a real male Dyspareunia. The patients complain pain during sexual intercourse and, above all, during ejaculation. The symptom is felt in pelvic-perineum area and it is often diagnosed asprostatitis, but in reality no organic therapy is effective at all. Some clinical cases will be presented and discussed.

Key words: Male genital pain, penodynia, chronic prostatitis, chronic pelvic pain syndrome, cronic scrotal pain syndrome, circumcision.

1. Introduction

The male sexual pain in Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM IV) has something to do with Dyspareunia. However, I can say by experience very few men feel pain during sexual intercourse.The patients that have this kind of pains how organic problems (dermatological, Induratio Penis, etc.).

In Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM V) dyspareunia and vaginismus have been classified as genital/pelvic pain or as a penetration disorder, considering them as disorders only affecting females. This leaves the question that why could not a disorder such as genital pain “sine materia” that is very common among women, also affects men. Actually, frequently in medical practice some patients complain of genital pain that cannot be explained by organic causes, while some characteristics could suggest a psychological etiology. In fact, the sexual ailment symptoms are often associated with significant anguish. Frequently there are alterations in urination, perineum discomfort and sometimes misdiagnosed as chronic prostatitis. Patients with these symptoms often carry out various medical examinations as well as long and strenuous therapies without seeing significant results. Sometimes the relationship between the doctor and the patient is affected, which results in the patient referring to other specialists for answers. Male sexual pain usually can begin during adolescence, and in some cases can severely affect the quality of life.

The authors classify at least 4 types of sexual pain disorders.

2. Classification

The first type which occurs quite frequently, experiences pain when touched above the testicles,

Corresponding author: Giorgio Del Noce, tutor and teacher SSSC, research fields: andrology, sexology

and can persist for a lifetime.

Normally this disorder is discovered during an urological or andrological visit for other motives. The pain is normally described to as pain or discomfort by palpation of the testicles. It rarely occurs spontaneously. Generally it does not cause serious/grave suffering for the patient, who normally has a regular life, also sexually and considers this hyper sensibility only as a characteristic of their body. It is often correlated with a positive medical history of surgical operations such as Hypospadia, Cryptorchidism, etc. and/or frequent genital medical examinations at a pediatric age. It could perhaps be considered as a defensive reaction to what we could consider a kind of sexual abuse for the child. The pain sometimes only occurs when the palpation is conducted by foreign hands and not by the subject himself. Normally treatments are not required as the patient is able to live without problems whilst being affected by this disorder. In some cases it can be useful to explain to the patient the probable causes of the disorder that increases awareness of possible psychological factors.

The second type may be quite related to penodynia. Also in this case the pain is discovered occasionally following an andrological visit. The patient normally shows discomfort especially when the glans is uncovered, which is almost never performed. The patient does not always experience pain, but very often feels discomfort or other unpleasant sensations. Often the patient is informed by the doctor that their poor hygiene has caused these symptoms. This humiliation sometimes does not assist the patient. In not all cases phimosis is present. Sometimes there is only a long prepuce. The symptoms could be defined as a true case of allodynia. The affected patients are able to have sexual intercourse, and curiously during sexual intercourse very few symptoms occur. During sexuological consultations, often the patient presents signs of conflict with their genitalia.

In these patients premature ejaculation is frequent. These patients usually have an andrologic exam with the intention of circumcision, which usually has a long postoperative recovery period.

The third type may be compared to a very true case of vaginismus. The patient cannot even tolerate any contact near the penis and make the same actions and movements of a vaginismic female. Due to this the patients are unable to have sexual intercourse. The causes of these symptoms are usually associated to a significant psychological distress, but fortunately the third type is quite rare.

The fourth and final type may be defined as a real case of male Dyspareunia. The patients experience pain in the pelvic-perineum region during sexual intercourse and especially during ejaculation. They are characterised by alterations to penile and perineal sensibility, with the feeling of hypogastric weight. Often it is found that there is an erectile dysfunction present. Normally symptoms of overactive bladder are also present, and due to this it is often diagnosed as prostatitis, even if in reality no organic treatment/therapy is effective. In fact, if we analyse the symptoms of non bacterial chronic prostatitis we can often find patients that fit into this category. However, some characteristics are identifiable in the patient’s medical history. First of all they often feel a sense of anguish and sometimes panic. In fact, frequently these patients go to the Emergency Department, even if their symptoms are vague. There is an absolute discordance between the extent of the modest symptoms and the suffering of the patients that often lasts for many years despite the countless amount of medical examinations attempted treatments. Frequently the patients suffering from this disorder are comparable to somatization (gastritis, colitis, intolerances, dermatologic diseases). The physician that sees patients with this type of disorder usually finds that they have a file with extensive medical history of examinations and previous medical visits. The physician tends to confirm a diagnosis of prostatitis and add other medical visits or

examinations to the patient's file. The patient-doctor relationship then becomes conflicting, and assisting the patient to find a permanent medical solution becomes difficult as the patient is satisfied with temporary improvements.

3. Treatment

Normally all the patients suffering from genital pain undergo an andrological or urological visit without considering the problem from a psychological aspect. In the first and second types, generally a treatment is not necessary. The patients suffering from Penodynia should be carefully considered, since in some cases general counseling allows for a psychological problem to be highlighted, which however, is not always necessary to cure. When carrying out a circumcision in a case of phimosis, it is necessary to take into account that the post-operative progress is no good. The circumcision that normally would be carried out using local anesthetic, in some cases requires the use of an additional sedative, due to the fact that the patient transforms tactile sensibility into pain. Circumcision is normally able to vanish the symptoms, but generally does not assist with the patients psychological problems even if sometimes the patients need/want for surgery is unconsciously born from the will to overcome their sexual difficulty.

In the third type counseling the patient is important, also to clarify that even if a circumcision operation is undertaken, it would not resolve the problem. Generally, circumcision is carried out in a deep state of narcosis. However, the postoperative progress is absolutely more complex. Unfortunately, the patient typically has many expectations about the results of the surgery, which usually turn out to be disappointing, since subsequently the emergence that the cause of the sexual disorder is due to psychological reasons, can convert and develop into other disorders which continue to prevent a normal sexuality. It is useful for the patient to be accompanied by psychological/psychiatric support, but it is an extremely difficult path and simply sanding the patient to a psycological consultation is generally not effective. It is important that the andrologist offers the first psycological support.

The fourth type of disorder affects a significant number of patients and the symptoms presented in the clinic are extremely variable. Consequently treating these patients is difficult, and when treating, it is necessary to use an integrated approach. From an aspect it is necessary to maintain contact with the body, and medical examinations are useful to exclude the presence of associated diseases. Medical treatment can also be useful to reduce symptoms related to this disorder. A treatment that can be very efficient in reducing symptoms is anti-depressant medication. However, this treatment is often rejected by the patient, and sometimes unconsciously he shows unbearable side effects. In fact, it is necessary to try to help the patient be aware that the disorder could originate from psychological reasons. However, it should never be said that the patient does not have a medical issue, because the pain felt is real, but doubt could be established. For example that the anguish and anxiety that patients feel is not caused by symptoms, but that they are symptoms and are caused by psychological malaise. The effectiveness of this approach depends on the time that these symptoms began to exist. If the disorder has been present in the patient for a significant period of time, it is quite unlikely that the patient can be easily healed. It is not said, that healing means the disappearance of symptoms, but with this type of disorder, often it is enough to inform the patient to be aware of the psychological etiology of the disorder. We must take into account that the use of some pharmaceutical anti-depressants can interfere with sexual activity. On the other hand the result is excellent in case Premature Ejaculation. In a perspective of multi-disciplinary and integrated methodology, the patients were treated with drugs and/or with sexual therapy according to the integrated Kaplan method and/or with techniques for

the rehabilitation of the pelvic floor. In particular the use of TENS (transcutaneous elettrical nerve stimulation) is highly effective for its antalgic effects. In fact it allows a significant relaxation of the pelvic floor and locally stimulates the production of endorphins. The method is very effective in controlling hyper-contraction on the perineal floor, even present among patients affected by the 4th type of disorder. In fact, frequently patients with this disorder suffer also from anal problems that interfere with defecation. The tension of the perineum is often the causeof the pain. The therapy has to be evaluated case by case and rigid protocols are not so easily applicable.

3.1 Clinical Case of the First Type

A 17-year-old patient comes with his mother for an andrologic consultation for an issue of bilateral testicular pain. The teenager has suffered from a late drop of the testicles. The patient tenses while being examined and pushes away the hands of the physician, which makes it difficult to palpate the testicles as the patient is defensive as says to be suffering from pain. The physician understands the situation and subtlety addresses the mother to closely observe the next part of the examination. From a distance the physician asks the teenager to palpate the testicles himself. This is done so without any problems as the patient is able to touch both of his testicles without feeling pain. The mother remained astonished, and the physician began to explain the possible reasons behind the symptoms, that it is likely the teenager became hypersensitive resulting from frequent medical visits during infancy and reassured the mother of the low extent of the problem.

3.2 Clinical Case of the Second Type

A 28-year-old patient was referred to see an andrologist by a sexual psychologist. The patient was having difficulty in sexual relations resulting from premature ejaculation. The examinations conducted by the physician showed hematochemical exams to be regular, with no reference to any particular disorder. The examination objectively showed no signs of illness, but as soon as the physician began to examine to penis and the glans, the patient began to suffer and asked the physician to cease the examination. The glans examined in a regular manner, but the very act of examining the penis provoked significant suffering to the patient, which confirmed high sensitivity. The physician then asked the patient to try and find the glans himself. The man says he is able to do it often without problems. However, it was noticed that he didnot seem to understand what to do. When asked if he was able to expose the glans during an erection, the man affirmed not to know it and to have never done it. There was no evidence of pain during masturbation, nor during sexual activity. The patient did not desire a circumcision and the physician encouraged him to conduct exercises exposing the glans. After talking with the sexual psychologist, it became evident that the patient has a conflicting relationship with sex.

3.3 Clinical Case of the Third Type

A 23-year-old patient consulted for a circumcision. Even if the patient did not have a true case of phimosis, it was almost impossible for the physician to touch the glans during the examination. In fact, the patient even before being touched, reacted by pushing away the hand of the physician because of the pain felt in view of the physical contact (anticipatory pain); however the patient did not show emotions (alessitimia) and this characteristic is quite frequent in these cases. The mother of this patient also gave insight that even from an infant age, this man did not like being caressed or touched in an affectionate way. The patient reports to have never had sexual intercourse, nor relations in an affectionate way. In fact he stated that with this problem it would be unthinkable to have an intimate relationship, and for this reason has submitted to have treatment, and a circumcision with the hope that it would resolve all

his problems. The postoperative recovery resulted in being very complex, with countless check-up visits. In the end, the patient declared to be satisfied with the result. A year later after the operation, the patient continued to not have intimate relations and the physician gave its full availability to help him.

3.4 Clinical Case of the Fourth Type

A 30-year-old patient came for a urological examination complaining of ejaculation pain for the last 13 years. The man is married with 2 children, and has a good relationship with his wife. The patient presented a file of medical history with numerous ultrasound scans and coltural examinations. The man had been given various antibiotic treatments over the years, for chronic prostatitis. This diagnosis was confirmed with testing that found presence of prostate calcifications. Throughout the consultation, various behaviors and comments made by the patient ("I feel pain with only the thought of ejaculation") drove the urologist to ask open questions. The physician realized that this patient liked to talk, and by the end of the consultation came close to the desk and revealed a fact that he had always hidden from everyone: when he was 17 years old, he was subjected to violent sexual abuse by two people. The patient had let out a wealth of detail about the episode to the physician, and at the end of the consultation he asked: "Do you think that this could be the cause of my disorder?" Actually, the patient is in psychological therapy, and has obtained promising results through the rehabilitation of the pelvic floor.

3.5 Second Clinical Case of the Fourth Type

A 31-year-old patient came for an andrological consultation for an arousal and erectile sexual disorder with constant ejaculatory pain. In previous examinations, the patient was diagnosed with chronic prostatitis and had used various medications as treatment, without seeing any significant improvement. He presented many recurring somatic symptoms, and others often changing. In the past 3 years he had carried out almost 20 blood tests for ematochemical examinations, 15 coltural tests of semen, urine and faeces, an electromyography, and a gastric biopsy. As well as seeing many specialists: an ophthalmologist, a dermatologist, a neurologist, a gastroenterologist, an allergist, an immunologist, a rheumatologist, a stomatologist, a nefrologist, and he had also been to an immunopathological and rare disease centre. The andrologist tried to direct the patient towards a colleague who is both sexologist and psychiatrist, and after a difficult initial approach, it was understood that the patient had not accepted investigation of his problem despite it being evident that he suffered from severe depression. The patient interrupted and left the consultation to visit a different andrologist/urologist

4. Discussion and Conclusion

If we search Vulvodynia on the internet we can find around 500,000 items, but if we look Penodynia up we can find only 519 items, which are above all due to dermatologic causes. If you search Penodynia in Pubmed you can find only 2 articles (1,200 for Vulvodynia). In reality, in surgical andrologic activities, male genital sine materia pains are very often referred and emphasized. In the DSM 5 the described patients could be placed in the category of Somatic Symptom and Related Disorders, but we do not think it is the link with male genitalia that characterises these patients. Chronic pain is highly linked with anxiety and depression. It is often associated with substantial financial, occupational, psychological, and social burdens. However, if the chronic pain involves the genitals, it is more likely to be related to relational and/or intrapsychic factors. In publications and literatures we can find very few articles that treat male genital pain with symptoms of psychological suffering. Yet, among normal general day-to-day consultations cases similar to those described in this article are frequent. Unfortunately, medical culture lacks a holistic vision of the patient

and between psychiatric/psychological and medicine there is not an integrated approach. The patients are usually only referred to a psychiatrist when the illness is at a severe level, and sometimes irreversible. This does not happen in other specialties where a consultation is requested, even if it is only precautional. It is now accepted that a psychological disorder such as depression, can provoke and cause physical symptoms and annoyance to patients, and surely a precocious treatment of the disorder can help to achieve the best results. Finally, I think that, up to now, male sexual pain has been studied in a superficial way and that there are many aspects that need to be further investigated and reported.

References

[1] Dauendorffer, J. N., Renaud-Vilmer, C., Bagot, M., and Cavelier-Balloy, B. 2012. "Circumcision-Induced Penodynia." *Ann. Dermatol.Venereol*. 139: 566-7.

[2] Dauendorffer, J. N., Renaud-Vilmer, C., and Cavelier-Balloy, B. 2014. "Diagnosis and Management of Penodynia." *Ann. Dermatol.Venereol*. 14: 383-6.

[3] Schover, L. R. 1990. "Psychological Factors in Men with Genital Pain." *Cleve. Clin. J. Med*. 57: 697-700.

[4] Bair, M. J., Robinson, R. L., Katon, W., and Kroenke, K. 2003. "Depression and Pain Comorbidity: A Literature Review." *Arch. Intern. Med*. 163: 2433-45.

[5] Verdu, B., Decosterd, I., Buclin, T., Stiefel, F., and Berney, A. 2008. "Antidepressants for the Treatment of Chronic Pain." *Drugs* 68: 2611-32.

[6] Abhineetha Hosthota, Swapna Bondade, Divya Monnappa, Vinay Basavaraja. 2016. "Penodynia and Depression." *Our Dermatology Online.* 2: 240-1.

[7] Guy, A., Bronselaer, J. M., Schober, Heino F.L., Meyer-Bahlburg, G. T., Vlietinck, R., and Hoebeke, P. B.2013. "Male Circumcision Decreases Penile Sensitivity as Measured in a Large Cohort." *Br. J. Urol. International* 111: 820-7.

[8] Morris, B. J.,and Krieger, J. N. 20123. "Does Male Circumcision Affect Sexual Function, Sensitivity or Satisfaction? A Systematic Review." *J. Sex. Med*. 10: 2644-57.

[9] Katz, J., Rosenbloom, B. N., and Fashler, S. 2015. "Chronic Pain, Psychopathology, and DSM-5 SomaticSymptom Disorder." *Can. J. Psychiatry* 60 (4): 160-7.

[10] Naim, M.,and Ende, D. 2011. "A New Approach to the Treatment of Non-specific Male Genital Pain." *Br. J. Urol. Int.* 107 (suppl 3): 34-7.

[11] Nickel, J. C., Mullins, C., and Tripp, D. A. 2008. "Development of an Evidence-based Cognitive Behavioral Treatment Program for Men with Chronic Prostatitis/Chronic Pelvic Pain Syndrome." *World J. Urol.* 26: 167-72.

[12] Delavierre, D., Rigaud, J., Sibert, L., and Labat, J.-J. 2010. "Approche symptomatique des douleurs péniennes chroniques." *ProgrèsenUrologie*. 20:958-61 .

[13] La coppia: Nuove realtà, nuovi valori, nuovi problem, Franco Angeli ed, 1: 255.