ISSN: 2755-6204

Case Report

Journal of Sexual Health and Reproductive Medicine

Marked Relief of Painful Ejaculation (Dysorgasmia) in a Young Male Treated with the Dopaminergic Drug Dextroamphetamine Sulfate

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Received: May 28, 2025; **Accepted:** June 02, 2025; **Published:** June 09, 2025

ABSTRACT

There are a variety of chronic disorders in women and men, including, but not limited to pelvic pain. Dysorgasmia in males associated with chronic pelvic pain is uncommon but possibly under reported. Though there is little or no published experience in treating dysorgasmia or for that matter, chronic pelvic pain in males, based on the very positive benefits of dopaminergic drug therapy (especially dextroamphetamine) for pelvic pain in women, a 29 year old male, who was diagnosed as having pelvic floor dysfunction (but not responding to pelvic floor physical therapy) was treated with dextroamphetamine sulfate. He had complete relief of his dysorgasmia and interstitial cystitis (mostly manifested as urgency, and chronic pelvic pain) with dextroamphetamine sulfate treatment. He did have some relief by treatment with another dopaminergic drug, cabergoline. He fulfilled Koch's postulates by the return of the symptoms whenever he ran out of dextroamphetamine with quick improvement once the drug was restored. This great relief has persisted over four years of treatment. Whether this therapy is effective just for idiopathic dysorgasmia, as seen in this case, or may be effective for dysorgasmia from other known causes, remains to be determined with future studies.

Keywords: Dysorgasmia, Painful Ejaculation, Interstitial Cystitis, Dopaminergic Drugs, Increased Cellular Permeability Syndrome

Introduction

The use of the dopaminergic drug dextroamphetamine sulfate has been shown to provide marked amelioration of treatment refractory interstitial cystitis in women [1-3]. Similarly, dextroamphetamine sulfate has provided marked relief of various types of pelvic pain including dysmenorrhea, dyspareunia, mittelschmerz, chronic pelvic pain, and vulvovaginitis [4-10]. Also, the dopaminergic drug cabergoline has also provided marked relief for patients with severe dysmenorrhea [11]. Levodopa has also been shown to improve vulvodynia [12].

The explanation of the mechanism as to how dopaminergic drugs seem to provide relief of these various types of pelvic pain is by the beneficial effect of dopamine in decreasing cellular permeability. It has been hypothesized that these various pelvic disorders are related to an increase in cellular permeability of these tissues related to intrinsic genetic susceptibility or acquired defects e.g., infection or trauma or combination of intrinsic and extrinsic origins allowing increased infusion into these tissues of irritants leading to excessive inflammation and pain [13].

Frequently related to genetic associated issues there may be a variety of different chronic pathological disorders associated with the pelvic pain e.g., Crohn's disease, or headaches which similar to the pelvic pain, also dissipate with dopaminergic therapy [13,14].

The various conditions related to increased cellular permeability, though perhaps more common in women, are also found in men who similarly respond to dopaminergic drugs [15-18]. We report a case of a male with chronic pelvic pain, interstitial cystitis, and dysorgasmia attributed to pelvic floor dysfunction who failed to respond to pelvic floor physical therapy, but who did respond to dopaminergic drugs.

Case Report

The patient consulted us at age 29 for chronic pelvic pain, a feeling of urgency and discomfort after urination, mid-epigastric

Citation: Jerome H Check,Naomi Ganko Nkwenkwa. Marked Relief of Painful Ejaculation (Dysorgasmia) in a Young Male Treated with the Dopaminergic Drug Dextroamphetamine Sulfate. J Sex Health Reprod Med. 2025. 1(2): 1-3. DOI: doi.org/10.61440/JSHRM.2025.v1.05

pain radiating to his testes and rectum after prolonged sitting, and lower back ache especially after prolonged sitting. However, the problem that bothered him the most was painful orgasm. The latter was so severe that he would still have intercourse but not try to ejaculate. The pain was not only present during the ejaculation but also for 30 minutes after the orgasm.

These symptoms had been present for several years and were gradually worsening. He was diagnosed with pelvic floor dysfunction and interstitial cystitis. However, pelvic floor physical therapy failed to provide any significant relief.

Based on our positive experience in treating women with pelvic pain and interstitial cystitis, we treated him with 15mg amphetamine salts (providing 9.4mg dextroamphetamine sulfate) upon arising and noon. All of his symptoms dissipated within the first two weeks of treatment.

His job necessitated that he move to another state over 800 miles away, one year after his initial visit. However, the law for prescribing for class II drugs requires an in person visit every 3 months, He thus decided to try cutting the pills in half and take 7.5 mg amphetamine salts twice daily. He found that this dosage provided the same relief as the higher dosage. During our 4 years of treating him he sometimes could not come for the appointment, so he ran out of medication. He had no withdrawal symptoms despite sudden cessation. However, within a week off medication his symptoms would insidiously return. However, the dysorgasmia would be extremely painful again if he had no amphetamine for one week. The pain would be most intense during the orgasm but would slowly dissipate over the next 30 minutes. The burning pain was most intense in the penis but would also be present in the lower abdomen especially as he described “at the belt level.” Also, the pain was experienced in the rectum and testes.

Prior to his evaluation at our clinic, he had been evaluated by two different urologists, and they could not find any evidence of urinary tract infection, chronic prostatitis, or benign prostatic hypertrophy. He was not taking any medication at all at the time They concluded that he has dysorgasmia and interstitial cystitis as a result of pelvic floor dysfunction. They recommended pelvic floor physical therapy. However, it was not effective.

We had tried to treat his problem with another dopaminergic drug cabergoline which would save him traveling to our office since the drug does not have any restriction as does dextroamphetamine sulfate. He did find that cabergoline was 50% as effective as dextroamphetamine in relieving pelvic pain with prolonged sitting, was 50% as effective in relieving urinary urgency, but the relief of dysorgasmia was insufficient. Thus, he has resumed treatment with dextroamphetamine and is once again fully enjoying intercourse and orgasm for the past year without pain.

Discussion

Lower urinary tract symptoms in males have been abbreviated as LUTS [19]. Only a minority of males with LUTS have dysorgasmia with estimates ranging from 1.9% to 25.9% depending on what percentage of the male population evaluated had prostatectomy [20,21].

Another term used to describe males with similar symptoms as the patient described here is known as chronic pelvic pain syndrome (CP) or chronic prostatitis/CPPS [22]. In those males with CPPS who also have dyaorgasmia, the proposed etiology of this pudendal neuropathy is nerve compression of the pudendal nerve as it passes between the sacrotuberous and sacrospinous ligaments [23,24]. Approximately one fourth of males with LUTS or CPPS report ejaculatory pain [25].

There are various etiologic factors that were all ruled out in the patient described here. These include infection causing urethritis, prostatitis, epididymitis, and orchitis [26]. Other conditions associated with dysorgasmia include benign prostatic hyperplasia and complications of radical prostatectomy [26,27]. Certain rare disorders have also been associated with dysorgasmia including seminal vesicle stones or ejaculatory duct obstruction [26,28,-30].

There are some medications that have also been associated with dysorgasmia especially with anti-depressant drugs e.g., impramine, desipramine, clomipramine, protriptyline, amoxapine, fluoxetine, and venlafaxine [31]. Also, cyclobenzaprine which is a muscle relaxer has been attributed to causing dysorgasmia [32]. Generally, the painful ejaculation will stop once these medications are stopped.

One may question what happens during the orgasm or ejaculation that causes the pain. Based on a case of an unusual post-orgasmic event in a woman, one hypothesis is that the process of orgasm causes the release of biogenic amines that negate the effect of dopamine on diminishing cellular permeability, or in contrast to dopamine, which normally functions to decrease cellular permeability, they have a direct effect on increasing cellular permeability. This would allow absorption of irritants into pelvic tissues which in his case involved the penis, scrotum, and testicles causing inflammation and pain. The reason that it does not occur in everyone is that this model suggests that there was or already intrinsic defect in cellular permeability which are exacerbated by the release of these hypothesized biogenic amine.

The aforementioned case that supports this hypothesis was a woman who would have diplopia for 30 minutes after each orgasm. Her consulting neurologist strongly suggested against future orgasms for fear of stroke. This was unacceptable to the patient, and she sought our opinion as reproductive endocrinologists. We hypothesized the possibility that the release of biogenic amines could increase the permeability of the 6th cranial nerve or the extra-ocular muscles it innervates leading to muscle dysfunction leading to diplopia and that possibly a dopaminergic drug could correct the problem. In fact, treatment with dextroamphetamine sulfate fully corrected the problem [33].

Conclusion

This case demonstrates that similar to women, the use of dopaminergic drugs are effective in relieving pelvic pain and interstitial cystitis. This case demonstrates that at least for idiopathic LUTS/CPPS, dopaminergic drugs, especially dextroamphetamine, and to a lesser degree cabergoline, are effective treatments for idiopathic dysorgasmia. Whether it could provide similar relief for infectious etiologies or benign

prostatic hypertrophy not responding to tamsulosin, or even from surgically induced dysorgasmia, remains to be determined. Hopefully this case report will generate interest in other clinicians to consider dopaminergic drugs for dysorgasmia and chronic pelvic pain in males related to various etiologies and report the outcome of dopaminergic therapy whether the experience was positive or negative.

References

1. Check JH, Katsoff B, Citerone T, Bonnes E. A novel highly effective treatment of interstitial cystitis causing chronic pelvic pain of bladder origin: case reports. Clin Exp Obstet Gynecol. 2005. 32: 247-249.
2. Check JH, Cohen G, Cohen R, Dipietro J, Steinberg B. Sympathomimetic amines effectively control pain for interstitial cystitis that had not responded to other therapies. Clin Exp Obstet Gynecol. 2013. 40: 227-228.
3. Check JH, Cohen R. The triad of luteal phase ocular migraines, interstitial cystitis, and dyspareunia as a result of sympathetic nervous system hypofunction. Clin Exp Obstet Gynecol. 2014. 41: 575-577.
4. Check JH, Cohen R. Chronic pelvic pain – traditional and novel therapies: Part II medical therapy. Clin Exp Obstet Gynecol. 2011. 38: 113-118.
5. Check JH, Cohen R. Marked improvement of vulvovaginitis of unknown origin in a pediatric patient – case report. Clin Exp Obstet Gynecol. 2014. 41: 723-724.
6. Check JH, Jaffe A. Resolution of pelvic pain related to adenomyosis following treatment with dextroamphetamine sulfate. Clin Exp Obstet Gynecol 2015. 42: 671-672
7. Check JH, Check DL. Eradication of long-term vaginismus type of genito-pelvic pain/penetration disorder by treating with dextroamphetamine sulfate. Gynecol Reprod Health. 2023. 7: 1-5.
8. Check JH, Neumann B, Check D. New insight into the etiology and treatment of the vulvostomatodynia and review of treating pelvic pain with dopaminergic drugs. Gynecol Reprod Health. 2024. 8: 1-8.
9. Check JH. Increased cellular permeability related to relative dopamine deficiency may play a major role in the etiology of dyspareunia by causing inflammation. J Sex Health Reprod Med. 2025. 1: 1-7.
10. Check JH, Wilson C. Dramatic relief of chronic pelvic pain with treatment with sympathomimetic amines – case report. Clin Exp Obstet Gynecol. 2007. 34: 55-56.
11. Check JH, Check D. Improvement of severe chronic pelvic pain and dysmenorrhea following treatment with cabergoline. Gynecol Reprod Health. 2023. 7: 1-6.
12. Ford B, Louis ED, Greene P, Fahn S. Oral and genital pain syndromes in Parkinson's disease. Mov Disord. 1996. 11: 421-426.
13. Check JH. Increased tissue permeability and sympathetic nervous system hypofunction may be the common link between dysmenorrhea, chronic pelvic pain, Mittelschmerz, and Crohn's disease. Clin Exp Obstet Gynecol 2016. 43: 112-113.
14. Check JH, Check DL, Neumann B. A Novel Treatment of Crohn's Disease that is Not Only Safe in Pregnancy but Can Correct Infertility and Recurrent Miscarriages. Gynecol Reprod Health. 2024. 8: 1-9.
15. Check JH. Most chronic conditions in women are related to increased cellular permeability and most can be effectively treated with dopaminergic drugs. J Biomed Res Environ Sci. 2024. 5: 373-386.
16. Check DL, Check JH. Various presentations of the increased cellular permeability syndrome in males responding very well to sympathomimetic amine therapy – possible treatment for endstage Covid-19 complications. J Med Clin Res & Rev. 2020. 4: 1-7.
17. Check JH, Neumann B, Check DL. Dopaminergic drugs to relieve pain from chronic pancreatitis – a novel therapy. J Med Clin Res Rev. 2024. 8: 1-4.
18. Check JH, Dougherty MP, Check DL. Long standing post-herpetic neuralgia resistant to standard anti-neuropathy medication showing quick dramatic improvement following treatment with sympathomimetic amines. Clin Exp Obstet Gynecol. 2019. 46: 335-336.
19. Irwin D, Milsom I, Reilly K, Hunskaar S. Prevalence of lower urinary tract symptoms (Luts) in men: European results from the epic study. Eur Urol Suppl. 2006. 5: 157.
20. Rosen R, Altwein J, Boyle P. Lower urinary tract symptoms and male sexual dysfunction: the multinational survey of the aging male (MSAM-7). Eur Urol. 2003. 44: 637-649.
21. Matsushita K, Tal R, Mulhall JP. The evolution of orgasmic pain (dysorgasmia) Following radical prostatectomy. J Sex Med. 2012. 9: 1454-1458.
22. Shoskes DA, Landis JR, Wang Y, Nickel JC, Zeitlin SI, Nadler R. Impact of post-ejaculatory pain in men with category III chronic prostatitis/chronic pelvic pain syndrome. J Urol. 2004. 172: 542-547.
23. Antolak SJ, Hough DM, Pawlina W, Spinner RJ. Anatomical basis of chronic pelvic pain syndrome: the ischial spine and pudendal nerve entrapment. Med Hypotheses. 2001. 59: 349-353.
24. Shoskes DA, Landis JR, Wang Y, Nickel JC, Zeitlin SI, Nadler R. Impact of post-ejaculatory pain in men with category III chronic prostatitis/chronic pelvic pain syndrome. J Urol. 2004. 172: 542-547.
25. Ilie CP, Mischianu DL, Pemberton RJ. Painful Ejaculation. BJU Int. 2007; 99:1335-1339.
26. Waqar M, Omar K, Moubasher A, Brunckhorst O, Ahmed K. Painful ejaculation - an ignored symptom. Cureus. 2020. 12: 11253.
27. Barnas JL, Pierpaoli S, Ladd P. The prevalence and nature of orgasmic dysfunction after radical prostatectomy. BJU Int. 2004. 94: 603-605.
28. Parnham A, Serefoglu EC. Retrograde ejaculation, painful ejaculation and hematospermia. Transl Androl Urol. 2016. 592:601.
29. Lira Neto FT, Bach PV, Miranda E de P. Management of ejaculatory duct obstruction by seminal vesiculoscopy: case report and literature review. JBRA Assist Reprod. 2020. 24: 382386.
30. Sundar R, Sundar G. Zinner syndrome: an uncommon cause of painful ejaculation. BMJ Case Rep. 2015. 1-5.
31. Simpson GM, Blair JH, Amuso D. Effects of antidepressants on genito-urinary function. Dis Nerv Syst. 1965. 26: 787-789.
32. Kraus MB, Wie CS, Gorlin AW, Wisenbaugh ES, Rosenfeld DM. Painful ejaculation with cyclobenzaprine: a case report and literature review. Sex Med. 2015. 3: 343-345.

33. Check JH, Katsoff B. Transient sixth cranial nerve palsy following orgasm abrogated by treatment with sympathomimetic amines. Clin Exp Obstet Gynecol. 2014. 41: 468-470.