

References

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Sexual dysfunction and sperm count—association?

To the Editor:

Our comments are directed to the study by Saleh and colleagues (1), which investigated sexual dysfunction in men after knowing that results from their semen analysis were abnormal. Apparently, these men had a normal sexual function before knowing the results of the semen analysis, which subsequently affected some of them to the point of significantly lowering their seminal characteristics, sexual function, and increasing their anxiety level (1). We reported the results of a similar study investigating differences in men with inability to produce semen specimens on demand at the time of semen analysis (2). Although the approaches were different with regard to the patient management, the results of Saleh and co-workers agree with our previous findings with regard to the lesser seminal profile and higher duration of infertility in couples where the man was experiencing difficulty in collecting semen samples. We also noted that these couples had a reduced sexual frequency by a factor of approximately 50% than those without male sexual dysfunction (2). The effect of reduced semen parameters has also been noted on the day of oocyte aspiration in IVF (3). However, no decline in semen quality or perceived stress was reported for patients with male factor infertility (3). In another study, similar parameters were evaluated but with men undergoing counseling during the IVF cycle. The authors concluded that the vast majority of patients were not affected by the stress of participation on the day of oocyte retrieval, although a higher rate of fertilization failure was observed in men with decreased semen parameters on the day of oocyte retrieval as compared to their semen analysis results (4). Thus, it may be advantageous to concentrate on alternatives of counseling during the period before the oocyte aspiration procedure. One aspect of the methodology used by Saleh and colleagues that may be of concern is the regimen that the patients failing to collect semen for the second analysis had to endure. It is possible that the continued dysfunction developed by these patients could be linked to an iatrogenic factor. In a similar fashion, ejaculatory dysfunction has been compared to a vicious cycle in which the more the man fails, the more likely he will continue to fail (5). In the past 2 years we have incorporated in our protocol to show each patient his semen sample and to give our impressions in a preliminary manner. Usually the patients have many questions regarding their samples and we

take the time to give them alternatives in the case of samples with one or more obvious deficiencies. The patients respond positively to this approach where they are observing their sample live as compared to explaining to them the results of the semen analysis report, which for some people may not make sense to listen to a parade of numeric results. Furthermore, we know that the results of a single semen analysis are not absolute. It has been documented that requesting a second semen sample shortly after the first one results in significant quantitative and qualitative differences (6), even to the point of reaching a normozoospermic classification in some individuals. This effect may be attributed to incomplete ejaculation due to the stress experienced during semen collection. In conclusion, the results of a single semen analysis do not necessarily mean a death sentence, and the way in which these results and alternatives are presented to the patient make a great difference according to our experience.

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Reply of the Author:

The results of our study indicate that some men undergoing infertility evaluation experience problems with erection or orgasm after detection of an abnormality in the results of their first semen analysis (1). Our study has an important implication as it identifies the need for psychological counseling for infertile men in parallel with medical assistance. Patients in our study who were diagnosed with infertility experienced decreased orgasm and erection confidence with significant decrease in International Index Erectile Function

(IIEF)-5 scores (from 22.6 to 11.2) without any decrease in the frequency of sexual intercourse.

We disagree with Dr. Zavos that sexual function in these patients could be linked to iatrogenic factors, as men in our study had a baseline IIEF-5 score of ≥ 20 , which is considered as good baseline sexual function. In our study, only patients who were diagnosed as infertile experienced decreased orgasmic and erectile function and abnormal semen parameter, whereas others with normal semen parameter had no difficulty in collecting semen. If this effect may be attributed to incomplete ejaculation due to the stress experienced during semen collection then the rest of the patients, 89% should have experienced significant decrease in IIEF-15 scores and semen abnormality. This study opens a new area of research to identify the link between fertility and potency and capacity to procreate as an essential component of male identity. Our results show that sexual performances in men undergoing initial fertility evaluation are negatively

affected by abnormal results of their laboratory workup. This abnormality may be due to psychogenic factors. Increased level of anxiety may result in arousal of inhibitory nerves and interfere with normal penile erection leading to partial or complete failure of erection.

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