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REVIEW

Male orgasmic disorder: comprehensive diagnostic and therapeutic approach from primary care with emphasis on the Latin American context. A narrative review

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Abstract

Male orgasmic disorder (MOD) is an underdiagnosed sexual dysfunction characterized by absence, delay, or significant reduction in orgasm following adequate stimulation, present in 75–100% of sexual encounters for a minimum of six months, with a global prevalence of 0.4–3% (1.6–2.8% in the Latin American population). Conceptual differentiation between orgasm and ejaculation is fundamental, as they represent separate neurophysiological processes that can dissociate pathologically. Multifactorial etiology includes organic components (endocrinopathies, neuropathies, pharmacological iatrogenesis: selective serotonin reuptake inhibitors (SSRIs) with odds ratio (OR) 7.0 for delayed ejaculation), psychological factors (performance anxiety, idiosyncratic masturbatory techniques, cognitive distortions), and relational factors (unresolved conflicts, loss of attraction). Primary care physicians play a crucial role in early detection through a structured evaluation protocol (directed sexological history, physical examination, selective laboratory workup: testosterone, prolactin, thyroid-stimulating hormone (TSH)). Effective therapeutic options include structured sexual psychotherapy (65–78% improvement), pharmacological modification (SSRI switch to bupropion: 58–72% resolution), couple therapy, and penile vibratory stimulation (72% orgasm recovery). A pragmatic diagnostic-therapeutic algorithm applicable in any primary care setting is proposed, with specific discussion of implementation challenges in Latin American health systems, particularly Colombia, Brazil, and Mexico.

Keywords

Sexual dysfunctions; Anorgasmia; Orgasm; Ejaculation; Diagnosis; Therapeutics; Primary care

Trastorno orgásmico masculino: enfoque diagnóstico y terapéutico integral desde la atención primaria con énfasis en el contexto latinoamericano. Una revisión narrativa

Resumen

El trastorno orgásmico masculino (TOM) es una disfunción sexual infradiagnosticada caracterizada por la ausencia, el retraso o la reducción significativa del orgasmo tras una estimulación adecuada, presente en el 75–100% de los encuentros sexuales durante un mínimo de seis meses, con una prevalencia global del 0.4–3% (1.6–2.8% en la población latinoamericana). La diferenciación conceptual entre orgasmo y eyaculación es fundamental, ya que representan procesos neurofisiológicos distintos que pueden disociarse patológicamente. La etiología multifactorial incluye componentes orgánicos (endocrinopatías, neuropatías, iatrogenia farmacológica: inhibidores selectivos de la recaptación de serotonina (ISRS) con odds ratio (OR) 7.0 para eyaculación retardada), factores psicológicos (ansiedad de desempeño, técnicas de masturbación idiosincrásicas, distorsiones cognitivas) y factores relacionales (conflictos no resueltos, pérdida de atracción). Los médicos de atención primaria desempeñan un papel crucial en la detección precoz mediante un protocolo de evaluación estructurado (historia sexológica dirigida, exploración física, análisis de laboratorio selectivos: testosterona, prolactina, hormona estimulante de la tiroides (TSH)). Entre las opciones terapéuticas eficaces se incluyen la psicoterapia sexual estructurada (mejora del 65–78%), la modificación farmacológica (cambio de ISRS a bupropión: resolución del 58–72%), la terapia de pareja y la estimulación vibratoria del pene (recuperación del orgasmo en el 72%). Se propone un algoritmo diagnóstico-terapéutico pragmático aplicable en cualquier entorno de atención primaria, con un análisis específico de los desafíos de su implementación en los sistemas de salud latinoamericanos, en particular en Colombia, Brasil y México.

Palabras Clave

Disfunciones sexuales; Anorgasmia; Orgasmo; Eyaculación; Diagnóstico; Terapéutica; Atención primaria

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1. Introduction

Male orgasmic disorder (MOD) is a profoundly disabling sexual dysfunction characterized by absence, marked delay, or significant reduction in orgasm intensity following adequate sexual stimulation, present in 75–100% of sexual encounters for a minimum of six months, according to Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria [1]. This definition is consistent with prior clinical descriptions of delayed orgasm and anorgasmia in the literature, which emphasize the multifactorial and complex nature of this condition [2, 3]. However, previous literature has highlighted limitations in the conceptual definition of this disorder, particularly regarding the distinction between orgasm and ejaculation [4]. Conceptual differentiation between orgasm and ejaculation is fundamental, as these represent distinct neurophysiological processes that may dissociate clinically [5].

Reported prevalence ranges from 0.4–3% in European and Asian population-based studies [6]. Broader epidemiological estimates derived from international classification systems such as International Classification of Diseases, 11th Revision (ICD-11) highlight the overall burden of sexual dysfunction in the general population, although data specific to male orgasmic disorder remain limited [7]. Large international surveys have described sexual problems across multiple regions, including Latin America, but region-specific data on male orgasmic disorder remain scarce [8]. The present work proposes a diagnostic-therapeutic algorithm with universal applicability for the primary care setting, with specific discussion of the sociocultural, structural, and epidemiological factors shaping implementation in Latin American health systems, particularly Colombia, Brazil, and Mexico.

2. Methods

A narrative review with structured literature search (structured narrative review) was conducted. This design was selected in accordance with the clinical-pragmatic objective of the work: to synthesize the state of knowledge on MOD to guide its management at the primary care level, without claiming the formal rigor of a systematic review with meta-analysis. The denomination and scope of the study are consistent with the criteria established for narrative reviews with structured search [9, 10].

Databases and search period: MEDLINE/PubMed, Embase, Cochrane Library, LILACS, PsycINFO, and Google Scholar were searched, covering January 2010 to December 2025. Search terms: “male orgasmic disorder”, “delayed ejaculation”, “anorgasmia”, “sexual dysfunction”, “orgasm”, “ejaculation”, “diagnosis”, “treatment”, combined using Boolean operators AND/OR.

Inclusion criteria: observational studies, controlled clinical trials, systematic reviews with or without meta-analysis, clinical practice guidelines from international scientific societies (European Association of Urology (EAU), International Society for Sexual Medicine (ISSM), Canadian Urological Association (CUA)), and publications in Spanish or English.

Exclusion criteria: studies with exclusively animal or *in vitro* designs; publications without full text available; articles in languages other than Spanish or English; studies with samples of fewer than 10 participants without detailed case-level analysis; publications prior to the year 2000, unless they provided irreplaceable foundational evidence.

Evidence prioritization hierarchy: (1) clinical practice guidelines (EAU, ISSM, CUA); (2) systematic reviews with or without meta-analysis; (3) randomized controlled trials; (4) prospective or cohort observational studies; (5) cross-sectional studies, case series, and instrument validation studies. Lower-level evidence was included only when no higher-level evidence was available.

3. Results and discussion

3.1 Multifactorial etiology

The etiology of MOD is multifactorial (Table 1, Ref. [3, 11–18]). Organic components include endocrinopathies (hypogonadism, hyperprolactinemia, hypothyroidism), baseline variability in intravaginal ejaculation latency time (IELT) as a normative parameter of ejaculatory function [19], and pharmacological iatrogenesis, including antidepressant-associated sexual dysfunction and post-SSRI sexual dysfunction [17, 18]. The narrative text focuses on the interpretive and heuristic aspects of greatest clinical relevance. Foundational studies have detailed the clinical presentation of delayed orgasm and related symptoms in selected clinical populations [3, 12]. Psychological factors include performance anxiety, disruptive cognitive self-observation during sexual activity, spectatoring, comorbid anxiety/depressive disorders, and restrictive sexual education [13–15].

3.2 Diagnostic evaluation protocol

Diagnostic evaluation requires a systematic approach (Table 2, Ref. [3, 11, 16, 17, 20–22]). Operational details of the protocol are provided in Table 2; the narrative text contextualizes the elements of greatest clinical complexity. The directed sexological history must characterize the symptom, temporal onset, context, and specific masturbatory techniques [3, 20, 23]. A structured and comprehensive sexual history is essential for identifying underlying causes and guiding management. In addition, validated instruments such as the male sexual function questionnaire (FSH) provide a standardized and reliable assessment of sexual response and may facilitate both diagnosis and follow-up [24]. A complete pharmacological history is essential given the high prevalence of iatrogenesis [11, 17].

3.3 Evidence-based therapeutic options

Therapeutic management must be individualized according to etiology (Table 3, Ref. [3, 13, 14, 16, 17, 21, 22, 25–27]). The details of each therapeutic modality are provided in Table 3. The narrative text is restricted to aspects of clinical selection and sequencing not fully captured in tabular format. Structured sexual psychotherapy is the first-line treatment for psychogenic MOD [16, 21, 25]. Pharmacological modification when MOD is iatrogenic has robust supporting

TABLE 1. Etiological classification of male orgasmic disorder.

Category	Specific Factor	Prevalence/OR	Refs.
Endocrine	Hypogonadism (<300 ng/dL), Hyperprolactinemia (>20 ng/mL), Hypothyroidism (TSH >10)	18–24% men >60 years. OR 2.4–3.8	[3, 16]
Pharmacological	SSRIs (fluoxetine, paroxetine, sertraline), Antipsychotics, Finasteride	Antidepressant-associated sexual dysfunction and post-SSRI sexual dysfunction have been described; finasteride-related sexual dysfunction has also been reported.	[11, 17, 18]
Neurological	Diabetic neuropathy, spinal cord injury T11–L2, multiple sclerosis	Diabetes >10 years: 28–41%. Spinal cord injury: 50–72%	[3, 12]
Individual Psychological	Performance anxiety, spectatoring, idiosyncratic masturbatory techniques Anxiety/depressive disorders, restrictive sexual education, prior abuse	Present 45–68% psychogenic MOD. OR 2.7 atypical techniques Comorbid depression: 31–48%. Strict religious education: OR 3.2	[13–15]
Relational	Loss of attraction, unresolved conflict, fantasy discrepancy, infidelity	Relational factors: 58–76% acquired MOD. OR 4.1	[13, 14]

References added to each data cell in the revised version. OR: odds ratio; TSH: thyroid stimulating hormone; SSRIs: selective serotonin reuptake inhibitors; MOD: Male orgasmic disorder.

TABLE 2. Diagnostic evaluation protocol in primary care.

Component	Key Elements	Refs.
Sexological History	Symptom characterization (absent/reduced orgasm, with/without ejaculation), Onset (primary/acquired, gradual/sudden), Context (generalized/situational), Masturbatory techniques (frequency, method, intensity)	[3, 20]
Pharmacological History	SSRIs, antipsychotics, antihypertensives, finasteride. Temporal relationship between medication and MOD	[11, 17]
Physical Examination	Penile sensitivity (biothesiometry >14 V = neuropathy, 128 Hz tuning fork), Bulbocavernosus/anal reflexes, Signs of endocrinopathies	[21, 22]
Laboratory Workup	First-line: Total testosterone (8–10 AM), Prolactin, TSH/free T4, Glucose/HbA1c. Second-line: Free testosterone (if total borderline), Brain MRI (prolactin >100)	[3, 16]

MOD: male orgasmic disorder; TSH: thyroid stimulating hormone; MRI: magnetic resonance imaging; SSRIs: selective serotonin reuptake inhibitors; HbA1c: hemoglobin A1c.

TABLE 3. Therapeutic options stratified by level of evidence.

Modality	Description/Efficacy	Level	Refs.
Sexual Psychotherapy	Sensate focus, progressive sensory refocusing, assertive sexual communication, masturbatory retraining. Improvement in 65–78% primary psychogenic MOD. Duration: 12–20 sessions	IIa	[16, 21, 25]
Pharmacological Modification	SSRI switch to bupropion (300–450 mg/day): resolution in 58–72% within 4–8 weeks. Mirtazapine: improvement 45–63%	I	[17, 22]
Couple Therapy	When relational factors are contributory. Sexual function improvement in 45–62% couples with acquired MOD. Duration: 10–16 sessions	IIa	[13, 14]
Vibratory Stimulation	Frenulum-glans device, 100–120 Hz, 10–15 min, 3–5 times/week, 8–12 weeks. Orgasm recovery: 72%	IIb	[26, 27]
Empirical Pharmacotherapy	Bupropion 150–300 mg/day off-label. Yohimbine up to 38 mg/day: resolution 66% (19/29 patients). Reserve for refractory cases	IIb	[3, 22]

Level I: high evidence, multiple RCTs; IIa: moderate evidence; IIb: limited evidence, observational studies. SSRIs: selective serotonin reuptake inhibitors; MOD: male orgasmic disorder.

evidence [17, 22]. Penile vibratory stimulation is particularly effective in cases of reduced penile sensitivity [26, 27]. Given the frequent overlap between male sexual dysfunctions and psychological difficulties, including anxiety, distress, and relational concerns, psychosexual assessment should remain integrated throughout the diagnostic and therapeutic process [28].

3.4 Primary care diagnostic and therapeutic approach

Male orgasmic disorder in primary care should be managed through a structured stepped-care approach integrating symptom confirmation, identification of modifiable contributors, initial management of reversible causes, and referral when clinically indicated [10, 12, 17, 25].

Primary care management should prioritize psychoeducation, optimization of comorbidities, medication review, and individualized interventions according to the predominant etiological domain, as summarized in Tables 2 and 3 [16, 17, 21, 22, 25].

Referral or escalation of care should be considered in cases of persistent symptoms, marked psychological distress, complex psychiatric or medical comorbidity, suspected neurological or endocrine disease, history of pelvic surgery or trauma, treatment failure after initial interventions, or diagnostic uncertainty [17, 25, 28–30].

In Latin American settings, limited access to sexual medicine specialists and psychosexual therapy reinforces the importance of a coordinated stepped-care model in which primary care provides initial assessment, counseling, reversible-cause management, and longitudinal follow-up while facilitating specialized input when needed [5, 7, 31, 32].

4. Discussion and clinical implications

The proposed primary-care approach has broad applicability because it is grounded in international clinical practice guidelines and can be adapted to different geographical and health-system contexts [1, 25]. The discussion that follows addresses, as a complementary layer, specific implementation challenges in Latin American health systems. The limited availability of clinical sexology specialists underscores the urgency of strengthening first-level care capacity. Average referral wait times for sexological assessment range from 4–8 months in Latin American public health systems [7]. Specialist referral criteria from primary care are summarized in Table 4 (Ref. [25, 30, 33]).

Country-specific data remain limited. In Colombia, the estimated density of clinical sexologists in the public sector (General System of Social Security in Health, GSCSS) is approximately 1:600,000 inhabitants, with average referral wait times of 5–7 months. In Brazil, data from the Unified Health System (SUS) and São Paulo metropolitan cohorts indicate that male dysfunctions are infrequent primary care consultation motives. In Mexico, the Latin American subgroup of the Global Study of Sexual Attitudes and Behaviors (GSSAB) provides regional context regarding sexual problems and help-seeking patterns [8]; however, available data remain insufficient to establish precise country-specific estimates for male orgasmic disorder [6]. In all three countries, cultural masculinity constructs constitute significant barriers to spontaneous consultation.

Effective strategies implemented in resource-limited settings include in-service training, self-administered sexual screening questionnaires [20, 29] and sexological telemedicine for rural/remote areas [25, 30]. Telemedicine applied to sexual medicine evaluation has shown favorable preliminary results in recent studies, particularly regarding accessibility and continuity of care during the COVID-19 pandemic [31].

Emerging therapies, including regenerative and neuromodulatory approaches, are under investigation, although current evidence remains limited and their role in primary care is not yet established [32].

5. Limitations

This narrative review presents inherent methodological limitations: it does not constitute a systematic review with meta-

TABLE 4. Specialist referral criteria for male orgasmic disorder from primary care.

Specialty	Referral criteria	Basis
Sexology/Clinical Psychology	• Primary generalized MOD (lifelong anorgasmia) • Sexual dysfunction associated with sexual trauma or prior abuse • Idiosyncratic masturbatory patterns refractory to psychoeducation • Failure of ≥8 weeks of first-line psychosexual intervention • Severe performance anxiety or partner-related sexual disorder	EAU 2024 [25]; CUA 2021 [30].
Urology	• Confirmed neuropathy: <14 V biothesiometry or absent 128 Hz tuning fork • Post-pelvic surgery (prostatectomy, cystectomy, colorectal surgery) • Spinal cord injury T11–L2 • Suspected structural pelvic or spinal pathology	EAU 2024 [25]; CUA 2021 [30].
Endocrinology	• Hyperprolactinemia >100 ng/mL (requires brain MRI) • Hypogonadism: testosterone <200 ng/dL + systemic symptoms • Hypothyroidism difficult to control at primary care level • Suspected pituitary neoplasm	EAU 2024 [25]; Hatzichristou [33].

MOD: male orgasmic disorder; MRI: magnetic resonance imaging; EAU: European Association of Urology; CUA: Canadian Urological Association.

analysis and lacks formal assessment of included study quality using validated scales or quantitative effect synthesis. Evidence on the effectiveness of psychotherapeutic interventions derives predominantly from observational studies [17, 24, 28]. Latin American population epidemiological data are limited [6, 8, 13].

The proposed diagnostic-therapeutic approach represents a clinically grounded synthesis of available evidence, conceived as a structured framework to guide MOD management at the primary care level. Its clinical utility and implementation feasibility require prospective efficacy evaluation in Latin American primary care cohorts—employing standardized outcomes including orgasm recovery rate, patient satisfaction, time to correct diagnosis, and appropriate specialist referral rate—before broader dissemination and eventual external population validation.

6. Conclusions

Male orgasmic disorder represents a complex, multifactorial, and underdiagnosed sexual dysfunction that can be effectively managed through a comprehensive biopsychosocial approach [1, 3]. Primary care physicians play a crucial role in early detection, structured initial evaluation, and coordination of interdisciplinary management [20, 25, 33]. The implementation of structured diagnostic and therapeutic strategies at the primary care level may optimize diagnostic opportunity, reduce therapeutic delay, and improve functional outcomes [16, 25, 34].

AVAILABILITY OF DATA AND MATERIALS

The data are contained within this article.

AUTHOR CONTRIBUTIONS

JSTL—conceptualization, methodology, literature search, data analysis, manuscript drafting, critical revision, and table preparation. MPV—literature search, data analysis, manuscript drafting, and critical revision. Both authors contributed to editorial revisions of the manuscript and approved the final version.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

Not applicable.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

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