Smyrna Tıp Dergisi ***Olgu Sunumu***

Premature Female Orgasm and Treatment in Primary Care Office with Some Easy Methods
Prematür Kadın Orgazmı ve Birinci Basamakta Bazı Basit Metotlar ile Tedavisi

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Summary
Premature orgasm in women is seldom researched because the number of women complaining of premature orgasm is very low. The majority of women who have premature orgasm continue to be aroused after orgasm, may continue the sexual intercouse and experience multiple orgasms. In this case report, the problem and management of premature orgasm in a sexually active woman who was unable to have orgasm for many years with her previous partner is described. The interesting side of the case was that the present complaint was developed after the second anorgasmia. The complaint of the patient was solved by the use of condom, antidepressant drug exchange and masturbation proposal.
Key words: Anorgasmia, female, orgasm, premature

Özet
Erken orgazmdan şikayetçi kadınların sayısı çok düşük olduğu için kadınlarda prematür orgazm nadiren araştırılmaktadır. Prematüre orgazmı olan kadınların çoğunluğu orgazm sonrasında uyarılmaya devam eder, cinsel arzuyu sürdürebilir ve birden fazla orgazm yaşayabilir. Bu olgu sunumunda, önceki eşiyle yıllarca orgazmı yaşayamayan cinsel açıdan aktif bir kadında erken orgazm problemi ve yönetiminden bahsedilmiştir. Vakanın ilginç yanı, mevcut şikayetin ikinci bir anorgrazmiden sonra gelişmesidir. Hastanın şikayeti prezervatif kullanımı, antidepresan ilaç değişimi ve mastürbasyon önerisi ile çözülmüştür.
Anahtar kelimeler: Anorgazmi, kadın, orgazm, erken

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Background

Premature ejaculation, is reaching the climax much earlier than the person desires. It manifests with physical findings. When it is carried far beyond the physical findings in a degree that disconnects the person from the outside world it becomes orgasm (1).

Sexual arousal consists of four following stages: the onset of arousal, plateau, orgasm, and dissolution. In women's sexuality, orgasm is a discharge of sexual tension due to sexual stimulation, accompanied by an intense pleasure sensation. The orgasmic capacity is subjective and varies according to the age of the woman, sexual knowledge, sexual experience and partner. Some women attach importance to the stimulation of the clitoris and reach orgasm by stimulating the clitoris. Some women prefer vaginal stimulation. In general, the clitoris and vagina are stimulated together in the orgasmic process (2). Although early orgasm is perceived as a male disease it can also be seen in women. However, premature orgasm in women is seldom researched because the number of women complaining of premature orgasm is very low compared to men. Sadock found early orgasm in approximately 3.3% of female participants (3). However, premature ejaculation in man was reported as 30% (4). It is a fact that it may be desirable compared to having orgasm after male climax.

The majority of women who have premature orgasm continue to be aroused after orgasm, may continue the sexual intercouse and experience multiple orgasms. In the diagnosis of premature orgasm in a sexuel activity with a partner, following points are important; occurrence of orgasm within one minute after

penis entering the vagina every time or repeatedly even though the women does not want to, occurrence of orgasm sometimes in foreplay period (5).

In this case report, the problem and management of premature orgasm in a sexually active woman who was unable to have orgasm for many years with her previous partner is described.

Case Report

A 28-year-old female patient applied to the primary care office with a complaint of premature orgazm. She is a housewife, mother of two boys (6 and 3 years old), divorced and lives with her parents. She got married at the age of 22 and divorced after three years. In the first year she experienced orgasms but in the next two years there was no orgasms. Her husband was suffering from premature ejaculation and in time their coitus was lasting less than a minute. She stated that this was the reason for the divorce. The patient has had five different partners since she got divorced. Once or twice a week, she has had sexual relations with her partner in daily rental houses and has not been orgasm for the last five years. But she was with her current partner for three weeks (she has not been with anyone in the last six months) and she was also having premature orgasm in the same period. Her coitus was lasting only 5-10 seconds. This was becoming a problem for both of them. Her partner's perfect sex wish was essential for her. But the quality of sexuality was poor because she was having orgasm before her partner could and getting tired.

She thinks in contrast to her previous partners, the current partner has a good knowledge of sexuality and he knows how to stimulate G spot hence orgasms happen. Detailed history particulars; she was having foreplays lasting 10 minutes for years, taking morning-after pil following each coitus, she never masturbated herself. She was masturbating her partners manually or orally, but that her partners did not masturbate her in the same ways. For the last 6 months, she has been using paroxetine regularly with the advice of a psychiatrist for the lack of enjoyment and low energy. She has been smoking nearly a pack of cigarettes for the last 7 years and consuming alcohol rarely in social circumstances. She has no chronic organic disease and her physical examination is normal.

Firstly, information about the anatomy of the female sexual organs and the cycle of sexual reactions was given to the patient. Daily masturbation home work was given and 'know how' was taught to achieve adaptation of the sexual organs when stimulated. Coitus with the partner was forbidden until next week. The couple were encouraged to have pleasant times and develop communication skills other than coitus in order to achieve a lower sexual arousal by disseminating it in other circumstances and activities through the day. Breathing, relaxation and feeling the whole body exercises were given in order to perceive the whole body instead of focusing only on sensations coming from the genital area.

Paroxetine was discontinued and treatment with essitolopram was commenced. When she came for next session after a week she reported to have complied all homeworks and willing to continue. Sexual ban was lifted, the masturbation frequency was reduced by half. In the next session she reported that the problem of early orgasm ended and the time for orgasm reached to 8-10 minutes. This was almost the same time with the partner. She was pleased with increase in quality of their sexuality. The patient came to the clinic several times at non-periodic intervals for control purposes and stated that everything went well.

Discussion

Premature orgasm can be caused by attachment of exaggerated importance to sexuality, having sex with feelings of shame, sin or prohibition in unfavorable environments, fear of getting caught and heard, negative thoughts learned from the family, strict moral codes, lack of sufficient knowledge or experience, and inability to manage extreme sexual arousal and sexual stimulation (1).

Our patient in contrast, is an sexually active lady who has plenty of knowledge and experience with different partners. Therefore she does not expected to have a problem of early orgasm. The fact that she was able to have orgasm in early period of her marriage and developed anorgasm later indicates secondary anorgasm and her situation can be explained as fast orgasms following anorgasms facilitated by partner change. The premature ejaculation of old partner may explain her secondary anorgasm.

Premature ejaculation creates dissatisfaction in the sexual life of individuals. Failure to treat can lead to sexual reluctance or avoidance and disorders of orgasm in both partners. This situation disrupts the

relationship and sometimes leads to divorce (6). Our patient blamed orgasm problems for ending her marrage.

Sexual stimulation is accompanied by emotional pleasure. The higher the pleasure, the more arousing desire and related behavior are accompanied. Thus, sexual arousal rises very quickly and the orgasmic reflex is fired more quickly. Psychosexual and/or bio-physiological factors play a role in the rapid rise of sexual stimulation. These factors may be the long duration between sexual intercourses, the environment, the partner himself, stimulating nature of sexual behavior, psychological disorders and drugs. In this case partner's particulars (the attractiveness and experience) and use of relevant drug (paroxetin) can be considered as accelerating factors of stimulation.

The orgasm has both clitoral and vaginal dimensions, with the clitoral region being more powerful. It is suggested that the G point facilitates the orgasm and triggers multiple orgasms (7).

The repertoire width of the vaginal intercourse facilitates the locating the G point. Her partner might have found and stimulated the G spot hence caused early orgasm. Wearing the condom might have reduced sensuality. The potential negative effects of the atidepresants on the sexual functions oare not the same. The effect of agomelatin, amineptin, bupropion, moclobemide, mirtazapine and nefazodone on sexual function is not different from placebo and can be considered as not causing sexual dysfunction. All other antidepressants lead to more sexual dysfunction than the placebo and this side effect may effect any cycle of the normal sexual response (8,9). Paroxetine is involved in orgasmic disorders. It is generally associated with anorgasmia (10). However, this generalization does not apply to our patient. On the contrary, there was no use of antidepressant drugs during periods of anorgasmia, Transition to essitolopram may have helped solve the problem of the patient. It has been reported that changes between antidepressants may improve sexual functions (11).

For men who do not masturbate, the likelihood of learning to control the ejaculatory reflex and experiencing premature ejaculation risk is increased (12). By the same logic, masturbation may be effective in controlling the orgasm in women. In fact, anorgasmic women often demonstrate negative attitudes toward sex and masturbation, and tend to experience guilt following sexual activities (13). But, the patient was not in this character. On the contrary, maybe she was always waiting for the day to live this complaint. So, the patient has an unusual anamnesis. Daily masturbation assignments helped her to prolong orgasm-reach time and take control. The positive contribution of masturbation on female sexual health and sexual function is well-known (14).

Coit prohibition has allowed attention to shift to other sexual interactions. Thus, the woman may have moved away from her anxiety which can trigger early orgasm and may have spread the stimulation from the sexual organs to the body.

Conclusion

The mentioned woman was treated in a family medicine center at the end of two interviews. Specialists working in primary care offices have a wide variety of patient populations. This causes various complaints. Sexual therapy is one of them. Primary care specialists can get themselves ready for any kind of confession by taking different training and certifications.

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