International Journal of Clinical Urology
2025, Vol. 9, No. 2, pp. 200–203
https://doi.org/10.11648/j.ijcu.20250902.26

Research Article

Anejaculation: Clinical and Etiological Aspects

Thiam Amath[1], Sow Ousmane[2,*], Bagayogo Ndeye Aissatou[1], Cissokho Oumar[1], Sine Babacar[1], Diao Babacar[1]

[1]Urology-Andrology Department, Ouakam Military Hospital, Dakar, Senegal

[2]Urology-Andrology Department, Aristide Le Dantec Hospital, Dakar, Senegal

Abstract

Introduction: Anejaculation is the absence of ejaculation through the urethral meatus despite appropriate and prolonged sexual stimulation and a normal erection. It is an uncommon disorder that often results from several causes: organic, psychological, environmental, or even medication. The diagnostic approach to anejaculation requires an approach that focuses on the patient's clinical history, the existence of psychosocial triggers, and analysis of the disorder. The objective of this study was to describe the clinical and etiological aspects of anejaculation. *Patients and methods:* Retrospective and descriptive study collecting all cases of anejaculation between January 2016 and December 2023 at the Urology-Andrology Department of the Ouakam Military Hospital. Results: 19 files were collected concerning 11 patients with primary anejaculation and 8 patients with secondary anejaculation. Anejaculation was permanent in 17 cases and sporadic in 2 cases. Four patients reported touching and sexual intercourse at a young age. Sixteen patients were aware of their anejaculation and had mentioned it at the consultation, and for the remaining three patients, the reason for consultation was primary infertility. The causes were psychological (n=10), neurological (n=5), drug-related (n=3), and endocrine (n=1). *Conclusion:* Anejaculation is the least understood, least common, and least studied sexual disorder. The interview is a crucial time to define the characteristics of anejaculation and the guidelines for determining the cause.

Keywords

Anejaculation, Psychological Causes, Neurological Causes

1. Introduction

Anejaculation is the absence of ejaculation through the urethral meatus despite appropriate and prolonged sexual stimulation and a normal erection [1]. It is an uncommon sexual disorder at presentation and often results from several causes: organic, psychological, environmental, or drug-related. The diagnostic approach to anejaculation requires an approach that focuses on the patient's clinical history, the existence of psychosocial triggers, and analysis of the disorder (primary or secondary, associated or not with the sensation of orgasm). The objective of this work is to describe the clinical aspects of anejaculation and to report the different causes in our work.

2. Patients and Methods

We conducted a retrospective and descriptive study col-

*Corresponding author: sowman87@yahoo.fr (Sow Ousmane)

Received: 26 October 2025; **Accepted:** 4 November 2025; **Published:** 11 December 2025

lecting all cases of anejaculation between January 2016 and December 2023. The parameters studied were age, medical and surgical history and contributing factors for anejaculation, marital status, primary or secondary nature of anejaculation, and the presence or absence of orgasm and the identified causes. The association of erectile dysfunction was assessed, as was the presence or absence of a desire disorder and the presence or absence of nocturnal emission.

3. Results

Table 1. *Patient characteristics according to the type of anejaculation.*

	Primary	Secondary	Total
Average age (year)	29.7	53.1	
Marital Single (S)	9	1	10
status Married (M)	1	8	9

Nineteen files were collected concerning 11 patients with primary anejaculation and 8 patients with secondary anejaculation. Anejaculation was permanent in 17 cases and sporadic in 2 cases. The mean age was 38.2 years, with a range of 19 to 66 years (Table 1).

Four patients reported touching and sexual intercourse with adult relatives when they were children. Their medical and surgical history and contributing factors are listed in Table 2. Sixteen patients were aware of their anejaculation and had discussed it at the consultation. For 3 patients, the reason for consultation was infertility in the couple, and anejaculation was suspected after several unsuccessful attempts at semen analysis.

Table 2. *Clinical history of patients and the character of anejaculation.*

Medical and surgical history	Numbers	Type of anejaculation
Depression followed in psychiatry under selective serotonin reuptake Inhibitors (SSRI)	2	Primary
Lumbar spine trauma	1	Secondary
Known non-insulin-dependent diabetes for 12 years	1	Secondary
Known for 21 years with insulin-dependent diabetes	1	Secondary
Hypertension complicated by hemorrhagic stroke	1	Secondary
Benign prostatic hyperplasia (BPH) on Tamsulosin 0.4 mg for 2 years	1	Secondary
Chronic alcoholic	1	Secondary

Fifteen patients (10 primary patients and 5 secondary patients) did not experience orgasm, and 6 patients reported nocturnal emissions. Erectile dysfunction was present in 5 cases and sexual desire was impaired in 6. These results are shown in Table 1.

Laboratory assessment led to the diagnosis of hypogonadism in one patient. Endorectal ultrasound and urethrocystoscopy did not reveal any morphological abnormalities.

The causes of anejaculation were psychological in 47.3% (n=10), neurological in 26.3% (n=5), drug-related in 15.8% (n=3), and endocrine in 5.3% (n=1). Table 3 shows that the primary nature of the anejaculation suggested a psychological cause, and that other risk factors were responsible for secondary anejaculation.

	Primary	Secondary	Total
Erectile dysfunction	0	5	5
Disorder of desire	2	4	6
Orgasm	1	4	5
Nighttime pollution	6	0	6

Table 3. *Correlation between causes and type of anejaculation.*

Causes	Primary	Secondary	Total
Psychological	10	0	10
Neurological	0	5	5
Medicinal	1	2	3
Endocrine	0	1	1
Total	11	8	19

Regarding management, patients suffering from psychological disorders benefited from an interview with a psychosexologist, and for patients with drug-induced anejaculation, a dosage reduction or a change in prescription was made. Testosterone supplementation was indicated for hypogonadism.

4. Discussion

Anejaculation can be primary or secondary. It can be permanent, occurring with every sexual encounter, or intermittent and situational. Perlman et al [2] revealed 25% primary anejaculation and 75% secondary anejaculation in a series of 75 patients.

The prevalence of ejaculatory disorders is unclear in the literature due to the lack of consensus on standards for the duration of ejaculatory latency leading to orgasm. Low rates rarely exceeding 3% are reported in the literature [2, 3]. Epidemiological surveys of sexual dysfunction conducted in several countries have revealed a significant prevalence of delayed or absent ejaculation. In France, in a survey of 13,308 men, 27% of these men often or sometimes presented with delayed or absent ejaculation [4]. In the United States, 8% of men experienced anejaculation in Laumann's survey of a sample of 1,249 men [5]. In Sweden, in a survey of 1,475 men aged 18 to 74, 2% experienced anejaculation often, almost all of the time, or all of the time [6].

The diagnosis of anejaculation is not subject to well-established diagnostic standards [7]. A well-conducted sexual history is the key to diagnosis and etiological investigation. During the history, the search for orgasm is fundamental to differentiate dry anejaculation from orgasmic anejaculation or probable retrograde ejaculation. The clinical examination will focus on the external genitalia and a digital rectal examination before an assessment of andrological impregnation [1].

In our study, 16 patients consulted for a complete absence of ejaculation, and 3 patients for infertility in the couple. Delavière et al [8] reported that 18% of patients who consulted for a desire for paternity were seeking information only about their sexual dysfunction, and 78% of patients suffered from an alteration in their sexual quality of life.

For many years, it has been suggested that anejaculation was caused by psychosexual, psychosocial, and relational problems. It is now established that the causes can also be neurobiological, anatomical, endocrine, or induced by medication [9].

In our series, the primary nature of anejaculation strongly pointed toward a psychological cause (10/11, Table 3). The same observation was made by Delavière et al [8], who found that 70% of patients had psychological risk factors (100% of primary anejaculations, 63% of secondary anejaculations). Several psychological factors may contribute to the pathophysiology of anejaculation. Four patients in this study reported early touching and sexual intercourse with adults. A psychiatric assessment would allow for the screening of other psychological factors. Sylla et al [10] reported psychological factors favored by incestuous sexual intercourse and sexual experiences before puberty. The affected subjects presented with a history of sexual trauma experienced with considerable guilt, even disgust [10]. Althof et al [11] summarized psychogenic factors into theories involving insufficient mental or physical stimulation; a pattern of unusual and fantasizing masturbation that leads to a tendency to prefer masturbation over heterosexual intercourse.

The neurological mechanisms that lead to anejaculation are lesions of the sympathetic ganglia or postganglionic sympathetic nerve fibers secondary to neurological disease, trauma, or pelvic surgery [9, 12].

The time to onset of ejaculatory disorders varies depending on the neurological pathology. In diabetics, ejaculatory disorders mark a turning point in the progression of the disease, i.e. the appearance of pelvic neuropathy [13]. In the study by Lindau et al [14], the inability to achieve orgasm was more frequent (21.1%) in diabetic subjects than in non-diabetic subjects (14%). Once established, these disorders are permanent and their management can only be considered within the framework of a desire for paternity.

The effect of psychotropic medications on sexuality is difficult to assess because depression and psychoses are frequently accompanied by sexual dysfunction, regardless of medication use [15, 16]. Sexual side effects disrupt the patient's quality of life and increase the risk of non-compliance or treatment discontinuation. Patients rarely report the sexual side effects they experience; Bonierbale et al [17] reported 35% of spontaneous complaints of sexual dysfunction and 69% when patients were questioned on this topic. In this context, the prescription of an antidepressant should be combined with information on the risk of sexual side effects and the available means to manage them.

5. Conclusion

Anejaculation is the least understood, the least common, and the least studied sexual disorder. Its frequency is underestimated in our sociocultural context. A positive diagnosis and etiological investigation rely on a careful examination of the patient's sexual history. A psychological assessment is always necessary for comprehensive treatment of this sexual disorder.

Abbreviations

S	Single
M	Married
SSRI	Selective Serotonin Reuptake Inhibitors
BPH	Benign Prostatic Hyperplasia

Author Contributions

Thiam Amath: Conceptualization, Data curation, Formal

Analysis, Investigation, Methodology, Resources, Software, Supervision, Validation, Visualization, Writing – original draft, Writing – review & editing

Sow Ousmane: Supervision, Validation, Visualization, Writing – original draft, Writing – review & editing

Bagayogo Ndeye Aissatou: Supervision, Validation, Visualization, Writing – original draft, Writing – review & editing

Cissokho Oumar: Conceptualization, Data curation, Investigation, Methodology, Writing – original draft, Writing – review & editing

Sine Babacar: Supervision, Visualization, Writing – review & editing

Diao Babacar: Supervision, Validation, Visualization, Writing – review & editing

Conflicts of Interest

The authors declare no conflicts of interest.

References

[1] Lemaire A. Diagnostic d'une anéjaculation [Diagnosis of anejaculation]. Andrologie 2004, 14(2): 160-163. https://doi.org/10.1007/BF03034790

[2] Perelman M. Retarded Ejaculation. Curr Sex Hlth Rep 2004; 1: 95-101. https://doi.org/10.1007/s11930-004-0023-2

[3] Simons JS, Carey MP. Prevalence of sexual dysfunctions: Results from a decade of research. Arch Sex Behav 2001; 30: 177–219. https://doi.org/10.1023/A:1002729318254

[4] Bejin A. L'orgasme de l'homme adulte. Quelques résultats des études quantitatives récentes sur le comportement sexuel notamment en France [The orgasm of the adult male. Some results from recent quantitative studies on sexual behavior, particularly in France]. Andrologie, 1997, 7: 336-342. https://doi.org/10.1007/BF03034551

[5] Laumann E. O, Park A., Rosen R. C. Sexual dysfonction in the United States: prevalence and predictors. J. Am. Med. Ass., 1999, 281: 537-544. https://doi.org/10.1001/jama.281.6.537

[6] Fugl-Meyer A. R, Sjogren Fugl-Meyer K. Sexual disabilities, problem and satisfaction in 18-74-year-old Swedes. Scand. J. Sexol. 1999; 2: 79-105.

[7] Butcher MJ, Welliver RC Jr, Sadowski D, Botchway A, Köhler TS. How is delayed ejaculation defined and treated in North America? Andrology 2015; 3: 626-31. https://doi.org/10.1111/andr.12041.

[8] Delavière D, Hapi ME, Nsabimbona B. Diagnostic d'une anéjaculation: à propos de 72 patients [Diagnosis of anejaculation: a study of 72 patients]. Andrology 2004; 14(2): 164-170. https://doi.org/10.1007/BF03034791

[9] Ibrahim A. Abdel-Hamid, Omar I. Delayed Ejaculation: Pathophysiology, Diagnosis, and Treatment. World J Mens Health 2017; 12: 1-19. https://doi.org/10.5534/wjmh.17051

[10] Sylla A, Ndiaye-Ndongo N D, Fall L, Guèye S M, Guèye M. Problématique des anéjaculations psychogènes au Sénégal: à propos de quatre cas [The problem of psychogenic anejaculation in Senegal: a report of four cases]. Andrologie 2012; 22: 112-115. https://doi.org/10.1007/s12610-012-0179-y

[11] Althof SE. Psychological interventions for delayed ejaculation/orgasm. Int J Impot Res 2012; 24: 131-6. https://doi.org/10.1038/ijir.2012.2

[12] Anderson KD, Borisoff JF, Johnson RD, Stiens SA, Elliott SL. Long-term effects of spinal cord injury on sexual function in men: implications for neuroplasticity. Spinal Cord 2007; 45: 338-48. https://doi.org/10.1038/sj.sc.3101978

[13] Rigot JM, Marcelli F, Giuliano F. Troubles de l'éjaculation à l'exception de l'éjaculation prématurée, troubles de l'orgasme. [Ejaculation disorders, with the exception of premature ejaculation, orgasmic disorders]. Prog Urol. 2013; 23: 657-663. https://doi.org/10.1016/j.purol.2013.01.011

[14] Lindau ST, Tang H, Gomero A, Vable A et al. Sexuality among middle-aged and older adults with diagnosed and undiagnosed diabetes: a national, population-based study. Diabetes Care 2010; 33: 2202-10. https://doi.org/10.2337/dc10-0524

[15] Martin-Du Pan R, Baumann P. Dysfonctions sexuelles induites par les antidépresseurs et les antipsychotiques et leurs traitements [Sexual dysfunctions induced by antidepressants and antipsychotics and their treatments]. Rev Med Suisse, 2008, 4, 758-762. https://doi.org/10.53738/REVMED.2008.4.150.0758

[16] Montejo-Gonzalez AL, Liorca G, Isquierdo JA, et al. SSRI-induced sexual-dysfunction: fluoxetine, paroxetine, sertraline, and fluvoxamine in a prospective, multicenter, and descriptive clinical study of 344 patients. J Sex Marital Ther, 1997; 23: 176-194. https://doi.org/10.1080/00926239708403923

[17] Bonierbale M. Lancon C, Tignol J, et al. The ELIXIR study: Evaluation of sexual dysfunction in 4557 depressed patients in France. Curr Med Res Opin 2003; 19: 114-24. https://doi.org/10.1185/030079902125001461