

Author Year; Country Dates included in the review Total sample size Level of evidence Type of study Score	Methods Databases	Outcomes
<p>Chéhensse et al. 2013; France</p> <p>Reviewed published articles from 1955 to 2012</p> <p>N=45</p> <p>Level of evidence Methodological quality not assessed</p> <p>Type of studies All cross-sectional studies 36 retrospective</p> <p>AMSTAR=3</p>	<p>Method: searched for all published articles examining the occurrence of antegrade rhythmic forceful or dribbling ejaculation as a function of the neurological characterization of the lesion. All levels of evidence were included.</p> <p>Databases: MEDLINE, EMBASE, EBSCOhost, Cochrane Library</p>	<ol style="list-style-type: none"> 1. Ejaculation occurred in response to (i)masturbation or coitus; (ii) penile vibratory stimulation (PVS) followed by masturbation; (iii)acetylcholinesterase (AchE) inhibitors followed by masturbation in: (i)11.8%; (ii)47.4%; (iii)54.7% of patients with complete SCI (i)33.2%; (ii)52.8%; (iii)78.1% of patients with incomplete SCI 2. Ejaculation in response to PVS or AchE inhibitors prior to masturbation was rhythmic forceful in 97.9% of patients with complete lesion strictly above segments S2-S4. Complete lesion of the S2-S4 segments precluded the occurrence of rhythmic forceful ejaculation. 3. Controlling for the number of the injured segments between T12 and L2, the ejaculation rate sharply decreased when the lesion extended to the L3 segment and below. 4. The spinal sympathetic and parasympathetic centres are crucial for emission and the somatic centre for expulsion. 5. The spinal segments between L2 and S2 are more than a pathway to connect the ejaculation centres; L3-L5 segments likely harbour a spinal generator of ejaculation.