

Table 11. Systematic Review - Sensation, Orgasm, and Ejaculation in Men With SCI

<p>Author Year; Country Dates included in the review Total sample size Level of evidence Type of study Score</p>	<p>Methods Databases</p>	<p>Results</p>
<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.
<p>Alexander & Marson 2018 Systematic Review</p>	<p>Objectives: To determine the percentage of persons with SCI able to achieve orgasm and ejaculation, the associations between ejaculation and orgasm and the subjective and autonomic findings during these events, and the potential benefits with regards to spasticity.</p> <p>Methods: Data bases</p>	<ol style="list-style-type: none"> 1. Approximately 50% of sexually active men and women report orgasmic ability after SCI. Time to orgasm is longer in people with SCI than in people without. 2. Depending on the level and severity of injury, people with SCI can have orgasms; though, there is a relative inability of people with complete lower motor neuron injuries affecting the sacral segments to achieve orgasm. 3. With penile vibratory stimulation and electroejaculation, BP elevation is common and prophylaxis is

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	<p>were searched for the terms orgasm and SCI and ejaculation and SCI. Search criteria were human studies published in English from 1990 to 12/2/2016.</p>	<p>recommended in persons with injuries at T6 and above.</p> <ol style="list-style-type: none"> 4. Dry orgasm occurs approximately 13% of the time in males. 5. Midodrine, vibratory stimulation, clitoral vacuum suction, and 4-aminopyridine may improve orgasmic potential.