

Painful Ejaculation: Causes and Assessment

Understanding Pain During or After Ejaculation — Causes, Diagnosis, Clinical Assessment and an Integrative Unani Approach

Painful ejaculation is a distressing but often under-discussed male sexual health problem. A man may experience burning, aching, pressure, sharp pain or discomfort during ejaculation, immediately after ejaculation, or for some time afterward.

In medical terminology, painful ejaculation may also be called **dysejaculation, odynorgasmia, dysorgasmia, orgasmalgia, or post-ejaculatory pain**. The discomfort may be felt in the penis, testicles, scrotum, perineum—the area between the scrotum and anus—lower abdomen, rectal region or deeper inside the pelvis.

The European Association of Urology describes painful ejaculation as discomfort or pain occurring during or after ejaculation, with pain potentially involving the penis, scrotum and perineum. Available studies suggest that it affects approximately **1–10% of men in the general population**, although the frequency can be considerably higher among men with chronic prostatitis/chronic pelvic pain syndrome. These prevalence estimates have limitations because the condition remains under-reported and has not always been defined consistently in research.

In my clinical experience, one of the most important messages for patients is this:

Pain during ejaculation should not simply be accepted as a normal part of sexual activity.

A single mild episode may sometimes settle spontaneously, but repeated or significant pain deserves proper medical assessment because the underlying cause may range from muscle tension or inflammation to an infection, prostate disorder, medication effect or obstruction of the ejaculatory pathway.

What Is Painful Ejaculation?

Normally, ejaculation should not be painful.

During sexual climax, semen travels through the reproductive tract and is expelled through the urethra. This process involves coordinated activity of the:

- testicles and epididymis,
- vas deferens,
- seminal vesicles,
- prostate gland,



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- ejaculatory ducts,
- urethra,
- bladder neck,
- pelvic-floor muscles,
- autonomic and somatic nerves.

Ejaculation therefore depends on a sophisticated interaction between the reproductive organs, urinary tract, nerves and pelvic muscles.

If inflammation, infection, obstruction, nerve irritation, excessive muscular contraction or another abnormality affects one part of this pathway, ejaculation may become uncomfortable or painful. Current international sexual-medicine guidance emphasizes that ejaculation and orgasm involve neurological, hormonal, anatomical, psychological and interpersonal factors, so assessment often needs to look beyond a single organ.

Where Can the Pain Be Felt?

Different patients describe painful ejaculation differently.

Pain may occur in the:

- tip or shaft of the penis,
- urethra,
- testicles,
- scrotum,
- perineum,
- prostate or deep pelvic region,
- rectum,
- groin,
- lower abdomen,
- lower back.

Some men experience pain for only a few seconds, while others experience discomfort that continues for minutes or occasionally much longer.

The location and duration of pain can provide valuable diagnostic clues.



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For example, pain associated with burning urination or urethral discharge raises different concerns from pain accompanied by chronic pelvic tightness and urinary hesitancy.

What Does Painful Ejaculation Feel Like?

Patients may describe the sensation as:

- burning during ejaculation,
- stinging inside the urethra,
- heaviness after ejaculation,
- deep aching behind the penis,
- pressure around the prostate,
- testicular discomfort,
- perineal pain,
- spasmodic pelvic pain,
- sharp pain at orgasm,
- lower abdominal pain,
- soreness lasting after intercourse.

Some men experience symptoms every time they ejaculate. Others experience them only occasionally or only under particular circumstances.

This pattern is diagnostically important.

Causes of Painful Ejaculation

Painful ejaculation does not have one single cause. Several different conditions can produce the symptom, and sometimes more than one factor is present at the same time.

Current European urology guidance identifies associations with prostate inflammation, sexually transmitted infections, benign prostate enlargement, seminal-vesicle stones, prostate procedures, pelvic radiation, hernia surgery, certain medicines and other conditions. Some cases remain unexplained even after investigation.

1. Prostatitis



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Prostatitis—an inflammatory condition involving the prostate—is one of the important causes that should be considered.

A patient may also experience:

- pain or burning while urinating,
- frequent urination,
- urgency,
- difficulty starting urine,
- weak urine stream,
- pelvic discomfort,
- perineal pain,
- penile or testicular pain,
- fever in acute bacterial cases,
- pain during or after ejaculation.

The NHS and the U.S. National Institute of Diabetes and Digestive and Kidney Diseases both recognize painful ejaculation as a possible symptom of prostatitis.

Importantly, prostatitis is not always caused by bacteria.

2. Chronic Prostatitis/Chronic Pelvic Pain Syndrome

Chronic prostatitis/chronic pelvic pain syndrome, commonly abbreviated **CP/CPPS**, is particularly relevant to men with recurrent ejaculatory pain.

Patients may experience persistent or intermittent pain involving:

- the perineum,
- penis,
- testicles,
- groin,
- lower abdomen,
- pelvic floor,
- lower back.

Urinary symptoms may or may not be present.



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Modern research recognizes CP/CPPS as a complex condition that can involve inflammatory, neurological, musculoskeletal and pain-processing mechanisms rather than simply representing an ongoing prostate infection.

Painful ejaculation is particularly common in this patient group.

3. Pelvic-Floor Muscle Dysfunction

This cause deserves special attention because it can easily be overlooked.

The pelvic-floor muscles participate in erection, orgasm and ejaculation. If these muscles remain excessively tense, tender or poorly coordinated, the strong muscular contractions occurring during orgasm may become painful.

The 2025 American Urological Association guideline on male chronic pelvic pain specifically notes an association between **pelvic-floor myalgia and painful ejaculation**. Pelvic-floor dysfunction may also be associated with:

- urinary hesitancy,
- straining while urinating,
- slow urine flow,
- constipation,
- pelvic pressure,
- groin pain,
- pain radiating toward the lower abdomen or coccyx.

This is one reason I advise patients not to assume that every case of painful ejaculation means infection.

4. Urinary-Tract or Urogenital Infection

Inflammation or infection affecting structures involved in ejaculation can sometimes produce pain.

Potential conditions include:

- urethritis,
- urinary-tract infection,
- prostatitis,

- epididymal or other genital infection.

Symptoms such as burning urination, urinary frequency, fever, abnormal urine, discharge or pelvic pain should therefore be discussed with the treating physician.

5. Sexually Transmitted Infections

Certain sexually transmitted infections can cause inflammation of the urethra or reproductive tract and may contribute to painful ejaculation.

The possibility of an STI becomes particularly important when symptoms are accompanied by:

- urethral discharge,
- burning while urinating,
- genital sores,
- recent unprotected sexual exposure,
- new sexual partner,
- testicular discomfort.

A sexual history is therefore an ordinary and medically important part of assessment. It should always be taken respectfully and confidentially.

6. Ejaculatory-Duct Obstruction

The ejaculatory ducts carry seminal fluid into the urethra.

Partial or complete obstruction can result from congenital abnormalities, inflammation, scarring, cysts or calculi.

Depending upon the underlying abnormality, a man may experience:

- painful ejaculation,
- reduced semen volume,
- blood in semen,
- infertility,
- pelvic or perineal discomfort.

When the history suggests obstruction, specialized investigations such as transrectal ultrasound or other imaging may be considered.



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7. Seminal-Vesicle Disorders

The seminal vesicles produce a significant portion of the fluid contained in semen.

Inflammation, stones or structural abnormalities involving the seminal vesicles have been reported in association with painful ejaculation.

These conditions are considerably less common than prostatitis or chronic pelvic pain, but they may become relevant when symptoms persist despite routine evaluation.

8. Benign Prostatic Hyperplasia

Benign prostatic hyperplasia, or **BPH**, refers to non-cancerous enlargement of the prostate and is particularly common with increasing age.

BPH commonly produces urinary symptoms such as:

- difficulty starting urination,
- weak stream,
- incomplete bladder emptying,
- increased frequency,
- nocturia.

Pain after ejaculation can occur in some men with prostate disorders, including BPH.

9. Medicines

Medication history is extremely important.

Certain medicines, particularly some antidepressants, have been reported in association with painful ejaculation or other ejaculation and orgasm disorders.

Other medicines can modify orgasm, ejaculation, semen emission or pelvic-muscle function.

Patients should not discontinue prescribed medication themselves. Instead, the prescribing physician should review whether a drug could be contributing to the problem and whether an alternative is appropriate.

10. Previous Prostate or Pelvic Surgery



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Painful ejaculation can sometimes begin after procedures involving the:

- prostate,
- bladder,
- pelvis,
- urinary tract,
- groin.

It has been reported after some prostate operations and after hernia surgery.

The precise mechanism depends upon the procedure and may include altered anatomy, inflammation, nerve irritation or scar formation.

11. Pelvic Radiation

Patients who have received radiation therapy involving the prostate or pelvis may occasionally develop ejaculatory discomfort because treatment can affect surrounding tissues, nerves and reproductive structures.

12. Nerve-Related Pain

Ejaculation involves coordinated neurological signalling.

Pelvic nerve irritation or neuropathic pain may therefore cause orgasm-associated discomfort in selected patients.

Neuropathic pain becomes particularly relevant when symptoms include:

- burning,
 - electric-shock-like pain,
 - altered genital sensation,
 - pain associated with prolonged sitting,
 - pain following pelvic surgery or trauma.
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13. Psychological and Psychosexual Factors

Pain is a genuine physical experience, even when psychological or relationship factors contribute to its intensity.



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Anxiety can increase pelvic-floor muscle tension and amplify pain perception. Repeated painful episodes may then create a cycle:

pain → anticipation of pain → muscular tension → more pain → sexual avoidance.

European urology guidance notes that psychological factors can contribute in selected cases, particularly when symptoms occur in one sexual situation but not another.

Psychological explanations should generally be considered **after appropriate medical causes have been evaluated**, rather than automatically assuming that a patient's symptoms are "only psychological."

14. Idiopathic Painful Ejaculation

Sometimes extensive assessment does not reveal a definite cause.

Such cases may be described as **idiopathic painful ejaculation**.

This does not mean that the patient's symptoms are imaginary. It means that currently available investigations have not identified a specific structural or infectious explanation.

Is Painful Ejaculation a Sign of Cancer?

Most men experiencing painful ejaculation do **not** have cancer.

However, painful ejaculation has occasionally been reported in association with prostate disease, including prostate cancer, so persistent unexplained symptoms—particularly in an older patient or someone with other concerning findings—should be clinically assessed rather than ignored.

Assessment becomes particularly important if there is:

- blood in urine,
- persistent or recurrent blood in semen,
- unexplained weight loss,
- significant urinary obstruction,
- abnormal prostate examination,
- strong family history,
- other concerning urinary symptoms.



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Testing for prostate cancer should be based on the patient's age, risk factors, examination and shared decision-making rather than painful ejaculation alone.

How I Assess a Patient With Painful Ejaculation

A good diagnosis begins with conversation.

Patients should never feel embarrassed discussing ejaculation, erection, sexual activity or reproductive symptoms. These are ordinary medical functions.

International guidance emphasizes that a careful medical and sexual history is central to the evaluation of ejaculation and orgasm disorders, with additional testing selected according to what that history and examination reveal.

During assessment, I usually want to understand several points.

When Did the Problem Begin?

Was the onset:

- sudden?
- gradual?
- after an infection?
- after surgery?
- after starting a medicine?
- after a sexual exposure?
- following injury?
- associated with a period of pelvic pain?

The timing can immediately narrow the possible causes.

Where Exactly Is the Pain?

I ask the patient to identify whether pain occurs in:

- penis,
- urethra,
- scrotum,
- testicles,



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- perineum,
- rectal region,
- groin,
- lower abdomen,
- lower back.

The location can help identify whether the prostate, urethra, pelvic floor, testicular structures or another part of the reproductive tract may be involved.

Does Pain Occur During or After Ejaculation?

Some patients experience pain:

- immediately before ejaculation,
- at the moment of ejaculation,
- immediately afterward,
- several minutes afterward.

Duration is equally important.

Does It Happen Every Time?

We should determine whether the condition is:

- occasional,
- frequent,
- present with every ejaculation,
- associated only with intercourse,
- present during masturbation as well,
- related to a specific position or activity.

This information can provide clues regarding pelvic-floor, psychological, anatomical and mechanical factors.

Associated Urinary Symptoms

I specifically ask about:



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- burning urination,
- urinary frequency,
- urgency,
- weak stream,
- incomplete emptying,
- difficulty starting urination,
- urinary retention,
- blood in urine.

Painful ejaculation accompanied by urinary complaints makes evaluation of prostate, bladder, urethral and pelvic-floor conditions particularly important.

Other Sexual Symptoms

Assessment should also consider:

- erectile dysfunction,
- premature ejaculation,
- delayed ejaculation,
- reduced orgasmic sensation,
- reduced sexual desire,
- low semen volume,
- blood in semen,
- loss of ejaculation,
- infertility.

Sexual disorders often overlap rather than occurring completely independently.

Medication History

Patients should bring a list of:

- prescription medicines,
- antidepressants,



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- psychiatric medicines,
- prostate medicines,
- blood-pressure medicines,
- hormonal medications,
- herbal preparations,
- nutritional supplements,
- recreational substances.

Drug-related sexual side effects can otherwise easily be missed.

Medical and Surgical History

Previous conditions and procedures may reveal the cause.

Important information includes:

- previous prostatitis,
 - urinary infections,
 - sexually transmitted infections,
 - diabetes,
 - neurological disorders,
 - pelvic trauma,
 - prostate surgery,
 - bladder surgery,
 - inguinal hernia surgery,
 - pelvic radiotherapy.
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Physical Examination

The physical examination is individualized.

Depending upon symptoms, examination may include assessment of:

- abdomen,
- groin,



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- penis,
- urethral opening,
- testes,
- epididymis,
- scrotum,
- prostate,
- pelvic floor.

When chronic pelvic pain or pelvic-floor dysfunction is suspected, assessment of pelvic-floor tenderness may be useful.

The 2025 AUA chronic-pelvic-pain guideline emphasizes examining for musculoskeletal and pelvic-floor sources rather than assuming that every patient has prostate infection.

Tests That May Be Required

Not every patient requires every test.

Investigations should be selected according to symptoms, examination and risk factors.

Urinalysis

Urine examination may help identify:

- infection,
 - blood,
 - inflammatory changes,
 - abnormalities requiring further investigation.
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Urine Culture

When bacterial infection is suspected, urine culture can identify organisms and guide appropriate antibiotic selection.

Antibiotics should not automatically be prescribed for every episode of painful ejaculation because chronic pelvic pain frequently occurs without bacterial infection.

STI Testing



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Testing for sexually transmitted infections may be advised when sexual history or symptoms suggest possible exposure.

This is important because treatment differs considerably between infection-related and noninfectious pelvic pain.

Blood Tests

Blood investigations are not automatically necessary in every patient.

They may be requested when the medical history suggests:

- infection,
 - systemic illness,
 - endocrine abnormalities,
 - metabolic disease,
 - other underlying problems.
-

PSA Testing

Prostate-specific antigen testing may sometimes be considered according to age, clinical findings, prostate-cancer risk and applicable screening recommendations.

Painful ejaculation by itself does not automatically mean PSA testing is required.

Semen Analysis

When painful ejaculation occurs along with infertility, reduced semen volume or suspected ejaculatory-duct obstruction, semen analysis may be useful.

A semen analysis may evaluate:

- semen volume,
- sperm concentration,
- motility,
- morphology,
- other relevant parameters.



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Chronic prostatitis and chronic pelvic pain have been studied in relation to semen parameters, although the relationship varies among patients and conditions.

Ultrasound and Imaging

Imaging is not routinely necessary for every patient.

Depending upon the clinical situation, a physician may consider:

- scrotal ultrasound,
- urinary ultrasound,
- transrectal ultrasound,
- CT,
- MRI,
- other targeted imaging.

For example, imaging can become relevant when obstruction, cyst, stone, structural disease or another pelvic abnormality is suspected.

Post-Void Residual Testing

If a patient also has difficulty emptying the bladder, post-void residual assessment may measure how much urine remains after urination.

The AUA guideline for chronic male pelvic pain includes urinalysis, urine culture and post-void residual assessment among components that can be considered during the appropriate evaluation of chronic pelvic pain presentations.

When Is Painful Ejaculation an Emergency?

Painful ejaculation alone is usually not an emergency, but urgent evaluation is necessary when it occurs with certain symptoms.

Seek prompt medical care for:

- inability to urinate,
- severe testicular pain or swelling,
- high fever or chills,
- severe pelvic pain,



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- significant blood in urine,
- severe systemic illness,
- rapidly worsening symptoms.

Acute bacterial prostatitis, for example, can cause fever, urinary difficulty and systemic illness and requires appropriate medical treatment. The NHS and NIDDK specifically advise urgent evaluation for inability to urinate and serious symptoms associated with prostate infection.

Treatment Depends on the Cause

One of the biggest mistakes in treating painful ejaculation is looking for one medicine that supposedly works for every patient.

There is no universal treatment.

European urology guidance recommends tailoring treatment to the identified underlying cause. Depending on the diagnosis, treatment may involve appropriate antimicrobial therapy, anti-inflammatory treatment, medicines affecting urinary or prostate function, pelvic-floor rehabilitation, psychological or relationship support, or selected surgical procedures where a definite correctable structural abnormality exists. Evidence for surgical treatment of painful ejaculation itself remains limited, so intervention should be carefully selected.

If Infection Is Present

A confirmed or strongly suspected bacterial infection should be treated according to medical guidelines.

Antibiotic selection should ideally be based on:

- suspected infection,
- culture findings when appropriate,
- clinical history,
- local antimicrobial guidance.

Repeatedly taking antibiotics without evidence of bacterial infection is not an appropriate approach to chronic pelvic pain.

Pelvic-Floor Physiotherapy



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When excessive pelvic-floor tension or myalgia contributes to symptoms, specialized pelvic-floor physiotherapy may be valuable.

The aim is generally not simply to "strengthen" the pelvic floor.

Some patients already have an excessively tense pelvic floor.

Therapy may instead focus on:

- muscle relaxation,
- coordination,
- manual techniques,
- breathing,
- reducing guarding,
- improving pelvic mechanics.

The 2025 AUA guideline recognizes pelvic-floor physical therapy as a relevant management approach when pelvic-floor myalgia is identified.

Painful Ejaculation and Male Fertility

Patients frequently ask me:

“Doctor, if ejaculation is painful, does that mean I will become infertile?”

The answer is **not necessarily**.

Painful ejaculation itself does not automatically mean sperm production is impaired.

However, some underlying conditions associated with ejaculatory pain—such as chronic prostatitis, inflammation or ejaculatory-duct obstruction—can potentially coexist with abnormalities affecting semen or fertility.

Research has reported associations between some forms of chronic prostatitis and changes in semen parameters, although individual outcomes vary considerably.

Therefore, a man trying to conceive who has persistent painful ejaculation should discuss fertility assessment rather than assuming that fertility is normal or permanently impaired.

Unani Perspective on Painful Ejaculation



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As a physician trained in Unani medicine with a focused practice in sexual disorders and infertility, I consider the patient as a whole rather than treating ejaculation as an isolated event.

This does **not** mean ignoring modern diagnostic investigation.

On the contrary, appropriate assessment for infection, prostate disease, urinary abnormalities, pelvic-floor dysfunction, obstruction and other identifiable causes should come first.

In Unani clinical practice, management may be individualized according to the patient's symptoms, constitution, associated urinary or digestive complaints, lifestyle, inflammatory features and the probable underlying disorder.

The objective of an integrative approach may include:

- reducing relevant inflammatory symptoms,
- addressing pelvic discomfort,
- supporting urinary function when affected,
- correcting lifestyle factors,
- addressing associated sexual dysfunction,
- improving general reproductive health.

What Does Research Say About Unani Management?

Research specifically evaluating Unani medicine for **painful ejaculation itself** remains limited, and this limitation should be communicated clearly to patients.

One published 2019 case report from researchers associated with Jamia Hamdard, Aligarh Muslim University and other institutions evaluated a Unani regimenal technique called **Nutool** in a patient with chronic prostatitis/chronic pelvic pain syndrome who had pelvic pain and painful ejaculation. Improvement was reported using pain and NIH Chronic Prostatitis Symptom Index measurements, but this was a **single case study**, not a large randomized clinical trial. Its authors themselves presented the findings as preliminary and called for further research.

The Ministry of AYUSH maintains an evidence-based research portal containing clinical and scientific research across AYUSH systems, including Unani medicine, reflecting ongoing efforts to strengthen the evidence base.

For this reason, I believe the most responsible clinical approach is integration—not exaggeration.



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Where appropriate, Unani measures can be considered as part of an individualized treatment strategy, while bacterial infections, STIs, significant urinary obstruction, suspected structural disease and other medically important conditions must receive appropriate conventional investigation and management.

What I Advise Patients Not to Do

If you experience painful ejaculation, avoid self-diagnosing the condition as simply "weakness" or "semen problem."

I also advise against:

- taking antibiotics repeatedly without assessment,
- purchasing unverified sexual medicines,
- using steroids or hormonal products without medical supervision,
- aggressively massaging the prostate yourself,
- ignoring persistent blood in semen or urine,
- suppressing symptoms for months without diagnosis,
- assuming the problem is psychological before medical evaluation,
- abruptly stopping prescription medicines.

Correct diagnosis is more important than collecting medicines.

Lifestyle and Self-Care

Lifestyle measures are supportive rather than a substitute for diagnosis.

Depending on the cause, patients may benefit from:

- maintaining adequate hydration,
- avoiding prolonged sitting if it worsens pelvic pain,
- managing constipation,
- reducing excessive pelvic muscle tension,
- regular comfortable physical activity,
- maintaining healthy sleep,
- reducing excessive stress,



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- avoiding activities that repeatedly trigger pelvic pain until assessment,
- following safer-sex practices where appropriate.

Patients with chronic pelvic pain may sometimes benefit from relaxation techniques and physiotherapy as part of a broader management plan.

Psychological Impact Should Not Be Ignored

Painful ejaculation can significantly affect sexual confidence.

After several painful episodes, a man may begin to fear intercourse.

This can produce:

- performance anxiety,
- reduced sexual desire,
- erectile difficulty,
- avoidance of intimacy,
- relationship tension,
- fear of infertility,
- excessive attention to genital sensations.

The resulting distress can reinforce pelvic muscular tension and make symptoms more difficult to manage.

A good treatment plan therefore addresses both the physical cause and the emotional consequences of the condition.

Frequently Asked Questions

Is painful ejaculation normal?

Occasional mild discomfort can occur, but persistent or recurrent painful ejaculation should not be regarded as normal and deserves medical assessment.

Is painful ejaculation always prostatitis?

No.



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Prostatitis and CP/CPPS are important causes, but pelvic-floor dysfunction, infection, medications, ejaculatory-duct problems, previous surgery and other conditions may also cause it.

Does painful ejaculation mean I have an STI?

No.

An STI is only one possible cause. Testing is appropriate when symptoms or sexual history indicate a possibility of infection.

Can stress cause painful ejaculation?

Stress and anxiety may contribute by increasing pelvic-floor tension and altering pain perception, but physical causes should also be appropriately assessed.

Can pelvic-floor problems cause ejaculatory pain?

Yes.

Modern urological guidance recognizes painful ejaculation as one of the symptoms that may be associated with pelvic-floor myalgia.

Can antidepressants cause painful ejaculation?

Some antidepressant medicines have been reported in association with painful ejaculation and other ejaculation or orgasm disorders. Never stop prescribed antidepressant treatment suddenly; speak with the prescribing physician.

Can painful ejaculation affect sperm?

Pain by itself does not necessarily reduce sperm quality.

However, underlying conditions such as chronic prostatitis or ejaculatory-duct obstruction may sometimes coexist with fertility abnormalities, so semen testing may be appropriate when fertility is a concern.

Which doctor should I consult?



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Depending upon the presentation, evaluation may involve a physician experienced in male sexual medicine, andrology or urology. Chronic pelvic-floor conditions may additionally require a pelvic-health physiotherapist, while fertility problems may require dedicated male-infertility assessment.

My Clinical Approach at Saira Health Care

At **Saira Health Care**, our approach to a patient with painful ejaculation begins by identifying the **cause rather than simply suppressing the symptom**.

Because my clinical work is focused on **sexual disorders and infertility**, I evaluate painful ejaculation in relation to the patient's broader sexual, urinary and reproductive health.

Assessment may include, according to individual need:

- detailed medical history,
- sexual and ejaculatory history,
- urinary symptoms,
- reproductive and fertility history,
- medication review,
- investigation of possible infection,
- assessment of prostate-related symptoms,
- consideration of pelvic-floor dysfunction,
- review of erectile and ejaculation disorders,
- appropriate laboratory or imaging investigations,
- fertility evaluation when relevant.

Where appropriate, I integrate principles of Unani medicine with modern clinical assessment while referring or coordinating for urological investigation whenever symptoms suggest a condition requiring specialized evaluation.

No responsible physician should promise that one medicine or one formulation will cure every case of painful ejaculation. Treatment must depend upon the diagnosis.

A Message to Patients



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Many men hesitate to seek medical help because they feel embarrassed discussing pain during ejaculation.

Please remember that ejaculation, erection, fertility and urinary function are medical subjects. For a physician working in sexual medicine, these conversations are routine.

If you are experiencing repeated painful ejaculation, do not assume that you have become sexually weak or infertile.

In many cases, identifying the correct underlying factor makes the condition much easier to manage.

The important step is **proper assessment before treatment**.

Conclusion

Painful ejaculation is medically known by terms including dysejaculation, dysorgasmia and odynorgasmia. It may range from mild discomfort to significant pelvic or genital pain during or after ejaculation.

Possible causes include:

- prostatitis,
- chronic prostatitis/chronic pelvic pain syndrome,
- pelvic-floor muscle dysfunction,
- urethral or urinary infection,
- sexually transmitted infection,
- benign prostate enlargement,
- ejaculatory-duct obstruction,
- seminal-vesicle abnormalities,
- medication effects,
- previous prostate or pelvic procedures,
- neurological pain,
- psychological and psychosexual factors.

Modern evidence emphasizes that evaluation should begin with a detailed medical and sexual history and focused physical examination, followed by selective investigations based on the findings. Current urology guidance does not support subjecting every patient to the same extensive test panel.



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At the same time, painful ejaculation may sometimes be part of a broader chronic pelvic-pain condition. Recognition of pelvic-floor muscle dysfunction has become increasingly important, and the 2025 AUA guideline specifically includes ejaculatory pain among clinical features seen in chronic pelvic pain and pelvic-floor disorders.

From an integrative Unani perspective, treatment can be individualized around the patient's overall condition and underlying diagnosis. However, available research specifically supporting Unani treatment for painful ejaculation is still limited, and further high-quality studies are needed. An integrative approach should therefore complement—not replace—appropriate investigation and established treatment of infection, obstruction, prostate disease or other identifiable pathology.

Pain during ejaculation should not become a source of silent suffering. Correct diagnosis is the first step toward appropriate treatment.

About the Author

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Dr. Nizamuddin Qasmi's clinical practice at Saira Health Care focuses particularly on the assessment and individualized management of male sexual disorders, reproductive-health concerns and infertility, with an integrative approach incorporating his training in Unani medicine and contemporary clinical assessment.

Medical Disclaimer

This article is intended for health education and general public awareness. It does not establish a diagnosis or replace consultation with a qualified medical professional. Painful ejaculation has multiple possible causes, and treatment should be selected

only after appropriate clinical assessment. Patients with fever, severe testicular or pelvic pain, inability to urinate, significant bleeding or rapidly worsening symptoms should seek prompt medical attention.