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Male Sexual Dysfunctions among Healthy Men in Kosovo

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Abstract

Aim

To describe the nature of male sexual dysfunction among men population in Kosovo.

Materials and Methods

Epidemiological cross-sectional study was done in Kosovo, during the year 2015 by the Institute for health and sexual research LIBIDO and Medical Faculty, Prishtina. The sample size selected randomly included 600 participants while response rate was 88.3% (530/600). Statistical analysis was performed using the Statistical Package for the Social Science (SPSS) software package.

Results

The percentage of men not satisfied with their sexual function was 32.2 %. Premature ejaculation was a leading problem (34%) followed by erectile dysfunction (24.4%) and problem with little or no interest in sex (17.9%). Sexual dysfunction is related to participant's age. The younger population < 25-50 year reported premature ejaculation as a main problem while the participants within age group over 50 year reported erectile dysfunction as a main problem. Moreover, 76.4% of men are ready to talk about these problems with their doctor.

Conclusion

Younger population reported premature ejaculation, whereas erectile dysfunction was the main problem among the older population.

Key Words: Sexuality; Dysfunction; Sexual Problems

Introduction

Sexual dysfunctions are common among men of all ages, ethnicities and cultural backgrounds. Sexual activity is a complex activity and it is not only meant for reproduction but also a source of enjoyment and natural relaxant. Sexual activity can validate one's gender, self esteem and a means of attractiveness between opposing gender for intimacy and relationship [1]. The burden of this problem in the US is unclear, as previous prevalence estimates of erectile dysfunction have varied markedly depending on the population and survey instrument used. The etiology of erectile dysfunction has not been rigorously characterized in the general US population, although studies suggest links with atherosclerosis and cardiovascular disease [2,5,13]. Sexual dysfunctions are believed to be among the most prevalent psychological disorders in the general population [3]. Sexual dysfunctions are highly prevalent, affecting about 43% of women and 31% of men [4]. Although risk factors for erectile dysfunctions (ED) are well described, there are almost no data for risk factors in other sexual dysfunctions [5]. According to The Massachusetts Male Aging Study, 51% of respondents reported at least some ED, with prevalence of complete ED increasing three-fold from the youngest age group to the oldest [6]. Sexual dysfunction may be caused by various biological and psychological factors. The role of psychological factors in the onset and maintenance of sexual dysfunctions has been highlighted extensively in the research literature [7-11].

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The aim of this study was to explore the nature of male sexual dysfunction among men population in Kosovo.

Material and Methods

The present study followed the standardized Brief Sexual Symptom Checklist (BSSC) for Men questionnaire to assess sexual satisfaction, sexual desire, erectile dysfunction, ejaculatory and orgasmic dysfunctions and pain during sex.

Study Settings

The study was carried out at six Family Medicine Health Centers in main Regions in Kosovo. This study included sexually active men, aged 19 years and above.

Participants and Sampling

The sample size was calculated to be 600 (the number of one hundred participants in each center with 95% Confidence Interval (CI) and 5% precision. Simple random sampling methodology was used for participant's selection. The lists of patients name were put into a column in an Excel spreadsheet. Then, in the column next to right by function = RAND ( ) which is EXCEL's way of putting a random number between 0 and 1 in the cells. . Then both columns were sorted and the list is rearranged in random order from the lowest to highest random number. Then, we took the first hundred names in the sorted list. The questionnaires were distributed and collected by nurses. The exclusion criteria were: diabetes mellitus, benign prostatic hypertrophy, cases with cancer, severe heart disease and chronic pulmonary diseases. The respond rate was 88.3 % (530/600).

Data Collection

The survey was conducted during May–June 2009. Prior to the survey, training was provided to the research nurses. The English language questionnaire was validated through translation into Albanian, back translation performed and followed by an independent third person checking the translation. To reduce the risk of response bias or participants feeling pressured to stay, the nurses were asked to leave the waiting room and it was emphasized that participants were free to leave or not complete the questionnaire. The purpose of the study was explained and participants were given time to ask questions. Participants were asked for their consent in the questionnaire and willing to participate were considered as a positive answer.

Data Analysis

Statistical analysis was performed using the Statistical Package for the Social Science (SPSS) software package (Version 20.0, Chicago, IL, USA). Frequency and percentage calculation were used to describe the determining socio-demographic factors and the total BSSC scores dichotomized as satisfied or not satisfied sexual function. In addition, the Fisher Exact test and Chi Square test were used to determine the relationship between the six different domains scores and the continuous values of the total score. For all, calculations, $P =<.05$ was considered as statistically significant.

Results:

In total, 530 respondents completed the questionnaire, giving a response rate of 88.3%. The high response rate minimized the risk of bias due to the population not being representative of the target population.

The prevalence of men not satisfied with their sexual function was 32.2 %. Premature ejaculation is leading problem (34%) followed by erectile dysfunction (24.4%) and problems with little or no interest in sex (17.9%). 76.4% of men were willing to discuss their problems with doctors (Table 1).

The problem is age related: the respondents, younger than 25 years old, reported premature ejaculation (40.8%) as their main problem while erectile dysfunction was primary problem in respondents above 50 years old (48 %). Little or no interest in sex in population > 50 year old was 22.5. Delayed ejaculation in this age group was 14.1% while in age group < 25 year was only 2% (Table 2).

Alcohol consumption plays an important role in increased number of sexually not satisfied men. The difference between two groups was statistically significant: about 45 % of men consuming alcohol are not satisfied with their sexual life (Table 3).

Table 1 : Prevalence, problems and willingness to talk with a doctor 95% CI

Sexual problems			
Overall satisfaction	**Yes**	**No**	
Are you satisfied with your sexual function?	67.74%	32.26%	
95% CI	(63.8 to 71.5)	(28.5 to 36.2)	
Problems:	**N**	**%**	**95 % CI**
Problems with little or no interest in sex	42	17.10%	(12.2 to 22.1)
Problems with erection	62	24.40%	(18.08 to 29.5)
Problems ejaculating too early during sexual activity	80	34.00%	(30.3 to 43.2)
Problems taking too long, or not being able to ejaculate	33	14.00%	(9.3 to 18.6)
Problems with pain during sex	8	3.40%	(4.9 to 11.6)
Problems with penile curvature during erection	10	4.30%	(6.4 to 14.1)
Other	40	17.00%	(12.1 to 21.8)
Would you like to talk about it with a doctor?	Yes	No	
	76.40%	23.60%	
95% CI	(71.4 to 81.4)	(18.6 to 28.5)	

Table 2: Sexual dysfunctions in relation to Age

	Little or no interest in sex		**Erectile Dysfunction**		**Premature Ejaculation**		**Delayed Ejaculation**	
Age (Years)	(%)	(95% CI)	(%)	(95% CI)	(%)	(95% CI)	(%)	(95% CI)
< 25	20.4	12.8 to 22.6	14	9.4 to 19.2	40.8	34.2 to 46.6	2	.6 to 2.1
26-35	14	9.2 to 18.9	11	6.5 to 14.2	54.4	47.6 to 60.8	12.3	7.1 to 16.8
36-50	12.3	7.1 to 16.8	16	17.9 to 26.8	47.4	41.4 to 53.6	10.5	6.6 to 14.3
> 50	22.5	18.2 to 27.4	48	41.2 to 53.8	11.3	7.1 to 15.8	14.1	10.3 to 18.2

Table 3 : Alcohol consumption has negative impact in sexual functions

Alcohol		Sexual Satisfaction		
Consumption		Yes	No	p value
	Nr	122	299	
No	%	29.00	71.00	
	Nr	49	60	<.05
Yes	%	45.00	55.00	
	Nr	171	359	
Total	%	32.30	67.70	
Pearson Chi-Square= 10.111				

Discussion

Our findings revealed that the level of sexually dissatisfaction among men was 32.26%. If we consider the characteristics of our population, the overall level of sexual education, culture, religion and other studies this is a "normal state". Problem with premature ejaculation (PE) is the major problem among ours participants. Studies over the past 12 months have increased the understanding of male sexual dysfunction and provided new therapeutic possibilities: Tramadol, a well-known analgesic has a new role in the treatment of PE, Pharmacological treatment with Tadalafil 5 mg oral dose daily for six months, is associated with significant improvement in sexual function, Phosphodiesterase 5 (PDE-5) inhibitors, vacuum devices, injection therapy and penile prostheses are the options for an evidence-based and individual treatment of affected patients [12,16,17]. In a Turkish population study, male sexual dysfunction MSD was detected as a desire problem in 7.3%, erectile dysfunction in 59.7%, ejaculation problem 52.7%, intercourse problem in 50.3%, sexual development problem in 54.7%, and satisfaction problem in 59.7% of the men [13].

The second most sexual problem revealed in our study was erectile dysfunction (ED). This problem was reported to be higher in almost all the studies having higher values than PE. Below the age of 40 years the prevalence of ED was 1–9%, in the decade from 40–59 the prevalence range was 2–9% to as high as 20–30% with some population showing marked differences between the 40–49 age groups compared to the 50–59 year age group. The 50–59 year age group showed the greatest range of reported prevalence rates. Most of the world showed a rather high rate from 20% to 40% for the ages of 60–69 years, some increasing after age 65 except for the Scandinavian reports where the age of 70 years and older is the decade of major prevalence rates change. Almost all of the reports showed high prevalence rates for those men in their 70s and 80s, ranging from 50% to 75% prevalence of ED in this decade [14]. In our study 60.5 % of all cases with ED belong to the age group above 50 year. Alcohol consumption is positive predictor for sexually not satisfied man. The difference between two groups is statistically significant: about 45 % of men consuming alcohol are not satisfied with their sexual life versus 29 %. Excessive drinking is a common cause of erectile dysfunction, according to the Mayo Clinic. As the amount of alcohol in the blood increases, the alcohol decreases the brain's ability to sense sexual stimulation. As a depressant, alcohol directly affects the penis by interfering with parts of the nervous system that are essential for sexual arousal and orgasm, including respiration, circulation, and sensitivity of nerve endings, according to *Health Promotion* at Brown University. Unlike women, who receive medical counseling throughout their reproductive life, men are less compliant with medical advice. This is an important aspect that must be considered when implementing health care policies for men's health. Culture defines the role of men and women, how they relate to each other, their cultural group and the community. When addressing men's sexual health, several levels of culture and beliefs are involved, including the individual and his religion, community and nation [15]. Younger population in our study are more liberal and expressed the willing to talk with a doctor in a high percentage (90.1%) while men in the age above 50 years still are conservative and not ready to talk with a physician for sexual problems.

Conclusion

In this study we noted that male sexual dysfunctions expressed by the level of sexual satisfaction in Kosovo are similar to other studies and are age related. Younger population reported premature ejaculation while as in the oldest population; erectile dysfunction was a main problem.

References

1. Amidu N, Owiredu W, Woode E, Addai-Mensah O, Gyasi-Sarpong KC, et.al (2010) Prevalence of male sexual dysfunction among Ghanaian populace: myth or reality? Int J Impot Res 22(6): 337–342.
2. Selvin E, Burnett A, Platz E (2007) Prevalence and Risk Factors for Erectile Dysfunction in the US. The Am J Med 120(2): 151-157.
3. Simons J, Carey M (2001) Prevalence of Sexual Dysfunctions: Results from a Decade of Research. Arch Sex Behav 30(2): 177–219.
4. Rosen C (2000) Prevalence and risk factors of sexual dysfunction in men and women. Curr Psychiatry Rep 2(3): 189-95.
5. Hatzimouratidis K (2007) Epidemiology of Male Sexual Dysfunction; Am J Mens Health 1(2): 103-125.
6. Kaminetsky J (2008) Epidemiology and pathophysiology of male sexual dysfunction; Int J Impot Res 20: S3–S10.
7. Oksuz E Malhan S (2005) Prevalence of MSD and potential risk factors in Turkish men; Int J Impot Res 17(6): 539–545.
8. Bancroft J (1998) Human sexuality and its problems. 3rd edn. Churchill Livingstone: Edinburgh. 360–411. 5
9. Wincze JP, Carey MP (2001) Sexual dysfunction: a Guide for Assessment and Treatment, 2nd edn. The Guilford Press. New York. 69–115.
10. De Silva P (2004) Sexual dysfunction: Investigation. The handbook of clinical adult psychology 2nd edn. Routledge: London. 199–212.
11. Manjula M, Prasadarao PS, Kumaraiah V, Mishra H, Raguram R, et.al. (2003) Sexual dysfunction in single males: a perspective from India. J Clin Psychol. 59: 701–713.
12. Lee KCJ, Fahmy N, Brock GB (2013) Sexual dysfunction in 2013: Advances in epidemiology, diagnosis and treatment. Arab Journal of Urology 11(3): 194-202.
13. Lewis RW, Fugl-Meyer KS, Bosch R, Fugl-Meyer AR, Laumann EO et.al. (2004) Epidemiology/risk factors of sexual dysfunction. J Sex Med 1(1): 35-39.
14. Bhavsar V, Bhugra D (2013) Cultural factors and sexual dysfunction in clinical practice. Vishal Bhavsar, Dinesh Bhugra. Advances in Psychiatric Treatment 19 (2): 144-152.
15. Christopher CK Ho, Singam P, Hong GE, Zainuddin ZM (2011) Male sexual dysfunction in Asia. Asian Journal of Andrology 13(4): 537-542.
16. Vignera S, Condorelli R, Mongioi M, Calogero A (2017) Chronic Administration of Tadalafil Improves the Symptoms of Patients with Amicrobic MAGI: An Open Study. Int J Endocrinol 2017: 3848545.
17. Leiber C (2017) Erectile dysfunction. Current diagnostics and treatment. Urologe A 56(4): 519-529.