

Commentary

Simultaneous penile-vaginal induced orgasms- do they facilitate conception?

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Van de Velde [1] declared, without any empirical studies, that 'in normal and perfect coitus mutual orgasms must be simultaneous' while Mace [2] opined that 'simultaneous orgasm was the ideal for husband and wife'. Hannah Frith [3] reviewed the contemporary sex advice literature and concluded that it has retained this 'simultaneous orgasm as the yardstick for sexual intimacy between couples' but the feminist academic AnnaMarie Jagose regarded the goal as an 'erotic relic' that most contemporary sexologists have abandoned [4]. In an internet conducted survey of 2613 men and 2223 women simultaneous orgasm occurred only rarely for 38% of the men and 35% of the women and never for 12% of the men and 21% of the women [5]. Controversial claims, however, have been made that simultaneous penile-vaginal intercourse (PVI) orgasm is associated with sexual, life, partnership and mental health satisfaction and has benefits even beyond those of vaginal orgasm and thus should be promoted [6]. As it focusses on performance, imposition of such a prescribed promotion for individuals to strive for in their coital encounters can lead to a psychological condition described as 'sexual perfectionism' creating sexual anxiety, sexually related depression and negative relationships [7] with a possible relation in hypersexual patients [8]. Because there have been suggestions, again without any empirical studies, that such mutually timed orgasms are more likely to result in conception [9] the question arises about the possible role of simultaneous male and female orgasms on reproductive fitness by facilitating sperm uptake. While there is no published empirical study supporting this, an oft repeated proposal that the female orgasm is involved in the transport of spermatozoa by its release of oxytocin creating an 'upsuck' of the ejaculated spermatozoa into the contracting uterus has been shown to be unsubstantiated (see Levin [10,11] for full references). However, despite the absence of data on mutual PVI orgasms it is feasible to come to a conclusion on any possible conception efficacy by applying the known physiology of the ejaculation of semen into the sexually aroused female.

During coitus in the female knee-chest position (ventral/ventral), a common position for creating pregnancy [10], sexual arousal causes the well-characterised ballooning of the distal vagina and its 'vaginal tenting' lifting the cervix up into the false pelvis clear from the posterior floor and the projectile path of any ejaculate to come [10-12]. At ejaculation, normally concomitant with the male orgasm, semen is spurted into the now ballooned distal portion of the vagina, whereupon it becomes a gelatinous coagulum with spermatozoa that are non-motile, uncapacitated (viz -unable to fertilise ova) and trapped in the gel [10]. It takes a finite time, minutes rather than seconds, for the chymotrypsin-like protease enzyme prostate-specific antigen (PSA) in the ejaculate to begin breaking down the gel and liquefy the semen, freeing spermatozoa which become fully motile under the influence of

the increased pO_2 in the aroused vagina and the vaginal and semen stimulants. Contact of the sperm with the latter male and female factors first induces pre-capacitation changes that facilitate full capacitation to occur later [10]. As the female orgasm lasts for approximately 20-30 seconds [13], the uterine contractions that occur during it will have no influence on sperm uptake because the elevated cervix is not in contact with the semen, it does not descend into the semen pool until after the female orgasm occurs [10-12]. Some early controversial studies [14] proposed that the female orgasm increased the retention of spermatozoa and reduced their semen-leakage loss from the vagina (reduced 'flowback') but the authors of the study clearly stated that 'the increased retention of sperm had no influence on the probability of conception'. However, even if some sperm were able to enter the cervical os and were rapidly transported to the patent fallopian tube serving the ovulating ovary they would be un-capacitated, unable to fertilise an ovum and be wasted.

The conclusion from the coital physiological scenario is that simultaneous PVI orgasm does not facilitate conception. In fact, allowing too rapid a transfer of spermatozoa can have a negative effect on fertility [10, 11]. Indeed, the female orgasm isn't always the ideal for facilitating conception. Masters & Johnson [12] recommended that 'From an anatomical point of view, there is probably a greater chance of conception if the parous female achieves only plateau phase levels of response during her sexual encounter, as opposed to enjoying an orgasmic experience. If only plateau phase levels of tension are experienced, the orgasmic platform vasocongestion will be dissipated at a much slower rate than that expected in a post orgasmic sequence and consequently the physiologic aid in seminal pool containment will be of longer duration. Without orgasm the narrowing of the distal vaginal lumen by the 'orgasmic platform' formation with its 'stopper-like action' could be maintained for 20-30 minutes. Couples who wish to conceive should thus best avoid having simultaneous orgasms and should be so advised, contrary to Brody & Weiss's promotion [6].

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