

Ejaculatory concerns that do not meet diagnostic criteria. It is necessary to identify males with normal ejaculatory latencies who desire longer ejaculatory latencies and males who have episodic premature (early) ejaculation (e.g., during the first sexual encounter with a new partner when a short ejaculatory latency may be common or normative). Neither of these situations would lead to a diagnosis of premature (early) ejaculation, even though these situations may be distressing to some males.

Comorbidity

Premature (early) ejaculation may be associated with erectile problems. In many cases, it may be difficult to determine which difficulty preceded the other. Lifelong premature (early) ejaculation may be associated with certain anxiety disorders. Acquired premature (early) ejaculation may be associated with prostatitis, thyroid disease, or drug withdrawal (e.g., during opioid withdrawal).

Substance/Medication-Induced Sexual Dysfunction

Diagnostic Criteria

- A. A clinically significant disturbance in sexual function is predominant in the clinical picture.
- B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):
 1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication.
 2. The involved substance/medication is capable of producing the symptoms in Criterion A.
- C. The disturbance is not better explained by a sexual dysfunction that is not substance/medication-induced. Such evidence of an independent sexual dysfunction could include the following:

The symptoms precede the onset of the substance/medication use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence suggesting the existence of an independent non-substance/medication-induced sexual dysfunction (e.g., a history of recurrent non-substance/medication-related episodes).

- D. The disturbance does not occur exclusively during the course of a delirium.
- E. The disturbance causes clinically significant distress in the individual.

Note: This diagnosis should be made instead of a diagnosis of substance intoxication or substance withdrawal only when the symptoms in Criterion A predominate in the clinical picture and are sufficiently severe to warrant clinical attention.

Coding note: The ICD-9-CM and ICD-10-CM codes for the [specific substance/medication]-induced sexual dysfunctions are indicated in the table below. Note that the ICD-10-CM code depends on whether or not there is a comorbid substance use disorder present for the same class of substance. If a mild substance use disorder is comorbid with the substance-induced sexual dysfunction, the 4th position character is "1," and the clinician should record "mild [substance] use disorder" before the substance-induced sexual dysfunction (e.g., "mild cocaine use disorder with cocaine-induced sexual dysfunction"). If a moderate or severe substance use disorder is comorbid with the substance-induced sexual dysfunction, the 4th position character is "2," and the clinician should record "moderate [substance] use disorder" or "severe [substance] use disorder," depending on the severity of the comorbid substance use disorder.

use disorder. If there is no comorbid substance use disorder (e.g., after a one-time heavy use of the substance), then the 4th position character is "9," and the clinician should record only the substance-induced sexual dysfunction.

	ICD-9-CM	ICD-10-CM		
		With use disorder, mild	With use disorder, moderate or severe	Without use disorder
Alcohol	291.89	F10.181	F10.281	F10.981
Opioid	292.89	F11.181	F11.281	F11.981
Sedative, hypnotic, or anxiolytic	292.89	F13.181	F13.281	F13.981
Amphetamine (or other stimulant)	292.89	F15.181	F15.281	F15.981
Cocaine	292.89	F14.181	F14.281	F14.981
Other (or unknown) substance	292.89	F19.181	F19.281	F19.981

Specify if (see Table 1 in the chapter "Substance-Related and Addictive Disorders" for diagnoses associated with substance class):

With onset during intoxication: If the criteria are met for intoxication with the substance and the symptoms develop during intoxication.

With onset during withdrawal: If criteria are met for withdrawal from the substance and the symptoms develop during, or shortly after, withdrawal.

With onset after medication use: Symptoms may appear either at initiation of medication or after a modification or change in use.

Specify current severity:

Mild: Occurs on 25%–50% of occasions of sexual activity.

Moderate: Occurs on 50%–75% of occasions of sexual activity.

Severe: Occurs on 75% or more of occasions of sexual activity.

Recording Procedures

ICD-9-CM. The name of the substance/medication-induced sexual dysfunction begins with the specific substance (e.g., alcohol, fluoxetine) that is presumed to be causing the sexual dysfunction. The diagnostic code is selected from the table included in the criteria set, which is based on the drug class. For substances that do not fit into any of the classes (e.g., fluoxetine), the code for "other substance" should be used; and in cases in which a substance is judged to be an etiological factor but the specific class of substance is unknown, the category "unknown substance" should be used.

The name of the disorder is followed by the specification of onset (i.e., onset during intoxication, onset during withdrawal, with onset after medication use), followed by the severity specifier (e.g., mild, moderate, severe). Unlike the recording procedures for ICD-10-CM, which combine the substance-induced disorder and substance use disorder into a single code, for ICD-9-CM a separate diagnostic code is given for the substance use disorder. For example, in the case of erectile dysfunction occurring during intoxication in a man with a severe alcohol use disorder, the diagnosis is 291.89 alcohol-induced sexual dysfunction, with onset during intoxication, moderate. An additional diagnosis of 303.90 severe alcohol use disorder is also given. When more than one substance is judged to play a sig-

nificant role in the development of the sexual dysfunction, each should be listed separately (e.g., 292.89 cocaine-induced sexual dysfunction with onset during intoxication, moderate; 292.89 fluoxetine-induced sexual dysfunction, with onset after medication use).

ICD-10-CM. The name of the substance/medication-induced sexual dysfunction begins with the specific substance (e.g., alcohol, fluoxetine) that is presumed to be causing the sexual dysfunction. The diagnostic code is selected from the table included in the criteria set, which is based on the drug class and presence or absence of a comorbid substance use disorder. For substances that do not fit into any of the classes (e.g., fluoxetine), the code for "other substance" should be used; and in cases in which a substance is judged to be an etiological factor but the specific class of substance is unknown, the category "unknown substance" should be used.

When recording the name of the disorder, the comorbid substance use disorder (if any) is listed first, followed by the word "with," followed by the name of the substance-induced sexual dysfunction, followed by the specification of onset (i.e., onset during intoxication, onset during withdrawal, with onset after medication use), followed by the severity specifier (e.g., mild, moderate, severe). For example, in the case of erectile dysfunction occurring during intoxication in a man with a severe alcohol use disorder, the diagnosis is F10.281 moderate alcohol use disorder with alcohol-induced sexual dysfunction, with onset during intoxication, moderate. A separate diagnosis of the comorbid severe alcohol use disorder is not given. If the substance-induced sexual dysfunction occurs without a comorbid substance use disorder (e.g., after a one-time heavy use of the substance), no accompanying substance use disorder is noted (e.g., F15.981 amphetamine-induced sexual dysfunction, with onset during intoxication). When more than one substance is judged to play a significant role in the development of the sexual dysfunction, each should be listed separately (e.g., F14.181 mild cocaine use disorder with cocaine-induced sexual dysfunction, with onset during intoxication, moderate; F19.981 fluoxetine-induced sexual dysfunction, with onset after medication use, moderate).

Diagnostic Features

The major feature is a disturbance in sexual function that has a temporal relationship with substance/medication initiation, dose increase, or substance/medication discontinuation.

Associated Features Supporting Diagnosis

Sexual dysfunctions can occur in association with intoxication with the following classes of substances: alcohol; opioids; sedatives, hypnotics, or anxiolytics; stimulants (including cocaine); and other (or unknown) substances. Sexual dysfunctions can occur in association with withdrawal from the following classes of substances: alcohol; opioids; sedatives, hypnotics, or anxiolytics; and other (or unknown) substances. Medications that can induce sexual dysfunctions include antidepressants, antipsychotics, and hormonal contraceptives.

The most commonly reported side effect of antidepressant drugs is difficulty with orgasm or ejaculation. Problems with desire and erection are less frequent. Approximately 30% of sexual complaints are clinically significant. Certain agents, such as bupropion and mirtazapine, appear not to be associated with sexual side effects.

The sexual problems associated with antipsychotic drugs, including problems with sexual desire, erection, lubrication, ejaculation, or orgasm, have occurred with typical as well as atypical agents. However, problems are less common with prolactin-sparing antipsychotics than with agents that cause significant prolactin elevation.

Although the effects of mood stabilizers on sexual function are unclear, it is possible that lithium and anticonvulsants, with the possible exception of lamotrigine, have adverse effects on sexual desire. Problems with orgasm may occur with gabapentin. Similarly, there may be a higher prevalence of erectile and orgasmic problems associated with benzodiazepines. There have not been such reports with buspirone.

Many nonpsychiatric medications, such as cardiovascular, cytotoxic, gastrointestinal, and hormonal agents, are associated with disturbances in sexual function. Illicit substance use is associated with decreased sexual desire, erectile dysfunction, and difficulty reaching orgasm. Sexual dysfunctions are also seen in individuals receiving methadone but are seldom reported by patients receiving buprenorphine. Chronic alcohol abuse and chronic nicotine abuse are associated with erectile problems.

Prevalence

The prevalence and the incidence of substance/medication-induced sexual dysfunction are unclear, likely because of underreporting of treatment-emergent sexual side effects. Data on substance/medication-induced sexual dysfunction typically concern the effects of antidepressant drugs. The prevalence of antidepressant-induced sexual dysfunction varies in part depending on the specific agent. Approximately 25%–80% of individuals taking monoamine oxidase inhibitors, tricyclic antidepressants, serotonergic antidepressants, and combined serotonergic-adrenergic antidepressants report sexual side effects. There are differences in the incidence of sexual side effects between some serotonergic and combined adrenergic-serotonergic antidepressants, although it is unclear if these differences are clinically significant.

Approximately 50% of individuals taking antipsychotic medications will experience adverse sexual side effects, including problems with sexual desire, erection, lubrication, ejaculation, or orgasm. The incidence of these side effects among different antipsychotic agents is unclear.

Exact prevalence and incidence of sexual dysfunctions among users of nonpsychiatric medications such as cardiovascular, cytotoxic, gastrointestinal, and hormonal agents are unknown. Elevated rates of sexual dysfunction have been reported with methadone or high-dose opioid drugs for pain. There are increased rates of decreased sexual desire, erectile dysfunction, and difficulty reaching orgasm associated with illicit substance use. The prevalence of sexual problems appears related to chronic drug abuse and appears higher in individuals who abuse heroin (approximately 60%–70%) than in individuals who abuse amphetamines or 3,4-methylenedioxymethamphetamine (i.e., MDMA, ecstasy). Elevated rates of sexual dysfunction are also seen in individuals receiving methadone but are seldom reported by patients receiving buprenorphine. Chronic alcohol abuse and chronic nicotine abuse are related to higher rates of erectile problems.

Development and Course

The onset of antidepressant-induced sexual dysfunction may be as early as 8 days after the agent is first taken. Approximately 30% of individuals with mild to moderate orgasm delay will experience spontaneous remission of the dysfunction within 6 months. In some cases, serotonin reuptake inhibitor-induced sexual dysfunction may persist after the agent is discontinued. The time to onset of sexual dysfunction after initiation of antipsychotic drugs or drugs of abuse is unknown. It is probable that the adverse effects of nicotine and alcohol may not appear until after years of use. Premature (early) ejaculation can sometimes occur after cessation of opioid use. There is some evidence that disturbances in sexual function related to substance/medication use increase with age.

Culture-Related Diagnostic Issues

There may be an interaction among cultural factors, the influence of medications on sexual functioning, and the response of the individual to those changes.

Gender-Related Diagnostic Issues

Some gender differences in sexual side effects may exist.

Functional Consequences of Substance/Medication-Induced Sexual Dysfunction

Medication-induced sexual dysfunction may result in medication noncompliance.

Differential Diagnosis

Non-substance/medication-induced sexual dysfunctions. Many mental conditions, such as depressive, bipolar, anxiety, and psychotic disorders, are associated with disturbances of sexual function. Thus, differentiating a substance/medication-induced sexual dysfunction from a manifestation of the underlying mental disorder can be quite difficult. The diagnosis is usually established if a close relationship between substance/medication initiation or discontinuation is observed. A clear diagnosis can be established if the problem occurs after substance/medication initiation, dissipates with substance/medication discontinuation, and recurs with introduction of the same agent. Most substance/medication-induced side effects occur shortly after initiation or discontinuation. Sexual side effects that only occur after chronic use of a substance/medication may be extremely difficult to diagnose with certainty.

Other Specified Sexual Dysfunction

302.79 (F52.8)

This category applies to presentations in which symptoms characteristic of a sexual dysfunction that cause clinically significant distress in the individual predominate but do not meet the full criteria for any of the disorders in the sexual dysfunctions diagnostic class. The other specified sexual dysfunction category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific sexual dysfunction. This is done by recording "other specified sexual dysfunction" followed by the specific reason (e.g., "sexual aversion").

Unspecified Sexual Dysfunction

302.70 (F52.9)

This category applies to presentations in which symptoms characteristic of a sexual dysfunction that cause clinically significant distress in the individual predominate but do not meet the full criteria for any of the disorders in the sexual dysfunctions diagnostic class. The unspecified sexual dysfunction category is used in situations in which the clinician chooses *not* to specify the reason that the criteria are not met for a specific sexual dysfunction, and includes presentations for which there is insufficient information to make a more specific diagnosis.
