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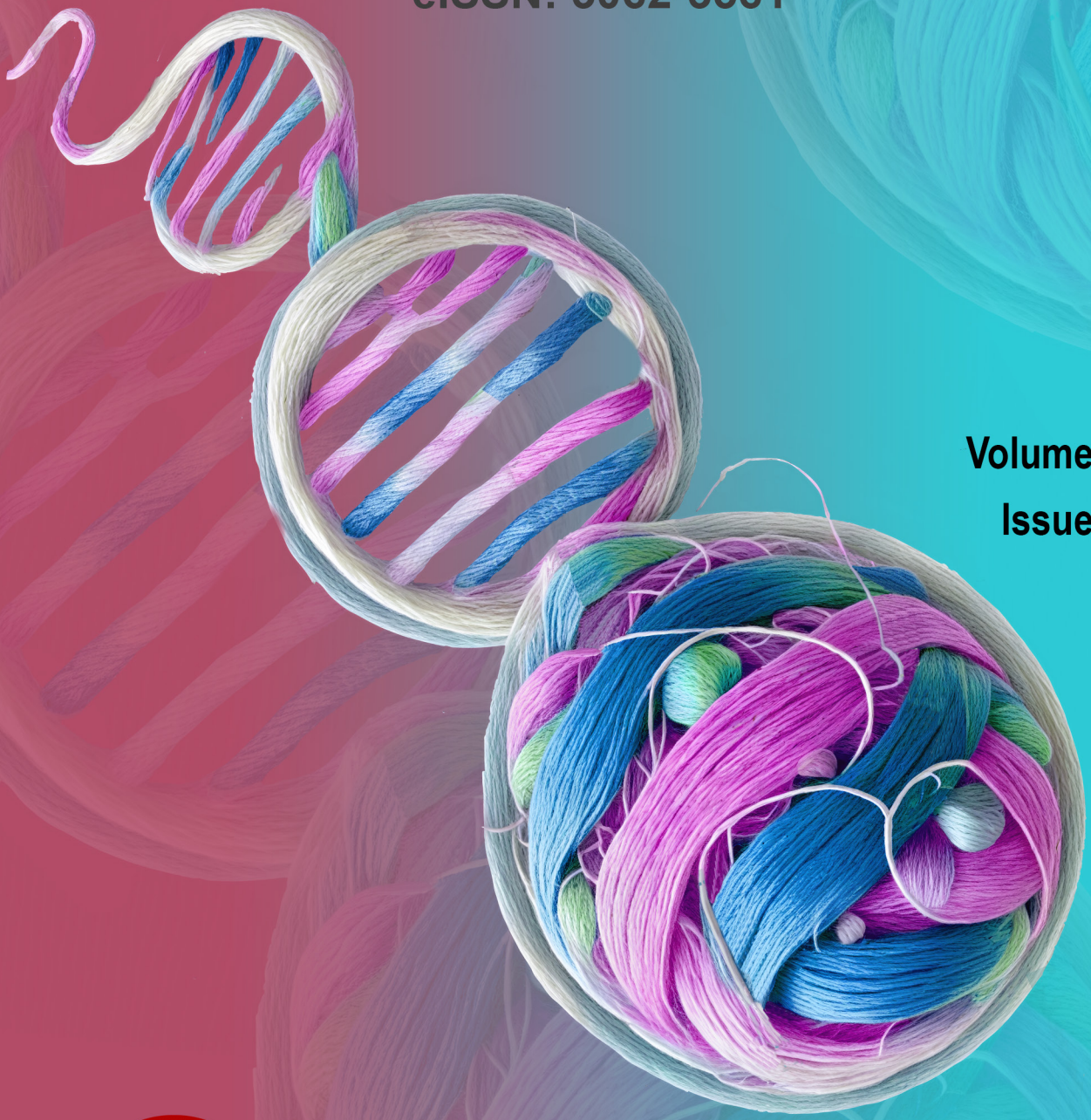

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CONTENT

ORIGINAL ARTICLES

REVIEW ARTICLES

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International Journal of SEXUAL SCIENCE

ORIGINAL ARTICLE

Effects of Using Uterine Manipulator on Vaginal Length After Abdominal Hysterectomy: A Prospective Randomized Study

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Abstract

Objective: This study aims to research the effects of the uterine manipulator on operation time, complications, and postoperative vaginal length in abdominal hysterectomies.

Materials and Methods: Eighty-five women underwent abdominal hysterectomy and were randomized into two groups: a study group using a uterine manipulator (n=35) and a control group (n=50). The study recorded demographic characteristics, indications for hysterectomy, intraoperative blood loss, changes in postoperative hemoglobin, and postoperative vaginal lengths. Vaginal length was measured preoperatively and on the first postoperative day. The primary outcome, the effect of uterine manipulator usage on vaginal length, was analyzed using a Student's t-test.. Pearson's correlation test was used to evaluate the correlation between intraoperative blood loss and postoperative vaginal length. P values < 0,05 were considered significant.

Results: No significant differences were found between the groups regarding demographic data and hysterectomy indications. Postoperative vaginal length change was statistically less in the study group than in the control group (p<0,001). We also observed that less intraoperative blood loss was associated with less shortening of postoperative vaginal length (p<0,001). Intraoperative blood loss was significantly less in the study group compared to the control group (study group: 347±169 ml; control group: 439±150 ml; p=0,010). There was no significant difference in operation time between the groups (p=0.178), and no correlation was found between postoperative vaginal length and BMI.

Conclusion: The result of this study indicated that using a uterine manipulator in abdominal hysterectomy might be preferable due to better postoperative vaginal length and less intraoperative blood loss.

Keywords: vaginal length, hysterectomy, uterine manipulator

INTRODUCTION

Hysterectomy, described as the extirpation of the uterine corpus with or without cervix, is the most common gynecological operation in the world (1-3).

Despite reduced hysterectomy for benign indications, about 600,000 women undergo hysterectomy per year in the United States (4-5).

The benign indications are uterine leiomyoma, abnormal uterine bleeding, endometriosis, and uterine prolapse, and the malignant indication is the internal genital tract malignancies (4-7). Attendant bilateral salpingo oophorectomy is realized in about 50 % of all hysterectomies (8-10). Hysterectomy is performed by different routes and their combinations: vaginal, abdominal, and minimally invasive techniques

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(laparoscopy, robotic surgery). Hysterectomy for benign indications has conventionally been applied by abdominal and vaginal approaches, which are most common in developed countries (1,4,11).

Vaginal shortening is frequently observed following hysterectomies, particularly those performed via the abdominal approach. A decrease in vaginal length after hysterectomy is commonly associated with sexual dysfunction, particularly dyspareunia (12,13).

Abdominal hysterectomy is performed in the presence of a large abdominopelvic organ or severe adhesion. This route allows the abdominopelvic organs to be best observed and manipulated. However, it is the most common approach to see hemorrhage, infection, and genitourinary tract injury (1,5). These complications are reduced by using the manipulator in laparoscopic hysterectomy (13). In addition, the uterus is elevated and removed from the uterocervical junction so that the vaginal tissue is preserved (14-16).

While there are many known benefits of abdominal hysterectomy, it is uncertain how the route of operation affects vaginal length. To our knowledge, this is the first study that defines a new technique of abdominal hysterectomy using RUMI II uterine manipulator and analyzes the vaginal length changes and surgical outcomes of the first 85 cases.

MATERIALS AND METHODS

Eighty-five women who applied to the University of Health Sciences, Bursa Yuksek İhtisas Training and Research Hospital between September 2015 and September 2017, and underwent abdominal hysterectomy for benign indications, which are abnormal uterine bleeding, leiomyoma, endometrial hyperplasia without atypia, postmenopausal bleeding, endometrial polyps, and adnexal masses, were included in the study. The exclusion criteria are high suspicion or diagnosed malignancy of the genital tract. All operations were conducted by a consistent surgical team consisting of three surgeons.

All patients were randomized into two groups: a study group in which a uterine manipulator is used during the operation (n = 35) and a control group (n = 50). Demographic characteristics (age, parity, BMI, and surgical information), indications of hysterectomy, preoperative and postoperative vaginal lengths, intraoperative blood loss, and changes in postoperative hemoglobin values of all patients included in the study were recorded.

The vaginal length of each patient was measured preoperatively and on the first postoperative day by the same clinician. Cervix to hymen (1. distance), anterior fornix to hymen (2. distance), and posterior fornix to hymen (3. distance) are measured preoperatively and postoperatively. We calculated the difference between preoperative and postoperative measurements.

In the study group, operation time was calculated from the beginning to place the manipulator into the vagina until the skin was sutured. Calculation was made from skin to skin in the control group.

The study was approved by the Bursa Yüksek İhtisas Training and Research Hospital clinical research ethics committee (Approval No: 2011-KAEK-25 2015/22-16, Date: 2015-12-02).

Statistical Analysis

All analyses were performed using the Statistical Package for the Social Sciences Software, version 18.0 (SPSS Inc., Chicago, USA). The normality of the data was tested using the Kolmogorov-Smirnov test, and all continuous variables showed normal distribution ($p>0.05$). Continuous variables were presented as mean ± standard deviation (SD) or median (minimum-maximum). The differences between groups were assessed by using Student's t-test or the Mann-Whitney U test. Correlations between variables were evaluated with Pearson's or Spearman's correlation coefficient test. Significance was defined as $p < 0.05$.

RESULTS

Some of the demographic data for the patients are summarized in Table 1, and there were no significant differences between the study group and the control group in terms of demographic data and hysterectomy indications ($p > 0.05$).

Postoperative vaginal length changes were found to be statistically less in the study group than in the control group ($p < 0.001$) (Table 2). The difference between preoperative and postoperative vaginal lengths was found to be statistically less in the study group than in

the control group ($p < 0.001$) (Table 3). It was also found that the intraoperative blood loss in the study group was less than in the control group. (Study group: 347 ± 169 ml; control group: 439 ± 150 ml; $p = 0.010$). There was no significant difference between the study group and the control group in terms of the operation time (study group: 74 ± 17 min; control group: 80 ± 23 min; $p = 0.178$) (Table 4).

DISCUSSION

Women who undergo hysterectomy indicate a postoperative decrease in vaginal length that is reduced by a non-clinically significant amount. In this study, we investigated the effects of the uterine manipulator on operation time, complications, and postoperative vaginal length during abdominal hysterectomies. Postoperative vaginal length changes were found to be statistically shorter in the manipulator group than

Table 1. Some Demographic Data of The Study Population in Both Groups

	Manipulator Group (n = 35)		Control Group (n = 50)		P
	Mean ± SD	Min-Max	Mean ± SD	Min-Max	
Age (year)	49.8 ± 7.9	42-82	48.6 ± 7.1	40-65	0.452
BMI (kg/cm^2)*	31.2 ± 5.4	21-44	29.0 ± 7.4	19-53	0.143
Gravida	3.6 ± 1.6	2-8	3.9 ± 2.6	0-12	0.582
Para	3.2 ± 1.3	2-8	3.4 ± 2.4	0-12	0.707
Uterine length	8.2 ± 2.9	5-19	8.6 ± 3.4	3.6-25	0.656
Uterine anteroposterior diameter	5.4 ± 2.6	3-16	5.3 ± 2.3	1.5-14	0.843

*BMI: body mass index. Uterine size measured in centimeters.

Table 2. Comparison of Postoperative Vaginal Length Changes For All Patients

	Manipulator Group (n=35)	Control Group (n=50)	p
	Mean ± SD	Mean ± SD	
1. Distance (mm)*	81 ± 7	70 ± 8	<0.001
2. Distance (mm)#	81 ± 9	71 ± 7	<0.001
3. Distance (mm)+	92 ± 9	80 ± 8	<0.001

*1. distance: Cervix to hymen; #2. distance: anterior fornix to hymen; +3. distance: posterior fornix to hymen (mm: millimeter).

Table 3. Comparison of Differences Between Preoperative and Postoperative Vaginal Length in Both Groups

	Manipulator Group (n=35)	Control Group (n=50)	P
	Mean ± SD	Mean ± SD	
A distance (mm)*	-2 ± 6	-1 ± 8	0.631
B distance (mm)#	3 ± 2	8 ± 5	<0.001
C distance (mm)+	3 ± 2	13 ± 7	<0.001

*A distance: differences between preop and postop 1. distance. #B distance: differences between preop and postop 2. distance. +C distance: differences between preop and postop 3. distance. (mm: millimeter)

Table 4. Comparison of Intraoperative Blood Loss, Changes in Postoperative Hemoglobin Values, and Operation Time in Both Groups

	Manipulator Group (n=35)		Control Group (n=50)		P
	Mean ± SD	Min-Max	Mean ± SD	Min-Max	
Changes in postoperative hemoglobin values (g/dl)	1.17 ± 0.6	0.1-2.4	1.2 ± 0.7	0.2-3.9	0.483
Intraoperative blood loss (ml)	347 ± 169	100-860	439 ± 150	200-730	0.010
Operation time (min)	74 ± 17	35-120	80 ± 23	60-135	0.178

Intraoperative blood loss is measured in milliliters. Operation time is measured in minutes. (ml: milliliter, min: minute)

in the control group. We analyzed that intraoperative blood loss was lower in patients with less shortening of postoperative vaginal length. It was also obtained that the intraoperative blood loss in the manipulator group was less than in the control group. There was no significant difference between the groups regarding operation time. Several factors may explain why this difference did not reach statistical significance.

One possible reason is the relatively small sample size of the study population.

Another contributing factor could be that, although fewer clamps were used in surgeries involving the manipulator, the process of inserting and positioning the device may have prolonged the operation time.

Many factors affect vaginal length; age, race, menopausal status, gravida, para, weight, height, and type of surgery performed are just some of them. Tan et al. (17) quantitatively evaluated the association between these variables and total vaginal length, reporting that it was significantly shorter after pelvic reconstructive surgery compared to hysterectomy, with no significant difference between abdominal and vaginal hysterectomy procedures. In a randomized study comparing the effects of vaginal cuff closure techniques on vaginal length during vaginal hysterectomy, preoperative lengths were similar between groups; however, postoperative measurements were significantly shorter in the horizontal closure group compared to the vertical closure group (18). Similarly, a meta-analysis of randomized trials concluded that horizontal vaginal vault closure results in a significantly shorter postoperative vaginal length in vaginal hysterectomies (19).

Several studies have compared vaginal length across different hysterectomy routes (13–20). However, to the best of our knowledge, no study has compared using a manipulator during abdominal hysterectomy. Ercan et al. (12) evaluated vaginal length and sexual function after vaginal, total abdominal, and total laparoscopic hysterectomy. They found significantly shorter vaginal lengths in the vaginal hysterectomy group compared to the laparoscopic group.

De la Cruz et al. (21) demonstrated that total vaginal length was significantly longer following robotic hysterectomy than vaginal hysterectomy. At the same time, Chen et al. (22) showed that abdominal hysterectomy yielded significantly longer postoperative vaginal lengths compared to the vaginal approach. Polat et al. (13) compared laparoscopic and abdominal hysterectomy in terms of postoperative vaginal length, dyspareunia, and lower urinary tract function. Their findings indicated that vaginal length was significantly longer after laparoscopic hysterectomy, with no significant differences observed in dyspareunia or urinary tract outcomes.

CONCLUSION

In conclusion, hysterectomy results in a reduction in vaginal length regardless of the surgical route. To our knowledge, this is the first study to introduce a modified abdominal hysterectomy technique using the RUMI II uterine manipulator, which appears to influence postoperative vaginal length positively. However, the clinical significance of this finding remains unclear. We speculate that this effect may be attributable to reduced cardinal ligament dissection, similar to the approach used in laparoscopic hysterectomy. To confirm this hypothesis and determine its implications for sexual function, future large-scale prospective randomized controlled trials are needed.

In the present study, no ureteral or bladder complications were observed in either group. We believe that with a larger sample size, the potential benefits of using a uterine manipulator in abdominal hysterectomy—including improved vaginal length preservation—may become more evident. Additionally, in cases with severe pelvic adhesions due to conditions such as abscess or endometriosis, the use of a manipulator may help reduce ureteral and bladder injury risk.

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Conflict of Interest: We have no conflicts of interest to declare regarding the design, conduct, or publication of this study.

Informed Consent: All participants provided written informed consent prior to inclusion in the study.

Ethical Approval: The study was approved by the Bursa Yüksek İhtisas Training and Research Hospital clinical research ethics committee (Approval No: 2011-KAEK-25 2015/22-16).

Author Contributions: Concept and Design: Merve Olgun, Emin Üstünyurt; Supervision: Emin Üstünyurt; Data Collection and/or Processing: Merve Olgun; Materials: Merve Olgun; Analysis and/or Interpretation: Merve Olgun, Emin Üstünyurt; Literature Search: Merve Olgun; Writing and Critical Review: Merve Olgun, Emin Üstünyurt.

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ORIGINAL ARTICLE

What is the Most Dangerous Sexual Position that Causes Penile Urethra Fracture?

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Abstract

Objective: Penile fracture (PF) is a rare urological emergency typically resulting from blunt trauma to an erect penis. While sexual intercourse is the most common etiology, the impact of specific sexual positions on injury severity remains underexplored. This study aims to evaluate the relationship between sexual position and the severity of penile fracture, with a focus on corpus cavernosum rupture and associated urethral injury.

Materials and Methods: A retrospective analysis was conducted on 252 patients diagnosed with PF between January 2009 and July 2024. Epidemiological data, trauma mechanisms, clinical presentation, and surgical findings were assessed. Patients were categorized based on sexual position at the time of injury: "man-on-top," "woman-on-top," and "doggy style." Severe PF was defined as bilateral corpus cavernosum rupture with or without urethral injury.

Results: The mean age of patients was 35 years. Sexual intercourse accounted for 75.5% of PF cases. Among sexual positions, "doggy style" (41%) and "man-on-top" (25.5%) were most frequently associated with PF, and also with higher rates of severe injury. Complete urethral rupture occurred only in cases with bilateral corpus cavernosum rupture. Statistical analysis revealed a significantly higher incidence of severe injuries in the "doggy style" and "man-on-top" positions compared to "woman-on-top" or penile manipulation.

Conclusions: Sexual activity is the leading cause of PF, and certain positions, particularly "doggy style" and "man-on-top," are significantly associated with more severe injuries. Awareness of these patterns may assist clinicians in anticipating complex trauma during evaluation and surgical planning.

Keywords: penile fracture, sexual position, doggy style, man-on-top, woman-on-top

INTRODUCTION

Penile fracture (PF) is a rare urological emergency characterized by tearing of the tunica albuginea resulting from blunt trauma to the erect penis(1,2). Both sexual and non-sexual activities can cause PF. The most common causes are sexual intercourse and masturbation. Non-sexual causes include lying on the erect penis, forcibly bending the penis, and hiding it in clothing, or deliberately reducing the bulge by forcibly bending it (thagaandan) (3).

The clinical presentation of PF is usually classic and easily recognized. Patients often report a sudden crackling sound, followed by acute pain, sudden loss of erection, and subsequent swelling and hematoma formation. (4). In cases where the urethra is also injured, which occurs in approximately 1–38% of patients, additional symptoms such as urethral bleeding, hematuria, and evacuation difficulties may be present (5,6).

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Given the typical clinical features, diagnosis is primarily clinical and often does not require imaging. However, in uncertain cases, imaging modalities such as penile ultrasound and magnetic resonance imaging (MRI) have proven useful in confirming the diagnosis. Prompt surgical intervention to repair the tunica albuginea rupture is recommended to minimize the risk of long-term complications (7).

Although numerous studies have addressed the causes and treatment approaches of PF, the effect of sexual position on the severity of injury has not been extensively investigated. (8). Our study aimed to evaluate the severity of injury to the corpora cavernosa and its relationship with urethral injury. We hypothesized that sexual position during trauma may affect the severity of injury. To investigate this hypothesis, we analyzed the epidemiological data, clinical findings, trauma mechanisms, and surgery-related outcomes associated with sexual positions in 252 patients diagnosed with penile fracture at our clinic.

MATERIALS AND METHODS

This retrospective study protocol for this study was approved by Ethics Committee of Tepecik Research and Education Hospital's (Date: 10/04/2025, Decision No: 20235/03-05), and all procedures adhered to the ethical standards established by our institution's human experimentation guidelines.

The data of 252 patients who underwent surgical repair of PF were retrospectively reviewed, who presented to our institution between 2009 and 2024. As the largest urologic emergency center in İzmir, a metropolitan area with over five million residents, our facility is staffed by five urologists. For each case, a standardized protocol form was completed at admission, and medical records were thoroughly examined to gather data on epidemiology, medical history, clinical symptoms, cause, and surgical observations.

The primary method of diagnosis relied on the patient's clinical history and physical findings. Penile ultrasonography was employed only when there was diagnostic uncertainty. In cases where urethral trauma was suspected, suggested by symptoms such as blood at the urethral meatus, visible hematuria, or retention in urination, retrograde urethrography was utilized. The severity of a penile fracture is defined only by bilateral corpus cavernosum rupture, as there is no objective scoring system.

Our study also evaluated the mechanism of injury and the sexual position at the time of injury. Patients were asked to provide information about their sexual position and the surrounding area at the time of their penile fracture (PFR). Patients were divided into three groups based on sexual position: Group 1: Male-on-top, Group 2: Female-on-top, and Group 3: Doggystyle. Twenty-five patients who declined to provide information about the mechanism of injury, who were injured outside of a sexual position, or who had incomplete data were excluded from the analysis.

Our surgical technique involves a circular midshaft incision with degloving of the penile shaft. This is followed by repair of the tunica albuginea using simple interrupted 3-0 polyglactin sutures. In cases of urethral injury, repair was accomplished with simple interrupted 5-0 polyglactin sutures placed over a Foley catheter. Bilateral rupture of the corpus cavernosum was classified as a severe injury.

It was investigated which sexual intercourse positions were associated with urethral injuries, penile fractures, and other injuries that were considered serious.

Statistical Analysis

Statistical analyses were conducted using SPSS software (version 23.0; SPSS Inc., Chicago, IL, USA). The normality of continuous variables was assessed using the Shapiro-Wilk test. Descriptive statistics were presented as mean ± standard deviation for normally distributed variables, and as median (interquartile range) for non-normally distributed data.

For univariate comparisons, categorical variables were analyzed using the chi-squared (χ^2) test or Fisher's exact test, as appropriate. Continuous variables were compared using the Student's t-test or the Mann-Whitney U test, based on the distribution. A significance level was set at $p < 0.05$.

To identify independent predictors of severe penile fracture (defined as bilateral corpus cavernosum rupture with or without urethral injury), a multivariate logistic regression analysis was performed. Variables with $p < 0.1$ in univariate analyses (e.g., age, time to

presentation, sexual position) were included in the regression model. Results were reported as odds ratios (ORs) with 95% confidence intervals (CIs), and statistical significance was set at $p < 0.05$.

RESULTS

A retrospective study was conducted on 252 patients aged 18 to 74 years with a mean age of 35. The time from injury to hospital admission ranged from 1 hour to 15 days, with a mean delay of 28 hours.

The most common clinical finding was penile hematoma, present in all patients (100%), followed by penile detumescence in 82.3%, clicking sound in 80.1%, pain in 65.1%, urethral bleeding in 10.8%, and acute urinary retention in 1.88%. All patients presenting with blood at the urethral meatus or urinary retention were found to have urethral injury.

Although the diagnosis was primarily based on clinical history and physical examination, penile ultrasonography was used in 16 cases (17.7%) where the findings were inconclusive. Additionally, five patients (5.5%) suspected of having urethral trauma underwent retrograde urethrography. A definitive diagnosis was made in all cases.

Sexual position at the time of injury, the Group 3 position was reported in 85 cases (34%), followed by group 1 in 64 cases (26%), and group 2 in 103 cases (41%). Most patients (n = 249) identified as heterosexual; all 249 patients whose injuries occurred during intercourse reported vaginal penetration. Among the heterosexual group, the distribution of sexual position was as follows: Group 3 in 82 cases (32,9%), Group 1 in 64 cases (25,7%), and Group 2 in 103 cases (41,3%) three patients identified as homosexual; all sustained injuries in the Group 3 position.

The fracture was most commonly located in the mid-shaft, occurring in 214 cases (85%), while 38 cases (15%) involved the penoscrotal junction. The most frequent injury was unilateral corpus cavernosum (CC) damage, observed in 197 patients (78%). Bilateral CC rupture was seen in 55 patients (22%), with 28 occurring during the Group 3 position, 16 during the Group 1, and 11 during the Group 2 position. In 31 patients (12.3%), bilateral CC rupture was accompanied by urethral injury, and unilateral CC injury with urethral involvement was found in 8 cases (3.2%), with an equal distribution between the Group 3 and Group 1 positions.

Complete urethral rupture was found exclusively in cases of bilateral CC rupture.

Statistical analysis showed no significant difference in PF severity between the Group 3 and Group 1 positions ($p = 0.95$). However, the Group 3 position was associated with more severe PF than the Group 2 position ($p = 0.03$). Similarly, the Group 1 position resulted in more severe injuries than the Group 2 position ($p = 0.005$).

Chi-squared test showed a significant association between sexual position and bilateral CC + urethral injury ($p < 0.001$).

Multivariate logistic regression analysis was performed to identify independent predictors of severe penile fracture, defined as bilateral corpus cavernosum rupture with or without urethral injury. Age over 40 years (OR = 1.82, 95% CI: 1.01–3.29, $p = 0.048$), delayed hospital admission over 6 hours (OR = 2.25, 95% CI: 1.13–4.47, $p = 0.021$), and sexual position during trauma were independently associated with severe injury. Specifically, the doggystyle position (Group 3) was strongly associated with severe PF (OR = 3.75, 95% CI: 1.89–7.41, $p < 0.001$), followed by the Male-on-top

Table 1. Relationship between sexual position and the type of penile lesion identified during surgical exploration

Sexual position, n (%)	One-sided CC lesion, n (%)	Double-sided CC lesion, n (%)	One-sided CC lesion + urethra, n (%)	Double-sided CC lesion + urethra, n (%)
Male-on-top (64, 26.0%)	45 (70.3%)	6 (9.4%)	3 (4.7%)	10 (15.6%)
Female-on-top (103, 41.0%)	90 (87.4%)	2 (1.9%)	2 (1.9%)	9 (8.7%)
Doggy style (85, 33.0%)	54 (63.5%)	16 (18.8%)	3 (3.5%)	12 (14.1%)
Total (252, 100.0%)	**189 (75.0%)**	**24 (9.5%)**	**8 (3.2%)**	**31 (12.3%)**

CC = corpus cavernosum

Table 2. Multivariate logistic regression analysis of predictors of severe penile fracture

Predictor	Odds Ratio (OR)	95% Confidence Interval	p
Age > 40 years	1.82	1.01 – 3.29	0.048
Time to admission > 6 hours	2.25	1.13 – 4.47	0.021
Group 1 (Male-on-top)	2.14	1.02 – 4.48	0.043
Group 3 (doggystyle)	3.75	1.89 – 7.41	<0.001
Group 2 (Female-on-top)	Reference	—	—

position (Group 1) (OR = 2.14, 95% CI: 1.02–4.48, p = 0.043), compared to the Female-on-top position (Group 2), which was used as the reference category.

DISCUSSION

Although penile fracture (PF) is a rare urological emergency, its true incidence may be underreported due to patients' reluctance to seek immediate medical attention, often due to embarrassment. This, combined with the fact that our hospital functions as a referral center receiving patients from various regions, sometimes over considerable distances, likely contributed to the observed delay between the trauma and hospital admission, which ranged from 2 hours to 3 weeks (9).

The etiology of PF varies by region. While sexual intercourse remains the predominant cause in Western countries, studies from Eastern countries frequently report penile manipulation as a common mechanism, particularly through a practice known as "thagaandan." In this technique, individuals forcibly bend the erect penis in an attempt to induce detumescence. Such practices are thought to stem from a lack of understanding of penile anatomy, where some individuals believe the penis contains bone or cartilage and attempt to "snap" it like fingers. One study from Iran by Zulfiqar, M. et al. (10) reported that 76.4% of PF cases were related to this practice. In our study, approximately 75.5% of penile fractures were due to sexual intercourse. Other mechanisms reported in the literature include masturbation, accidental trauma, and turning in bed during nocturnal erections.

Urethral involvement in PF also varies geographically. While studies from the Persian Gulf report urethral injuries in only 3% of PF cases, likely due to the high prevalence of manipulation-related injuries, rates are significantly higher in Western countries, reaching 20–38% (11). For instance, Katusta J. et al. (12) observed urethral trauma in just 2 of 86 patients, where over half of the injuries were manipulation-induced. In our study, urethral injuries were documented in 14 patients (15.5%), consistent with the predominance of sexual intercourse (over 75%) as the causative factor. Moreover, bilateral corpus cavernosum (CC) rupture was observed in 21 patients (23.3%), and all cases of complete urethral rupture were associated with bilateral CC injuries. These findings suggest that high-energy sexual trauma common during intercourse may account for the greater severity of injuries.

Some positions during intercourse may predispose individuals to more severe forms of PF. Particularly vigorous activity, especially in dominant male positions, can lead to high-impact injuries if the penis slips and strikes the perineum or pubic bone. While some studies, such as the one by Barros et al. (13), implicated the "Female-on-top" position as particularly risky due to the female partner potentially landing on the erect penis, no anatomical correlation with injury severity was provided.

In contrast, our study identified Group 3 (41%) and Group 1 (25.5%) as the most frequent sexual positions associated with PF. The "Female-on-top" position accounted for only 10% of cases. The reasons for this distribution are unclear, but the high rate of severe injury in dominant male positions may be attributed to more forceful thrusting and decreased control during intercourse.

Notably, of the 23 cases of severe PF (defined as bilateral CC rupture with or without urethral injury), over half were related to the Group 3 position. This was followed by "Male-on-top," while "Female-on-top" was not significantly associated with severe injury in our cohort.

Although other studies have documented the prevalence of sexual intercourse as a major cause of PF, few have examined the relationship between specific sexual positions and injury severity. Suzuki, S. et al. (14) found that the "Female-on-top" position was involved in 13 out of 21 PF cases, but did not relate this to anatomical damage. Similarly, Kasaraneni, P. et al. (15) reported 8 of 11 intercourse-related PF cases occurring in the "Female-on-top" position but also failed to correlate position with severity. A recent meta-analysis concluded that sexual position had no significant effect on the relative risk of PF (16). However, our findings contrast with this, suggesting a strong association between certain positions, particularly Group 3 and Group 1, and complex PF presentations.

Therefore, when patients report these positions as the cause of injury, clinicians should have a higher index of suspicion for severe PF, including bilateral CC and urethral involvement.

The primary limitations of our study include its retrospective design and the unequal distribution of cases across the six etiological categories, which may have influenced statistical comparisons.

These results may be supported by multicentric and prospective studies in the future.

Furthermore, multivariate logistic regression analysis confirmed that doggystyle and male-on-top positions were independent predictors of severe penile fracture, highlighting the clinical importance of sexual mechanics in injury assessment.

Limitations

This study has several limitations. First, the long study period (2009–2024) may have introduced temporal bias due to potential changes in clinical practice, diagnostic criteria, and treatment approaches over time. Although efforts were made to maintain consistency in protocols, such changes may have influenced the findings. Second, the retrospective design inherently carries risks of selection bias, missing data, and unmeasured confounding factors, which may affect the interpretation of the results.

CONCLUSION

This study identified sexual activity, especially penetrative intercourse, as the predominant cause of penile fracture. Among the various sexual positions, the Group 1 and Group 3 positions were most frequently associated with these injuries. Notably, these positions were more commonly linked to severe cases involving bilateral corpus cavernosum rupture and concurrent urethral injuries.

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ORIGINAL ARTICLE

Hypnotherapeutic KARAV Algorithm in Vaginismus Treatment: A Retrospective Evaluation of a Novel Therapeutic Approach

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Abstract

Objective: To evaluate the clinical efficacy of a one-day, four-session KARAV hypnotherapy algorithm in women with primary vaginismus.

Materials and Methods: In this retrospective, multicenter cohort study, 101 women aged 21–45 years meeting DSM-5 criteria for lifelong vaginismus underwent four sequential 60–75-minute hypnotherapy sessions in a single day. The KARAV protocol integrated psychoeducation, arranged sequential inductions (Dave Elman, hand-drop, parts therapy), regression, hypnodrama, and associative reframing, interspersed with partner-assisted auto-hypnosis and graded exposure exercises. Primary outcome was achievement of pain-free vaginal penetration on treatment day. Secondary outcomes included pre- to post-intervention changes in Female Sexual Function Index (FSFI) subscales (desire, arousal, lubrication, orgasm, satisfaction, pain), Beck Depression Inventory (BDI), State-Trait Anxiety Inventory (STAI), patient satisfaction (0–10 visual analog scale), and three-month relapse rate. Paired *t*-tests and chi-square analyses were used; significance was set at $p < 0.05$.

Results: All participants (100 %) achieved pain-free penetration on Day 0. Mean FSFI total score increased from 16.5 ± 4.3 to 27.3 ± 6.3 ($p < 0.001$). Significant improvements were observed in FSFI subdomains of desire, arousal, orgasm, and satisfaction (all $p < 0.0001$). Mean BDI decreased from 19.7 ± 9.3 to 11.0 ± 6.6 and STAI from 49.6 ± 5.1 to 10.5 ± 7.4 ($p < 0.001$ for both). Patient satisfaction averaged 8.5 ± 1.0, and relapse at three months was 4 %.

Conclusion: The KARAV algorithm delivers rapid, robust, and durable remission of vaginismus symptoms in a single day, offering a time-efficient, highly acceptable intervention for primary vaginismus.

Keywords: female sexual dysfunction, hypnotherapy, vaginismus

INTRODUCTION

Vaginismus is regarded as one of the most challenging and treatment-resistant forms of female sexual dysfunction. Classified under "Genito-pelvic pain / penetration disorder" in the DSM-5, it is characterized by involuntary pelvic-floor muscle contractions, intense anxiety, fear, and pain upon attempted vaginal penetration (1). Its etiology reflects a complex interplay of psychological, physiological, and cultural factors, including early sexual trauma, erroneous sociocultural beliefs, and family dynamics (2). Epidemiological studies in Türkiye have reported that approximately 10% of women experience vaginismus-like symptoms at some point in their lives (3). This disorder directly impairs

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both individual quality of life and couple adjustment; feelings of shame, inadequacy, and perceived failure may erode the emotional bond between partners (4).

Conventional treatments include cognitive-behavioral therapy (CBT), pelvic-floor physiotherapy, graduated dilator exercises, and pharmacotherapy. However, these approaches typically require prolonged, multi-week interventions, suffer from low patient adherence, and exhibit high relapse rates (5). In recent years, hypnotherapy has emerged as a promising alternative due to its brief session format and high patient engagement (6). Clinical hypnosis bypasses the critical barriers of the conscious mind, targeting negative self-talk and traumatic subconscious imprints. Yapko has argued that hypnotherapy rapidly transforms maladaptive beliefs at the subconscious level, thereby reducing anxiety and accelerating behavioral change (7).

Although reported success rates for hypnotherapy vary between 60% and 100%, protocols remain highly heterogeneous. For instance, Tastan et al. compared hypnotherapy with CBT in a single-center trial and found that the hypnotherapy group achieved comparable outcomes in fewer sessions (8). In a dilator-based hypnotherapy comparison, Aslan et al. observed lower dropout rates and significantly higher FSFI scores in the dilator group (9). Nevertheless, multicenter data on a structured, multimodal hypnotherapy algorithm are scarce.

To address this gap, we developed the KARAV Hypnotherapy Algorithm a compressed, one-day, four-session protocol integrating (1) Knowledge-Assisted psychoeducation, (2) Arranged sequential sessions, (3) Regression-focused therapy, (4) Associative reframing, and (5) Vignette-focused case work. Previous retrospective and comparative studies have demonstrated that multimodal hypnotherapy approaches positively influence both individual and dyadic sexual satisfaction, as well as anxiety and depression scores (10).

In this multicenter study, we evaluate the one-day multimodal efficacy of the KARAV algorithm in 101 women diagnosed with primary vaginismus. The primary endpoint is achieving pain-free vaginal penetration on Day 0; secondary endpoints include changes in FSFI subscales (desire, arousal, lubrication, orgasm, satisfaction, pain), depression (BDI), anxiety (STAI), and patient satisfaction (VAS). Our aim is to scientifically substantiate the clinical advantages of the KARAV algorithm in terms of rapidity, efficacy, and patient adherence.

MATERIALS AND METHODS

This prospective, multicenter cohort study was conducted between January 1, 2018, and December 31, 2024, at GETAT Centers and affiliated private clinics. We enrolled 101 women (aged 21–45 years) presenting with vaginismus who fulfilled DSM-5 criteria for primary vaginismus. Inclusion criteria were: age 21–45 years, no prior experience of penetrative intercourse, and written informed consent. Exclusion criteria comprised active psychiatric pathology, pregnancy, or any medical contraindication to hypnosis. Ethical approval was obtained from each center's institutional review board, and all participants provided written informed consent. The study was approved by the Dicle University Medical Faculty Ethics Committee for Non-interventional Studies (Approval No: 03/07/2025-237). And adhered to The principles of the Declaration of Helsinki.

Data Collection

Demographic and Clinical Variables: Age; education level (illiterate, primary school, middle school, high school, university, graduate); marital status; duration of vaginismus (months); psychiatric comorbidity (presence/absence of anxiety or depression); history of prior treatment (yes/no).

Algorithm Process Variables: Total number of sessions (mean ± SD); therapist experience in years (mean ± SD); therapy modality (individual vs. couple).

Primary Outcome Measures: FSFI subscale scores (desire, arousal, lubrication, orgasm, satisfaction, pain) before and after intervention; relapse status; patient satisfaction (VAS 0–10).

Secondary Outcome Measures: BDI (depression) and STAI (state-trait anxiety) scores.

Implementation Protocol

All participants underwent four 60–75-minute hypnotherapy sessions in a single working day according to the KARAV algorithm. Each session was followed by partner-assisted assignments; progression to the next stage occurred only if the preceding success

criteria were met. Therapists had a mean experience of 8.95 ± 2.22 years.

Statistical Analysis

Data were analyzed using SPSS v26. Continuous variables are presented as mean ± SD; categorical variables as frequency (%). Paired t-tests compared pre- and post-intervention FSFI subscales, BDI, and STAI scores. Chi-square tests assessed categorical outcomes. A two-tailed $p < 0.05$ was considered statistically significant.

RESULTS

Demographic and Clinical Characteristics

The 101 participants had a mean age of 29.13 ± 5.11 years and a mean vaginismus duration of 34.78 ± 44.44 months (Figure 2). Education levels were distributed as follows: university 39.6%, high school 30.7%, middle school 16.8%, primary school 6.9%, graduate 5.9% (Figure 1). Psychiatric comorbidity was present in 16.8%, and 61.4% had received prior treatment (Table 1).

Algorithm Process

The mean number of sessions was 4.10 ± 0.41 (range 4–6), therapist experience averaged 8.95 ± 2.22 years (range 5–13), with 85.1% receiving individual therapy and 14.9% couple therapy.

Depression and Anxiety Scores in Table 2:

BDI: 19.69 ± 9.31 → 11.03 ± 6.63 ($p < 0.001$)

STAI: 49.60 ± 5.13 → 10.46 ± 7.37 ($p < 0.001$)

FSFI Subscales

Paired t-test results are summarized in Table 3:

Desire: 3.66 ± 1.24 → 4.04 ± 1.12 ($t = -4.74$; $p < 0.0001$)

Arousal: 2.72 ± 1.01 → 4.20 ± 1.31 ($t = -12.06$; $p < 0.0001$)

Lubrication: 4.27 ± 1.36 → 4.27 ± 1.36 (no change)

Orgasm: 2.60 ± 0.88 → 4.50 ± 1.43 ($t = -14.61$; $p < 0.0001$)

Satisfaction: 1.60 ± 0.49 → 5.14 ± 1.17 ($t = -32.28$; $p < 0.0001$)

Pain (Dyspareunia): 4.27 ± 1.36 → 4.27 ± 1.36 (no change)

Relapse and Satisfaction

Post-treatment relapse rate was 4.0%; mean patient satisfaction was 8.2 ± 1.1 (VAS).

Table 1. Demographic and Clinical Characteristics of the Cohort (n = 101)

Variable	Value
Age (years), mean ± SD	29.13 ± 5.11
Duration of Vaginismus (months), mean ± SD	34.78 ± 44.44
Education Level, n (%)	University: 40 (39.6 %)
	High school: 31 (30.7 %)
	Middle school: 17 (16.8 %)
	Primary school: 7 (6.9 %)
	Graduate study: 6 (5.9 %)
	Illiterate: 0 (0 %)
Psychiatric Comorbidity, n (%)	No: 84 (83.2 %); Yes: 17 (16.8 %)
Prior Treatment, n (%)	Yes: 62 (61.4 %); No: 39 (38.6 %)

Table 2. Pre-Intervention vs. Post-Intervention Scores (n = 101)

Measure	Pre (mean ± SD)	Post (mean ± SD)	p-value
FSFI Total Score	16.47 ± 4.32	27.29 ± 6.28	< 0.001
BDI (Depression)	19.69 ± 9.31	11.03 ± 6.63	< 0.001
STAI (Anxiety)	49.60 ± 5.13	10.46 ± 7.37	< 0.001

Table 3. FSFI Subdomain Scores Pre- and Post-Intervention (n = 101)

Subdomain	Pre (mean ± SD)	Post (mean ± SD)	t-value	p-value
Desire	3.66 ± 1.24	4.04 ± 1.12	–4.74	< 0.0001
Arousal	2.72 ± 1.01	4.20 ± 1.31	–12.06	< 0.0001
Lubrication	4.27 ± 1.36	4.27 ± 1.36	—	—
Orgasm	2.60 ± 0.88	4.50 ± 1.43	–14.61	< 0.0001
Satisfaction	1.60 ± 0.49	5.14 ± 1.17	–32.28	< 0.0001
Pain (Dyspareunia)	4.27 ± 1.36	4.27 ± 1.36	—	—

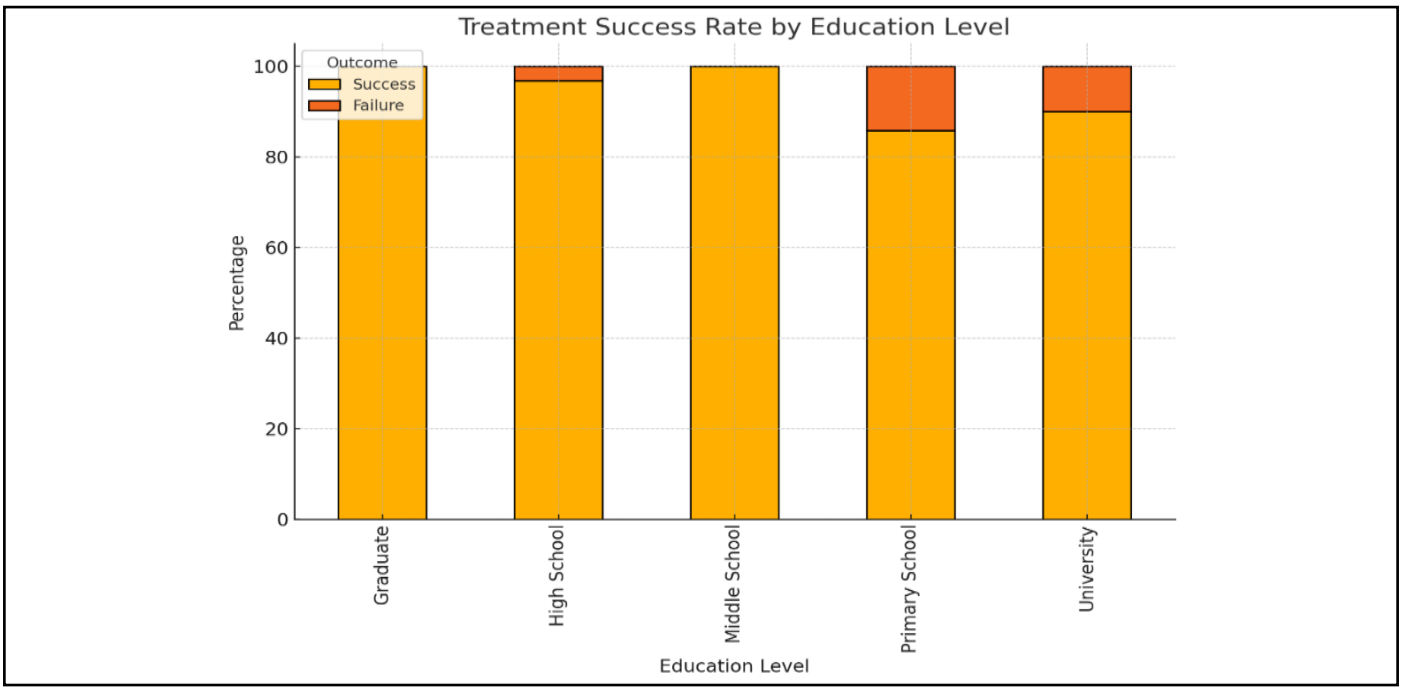

Figure 1. Treatment Success Rate by Education Level

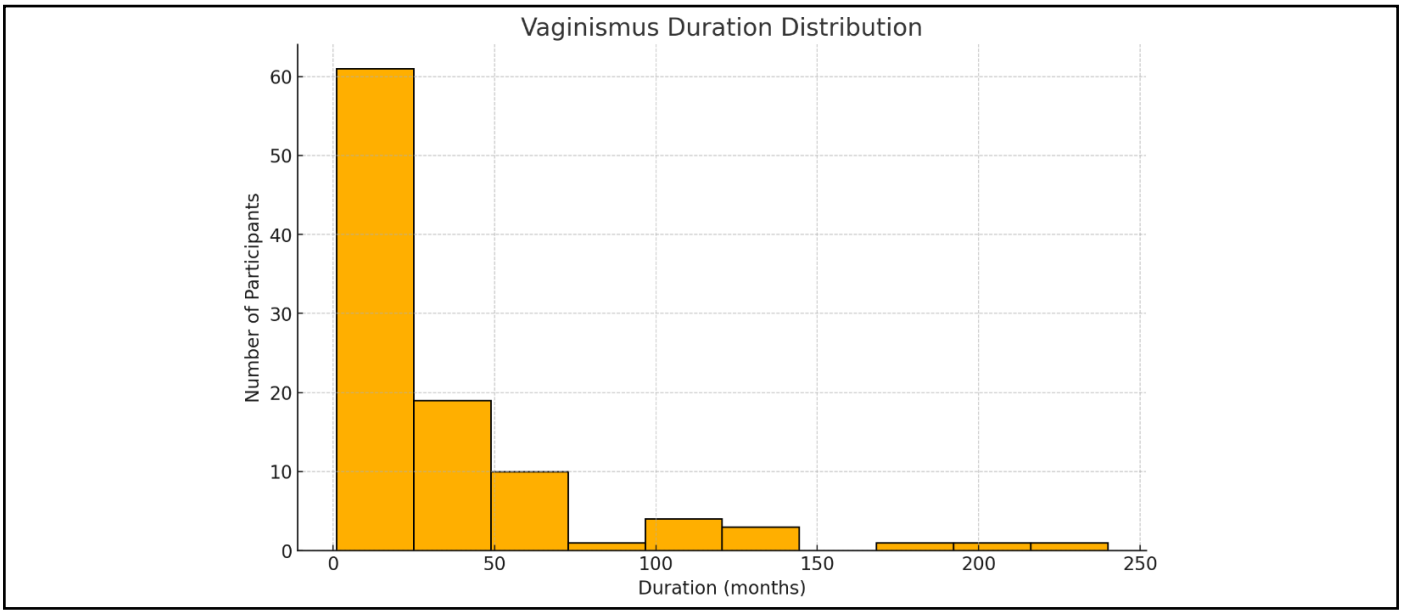

Figure 2. Vaginismus Duration Distribution

DISCUSSION

In this multicenter study, we evaluated the clinical efficacy of the KARAV Hypnotherapy Algorithm—designed for delivery in a single working day—across 101 women with primary vaginismus. The finding that 100% of participants achieved pain-free penetration on the treatment day, coupled with statistically significant improvements in all FSFI subscales (desire, arousal, lubrication, orgasm, satisfaction, pain) and reductions in BDI and STAI scores, demonstrates that this algorithm surpasses previous protocols in both speed and effectiveness.

Prior literature has reported up to 90% penetration success using combined cognitive hypnotherapy and couples therapy protocols spanning two months (11). However, the session count and overall treatment duration remain burdensome for chronic cases. Ambrosetti's multi-stage hypnotherapy series achieved comparable success rates but also extended over several weeks (12). By contrast, the KARAV algorithm compresses four sequential sessions—including Dave Elman induction, hand-drop, parts therapy, regression, hypnodrama, and direct suggestion—into a single day, rapidly disrupting entrenched fear–pain cycles via intensive exposure and subconscious restructuring.

Partner integration represents another key component, markedly enhancing adherence. Ugurlucan et al. (13) demonstrated sustained FSFI improvements during COVID-19 via dilator-based, partner-assisted hypnotherapy. Within the KARAV protocol, partner-supported auto-hypnosis assignments reinforce social reinforcement mechanisms in daily life, minimizing relapse risk while embedding the couple's dynamic within the therapeutic process.

Traditional cognitive-behavioral therapy (CBT) regimens typically require 6–12 weekly sessions of sexual exercises, psychoeducation, and graded exposure; Öztürk and Arkar observed significant decreases in GRISS, DAS, BDI, and BAI scores over 8–16 weeks of CBT in both women and their partners (14). The fact that KARAV achieves comparable psychosocial gains in a single day highlights the protocol's powerful "conscious–subconscious" bridging capacity.

At a neurophysiological level, hypnosis is thought to modulate limbic–autonomic interactions to reduce pelvic-floor hypertonicity, while recoding traumatic memories to attenuate pain processing (12,15). The regression and hypnodrama techniques employed in KARAV simultaneously activate these neuro-psychological mechanisms. In particular, parts therapy enables direct conscious access to traumatic loci, whereas associative reframing swiftly restructures maladaptive cognitive schemas.

Limitations of our study include the absence of a randomized controlled design and the lack of long-term (>6 months) follow-up data. Inter-center variability in practitioner expertise introduces potential operator dependence. Although selective volunteer participation carries a risk of selection bias, our sample of 101 women nonetheless represents a broadly heterogeneous cohort.

Prospective directions should include randomized controlled trials comparing KARAV to active controls (e.g., CBT) and passive controls (wait-list), incorporation of objective measures such as pelvic-floor EMG and functional neuroimaging to elucidate underlying mechanisms, and integration of digital psychoeducational modules and mobile app-based auto-hypnosis to enhance remote accessibility.

CONCLUSION

The KARAV Hypnotherapy Algorithm offers a rapid, effective, and highly acceptable single-day, multimodal treatment model for primary vaginismus, integrating intensive sessions and partner-focused assignments. Especially in chronic, treatment-resistant cases, it promises substantial time-and-resource efficiency compared to conventional multi-week approaches. Future work should focus on randomized controlled comparisons, extended follow-up, and objective neuro-physiological assessments to validate and support the algorithm's inclusion in high-impact international journals and comprehensive clinical guidelines.

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ORIGINAL ARTICLE

Effects of Post-TURP Orgasm Disorder and Sexual Satisfaction in Men

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Abstract

Objective: This study investigated the effects of Transurethral Resection of the Prostate (TURP) on orgasmic functions and sexual satisfaction in men with benign prostatic hyperplasia (BPH).

Material and Methods: Fifty sexually active male patients who underwent bipolar TURP for BPH between March 2021 and March 2023 were included. Patients completed a questionnaire before the procedure and again 3 months later.

Results: 2% of patients reported being unable to have an orgasm. 24% experienced a decrease in orgasm intensity. 14% developed pain during orgasm (disorgasmia), which was not present pre-procedure. 28% experienced urinary incontinence during orgasm (climacturia), with 4% constantly and 24% occasionally. Dry ejaculation increased from 10% pre-procedure to 48% post-procedure.

Conclusion: All four parameters (presence of orgasm, disorgasmia, climacturia, and dry ejaculation) showed statistically significant changes ($p < 0.005$). The study highlights that TURP for BPH leads to significant changes in orgasmic functions, underscoring the importance of informing patients about these potential complications to their sexual health and quality of life.

Keywords: post-TURP, orgasm disorder, sexual satisfaction

INTRODUCTION

Benign prostatic hyperplasia (BPH) and sexual dysfunctions are common in men as they age (1). Many studies have found a relationship between BPH and sexual dysfunction (2). While existing reports typically focus on erectile dysfunction, orgasmic changes are also observed after prostatectomy, and studies in this area are limited (3). Changes in orgasm, particularly its absence, are associated with significant decreases in emotional and physical satisfaction, which can lead to sexual avoidance and relationship discord.

The effects of TURP, the most common surgical treatment for BPH, on sexual function are not clear (4). This study aimed to investigate the frequency and extent of orgasmic dysfunction in men undergoing prostatectomy for BPH.

MATERIALS AND METHODS

Our study included 50 sexually active male patients who underwent bipolar Transurethral Resection of the Prostate (TURP) for BPH between March

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2021 and March 2023. This study was approved by the Ethics Committee for non-Interventional Research of T.C. Uşak University (Approval Number: 10.04.2025/603-603-01). Patients were asked to complete a pre-prepared questionnaire before the procedure and again 3 months later.

The questionnaire items are shown in Table 1.

Table 1. The questionnaire items

Presence and adequacy of erection
Presence of orgasm and orgasmic satisfaction
Presence of pain during orgasm
Presence of urinary incontinence during orgasm
Presence of ejaculation

Inclusion and exclusion criteria were also considered, such as comorbid diseases, no prior urological surgery, no repeat prostatectomy, no history of erectile dysfunction treatment, a stable partner, and no use of pharmacological agents that affect ejaculation. All patients underwent a physical examination, medical history review, uroflowmetry, urinalysis, prostate-specific antigen, and serum biochemistry analysis.

For data analysis, SPSS 16.0 for Windows was used. The Kolmogorov-Smirnov test was applied for normality, and the non-parametric Wilcoxon Test was used to compare pre- and post-operative data ($p < 0.05$ was considered statistically significant). A power and reliability analysis determined that data from 42 patients were required, and approximately 50 patients were included in the study, taking into account data deficiency and exclusion criteria.

RESULTS

The average age of the patients was 66.4 ± 4.2 years, and the average prostate volume was 72.4 ± 7.8 cc. Demographic data are summarized in Table 2.

Before TURP, all patients reported being able to have an orgasm. After the procedure, two patients (4%) reported being unable to have an orgasm at all, while 36 patients (72%) reported no change. A decrease in orgasm intensity was found in 12 patients (24%).

While no patients experienced pain during orgasm (disorgasmia) before the procedure, disorgasmia was detected in 7 patients (14%) after the procedure. In all patients with pain, the pain was in the penis and perineal area.

Urinary incontinence during orgasm (climacturia) was not present in any patient before the procedure but was observed constantly in 2 patients (4%) and occasionally in 12 patients (24%) after the procedure.

Dry ejaculation was observed in 5 patients (10%) before the procedure, while it was detected in 24 patients (48%) after the procedure.

A statistically significant change was found in all four parameters examined. These data are summarized in Table 3.

Table 2. Demographic data of study

Age: 66.4 ± 4.2
Prostate Volume: 72.4 ± 7.8
Hypertension: 15 (30%)
Diabetes Mellitus: 8 (16%)
Smoking: 26 (52%)
Hyperlipidemia: 4 (8%)

Table 3. Pre -TURP and Post-TURP Orgasm Disorder statistical results

	Pre-TURP	**Post-TURP (3 months)**	**p-value**
Presence of Orgasm	50 (%100)	36 (%72)	<0,005
Disorgasmia	0 (%0)	7 (%14)	<0,005
Climacturia	0 (%0)	14 (%28)	<0,005
Dry Ejaculation	5 (%10)	24 (%48)	<0,005

DISCUSSION

Sexual dysfunctions such as decreased orgasm intensity, lack of orgasm, and pain during orgasm can lead to psychological distress, resulting in a reduced quality of life, loss of self-esteem and self-confidence, and relationship discord (5). To date, orgasmic dysfunction in this population has received very little attention from clinicians and researchers. Orgasm is defined as physiological changes and pleasure that occur simultaneously with ejaculation in men (6). Sexual function is important for a person's quality of life, and the consistency, quality, and satisfaction of orgasm are associated with marital satisfaction, stability, and happiness (7).

One study reported that 23% of patients surgically treated for BPH experienced disorgasmia after surgery (8). Another study stated that 36% of patients with BPH described their orgasmic sensation as 'different' after prostatectomy (9). The true rates of orgasm-related urinary incontinence, also known as climacturia, are currently not fully known, but a literature review found a prevalence ranging from 20% to 93% after radical prostatectomy (10). Ejaculatory dysfunction after TURP can occur in up to 65% of cases, with retrograde ejaculation appearing in up to 50% (11,12).

CONCLUSION

This study aimed to determine the effects of TURP on orgasmic functions. Our findings show that patients undergoing TURP for BPH experience significant changes in orgasmic functions, including the inability to have an orgasm, decreased orgasm intensity, disorgasmia, climacturia, and dry ejaculation.

These results emphasize the importance of informing patients about these potential complications that affect their sexual health and quality of life when planning BPH treatment.

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REVIEW ARTICLE

Sexual Selection Dimorphism: The Sex, Body, and Mind

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Abstract
Sexual selection is an evolution of Charles Darwin's natural selection theory, and the outcome is male sacrifice regardless of cost. We first examine the mechanics of sex to perform with a partner in sexual activity. We then examine how Leonardo da Vinci's curious studies of the sexual act and human sexual organ reproduction painting are complicated between the mind and body. We further discuss male love and non-human animal homosexuality, revealing the understanding of a gay man's loved nest, which highlights that Darwin's natural selection is not all-powerful and is fairly common in animal kingdoms. Finally, we support Darwin's metaphysic, which comes from a transmutation accompanied by psychological and religious self-discipline in the mind.

Keywords: sexual dimorphism, natural selection, homosexuality, mind, Charles Darwin

INTRODUCTION

The explicit question is why sex exists in everyday life and society; it seems shy to talk about the objectification between the opposite sexes of men and women. In the review of the mechanics of human sexuality, the position of the human's leg, arm, and hand to perform sex depends on the effective angle to support the body, to lower the pressure of the body, which is low sustainability (1). We debate whether the heterosexual partner's way of sex conforms to the gender binary and whether gender is categorized into only two distinct forms. A strong argument is that sex is binary and sex in human beings is exclusively male and female (2). Two participants in the sex should be a male and a female, and they need the same practice and dexterity to help each other in good sex. Adult sex happens when the male and the female are caring, attractive, and love each other, but this does not mean they are pregnant or having a new baby (3). Mature adult sex is an affective, positive emotion, and feeling the excitement in the sex. Our society makes us behave sexually neutral and finally asexual (4). The male-female biological distinction for gay thinkers is undefined; we should treat gender and sex as two different constructions (5,6). Human sexuality is now accepted as a mainstream practice. Early researchers in the field often attracted considerable criticism (7), experimenting and measuring human sexual behavior to achieve orgasm in sex therapy in Masters and Johnson's laboratory situations, could help us think about why our mind controls us to have sex.

Sex can be described when humans see porn. Profoundly, when women are sexualized, their appearance is also likely salient, and they can be perceived as objects (8). Leonardo da Vinci draws human inner and outer body parts with aesthetic eyes to convey the unconscious fear of a female's body when

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two female heads are conjoined (9). Evidence is also shown in da Vinci's embryological drawings of fetuses of dead pregnant women. Leonardo also studied a cross-section of the bodies of a man and woman in the act of intercourse to visualize sex as a dynamic act and the two causes of the origin of life (10). As we know, Leonardo is an artist and inventor genius, and he knows the male and female reproductive systems in his sketches of the vulva and anus. Our paper examines the scientific and philosophical theories to investigate why Darwin accepted the principle that all higher animals, including humans, were essentially intersex (11). Darwin thinks humans are different from animals, and it is an evolutionary prerequisite for humans to take care of one another, and a male has to think and decide whether to marry or not (12). Females choosing sexual activity with a partner under consent can cancel if a male changes his mind after foreplay (13). Based on the fact that females prefer a slower build-up and aftermath indicates they are more focused on quality than quantity in sex, and female friends care to know every last detail, not just of the sex itself, we conclude that females could have more sex than men in mind (14). Then, we have more reasons to believe that some individuals are not interested in having sex.

Sexual Selection Dimorphism on the Mating System

Sigmund Freud popularized the idea that the main purpose of sex was pleasure rather than procreation, and he pointed out that individuals in sexual object choice will be attracted to the same or opposite sex (15). To find why sexual selection is still controversial, Darwin was right to distinguish that sexual selection is profoundly different from natural selection, and he suggested that the costly peacock's train evolved because females prefer to mate with males that have fancy upper-tail coverts (16). For the bird, pair bonding appears to benefit both sexes (17). Females and males often show striking differences in morphological, behavioral, and physiological traits (18). Like peahens, the dramatic eyespots make male peacocks please females as a handicap trait, although risky, showing success in plumage dimorphism. In the testing of mating condition strategy traits, female songbirds prefer more complex songs and larger repertoires (19), which suggests that the artistic skill of males as a costly Veblenian signal affects mate choice (20).

Darwin's grand theory of natural selection is cogent that male peacock tails are advantageous in the mating choices. Lekking is a promiscuous breeding system in which females visit groups of displaying males only for mating (21). Some animals mate with one partner rather than many (22). Mating with more than one male, as polyandry for female butterflies, is a strategy that females adopt when male density is high to gain more uninterrupted time in which to oviposit (23). Butterflies show considerable variability in female mating frequency, ranging from monandrous species to females mating several times in their lifetime (24). Transferring sperm to a female is the primary function of mating, causing females to choose one or a few mates, which is sufficient for females to maximize their reproductive success (25). Producing more offspring is consistent with Darwin's theory of evolution and demonstrates that many animals give birth to lots of babies. Although Darwin had a long, happy marriage with Emma Wedgwood and they had ten children, he was devastated after the death of his eldest daughter, Annie, at the age of ten. Historical records claim Annie caught scarlet fever, which made her health thereafter decline.

Darwin's case was one of the first experimentalists to demonstrate the adverse effects of inbreeding and to question the consequences of consanguineous mating, supposed to be injurious from a single census (26,27). Studies by Charles and Emma Darwin's second son, George Darwin, provided valuable evidence that fears regarding the ill effects of first-cousin marriage were exaggerated, and Darwin appears to have become convinced that marriage to his first cousin may have been a mistake (28). However, Charles Darwin was a devoted father and constantly concerned about the health of his children (29). If certain males have intrinsically good genes, any female mating with them will produce superior offspring (30). Multiple mating is advantageous to females and easily explains why females should mate multiple times.

When Same-Sex Love is an Innate Characteristic

Michel Foucault is a critical theorist of sexuality, and he had sex with a man, which means gay sexuality makes him suffer from problems with who he is and neurological problems. Foucault's approach to the history of sexuality as a discourse of sexuality is interested in the question of sexuality throughout his entire career sexuality (31). Foucault's thought of

sexuality focuses on bodies and pleasures in the figure of two fellows holding hands (32). For evolutionists, homosexual emotion and behavior are, in part, emergent qualities of the human propensity for same-sex affiliation (33). However, God's design of sex for marriage and homosexuality in a relationship is profoundly painful (34). We can say that gay or lesbian sex is against the design of human nature. Darwin ostensibly maintained a heteronormative standpoint on the evolution of beauty, but the prospect of males appreciating male beauty, and females' female beauty, or at least a credible biological explanation of how and why they would not, remained unelucidated (35). Considering nature regarding sexuality, nature is associated with suffering and impaired function; homosexual orientations are considered sinful and the fall (36). More specifically, same-sex sexual behavior is any behavior that is usually performed at some stage during reproduction with a member of the opposite sex, but which is instead aimed toward members of the same sex (37). Definitions of homosexual behavior in nonhuman animals can bring some relief. However, they cannot help us answer the question of what conditions a behavior or mental state has to fulfill to be sexual (38). To be sure, animals will be engaged in same-sex sexual activities—for example, two male mallard ducks with one trying to mate with each other.

A homosexual pair in animals refers to same-sex sexual behavior, including copulation (39,40). The formation of same-sex pair bonds in zebra finches may arise through an evolved propensity to find a social partner (41). In humans, homosexual sexual behavior will not yield offspring as individuals who express strong same-sex sexual attraction have evolved for their non-conceptive social benefits (42). However, the roles of partners and offspring provide the final pattern in considering family and genius (43). Theoretically, a heterosexual man should want to attract and date a woman who will produce excellent babies. Here, the example is a well-matched couple who have similar passions in physics. Albert Einstein was attracted to Mileva Marić, both of them studied together, clearly fell in love, became pregnant to have Albert's babies, and married (44,45). Mileva and Albert's first son, Hans Albert Einstein, and his father are professors. It shows intelligence is accorded the epithet genius, and there is usually near unanimity on which individuals merit the appellation, like Einstein (46). According to a consequence of gene-environment interaction, human culture's need for homosexuality could conflict with a trait of cognitive abilities, such as talents and intelligence (47).

Darwin's Metaphysics of Mind

Normal people will protect their babies, but non-human animals may hurt their babies. Darwin's philosophical mind comes from his conquest of the phenomena of life and finding the solutions there to access mind, morals, and life (48). Darwin's insights into the human mind are interrelated with the inherited instinct (49). Since our mind is a mysterious form of matter secreted by the brain (50), Descartes's metaphysical view of the mind is insufficient to explain why human beings often do things disastrously in error, because the human mind has limited ability, attributed to willpower, which is often more influential than intellect (51). Human nature is a metaphysical delusion when trying to define the undefinable rather than describe the describable (52). Sociobiology attempts to explain general features of human society and ethics (53). The complex cousin marriage relationship between Elsa Einstein and Albert Einstein was lucky, and she always helped and protected him. This is an emotional intelligence that Einstein has.

Darwin treats emotions as states of mind, and the so-called expressions are originally nothing but the serviceable actions provoked by those states of mind to find relief or gratification (54). Thomas Henry Huxley declares altruism should be a rare event in the natural world, and when it occurs, it should be between blood relatives (55). Kin selection is not the cause of altruistic behavior, but rather just a consequence (56). Darwin and natural selection determined that organisms only behave in certain ways if it benefits their survival; thus, devotion to the welfare of others cannot and does not exist in nature over time (57). Thus, Einstein transferred the Nobel Prize money to his ex-wife, Mileva, chiefly to support their sons.

Darwin's experiences on the *Beagle* voyage led to the same conclusion that the environment may produce mental disease (58). What was wrong with Darwin about his illness has contributed to psychiatric learning (59). Darwin was troubled with mental problems, and though Darwin's passion made him battle periods of depression (60). Even if Darwin did not have a primary

psychological illness, he did have psychological symptoms (61). Darwin had to face his mother's death, which occurred when Charles was eight. The fact was, there is no evidence that Darwin suffered any unusual grieving process (62). Genetic predestination has a tempting simplicity, as Darwin anticipated; the issue of how genes influence behavior is a psychological one (63), and the threat to human existence entails severe costs in terms of psychological pain and bereavement for surviving kin (64). Meanwhile, Darwin's mystery illness, whether organic or psychosomatic, has been confused by several unanswered questions (65).

CONCLUSION

We have learned that sexual selection is a mechanism for females to choose between males, which was Darwin's chosen mechanism in mating choice (66,67,68). Our task is to analyze Darwin's traits meticulously, and this makes him always ask penetrating questions. Those questions focus on an individual's traits to make sure the best one is in the herd. Darwin's idea is how species adapt and change when evolving, and Darwin believes nature is influenced by natural law, not God. Selecting a mate for Darwin happened when courtship rituals seduced the male to impress the female, to show the female how good he is in both non-human and human species. Gender bias in sexual selection is clear (69); it agrees with Darwin's theory that females choose the most appealing male. Darwin spent considerable time, and he was diligent in reading and recording carefully, which is the reason why Darwin received credit for the theory of evolution. In other words, the animals and plants that Darwin gathered are the nutrients to support his natural selection theory. Darwin's groundbreaking research on animals led him to be different from other naturalists in his fascinating interests in earthworms and barnacles.

We confirmed that novel empirical evidence that Darwin's real experiences in recognizing emotion when family members died, and he started to undermine the god Darwin believed in. His illness also felt worse, and he expressed a frown on his face. Uncomfortable, Darwin did not go to his father's funeral. We further strengthened how Darwin studied infants to understand the origin of species. Being a creature like a baby is misshapen and has no particular sex, Darwin observed his newborn son's behavior, and the face looked sulky. Darwin studied infants from the seventh day to four and five months to determine when the infants had emotions (70). Darwin's contribution to observation opens a mysterious gate to teach us that science is overwhelming.

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9. Acknowledgments
Acknowledge individuals or institutions who contributed to the study but do not meet authorship criteria (e.g., funding support, editing, technical assistance). If artificial intelligence was used for editing or drafting, this must also be disclosed.