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# The Impediments of Impotency and The Conditions of Male Impotence A Canonical Medical Study

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(Conclusion of this study which began in the August, 1958  
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## PART II

### MEDICAL CONSIDERATIONS

In hypogonadism, the hypoplasia of the interstitial cells causes eunuchoidal manifestations due to deficient endocrine elaboration. The scrotal contents may lack testicular elements entirely because of cryptorchism when neither testis has descended, or the testes may be extremely small, difficult to feel and soft in consistency. These latter conditions indicate either a failure to develop in early life or demonstrate a primary atrophy. These victims manifest variable physical patterns depending on the degree of gonadal deficiency. There may be extreme obesity with feminine body configuration, absence of normal hair distribution, voice changes, and a general loss of secondary male sex characteristics. Loss of libido and accompanying impotence are frequently seen as results of such deficiency.

The site of the primary defect will be either the pituitary or the testis, and the diagnosis can be established by biopsy of the testis when possible and the urinary assay of the gonadotrophic hormones. Cytological sex chromatin

tests are also significant. The conditions associated with hypogonadism have been classified into three categories: 1) Testicular aplasia or atrophy due to prepubertal failure of the testes — 2) The "so-called" Klinefelter syndrome — a heterogenous assemblage of cases generally characterized by high gonadotrophin, small testes with variable degrees of eunuchoidism, gynecomastia and hyalinization of seminiferous tubules. Many of these persons, by the available sex chromatin tests, are shown to be genetic females and in fact are female pseudo-hermaphrodites — 3) Hypogonadotrophic eunuchoidism. The first and second groups are the result of a primary testicular defect, while the hypogonadotrophic group, which is the most frequently noted, is of pituitary origin and is caused by deficient production of gonadotrophin. This latter defect results in a secondary depression or loss of testicular activity with the result that the testes fail to undergo maturation and, if the condition is not treated early and adequately, they remain

permanently in the infantile state. This type is designated as secondary hypogonadism. Testicular biopsy is characteristic and the urinary gonadotrophin hormone assay is low which is indicative of pituitary deficiency whereas in cases of testicular aplasia or atrophy and in the Klinefelter syndrome, the so-called primary group, the assay is high. When primary hypogonadism is found in the adult, the testes are beyond salvage and no treatment will improve the testes as such, but benefits may be attained by androgenic therapy and as, in the previously discussed indications, regression will occur if therapy is not maintained on a permanent basis. Even in the prepubertal and immediate post-pubertal period, the testicular changes are irreversible and the role of therapy, replacement and substitute, is directed towards the improvement of the secondary male sex characteristics and the subsequent accomplishment in later life of the sex act. As we have repeatedly noted, individual evaluation is fundamental. In the young male, the evaluation of potency will of necessity be delayed until later in life.

The response to anterior pituitary therapy in secondary hypogonadism is frequently dramatic. Therapy, however, should be discontinued if there is no response within six months. In those who demonstrate a beneficial reaction, spontaneous and continuous improvement has followed even after therapy has been interrupted. For some unexplained reason the previously underactive anterior pituitary has been stimulated to

maintain activity. This favorable response is manifested by increased genital growth and a general systemic hormonal improvement.

It must be appreciated that various grades of testicular deficiency exist in both the primary and secondary hypogonads. When the ability of the hypogonad to ejaculate and inseminate has been established with or without therapy, the presence or absence of the testicular component is of paramount significance in view of the Caspary opinion. A hypogonadal male with the ability to effect the sex act in the absence of any demonstrable condition, which might indicate occlusion of the seminal tract, can be assumed to emit a testicular component even though the presence of sperm cannot be proved. The loss of spermatogenic power which occurs very frequently, would not necessarily preclude the possibility of a testicular component in the ejaculate but at present there is no known method of determining its presence or absence.

The prognosis of potency in the hypogonad will depend on the type of condition, the age of the person and the response to adequate therapy. Modern investigators have proved conclusively that regardless of age, primary hypogonadism is irreversible, but that replacement therapy may reverse the clinical manifestations. In the so-called secondary group, however, anterior pituitary hormone administration may be not only beneficial, but curative. It must be noted that there is an indefinite group among the hypogonads

who, as they attain maturity, outgrow their stigma and without recognition and treatment almost among normal males. A certain group are encountered the same in males and in many instances the impotent males, who, unconsciously of their inadequacies, show the manifestations of eunuchoidism, but in whom no definite physical or psychic factors can be found. It is our personal opinion that a relatively high percentage of sterile and impotent males can be allocated to this indefinite undivided group. These men are generally seen in early adult life, the marriageable age, and are not cognizant of their physical handicaps and apparently previous physical examinations on them have been unrevealing. Careful study will assist this group and direct proper therapy.

Hypogonadism in the male, therefore, is a definite factor in impotency as an impediment to marriage but it must be emphasized that each person must be meticulously classified by the utilization of the available diagnostic studies which will indicate the proper therapy. Thus, many of these handicapped males can be helped and a return to normalcy will enable them to contract marriage and/or to function normally in marriage.

Congenital anatomic variations of the genital system may occasionally present almost insurmountable problems. The term intersexualists has been applied to this group of individuals — and should be limited to those in whom abnormalities of sex development

have led to a confusion of the exact sex and to those with some of the reproductive organs of both sexes, and also to patients whose anatomic appearance is one sex but whose somatic chromatin is the opposite. The true sex is difficult and at times impossible to determine by external examination as the genital configuration may be ambiguous, and even after highly sensitive laboratory procedures and biopsy there may be considerable doubt, although oral cytologic smears are now believed to have confirmatory value. Meticulous abdominal exploration may be necessary in many instances. The sex of the person may be opposite to that presented by the gonads themselves. They are referred to as pseudo-hermaphrodites, and are regarded as masculinized females or feminized males. They possess the reproductive organs and the psychic characteristics of the opposite sex. In the male the external genitalia may appear masculine, but surgery reveals the presence of a uterus or other female development of internal ducts. The true hermaphrodite is relatively rare and is a condition in which the gonadal elements of both sexes are present in the same individual either as separate ovary and testis or more commonly combined as an ova-testis. The genital development and sex characteristics may be extremely variable, although generally predominant of one sex. It has been previously noted that certain types of primary hypogonadism represent a form of intersexuality. It is a deplorable fact that the recognition of the intersexuals in many in-

stances does not take place until early adult life and occasionally after marriage has been contracted. From our viewpoint this is particularly significant in these individuals with male external genitals of relatively normal configuration. Correct diagnosis may be extremely difficult but with careful inspection of genitals at birth, cytological studies and scrutiny of suspiciously abnormal sex manifestations in the early years of life, disastrous errors and future tragedy can be prevented. These individuals must be definitely considered permanently impotent although in the rare and isolated instance surgical methods may remedy the picture.

Neurophysiologic dysfunction following disease or injury affecting the centers of erection and ejaculation, or the nerves conveying impulses to (afferent) and from (efferent) the genital organs may play a primary role in impotence. These lesions may occur at any point along the nerve tract from the highest centers of the brain to the terminal peripheral nerves. The closer the lesion to the reflex centers of erection and ejaculation in the lumbar and sacral cord, the more likelihood of interference with sex function.

Peripheral nerve injury, productive of impotence, may be a secondary effect of radical surgery for the removal of serious disease. Impotence, irreversible in type, is a well-recognized sequela of total cystectomy for advanced carcinoma of the urinary bladder in which the bladder, prostate, and seminal vesicles are removed. Sur-

gical eradication of rectal malignancy is likewise frequently followed by impotence due to neurogenic dysfunction.

The problem of paraplegia presents itself quite frequently in the young and age, as the ravages of war and our highly industrial era have notably increased the incidence of this condition. In our discussion, the term paraplegia is limited to persons on whom all available measures directed to the treatment of the primary cord lesion have been employed and time has demonstrated the futility and inefficacy of the therapy. Talbot, in a personal communication, defines paraplegia — "paralysis of and loss of sensation in both lower extremities, resulting from complete or nearly complete transection of the spinal cord due to injury or disease. When the transection is in the upper portion of the spinal cord so that the upper extremities also are involved, the term quadriplegia is used. There is associated disturbance of bladder and bowel function and also of the neuromuscular component of the sexual function, but usually not complete impotence." At the present time, there is no therapy known to science which is available to the long-standing paraplegic. Thus, if an impotent condition is verified, it must be considered permanent. Obviously, this does not include the man who has a cord lesion which may readily be amenable to partial or complete cure by surgery and physiotherapy.

Talbot has reported a study of 408 cases of spinal cord injury

and disease, which were sufficiently severe to produce paraplegia and he refutes with emphasis the popular belief that all are sexually inadequate. He demonstrated sexuality on a psychic level essentially unaltered and the gonadal function is not markedly affected. Testicular changes are generally confined to the germinal epithelium as a result of radiation debility, infection, and probably alteration of pituitary function associated with the severe trauma and shock of spinal cord injury. There is a high incidence of seminal duct obstruction due to sepsis. The endocrine factor is not primarily affected. It is reasonable therefore to state that the psychic and endocrine elements may remain fundamentally unaltered if the patient remains in good physical status and makes a satisfactory adjustment to his new way of life.

The neuromuscular mechanisms are drastically modified. In Talbot's series, the levels of neural involvement varied from the 5th cervical vertebra to the cauda equina. He found that 34% had lost the power of erection, 45% were able to develop an erection on local stimulation and 21% had erections as a result of psychic stimuli. Of these who attained erection as a result of local stimuli, 21% were capable of intercourse, while 66% were capable following psychic stimuli. There was a definite closer approach to normal in those with the capacity to evoke erection by psychic stimuli. The mechanism was less affected when the site of the cord lesion was above the 11th dorsal segment.

It is worthy of note that every clinic treating a considerable number of paraplegics has reported the occurrence of pregnancy among their wives. Five percent of Talbot's series proved their fertility. It must be appreciated that, in the evaluation of this group, accurate statistics are difficult to obtain as individual reactions to the problem vary considerably. Many of the paraplegic patients are hospitalized which preclude a normal way of life and affects the interpretation of findings.

In the investigation of the paraplegic's impotence every case must be studied in meticulous detail as to the type and extent of injury, the neurologic damage and the presenting sex pattern. In our practice we have encountered two instances of paraplegics who were presumed potent prior to marriage, but who were unable to consummate the union because of impotence.

Even if paraplegia exists and the individual is permanently impotent, the canonical impediment is not always present as the condition was subsequent to the marriage for example—the husband may become a paraplegic as a result of a war injury following a consummated marriage. However, if marriage was not consummated prior to injury the marriage might be dissolved on the basis of non-consummation. If the condition is antecedent but there is doubt of its permanency, the validity of the marriage would have to be upheld but the union might be dissolved on the basis of non-consummation.

It must be emphasized that

among the group of paraplegic in whom erection or ejaculation has been effected by local, tactile and psychic response, no particular pattern has been demonstrated. The picture, according to reports, has varied from a transient incomplete non-sustained erection with or without ejaculation to an occasional sustained erection with or without a satisfactory ejaculation. At times the erection is insensible. Libido has been a variable factor as well. In most instances, however, the ejaculation has been in the form of the so-called distillate of urethral origin rather than the true emission of the normally accepted origin. Unfortunately, and extremely pertinent to the present problem, most of the studies, which have been carried out among paraplegics, have been based on the attainment of erection and ejaculation in the achievement of masturbation rather than the goal of normal conjugal sexual accomplishment. Talbot, however, has reported as mentioned above successful pregnancies in this group. Erection and ejaculation in these individuals is certainly not spontaneous and is effected only with a great deal of effort by both psychic stimulus and by local manipulation on the part of the partners involved.

In this whole discussion, it must be noted that in the conclusions reached, specific information about the site and extent of neurologic trauma must be elicited as well as a careful history of the individual's libido and reaction to the accepted moral sex stimuli. A most confidential and frank discussion of his sexual reactions to

his inspired spouse must be minutely and carefully evaluated and it must be premised on an acceptance of mutual confidence between the involved male and the que-

There may be a definite derangement of sex function, temporary or permanent, as a secondary or remote effect of operations on the sympathetic component of the autonomic nervous system. It is logical to expect that if a portion of the sympathetic pathways is interrupted to modify a particular disease process, unrelated physiologic mechanisms will also be affected. These operations include transthoracic splanchnectomy and sympathectomy, lumbodorsal splanchnicectomy and sympathectomy. Impotence, as a result of disturbance with centers of erection and ejaculation have been observed. Whitelaw and Smithwick, in an excellent treatise, reviewed from this point of view 161 persons who had undergone such surgery.

As previously noted, the sympathetic fibers innervate the smooth muscles of the vas, seminal vesicles and prostate and are also a factor in contraction of the internal sphincter. After sympathectomy, there may be interference with the contraction of these smooth muscles with resultant failure of ejaculation into the posterior urethra and what emission is present may enter the bladder due to the relaxed internal sphincter.

In the process of erection the neurogenic pathways are almost wholly parasympathetic and the

erectile disturbances cannot be entirely explained but it is probably due to vaso-constriction of the penile vessels due to circulatory adrenergic and to the shunting of blood to the viscera and resulting diminished circulation to the genitals. In the transthoracic procedures, there has been no permanent loss of ejaculation and loss of erection has been only transitory.

In Whitelaw's series, there were 116 lumbo-sacral operations in which significant disturbance of erection were noted in 27% and of ejaculation in 26%, and 19% of the latter were permanent. It has been demonstrated that if the derangement has not returned to relative normalcy after six months, the condition will probably be permanent. In the evaluation of this type of impotence, the indications for surgery must be determined, the date of surgery and the technical procedure carried out in the particular case should be obtained.

Following the lumbo-sacral procedure there should be no interference with sex function if operation is not extended to include L-1 on one side and D-12 on the other. In bilateral cases, there should be no interference if the operation is not extended to include L-1 on either side. When L-1 to L-3 are included significant changes may be expected to occur in a high percentage of cases. It must be appreciated that there is a great anatomical variation of the sympathetic system especially in the ganglia of the lumbar area, but, when necessary, certain sur-

gical modifications may be warranted to eliminate the side effects and thus insure the preservation of sex function in the individual patient.

It is obvious, from the above-mentioned statistics, that an impotent condition can result as a secondary development and side-effect of sympathectomy surgery. However, no general statements or principles can be set forth as the gravity and extent of any injury must be investigated in each individual case to determine if there has been any disturbance of the centers controlling the processes of erection and ejaculation. If such has been demonstrated, the temporary or permanent nature of the condition must be considered. If the impotency has been proved to have been antecedent but a doubt arises as to its perpetuity, the impediment of impotency cannot be established, the marriage must be held to be valid but there remains the possibility of a dissolution on the grounds of non-consummation.

If the condition is detected before a contemplated marriage takes place and a doubt of the permanency of the condition arises, the marriage cannot be prohibited, but if after the marriage, the permanency has been demonstrated with greater certainty, the marriage could be declared invalid.

Complete impotence is a common sequela of prostatic surgery, especially following radical perineal prostatectomy for cancer in which the posterior urethra, prostate and seminal vesicles are re-

moved. Loss of sexual power following surgery for the removal of benign prostatic obstruction varies with the type of procedure carried out. The incidence of such loss following transurethral measures is relatively low, although the interference with ejaculation is greater when a large portion of the gland is resected. When open surgery is performed, impotence is less likely to occur after the suprapubic procedure than following the perineal approach, in which complete impotence is the rule rather than the exception. The ability to attain and maintain an erection may not be significantly modified, but the ejaculate is reduced to a minimum or is completely absent since the component of the prostate and probably the vesicles and testes are eliminated and the ejaculate, if present at all, is formed by the glands of Cowper and of Littré. It must be appreciated that in this group of cases, except in the isolated instance, the problem of impotence as a marriage impediment is not presented as the great bulk of the patients are in the evening of life and normal testicular involution is taking place.

As indicated, there may be little interference with the power of erection by reason of prostatic surgery. However, there can be a serious diminution in the content of the ejaculate and, in some instances, there is no ejaculation at all. It is very important, in such cases, to determine the diagnosis and receive a complete record on the surgical procedure followed and the organs which have been excised.

If there has been any interference with the normal continuity extending from the testes to the urethral orifice, so that it can be said that no testicular component can be found in the ejaculate, the impediment of impotence must be said to be present under the Gasparri opinion, since the surgery is irreversible and the organs, once removed, cannot be restored. This presumes that the condition existed at the time of the marriage, which is not so likely, since this type of surgical intervention is usually found only in aging men. If there is no ejaculation at all or the amount is seriously diminished, so that it cannot be said to be that of a normal man, there is even the possibility of declaring the marriage invalid under the terms of the modern opinion. Bilateral vasectomy at the time of or immediately prior to prostatic surgery is a common practice and obviously totally and completely eliminates the testicular component which would be a consideration, if the Gasparri opinion is to be invoked.

The late effects of the interference with the integrity of the blood supply to the testes are occasionally encountered following surgical repair of inguinal hernia. It has been demonstrated that even temporary interference may result in irreversible damage. This is particularly damaging when the changes are bilateral. We have personally noted several cases of bilateral testicular atrophy in the young adult which had its origin in the surgical repair of bilateral herniae in childhood. Impotence, and especially sterility, may be the

sequelae in such cases. Testicular dysfunction will vary with the degree and type of injury. If the cord is ligated or cut and the testes are bilateral, sterility will result. If loss of integrity of the blood supply results, complete testicular atrophy may result with associated elimination in whole or in part of the androgenic function. Substitute therapy is indicated in such cases after adequate studies have been carried out. Infarction of the spermatic cord may result in testicular atrophy unless recognized early and managed promptly.

Varicocele is generally insignificant but in a rare example, atrophy of the testis may occur.

Mumps orchitis in the young adult may, in severe cases, cause permanent loss of spermatogenic function, but is rarely a factor in impotence. Thrombosis of the distal aorta (Leriche's Syndrome), manifested by absent femoral pulse, back pain, claudication and impotence, is not infrequently encountered in the young male adult. In this disease, modern surgery has at least been temporarily successful and only time alone will prove its value. Excision of the involved portion of the aorta is performed and is replaced by a graft.

Occlusion of the excretory pathways leading from the testes to the upper seminal tract is a frequent cause of sterility and in the light of the opinion of some canonists and moral theologians must also be considered a significant factor in impotence.

The interruption of the continuity of the *vas deferens* by simple ligation, division, or segmental

resection is a standard procedure among urologists in doing prostatic surgery in order to prevent the spread of infection from the prostatic bed to the epididymis. Vasectomy, so-called, is often performed, in the absence of medical indications, to effect sterilization. Eugenic and primitive sterilization, by this method is a common practice. Inadvertent injury to the *vas* may occur in the surgical correction of hernia, hydrocele, varicocele and undescended testicle. Spontaneous re-canalization has taken place following simple ligation. Congenital maldevelopment of the vasa-epididymal tract has been observed and is probably more common than reported, as in the absence of external manifestations, there is nothing to direct the attention of the individual to the condition and recognition may be made only at the time of surgical exploration. The *vas* may be absent, particularly in the scrotal portion, or there may be failure of fusion with the epididymis. Absence of the epididymis has also been reported. Epididymitis, non-specific, post-gonorrhoeal, or tuberculous in origin, frequently results in occlusion of the *vas* or epididymal tubule and when bilateral, the testicular component of the ejaculate may be entirely lacking. Epididymectomy is a surgical procedure in tuberculosis and chronic intractable infection of the epididymis, and when bilateral, permanent loss of continuity between the testes and the posterior urethra is effected.

Surgical attempts to restore *vas* continuity after vasectomy have been carried out with variable suc-

cess. Except in the hands of a few enthusiasts, however, the operation has not been performed. O'Connor in 1948 sent 1240 questionnaires concerning vas anastomosis to qualified urologists. He received responses from 750 doctors of whom fewer than 17% had ever attempted the operation. 135 urologists had performed 420 operations and reported a success of 38%. The vasectomized person who desires or requests restoration is rarely encountered and no surgeon is able to acquire a large group of cases. O'Connor, however, in 1953 reported successful results in 63% of thirty cases.

Post-inflammatory constriction of the vasa-epididymal ductal system may likewise be amenable to corrective surgery by creating a new and patent passage for the conduction of the testicular component. The tail of the epididymis (globus minor) and the adjoining portions of the vas are more likely to have the most dense scar. Several techniques have been devised for anastomosis of the vas and epididymis including anastomosis of the vas with an individual epididymal tubule or with a spermatocele. The most frequently employed procedure is the anastomosis of the vas to the head of the epididymis (globus major), thereby shunting the sperm along a new conduit. O'Connor operated on sixty-one men with bilateral chronic non-tuberculosis epididymitis with a resultant occluded epididymis and reported 8-10% success. Simmons states that, in proper hands, with highly selected cases the surgeon may expect relief in about one-third of obstruct-

ed epididymis cases and he decries the defeatist attitude concerning this technically difficult procedure and makes a plea for "more and better anastomoses." There are several reasons for the high percentage of failure in this type of surgery: the minute size of the tubules, the tendency to scar formation at point of union, the friability of epididymal tubule, tension on the anastomosis, the high incidence of infection and the technical inefficiency of the surgeon in the particular procedure.

It is reasonable to expect that the success of the vas anastomosis procedure will be greater as the success of the vas anastomosis approximation of tubular structures of comparable size. When surgical attempts are made to circumvent occlusion of this system they should be preceded by tests to determine the patency of the lumen above the block and to prove the integrity of the testis by biopsy. It can be stated without fear of contradiction, therefore that occlusion of the vas and epididymis may be reversible and amenable to surgical restoration. The surgical procedures, although technically difficult, entail no mortality, slight morbidity, and, even if unsuccessful, result in no permanent disability.

In commenting on these conditions, it might be mentioned that, in cases of vasectomy and occlusion of the epididymis, the power of erection and ejaculation in the individual is not disturbed in any way. However, the ejaculate will contain no testicular component and will consist mainly of fluid provided by the seminal vesicles.

the prostate gland and the bulbourethral glands.

Since the modern opinion requires no testicular component in the ejaculate, cases of double vasectomy and bilateral occlusion of the epididymis will not constitute an impotent condition and, regardless of the temporary or permanent nature of the condition, will never constitute the element of impotency.

Inasmuch as the classic opinion of Cardinal Gasparri requires a testicular component in the ejaculate, the conditions of double vasectomy and bilateral occlusion of the epididymis, because there is an obstruction in the continuous channel, leading from the testes to the urethral orifice, would constitute an impotent condition. The important question that arises is whether or not this occlusion or obstruction can be reversed by the surgical procedure known as anastomosis. This particular technique requires great skill, if the effort is to be successful and yet very few surgeons have had the opportunity or have taken advantage of the opportunity to perform an anastomosis. Thus, there is serious question as to the successful outcome of this type of surgery in the hands of most surgeons. Even at best, O'Connor only reports 63% success in thirty cases of double vasectomy. Since this represents a very limited series, the results are not conclusive and the statistics cannot be taken on face-value. He points to only 8-10% success in his surgical efforts on sixty-one cases of bilateral chronic non-tuberculous epididymitis. This is a negligible percentage, when

it is considered that he has had much more experience in this particular type of surgery than the greater number of surgeons.

In view of the above statistics, it must be admitted that there exists the possibility of once again restoring the continuous pathway from the testes to the urethral orifice but the probability is open to serious question when a surgeon, inexperienced in this specialized and difficult type of surgery, attempts to undertake it.

Many authors believe that the repair surgery, while it does not involve any danger to the life of the individual and is licit, still has only limited probability of success; that this type of surgery cannot be considered an ordinary means and therefore, the conditions of double vasectomy and bilateral occlusion of the epididymis are to be considered permanent.

Cappello states that the possibility of a cure is to be evaluated not absolutely but relatively, by taking into consideration the important circumstances of person and place. Thus, if a person has undergone a double vasectomy operation or is suffering from bilateral occlusion of the epididymis and is living in an area where there are no surgeons with any experience in anastomosis surgery, and the possibility of a successful outcome is thereby diminished, the condition might well be termed irreversible and permanent.

On the other hand, where the possibility of a remedy is at least theoretically at hand, the permanency of the condition might be considered to be doubtful. In this case, the impediment of impotency

could not thereby be verified and a contemplated marriage could not be prohibited and a marriage, already contracted, must be considered to be valid, since at least a doubt of fact is said to exist. All of this consideration is under the Gasparri opinion, since the modern opinion would not consider these conditions, even if permanent, to constitute impotency.

#### CONCLUSIONS

1) An impotent condition, whether on the part of the man or on the part of the woman, whether absolute or relative, which has certainly been proved to have been antecedent and permanent, constitutes a diriment impediment, with basis in the natural law, and prohibits a marriage to be contracted and nullifies a marriage that has already been contracted.

2) An impotent condition will be considered antecedent if it has been proved to have been congenital or if the surgery, or accident, which accounted for it, antedated the marriage in question.

3) An impotent condition will be judged permanent, if absolutely no cure or remedy exists or if an actual cure was considered to have been effected by miraculous intervention rather than by natural means or if an existing remedy is judged to be illicit, immoral or sinful by reason of the means employed, or if it presents a danger to the life of the patient. The availability of a remedy must be judged on a relative rather than on an absolute basis, taking into consideration how advanced and modern is the medical and surgical practice in the area where the patient resides. If a remedy is

readily available but the impotent person refuses to submit to the required surgery or therapy and if impotency persists, the condition must still be judged to be temporary and not permanent. However, in such an eventuality, the other party might seek a dissolution of the marriage on the ground of non-consummation. Because medical science, through experimentation and research, is making rapid strides in conquering and finding cures for many illnesses, it is very possible that an impotent condition, considered permanent today, might be thought only temporary in the years to come and thus that which might prohibit or invalidate a marriage today will not be considered an impediment in the future. If a doubt arises as to the temporary or permanent nature of an impotent condition, the impediment of impotency cannot be said to be present and, therefore, a contemplated marriage cannot be prohibited or a contracted marriage cannot be invalidated but the possibility remains of having a marriage dissolved on the basis of non-consummation.

4) It is unanimously accepted that male potency requires the presence of a normally constructed and developed male organ, which is capable of being erected and of being sustained in erection long enough to penetrate the female vagina and to seminate within it.

5) What constitutes proper semination is a matter of controversy at the present time. The followers of Cardinal Gasparri demand that a testicular component be contained in the ejaculate and

therefore, in addition to the above-mentioned requirements, there should also be present at least one healthy testicle, which will elaborate some proper liquid over and above the spermatozoa and this liquid should pass through an uninterrupted passage from the testicle through the *vas deferens* and seminal vesicles to the urethra and ultimately be deposited in the vagina of the woman at the moment of ejaculation. The devotees of the modern opinion would not demand any testicular component in the ejaculate or an uninterrupted passage from the testicles to the urethra and would require only a satiative copula to be effected by a semination from the seminal vesicles, prostate gland, Cowper's gland and the bulbo-urethral glands. Those favoring this opinion would usually insist on the presence of at least one healthy testicle, which, by its elaboration of androgen hormone, would account for the erection of the male organ. However, the present writers feel that if an erection can be experienced, and sustained by maintaining the proper androgen level through the administration of a synthetic hormone in a male who had properly developed testicles up to puberty, then this modern theory should not require the presence of even one healthy testicle in those instances. Since synthetic androgen therapy is not effective in every instance, each case must be studied individually and decided on its own merits.

6) Since the Gasparri opinion and the modern opinion both enjoy probability, intrinsically and extrinsically, either can be pre-

ferred or invoked or there remains a third possibility, in the opinion of the present writers, that, because certainty does not exist on either side, a judgment can be made that a positive and probable doubt of law exists. Because of this doubt of law, in instances where at least one functioning testicle is not had or a testicular component is not present in the ejaculate because of the absence of the testicles or because of some irreversible obstruction along the passage, leading from the testicle to the urethral orifice, an anticipated marriage cannot be impeded or a contracted marriage cannot be declared null.

7) Although some few medical anomalies can be readily considered as impotent conditions and, because of their permanent nature, can be judged to constitute the impediment of impotency as well, yet, in most instances, an unqualified and categorical answer cannot be given but rather the individual, specific symptoms and factors of each case must be studied and analyzed before it can be determined that a given condition is one of impotency or that an impotent condition is permanent.

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