PREMATURE EJACULATION (PE) BASHH GUIDELINES UPDATE NOVEMBER 2012

PREMATURE EJACULATION IN A GU MEDICINE CLINIC SETTING

UK population studies suggest that up to 15% of men with sexual problems will opt to go to the GU clinic as a first port of call

DEFINITION OF PE

In 2010 the International Society for Sexual Medicine presented and discussed 10 possible definitions. After carefully reviewing the literature, the Committee on PE proposed that lifelong PE should be defined as

The male sexual dysfunction characterized by ejaculation which always or nearly always occurs prior to or within about one minute of vaginal penetration, and the inability to delay ejaculation on all or nearly all vaginal penetrations, and negative personal consequences, such as distress, bother, frustration and/or the avoidance of sexual intimacy. This only obtains in regard to heterosexual vaginal intercourse. (Evidence for this is Level 1a).

Additionally, the Committee concluded that there was insufficient published objective data to propose a new evidence-based definition of acquired PE, although it believed the proposed criterion for lifelong PE might be applied to acquired PE as well. (Evidence for this is level 5)

Waldinger proposed two additional “subtypes” for men who are distressed about their ejaculatory function. The ICSM committee felt these subtypes should be considered provisional. One is “natural variable PE”- which is characterized by early ejaculations
which occur irregularly and inconsistently with some subjective sense of diminished control of ejaculation. This subtype is not considered a sexual dysfunction or psychopathology but rather a normal variation in sexual performance\(^{3}\). The other is premature-like ejaculatory dysfunction and is characterized by: (i) subjective perception of consistent or inconsistent rapid ejaculation during intercourse; (ii) preoccupation with an imagined early ejaculation or lack of control of ejaculation; (iii) actual intravaginal ejaculation latency time (IELT) in the normal range or even of longer duration (i.e., an ejaculation that occurs after 5 minutes); (iv) ability to control ejaculation (i.e., to withhold ejaculation at the moment of imminent ejaculation) may be diminished or lacking; and (v) the preoccupation is not better accounted for by another mental disorder\(^{3}\) (level 5 evidence).

**PREVALENCE**

A number of recent population studies suggest the self reported prevalence of PE may be as high as 25%\(^{2}\). However applying only the time parameter (IELT approximately 1 minute) definition of PE to a population-based cohort of 500 men with stopwatch measured IELTs, only 1–3% would be eligible for the diagnosis\(^{4}\). These men were not given measures to assess control or distress. This lower prevalence estimates is more consistent with the numbers of men who present for treatment of PE.

**AETIOLOGY**

Based on a number of genetic studies Marcel Waldinger and others have suggested that there is a predisposition/diathesis model rather than true genetic influences that underlie men with lifelong PE. Clinical evidence suggests that men with PE should be assessed for varicoceles, withdrawing from medications such as citalopram and roboxetine and thyroid dysfunction\(^{2}\).
TREATMENT

Dapoxetine, an SSRI with a very short half life, has received a treatment license in a number of European countries. It has a rapid time to onset of action and should be taken 1-2 hours prior to intercourse. There are no significant drug interactions associated with dapoxetine. In randomized controlled trials dapoxetine 30 mg or 60 mg was more effective than placebo from the first dose, resulting in up to a 3 fold increases in IELT, increased ejaculatory control, decreased distress, and increased sexual satisfaction. Dapoxetine was comparably effective both in men with lifelong and acquired PE. Treatment-related side effects (nausea, diarrhea, headache, and dizziness) were uncommon and dose dependent (fewer on 30mg). They were responsible for study discontinuation in 4% (30 mg) and 10% (60 mg) of subjects. There was no indication of an increased risk of suicidal ideation or suicide attempts and little indication of withdrawal symptoms with abrupt dapoxetine cessation.

Dapoxetine will doubtlessly appeal to many men with PE. However, some will prefer to take daily conventional SSRIs, possibly because this helps sexual spontaneity and decreases generalized affective disorders which may accompany PE. It also may afford a useful opportunity to optimize the learning effects of a behavioral program.

LOCAL ANAESTHETICS

A eutectic mixture of prilocaine and lidocaine, specifically designed for men with PE has undergone extensive clinical trials. It is applied topically 5 min before intercourse and produces very rapid absorption of these drugs into the penile skin. This compound has undergone placebo controlled trials and shows improved ejaculatory latency and
significantly improved ejaculatory control and sexual satisfaction. It was well tolerated by both patients and partners, with no systemic side-effects and a low incidence of localized effects.

**TRAMADOL**

Treatment with on-demand tramadol, a centrally acting opioid analgesic with serotonergic activity, has been reported to significantly increase IVELT when taken as needed in placebo controlled studies. Because of its potential for dependency it is not generally recommended for routine use in men with PE.

**PDE5is**

It continues to be suggested that PDE5is may be useful in men with PE, although a systematic review did not support this contention. A recent well-designed study, however, suggests a potential role for these agents, and further evidence based research is needed. It may be that PDE5is may be helpful for men with PE in that they allow a subsequent erection soon after the first ejaculation- with concomitant physiological lengthening of IVELT in that scenario.

**BENEFITS OF COMBINATION MEDICAL AND PSYCHOLOGICAL THERAPY**

The few studies that exist support the contention that a combination of psychological/behavioral and pharmacotherapy is superior to each treatment component on its own. We believe that where possible this combination should be offered to all patients with PE.