Premature Ejaculation
fact sheet

Premature Ejaculation (PE) is **the most common male sexual dysfunction in men <60 years**, yet it is one of the most **under-diagnosed and under-treated**.[i]

It affects around **1 in 5 men** (according to the DSM-IV definition) worldwide and regardless of age.[ii] It's a complex medical condition which can be caused by various factors and can be described as **short ejaculatory latency time**, a **low or absent sense of control over ejaculation** and **negative personal consequences**.[iii]

Essentially, for men with PE, the sexual response presents an **ejaculation sequence that is compressed, occurring more quickly and with less control** than for non-PE men. In fact, the excitement phase is very quick, with generally a normal erection, a brief plateau followed by rapid ejaculation and orgasm.[iv]

<u>**Issue and prevalence**</u>

According to the ISSM (International Society for Sexual Medicine) PE is defined by:[v]

1. **Ejaculatory latency time (IELT) of about 1 minute** - *Ejaculation which always or nearly always occurs prior or within about one minute of vaginal penetration*
2. **Lack of control over ejaculation** - *Inability to delay ejaculation in all or nearly all vaginal penetration*
3. **Negative personal problems related to the condition** - *Negative personal consequences, such as distress, frustration and/or the avoidance of sexual intimacy*

The IELT (Intravaginal Ejaculatory Latency Time – it's the time from vaginal penetration to ejaculation) limit of about 1 minute is based on the observation that approximately 90% of men with Lifelong PE report IELTs of less than 1 minute and 10% have an IELT of 1 to 2 minutes.[vi]

IELT has a direct effect on the man's sense of control over ejaculation, but does not directly influence satisfaction or personal distress.[vii]

A man's level of perceived control over ejaculation is linked to whether he also experiences negative consequences associated with PE, including low satisfaction with sexual intercourse and personal distress related to ejaculation.[viii]

There are two types of PE:

1. **Primary PE** (also referred as "*lifelong*") – characterised by onset from the first sexual experience, which continues throughout life. In these cases ejaculation occurs too fast, before vaginal penetration or less than 1-2 minutes after[ix]
2. **Secondary PE** (also referred as "*acquired*") – characterised by gradual or sudden onset with ejaculation previously being normal.[x]

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PE is more prevalent in men < 60 years than Erectile Dysfunction (ED)[xi] and is not age-related[xii]. Approximately 50% of men with symptoms of PE indicated that these symptoms had been present since their first sexual intercourse experience.[xiii]
Despite its prevalence, PE still represents an underdetected and undertreated medical condition[xiv] as **men are often unwilling to discuss their symptoms with their doctors, often due to embarrassment or the perception that there are no solutions**. Also, men with PE believe there is no promising treatment for their condition.[xv] As a result, only **9%** of those with self-reported PE consulted a doctor[xvi] and of this small group nearly 70% did so at a visit scheduled for another reason. Of the 91% of men that had not consulted a physician 52.2% noted that they had never considered this option.[xvii]

Causes

The sexual response in men has been described as a cycle of characteristic physical changes, composing 4 phases: **desire, excitement, orgasm (ejaculation) and resolution**. Male sexual dysfunction generally occurs in one or more of the first 3 phases of the sexual response cycle, including dysfunctions of sexual desire (i.e. hypoactive sexual desire), arousal (i.e. erectile dysfunction and longer time needed until getting sexually aroused) and orgasm/ejaculation (i.e. premature ejaculation, delayed ejaculation and anejaculation).[xviii]

PE results from the rapid progression of the first 2 phases of the sexual response cycle but is not necessarily related to elevated or altered arousal.[xix] **Ejaculation is primarily influenced by central nervous system control and current evidence suggests that PE is a more neurobiological than psychological phenomenon**.[xx]
The process of ejaculation is centrally regulated and involves **a range of neurotransmitters**, including serotonin (5-HT), dopamine, oxytocin and others. Many data suggests that **serotonin and specific 5-HT receptors** subtypes are predominantly involved in the process of delaying ejaculation.
Consequently, **PE might be associated with the presence of low synaptic levels of serotonin in regions of the CNS that modulate ejaculation**.[xxi]

Secondary PE can be caused by both psychological and physical factors. Common physical causes of Acquired Premature Ejaculation include:

- Prostate diseases, especially prostatitis
- Erectile Dysfunction (ED)
- Hyperthyroidism
- Using recreational drugs

Common psychological causes include:

- Stress
- Anxiety about sexual intercourse

PE&Personal Distress – PE&Couples

A satisfying sex life is essential to any successful relationship, and sexual well-being is crucial to a person's overall health. The World Health Organisation (WHO) defines health as: *"A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"*.

Many aspects of the lives of both men and their partners are impacted by PE.[xxii]

Men with PE reported:

- a "very poor" or "poor" control over ejaculation (95%)
- personal distress "moderate" to "extreme" (90%)
- a "very poor" or "poor" satisfaction with intercourse (57%)
- interpersonal difficulty related to ejaculation (63%)

IELT was significantly shorter in men with PE compared with men without PE (1.8 median IELT for PE and 7.3 for non-PE men).[xxiii] The negative impact of PE can have a detrimental effect on self-confidence and may cause **mental distress, anxiety, embarrassment, frustration and depression.**[xxiv]

Partners of men with PE are also affected by this condition.

- more than 60% of the partners of PE men are not satisfied with the sexual intercourse[xxv]
- 60% of men with PE stated to believe that their relationship would be stronger if they were better able to satisfy the partner sexually[xxvi]
- the majority of men with PE (60%) would seek medical treatment if their partner suggested it and approximately 75% of those who have sought solutions have done so especially to improve their partner's sexual satisfaction[xxvii]

Treatment options

PE was initially seen as a psychological problem and for decades was treated with behavioural and cognitive therapies. Subsequently, pharmacological treatments such as prescription drugs and topical preparations have become available.

PE, both chronic (Lifelong) or Acquired, is often a condition of organic/neurobiological etiology that can be treated. If PE is caused by another disease (for instance by a non-diagnosed chronic prostatitis), the treatment of that disease will have positive effects also on PE. Even for treatment of Lifelong PE there are different options the doctor can offer to their patients.

In any case, a doctor's consultation is strongly recommended for a correct diagnosis and treatment.

Here are some of the treatments generally used in men with PE symptoms, that include a range of cognitive/behavioural approaches (e.g., special positions during sex, interrupted stimulation), topical desensitising agents, and prescription drugs.[xxviii]

Behavioural and cognitive therapy

These include different psychological and physical techniques aimed at training men to recognise pre-ejaculatory signs enabling them to improve their control over ejaculation.

- The most often used behavioural techniques are the **"stop-start"** technique (first introduced by Dr. J. Semans in 1956) and the **"squeeze" technique** (described by Masters and Johnson, 1970). (Porst, 2012) Several modifications of these techniques are available, but after initial success rates of 50-60%, clinical experience shows that they often fail to provide long term improvements. Instead of the "stop-start" technique, which can be unsatisfactory for the female partner, it is better for men to learn how to modulate and reduce the level of arousal and excitement by doing **slow, sensual movements while breathing deeply and slowly**. The goal is to keep the level of arousal below the ejaculation threshold, while maintaining a good erection. These breathing control techniques seem to have a calming effect and, at that moment, seem to really work. But clinical experience and scientific studies suggests that improvements achieved with these methods are generally not maintained on a long term.[xxix]
- **Masturbation before sexual intercourse** is a technique used by many younger men. Following masturbation, the penis can be desensitised, possibly resulting in greater ejaculatory delay after the recovery period. In a different approach, the man learns to recognise the signs of increased sexual arousal and how to keep his level of sexual excitement below the intensity that finally triggers the ejaculatory reflex.[xxx] Such self-help techniques, while partially effective in the short term, may actually exacerbate rather than alleviate PE, as they deliberately ignore or dampen the sexual sensations that need to be controlled in order to improve the condition. Furthermore, bad masturbation practice, i.e. a non-stop rush to climax, can further impede the development of ejaculation control mechanisms.[xxxi]

In general, there is no controlled research to support the efficacy of behavioural techniques.[xxxii]

Pharmacological treatment

Different oral treatments have been successfully used under medical prescription following PE diagnosis.

Topical creams or sprays containing anaesthetic compounds such as lidocaine and prilocaine, that desensitise the penis and thus help delaying ejaculation, provided moderate success-rates in smaller studies.[xxxiii] But these topical anaesthetic medications are often difficult

to dose and may therefore cause numbness of the glans/penis resulting in a loss of erection and/or ejaculation if they are overdosed. There is also the possibility of transferring the anaesthetic compound to the partner, thus reducing pleasurable sensations resulting in anorgasmia.[xxxiv]

Other methods

Other self-help techniques, including double condoms or condoms containing anaesthetics ("delay" condoms), which produce a slight numbing effect, while partially effective in the short term, they may ultimately exacerbate rather than alleviate PE, as they deliberately ignore or dampen the sexual sensations that need to be controlled in order to improve the condition.[xxxv]

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[i] Lindau 2007, McCarty 2012, Sotomayor 2005
[ii] EAU Guidelines 2012, Porst 2007
[iii] Shabsigh R. et al. 2007
[iv] Halvorsen 1992, Giuliano 2008
[v] McMahon 2008, EAU 2012, Althof 2010
[vi] McMahon et al. 2008
[vii] Giuliano et al. 2008, Patrick et al. 2007
[viii] Giuliano et al. 2008, Patrick et al. 2007
[ix] McMahon 2013, EAU 2012, Waldinger 2007, Jannini 2007, Broderick 2006
[x] McMahon 2013, EAU 2012, Buvat 2011, Rowland 2010, Waldinger 2007, Jannini 2007, Broderick 2006
[xi] Broderick 2006
[xii] McMahon 2008, Porst 2007, EAU 2012
[xiii] Laumann et al, 1999
[xiv] Lindau 2007, McCarty 2012, Sotomayor 2005
[xv] EAU 2012, Porst 2007, Sotomayor 2005
[xvi] EAU 2012, McMahon 2008, Porst 2007
[xvii] Laumann et al, 1999
[xviii] Miner 2008
[xix] Rosenberg 2011
[xx] Waldinger 2002, Giuliano 2006
[xxi] Giuliano 2006, 2008
[xxii] McMahon 2011, Buvat 2011, McCarty 2012
[xxiii] Giuliano 2008
[xxiv] Jannini 2002, Porst 2007
[xxv] Patrick 2005
[xxvi] Montorsi 2005
[xxvii] Porst 2007
[xxviii] Porst, 2012
[xxix] Revicki, 2008
[xxx] EUA, 2012
[xxxi] Revicki, 2008
[xxxii] EAU, 2012
[xxxiii] Althof, 2010
[xxxiv] ESSM.org, 2013
[xxxv] Sotomayor M, 2005; Atikeler MK, 2010

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