Definition of Premature Ejaculation

There are a number of definitions, none of which is wholly satisfactory. The DSM IV categorisation of the American Psychiatric Association defines premature ejaculation (PE) as “persistent or recurrent ejaculation with minimal sexual stimulation before, on or shortly after penetration, and before the person wishes” (1). The definition also stipulates that the PE results in marked distress or interpersonal difficulties, and that drugs (e.g. opiate withdrawal) should not be causative. Clinicians should also take into account factors such as age (the younger the patient the more likely that quick ejaculation will take place), the novelty of the situation or the partner and the frequency of the sexual activity (1).

However, it is important for clinicians to remember that in the community at large men and their partners may learn to adjust to fast ejaculation (e.g. by extended foreplay with brief intravaginal sex) and may not be distressed or dissatisfied in this scenario (2).

Primary PE is defined as PE that has always been present and secondary PE as the development of PE after a period of perceived normal ejaculatory functioning.

Prevalence of PE

In a recent, random survey of 1511 men in the USA, about one third considered that they had ejaculated prematurely over the past year (2). However, the proportion that perceived their condition as problematic was not stated. Studies carried out by the authors, of a GUM population attending a Central London clinic revealed substantial
rates of premature ejaculation and erectile dysfunction among routine GUM attenders (3) (4).

Aetiology of PE

The reader is referred to a detailed review of this elsewhere (5). However, the main factors are summarised below.

Idiopathic primary premature ejaculators may have lower penile sensory thresholds (6) and/or greater cortical penile representation (7) than their normal counterparts. Other workers contend that men with PE become sexually aroused more rapidly than normals (8). Both anxiety and depression have been associated with PE(9) although this may be a consequence of the condition rather than a cause. Others have failed to find such an association (10).

A number of psychodynamic theories have been proposed to explain PE, as well as psychosocial and relationship factors (5) (e.g. family problems or a recent new baby). It is possible that some racial groups are more susceptible than others to PE (11), particularly men from the Indian subcontinent who may present with the Dhat syndrome (12) (a clinical picture with some or all of the features of concern about spontaneous seminal loss, affective illnesses, psychosomatic complaints and PE).

There are a number of anecdotal reports of PE being associated with neurological disease, diabetes, pelvic injury, vascular disease, prostatic hypertrophy, chronic prostatitis and hypogonadotrophic hypogonadism (5)
Patient Assessment

(i) History
This should include a brief but thorough assessment of whether the problem is primary or secondary in nature, and any associated personal, social or religious correlates, as well as a brief medical and psychiatric history (including alcohol and illicit drug details). The presence of sexual desire should be documented finally it is important to ensure that fast detumescence is in fact not caused by erectile problems rather than PE. An interpreter may be needed to obtain the correct history.

(ii) Clinical examination
An assessment of the penis and other secondary sexual characteristics is mandatory as well as brief general physical and mental state assessments.

(iii) Investigations
No special investigations are routinely necessary to make the diagnosis of PE.

We consider that all new patients merit at least a 30 minute minimal consultation time for their first appointment.

Treatment of PE
General considerations
Treatment of PE should primarily attempt to alleviate concern about the condition as well as to increase sexual satisfaction in the patient and partner (if he has one). Simple measures such as education to discuss sexual norms, and facilitation of sexual negotiation between the couple (e.g. the man clitorally stimulates his partner to orgasm before vaginal penile entry) may be useful. Formal cognitive behaviour
therapy (CBT) may be usefully incorporated into the specific techniques described below.

Specific Treatments

These therapeutic options include:-

1. The squeeze/stop-start techniques
2. Pharmacotherapies
3. Other therapies

Squeeze/stop-start techniques

Most men learn to achieve ejaculatory control by various self learned techniques e.g. thought distraction, transient cessation of penile thrusting. The techniques described below merely attempt to formally train men in ejaculatory control.

In the “squeeze” technique (13) the glans is firmly squeezed between thumb and forefingers, at the frenular level until some detumesence results. This is usually accomplished using one hand, with the index finger and forefinger being placed dorsally over the glans and distal shaft and the thumb over the ventral subcoronal frenular area. The “squeeze” is usually accompanied by a diminution of sexual arousal. It should take place before the patient has reached the stage that he feels it is inevitable he is going to ejaculate/orgasm. This point may not be initially discernible to the patient with PE, but he usually learns to recognise it with time. A partner usually carries out the squeeze but the patient may train himself to control the PE by undertaking the squeeze himself.

A similar end point is reached by merely ceasing penile stimulation at the “pre-inevitable point” and then restarting penile stimulation when arousal and the erection have subsided. This is the so-called “stop-start” technique (14).
Both these techniques may be incorporated into a sensate focus regime. This is essentially a series of graded massage exercises, in which an initial ban is put on intercourse and the touching of erotic zones in order to relieve any performance anxiety. There is a gradual reintroduction of erotic massage, vaginal penetration (using the female –superior position) and, lastly penetrative intercourse. These behavioural techniques may take up to 3-6 months to achieve significant changes (5).

Masters and Johnson reported an initial success rate of greater than 95% in the treatment of PE using the squeeze technique (13). Less biased surveys indicate initial success rates of about 60%. Most of the initial treatment gains appear to be lost over follow up with time (15)(16)(17)(18).

Pharmacotherapies
Systemic therapies

A number of placebo-controlled studies show that both clomipramine and the SSRI antidepressants (e.g. fluoxetine, paroxetine, sertraline) significantly retard ejaculation (19)(20)(21)(22)(23). However, they may all produce quite marked side effects, particularly in higher dosages e.g. low sexual desire, erectile dysfunction and fatigue. They can be taken on a continuous basis, which is the usual practice, or as required some hours before sex is anticipated (24) The intermittent therapy can be commenced de novo (20) or after about a month of daily therapy (24).

The daily dosages used tend to be lower than those used to treat depression e.g. 10mg to 50 mg of clomipramine, 10mg to 20mg per day of fluoxetine, 10mg to 20mg of paroxetine or 50mg of sertraline. Once begun, medication needs to be continued
to retain its beneficial effect. However, it is possible there can be a learning effect while on medication, as in one study two thirds of the patients on continuous sertraline for 7 months maintained their improvement after drug withdrawal (25).

**Local therapies**

EMLA cream (prilocaine-lidocaine) or lidocaine ointment used on the frenular area of the penis 15-30 minutes before intercourse (but wiped off before sexual contact) can produce useful results in retarding ejaculation (26). Titrating the area of application against its effects can minimise penile numbness.

**Other treatments**

Both pelvic floor rehabilitation (27) and dorsal nerve neurotomy (28) have been shown to give good results in the short term but are experimental techniques at present and are not recommended for routine use.
References


