International Society for Sexual Medicine

QUICK REFERENCE GUIDE TO PE

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www.issm.info

What is PE?

Definition

Several definitions for PE exist but most are not evidenced-based, lack specific operational criteria and rely on the subjective judgment of the diagnostician. Three common constructs underlie most definitions of PE: (i) a short ejaculatory latency - the time from penetration to ejaculation; (ii) a lack of perceived self-efficacy or control about the timing of ejaculation; and (iii) distress and interpersonal difficulty (related to the ejaculatory dysfunction). After carefully reviewing the literature the ISSM offered the following evidence-based definition of lifelong PE:

A 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* *(LOE 1a)*.

Types of PE

PE can be divided into two subtypes:

Lifelong, with PE symptoms present since first sexual intercourse, and acquired, with PE symptoms developing after a period of satisfactory ejaculatory function.

Acquired PE: A male sexual dysfunction characterised by PE symptoms beginning after a period of normal ejaculatory function. There are insufficient data to propose an evidence-based definition but it is believed the proposed criterion for lifelong PE might be applied to acquired PE as well *(LOE 5d)*.

Anteportal ejaculation is the term for men who ejaculate prior to vaginal penetration and is considered the most severe form of PE.

** Althof SE, Abdo CHN, Dean J, et al. International Society for Sexual Medicine's Guidelines for the Diagnosis and Treatment of Premature Ejaculation. J Sex Med 2010;7:2947–2969*

Median Intravaginal Ejaculatory Latency Time (IELT)

In multinational studies, the median IELT is 5.4 minutes; median IELT may differ between countries *(LOE 2a)*.

Aetiology

The aetiology of premature ejaculation is not known. To date, no biological factor has been shown to be causative in the majority of men.

Epidemiology

Reliable information on the prevalence of lifelong and acquired PE in the general male population is lacking. Local and regional variations should be considered in the context of different cultural, religious, and political influences. Additionally, prevalence may vary across different demographics, including geography, ethnicity, and social status. Based on patient self-report, PE is routinely characterized as the most common male sexual dysfunction, with prevalence estimates ranging from 3% to 30%. In population-based studies using stopwatch assessment of ejaculatory latency, the prevalence is less than 3%. The true prevalence of PE is difficult to assess in clinical practice and probably less than 10% of PE sufferers seek help.

Is PE important?

In a systematic review of studies conducted between 1997 to 2007, all consistently confirmed a high level of personal distress reported both by men with PE *and* by their female partners. The negative impact on single men may be greater than on men in relationships as it serves as a barrier to seeking out and becoming involved in new relationships. Both affected men and their partners affirm negative effects and interpersonal difficulty related to their PE and an overall reduction in their quality of life *(LOE 1a–3a)*.

Clinical Assessment

Sexual problems, including PE, require a bio-psycho-social approach to their assessment. Enquiry about partner, relationship, social, cultural and contextual issues related to PE is mandatory. Self-estimation by the patient and partner of ejaculatory latency is recommended as the method for determining IELT in clinical practice *(LOE 2b)*. Two validated questionnaire instruments, the Premature Ejaculation Profile (PEP) and the Index of Premature Ejaculation (IPE), may serve as useful adjuncts, but are not substitutes for a full sexual history taken by a clinician *(LOE 2b)*. Healthcare professionals (HCP) have a responsibility to recognize PE and make affected individuals and couples feel comfortable about getting help. Initial work-up and treatment can be planned by any HCP who has good communication skills about sexual issues and who is knowledgeable about first-line treatments. If the HCP does not feel able to discuss and manage treatment options, or is faced with difficult or complex situations, referral to a sexual health specialist is appropriate.

Recommended questions	
For diagnosis	- What is the time between penetration and ejaculation (cumming)? - Can you delay ejaculation? - Do you feel bothered, annoyed, and/or frustrated by your premature ejaculation?

Optional questions	
Differentiate lifelong and acquired PE	- When did you first experience premature ejaculation? - Have you experienced premature ejaculation since your first sexual experience on every/almost every attempt and with every partner?
Assess erectile function	- Is your erection hard enough to penetrate? - Do you have difficulty in maintaining your erection until you ejaculate during intercourse? - Do you ever rush intercourse to prevent loss of your erection?
Assess relationship impact	- How upset is your partner with your premature ejaculation? - Does your partner avoid sexual intercourse? - Is your premature ejaculation affecting your overall relationship?
Previous treatment	- Have you received any treatment for your premature ejaculation previously?
Impact on quality of life	- Do you avoid sexual intercourse because of embarrassment? - Do you feel anxious, depressed, or embarrassed because of your premature ejaculation?

Examination

For lifelong PE, a physical examination is highly advisable but not mandatory; no routine investigations are recommended. For acquired PE, a targeted physical examination is mandatory to seek out associated problems, such as ED, thyroid dysfunction, and prostatitis; choice of any investigation should be guided the clinical picture *(LOE 5d)*.

Treatment

Pharmacological, psychological/behavioural, educational and combination treatment interventions may be appropriate and choice should be guided by patient preference and the bio-psycho-social assessment. Inclusion of the partner in the treatment process is an important but not a mandatory ingredient for treatment success. Where ED and PE co-exist, ED should be treated and erections optimised first *(LOE 1a)*; if PE remains a problem, it should be assessed and treated in accordance with contemporary clinical guidance *(LOE 3c)*.

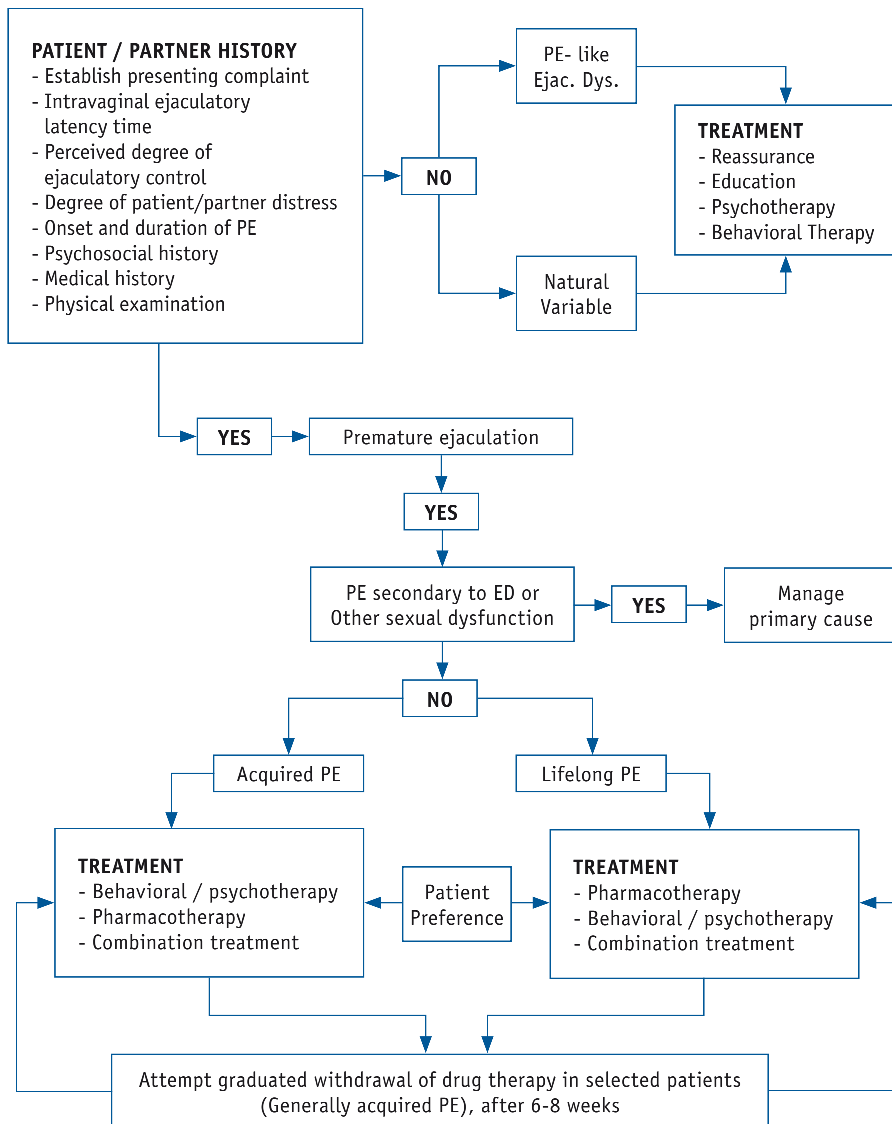
Monitoring treatment outcome

Treatment outcome can be assessed by a single-question Clinical Global Impression of Change (CGIC): “Compared to before starting treatment, would you describe your premature ejaculation problem as: much worse, worse, slightly worse, no change, slightly better, better, or much better?”

About these guidelines

In September 2009, the International Society for Sexual Medicine (ISSM) convened a three-day meeting to develop evidence-based clinical practice guidance on the management of PE for physicians. The 26 participants, who included most of the world’s recognized experts on PE, were selected to provide diversity of discipline, balance of opinion, knowledge, gender and cultural group. A comprehensive review of scientific literature on PE was conducted and quality of evidence and the strength of any recommendations were graded using the Oxford Centre of Evidence-Based Medicine system. The process was supported by an unrestricted grant from Johnson and Johnson but ISSM required complete independence from industry influence during the development of the guideline and related resources. There was no attempt by industry to influence any part of the development or writing process at any time.

Algorithm for the Management of PE*



** with permission of D. Rowland*

Summary of recommended pharmacological treatments for premature ejaculation

Drug	Daily dose/ as needed	Dose	IELT fold increase	Side effects	Status	Level of evidence
Oral therapies						
Dapoxetine	As needed	30-60 mg	2.5-3	- Nausea - Diarrhea - Headache - Dizziness	Approved in some countries	1a
Paroxetine	Daily dose	10-40 mg	8	- Fatigue - Yawning - Nausea - Diarrhea - Perspiration - Decreased sexual desire - Erectile dysfunction	Off label	1a
Clomipramine	Daily dose	12.5-50 mg	6		Off label	1a
Sertraline	Daily dose	50-200 mg	5		Off label	1a
Fluoxetine	Daily dose	20-40 mg	5		Off label	1a
Citralopam	Daily dose	20-40 mg	2		Off label	1a
Paroxetine	Daily dose for 30 days and then as needed	10-40 mg	11.6		Off label	1a
Paroxetine	As needed	10-40 mg	1.4		Off label	1a
Clomipramine	As needed	12.5-50 mg	4		Off label	1a
Topical therapy						
Lidocaine/ prilocaine	As needed	25 mg/gm lidocaine 25 mg/gm prilocaine	4-6	- Penile numbness - Partner genital numbness - Skin irritation - Erectile dysfunction	Off label	1b

IELT = Intravaginal Ejaculation Latency Time.

For more information

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