

# PREMATURE EJACULATION AND OTHER EJACULATORY DISORDERS

## DIAGNOSIS AND MANAGEMENT



### PREMATURE EJACULATION (PE)

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- The most common ejaculatory disorder
  - Ejaculation that occurs sooner than desired
  - Commonly defined as an intravaginal ejaculatory latency time of less than 2 minutes
    - however, clinically it can be defined by the distress it causes to either one or both partners
  - Can be classified into 2 main types, primary and secondary PE
  - Primary (lifelong) PE
    - patient has never had control of ejaculation
    - disorder of different/lower set point for ejaculatory control
    - unlikely to diagnose an underlying disease
    - younger men don't usually present early
  - Secondary (acquired) PE
    - patient was previously able to control ejaculation
    - most commonly associated with erectile dysfunction (ED)
- ▶ **Clinical note:** PE is a self reported diagnosis, and can be based on sexual history alone

➔ Refer to Comprehensive Guide 8

#### The GP's role

- GPs are typically the first point of contact for men with a disorder of ejaculation
- The GP's role in management of PE includes diagnosis, treatment and referral
- Offer brief counselling and education as part of routine management

#### How do I approach the topic?

- "Many men experience sexual difficulties. If you have any difficulties, I am happy to discuss them"

### Diagnosis

#### Medical history

##### Sexual history

- ❑ Establish presenting complaint (i.e. linked with ED)
- ❑ Intravaginal ejaculatory latency time
- ❑ Onset and duration of PE
- ❑ Previous sexual function
- ❑ History of sexual relationships
- ❑ Perceived degree of ejaculatory control
- ❑ Degree of patient/partner distress
- ❑ Determine if fertility is an issue

##### Medical

- ❑ General medical history
  - ❑ Medications (prescription and non prescription)
  - ❑ Trauma (urogenital, neurological, surgical)
  - ❑ Infections
- ##### Psychological
- ❑ Depression
  - ❑ Anxiety
  - ❑ Stressors
  - ❑ Taboos or beliefs about sex (religious, cultural)

#### Physical examination

- General examination
- Genito-urinary: penile and testicular
  - rectal examination (if PE occurs with painful ejaculation)
- Neurological assessment of genital area and lower limb

➔ Refer to GP Summary Guide 1

➔ Refer to GP Comprehensive Guide 8

### Management

#### Treatment

#### Treatment decision-making should consider:

- Aetiology
- Patient needs and preferences
- The impact of the disorder on the patient and his partner
- Whether fertility is an issue

Management of PE is guided by the underlying cause

Primary PE:

- 1st line: SSRI, reducing penile sensation
- 2nd line: Behavioural techniques, counselling
- Most men require ongoing treatment to maintain normal function

Secondary PE

- Secondary to ED: Manage the primary cause **or**
- 1st line: Behavioural techniques, counselling
- 2nd line: SSRI, reducing penile sensation
- Many men return to normal function following treatment

#### Treatment options:

##### Erectile Dysfunction (ED) treatment

- If PE is associated with ED, treat the primary cause (e.g. PDE5 inhibitors)

➔ Refer to GP Summary Guide 9

##### Behavioural techniques

- 'Stop-start' and 'squeeze' techniques, extended foreplay, pre-intercourse masturbation, cognitive distractions, alternate sexual positions, interval sex and increased frequency of sex
- Techniques are difficult to maintain long-term

##### Psychosexual counselling

- Address the issue that has created the anxiety or psychogenic cause
- Address methods to improve ejaculatory control. Therapy options include meditation/relaxation, hypnotherapy and neuro-biofeedback

##### Oral pharmacotherapy

A common side-effect of some selective serotonin reuptake inhibitors (SSRI) and tricyclic antidepressants is delayed ejaculation. SSRIs are now commonly prescribed for PE. A number of treatment regimes have been reported, including:

- **Clomipramine hydrochloride\***: 25-50mg/day or 25 mg 4-24 hrs pre-intercourse.  
*\*Suggest 25mg on a Friday night for a weekend of benefit (long acting)*
- **Fluoxetine hydrochloride**: 20mg/day
- **Paroxetine hydrochloride**: 20mg/day. Some patients find 10mg effective; 40mg is rarely required. Pre-intercourse dosing regime is generally not effective
- **Sertraline hydrochloride**: 50mg/day or 100mg/day is usually effective. 200mg/day is rarely required. Pre-intercourse dosing regime is generally not effective

'Start low and titrate slow'. Trial for 3-6 months and then slowly titrate down to cessation. If PE reoccurs, trial drug again. If one drug is not effective, trial another

- ▶ **Clinical note:** New SSRI drugs which can be taken on demand are currently being investigated

### Reducing penile sensation

- **Topical applications:** Local anesthetic gels/creams can diminish sensitivity and delay ejaculation. Excess use can be associated with a loss of pleasure, orgasm and erection. Apply 30 minutes prior to intercourse (or use condom) to prevent trans-vaginal absorption
- **Lignocaine ointment:** 5% 20-30 minutes pre-intercourse
- **Lignocaine spray:** 10% ('Stud' 100 Desensitising spray for men)
- **Double condoms:** Using 2 condoms can diminish sensitivity and delay ejaculation

▶ **Clinical note:** combination treatment can be used.

### Specialist referral

For general assessment refer to a specialist (GP, endocrinologist or urologist) who has an interest in sexual medicine.

**Refer to a Urologist:** If suspicion of lower urinary tract disease

**Refer to an Endocrinologist:** If a hormonal problem is diagnosed

**Refer to counsellor, psychologist, psychiatrist or sexual therapist:**

For issues of a psychosexual nature

**Refer to Fertility specialist:** If fertility is an issue

## OTHER EJACULATORY DISORDERS

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- Spectrum of disorders including delayed ejaculation, anorgasmia, retrograde ejaculation, anejaculation and painful ejaculation
- Can result from a disrupted mechanism of ejaculation (emission, ejaculation and orgasm)
- Disorders of ejaculation are uncommon, but are important to manage when fertility is an issue
- Etiology of ejaculatory dysfunction are numerous and multifactorial, and include psychogenic, congenital, anatomic causes, neurogenic causes, infectious, endocrinological and secondary to medications (antihypertensive, psychiatric,  $\alpha$ -blocker)

↓ Refer to Comprehensive Guide 8

### Delayed ejaculation / no orgasm

#### Delayed ejaculation

- Delayed ejaculation occurs when an 'abnormal' or 'excessive' amount of stimulation is required to achieve orgasm with ejaculation
- Often occurs with concomitant illness

#### Investigation

- Testosterone levels

#### Treatment:

- **Aetiological treatment:** Management of underlying condition or concomitant illness e.g. androgen deficiency
- **Medication modification:** consider alternative agent or 'Drug holiday' from causal agent
- **Psychosexual counselling**

#### Anorgasmia

- Anorgasmia is the inability to reach orgasm
- Some men experience nocturnal or spontaneous ejaculation
- Etiology is usually psychological

#### Investigation

- Testosterone levels

#### Treatment:

- **Psychosexual counselling**
- **Medication modification:** consider alternative agent or 'Drug holiday' from causal agent
- **Pharmacotherapy:** PDE-5 Inhibitors - e.g. Sildenafil (Viagra®: 25-50mg), 30-60 minutes pre-intercourse.

### Orgasm with no ejaculation

#### Retrograde "dry" ejaculation

- Retrograde ejaculation occurs when semen passes backwards through the bladder neck into the bladder. Little or no semen is discharged from the penis during ejaculation
- Patients experience a normal or decreased orgasmic sensation
- The first urination after sex looks cloudy as semen mixes into urine

#### Investigation

- Post-ejaculatory urinalysis - presence of sperm and fructose

#### Treatment:

- **Counselling:** to normalise the condition
- **Pharmacotherapy:** possible restoration of antegrade ejaculation and natural conception
  - Imipramine hydrochloride (10mg, 25mg tablets) 25-75mg three times daily
  - Pheniramine maleate (50mg tablet) 50mg every second day
- **Medication modification:** consider alternative agent or 'Drug holiday' from causal agent
- **Behavioural techniques:** The patient may also be encouraged to ejaculate when his bladder is full, to increase bladder neck closure
- **Vibrostimulation, electroejaculation, or sperm recovery from post-ejaculatory urine:** Can be used when other treatments are not effective, to retrieve sperm for assisted reproductive techniques (ART)

#### Anejaculation

- Anejaculation is the complete absence of ejaculation, due to a failure of semen emission from the prostate and seminal ducts into the urethra
- Anejaculation is usually associated with normal orgasmic sensation

#### Investigation

- Testosterone levels
- Post-ejaculatory urinalysis - absence of sperm and fructose

#### Treatment:

- **Counselling:** to normalise the condition
- **Medication modification:** consider alternative agent or 'Drug holiday' from causal agent
- **Vibrostimulation or electroejaculation:** Used when other treatments are not effective, to retrieve sperm for ART

### Painful ejaculation

- Painful ejaculation is an acquired condition where painful sensations are felt in the perineum or urethra and urethral meatus
- Multiple causes e.g. ejaculatory duct obstruction, post-prostatitis, urethritis, autonomic nerve dysfunction

#### Investigation

- Urine analysis (first pass urine- Chlamydia & Gonorrhoea urine PCR test; midstream urine MC&S)
- Cultures of semen (MC&S)
- Cystoscopy

#### Treatment:

**Aetiological treatment (e.g. infections-prostatitis, urethritis):** Implement disease specific treatment

**Behavioural techniques:** If no physiological process identified. Use of relaxation techniques (i.e. ejaculation in conditions when muscles can be relaxed), use of fantasy for distraction

**Psychosexual counselling** ↓ Refer GP Comprehensive Guide 8