

PREMATURE EJACULATION (PE)

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Management

- The most common ejaculatory disorder
 - Ejaculation that occurs sooner than desired
 - Commonly defined as an intravaginal ejaculatory latency time of less than 1–2 minutes
 - however, clinically it can be defined by the distress it causes to either one or both partners
 - Can be classified into two main types, primary and secondary PE
 - Primary (lifelong) PE
 - patient has never had control of ejaculation
 - disorder of 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 notes:** PE is a self reported diagnosis, and can be based on sexual history alone

✚ Refer to Clinical 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 Clinical Summary Guide 1

✚ Refer to Clinical Comprehensive Guide 8

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, PDE5 inhibitors
- 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 Clinical 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 notes:** 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 spray:** 10% ('Stud' 100 Desensitising spray for men)
- **Condoms:** Using condoms can diminish sensitivity and delay ejaculation

► **Clinical notes:** 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, α -blocker)

↓ Refer to Clinical 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
- Causes include prostate surgery, diabetes
- 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 to Clinical Comprehensive Guide 8