PREMATURE EJACULATION
AND OTHER EJACULATORY DISORDERS
– DIAGNOSIS AND MANAGEMENT

PREMATURE EJACULATION (PE)

- The most common ejaculatory disorder
- Ejaculation that occurs sooner than desired
- Primary (lifelong) PE
  - patient has never had control of ejaculation
  - disorder of lower set point for ejaculatory control
  - unlikely to diagnose an underlying disease
- Secondary (acquired) PE
  - patient was previously able to control ejaculation
  - most commonly associated with erectile dysfunction (ED)
- Definition (ISSM, 2014):
  - an intravaginal ejaculatory latency time of less than about 1 minute (lifelong) or about 3 minutes (acquired), and
  - an inability to delay ejaculation on nearly all occasions, and
  - negative personal consequences such as distress.
- Primary (lifelong) PE tends to present in men in their 20s and 30s; secondary (acquired) PE tends to present in older age groups

Clinical notes: PE is a self reported diagnosis, and can be based on sexual history alone

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)
  - Prostatitis or hyperthyroidism (uncommonly associated)

- 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

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)

Behavioural techniques
  - Refer to Clinical Summary Guide 9
  - ‘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

Psychosocial 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 regimens have been reported, including:
  - Dapoxetine hydrochloride (Priligy®): a short-acting on-demand SSRI, recently approved for use in Australia; 30 mg taken 1-3 hours before intercourse.
  - Fluoxetine hydrochloride: 20 mg/day
  - Paroxetine hydrochloride: 20 mg/day. Some patients find 10mg effective; 40 mg is rarely required. Pre-intercourse dosing regime is generally not effective
  - Sertraline hydrochloride: 50 mg/day or 100 mg/day is usually effective. 200 mg/day is rarely required. Pre-intercourse dosing regime is generally not effective
  - Clomipramine hydrochloride*: 25-50 mg/day or 25 mg 4-24 hrs pre-intercourse.
* Suggest 25 mg on a Friday night for a weekend of benefit (long acting)

- PDE-5 Inhibitors: e.g. Sildenafil (Viagra®: 25-50 mg), 30-60 minutes pre-intercourse if PE is related to ED.
  - ‘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.
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 a condom (note that a condom containing anesthetic - ‘Durex Extended Pleasure’ – is available) to prevent trans-vaginal absorption
- **Lignocaine spray:** 10% (‘Stud’ 100 Desensitising spray for men; this should be used with a condom to prevent numbing of partner’s genitalia)
- **Condoms:** Using condoms can diminish sensitivity and delay ejaculation, especially condoms containing anesthetic

**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

- 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)

#### Delayed ejaculation / no orgasm

**Delayed ejaculation**

- Delayed ejaculation occurs when an ‘abnormal’ or ‘excessive’ amount of stimulation is required to achieve orgasm with ejaculation (emission, ejaculation and orgasm)
- Often occurs with concomitant illness
- Associated with ageing
- Can be associated with idiosyncratic masturbatory style (psychosexual)

**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
- Aetiology is usually psychological

**Investigation**

- **Testosterone levels**

**Treatment:**

- **Psychosexual counselling**
- **Medication modification:** consider alternative agent or ‘Drug holiday’ from causal agent
- **Pharmacotherapy:** Pheniramine maleate, decongestant medication such as Sudafed® or antihistamines such as Periactin® may help but have a low success rate.

### 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; note that pharmacotherapy may not be successful
  - Imipramine hydrochloride (10 mg, 25 mg tablets) 25-75 mg three times daily
  - Pheniramine maleate (50 mg tablet) 50 mg every second day
  - Decongestant medication such as Sudafed®; antihistamines such as Periactin®
- **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
- **Pharmacotherapy:** Pheniramine maleate, decongestant medication such as Sudafed® or antihistamines such as Periactin® may help but have a low success rate.

#### 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**

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