PREMATURE EJACULATION (PE)

- 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
- Secondary (acquired) PE
  - patient was previously able to control ejaculation
  - most commonly associated with erectile dysfunction (ED)
- 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
- 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

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, 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
- ‘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*: 25-50 mg/day or 25 mg 4-24 hrs pre-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
  - Dapoxetine hydrochloride (Priligy®): a short-acting on-demand SSRI, recently approved for use in Australia; 30 mg taken 1-3 hrs before intercourse.
  - 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.

* Suggest 25 mg on a Friday night for a weekend of benefit (long acting)
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
- 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®
  - ‘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
- **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 MChS)**
- **Cultures of semen (MCtS)**
- **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**