International Society for Sexual Medicine - www.issm.info

ISSM QUICK REFERENCE GUIDE TO PE

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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).

In 2014, the ISSM PE Guidelines Committee introduced a unified (for both lifelong and acquired subtypes of PE) definition of PE that states

"PE is a male sexual dysfunction characterized by:

- **ejaculation which always or nearly always occurs prior to or within about one minute of vaginal penetration from the first sexual experience (lifelong premature ejaculation), OR, a clinically significant reduction in latency time, often to about 3 minutes or less (acquired premature ejaculation), 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)*.***

In 2013, the DSM 5 adopted the ISSM definition of lifelong premature ejaculation. It included the requirement that the dysfunction occur in 75% - 100% of encounters and needs to be present for 6 months.

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

Additionally, two provisional subtypes termed natural variable and subjective may be helpful to clinicians who have patients complaining of premature ejaculation but do not meet the diagnostic criterion:

- Natural variable PE is characterized by short ejaculatory latency which occurs irregularly and inconsistently with some subjective sense of diminished control of ejaculation. This subtype is not considered a sexual dysfunction but rather a normal variation in sexual performance.
- Subjective PE is characterized by one or more of the following:
  1. subjective perception of consistent or inconsistent short IELT;
  2. preoccupation with an imagined short ejaculatory latency or lack of control over the timing of ejaculation;
  3. actual IELT in the normal range or even of longer duration (i.e. an ejaculation that occurs after 5 minutes);
  4. ability to control ejaculation (i.e. to withhold ejaculation at the moment of imminent ejaculation) that may be diminished or lacking and;
  5. the preoccupation that is not better accounted for by another mental disorder *(LOE 5d)*.

** Althof S, McMahon C, Waldinger M, Serefoglu E, Shindel A, et. al An Update of the International Society of Sexual Medicine's Guidelines for the Diagnosis and Treatment of Premature Ejaculation (PE). Journal of Sexual Medicine, 11: 1392 - 1422.*

Serefoglu EC, McMahon CG, Waldinger MD, Althof SE, Shindel An Evidence-Based Unified Definition of Lifelong and Acquired Premature Ejaculation: Report of the International Society for Sexual Medicine (ISSM) Second Ad Hoc Committee for the Definition of Premature Ejaculation. Journal of Sexual Medicine, 2014, 11: 1423 - 1441.

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

Utilizing the ISSM and DSM-5 definition of PE, in terms of an IELT of about 1 minute, the prevalence of lifelong PE is unlikely to exceed 4% of the general population *(LOE 3b)*. Recent studies suggest the prevalence of acquired PE is approximately 4% as well. The prevalence of Variable PE and Subjective PE was 9.5 and 6% respectively.

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. 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)*.

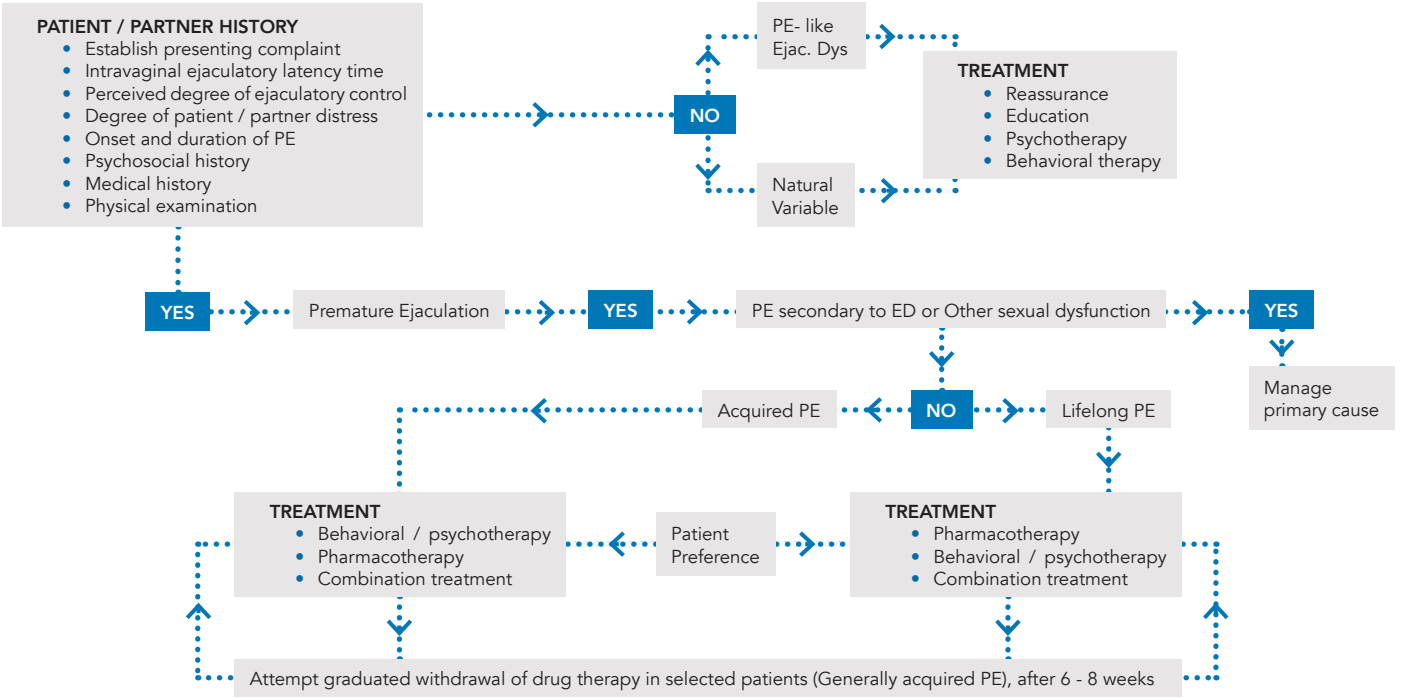
Monitoring treatment outcome

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 April, 2013, the International Society for Sexual Medicine (ISSM) convened a two-day meeting to develop evidence-based clinical practice guidance on the management of PE for physicians. The 20 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
Topical therapy						
Lidocaine / Prilocaine	As needed	22.5 mg Lidocaine 7.5 mg Prilocaine	4 - 6	• Penile numbness • Partner genital numbness • Skin irritation • Erectile dysfunction	Approved in certain countries	1a
Lidocaine	As needed	9.6% (w/w)	2 - 3		Sold over the counter	1b

IELT = Intravaginal Ejaculation Latency Time

For more information

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