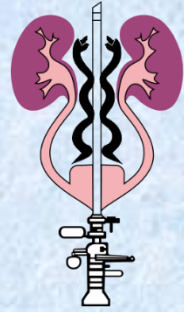


PREMATURE EJACULATION



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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 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)
- PE is a self reported diagnosis, and can be based on sexual history alone

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

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 (antidepressants) , 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*: 25-50mg/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.

Teşekkürler