Urology CHEAT SHEETS

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PREMATURE EJACULATION

CONCEPT OF EARLY EJACULATION

"Premature ejaculation (PE) is characterized by ejaculation that occurs prior to or within a **very short period** after the initiation of vaginal penetration or other relevant sexual stimulation, **with no or little perceived control over ejaculation**. It can occur episodically or persistently over a period of at least several months and is associated with significant **distress** "

* Int. Classification of Diseases 11th Rev.

TYPES OF PREMATURE EJACULATION

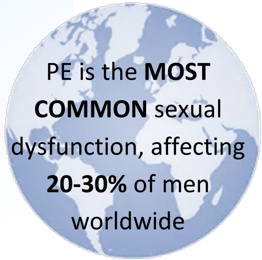
LIFELONG: < 1 min. Primary. Genetic/neurobiological causes.

ADQUIRED: < 3 min. Psychological or somatic.

VARIABLE: It occurs only on certain occasions. Normal variant.

SUBJECTIVE: The patients complain despite a normal ejaculation time (> 3 min). Psychological origin.

DMS-V / ISSM.



DIAGNOSIS

CLINICAL AND SEXUAL INFORMATION provided by the patient and/or partner.

To evaluate: **IELT (Intravaginal ejaculatory latency time: time from penetration to ejaculation):** self-estimated, perceived control, distress, bother, frustration, interpersonal difficulty related to the ejaculatory dysfunction.

Exploration: identify anatomical abnormalities that may be associated with PE or other sexual dysfunctions, particularly erectile dysfunction (ED).

Standardized questionnaires (optional):

- **PEDT** (Premature Ejaculation Diagnostic Tool)*
- **AIPE** (Arabic Index of Premature Ejaculation)*
- **PEP** (Premature Ejaculation Profile)
- **MSHQEjD** (Male Sexual Health Questionnaire Ejaculatory Dysfunction)
- **IPE** (Index of Premature Ejaculation)

* Discriminate patients who have PE and those who do not

Routine neurophysiological or laboratory tests are **not recommended**

TREATMENT

- **Counseling / patient education**
- Discussion of **treatment options**
- Include the **partner** if possible and assess the impact of the PD on her.
- If PD **is secondary to erectile dysfunction (ED), treat it first or concomitantly**
- Surgical treatment: (postectomy, neurotomy) Little evidence, difficult to establish risk / benefit. It is considered experimental.

ETIOLOGICAL TREATMENT (if organic cause)
ED, prostatitis, lower urinary tract symptoms (LUTS), anxiety, hyperthyroidism.

SEXOLOGICAL THERAPY
(usually combined with pharmacological treatment)

INDIVIDUAL
Relaxation exercises. Anxiety control
Kegel exercises, pelvic floor training.

COUPLE
Stop / start technique
Penis compression technique (*squeeze*)
Vaginal penetration without movements
Cognitive behavioral arousal technique
Elimination of cognitive distortions in sexual intercourse
Sensory targeting techniques

PHARMACOLOGICAL TREATMENT (1st line in Permanent PE) APPROVED:

DAPOXETINE: short-acting SSRI, the first drug specifically designed for PE. Works on permanent and acquired EP. Use on demand; **30 or 60 mg, 1-2 h. before intercourse**. Increase IELT 2.5-3 times, respectively. Dose dependent adverse effects (AEs) (4-10%): nausea, diarrhoea, headache and dizziness.

LIDOCAINE / PRILOCAINE SPRAY (150/50 mg/ml): Concentrates a controlled dose film covering the glans, maximizing **neural blockage and minimizing the appearance of numbness.** AEs: genital hypoesthesia (4.5% and 1% in couples), ED (4.4%), and vulvovaginal burning (3.9%). No systemic effects.

OFF-LABEL TREATMENTS:

- **Tramadol:** Inhibits norepinephrine and serotonin reuptake. On demand, 50 mg 2 h. before intercourse, it has shown to increase the IELT significantly. Very few EAs.
- **Topical anaesthetics:** May cause skin reactions and an excessive hypoesthesia in the penis and vagina. Little evidence.
- **Clomipramine:** serotonergic tricyclic antidepressant. On demand, 15 mg, 2-6 h before intercourse. EAs: nausea (15.7%), dizziness (4.9%)
- **SSRI:** Daily use, little evidence. Paroxetine, fluoxetine, sertraline. Effect at 2 weeks, tachyphylaxis from 6 m. Many EAs, some serious.
- **PDE5I:** The combination of SSRIs and PDE5I may be more effective compared to SSRIs or PDE5I alone.