Urology CHEAT SHEETS

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EAU Guidelines on Sexual and Reproductive Health

Premature ejaculation

DISORDERS OF EJACULATION:

Introduction

Ejaculation is a complex physiological process that comprises emission and expulsion processes and is mediated by interwoven neurological and hormonal pathways. Any interference with those pathways may cause a wide range of ejaculatory disorders. The spectrum of ejaculation disorders includes premature ejaculation (PE), retarded or delayed ejaculation, anejaculation, painful ejaculation, retrograde ejaculation, anorgasmia and haemospermia.

Premature ejaculation

Male early ejaculation is characterized by ejaculation that occurs prior to or within a very short duration of the initiation of vaginal penetration or other relevant sexual stimulation, with no or little perceived control over ejaculation.

The pattern of early ejaculation has occurred episodically or persistently over a period of at least several months and is associated with clinically significant distress.

Pathophysiology and risk factors:

The aetiology of PE is relatively unknown, with limited data supporting biological and psychological hypotheses like anxiety, penile hypersensitivity, and 5-HT receptor dysfunction.

Classification into four subtypes—lifelong, acquired, variable, and subjective PE—helps in understanding its variations. Lifelong PE may involve serotonergic, dopaminergic, oxytocinergic, genetic, and epigenetic factors, while acquired PE often relates to psychological issues or comorbidities such as ED.

PE prevalence isn't age-dependent but may be higher in men with lower education and certain ethnic backgrounds.

Men with PE report lower relationship satisfaction, difficulty relaxing, and less frequent intercourse, affecting self-confidence and causing mental distress.

Diagnostic evaluation:

Diagnosis of PE relies on the patient's medical and sexual history, classifying PE as lifelong or acquired, situational or consistent, and evaluating ejaculation duration, sexual stimulus, and QoL impact.

Intravaginal ejaculatory latency time (IELT) measurement is used but not solely sufficient to define PE, with self-estimated IELT adequate in clinical practice. Diagnostic tools include the Premature Ejaculation Diagnostic Tool (PEDT), Arabic Index of Premature Ejaculation (AIPE), Premature Ejaculation Profile (PEP), Index of Premature Ejaculation (IPE), and Male Sexual Health Questionnaire Ejaculatory Dysfunction (MSHQ-EjD) questionnaires, with physical exams and tests recommended based on specific findings.

Recommendations	Strength rating
Perform the diagnosis and classification of premature ejaculation (PE) based on medical and sexual history, which should include assessment of intravaginal ejaculatory latency time (IELT) (self-estimated), perceived control, distress and interpersonal difficulty due to the ejaculatory dysfunction.	Strong
Use patient-reported outcomes in daily clinical practice.	Weak
Include physical examination in the initial assessment of PE to identify anatomical abnormalities that may be associated with PE or other sexual dysfunctions, particularly erectile dysfunction.	Strong
Do not perform routine laboratory or physiological tests. They should only be directed by specific findings from history or physical examination.	Strong

Clinical diagnosis of premature ejaculation based on patient +/- partner history
- Time to ejaculation (IELT)
- Perceived degree of ejaculatory control
- Degree of bother/stress
- Onset and duration of PE
- Psychosocial/relationship issues
- Medical history
- Physical examination

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Treatment of premature ejaculation
Patient counselling/education
Discussion of treatment options
If PE is secondary to ED, treat ED first or concomitantly

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- Pharmacotherapy (recommended as first-line treatment option in lifelong PE)
  - Approved on-demand treatment options for PE: Dapoxetine and Lidocaine/prilocaine spray
  - Off-label treatments include chronic daily use of antidepressants (SSRIs or clomipramine) or tramadol on demand
- Combination treatment (pharmacotherapy with behavioural therapy)

Diagnosis | Treatment | Follow-up

Disease management:

Before treatment, define the PE subtype and discuss expectations.

Pharmacotherapy is first-line for lifelong PE, while treating underlying causes is key for acquired PE. Behavioral techniques benefit variable/subjective PE, and psychotherapy is an option.

Recommendations for assessment	Strength rating
Assess sexual history and psychosexual development.	Strong
Assess anxiety, and interpersonal anxiety; focus on control issues.	Strong
Include the partner if available; check for the impact of PE on the partner.	Strong
Recommendations for treatment (psychosexual approach)	
Use behavioural, cognitive and/or couple therapy approaches in combination with pharmacotherapy. Discuss the use of mindfulness exercises.	Weak

Pharmacotherapy:

- **Dapoxetine, a short-acting selective serotonin reuptake inhibitors (SSRI), is approved in Europe (not the USA) for on-demand PE treatment, doubling IELT at 30 mg and tripling at 60 mg, with common side effects including nausea and headache. It can be combined safely with PDE5Is for better outcomes.**
- **Off-label-Antidepressants: SSRIs like paroxetine, sertraline, and clomipramine delay ejaculation, though side effects include fatigue and nausea. Their use requires caution in those with depressive disorders due to risks like suicidal ideation.**
- **Topical-Anaesthetics: Lidocaine/prilocaine creams or sprays, applied before sex, can significantly increase IELT but may cause numbness if transferred to the partner.**
- **Tramadol: As a centrally acting analgesic, can increase IELT twofold but carries risks of addiction, sedation, and breathing issues, limiting long-term use.**
- **PDE5-Inhibitors: Though not improving IELT, sildenafil boosts ejaculatory control, satisfaction, and reduces anxiety. Combined with SSRIs, it enhances outcomes.**
- **Other-Drugs: selective α-blockers, oxytocin antagonists and pregabalin show mild efficacy but need further research to confirm their safety and effectiveness.**

Psychosexual interventions for PE aim to improve ejaculatory control, confidence, and reduce anxiety. Combined techniques, like start-stop exercises with mindfulness, show benefits, and smartphone-based approaches support E-health in PE management.

The role of other proposed treatment modalities for the treatment of PE, such as penis-root masturbation, vibrator-assisted start-stop exercises, transcutaneous functional electric stimulation, transcutaneous posterior tibial nerve stimulation, acupuncture, and practising yoga need more evidence to be considered in the clinical setting.

Recommendations for assessment	Strength rating
Treat erectile dysfunction (ED), other sexual dysfunction or genitourinary infection (e.g., prostatitis) first.	Strong
Use either dapoxetine or the lidocaine/prilocaine spray as first-line treatments for lifelong premature ejaculation (PE).	Strong
Use off-label oral treatment with daily selective serotonin re-uptake inhibitor (SSRIs) or daily/on-demand clomipramine as a viable alternative for second-line treatments.	Strong
Use off-label tramadol with caution as a viable on-demand third-line treatment alternative to on-demand/daily antidepressants (SSRIs or clomipramine).	Strong
Use PDE5Is alone or in combination with other therapies in patients with PE (without ED).	Strong
Use psychological/behavioural therapies in combination with pharmacological treatment in the management of acquired PE.	Weak
Use hyaluronic acid injection with caution as a treatment option for PE compared to other more established treatment modalities.	Weak
Do not perform dorsal neurectomy because more safety data are warranted.	Weak

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