

## Attitudes of Sexual Medicine Specialists Toward Premature Ejaculation Diagnosis and Therapy



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### ABSTRACT

**Introduction:** Premature ejaculation (PE) is one of the commonest sexual dysfunctions in men. Because the definition of and guidelines for the management of PE have been revised in recent years, our understanding of PE has changed.

**Aim:** To investigate the clinical practice patterns of sexual medicine specialists regarding the diagnosis and treatment of PE.

**Methods:** Attendees of the 17th Annual Congress of the European Society of Sexual Medicine, held in February 2015 in Copenhagen, Denmark, were asked to participate in a survey during the congress.

**Main Outcome Measures:** A 23-item, self-reported, closed-question questionnaire was distributed. Sociodemographic data, professional background, and personal practice patterns of the attendees were assessed in relation to PE.

**Results:** In total, 217 physicians (median age = 47 years, range = 22–74) completed the survey. Most responders (79.3%) considered PE an important sexual dysfunction that should be treated. Almost half the participants stated there is insufficient information about PE for patients and physicians (46.1% and 45.2%, respectively). When asked about the main goal of treating PE, two thirds responded that main goal is to improve patients' sexual function and 35.9% responded that the main goal was to improve partners' satisfaction.

**Conclusion:** These findings confirmed that there are many differences among sex health experts in their understanding of PE. Educational activities are crucial in implementing the new guidelines on PE.

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**Key Words:** Premature Ejaculation; Diagnosis; Therapy; Attitude; Premature Ejaculation Profile; Treatment; Sexual Dysfunction

### INTRODUCTION

Premature ejaculation (PE) is one of the commonest sexual dysfunctions in men, with prevalence rates estimated at 3% to 30%.<sup>1–4</sup> Previous surveys have found that most men with PE

do not seek treatment; therefore, there is a large discrepancy in the estimated prevalence of PE in the population vs those who are referred to clinics.<sup>5,6</sup> This problem can present since the first sexual experience and can be defined as lifelong (primary) PE or it can be acquired (secondary) later in life.<sup>7</sup> These two types of PE often cause distress for men and their partners.<sup>8</sup>

Several professional organizations have drafted definitions of PE because of the difficulty of using objective measurements for this problem.<sup>9</sup> The International Society for Sexual Medicine recently developed a unified definition for lifelong and acquired PE: “PE is a male sexual dysfunction characterized by:

- ejaculation that always or nearly always occurs prior to or within about 1 minute of vaginal penetration from the first sexual experience (lifelong PE), OR a clinically significant reduction in latency time, often to about 3 minutes or less (acquired premature ejaculation);

Received January 23, 2016. Accepted May 22, 2016.

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<http://dx.doi.org/10.1016/j.esxm.2016.05.001>

- 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.”<sup>10</sup>

The American Psychiatric Association also published a definition of PE in the *Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition* (DSM-5), where PE is defined as “A persistent or recurrent pattern of ejaculation occurring during partnered sexual activity within approximately 1 minute following vaginal penetration and before the individual wishes it. This must have been present for at least 6 months and must be experienced on almost all or all (approximately 75%–100%) occasions of sexual activity (in identified situational contexts or, if generalized, in all contexts). In addition, it causes clinically significant distress in the individual and it is not better explained by a nonsexual mental disorder or as a consequence of severe relationship distress or other significant stressors and is not attributable to the effects of a substance/medication or another medical condition.”<sup>11</sup>

A recent survey conducted by Shindel et al<sup>12</sup> evaluated the practice pattern among American urologists in the management of PE. The results demonstrated that most urologists who responded to the survey followed the American Urological Association 2004 guidelines on the management of PE.<sup>13</sup>

Because definitions of and guidelines for PE have undergone some revisions in recent years, the present survey investigated clinical practice patterns of specialists working in sexual medicine regarding the diagnosis and treatment of PE. Based on the responses, our intention was to develop an official statement of the European Society for Sexual Medicine on the management of PE.

## METHODS

Attendees of the 17th Annual Congress of the European Society for Sexual Medicine, held in February 2015 in Copenhagen, Denmark, were invited to participate anonymously in a self-administered questionnaire comprising 23 closed questions (Appendix 1). The survey included a short introduction, which requested the participants to complete the questionnaire covering the criteria for diagnosis of PE and their current clinical practice patterns related to PE treatment.

## MAIN OUTCOME MEASURES

The survey consisted of two sections: (i) five items assessing sociodemographic data and information addressing the professional background of the respondents and (ii) 18 items assessing information about participants' current clinical practice patterns in the diagnosis and treatment of PE (Appendix 1).

## Statistical Analyses

All statistical analyses were performed using SPSS 22 (IBM Corp, Armonk, NY, USA).

**Table 1.** Characteristics of sexual medicine experts

	n	%
Professional background		
Urologist	183	84.3
Psychiatrist	20	9.2
General practitioner	14	6.5
Sex		
Men	148	68.2
Women	69	31.8
Location of practice		
Europe	171	78.9
Middle East	37	17
Asia	9	4.1
Duration of practice in sexual medicine		
<5 y	52	23.9
5–10 y	54	24.9
>10 y	111	52.1
Type of practice		
Private	63	29
Academic hospital	74	34
Public hospital	36	16.6
Private practice and public hospital	38	17.5
Other	6	2.9

## RESULTS

Overall, 217 sexual medicine experts participated in the survey. The median age was 47 years (age range = 22 to 74 years) and 68.2% were men. Urologists were in the majority (84.3%), followed by psychiatrists (9.2%) and family physicians (6.5%). Of the participants, 52.1% had practiced sexual medicine for more than 10 years, 24.9% had practiced for 5 to 10 years, and 23.5% had practiced for less than 5 years in their discipline (Table 1).

Most responders (79.3%) considered PE an important sexual dysfunction that should be treated. Of the participants, 11.5% recorded that PE should be treated only if the patient is really bothered by it, whereas 9.2% did not believe that PE should be treated. Almost half the participants stated that the information available about PE was insufficient for patients and physicians (45.6% and 45.2%, respectively).

Forty-nine percent of participants reported that they frequently encountered men with PE (more than 10 new cases per month) and another 9.2% reported such encounters at least occasionally. Of the participants, 51.1% responded that the pivotal measurement for a PE diagnosis is the measured or estimated intravaginal ejaculation latency time, followed by perceived control over ejaculation (24.5%) and personal distress related to ejaculation (24.4%). Of the participants, 62.2% responded that it is “very important” to involve the partner in the treatment decision and 30.8% responded that it is “quite important” to include the partner.

When asked about the main goal of treating PE, 66.4% responded that the main goal was to improve the patient's sexual

satisfaction, 35.5% responded that the main goal was to improve the partner's satisfaction, and the rest responded that the main goal was to improve control over ejaculation. Most participants (66.4%) recommended combined treatment of pharmacotherapy and psychotherapy for PE, whereas 17.1% recommended psychotherapy (performed by sexologist) only and the rest recommended pharmacotherapy only. The most commonly prescribed drug for lifelong PE was an on-demand selective serotonin reuptake inhibitor (SSRI; 44.2%), whereas 26.3% and 10.1% prescribed daily SSRI and topical treatment, respectively. The vast majority of participants (98.2%) noted that they informed their patients properly before prescribing an off-label antidepressant for the treatment of PE. Of the participants, 51.6% considered topical treatments an effective therapeutic option for PE and 18.9% stated that they also prescribed tramadol. Most participants scheduled a follow-up visit 4 weeks after the prescription of a treatment for PE (56.2%), whereas 20.3% scheduled it within 2 months and the rest scheduled a visit after a longer period.

Participants also were asked about their approach to patients with acquired PE; 16.4%, 18.8%, and 47.2% reported that they preferred topical treatments, daily SSRI, and on-demand SSRI, respectively. Of note, 17.6% stated that they referred the patient to a sexologist.

## DISCUSSION

Although PE was initially described more than a century ago,<sup>14</sup> its definition, epidemiology, and management continue to be a matter of discussion among physicians.<sup>15</sup> Our findings confirmed that there are many differences among sexual health experts in their understanding of PE. Despite the numerous studies and guidelines published within the past two decades and recently accumulated data on the pathophysiology and treatment modalities of PE,<sup>16</sup> 9% of participants reported that patients with PE do not need to be treated. We believe that this underestimation of PE is because of the lack of proper education in sexual medicine during medical training. A recent survey of European urology residents showed that they could not follow the recommendations of current treatment guidelines, although almost 15% of patients presenting to clinics complain of PE.<sup>17</sup>

Diagnosis of PE has evolved owing to the establishment of "normal" and "premature" ejaculation latencies.<sup>18–20</sup> After the pivotal studies of Waldinger et al<sup>20,21</sup> that demonstrated that most patients with lifelong PE ejaculate within 1 minute of penetration, the evidence-based PE definitions included the "short ejaculation time" criterion.<sup>9,10</sup> Recently, the DSM-5 also stated the 1-minute ejaculation time criterion for the diagnosis of PE.<sup>11</sup> Moreover, the DSM-5 classified the severity of PE as mild, moderate, or severe according to ejaculation time.<sup>11</sup> However, ejaculation time is not the only criterion for the diagnosis of PE, because several well-designed observational studies have demonstrated that distress, lack of ejaculatory control, and

interpersonal difficulty also are bothersome for patients with PE.<sup>22,23</sup> Owing to these different aspects of the problem, participants of this survey indicated that estimated intravaginal ejaculation latency time (51.1%), perceived control over ejaculation (24.5%), and personal distress (24.4%) were the pivotal measurements for PE.

Recent guidelines have recommended topical anesthetic creams or daily or on-demand SSRIs as first-line pharmacotherapy for PE.<sup>16</sup> However, psychotherapy (alone or in combination with pharmacotherapy) also can be beneficial. Most participants in this survey noted that they preferred the combination of pharmacotherapy and psychotherapy for PE, whereas 17% recommended psychotherapy only, despite inconsistent evidence supporting its long-term efficacy.<sup>24</sup> Although we believe that sexual counseling and other psychological interventions should not be completely abandoned, educational courses on modern PE treatment could be of benefit for increasing the awareness of physicians of pharmacologic treatment options.

In a similar study designed to ascertain the practice patterns of 207 U.S. urologists in the management of PE, Shindel et al<sup>12</sup> reported that 73% of respondents saw fewer than one patient with PE per week. However, half the physicians who participated in our survey reported that they frequently encountered men with PE (more than 10 new cases per month). This discrepancy could be explained by the different characteristics of the participants, because in the present study the survey was administrated to attendees of a sexual medicine congress, whereas Shindel et al<sup>12</sup> randomly generated a mailing list of practicing urologists from the American Urological Association member directory. In contrast, the most commonly preferred drug in the present study was on-demand SSRI (44%), which is in accordance with the findings of Shindel et al.<sup>12</sup>

Dapoxetine, which is a rapidly acting SSRI with a short half-life, is the first approved oral medication for the treatment of PE in many countries.<sup>16</sup> Several well-controlled studies have demonstrated the efficacy of dapoxetine 30 or 60 mg when taken orally 1 to 2 hours before intercourse. These studies reported intravaginal ejaculation latency time increases of 2.5- to 3.0-fold.<sup>25–27</sup> However, it must be noted that 20% of patients with PE who were prescribed on-demand dapoxetine did not start the medication because of fear of using a new drug or because of the cost of the treatment.<sup>28</sup> Moreover, one study found that 90% of patients with PE who initiated dapoxetine therapy discontinued the treatment within 1 year owing to an efficacy below expectations (24.4%), cost (22.1%), adverse effects (19.8%), and loss of interest in sex (19.8%).<sup>28</sup> We believe that physicians must be aware of these high discontinuation rates when prescribing dapoxetine to patients with PE.<sup>29</sup> Further studies must be conducted to determine the true effectiveness and adverse effects of the different treatments of PE and for the possibility of educational activities to change the treatment approaches of medical specialists.

Our study is not without limitations. We limited the number of questions in the survey after considering that expanding the content of our questionnaire would significantly decrease the overall response rate, because congress attendees usually have a busy agenda and might not be willing to complete a questionnaire that consisted of several pages. Moreover, comparison of the approaches of physicians with different professional backgrounds and different experience levels would provide more information about the variations in PE management. However, the number of participants was not homogeneously distributed when we stratified them and there was not enough power to have valid statistical outcomes. We believe that future studies with more participants could elucidate this issue.

## CONCLUSIONS

Our findings confirmed that there are many differences among sex health experts in their understanding of PE and their treatment approaches. Educational activities might be necessary to increase their awareness and knowledge about the recent developments and evolved guidelines for the treatment of PE.

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*Conflict of Interest:* The authors report no conflicts of interest.

*Funding:* None.

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**Appendix 1. Questionnaire**

Section 1: demographic data	
Please specify your	
Age (y):	
Sex: <input type="checkbox"/> man <input type="checkbox"/> woman	
Country of origin:	
Country of practice:	
Section 2: professional background	
1. Please specify your occupation	
Physician	1 <input type="checkbox"/>
Psychologist	2 <input type="checkbox"/>
Sexual therapist	3 <input type="checkbox"/>
Physical therapist	4 <input type="checkbox"/>
Nurse (RN)	5 <input type="checkbox"/>
Preclinical researcher	6 <input type="checkbox"/>
Other; please specify	
2. If you are a physician, please specify your specialty	
Urologist	1 <input type="checkbox"/>
Gynecologist	2 <input type="checkbox"/>
Psychiatrist	3 <input type="checkbox"/>
Endocrinologist	4 <input type="checkbox"/>
Cardiologist	5 <input type="checkbox"/>
General practitioner	6 <input type="checkbox"/>
Other; please specify	
3. For how long have you been practicing sexual medicine?	
<5 y	1 <input type="checkbox"/>
5–10 y	2 <input type="checkbox"/>
>10 y	3 <input type="checkbox"/>
4. Do you practice in a private clinic or in the public health care system?	
Academic hospital	1 <input type="checkbox"/>
Private clinic and private practice	2 <input type="checkbox"/>
Public health care system	3 <input type="checkbox"/>
Private and public health care systems	4 <input type="checkbox"/>
Other; please specify	
5. How many new patients with premature ejaculation do you encounter in a month (on average)?	
<10	1 <input type="checkbox"/>
10–20	2 <input type="checkbox"/>
>20	3 <input type="checkbox"/>
6. Do you consider premature ejaculation an important sexual dysfunction that deserves to be treated?	
Yes	1 <input type="checkbox"/>
No	2 <input type="checkbox"/>
Only if the patient is really bothered by the condition	3 <input type="checkbox"/>
7. How do you consider the available patient information on premature ejaculation?	
Sufficient; there is no necessity for further information	1 <input type="checkbox"/>
Quite sufficient; only some information is needed	2 <input type="checkbox"/>
Largely insufficient; there is a substantial lack of information	3 <input type="checkbox"/>
8. How do you consider the physician information on premature ejaculation?	
Sufficient; there is no necessity for further information	1 <input type="checkbox"/>
Quite sufficient; only some information is needed	2 <input type="checkbox"/>
Largely insufficient; there is a substantial lack of information	3 <input type="checkbox"/>
9. What do you think is the pivotal measurement for premature ejaculation?	
Measured intravaginal ejaculation latency time	1 <input type="checkbox"/>
Estimated intravaginal ejaculation latency time	2 <input type="checkbox"/>
Personal distress	3 <input type="checkbox"/>
Perceived control over ejaculation	4 <input type="checkbox"/>

(continued)

## Appendix 1. Continued

Satisfaction with sexual intercourse	5 <input type="checkbox"/>
Partner's satisfaction or distress	6 <input type="checkbox"/>
10. How important do you consider the partner's involvement in the treatment decision?	
Not very important	1 <input type="checkbox"/>
Quite important	2 <input type="checkbox"/>
Very important	3 <input type="checkbox"/>
11. What's your main goal on treating premature ejaculation? (you can mark several answers)	
Improve intravaginal ejaculation latency time	1 <input type="checkbox"/>
Improve control over ejaculation	2 <input type="checkbox"/>
Improve patient sexual satisfaction	3 <input type="checkbox"/>
Improve partner's sexual satisfaction	4 <input type="checkbox"/>
12. According to you, what is the main treatment for premature ejaculation to achieve a lifelong satisfactory result?	
Pharmacologic treatment	1 <input type="checkbox"/>
Sexological treatment (psychotherapy)	2 <input type="checkbox"/>
Pharmacologic therapy plus psychotherapy	3 <input type="checkbox"/>
13. Do you consider topical treatment an effective treatment option for premature ejaculation?	
Yes	1 <input type="checkbox"/>
No	2 <input type="checkbox"/>
14. What is your usual approach after you have diagnosed lifelong premature ejaculation in a patient?	
I prescribe a topical treatment	1 <input type="checkbox"/>
I prescribe a daily dose of an antidepressant selective serotonin reuptake inhibitor	2 <input type="checkbox"/>
I prescribe an on-demand selective serotonin reuptake inhibitor (dapoxetine)	3 <input type="checkbox"/>
I refer him to a sexologist	4 <input type="checkbox"/>
Other; please specify	5 <input type="checkbox"/>
15. What is your approach for a patient diagnosed with acquired premature ejaculation?	
I prescribe a topical treatment	1 <input type="checkbox"/>
I prescribe a daily dose of an antidepressant selective serotonin reuptake inhibitor	2 <input type="checkbox"/>
I prescribe an on-demand selective serotonin reuptake inhibitor (dapoxetine)	3 <input type="checkbox"/>
I refer him to a sexologist	4 <input type="checkbox"/>
Other; please specify	5 <input type="checkbox"/>
16. When you prescribe an off-label antidepressant selective serotonin reuptake inhibitor for the treatment of premature ejaculation, do you inform your patients that the prescription is off label?	
Yes	1 <input type="checkbox"/>
No	2 <input type="checkbox"/>
Do not prescribe	3 <input type="checkbox"/>
17. Do you prescribe dapoxetine (Priligy) for the treatment of premature ejaculation?	
Yes	1 <input type="checkbox"/>
No	2 <input type="checkbox"/>
18. If yes, to how many new patients do you prescribe dapoxetine (Priligy) in a month (on average)?	
<10	1 <input type="checkbox"/>
10–20	2 <input type="checkbox"/>
>20	3 <input type="checkbox"/>
19. Do you prescribe tramadol for the treatment of premature ejaculation?	
Yes	1 <input type="checkbox"/>
No	2 <input type="checkbox"/>
20. Do you prescribe other pharmacologic treatments for premature ejaculation?	
Yes	1 <input type="checkbox"/>
If yes, please specify	
No	2 <input type="checkbox"/>
21. Do you believe that sexual therapy (psychotherapy) is applicable to a patient who has no partner?	
Yes	1 <input type="checkbox"/>
No	2 <input type="checkbox"/>

(continued)

## Appendix 1. Continued

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22. Do you always schedule follow-up visits with your patients after prescription of a treatment for premature ejaculation?	
Yes	1 <input type="checkbox"/>
No	2 <input type="checkbox"/>
23. If yes, when do you schedule the follow-up?	
After 2 wk	1 <input type="checkbox"/>
After 4 wk	2 <input type="checkbox"/>
After 8 wk	3 <input type="checkbox"/>
After >10 wk	4 <input type="checkbox"/>

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