

## **Bedfordshire and Hertfordshire INTERIM Priorities Forum Statement**

**Number: 67**

**Subject: Management of Premature Ejaculation**

**Date: May 2015**

**Date review needed: December 2015**

### **Guidance**

#### **Definition**

The definition for premature ejaculation has been debated over the years but many experts in the field currently rely on the International Society of Sexual Medicine (ISSM) definition which identifies the following criteria:

- Ejaculation which occurs always or nearly always before or within one minute of vaginal penetration.
- Failure to delay ejaculation during nearly all episodes of vaginal penetration.
- Personal distress, bother, frustration and/or the avoidance of sexual encounters.

Premature ejaculation may be classified as 'lifelong' (primary) or 'acquired' (secondary):

- Lifelong premature ejaculation is characterised by onset from the first sexual experience and remains a problem during life.
- Acquired premature ejaculation is characterised by a gradual or sudden onset with ejaculation being normal before onset of the problem. Time to ejaculation is short but not usually as fast as in lifelong premature ejaculation.

The European Association of Urology (EAU) points out that the ISSM definition only applies to men with lifelong premature ejaculation who have vaginal intercourse. The prevalence of premature ejaculation varies according to definition and is difficult to assess in view of many men not wanting to seek help or even discuss the problem.

The EAU reports a prevalence of 20-30% whilst a Cochrane review quoted a prevalence of 3-20%.

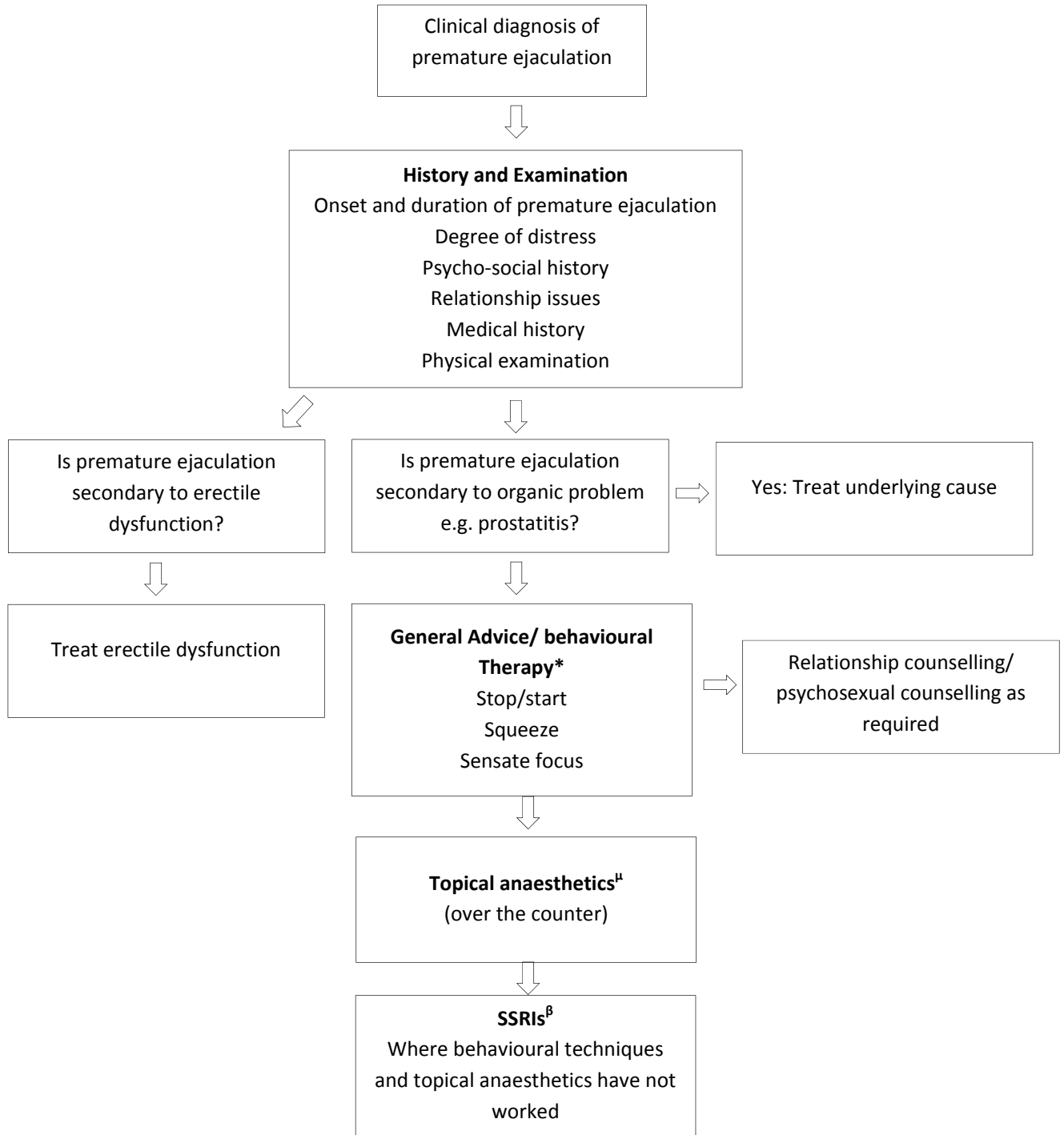
Risk factors include:

- Premature ejaculation may be anxiety-related. It is therefore more common in young men and early in a relationship. In these situations, the problem usually resolves with time.
- Iatrogenic causes include amphetamine, cocaine and dopaminergic drugs. Although effective for the treatment of premature ejaculation in some men, sildenafil may also be a cause of premature ejaculation in others.
- Urological causes - eg, prostatitis.
- Neurological causes - eg, multiple sclerosis, peripheral neuropathies.

#### **Management**

Management should be tailored to the needs of the individual, and is usually conservative in the first instance. The condition may be more of an issue in some relationships than others and patient expectation should be explored.

The pathway below is recommended for most patients:



**\*General advice/ behavioural techniques:**

- More frequent sex (or masturbation): premature ejaculation is more likely if there is a longer gap between sexual intercourse.
- Using a condom to decrease sensation.

- Sex with the woman on top reduces the likelihood of premature ejaculation.
- Squeeze and stop-go techniques:
  - **Squeeze technique:** In the squeeze technique, the glans is firmly squeezed between the thumb and the forefingers, at the penile level until some detumescence results. This is usually accomplished using one hand, with the index finger and forefinger being placed dorsally over the glans and distal shaft and the thumb over the ventral subcoronal frenular area. The squeeze is usually accomplished by the diminution of sexual arousal. It should take place before the patient has reached the stage that he feels it is inevitable that he is going to ejaculate. This point may not be discernible to the patient with premature ejaculation, but he usually learns to recognize it with time. A partner usually carries out the squeeze, but the patient may train himself to control the premature ejaculation by undertaking the squeeze himself.
  - **Stop-start technique:** A similar end point is reached by merely ceasing penile stimulation at the pre-inevitable point and the restarting penile stimulation when arousal and the erections have subsided.
  - Both of these techniques can be incorporated into the **sensate focus regime**. This is essentially a series of graded massage exercises designed to focus on touch in a non-judgemental approach. An initial ban is put on intercourse and the touching of erotic zones in order to eliminate performance anxiety. There is a gradual re-introduction of erotic massage, vaginal penetration and finally penetrative intercourse.
  - These behavioural techniques may take up to 3–6 months to achieve significant changes.
- Behavioural treatments are useful for secondary premature ejaculation but are not recommended first-line for lifelong premature ejaculation. They are time-intensive and require commitment from the partner.

#### <sup>H</sup>Topical Anaesthetics

- Topical anaesthetics can be purchased over the counter
- Premjact® spray / STUD 100® is licensed for PE and contains lidocaine 9.6%
- Lidocaine 2.5% and prilocaine 2.5% cream are available for off-label use

#### <sup>B</sup>Selective Serotonin Reuptake Inhibitors (SSRIs)

- A number of SSRIs can be used for treatment of premature ejaculation (PE). Of these, only dapoxetine (an on-demand SSRI) is currently licensed for treatment of PE. Dapoxetine is not approved by the Bedfordshire or Hertfordshire Pharmacy Prioritisation Committees for Premature Ejaculation.
- Off label daily use of SSRIs such as Fluoxetine, Citalopram, Sertraline, Paroxetine, Clomipramine have been used in the treatment of PE, as has on demand off label use of tramadol. No NICE guidance on the use of SSRIs for PE is available.

#### Relationship Counselling and Psychosexual Therapy

- **Psychosexual counselling** – Referral to a psychosexual counsellor can be made where appropriate, who will agree a plan of therapy.
- If psychosexual counselling is not appropriate, a referral to another specialist may be advised, i.e. for couples counselling, general counselling or for further medical assessment.

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