Ejaculatio praecox, or premature (rapid, early) ejaculation (PE), is a prevalent male sexual complaint. It may be part of the normal ejaculation variability in men, but it may also be the symptom of an ejaculatory dysfunction.

Recently, it was shown that DSM-IV-TR definition of PE has a low positive predictive value, indicating a high risk of false-positive diagnoses. For example, because of the absence of an evidence-based cutoff point of the ejaculation time, DSM allows the clinician to diagnose PE in men who actually ejaculate in 10 to 20 minutes, which obviously is not a rapid ejaculation. This inaccuracy hampers clinical, epidemiological, and drug treatment research. In the past decade, various developments paved the way for a better definition of PE. In 1994, in a report by Waldinger and colleagues, the term "intravaginal ejaculation latency time" (IELT) was introduced and defined as the time between vaginal penetration and intravaginal ejaculation. For research purposes, the preferable method for assessing IELT is with the use of a stopwatch during coitus.

Complaint vs disorder
It is important to distinguish PE as a "complaint" versus PE as a "syndrome." The high prevalence (20% to 30%) of PE that has been repeatedly found in epidemiological studies might be a consequence of the fact that many men occasionally, or more frequently, experience a rapid ejaculation. In other words, the high prevalence of PE only indicates a high prevalence of PE complaints. It does not mean that all these men have an ejaculatory "disorder."

PE as a disorder is characterized by a specific cluster of symptoms, ie, a syndrome. For example, men with the syndrome of lifelong PE usually report a cluster of symptoms. They not only report the experience of rapid ejaculations but also report that these rapid ejaculations have occurred since their first sexual encounters, that they occur in more than 90% of their sexual intercourse experiences, that they happen with nearly every female partner, and that the ejaculation mostly occurs within 30 to 60 seconds after penetration. Although a biological marker for this syndrome has not yet been found, there are indications from both animal and clinical research that lifelong PE is a (mainly) neurobiological dysfunction, with secondary psychological consequences. This syndrome should be distinguished from complaints of men who have rapid ejaculations with no other associated well-known symptoms that are based on underlying pathology. For example, when a man reports "sometimes" experiencing rapid ejaculation, his rapid ejaculation is probably only the manifestation of normal variability of ejaculatory performance. Proposal for DSM-V classification
About 20 years ago, PE was classified into "lifelong PE" and "acquired PE." Recently, a new classification of PE was proposed based on controlled clinical and epidemiological stopwatch studies, and it included 2 other PE syndromes: "natural variable PE" and "premature-like ejaculatory dysfunction."

Men with lifelong PE experience rapid ejaculations from their first sexual encounters with nearly every female partner; and the IELT is consistently very short, ie, less than 1 to 1.5 minutes. The cause is thought to be neurobiologically and genetically determined. However, one should not exclude the possibility that in some instances it may have a pure psychological cause. Although specific research into its prevalence has not yet been performed, it is thought to be about 2% to 5%.

Some men with lifelong PE experience an ejaculation during foreplay (ejaculatio ante portas); other men, as soon as their penis touches the vagina. Usually men with anteportal ejaculation are only able to penetrate for about 10 to 20 seconds. The majority of men with lifelong PE can stay in the vagina for a maximum of 30 to 60 seconds. Although some men and couples may cope well with the problem and experience sexual satisfaction, these men feel embarrassed, and depending on the consistency of the complaint, PE may lead to lower self-esteem, anticipatory anxiety, avoidance of sex, relationship problems, and female sexual complaints. Lifelong PE is not associated with thyroid
dysfunction. Treatment consists of medication, usually an SSRI, with or without additional counseling.

The IELT in acquired PE is consistently short or very short (ie, less than 2 minutes) and results from either organic disorders, such as hyperthyroid dysfunction, or psychological problems, including relationship problems (eg, having sex while angry at the partner). Its prevalence is unknown, but it is estimated to be in the lower range. Men with premature-like ejaculatory dysfunction complain of early ejaculations while their IELTs are actually in the normal range (ie, between 3 and 7 minutes) or even longer duration (ie, longer than 10 minutes). Its cause is most likely psychological, and its prevalence is estimated to be rather high, at about 15% to 20%. It is argued that treatment of this syndrome should consist of psychotherapy or counseling and not a priori of medication.

Natural variable PE is actually not a real syndrome and is not pathological. Men may occasionally experience early ejaculations; the IELT is objectively short or may be perceived as short. Its prevalence is, as yet, unknown. Natural variable PE is most likely a normal variation of ejaculatory performance. Treatment should consist of patient reassurance and psychoeducation to explain that irregular early ejaculation is a normal variation.

Diagnosis

Lifelong PE, acquired PE, natural variable PE, and premature-like ejaculatory dysfunction are diagnosed by taking a brief medical and sexual history with special attention to the duration of the ejaculation time. The men often complain of rapid ejaculations, ejaculating too soon, or experiencing a lack of control. In general, men with lifelong PE are mentally and physically healthy. Sometimes it becomes an obsession, and in rare instances it may even lead to suicidal thoughts. The reaction of the female partners differs. Quite a number cope well with PE; on the other hand, there are women who are disappointed, irritated, and angry about their partner's ejaculatory problems.

Psychotherapy

Although PE was initially treated mainly by psychoanalysis or psychoanalytic psychotherapy, behavioral therapy, particularly the stop-start method, either on its own or combined with the squeeze technique, became the first-choice treatment in the 1970s and 1980s. However, despite anecdotal reports of its success, given the lack of evidence-based studies conducted according to current standards of evidence-based research, there is no hard evidence for the efficacy of behavioral psychotherapy in delaying ejaculation in the long term. However, it should be noted that whether or not psychotherapy is able to delay ejaculation, it may be helpful in strengthening coping strategies. Evidence-based research

In the past decade, an evidence-based drug treatment research strategy has been developed by independent researchers. Apart from randomized, double-blind controlled study designs, drug treatment studies of PE should include a baseline and a drug treatment period in which the IELT is measured prospectively at each coitus using a stopwatch handled by the female partner. Because the IELT distribution is skewed toward the positive, the IELT values should be logarithmically transformed and results should be reported as geometric mean IELT or median IELT. In addition, ejaculation delay should be expressed as percentage or fold-increase from baseline with 95% confidence intervals (CIs). Adverse effects should be assessed with a validated questionnaire. Moreover, adverse effects of on-demand treatment should be assessed on the day of drug intake and on the next day. Daily drug treatment

Daily treatment with either clomipramine or some SSRIs effectively delays ejaculation. For lifelong and acquired PE, daily treatment with SSRIs or combined daily treatment with on-demand use of some SSRIs has become the first choice of treatment. However, these drugs have not been approved by the FDA for the treatment of PE. A meta-analysis of 35 clomipramine and SSRI daily treatment studies that were conducted between 1973 and 2003 revealed that the use of placebo may delay ejaculation to some extent. It was also shown that of all SSRIs, daily treatment with 20 mg of paroxetine exerts the strongest ejaculation delay. Expressed in fold-increase compared with baseline values and using the geometric mean IELT, it was shown that placebo exerts a geometric mean 1.4-fold IELT increase (95% CI, 1.2-1.7) and that SSRIs differ in their ability to delay ejaculation. The rank order (geometric mean fold-increase of IELT) was paroxetine, clomipramine, sertraline, and fluoxetine.

| TABLE | Increase in IELT with daily SSRI and clomipramine treatment* |
### Daily drug treatment | IELT fold-increase (95% CI)
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Paroxetine | 8.8 (5.9 - 13.2)
Clomipramine | 4.6 (3.0 - 7.4)
Sertraline | 4.1 (2.6 - 7.0)
Fluoxetine | 3.9 (3.0 - 5.4)
Placebo | 1.4 (1.2 - 1.7)

IELT, intravaginal ejaculatory latency time; CI, confidence interval. Data according to meta-analysis. *Increase is expressed in geometric mean IELT (study end point IELT/baseline IELT).

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**References:**


Links:
[2] [http://www.psychiatrictimes.com/authors/marcel-d-waldinger-md-phd](http://www.psychiatrictimes.com/authors/marcel-d-waldinger-md-phd)