

## Australasian Sexual Health Conference 2014

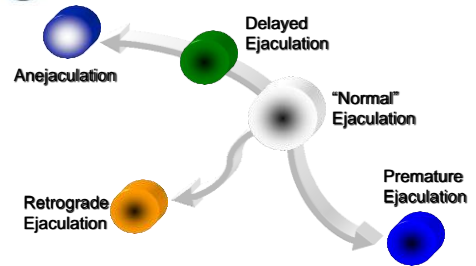
### Ejaculation disorders Premature & Inhibited

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## Spectrum of Ejaculatory Disorders



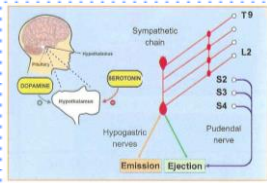
Source : Perelman M. "The 'Ejaculatory Tipping Point': A Model for the Etiology, Diagnosis, and Treatment of Delayed/Retarded Ejaculation." 12th World Congress of the International Society for Sexual Medicine, Cairo, Egypt, September 2008).

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### Neurological control of ejaculation

Hyposensitivity of MPO of hypothalamus - 5-HT<sub>2C</sub>  
Hypersensitivity of MPO area of hypothalamus - 5-HT<sub>1A</sub>



Ejaculation is also controlled by the hypothalamus, where dopamine promotes ejaculation while serotonin inhibits.

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## Stages of normal ejaculatory physiology

- **Emmission**
  - Bladder neck closure
  - Deposition of seminal fluid into posterior urethra
- **Ejection**
  - Expulsion of seminal fluid from the urethra
  - Relaxation of the external sphincter
  - Co-ordinated pelvic floor, bulbospongiosis contraction
- **Orgasm**
  - A sensory experience associated with all these events

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## Ejaculatory Dysfunction

- 30% of men say they have a problem controlling ejaculation
- 90% of ejaculation problems are PE
- 5-10% of men complain of severe PE (anteportal)
- Prevalence PE 8-31%, delayed 2-4%

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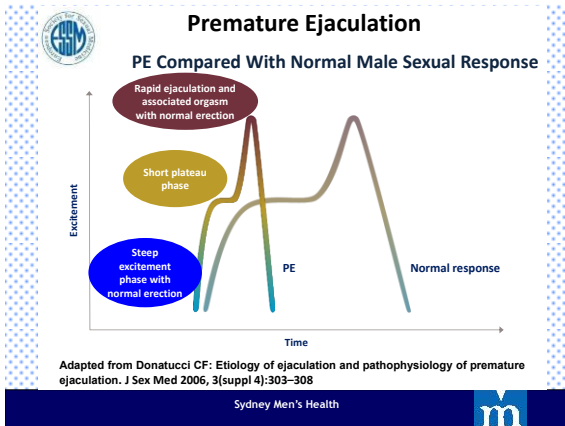


I'M READY TO START!      I'M FINISHED...



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### PE - a neurobiological event

Table 4: Proposed etiologies of premature ejaculation

|                    |   |
|--------------------|---|
| <b>Psychogenic</b> | Anxiety<br>Psychosocial Problems<br>Early sexual experience<br>Frequency of sexual intercourse<br>Ejaculatory control techniques<br>Evolutionary<br>Psychoanalytic theories           |
| <b>Biological</b>  | Genetic predisposition<br>Penile hypersensitivity<br>Hyper-excitable ejaculatory reflex<br>Arousal<br>Enkephalin<br>Hypothyroidism<br>Prostate<br>Chronic Pelvic Pain Syndrome (CPPS) |

#### Causes of PE

- Neurobiological (e.g. serotonin hypoactivity)<sup>10</sup>
- Urological (e.g. chronic prostatitis)<sup>11</sup>
- Andrological (e.g. secondary to another sexual dysfunction)<sup>12</sup>
- Hormonal (e.g. hyperthyroidism)<sup>13</sup>
- Psychorelational (e.g. anxiety related to sexual performance)<sup>14</sup>

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### ISSM definition of PE

J Sex Med 2014;11:1392-1422

- Ejaculation which always or nearly always occurs prior to or within about 1 minute of vaginal penetration (1° lifelong), 3 minutes (2° acquired)
- Inability to delay ejaculation on all or nearly all vaginal penetrations
- Negative personal consequences, such as distress, bother, frustration &/or the avoidance of sexual intimacy

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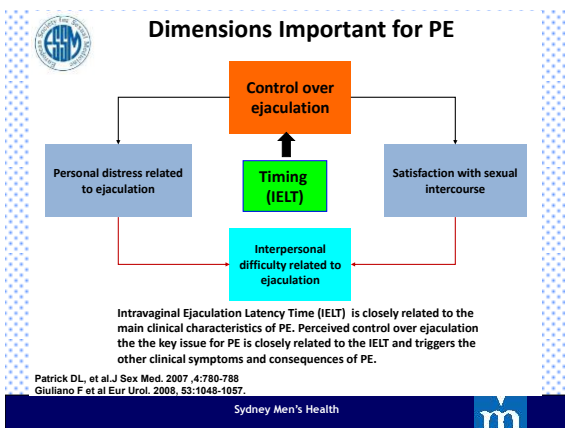
### PE Diagnostic Tool (PEDT)

**Patient Instructions**  
This questionnaire is designed to help identify men who may have a problem with ejaculating too soon during sexual activity. Even if you do not have difficulties, please answer all the questions.  
Please mark X in the box that best represented you answer for each of the questions below.  
Please mark only one box for each question.  
Write your experiences may change from time to time, please report your general experiences with intercourse.  
Definition: Ejaculation here refers to ejaculation (release of semen) after penetration (when your penis enters your partner).

|  | Not difficult at all       | Somewhat difficult            | Moderately difficult       | Very difficult                | Extremely difficult            |
|--|----------------------------|-------------------------------|----------------------------|-------------------------------|--------------------------------|
| 1) How difficult is it for you to delay ejaculation?   | <input type="checkbox"/> 0 | <input type="checkbox"/> 1    | <input type="checkbox"/> 2 | <input type="checkbox"/> 3    | <input type="checkbox"/> 4     |
| 2) Do you ejaculate before you wish?   | Almost never or never (0%) | Less than half the time (25%) | About half the time (50%)  | More than half the time (75%) | Almost always or always (100%) |
| 3) Do you ejaculate with very little stimulation?  | <input type="checkbox"/> 0 | <input type="checkbox"/> 1    | <input type="checkbox"/> 2 | <input type="checkbox"/> 3    | <input type="checkbox"/> 4     |
| 4) Do you feel frustrated because of ejaculating before you want to?                             | Not at all                 | Slightly                      | Moderately                 | Very                          | Extremely                      |
| 5) How concerned are you that your time to ejaculation leaves your partner sexually unfulfilled? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1    | <input type="checkbox"/> 2 | <input type="checkbox"/> 3    | <input type="checkbox"/> 4     |

J Sex Med 2014;11:1392-1422

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### Recommended questions

For diagnosis

- What is the time between penetration and ejaculation (cumming)?
- Can you delay ejaculation?
- Do you feel bothered, annoyed, and/or frustrated by your premature ejaculation?

### Optional questions

|  |   |
|--|---|
| Differentiate lifelong and acquired PE | - When did you first experience premature ejaculation?<br>- Have you experienced premature ejaculation since your first sexual experience on every/almost every attempt and with every partner?                   |
| Assess erectile function               | - Is your erection hard enough to penetrate?<br>- Do you have difficulty in maintaining your erection until you ejaculate during intercourse?<br>- Do you ever rush intercourse to prevent loss of your erection? |
| Assess relationship impact             | - How upset is your partner with your premature ejaculation?<br>- Does your partner avoid sexual intercourse?<br>- Is your premature ejaculation affecting your overall relationship?                             |
| Previous treatment                     | - Have you received any treatment for your premature ejaculation previously?  |
| Impact on quality of life              | - Do you avoid sexual intercourse because of embarrassment?<br>- Do you feel anxious, depressed, or embarrassed because of your premature ejaculation?  |

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**Table 1** Classification of premature ejaculation

| Variable   | Lifelong premature ejaculation (younger men) | Acquired premature ejaculation (older men) | Variable premature ejaculation              | Subjective premature ejaculation |
|------------|--|--|---|----------------------------------|
| IELT       | Very short IELT (<1-1.5 min)                 | (Very) short IELT (<1.5-2 min)             | Normal IELT (3-8 min)                       | Normal or long IELT (3-30 min)   |
| Frequency  | Consistent                                   | (In)consistent                             | Inconsistent                                | (In)consistent                   |
| Aetiology  | Neurobiological and genetic                  | Medical and/or psychological               | Normal variation of ejaculatory performance | Psychological                    |
| Treatment  | Medication with or without counselling       | Medication and/or psychotherapy            | Psycho-education, reassurance               | Psychotherapy                    |
| Prevalence | Low  | Low  | High  | High                             |

IELT, intravaginal ejaculatory latency time.

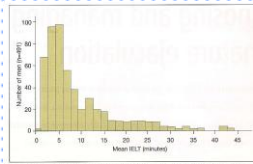
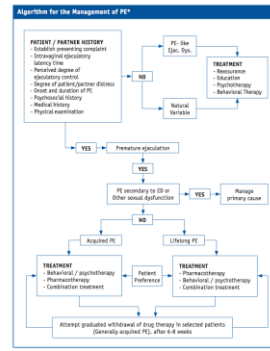


Figure 1. Distribution of intravaginal ejaculatory latency times (IELT) values in a random cohort of 489 men.<sup>16</sup>

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ISSN Quick Reference Guide to PE



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## Treatment of Premature Ejaculation

- Incorporate into sexual practice/adjust sexual script
- Behavioural techniques - stop/start, squeeze
- Oral medication - SSRI, clomipramine, PDE5i
- Intra-cavernosal injections
- Anaesthetic spray (Stud) & condoms (Durex)
- Pelvic floor exercises
- Selective neurotomy surgery



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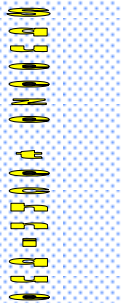
ISSN Quick Reference Guide to PE

**Summary of recommended pharmacological treatments for premature ejaculation**

| Drug                   | Daily dose as needed                      | Dose                                    | IELT fold increase | Side effects   | Status                     | Level of evidence |
|------------------------|---|---|--------------------|--|----------------------------|-------------------|
| <b>Oral therapies</b>  |   |   |                    |  |                            |                   |
| Bupropion              | As needed                                 | 30-60 mg                                | 2.5-3              | - Nausea<br>- Diarrhea<br>- Headache<br>- Dizziness  | Approved in some countries | 1a                |
| Paroxetine             | Daily dose                                | 30-40 mg                                | 6                  | - Fatigue<br>- Nausea  | Off label                  | 1a                |
| Clomipramine           | Daily dose                                | 12.5-50 mg                              | 6                  | - Diarrhea<br>- Parosmia   | Off label                  | 1a                |
| Sertraline             | Daily dose                                | 50-200 mg                               | 5                  | - Decreased sexual desire  | Off label                  | 1a                |
| Fluoxetine             | Daily dose                                | 20-40 mg                                | 5                  | - Erectile dysfunction   | Off label                  | 1a                |
| Citalopram             | Daily dose                                | 20-40 mg                                | 2                  | -  | Off label                  | 1a                |
| Paroxetine             | Daily dose for 30 days and then as needed | 30-40 mg                                | 11.6               | -  | Off label                  | 1a                |
| Paroxetine             | As needed                                 | 30-40 mg                                | 3.4                | -  | Off label                  | 1a                |
| Clomipramine           | As needed                                 | 12.5-50 mg                              | 6                  | -  | Off label                  | 1a                |
| <b>Topical therapy</b> |   |   |                    |  |                            |                   |
| Lidocaine/prilocaine   | As needed                                 | 25 mg/g lidocaine<br>25 mg/g prilocaine | 4-6                | - Paresthesia<br>- Partner genital numbness<br>- Skin irritation<br>- Erectile dysfunction | Off label                  | 1b                |

IELT = Intravaginal Ejaculatory Latency Time.

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## Why treat PE with a pharmacologic agent?

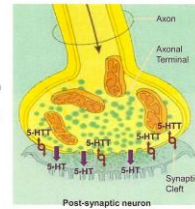
Serotonin is considered as the key neurotransmitter involved in controlling the process of ejaculation

There are multiple serotonin receptors in the hypothalamus, brain stem, and the spinal cord

Increasing serotonin levels results in delayed ejaculation

SSRIs increase serotonin levels

Dapoxetine increases serotonin levels



5-HT = serotonin

5-HTT = serotonin transporter system

Goldman et al. (2010) Classification of organic and functional PE. In Sexual Medicine: Sexual dysfunction in men and women. 2nd International Consultation on Sexual Dysfunction, Paris.

Goldman (2007) Trends Neurosci 30(2):79-84

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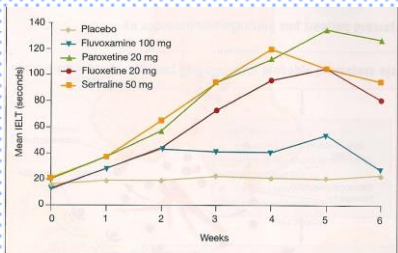


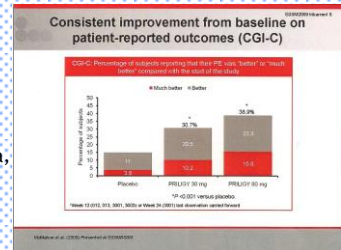
Figure 3. Selective serotonin re-uptake inhibitors produce ejaculatory delay within five to 10 days and achieve their full therapeutic effect within two to three weeks.<sup>17</sup>

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## Dapoxetine - Priligy

- T max 1.2 hours
- T ½ 18 hours
- IELT 30mg 3.48x
- IELT 60mg 3.68x
- Side effects: nausea, headache



## Inhibited/Delayed/Retarded Ejaculation

- Often a normal part of ageing
- Younger men - angry, withholding
- Relationship issues - conception
- Consider idiosyncratic masturbatory style (traumatic masturbatory syndrome) - conditioned inhibition
- Most can masturbate to orgasm on own

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Table 3 Causes of delayed ejaculation, anejaculation and anorgasmia

|                         |  |
|-------------------------|--|
| Ageing male psychogenic | Degeneration of penile afferent nerves inhibited ejaculation   |
| Congenital              | Mullerian duct cyst<br>Wolffian duct abnormality<br>Prune belly syndrome   |
| Anatomic causes         | Transurethral resection of prostate<br>Bladder neck incision   |
| Neurogenic causes       | Diabetic autonomic neuropathy<br>Multiple sclerosis<br>Spinal cord injury<br>Radical prostatectomy<br>Proctocolectomy<br>Bilateral sympathectomy<br>Abdominal aortic aneurysmectomy<br>Para-aortic lymphadenectomy |
| Infective               | Urethritis<br>Genitourinary tuberculosis   |
| Endocrine               | Schistosomiasis<br>Hypogonadism<br>Hypothyroidism  |
| Medication              | Alpha-methyl Dopa<br>Thiazide diuretics<br>Tricyclic and SSRI antidepressants<br>Phenothiazine<br>Alcohol abuse  |

SSRI, selective serotonin re-uptake inhibitor.

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## Evaluation

- Differentiate between anejaculation, anorgasmia and retrograde ejaculation
- Physical examination
- Analyse semen, urine, hormones
- U/S upper & lower renal tract

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Table 4 Drug therapy for delayed ejaculation

| Drug            | Dosage                                  |                        |
|-----------------|---|------------------------|
|                 | As needed                               | Daily                  |
| Cabergoline     | ND                                      | 0.25-2 mg twice weekly |
| Amantadine      | 100-400 mg (for 2 days prior to coitus) | 100-200 mg bid         |
| Pseudoephedrine | 60-120 mg (1-2 h prior to coitus)       | ND                     |
| Reboxetine      | ND                                      | 4-8 mg daily           |
| Bupropion       | ND                                      | 150 mg daily or bid    |
| Bupropion       | ND                                      | 5-15 mg bid            |
| Cyproheptadine  | 4-12 mg (3-4 h prior to coitus)         | ND                     |
| Oxytocin        | 24 IU intranasal during coitus          | ND                     |

ND, no data.

### Non-drug treatment (enhances arousal)

- Pre & post masturbation/vibration
- Scrotal/perineal tickling
- Incorporate into normal practice

## Understanding and Treating Retarded Ejaculation: A Sex Therapist's Perspective

Michael A. Pentiman, Ph.D.  
N. Y. Weill Cornell Medical Center  
New York, N.Y. USA  
February 2009

- 1° & 2° , worse with age, usually good quality erection & ejaculate OK on own
- 3% incidence
- Biological - SSRI, anti-psychotics, diabetes, MS, spinal cord injury, radical prostatectomy
- Psychological - religious issues, idiosyncratic masturbatory style, performance anxiety
- Medical & sexual history plus genito-urinary examination
- Sex therapy, masturbation retraining, pelvic floor muscles
- Ask masturbatory style & frequency
- Partner issues, conception issues
- Pharmacological treatment
- Penile vibratory stimulation



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## Retrograde Ejaculation

- Common after benign prostate or bladder neck surgery
- Some disease conditions - diabetes, neurological
- Ejaculation into the bladder

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## Pharmacotherapy retrograde & inhibited ejaculation

- Alpha 1 adrenergic receptors agonist - pseudo-ephedrine (Sudafed)
- SNRI reboxetine (Edronax) & bupropion
- Tricyclic anti-depressant imipramine
- Dopamine agonist amantadine (Symmetrel) & apomorphine
- Serotonin agonists cyproheptadine (Periactin) & Buspirone
- Oxytocin
- PDE5i



## Too Fast? LEARN TO LAST LONGER

Michael Lowy  
Brett McCann

A GUIDE TO PREMATURE EJACULATION



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## The End



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