Premature ejaculation

Premature ejaculation (PE), also known as rapid ejaculation, premature climax, early ejaculation, or by the Latin term ejaculatio praecox, is the most common sexual problem in men, affecting 25%-40% of men. It is characterized by a lack of voluntary control over ejaculation. Masters and Johnson stated that a man suffers from premature ejaculation if he ejaculates before his partner achieves orgasm in more than fifty percent of his sexual encounters. Other sex researchers have defined premature ejaculation as occurring if the man ejaculates within two minutes or less of penetration; however, a survey by Alfred Kinsey in the 1950s demonstrated that three quarters of men ejaculated within two minutes of penetration in over half of their sexual encounters. Today, most sex therapists understand premature ejaculation as occurring when a lack of ejaculatory control interferes with sexual or emotional well-being in one or both partners. Masters and Johnson recommended the use of the Lateral coital position to help alleviate premature ejaculation.

Most men experience premature ejaculation at least once in their lives. Often adolescents and young men experience "premature" ejaculation during their first sexual encounters, but eventually learn ejaculatory control. Because there is great variability in both how long it takes men to ejaculate and how long both partners want sex to last, researchers have begun to form a quantitative definition of premature ejaculation. Current evidence supports an average intravaginal ejaculation latency time (IELT) of six and a half minutes in 18-30 year olds. If the disorder is defined as an IELT percentile below 2.5, then premature ejaculation could be suggested by an IELT of less than about one and a half minutes. Nevertheless, it is well accepted that men with IELTs below 1.5 minutes could be "happy" with their performance and do not report a lack of control and therefore do not suffer from PE. On the other hand, a man with 2 minutes IELT could present with perception of poor control over his ejaculation, distressed about his condition, has interpersonal difficulties and therefore be diagnosed with PE.

Scientists have long suspected a genetic link to certain forms of premature ejaculation. In one study, ninety-one percent of men who suffered from lifelong premature ejaculation also had a first-relative with lifelong premature ejaculation. Other researchers have noted that men who suffer from premature ejaculation have a faster neurological response in the pelvic muscles. Simple exercises commonly suggested by sex therapists can significantly improve ejaculatory control for men with premature ejaculation caused by neurological factors. Often, these men may benefit from anti-anxiety medication or selective serotonin reuptake inhibitors (SSRIs), such as sertraline or paroxetine. Some men prefer using anaesthetic creams; however, these creams may also deaden sensations in the man's partner, and are not generally recommended by sex therapists.

Psychological factors also commonly contribute to **premature ejaculation**. While men sometimes underestimate the relationship between sexual performance and emotional well-being, premature ejaculation can be caused by temporary depression, stress over financial matters, unrealistic expectations about performance, a history of sexual repression, or an overall lack of confidence. Interpersonal dynamics strongly contribute to sexual function, and premature ejaculation can be caused by a lack of communication between partners, hurt feelings, or unresolved conflicts that interfere with the ability to achieve emotional intimacy. Neurological premature ejaculation can also lead to other forms of sexual dysfunction, or intensify the existing problem, by creating performance anxiety. In a less pathological context, premature ejaculation could also be simply caused by extreme arousal.

Some physical illnesses, such as a prostate infection, are also known to induce premature ejaculation. In other instances, premature ejaculation is caused by a physical injury that affects the nervous system. Certain medications, such as cold medications containing pseudoephedrine, also cause premature ejaculation. Sexual dysfunction is a common symptom of psychiatric afflictions ranging from bipolar disorder to post-traumatic stress disorder. In these cases, it is best to discuss the issues openly with a physician.

Today it is believed that the neurotransmitor serotonin (5HT) has a central role in modulating ejaculation. Several animal studies have demostrated its inhibitory effect on ejaculation modulated through the PGI system in the brain. Therefore, it is perceived that low level of serotonin in the synaptic cleft in these specific areas in the brain could cause premature ejaculation. This theory is further supported by the proven effectiveness of SSRIs, which increase serotonin level in the synapse, in treating PE.

Science of Mechanism of Ejaculation
The process of ejaculation requires two sexually sequentially distinct actions, emission and expulsion.

The emission phase is the first one to happen and it involves deposition of semenal fluid from ampullary vasa

deferens, seminal vesicles & prostate gland into posterior urethra (Bohlen, et al., 2000). Second phase is the expulsion of semen which involves closure of bladder neck followed by the rhythmic contractions of urethra by pelvic-perineal and bulbospongiosus muscle and intermittent relaxation of external Sphincter urethrae (Master and Turek, 2001).

Sympathetic motor neurons control the emission phase of ejaculation reflex and expulsion phase is executed by somatic and autonomic motor neurons. These motor neurons are located in the thoracolumbar and lumbosacral spinal cord and are activated in a coordinated manner when sufficient sensory input to reach the ejaculatory threshold has entered the central nervous system (De Groat and Booth 1980; Truitt and Coolen 2002). Several areas in the brain, and especially the nucleus paragigantocellularis, have been identified to be involved in ejaculatory control (Coolen, et al., 2004).

Can premature ejaculation develop later in life?
Premature ejaculation (PE) can occur at any age. Surprisingly, aging appears not to be a cause of PE. However, the aging process typically causes changes in erectile function and ejaculation. Erections may not be as firm or as large. Erections may be maintained for a shorter period before ejaculating. The feeling that an ejaculation is about to happen may be shorter. These factors can result in an older man having an ejaculation earlier than when he was younger.

Can both premature ejaculation and erectile dysfunction affect a man at the same time?
Sometimes premature ejaculation (PE) may be a problem in men who have erectile dysfunction (ED)—the inability to achieve and/or maintain an erection sufficient for satisfactory sexual performance. Some men do not understand that the loss of erection normally occurs after ejaculation and may wrongly complain to their doctor that they have ED when the actual problem is PE. It is recommended that the ED be treated first if you experience both ED and PE, since the PE may resolve on its own once the ED has been adequately treated.

Treatment

Depending on severity, premature ejaculation symptoms can be significantly reduced. In mundane cases, treatments are focused on gradually training and improving mental habituation to sex and physical development of stimulation control. In clinical cases, various medications are being trialled to help slow down the speed of the arousal response.

SSRI antidepressants have been shown to delay ejaculation in men treated for different psychiatry disorders. SSRIs are considered the most effective treatment currently available for PE. These include paroxetine, fluoxetine, sertraline and more. The use of these drugs, that require chronic therapy is limited by the neuropsychiatric side effects. New SSRI drugs specifically targeted to treat premature ejaculation (e.g. dapoxetine) can be taken on an as needed basis and have been recently shown positive results in large phase III studies. Nevertheless dapoxetine is not yet approved by any regulatory authority around the world. There is speculation that some of the associated effects are caused by lowered libido and blood pressure as well as lowered anxiety levels. Other pharmaceutical products known to delay male orgasm are; opioids, cocaine, and diphenhydramine.

The effects of the hyperforin extract of Hypericum perforatum has been evaluated on the ejaculatory reflex duration by using the intravaginal ejaculatory latency time (IELT) and sexual satisfaction (Cannon-Smith and Kaufman, 2007).

Local anesthetic creams (like lidocaine, prilocaine and combinations) have shown to be very effective in clinical trials and are being used of the treatment of PE. Their use is limited by its own anesthetic effect that reduce sensation on the penis and vagina.

Most sex therapists prescribe a series of exercises to enable the man to gain ejaculatory control. While the exercises are intended for men who suffer from premature ejaculation, other men can use the exercises to enhance their sex lives. By far the most common exercise is the so-called start-stop technique. While the technique varies, the purpose is to get the male accustomed to maintaining an erection for an extended period of time while gradually increasing sexual tolerance. In doing this exercise, the male obtains an erection through self-stimulation, or masturbation. After achieving an erection, he stops stimulating himself until he begins to lose his erection; at that point, he begins to stimulate himself again. Gradually, over a period of several weeks, he is able to stimulate himself for longer periods of time, eventually gaining ejaculatory control. In order for this technique to be successful, the male should avoid feeling discouraged if he ejaculates rapidly; instead, he should use his sexual responses to learn how to vary the technique in a way that most benefits him. Another variant, for example, is to stimulate the shaft and frenulum of the penis, exploring the glans more as control

improves.

The male's partner is usually integrated into the exercises. They can stimulate the partner using the stop-start technique. When the male has achieved some level of ejaculatory control, he can insert his penis into his partner without thrusting. After his penis becomes accustomed to being inside his partner, thrusting can be gradually included, according to the male's abilities, using the stop-start technique. In less severe cases, the male might overcome his premature ejaculation early on, making exercises with his partner superfluous.

The male's partner plays an essential role in enabling him to overcome premature ejaculation. Without understanding and emotional support, the male is unlikely to obtain the level of relaxation required for sexual satisfaction. Both the male and his partner should communicate their feelings openly and with sensitivity. The male should learn to sexually satisfy his partner, orally or otherwise, while they work with him to overcome his premature ejaculation.

External latex rigid sheathes fastened to the body have been developed that cover all part of the penis during penetration so that the penis is protected from all the stimulation of the vagina. These help to gain control and to provide satisfaction to the partner.

Psychological therapies
Psychological therapy can be used as the only treatment or can be used together with medical therapy or behavioral therapy. The focus of psychological therapy is to help you to identify and solve any difficulties in your relationships that may have added to the cause of premature ejaculation (PE). This therapy can also help couples to talk about problems with intimacy that occurred after PE began. Psychological therapy can also help a man learn to be less anxious about his sexual performance and have greater sexual confidence. Typically, a man will receive specific advice on how to enhance his and his partner's sexual satisfaction.

Behavioral therapies
Behavioral therapy can play a key part in the usual treatment of premature ejaculation. Exercises are effective; however, they may not always provide a lasting solution to the problem. Also, they rely heavily on the cooperation of the partner, which in some cases, may be a problem.

With the squeeze method, an exercise developed by Masters and Johnson, the partner stimulates the man's penis until he is close to ejaculation. At the point when he is about to ejaculate, the partner squeezes the penis hard enough to make him partially lose his erection. The goal of this technique is to teach the man to become aware of the sensations leading up to orgasm, and then begin to control and delay his orgasm on his own.

With the stop-start method, the partner stimulates the man's penis until just before ejaculation. The partner should then stop all stimulation until the urge to ejaculate subsides. As the man regains control, he instructs the partner to begin stimulating his penis again. This procedure is repeated three times before allowing the man to ejaculate on the fourth time. The couple repeats this exercise three times a week, until the man has gained good control.

Medical therapies
Although not approved by the U.S. Food and Drug Administration (FDA) for this purpose, drugs used for depression and anesthetic creams have been shown to delay ejaculation in men with premature ejaculation (PE).

Medications are a relatively new form of treatment for PE. Doctors first noticed that men and women who were taking drugs for the treatment of depression (antidepressants) also had delayed orgasms. Doctors then began to use these drugs "off-label" (this implies using a medication for a different illness than what it was originally manufactured for) to treat PE. These medications include antidepressants that affect serotonin such as fluoxetine, paroxetine, sertraline and clomipramine.

If one medication fails to work, a second one is usually recommended. If the second one fails, trying a third medication will not likely be beneficial. An alternative is to combine medication with behavioral therapy and/or creams.

For use in PE, the doses of antidepressants are usually lower than those recommended for the treatment of depression. Common side effects of antidepressants can include nausea, dry mouth, drowsiness and reduced desire for sexual activity.

These drugs can be taken either every day or only taken before sexual activity. Your doctor will decide how

you should take the medication based on the frequency of intercourse. The best time for taking the antidepressant medications before sexual activity has not been established, but most doctors will recommend from two to six hours depending on the medication. Because PE can recur when the medication is not taken, you most likely will need to take it on a continuing basis.

Local anesthetic creams can be used to treat PE. These creams are applied to the head of the penis about 20 to 30 minutes before intercourse to lessen the sensitivity. Prior to sexual intercourse, a condom (if used) may be removed and the penis washed clean of any remaining cream. A loss of erection can occur if the anesthetic cream is left on the penis for a longer period of time than recommended. Also, the anesthetic cream should not be left on the exposed penis during vaginal intercourse since it may cause vaginal numbness.

Alternative therapies

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This article has been tagged since January 2007.

Many alternative therapies are available for the treatment of PE. Caution should be exercised when researching alternative sources of advice however, most treatments have not actually been shown to be effective. Some web sites even advocate the dangerous and antiquated method of pulling the testes downwards when aroused. This is actually a good way to slightly strain the interior of the testes and is associated with reports of injury and weakened/deteriorated erection. For some reason this advice is still widespread on the Internet.

Hypnosis has also proven very effective in the treatment of premature ejaculation. It is believed by some that ejaculation is a subconscious habit and by giving the mind hypnotic suggestions to last longer, the problem can be greatly alleviated if not completely cured. Most men report dramatic improvement after only a few sessions of hypnosis.

The prostate gland plays a very important part in regulating arousal. Pressure in between the engorged prostate and the erection causes most of the pleasurable sensations and it may be emptied manually before sex by prostate massage. This causes the erection to be strong but less sensitive, and increases a patient's awareness of his physiology.

There is a trend toward the use of nutritional supplements when treating men who suffer from PE. Effective supplements must contain 5HTP which is a precursor to serotonin. A Dr. William Ganong, noted that serum serotonin levels could be increased through dietary means. Increasing the serum level of serotonin helps inhibit the ejaculatory reflex. There are a number of nutritional remedies available primarily on the Internet.

Diagnosis

Diagnostic criteria for Premature Ejaculation DSM-IV-TR (American Psychiatric Association)

A. Persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it. The clinician must take into account factors that affect duration of the excitement phase, such as age, novelty of the sexual partner or situation, and recent frequency of sexual activity.

B. The disturbance causes marked distress or interpersonal difficulty.

C. The premature ejaculation is not due exclusively to the direct effects of a substance (e.g., withdrawal from opioids).

Differential diagnosis

Premature ejaculation should be distinguished from erectile dysfunction related to the development of a general medical condition. Some individuals with erectile dysfunction may omit their usual strategies for delaying orgasm. Others require prolonged noncoital stimulation to develop a degree of erection sufficient for intromission. In such individuals, sexual arousal may be so high that ejaculation occurs immediately. Occasional problems with premature ejaculation that are not persistent or recurrent or are not accompanied by marked distress or interpersonal difficulty do not qualify for the diagnosis of premature ejaculation. The clinician should also take into account the individual's age, overall sexual experience, recent sexual activity, and the novelty of the partner. When problems with premature ejaculation are due exclusively to substance use (e.g., opioid

withdrawal), a substance-induced sexual dysfunction can be diagnosed.

Associated conditions

* Neurological disorders, e.g., multiple sclerosis
* Prostatitis
* Psychological disorders
* Interpersonal disorders
* ABC's Premature Ejaculation, e.g.,