

# Practise Patterns in the Management of Premature Ejaculation: A Nationwide Survey among Indian Sexual Medicine Practitioners

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## Abstract

**Background:** Premature ejaculation (PE) is a common male sexual dysfunction encountered in day to day clinical practise. The management strategies of PE vary widely. In this nationwide online survey among sexual medicine practitioners of India we are assessing common practise pattern followed in the evaluation of PE.

**Methods:** The study used anonymous self-responsive questionnaire survey among sexual medicine practitioners of India. The survey questionnaire containing various aspects of management of PE was prepared. Data collected and basic descriptive statistics were calculated.

**Results:** Response rate in our study was 100 (44%). 50% of our respondents work in tertiary care level. 11% were in exclusive sexual medicine practise. Majority of the respondent diagnose PE based on patient symptoms and only 7% used objective time based criteria. Only 30% of sexual medicine practitioners used PE diagnostic tool. Psychological disorders (81%), hypertension and diabetes (7%) and Prostate related problems (2%) are the common comorbidities associated with PE as per our survey. 49% of them opined that 20-50% of PE had ED. 57% of respondents say that oral pharmacological agents are the most common treatment modality employed for their PE patients. Dapoxetine is the most commonly prescribed oral agent by majority (49%) of the participants in our study.

**Conclusions:** The majority of sexual medicine practitioners in India diagnose PE by patient's symptoms. Oral dapoxetine is the most commonly used treatment for PE. Through this nationwide survey, we will be able to understand how contemporary sexual medicine practitioners in India manage patients with PE.

**Keywords:** Premature Ejaculation; Practice Patterns; Therapy, Dapoxetine

## Introduction

Premature ejaculation (PE) is a common male sexual dysfunction, with an incidence of around 30%, even though the incidence varies with the diagnostic criteria used [1]. The diagnosis of PE is based on three components: short IELT, inability to delay ejaculation, and negative personal consequences. PE can be classified mainly into lifelong PE and acquired PE [2]. Erectile dysfunction, prostatitis, thyroid dysfunction, and psychological problems were also

considered as possible causes for acquired PE [3].

Pathophysiology of PE is poorly understood. There are several proposed pathological mechanisms for the development of PE which include 5HT1A hypersensitivity, 5HT2C receptor hyposensitivity, genetic factors, biologic hypersensitivity and hyper-excitability of glans penis [4,5].

American urology association defines PE as "Ejaculation occurring sooner than desired causing distress to one or both partners" [6]. International Society for Sexual Medicine (ISSM) defines Premature ejaculation as "A male sexual dysfunction characterized by ejaculation which always or nearly always occurs prior to or within about one minute of vaginal penetration (lifelong PE), or, a clinically significant and bothersome reduction in latency time, often to about 3 minutes or less (acquired PE) and; inability to delay ejaculation on all or nearly all vaginal penetrations;

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and negative personal consequences, such as distress, bother, frustration, and/or the avoidance of sexual intimacy” [7]. Some experts advocate importance of time where as others argue that the associated distress has to be given importance while making the diagnosis of PE [8].

Non pharmacological therapy like squeeze technique and stop and start techniques are the mainstay of treatment for PE for many years and masters and Johnson reported excellent response to these techniques. But later studies failed to replicate these results [9]. Later topical anaesthetic agents become the treatment of choice. Identification of ejaculation delaying properties of SSRIs opened a new armamentarium for the treatment of PE [10]. Discovery of PE specific action of dapoxetine emerged as a new treatment option for PE and became the drug of choice for PE [11].

The practice pattern varies widely among the sexual medicine practitioners. In order to find out how PE is managed in day to day practise we conducted online survey among sexual medicine practitioners in India. Through this nationwide survey, we will be able to understand how contemporary sexual medicine practitioners in India manage patients with PE. So we hope that this study will help doctors to know about the management of PE in day to day clinical practice and improve patient care.

## Materials and Methods

A specifically designed survey questionnaire containing various aspects of management of PE was prepared. The questionnaire consisted of questions about responder demographics, clinical profile, diagnosis and management of PE. The questionnaire prepared was scrutinised independently by three other researchers, and corrected the ambiguity of the questions and the final version is approved by all of them. The survey questionnaire is designed to explore practice characteristics and attitudes, as well as diagnostic approach and treatment of PE. The survey assessed several practice-related factors and asked questions of how the doctors handled various issues related to management of PE in their clinical practice.

We collected the details of sexual medicine practitioners with modern medicine qualification (M.B.B.S and above) registered with various association of sexual medicine practitioners (CSEPI and IASMP). After Ethical Committee approval, we send the survey questionnaire containing various aspects of the management of PE online by e-mail/ WhatsApp to 225 sexual medicine practitioners with a short introduction about the study. We initially received filled survey response from 79 sexual medicine practitioners. We send reminder to non responders and finally we could get total 100 responses from sexual medicine practitioners during one-month survey period. Eight sexual medicine practitioners replied that they are not in active patient

management now.

The data was coded for each question and basic descriptive statistics like frequency distribution, measures of central tendencies, and measures of distribution were calculated for all sections.

## Results

We received 100 completed survey reports online showing a response rate of 44% (100/225) of participants in our study. Among the sexual medicine practitioners responded in our study 37% were psychiatrist, 24% urologist, 7% gynaecologist and 3% were internist. Majority of our respondents were males 95% and 36% of our respondents are having 15 or more years of clinical experience, 15 % of our respondents work in primary care level, whereas 50% in tertiary care level. Majority practice in urban areas 84%. The demographic of the sexual medicine practitioners responded in our study is given in table 1.

“Decrease in the time” is the most common symptom described by the patient with PE as per our respondents. Majority of the respondent diagnosed PE based on patient symptoms and only 7% used objective time based criteria (figure 1). Only 30% of sexual medicine practitioners used PE diagnostic tool and lack of time is a major hurdle to use PE diagnostic tool in day-to-day clinical practice (figure 2). Some of the sexual medicine practitioners in our study believe that it is a clinical diagnosis based on patients symptoms and associated distress.

Majority (46%) of sexual medicine practitioners opined that the cut-off time of IELT to diagnose PE should be less than 1 minutes (figure 3). 22% of the respondents reported that more than 40% of their male patients with sexual dysfunction is having PE and PE is most commonly seen in the age group of 30-50 years. Most of them opined that secondary PE is the most common type of PE they see in day today practice. Psychological disorders (81%), hypertension and diabetes (7%) and Prostate related problems (2%) are the common co-morbidities associated with PE as per our survey. 49% of them opined that 20-50% of PE had ED (figure 4). Only 10% or less of PE patients bring their spouses during medical consultation as per 69% of our respondents and 84% of respondents routinely enquire about the sexual function of the female partner; where as only 66% evaluate the partner if they suspect sexual dysfunction and only 53% routinely treat the sexual dysfunction of the partner (figure 5 and 6).

57 % of respondents say that oral pharmacological agents are the most common treatment modality employed for their PE patients. But behavioural therapy is the initial treatment advised by 54% of the sexual medicine practitioners (figure 7). Dapoxetine is the most commonly

Table 1: Demographic features of the participants of the study

Demographic features of the Participants of the Study	
<b>Sex</b>	
Male	95 (95%)
Female	5 (5%)
<b>Years of Clinical Practice</b>	
Less than 5	12 (12%)
5-10	28 (28%)
10-15	24 (24%)
15-20	19 (19%)
20-25	6 (6%)
More than 25	11 (11%)
<b>Highest Educational Qualification</b>	
M.B.B.S	5 (5%)
PG Diploma	13 (13%)
PG Degree	58 (58%)
DM/MCh	24 (24%)
<b>Type of Institution</b>	
Primary care	15 (15%)
Secondary care	35 (35%)
Tertiary care	50 (50%)
<b>Area of Practice</b>	
Exclusive sexual medicine	11 (11%)
Not exclusive sexual medicine	89 (89%)
<b>Specialty</b>	
Psychiatry	37 (37%)
Urology	24 (24%)
Gynecology	7 (7%)
Internal medicine	3 (3%)
General practice	9 (9%)
Others	20 (20%)
<b>Place of Practice</b>	
Urban	84 (84%)
Rural	16 (16%)

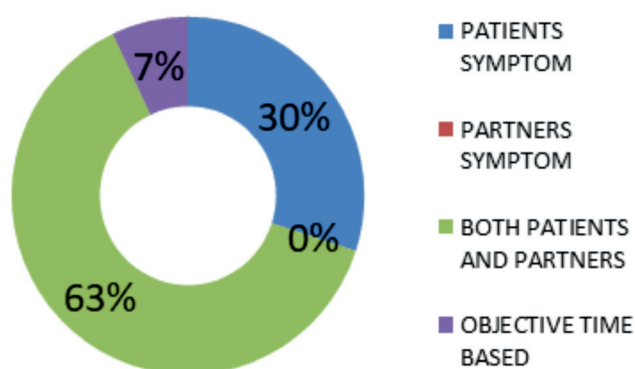


Figure 1: Basis of diagnosis of PE

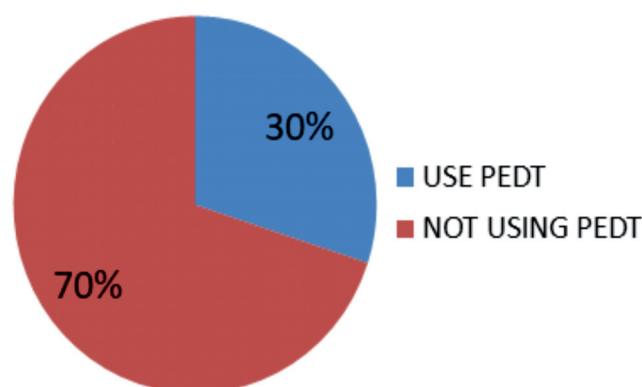


Figure 2: PEDT usage in clinical practice

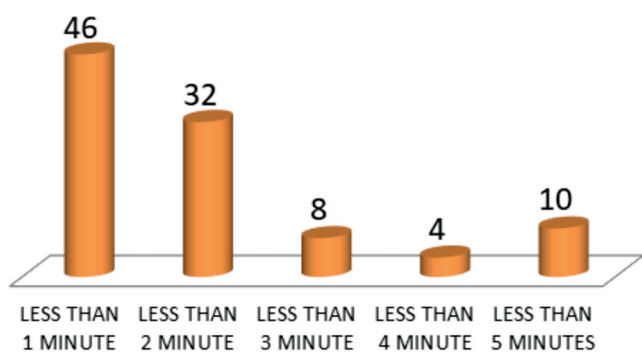


Figure 3: Pattern of cut of values of IELT used by the study participants to diagnose PE

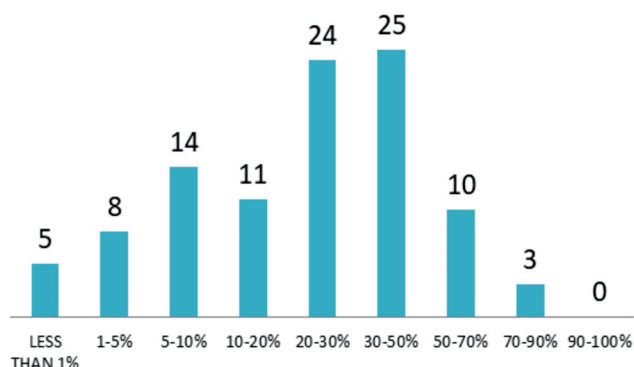


Figure 4: Percentage of PE patients who had ED also as per participants' experience

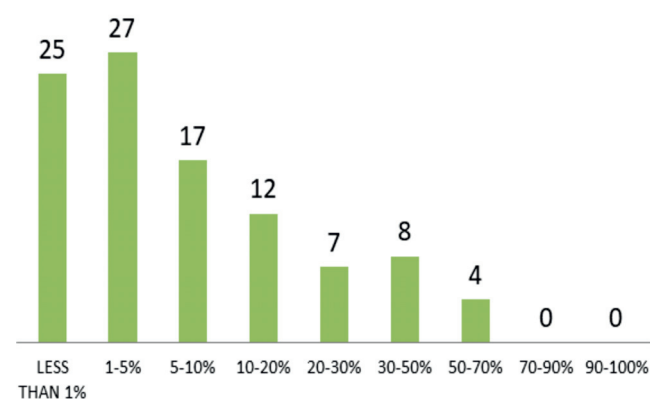


Figure 5: Percentage of PE patients who brings their spouse will coming for consultation

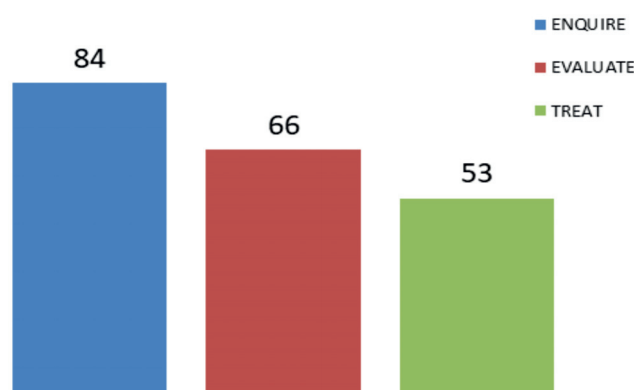


Figure 6: Percentage of sexual medicine practitioners who enquire, evaluate and treat sexual dysfunction in the female partners of patients with PE.

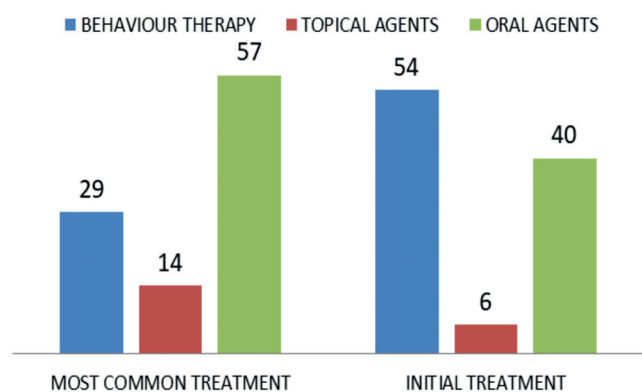


Figure 7: Treatment of PE – initial treatment and most commonly used treatment modality

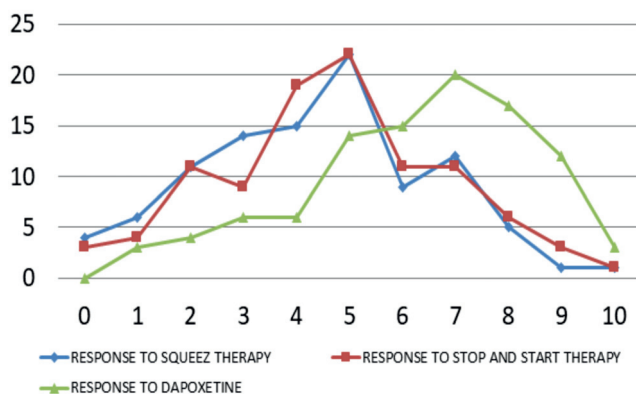


Figure 8: Response to various treatment modalities in PE

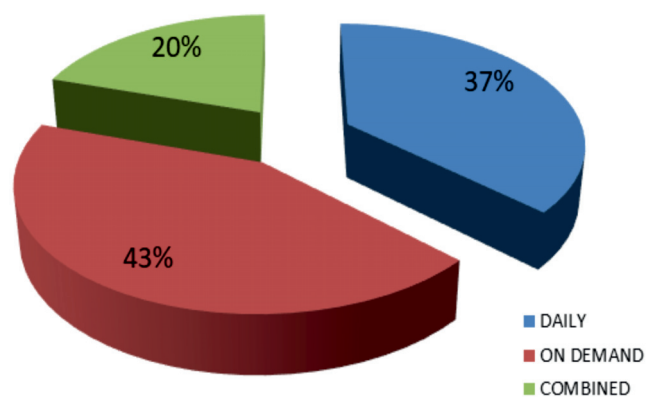


Figure 9: Usual way of SSRI prescription

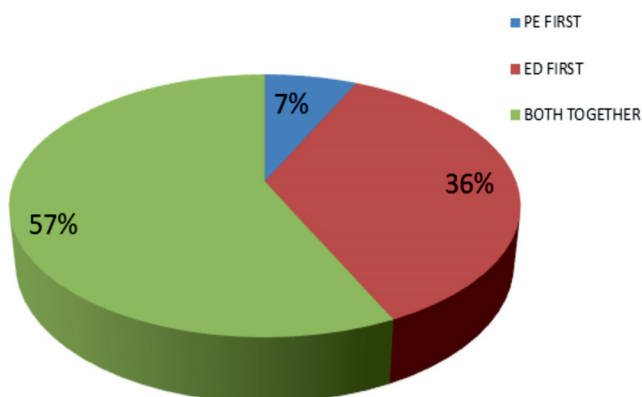


Figure 10: Treatment options in patients with both PE and ED

prescribed oral agents by majority (49%) of the participants in our study. In a scale of 0 - 10 where 0 represent "Not all effective" and 10 represent "100% effective" 72% of the respondents rate the success of squeeze technique as 0 to 5, 68% rate the success of stop and start therapy as 0 to 5 and 81% rate the success of dapoxetine as 5 to 10 in the treatment of PE (figure 8).

Most of the practitioners (43%) prescribe SSRIs on demand in the treatment of PE (figure 9). If first oral agent fails, 41% of the practitioners prefer to increase the dose, 31% prefer to start combination and 25% prefer to change the medication. Dapoxetine with PDE 5 inhibitor is the commonly used combination in the treatment of PE by sexual medicine practitioners of India.

In patients with combined PE and ED 36% prefer to treat ED first, 7% prefer to treat PE first and 57% prefer to treat both together (figure 10). Cost of the medicine and inconvenience to take daily medication are the major obstacles in the treatment of PE in real world as per the sexual medicine practitioner's opinion.

## Discussion

In a Korean study conducted in 2014, which was based on an email survey the response rate was 32.5% [12]. In another survey conducted among American urologist the mail survey response rate was 23% [13]. In a Korean email-based survey to analyse Korean urologist practice pattern the response rate was 21.8% [14]. In our study, the response rate is 44%.

The diagnosis of PE is based on three principles - short IELT, inability to delay ejaculation and personal distress. In the survey conducted among Korean urologists, PE diagnosis is based on the definition of ISSM in 63.4%, DSM 4-TR in 43.8%, ICD-10 in 61.7% and by patient symptoms alone in 23.5% of cases [14]. In the study analysing U.S. urologist's "Real World" practice patterns in treating premature ejaculation, the majority of the respondents diagnose PE by patient complaint [13]. Similarly, in our study also majority diagnose PE based on symptoms and only 7% of respondents uses objective time-based criteria.

PEDT which contains 5 questions is used as a tool to objectivity diagnoses PE. In the Korean Nationwide Survey among urologist 42.5% used PE diagnostic tool, a self-administered questionnaire given to patients [14]. In another study among urologists in South Korea 42% used PE diagnostic tool in their clinical practise [12]. In our study, only 30% of respondents used PE diagnostic tool in their practise.

Major reason for not using PE diagnostic tool as per the respondent are as follows: as per 63% of respondents, patients subjective symptoms are more important, as per

40% limitation of counselling time, 27% think it is not necessary, 16% opined that it has insufficient diagnostic value and 16% thinks that it is not useful for deciding treatment, 12% says that patient did not want this and 4% answered that they are not aware of PEDT [12]. Our result shows that majority of sexual medicine practitioners still diagnose PE based on patient's symptoms. The major obstacles to use PE diagnostic tool in our study are lack of time and majority of sexual medicine practitioners believe that PE is a clinical diagnosis. Few of our respondents are not aware of PEDT.

In the Korean Nationwide Survey 29.8% of participants opined considering IELT less than 1 minute appropriate and 22.2% opined less than 2 minute appropriates. 20.7% percentage based their diagnosis of PE on subjective symptoms irrespective of IELT [14]. In the other Korean study for the diagnosis of PE appropriate time to ejaculation was considered less than 1 minute by 12% of respondent, 2 minutes by 27% of respondent, 3 minutes by 28% and 5 minutes by 13 % [12]. In our study for the diagnosis of PE appropriate time to ejaculation was considered less than 1 minute by 46% of respondent, 2 minutes by 32% of respondent, 3 minutes by 8% and 5 minutes by 10 %.

In the Korean study co-morbidities associated with PE in descending order was as follows: ED (58%), prostatitis (25%), psychological issues (31%), prostatic hypertrophy (2%) and no commodities in 10% [12]. In our study psychological issues (81%) and hypertension and diabetes (7%) was the common co-morbidities associated with PE.

The dictum is to evaluate both the partners together in case of sexual dysfunction, as sexual dysfunction is a disorder of the couple rather than the individual partner. The chance of successful treatment outcome also will be less if unidentified sexual dysfunction is present in the partner. In a study conducted among American urologist, good number of them enquire about the partner's sexual dysfunction but very few evaluate and offer treatment for the partner [13]. In our study, 84% enquire about the partner's sexual dysfunction and 66% evaluate them but only 53% opined that they will offer treatment to them.

In the Korean study, it was found that majority of patient opted for pharmacological therapy (87%) compared to surgical treatment (9.5 %) and behaviour management (3.5 %) [12]. For the treatment of PE behaviour therapy was used by 47.6% and local anaesthetics were used by 53.7% of urologist in the Korean study [14]. In our study, 57% of respondents say that oral pharmacological agents are the most common treatment modality employed. But 54% uses behavioural therapy as the initial treatment

The Korean urologist uses local anaesthetics in 53.7% of their cases. Common local preparation they used on

decreasing order is lidocaine gel (58.8%) severance secret cream (19.4%) and lidocaine-prilocaine cream (12%) [14]. Local anaesthetic agents do not produce systemic side effects, but cause local irritation, loss of sensation and even loss of vaginal sensation in the female partner. In our study, only 14% opined that topical agents are most commonly used in their practise to treat PE.

Korean urologists consider that SSRIs are the primary treatment of choice for PE and 95% of urologist uses SSRIs for the treatment of the same. Dapoxetine is the most commonly prescribed oral agent (87.3%) followed by sertalin (29.7%) fluoxetine (19.7%) and paroxetine (11.6%) [14]. In the other Korean study also Dapoxetine was the most commonly prescribed drug (97%) compared to clomipramine (59%) and other SSRIs (35%) like sertalin, fluoxetine and paroxetine [12]. Even though Dapoxetine was the most widely prescribed drugs for PE, the patient satisfaction rate and response rate with dapoxetine was 45.0% and 74.6% [15]. In our study also dapoxetine was the most commonly (49%) prescribed oral medication followed by paroxetine (23%).

SSRIs are effective in prolonging IELT. Daily dose of paroxetine 20 mg increased IELTS up to 78.3%, sertaline 50 mg by up to 313%, fluoxetine 20-40 mg by up to 299%. On demand SSRI dapoxetine increase IELT from 0.9 minutes to 3 minutes [16]. Another study showed that drop out because of adverse effect from a 6-week daily SSRI trial was 12.6%. The common reported side effects of SSRI include fatigue, nausea and vomiting, dry mouth, drowsiness, decrease libido and ED [17].

The role of PDE-5 inhibitor in the management of PE without ED is controversial. Some studies report that PDE-5 inhibitors have an overall positive effect in patients with PE [18]. In the Korean study, 40.2% of urologist prescribed PDE-5 inhibitors for the treatment of PE [14]. In our study, 6% uses PDE-5 inhibitor in people with isolated PE.

Behaviour treatments like squeeze technique and stop and start technique needs partners corporation and there is risk of recurrence. Studies showed that behaviour therapy combined with pharmacological agents is more effective than pharmacological agents alone [19].

The role of surgical therapy in PE is controversial. Studies show that selective neurectomy of dorsal nerve of penis and penis augmentation using hyaluronic acid are safe and effective [20,21]. In the Korean study, some of the urologist used surgical techniques like SDN (54.3%) and hyaluronic acid gel glans or autologous fat glans augmentation (16.9%) to treat PE. Urologist opined that SDN was done most commonly following patients demand. Urologist suggested SDN to patients with PE who responded to treatment with local anaesthetic agents or who have penile hypersensitivity

diagnosis by penile vibration perception threshold test [14]. Korean urologist opined that 56% of PE patients who underwent SDN are satisfied and only 3.4 % dissatisfied. They observed a recurrence of PE in 10% of cases [14].

In the study conducted among American urologist 90% opined that in people with both PE and ED they will treat ED first which is consistent with AUA guideline [13]. In the Korean study, 60% answered that they will treat ED first in those having both ED and PE. Other studies also showed that in patients with both PE and ED, it is more effective to treat ED first [22,23]. In our study only 36% only opined that they will treat ED first and majority opined that they will treat both PE and ED together.

Major obstacles in the pharmacological treatment was cost of the medicine (42%) followed by patients resistance to take medication daily (38%) [12]. In the Korean study, they found that the high price of the oral medication is a major obstacle in treating PE [14]. In our study also we found that cost of medication is an important issue.

Through this nationwide survey, we will be able to understand how contemporary sexual medicine practitioners in India manage patients with PE.

### Limitation of the study

Limitation of our study includes a small sample size and high proportion of non-responders. But most of the mailed surveys in this aspectis showing similar or even lower response rate. Our study did not include all the sexual medicine practitioners in India. Study with large sample size and on real patients with PE may be conducted as part of further understanding the problem.

Our study is the first of its kind conducted among sexual medicine practitioners in India as per our knowledge. In the absence of other practice pattern survey among Indian sexual medicine practitioners we believe that our study shows light into the contemporary management pattern of PE. But additional research is needed in this area to understand further aspects of PE management which will help us to provide better care for our patients with PE.

### Conclusion

Premature ejaculation (PE) is common male sexual dysfunction encountered in day to day clinical practise. The management strategies of PE vary widely. In our nationwide online survey among sexual medicine practitioners of India, we found that majority of our sexual medicine diagnose PE based on symptoms. The most commonly used treatment for PE as per our study is oral dapoxetine. We hope that our study will help to throw more light into the contemporary management of PE in India and may help us to improve the care delivered to people with PE. This is the first study of its

kind conducted among Indian sexual medicine practitioners.

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<b>Ethics:</b>	There is no ethical violation as it is based on voluntary anonymous interviews
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<b>Guarantor:</b>	Dr. A. V. Raveendran will act as guarantor of this article on behalf of all co-authors.

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