MEETING THE CHALLENGE OF SEXUAL DYSFUNCTION IN MEN: PART 1

Young men are often reluctant to present to their GP with sexual problems. When they do, a thorough and effective assessment is essential to ensure effective management. In this two-part series, the authors look at the key main sexual problems experienced by this patient group. Part 1 explores the landscape of male sexual dysfunction and looks at assessment and management of premature ejaculation.

Dr Odunayo Kalejaiye
Urology SpR

Professor Raj Persad
Consultant Urologist; Honorary Professor of Urology

Dr Jon Rees
GP Partner

Department of Urology, North Bristol NHS Trust

Sexual function is a vital part of male identity and has a significant impact on quality of life (QoL). In an international survey of both sexes, satisfaction with sex was associated with a positive outlook on life, especially with regard to physical health, family life and financial well-being.[1] Most men reported sex as very or absolutely essential when compared with other life priorities – in contrast to women who ranked sex as the eighth most important priority. This has significance for couple counselling when sexual dysfunction becomes problematic.

> *Male sexual dysfunction is under-reported and undertreated*

Sexual dysfunction is a difficult topic for both patients and clinicians to discuss. In a poll from the USA, 71% believed that their physician would dismiss their concerns, while 68% reported that they believed their physician would be uncomfortable talking about sexual problems.[2]

Male sexual dysfunction is under-reported and undertreated.[3] Surveys in Australia and the UK found that even after reporting erectile dysfunction (ED), only 10-12% received treatment.[3] A survey across six countries to determine the drivers and barriers for seeking treatment for erectile dysfunction found the prevalence of ED was 4-6% in men under 40 years old.[3] Men in this age group were more likely to believe their ED would resolve spontaneously. In addition, young men and those with severe ED were more likely to be resistant to seeking treatment due to embarrassment about discussing their condition.[3]

Another survey reviewing the unmet needs of men with ED across five EU countries found that the prevalence of ED was 5% in the age group 18-39 years.[4] The proportion discussing their ED with their doctor increased with age. However, the proportion not recommended a prescription for their ED was 64% in men aged 18-39 years, compared with 81% in the group 40-59 and 68% in the group 60 years or older.[4] This is rather disappointing when one considers the difficulty these men have overcome in presenting to their clinicians and the available treatment options.

Helplines and internet-based services with e-mail access are being increasingly used to circumvent some of the embarrassment which may be associated with face-to-face consultations. They are also a useful tool in collecting data on this often shy group.

An Italian helpline collected data on their users over three years (2006-8).[5] The commonest sexual problems reported were ED and premature ejaculation (PE) with 37.2% having never consulted a specialist about their problem. 52.3% of the male callers were in the age group 26-35 years. In this age group, 25% and 19.8% called about PE and ED respectively[3] A small proportion (4.6%) reported desire disorder, with 11.4-17.2% calling for reassurance about what constitutes normal and for information. Among the 49 women who called about their partner, 55% reported ED. Many reported more than one sexual problem with desire disorder associated with ED in 41.7%. Sexual dysfunction was associated with relationship problems in approximately a third.[5]

In a similar study from 2009-10 involving users of a UK-based sexual function service,[6] the commonest problems reported were ED and PE (90% of phone calls and 78% of e-mails).[6] A smaller proportion also reported delayed ejaculation, Peyronie's and low sex drive. Men over 40 years were significantly more likely to report ED than younger men. However, younger

men were significantly more likely to report PE and concerns about their genitalia, e.g. bends and size.[6]

Sexual dysfunction is associated with significant physical and psychological co-morbidities, including relationship problems, depression and sexual avoidance. Sexual bother (i.e. the degree to which sexual dysfunction is upsetting) is more frequent with depressive symptoms, zero or multiple partners and low sexual frequency.[7] Both PE and ED increase the likelihood of sexual bother.[7]

In this part, we will discuss assessment and management of PE. ED and Peyronie's will be discussed in the next issue of *BJFM*.

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Premature ejaculation (PE)

PE is the most common sexual dysfunction; estimated to affect 5-30% of the world's male population.[8,9,10,11] The variable reported prevalence figures are due to the absence of a standard definition until 2008.[10] Despite its high prevalence, PE is the dysfunction for which men are least likely to seek help.[8] It may co-exist or precipitate other sexual dysfunctions such as ED or reduced desire. The treatment aims for ED and PE oppose each other; men with PE need to reduce arousal and excitement which may result in loss of erection.[11] Contrastingly, men with ED need to increase their excitement and arousal, which may result in lack of ejaculatory control and PE.[11] In addition, reduced desire may be due to the chronic frustration of PE or ED. Alternatively; PE may be precipitated by an unconscious desire to shorten sexual intercourse for a variety of reasons.[11] The aetiology of PE is not fully understood but may have a biological/genetic and psychological basis.[10, 11]

Definition

The ISSM (International Society of Sexual Medicine) definition is:

- Male sexual dysfunction characterised by ejaculation which always or nearly always occurs prior to or within one minute of vaginal penetration (intravaginal ejaculatory latency time: IELT)
- Inability to delay ejaculation on all or nearly all vaginal penetrations
- Associated with negative personal consequences such as distress, bother, frustration and/or avoidance of sexual intimacy.[8]

There are four types of PE:

- Lifelong PE (LPE)
- Acquired PE (APE)

TABLE 1: TYPES OF PE [8,11]

Type	Characteristics	Treatment
LPE	Lifelong 80% IELT within 30-60s (20% within 1-2 mins) Starts from first sexual intercourse Occurs too early with almost every intercourse and woman Genetic cause	Pharmacological
APE	Gradual/sudden onset Previous normal ejaculation Ejaculation time normal/short May have underlying cause	Treat underlying cause All options
NVPE	Irregular/inconsistent early ejaculations Reduced/absent ability to delay ejaculation Impression of reduced control of ejaculation	Psychological
PLED	Normal/longer IELT Subjective perception of rapid ejaculation Imagined PE or lack of control over ejaculation Reduced/absent ability to delay ejaculation	Psychological

AETIOLOGY OF PREMATURE EJACULATION:

Psychological
- Early sexual experience
- Anxiety
- Reduced frequency of sexual intercourse

Biological
- Penile hypersensitivity
- 5HT (hydroxytryptamine) receptor sensitivity
- Hyper-excitable ejaculatory reflex

Secondary causes
- Erectile dysfunction
- Prostatitis
- Thyroid dysfunction (especially hyperthyroidism)
- Neurological conditions: acquired or congenital

- Natural variable PE (NVPE)
- Premature-like ejaculatory dysfunction (PLED)[8,11]

The types of PE differ in their characteristics and treatment which is of importance when assessing the patient (Table 1).[8,11]

Assessment

History taking is the most important part of patient assessment and should also be used to manage and determine patient expectations. The following aspects should be considered:

- Presenting complaint: PE vs. ED vs. reduced desire
  - Onset and duration
  - Time taken to ejaculate after vaginal penetration
  - Perceived degree of ejaculatory control
  - Frequency of sexual intercourse
  - Presence of other sexual problems
  - Degree of patient and partner distress
  - Assessment of relationship or work problems
- Drug history: illicit or prescription drugs
- Psycho-social history
- Co-morbidities
- Underlying condition.[8,11]

Examination of these men should be determined by findings from the history.

Treatment

Treatment options may be divided into:

- Behavioural
- Topical
- Oral

Behavioural techniques

These require a lot of time, both by the clinician and the couple; they should be used for men with all the different types of PE except lifelong PE. Ideally these men should be referred to a sex therapist. The techniques involve delaying their arousal and reducing their excitement. This may involve:

- Stop-start
- Pause squeeze
- Masturbation prior to sexual intercourse
- Mental imagery
- Trying alternative sexual positions including non-penile focusing activities.[8, 11, 12]

This treatment modality requires partner co-operation, increased communication and time, as results are unlikely to be quick.[11] Success rates are estimated to be 50-60% short-term but are not maintained long-term.[12]

Topical anaesthesia

PE is associated with an increase in sensory response to penile stimulation; therefore any agent acting to cause penile desensitisation may result in an increase in IELT.[13] This forms the rationale for the use of topical anaesthetic agents in the treatment of PE. There are a variety of agents, all of which have been shown in studies to increase IELT vs. placebo.[8,11,13,14] The agents currently available are:

- Lidnocaine-prilocaine cream (EMLA)
- Prilocaine-lidnocaine spray (TEMPE).

The cream needs to be applied 5-20 minutes prior to intercourse and must be used with a condom to reduce vaginal absorption, which may result in numbness in the partner. However, the sprays may be applied without the use of a condom five minutes before intercourse and wiped off prior to intercourse. The main disadvantage of these agents is that they may be messy, interfere with intercourse, and there may be a lag between application and intercourse.[8,10,13,14] Other side effects include mild localised irritation.[13]

SSRIs increase the level of synaptic serotonin, thereby inhibiting the ejaculatory reflex and increasing IELT

Oral agents

The main oral agents used are selective serotonin re-uptake inhibitors (SSRI). Their use is based on the side effects which were noted in depressed men with normal sexual function who reported delayed ejaculation.[13] SSRIs increase the level of synaptic serotonin, thereby inhibiting the ejaculatory reflex and increasing IELT.[11,13] This has been proven in randomised controlled studies to significantly increase the IELT compared with placebo, with additional improvement in sexual satisfaction.[9] They are given in smaller doses than that prescribed in depression and may be given on-demand or daily.[8, 11, 13] On-demand is less effective than daily but is associated with fewer side effects.[8] The main side effects are dry mouth, drowsiness, nausea, reduced libido.[13] There may also be serious drug interactions resulting in a rise in the number reporting suicidal ideation.[13] The main available agents are:

- Paroxetine
- Sertraline
- Fluoxetine
- Dapoxetine

Dapoxetine (Priligy), a short-acting SSRI, is the only agent in this class indicated and developed specifically for the treatment of PE.[8,9,11]

The other oral agents are tramadol, which may be used in the presence of pain, and PDE5i if PE co-exists with ED.[8]

Conclusion

Premature ejaculation although common, is a difficult condition for men, their partners and clinicians. The exact pathogenesis is poorly understood. However, the patient-clinician relationship forms a vital part of the management. The man, his partner and the clinician must all be comfortable discussing various sexual activities. The terminology "premature" is subjective and may be upsetting for some men. The variability in ejaculation latency times must be emphasised as there is some suggestion that this may be culturally and genetically determined.[11] Sexual satisfaction must always be the aim rather than time to ejaculate. It is also a vital opportunity for couples to increase their communication, intimacy and sexual experimentation.

The second part of this review will discuss erectile dysfunction, Peyronie's and disorders of desire.

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