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Global Andrology Forum Clinical Practice Guidelines on the Management of Premature Ejaculation

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Purpose: Premature ejaculation (PE) is a commonly encountered male sexual dysfunction (MSD) with various definitions, diagnostic criteria, and treatment options, leading to significant heterogeneity and controversy in its management. This study aimed to explore the global practice patterns of the diagnosis and management of PE.

Materials and Methods: A cross-sectional, global, online survey on PE was conducted using a questionnaire developed by an international cohort of experts. Results were analyzed using R version 4.1.2. Additionally, expert recommendations were formulated using a modified Delphi method.

Results: The survey was completed by 264 participants from 41 countries. The majority of respondents were below the age of 45 years and were urologists focusing on andrology and sexual health. PE diagnosis was primarily based (by 61.5%) on an intravaginal ejaculatory latency time of less than one minute. Lifelong PE was the most common category reported (47.7%), and most respondents (84.2%) observed ante-portas PE in less than 25% of cases. Distinguishing PE from erectile dysfunction was challenging for many respondents (60.7%). Diabetes mellitus was the most common comorbidity (17.1%). Pharmacological therapy was the most common treatment method (34.3%), with dapoxetine being the most preferred medication (37.9%). Surgical methods were infrequently used. Emerging treatments like hyaluronic acid gel glans augmentation were favored by only 11.7%. Patient satisfaction was the primary criterion for successful PE treatment (55.9%), and cost was a significant concern for many (35.5%).

Conclusions: This global survey highlights significant diversity in the diagnostic and treatment strategies for PE. Standard diagnostic criteria are generally accepted, off-label medication is widely used in therapy, and the role of surgery is still controversial. A multi-modal therapy approach, tailored to the patient's specific needs, is favored. Further research into the neurobiology of PE and the development of effective and safe options is crucial for improving the management of PE.

Keywords: Ejaculation; Medicine; Premature ejaculation; Sexual health; Surveys and questionnaires; Therapy

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INTRODUCTION

Premature ejaculation (PE) is one of the most prevalent forms of sexual dysfunction affecting men worldwide. It is characterized by ejaculation that occurs sooner than desired, either before or shortly after vaginal penetration. Several studies have shown that PE significantly impacts the quality of social life of the individual and the partner's sexual satisfaction and psychological well-being [1,2].

The definitions of PE can vary depending on scientific organizations [3,4]. The International Society of Sexual Medicine (ISSM), and subsequently the International Consultation on Sexual Medicine, defined PE as "ejaculation that always or nearly always occurs before 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

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less (in cases of acquired PE), with associated negative personal consequences, such as distress, bother, frustration, and/or the avoidance of sexual intimacy" [4-7].

Later on, the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders Fifth edition, Text Revision (DSM-V-TR®) defined PE as "a persistent or recurrent pattern of ejaculation occurring during partnered sexual activity within 1 minute following vaginal penetration and before the individual wishes it." This behavior must be present in 75% or more of sexual encounters and persistent over at least the last 6 months and the man must experience personal distress related to this dysfunction, and the condition cannot be better explained by a comorbid or concomitant diagnosis [8]. The DSM-V-TR definition permits the categorization of PE into lifelong *versus* acquired and generalized *versus* situational subtypes. Similarly, the World Health Organization's International Classification of Diseases 11th revision (ICD-11) [9] mirrors that of DSM-V-TR and defines PE as "ejaculation that occurs before or within a very short duration of the initiation of vaginal penetration or other relevant sexual stimulation, with no or little perceived control over ejaculation" and "the pattern of early ejaculation has occurred episodically or persistently over at least several months and is associated with clinically significant distress" [9]. In addition to lifelong and acquired PE, variable PE is characterized by occasional PE complaints, and subjective PE, as a subjective perception of ejaculating early despite a normal ejaculation duration, has also been proposed.

It is estimated that up to 38% of men may experience PE [10,11], however, the exact prevalence can be challenging to determine due to variations in definitions, cultural perceptions, and differences in study methodologies. PE can be classified into two main categories: lifelong (primary) and acquired (secondary). Lifelong PE typically begins with the individual's first sexual experiences and persists across different partners and situations. In contrast, acquired PE develops after a period of normal sexual functioning and is often associated with specific physical or psychological factors [12]. Despite its prevalence and negative impact, PE remains underdiagnosed and undertreated, partly due to the stigma and embarrassment associated with the condition [2]. Hence, increasing awareness and encouraging open communication about sexual health are crucial steps toward improving the management of PE.

The etiology of PE is multifaceted, involving an interplay of biological, psychological, and relational factors. Various neurobiological pathways have been studied, showing that PE is likely mediated by a complex interplay of central and peripheral serotonergic, dopaminergic, oxytocinergic, endocrinological, genetic, and epigenetic factors [13]. Clinical evidence suggests that lower levels of serotonin in the brain may be linked to earlier ejaculation times [14]. Moreover, men's anxiety, depression, and decreased sexual desire due to PE might cause sexual dysfunction in female partners [14].

Specific causes of PE include abnormality in the neurotransmitters, 5-hydroxytryptamine (HT) receptor dysfunction, anxiety, penile hypersensitivity, erectile dysfunction (ED), genetic polymorphisms, traumatic sexual experiences, endocrine disorders, and prostatic diseases [15]. In this context, various standardized questionnaires have been developed to diagnose PE, including validated tools such as the Index of Premature Ejaculation (IPE), the Premature Ejaculation Profile (PEP), or the Premature Ejaculation Diagnostic Tool (PEDT) [16].

Treatment approaches for PE are varied, reflecting its multifaceted etiology. These approaches range from behavioral techniques, such as the stop-start method and the squeeze technique, to pharmacological interventions or even surgery. Oral selective serotonin reuptake inhibitors (SSRIs), typically used to treat depression, have been found to be effective in delaying ejaculation [17]. Additionally, topical anesthetics can reduce penile sensitivity, thereby prolonging the time to ejaculation. Counseling and sex therapy can also be beneficial, particularly when psychological or relationship issues contribute to this ejaculatory dysfunction.

Surgical or interventional methods may be indicated for patients with PE who have no response or a poor response to pharmacological, psychological, and behavioral therapies. These methods for the interventional treatment of PE include selective penile dorsal nerve resection, cryoablation and pulsed radiofrequency, pudendal neuromodulation, injection of hyaluronic acid into the glans penis, Botulinum toxin A injection into the bulbospongiosus muscles, implantation of graft material under Buck fascia, neuromuscular electrical stimulation of the pelvic floor muscles, and transcutaneous posterior tibial nerve stimulation [15,18-20].

Multiple well-controlled, evidence-based studies have

demonstrated the efficacy and safety of combined drugs, psychotherapy, and surgical treatment in a holistic multi-disciplinary care model of PE [21,22].

Further, despite the availability of numerous society guidelines and well-controlled, evidence-based studies that have elucidated the pathways for defining and managing PE, there remains significant heterogeneity in clinical practice worldwide.

Therefore, this study aimed to carry out an extensive global survey on the clinical approaches to PE management among clinicians worldwide, and complement these findings with expert recommendations on various aspects of PE therapy formulated by a group of Global Andrology Forum (GAF) experts using the Delphi method.

MATERIALS AND METHODS

A cross-sectional, online survey was designed and distributed per CHERRIES checklist criteria (Checklist for Reporting Results of Internet E-Surveys) [23] to assess the worldwide perception and practice of PE therapy (Supplement File 1). This comprehensive survey gathered diagnostic and therapeutic perspectives on PE, including respondents' demographics, PE diagnosis, partner roles, and both pharmacological and non-pharmacological treatments. The survey questionnaire underwent several rounds of expert reviews and revisions before finalizing a 53-question format (Supplement File 2) to ensure the inclusion of all relevant aspects. The overall survey strategy is illustrated in Fig. 1.

The final questionnaire was divided into three sections:

Demographic data (Q1-Q5): Age, country, profession, practice setting, and years of experience.

Diagnosis of PE (Q6-Q28): Criteria for diagnosing PE, categories of PE, co-existing conditions and diseases, partner involvement, and patient evaluation and assessment.

PE Therapy (Q29-Q53).

The survey was created using Google Forms to ensure global access through a secure platform, thereby safeguarding participants' personal information. It was made available online from August 7, 2024 to February 17, 2024. The survey link was distributed to specialists in the treatment of PE through direct emails to members of the GAF. Additionally, it was distributed via social media channels and the websites of several professional societies in urology, andrology, and sexual medicine. The participants were informed about the survey's purpose and objectives and were requested to complete the online questionnaire. The questionnaire was provided in English and employed standard medical terminology. This global online survey on PE therapy received approval from the GAF Ethics Committee, with approval number IR-02-23-113 on 06-02-2024.

The answers to the questionnaire were described as numbers and percentages of each choice. For questions where the participant could choose more than one answer, each response frequency was calculated from the total number of participants. The R version 4.1.2 programming language (www.r-project.org) was used to create the bar charts (Supplement File 3).

Finally, expert recommendations were formulated through collaboration among senior GAF members who possessed significant academic expertise and clinical experience in treating PE. These statements included the essential aspects of PE diagnosis and treatment and were shared among experts to reach a consensus using the Delphi method [24]. The initial statements were drafted based on the survey findings, guidelines from professional societies, and pertinent literature. These draft statements were then evaluated through a consensus-building Delphi process. This includes creating a Google survey with each initial recommendation listed and participants invited to rate it on a scale of 1 to 10; with 1 indicating “strongly disagree” and 10 indicating “strongly agree”. A score of 7 or more indicates acceptance of the recommendation, while a score of 1 to 6 indicates disagreement. A space was provided below each score to allow participants to propose an alternative recommendation if they gave a score of 1 to 6. A passing criterion of scoring 7 or more by >80% of participants was set. A total of 15 recommendations were included in the survey (Supplement File 4). An invitation email with clear instructions was sent to a selected group of GAF experts, considering a variety in age, academic position, geographical distribution, and subspecialty. The invitation included a description of the Delphi method, complete instructions, a link to the survey, and a copy of the manuscript. Any statements that did not reach a score of 7/10 by 80% of the respondents were revised based on the feedback and subjected to further rounds of assessment until consensus was reached for all the recommendations.

The final recommendations were then graded by 29

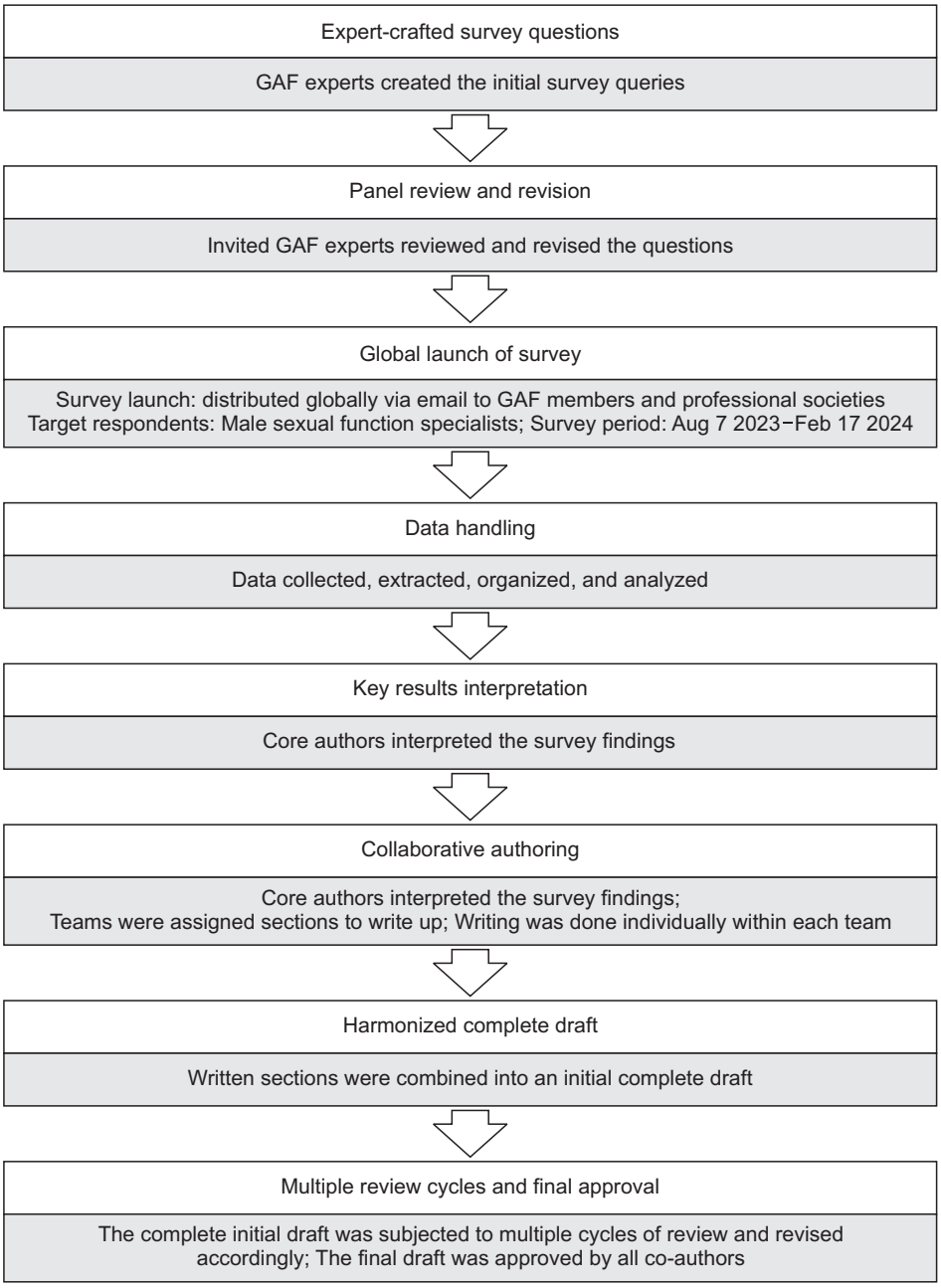


Fig. 1. The overall survey strategy.

GAF experts as "Strong" or "Weak" as per the guidelines of the GRADE working group [25], which take into account the quality of evidence, the "balance between desirable and undesirable effects" and cost. The recommendations that were rated "strong" by at least 80% of the experts were accepted as "strong" while the other recommendations were graded as "weak". The detailed responses to the Delphi survey and the expert grading of recommendations are presented as Supplement File 5.

RESULTS

A total of 264 participants from 41 countries completed the survey. Participants from Turkey comprised the highest proportion (67/264, 25.4%), followed by those from Vietnam (23/264, 8.7%), and from Egypt (21/264, 8.0%) (Fig. 2).

The age group of 35 to 44 years comprised the highest proportion (83/264 participants, 31.4%), followed by the age groups 25 to 34 years (78/264 participants, 29.6%), 45 to 54 years (52/264 participants, 19.7%), 55 to

64 years (36/264, 13.6%), and >65 years (15/264, 5.7%). Thus, the younger age groups 25 to 44 years constituted 60% of the participants denoting their scientific interest in this subject.

1. Professional background

The largest proportion of participants were urologists with a predominant focus on andrology and sexual health, comprising 41.7% (110/264 participants). This group was followed by urologists with some involvement in andrology and sexual health, accounting for 33.3% (88/264 participants). Additionally, 17.4% (46/264 participants) were andrologists, and 3.8% (10/264 participants) were urology residents. Other represented professions included gynecologists accounting for 1.1% (3/264 participants), certified sexologists 0.75% (2/264 participants), endocrinologists 0.75% (2/264 participants), dermatologists 0.4% (1/264 participants), general practitioners (0.4%, 1/264 participant), and geneticists (0.4%, 1/264 participant), as shown in Fig. 3 (answer values below 10 are grouped in the category "others").

2. Premature ejaculation diagnosis in clinical practice

The majority of practitioners rely on well-established definitions to diagnose PE. The ISSM definition was the most frequently utilized, with 142/262 respondents (54.2%) adhering to this standard. The ICD-11 mortality and morbidity statistics (MMS) definition was the second most commonly used definition, reported by 24/262 respondents (9.2%). The DSM-5-TR definition was employed by 17/262 respondents (6.5%), highlighting its lesser relevance. Notably, 42/262 respondents (16.0%) reported using a combination of all three definitions (ISSM, ICD-11 MMS, and DSM-5-TR), indicating a comprehensive approach to diagnosing PE. Conversely, 37/262 respondents (14.1%) indicated that they did not use any of these standardized definitions, possibly reflecting either the use of alternative diagnostic criteria

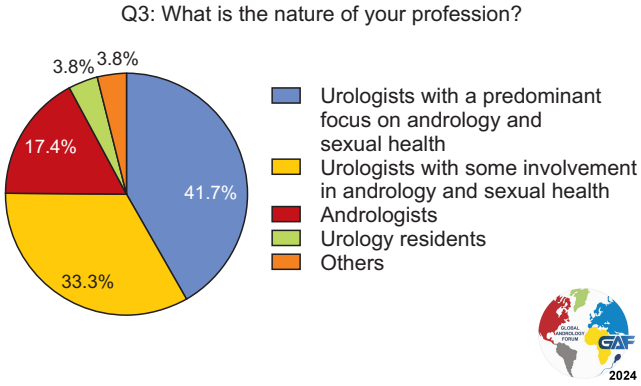
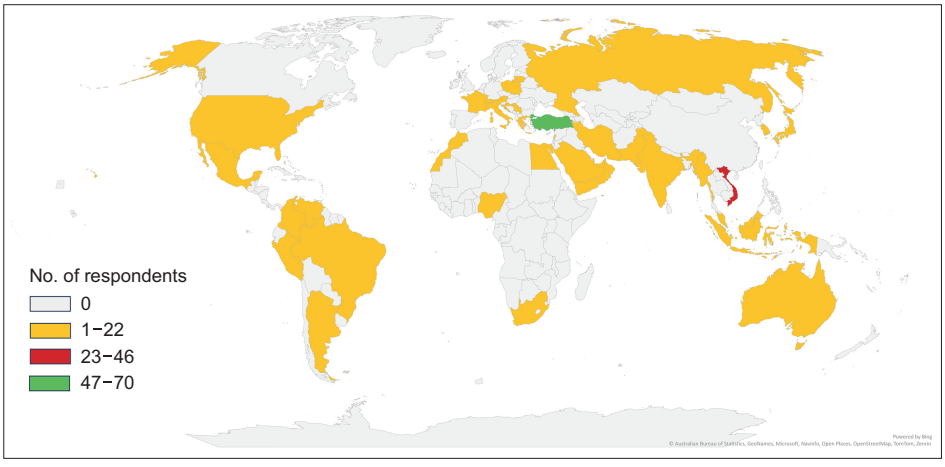


Fig. 3. Distribution by nature of professional background.



1. Argentina (n=1)
2. Australia (n=1)
3. Austria (n=9)
4. Bahrain (n=1)
5. Brazil (n=16)
6. Burma (n=1)
7. Colombia (n=7)
8. Croatia (n=5)
9. Egypt (n=21)
10. France (n=1)
11. Greece (n=11)
12. Morocco (n=1)
13. Oman (n=2)
14. Peru (n=2)
15. Qatar (n=2)
16. Saudi Arabia (n=4)
17. Singapore (n=1)
18. Switzerland (n=1)
19. UAE (n=2)
20. Venezuela (n=1)
21. Hong Kong (n=2)
22. India (n=11)
23. Indonesia (n=21)
24. Iran (n=6)
25. Italy (n=19)
26. Japan (n=4)
27. South Korea (n=3)
28. Lebanon (n=1)
29. Lithuania (n=1)
30. Malaysia (n=1)
31. Mexico (n=3)
32. Nigeria (n=2)
33. Pakistan (n=2)
34. Poland (n=1)
35. Russia (n=2)
36. Serbia (n=1)
37. South Africa (n=1)
38. Türkiye (n=67)
39. USA (n=2)
40. Vietnam (n=23)
41. Yemen (n=1)

Fig. 2. Participants distribution by the country (n=264).

or a more individualized approach to PE diagnosis, as shown in Fig. 4.

3. Criteria for diagnosing premature ejaculation

In clinical practice, the criterion used, based on ejaculation time, is critical for an accurate diagnosis of PE. The most frequently used criterion, reported by 61.5% of respondents (161/262), was an intravaginal ejaculatory latency time (IELT) of less than one minute. This is followed by an IELT of less than two minutes, utilized by 21.4% of respondents (56/262), and an IELT of less than three minutes, reported by 16.0% of respondents (42/262). A small minority (1.1%, 3/262 respondents) indicated that ejaculation always occurring before penetration is a criterion for diagnosing PE, as shown in Fig. 5.

4. Patient perceptions of normal sexual intercourse duration

Understanding patient's perceptions of normal sexual intercourse duration is essential for contextualizing PE diagnoses and managing patient expectations. More than half of the respondents (51.1%, 133/260) stated that their patients consider a normal duration of sexual intercourse to be between 6 and 10 minutes. This is followed by 25.8% of respondents (67/260), who indicated that their patients view 3 to 5 minutes as normal, and 19.6% of respondents (51/260), who reported that their patients believe 11 to 20 minutes is normal. A small percentage of respondents (2.3%, 6/260) indicated

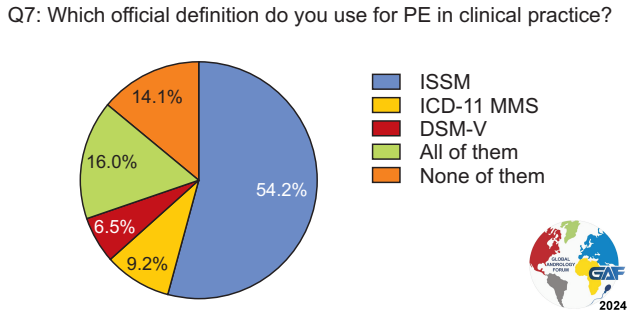


Fig. 4. Official definitions of PE used in clinical practice. PE: premature ejaculation, ISSM: International Society of Sexual Medicine, ICD-11 MMS: International Classification of Diseases 11th Revision for mortality and morbidity statistics, DSM-V: American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders Fifth edition.

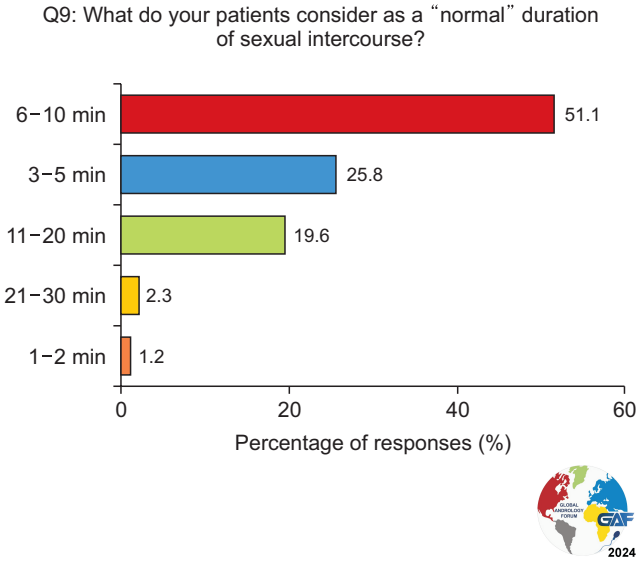


Fig. 6. Premature ejaculation patients' perceptions of "normal" duration of intercourse.

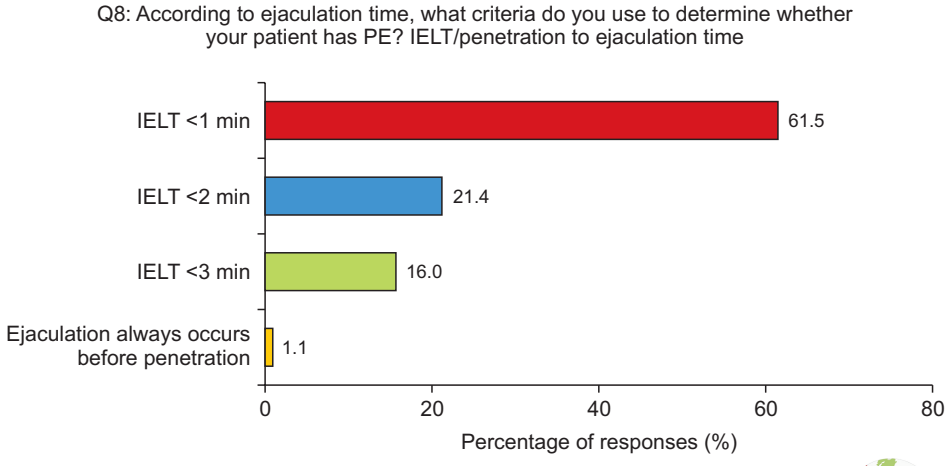


Fig. 5. Criteria utilized to diagnose PE. PE: premature ejaculation, IELT: intravaginal ejaculatory latency time.

that their patients consider 21 to 30 minutes as normal, while a minority (1.2%, 3/260 respondents) believed that 1 to 2 minutes is a normal duration, as shown in Fig. 6.

5. Categories of premature ejaculation cases

In addressing the various categories of PE, the survey revealed that lifelong PE (primary type) is the most common, with 47.7% of respondents (125/262) managing cases in this category. Acquired PE (secondary type) follows, reported by 31.7% of respondents (83/262). Variable PE, characterized by inconsistent patterns of ejaculation, was reported by 18.3% of respondents (48/262). The least common category is selective PE (occurring with one partner but not with another), reported by 2.3% of respondents (6/262), as shown in Fig. 7.

6. Prevalence of ante-portas premature ejaculation

Ante-portas PE, where ejaculation occurs before vaginal penetration, is observed in less than 25% of PE cases, as reported by 84.2% of respondents (219/260). A smaller group of respondents (13.1%, 34/260) indicated that ante-portas PE occurs in 26% to 50% of cases, while 2.3% of respondents (6/260) noted a prevalence of more than 51% to 75%. Only 0.4% of respondents (1/260) reported ante-portas PE occurring in 76% to 100% of their cases, as shown in Fig. 8.

7. Differential approach to lifelong *vs.* acquired premature ejaculation

The treatment strategies for lifelong *versus* acquired PE differ significantly among clinicians. A majority (52.9%, 138/261 respondents) employ distinct treatment protocols for each condition, tailoring interventions to the specific etiology and characteristics of PE. Additionally, 31.0% of respondents (81/261) adopt differential approaches in selected cases, based on individual patient factors. Conversely, 12.6% (33/261 respondents) treat both lifelong and acquired PE in the same manner, suggesting a unified therapeutic approach, while 3.5% (9/261 respondents) were uncertain about their treatment strategy.

8. Distinguishing premature ejaculation from erectile dysfunction

Distinguishing between PE and ED is a crucial aspect in clinical pratice, and the survey addressed specifically this topic with a distinct question. More than one-third of respondents (38.3%, 100/261) determine the

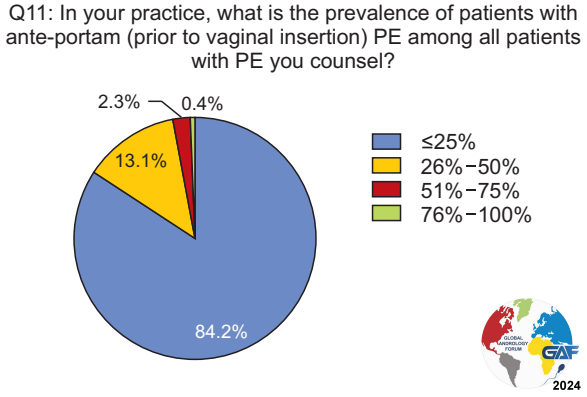


Fig. 8. Prevalence of ante-portas premature ejaculation (PE) among all counseled PE patients.

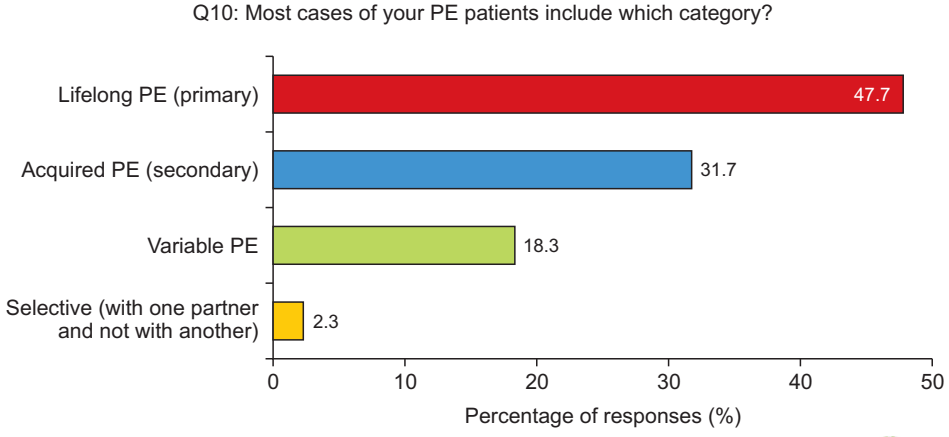


Fig. 7. The most common PE category encountered on practice by the respondents.

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diagnosis based on patient satisfaction with erection strength, if the patient reports satisfaction with erection, the condition is diagnosed as PE. Furthermore, 26.4% of respondents (69/261) diagnose PE if it is the predominant complaint over ED. Additionally, 18.8% of respondents (49/261) diagnose PE if the patient can penetrate, whereas 16.5% of respondents (43/261) diagnose ED if the patient reports dissatisfaction with erection strength.

Moreover, a significant proportion of respondents (60.7%, 159/262) reported frequent difficulties in acquiring a clear history to differentiate and distinguish between PE and ED. Conversely, 30.5% of respondents (80/262) rarely faced this issue, 4.6% of respondents (12/262) never encountered it, and 4.2% of respondents (11/262) always found it challenging to obtain a definitive history. The co-existence of PE and ED is a common clinical observation sometimes leading to therapeutic difficulties; thus, this co-existence was specifically explored. Indeed, a majority of clinicians (81.3%, 213/262 respondents) occasionally encountered patients presenting with both conditions simultaneously. This dual occurrence highlights the intertwined nature of these sexual dysfunctions. In contrast, 15.6% of respondents (41/262) rarely saw this co-occurrence, while a small fraction (3.1%, 8/262 respondents) always observed both conditions in their patients.

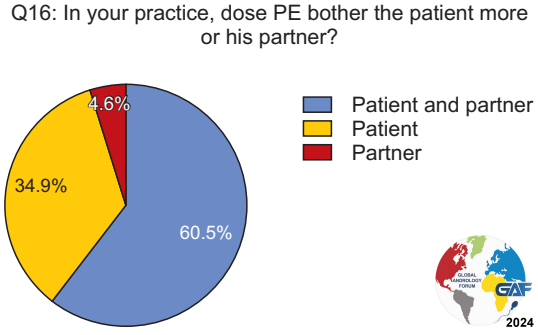

Fig. 9. The distressing situation in the premature ejaculation (PE)-partnership.

9. Distressing situation in premature ejaculation-partnership

The study revealed that the majority of practitioners (60.5%, 158/261 respondents) believe that PE distresses both the patient and his partner equally. Following this, 91/261 respondents (34.9%) believed that PE bothers the patient more, while a smaller group (4.6%, 12/261 respondents) reported that it bothers the partner more as shown in Fig. 9. This distribution suggests that the impact of PE is generally perceived to be shared between both partners, though the patient is often considered to bear a slightly greater burden. Responses are reported in Fig. 9.

10. Correlation between testosterone level and premature ejaculation

The majority of participants expressed uncertainty when queried about the correlation between testosterone levels and PE. A total of 106/260 respondents (40.8%) indicated that they did not know if there was a correlation. Meanwhile, 36.1% of respondents (94/260 respondents) stated that they occasionally think about a notable correlation. Additionally, 32/260 respondents

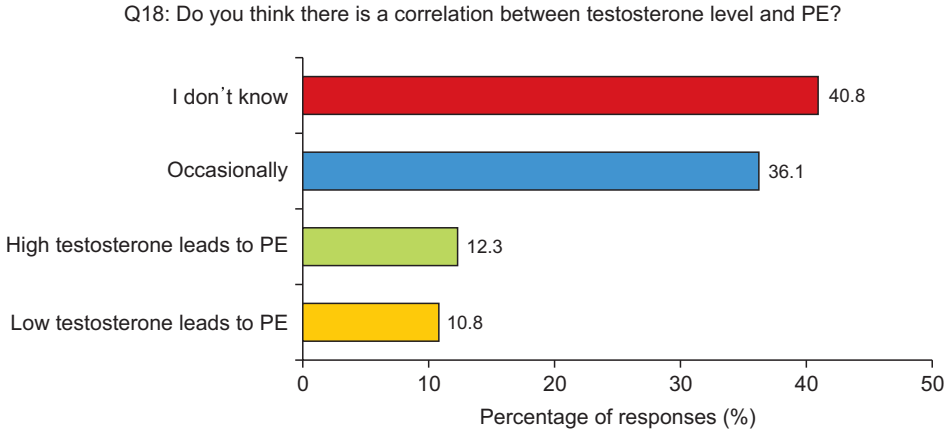

Fig. 10. Correlation between testosterone level and premature ejaculation (PE).

(12.3%) believed that high serum testosterone levels might lead to PE, while 28/260 respondents (10.8%) thought that low serum testosterone levels could be a contributing factor, as shown in Fig. 10.

11. Assessment of patient's family history of premature ejaculation

The clinicians' attitudes towards assessing family history in PE patients were as follows: one-third of respondents (34.0%, 89/262), reported that they never assess family history. Others occasionally (25.2%, 66/262 respondents) or rarely (24.0%, 63/262 respondents) assess it, while a minority (16.8%, 44/262 respondents) always conduct this assessment as shown in Fig. 11.

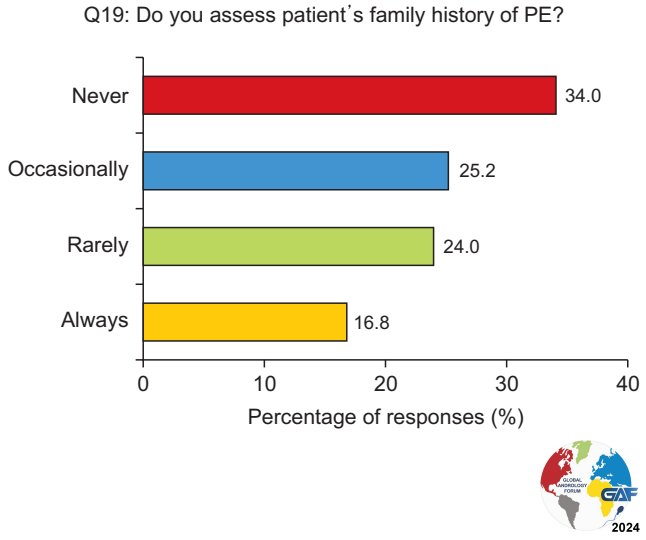

Fig. 11. Assessment of the patient's family history of premature ejaculation (PE).

12. Medical conditions commonly encountered in patients with premature ejaculation

The survey data provides valuable insights into the prevalence of various comorbidities among patients with PE. According to the majority of respondents, diabetes mellitus (DM) is the most frequently observed comorbidity, affecting 17.1% (130/760 responses) of their PE patients. This is followed by chronic prostatitis, reported by 15.5% (118/760 responses), and metabolic syndrome, noted by 13.9% (106/760 responses) of respondents. Additionally, 12.1% (92/760 responses) indicated that lower urinary tract disorders frequently co-exist with PE among their patients. The survey also revealed that less than 10% of respondents identified other comorbidities such as hyperthyroidism, hypogonadism, cardiovascular disease, hypertension, hyperprolactinemia, and Klinefelter syndrome as common among their PE patients. Furthermore, some respondents reported no co-existing disorders among their PE patients, suggesting that PE can occur in the absence of these common comorbidities, as shown in Fig. 12 (more than one selection was permitted).

13. Sexual position allows a longer time to ejaculate

The majority of the respondents (34.1%, 89/261 respondents) identified that the "man on top" position (the missionary position), provided the most time before ejaculation. The "woman on top" position was the second most preferred (29.5%, 77/261), allowing for better control of the pace of intercourse by the partner. The

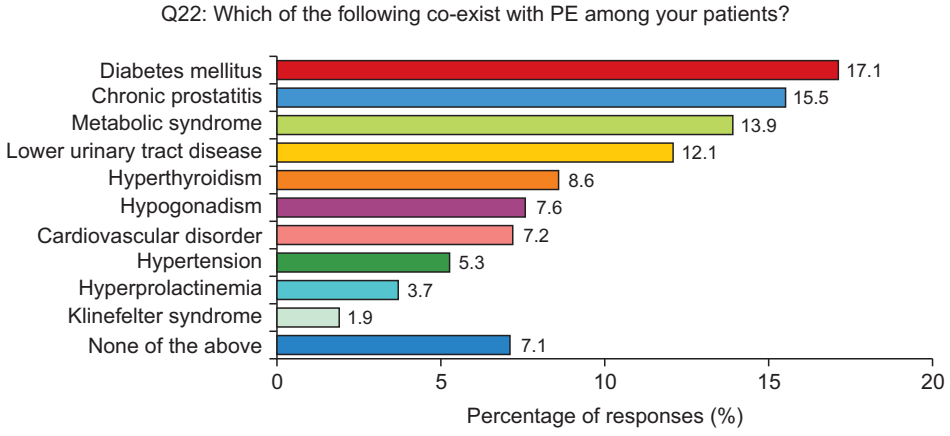

Fig. 12. Medical conditions commonly encountered in patients with premature ejaculation (PE).

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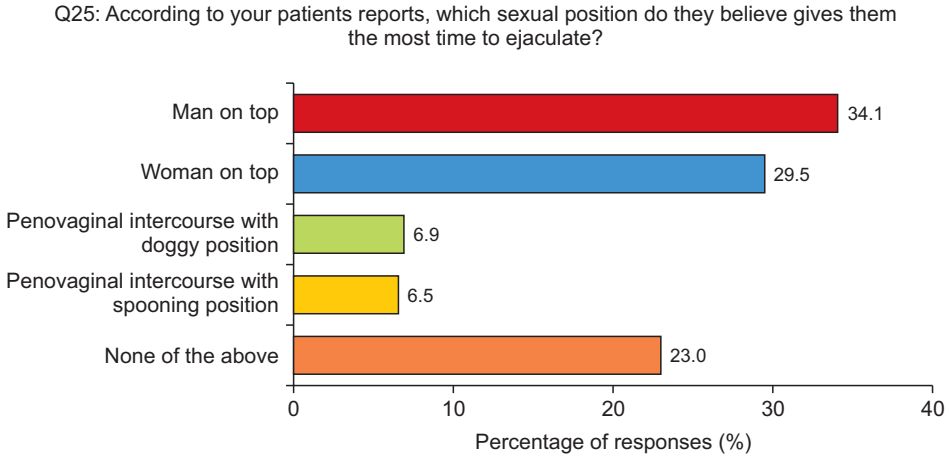

Fig. 13. Patient reports on sexual positions that allow longer time to ejaculate.

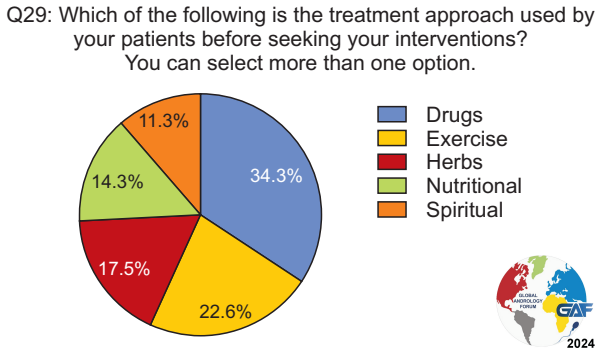

Fig. 14. Treatment approaches utilized by patients before seeking professional intervention.

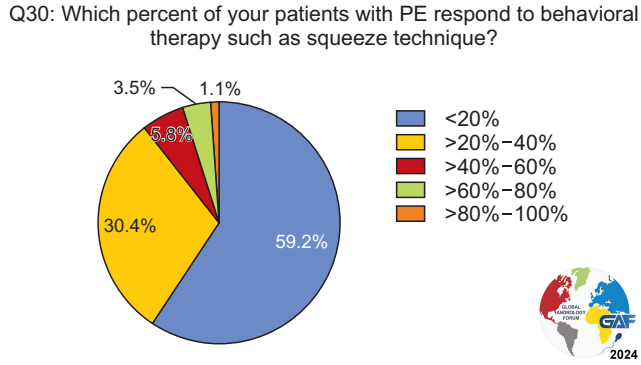

Fig. 15. Premature ejaculation (PE) patients' response to behavioral therapy.

"doggy style" position ranked third (6.9%, 18/261), followed by the "spooning" position (6.5%, 17/261). Notable, 23.0% (60/261) of the respondents indicated that their patients did not find any specific sexual position as significantly prolonging the time to ejaculation. These findings are shown in Fig. 13.

14. Premature ejaculation therapy

Surprisingly, one-third of respondents (34.3%; 173/504) reported that their patients had already tried some pharmacological treatment for PE before seeking their professional help. Additionally, some patients engaged in exercises aimed at enhancing their sexual performance (22.6%, 114/504 responses). Herbal remedies were used by 17.5% (88/504 responses) while the use of nutritional interventions, including dietary changes and supplements, was reported by 14.3% (72/504 responses). Spiritual practices, which included meditation or other mindfulness techniques, were also reported as pretreatment strategies by a small portion of 11.3% (57/504 responses). These findings are visually represented in Fig. 14 (more than one selection was permitted).

The majority (59.2%, 154/260 respondents) indicated that fewer than 20% of their patients reported a response to behavioral therapy, such as the squeeze technique. However, a significant number (30.4%, 79 of 260 respondents) stated that 20% to 40% of their patients reported benefitting from behavioral therapy. Only a minority of respondents were convinced and mentioned that behavioral therapy could benefit the majority of their PE patients in >40% to 60% of their cases (15/260 respondents, 5.8%), in >60% to 80% of their cases (9/260 respondents, 3.5%), and in >80% to 100% of their cases (3/260 respondents, 1.1%), as shown in Fig. 15.

15. Pharmaceutical drugs

When asked for the specific use of pharmaceutical drugs in the treatment of PE the most preferred option was dapoxetine (37.9%, 185/488 responses) followed by paroxetine (121/488 responses, 24.8%), sertraline (60/488 responses, 12.3%), fluoxetine (56/488 responses, 11.5%), clomipramine (25/488 responses, 5.1%), escitalopram (25/488 responses, 5.1%), and citalopram (16/488 responses, 3.3%), as shown in Fig. 16 (more than one selection was permitted).

Most of the participants also reported that a substantial number of their PE patients discontinue pharmacotherapy due to efficacy being below expectations (149/419 responses, 35.6%), adverse effects (103/419 responses, 24.6%), cost (89/419 responses, 21.2%), or loss of interest in sex (5.7%, 24/419 responses). Some respondents noted that a significant number of their PE patients discontinue pharmacotherapy due to all of these causes combined (54/419 responses, 12.9%), as shown in Fig. 17.

The abrupt cessation of SSRI medication is recognized as a critical issue, with more than half of the participants (53.8%, 136/253 respondents) reporting that withdrawal syndrome occurs within 1 to 3 days after stopping SSR agents. This is followed by one week (20.1%, 51/253 respondents), 24 hours (11.1%, 28/253 respondents), 5 days (9.1%, 23/253 respondents), and 12 hours (5.9%, 15/253 respondents), as shown in Fig. 18.

When asked about the ideal time frame for gradual withdrawal of SSRIs a considerable proportion (41.8%, 105 out of 251 responses) recommended a gradual withdrawal over 2 to 4 weeks, followed by one week (24.3%,

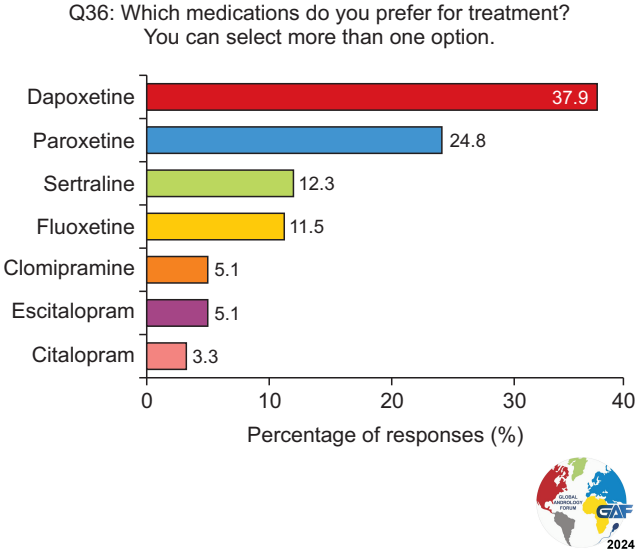

Fig. 16. Preferred medications for premature ejaculation.

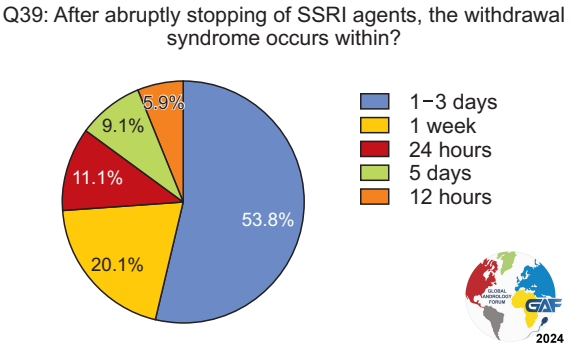

Fig. 18. Time for occurrence of withdrawal syndrome after abruptly stopping oral SSRIs. SSRI: selective serotonin reuptake inhibitor.

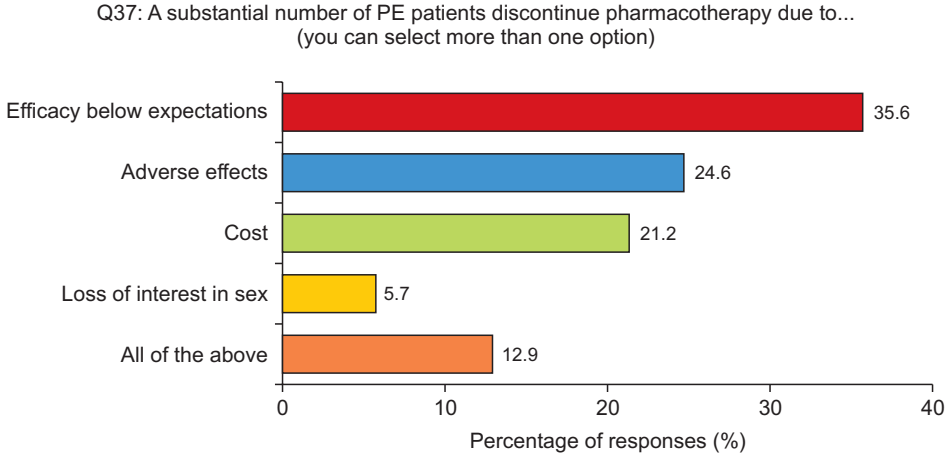

Fig. 17. Premature ejaculation (PE) patients' causes to discontinue pharmacotherapy.

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61/251 responses), 1 to 3 weeks (22.3%, 56/251 responses), 5 days (16/251 responses, 6.4%), and 24 hours (13/251 responses, 5.2%), as shown in Fig. 19.

16. Preferred non-SSRI medications for premature ejaculation

In reply to the survey question concerning therapy options beyond SSRI medications, the respondents expressed a preference for local topical anesthetics (44.0%, 192/436 responses). This was followed by oral PDE5 inhibitors, which were used by 36.2% of participants (158/436 respondents). Oral tramadol was reported by 10.6% (46/436 respondents), while 2.1% (9/436 responses) reported using none of the aforementioned options, relying solely on the use of SSRIs. Additionally, 4.3% (19/436 responses) reported not using any non-SSRI medications, and 2.8% (12/436 responses) mentioned the use of other therapeutic options including topical hyaluronic acid application in the area of the frenulum, unspecified herbal drugs, or alpha-adrenergic blockers, as shown in Fig. 20.

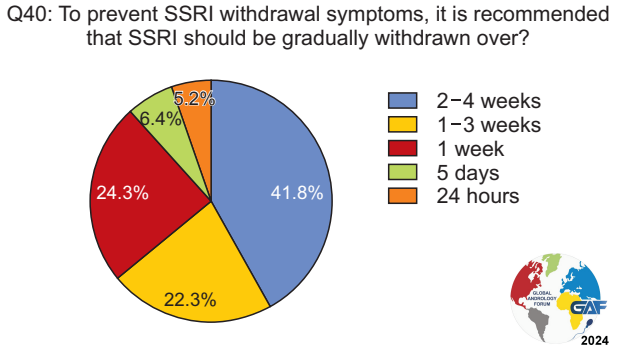

Fig. 19. Recommended time that SSRI should be gradually withdrawn. SSRI: selective serotonin reuptake inhibitor.

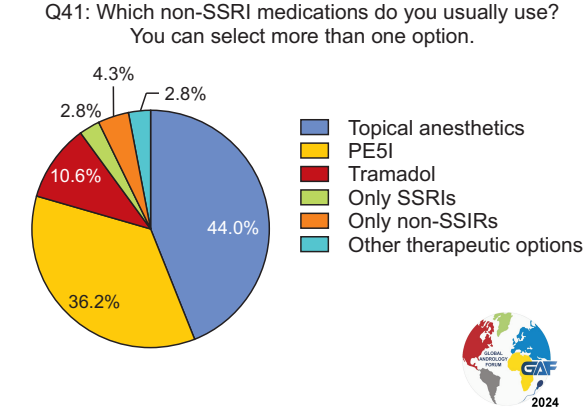

Fig. 20. Commonly preferred non-SSRI medications for treating premature ejaculation. SSRI: selective serotonin reuptake inhibitor.

17. Surgical methods for treating premature ejaculation

The majority of participants (61.3%, 160/261 respondents) indicated that they do not employ surgical methods to treat PE. Additionally, 29.5% (77/261 respondents) noted the use of surgical methods in 1% to 20% of their patients. A smaller proportion reported employing surgical methods in 21% to 40% of cases (5.0%, 13/261 respondents), while 4.2% (11/261 respondents) reported using surgical methods in more than 41% to 60% of cases as shown in Fig. 21.

A considerable proportion of participants (49.6%, 129/260) supported a role for surgery in the management of PE, while an almost equal number (46.5%, 121/260 respondents) were uncertain and responded with "I do not know." A small percentage of participants, 3.8% (10/260 respondents), expressed strong support by answering "definitely Yes."

A considerable proportion of participants reported using frenuloplasty as a treatment for PE, accounting for 21.3% (78/366) of respondents. This was followed by circumcision, used by 16.4% (60/366 respondents), and selective penile dorsal nerve neurotomy, reported by 13.4% (49/366 responses). Additionally, glandular augmentation with hyaluronic acid gel was used by 11.8% (43/366 responses), penile prosthesis placement by 5.2% (19/366 responses), and the inner condom technique and cryoablation/radiofrequency were each used by 4.9% (18/366 responses). Notably, 22.1% (81/366 responses) of participants expressed skepticism regarding the role of surgery in treating PE, as shown in Fig. 22.

The effectiveness of frenulotomy was specifically

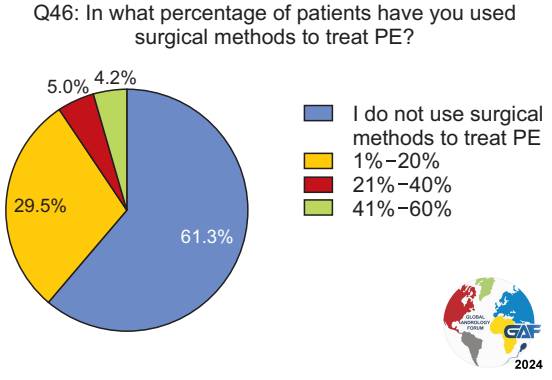

Fig. 21. Percentage of patients who used surgical methods to treat premature ejaculation (PE).

assessed for the specific medical condition of a short frenulum in relation to PE. Herein, more than two-thirds of the participants (71.9%, 174/242 respondents) indicated that frenulotomy is helpful for only 1%–20% of their patients. This was followed by 17.3% (42/242 respondents) who found it helpful in 20%–40% of cases, 7.9% (19/242 respondents) who reported its usefulness in 40%–60% of cases, and 2.9% (7/242 respondents), who found it beneficial in 60%–80% of their patients.

The survey revealed a range of other emerging therapeutic options favored by medical practitioners. A notable 12.0% of participants (31/259 respondents) identified hyaluronic acid gel glans augmentation as the most useful method, indicating significant interest in this innovative approach for managing PE. Following this, 7.3% of respondents (19/259) supported neuromodulation, reflecting its growing acceptance in clinical practice as a viable treatment option. Circumcision was favored by only 6.9% of the respondents (18/259), suggesting limited relevance as a treatment method for PE. Additionally, both dorsal penile nerve cryoablation and botulinum toxin injection were supported by 4.6% and 4.2% of respondents, respectively (12 and 11/259, respectively), demonstrating limited interest in these novel techniques. However, a substantial majority of 64.9% (168/259 respondents) reported that they did not utilize any of the aforementioned new treatment options in their practice as shown in Fig. 23.

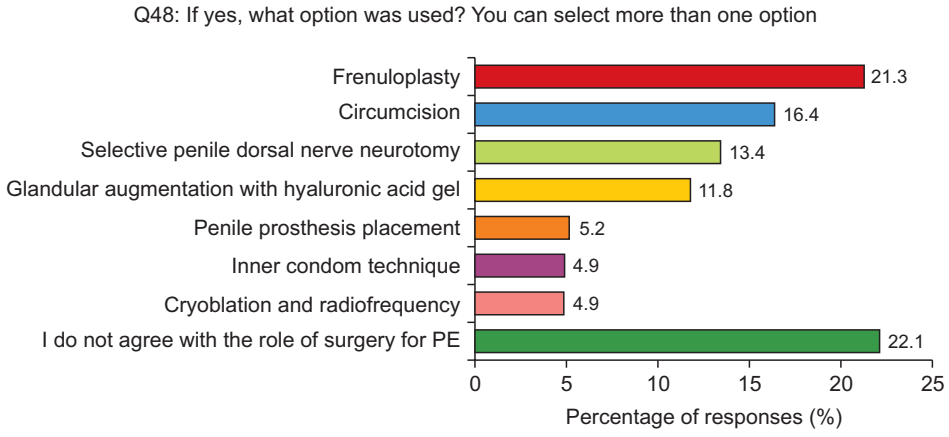

Fig. 22. Percentage of doctors who used different surgical methods to treat premature ejaculation (PE).

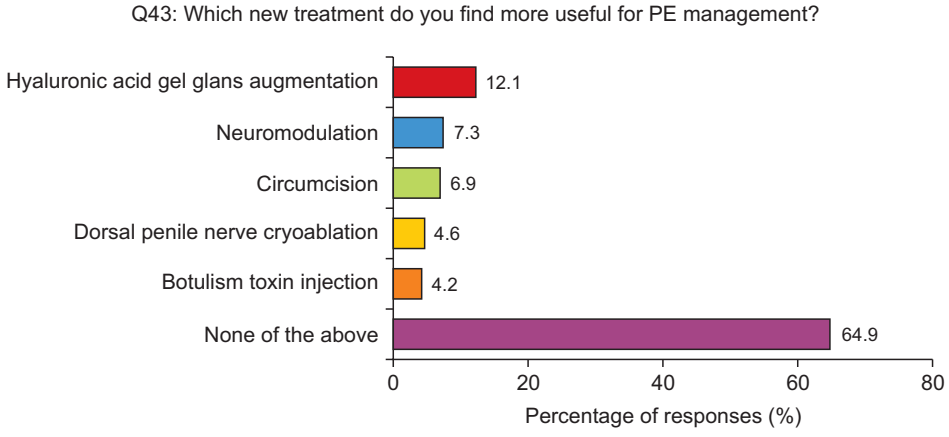

Fig. 23. Treatments potentially beneficial for managing premature ejaculation (PE).

18. Criteria for successful premature ejaculation treatment

More than half of the participants (146/261 respondents, 55.9%) indicated that they defined success based on patient satisfaction. This was followed by the use of the IELT, reported by 54/261 respondents (20.7%). Patient-reported clinical outcome measures, such as the PE diagnostic tool and index of PE, were utilized by 50/261 respondents (19.2%), 9/261 respondents (3.4%), relied on their clinical judgment, whereas 2/262 respondents (0.8%) chose the option of others as shown in Fig. 24.

Besides, the survey posed the question, "Is the cost a major concern in your practice when dealing with patients with PE?", and more than one-third of participants (35.5%, 92/259 respondents) indicated that cost is a significant concern. This was followed by 34.0% (88/259 respondents), who stated that cost is rarely a concern, 18.5% (48/259 respondents), who reported that cost is never a concern, and 12.0% (31/259 respondents) who indicated that cost is always a major concern.

SOCIETY GUIDELINES

1. Overview of four guidelines for management of premature ejaculation

PE is characterized by ejaculation that occurs without control, on or shortly after vaginal penetration, and before the individual desires it, often leading to distress or interpersonal difficulties [26]. It is the most common male sexual complaint, with prevalence rates estimated to be between 20%–40% [27,28]. Currently, several published guidelines have been created by different professional societies for the management of PE. Some of the most widely recognized guidelines include the American Urological Association (AUA), Sexual Medicine Society of North America (SMSNA), European Association of Urology (EAU), ISSM, and Italian Society of Andrology and Sexual Medicine (SIAMS).

Each organization has contributed valuable insights and recommendations for the effective management of PE, including the development of new therapeutic approaches according to the geographical and patient needs and culture.

In this context, we analyzed the similarities and differences between the current guidelines. 1. The AUA/SMSNA stated that for individuals who have experienced a short IELT throughout their sexual life, the average estimated IELT during partnered sex should be 2 minutes or less, as measured from the moment of penetration to ejaculation. This differs from the definitions provided by the ISSM and DSM-V, which employ a threshold of 60 seconds [20].

About subtypes of PE, the AUA/SMSNA guidelines subdivide PE into two main types: (1) lifelong PE and (2) acquired PE, which are two separate conditions that have distinct risk factors and associations with other sexual dysfunctions [20].

1. Epidemiological studies have shown that the prevalence of lifelong PE is much lower than that generally cited in the guidelines and that the prevalence of acquired PE may be increasing. This shifting epidemiological pattern may be due to limitations of the studies or may be a true charac-

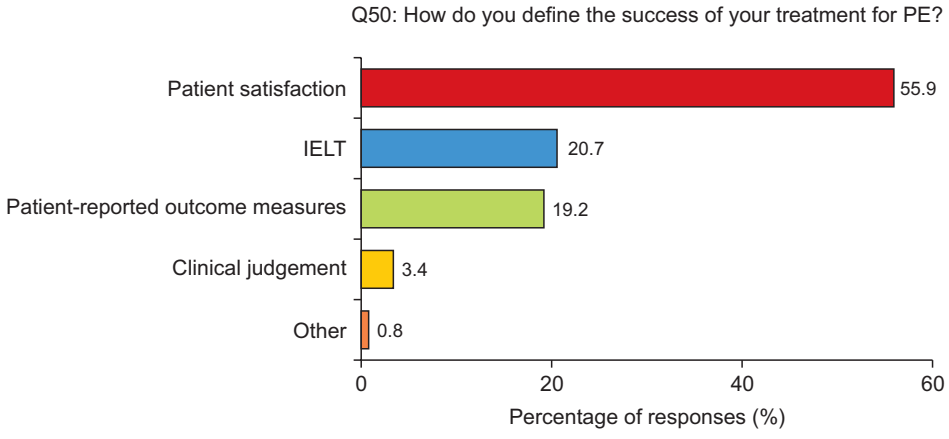

Fig. 24. Criteria for successful PE treatment. PE: premature ejaculation, IELT: intravaginal ejaculatory latency time.

teristic of the condition. A recent trend has been observed for patient-reported outcomes and preference studies to guide treatment decisions [20,29-32].

2. The EAU distinguishes four subtypes of PE: (1) lifelong, (2) acquired, (3) variable, and (4) subjective PE. Life-long and acquired PE are the primary categories, whereas variable PE is characterized by inconsistent and irregular early ejaculations and is considered a normal variation in sexual performance. Subjective PE is characterized by a subjective perception of consistent or inconsistent rapid ejaculation during intercourse, with IELT within the normal range or even lasting longer. It is crucial to emphasize that subjective PE should not be confused with the symptoms or manifestations of genuine medical pathology [16].
3. The SIAMS has another classification for PE. Patients with PE were classified according to the following characteristics: clinical/subclinical, lifelong/acquired, absolute/relational; and (iv) severity [28].
4. The International Classification of Diseases for mortality and morbidity statistics (ICD-11 MMS) [9] in 2019 identifies PE as early ejaculation in men characterized by ejaculation that occurs before or within a very short duration of the initiation of vaginal penetration or other relevant sexual stimulation, with no or little perceived control over ejaculation. The pattern of early ejaculation has occurred episodically or persistently over a period of at least several months and is associated with clinically significant distress. The ICD-11 recognizes five categories: (1) lifelong, generalized; (2) lifelong, situational; (3) acquired, generalized; (4) acquired, situational; and (5) unspecified (as a residual category) [9,29].

Collectively, the AUA/SMSNA guidelines were uncertain about the importance of using validated instruments to assist in diagnosing PE, and the recommendation was conditional with evidence level C. On the other hand, the EAU guidelines were more certain and emphasized the use of questionnaires such as the PEDT and Arabic Index of Premature Ejaculation with a level of evidence [LOE] 2b. The ISSM also supports the use of two validated questionnaire instruments, the PEP and the IPE, which may serve as useful adjuncts but are not substitutes for a full sexual history obtained by a clinician (LOE 2b). In addition, the SIAMS strongly recommends the use of standardized, validated psychometric tools for the assessment of PE and the bother related to PE, for both the patient and the partner [16,20].

The guidelines of these professional bodies agree that the self-estimation of IELT by the patient and his partner is sufficient to diagnose PE. The EAU guidelines add perceived control, distress, and interpersonal difficulty due to ejaculatory dysfunction with strong recommendations. Moreover, EAU supports the use of a stopwatch to measure IELT, giving a sensitivity and specificity of 80% in diagnosing PE [16].

Comprehensive clinical examination of patients with acquired PE is an indispensable component of all the guidelines. Such an examination is mandatory in the EAU guidelines and highly recommended in the ISSM guidelines. It is crucial to investigate patients with acquired PE to uncover any underlying pathologies, including ED, prostatitis, hormonal disruptions (HPG-axis and thyroid function), and DM.

On the other hand, the SIAMS weakly recommends excluding chronic prostatitis in all subjects with PE and suggests a trial with specific antibiotics in patients with PE associated with bacterial prostatitis before any symptomatic treatment of PE. However, it is strongly recommended to investigate and treat sexual comorbidities, such as ED, in patients with both ED and PE before treating PE [29].

2. Treatment rationale for premature ejaculation

For acquired PE, the underlying pathology should be identified and treated accordingly. This is agreed upon by all the guidelines.

Psychotherapy is often recommended for individuals experiencing psychological and interpersonal factors associated with PE, such as depression, anxiety, low self-esteem, decreased emotional intimacy, and conflicts within relationships. An association of cognitive and behavioral therapy (*e.g.,* stop-start and squeeze techniques) adds more improvement due to the focus on improving ejaculatory control through self-regulation.

Pharmacotherapy is the mainstay in treating PE, as agreed upon by all guidelines, but there are differences in treatment protocols.

3. AUA/SMSNA 2022 [20]

The AUA/SMSNA strongly recommends the use of daily SSRIs, on-demand clomipramine or dapoxetine,

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and topical anesthetic creams as first-line treatment options for PE. (strong recommendation, LOE: Grade B).

On-demand tramadol is considered a second-line therapy (conditional recommendation; LOE: Grade C). Men who have failed first-line therapy may be treated with alpha1-adrenoreceptor antagonists (expert opinions).

A combination of behavioral and pharmacological approaches may be more effective than either modality alone (moderate recommendation; LOE: Grade B).

Using of surgical and injection of bulking agents are considered experimental (expert opinion).

4. EAU 2024 [16]

The EAU strongly recommends treating ED, other sexual dysfunctions, or genitourinary infection (*e.g.*, prostatitis) first (strong recommendation).

The EAU recommends either dapoxetine or lidocaine/prilocaine spray as first-line treatments for lifelong PE (strong recommendation), while using off-label oral treatment with daily SSRIs or daily/on-demand clomipramine as a second-line treatment (strong recommendation). The use of off-label tramadol with caution is strongly recommended as an on-demand, third-line treatment alternative to on-demand/daily antidepressants (SSRIs or clomipramine) (strong recommendation).

The EAU also recommends the use of PDE5 inhibitors alone or in combination with other therapies for patients with PE (without ED) (strong recommendation). Unlike AUA/SMSNA, EAU weakly recommends the use of psychological/behavioral therapies in combination with pharmacological treatment to manage acquired PE (weak recommendation).

The EAU recommends caution when considering injection of bulking agents as a treatment option (weak recommendation).

The EAU recommends against dorsal neurectomy because more safety data are warranted (weak recommendation).

5. ISSM 2015 [33]

ISSM adopts pharmacotherapy as the first-line treatment for life-long and behavioral/psychotherapy as the first-line treatment for acquired PE. Pharmacotherapy includes SSRIs, such as dapoxetine and other off-label SSRIs (LOE 1b).

Also, recommended are local anesthetic creams of

Table 1. International Societies recommendations for the management of PE

	ISSM		AUA/SMSNA		EAU		SIAMS		ICD-11		DSM-V	
Term	PE		PE		PE		PE		Male early ejaculation		Early ejaculation	
Classification	Lifelong	Acquired	Lifelong	Acquired	Lifelong generalized & situational	- Acquired generalized & situational	For scientific and experimental purposes: ISSM Definition[a]	Clinical purposes: clinical/subclinical lifelong/acquired absolute/relational severity level	Lifelong generalized & situational	Acquired generalised & situational	Lifelong generalised & situational	Acquired generalised & situational
						- Unspecified				Unspecified		
						- Variable						
						- Subjective						
IELTS	1 min for lifelong 3 min for acquired		2 min for lifelong Not specified for acquired		1 min for lifelong 3 min for acquired		3 min[a]		Not specified		1 min or less	
Control over ejaculation	Inability to delay ejaculation		Poor ejaculatory control		Inability to delay ejaculation		Persistent and recurrent subjective loss of control		No or little perceived control over ejaculation		Ejaculation before the individual wishes it	
Frequency	Always or nearly always		-		All or nearly all				Persistent or episodically		75%–100%	
Trigger	Vaginal penetration		-		Vaginal penetration		Vaginal, masturbation, or oral and anal intercourses, as well to non-heterosexual settings		Vaginal penetration or other relevant sexual stimulation		Vaginal penetration	

Table 1. Continued

	ISSM	AUA/SMSNA	EAU	SIAMS	ICD-11	DSM-V
Distress (patient/partner)	Associated	Associated	Associated	Associated	Associated	Associated
Extra-criteria	-	-	-	-	-	Not caused by mental disorders, medical conditions or medications
Diagnosis	Screening not recommended Validated questionnaire (PEP and IPE) Patient-reported outcomes may be used For lifelong PE, physical exam is advisable For acquired PE, physical exam and assess associated conditions	Medical, sexual and relationship history[c] Physical exam[c] Validated questionnaire Lab tests not recommended for PE[f] Lab tests may be utilized in acquired PE[f] Refer to mental-health professional[e]	Medical & sexual history for classification[a] Physical exam[a] Patient reported outcome may be used[b] Stop-watch for ILET not recommended[b] Lab tests not recommended[a]	Patient reported outcome[b] ILETS, masturbation (MELT), or oral (OELT) and anal (AELT) intercourses latency times[b] Validated questionnaires[a] Medical and psychosexual history[a] Exclude prostatitis/CPPS in all PE cases[b] Thyroid stimulating hormone in suspected thyroid hyperfunction[b] Investigate for other sexual dysfunctions[a]	-	-
Treatment	On demand dapoxetine[a] Daily SSRIs[a] Topical anesthetics for lifelong PE[b] PDE5i not recommended[a] Tramadol (2nd option)[b] Psychotherapy/Behavioral therapy[e] Treat associated ED[b] Surgical intervention is not recommended[a]	SSRIs (clomipramine or Dapoxetine) and topical anesthetic (1st option)[a] On demand tramadol (2nd option)[b] α1-adrenoreceptor antagonists (3rd option)[d] Treat ED[d] Psychological/behavioral combined with medication[e] Alternative therapy not recommended[d] Surgical therapy is experimental[d]	Dapoxetine or topical anesthetic alone or combined (1st option)[a] Topical anesthetic (alternative)[a] PDE5i alone or combination with no ED[a] Tramadol (alternative)[b] Psychological/Behavioral combined with medication[b] Treat ED, GTI[a]	Treat associated hyperthyroidism[b] Antibiotic for associated prostatitis first[b] Treat ED first[a] Pharmacotherapies and cognitive-behavioral therapy[b] Dapoxetine 30 mg (1st option)[a] Topical anesthetic for lifelong PE[b] PDE5i+Dapoxetine[b] PDE5i alone in ED+PE[b] Refractory cases: Topical anesthetic +Dapoxetine[b] Clomipramine/SSRIs[b] Don't recommend: Using antidepressants without screening for depression[b] α1-adrenergic receptor blockers[b] Tramadol[b] Routinely performing circumcision and frenulotomy in patients with PE[b]	-	-

ISSM: International Society of Sexual Medicine, AUA: American Urological Association, SMSNA: Sexual Medicine Society of North America, EAU: European Association of Urology, SIAMS: Italian Society of Andrology and Sexual Medicine, ICD-11: International Classification of Diseases 11th Revision, DSM-V: American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders Fifth edition, PE: premature ejaculation, ED: erectile dysfunction, CPPS: chronic pelvic pain syndrome, PEP: Premature Ejaculation Profile, IPE: Index of Premature Ejaculation, IELT: intravaginal ejaculatory latency time, MELT: masturbation ejaculatory latency time, OELT: oral ejaculatory latency time, ALET: anal ejaculatory latency time, SSRI: selective serotonin reuptake inhibitor, -: not available.

[a]Strong recommendation; [b]Weak recommendation; [c]Clinical principal; [d]Expert opinion; [e]Moderate recommendation; [f]Conditional recommendation.

Lidocaine with Prilocaine (LOE 1a) or Lidocaine alone (LOE 1b).

6. SIAMS 2020 [29]

SIAMS provided guidelines for PE management in 2020, including recommendations on approved European medications for treating PE. These medications include dapoxetine as a first-line oral therapy for both lifelong and acquired PE, with a suggested starting dose of 30 mg taken 1–3 hours before intercourse.

Eutectic lidocaine/prilocaine spray is recommended for local therapy in lifelong PE patients.

SIAMS also offers recommendations for off-label therapy, including obtaining informed consent before initiating treatment, using dapoxetine and PDE5 inhibitors to improve ejaculatory control in patients with comorbid ED and PE, and considering the combination of dapoxetine and lidocaine/prilocaine in patients with refractory PE. Besides, SIAMS recommends against prescribing antidepressants without thorough screening for depression and against using alpha-1 adrenergic receptor blockers, tramadol, and SSRIs for PE without psychiatric consultation and psychometry (Table 1).

All guidelines recommend a combination of psychotherapy, specifically sex therapy, with medication (either on-demand or daily), thus supporting a combined model of psychosocial and medical management of PE. The merit of such an approach is that it is based on a sound scientific rationale that the combination targets both psychological and biological aspects of PE. It is also notable that the recommendations for counseling from all guidelines are based on good levels of evidence. The guidelines have also emphasized communication, patient education, and the important role of the partner in the consultation. Such an approach would lead to a more patient-centric treatment strategy with high patient satisfaction, leading to increased adherence.

Table 2. Management of PE: Global Andrology Forum recommendations

	Recommendation	Grade
Diagnosis	1. In research and clinical trial settings, PE can be diagnosed as per the definition of the ISSM, which considers an IELT of <1 minute (life-long PE) or <3 minutes (acquired PE), in combination with a lack of ejaculation control and sexual distress.	Strong
	2. In clinical practice settings, the diagnosis of PE requiring therapy need not be restricted to a cut-off of <1 minute, since many couples with an IELT of >1 minute are dissatisfied and desire more prolonged intercourse.	Weak
Type	3. Lifelong (primary) PE is more likely to have a neurobiological basis, and therefore long-term pharmacological management, with daily or on-demand dosing, is usually required.	Strong
	4. Acquired or secondary PE is defined by its onset following a period of normal intravaginal latency time. It is often associated with various acquired factors and hence may be cured once the underlying cause is treated.	Strong
Treatment	5. Treatment strategies for lifelong *versus* acquired PE should employ different protocols for each condition, tailoring interventions to the specific etiology and characteristics of the patient.	Strong
	6. All individuals experiencing PE should undergo a thorough evaluation, including comprehensive medical, sexual, and relationship history, along with a focused examination.	Strong
	7. ED and PE often coexist. In such cases, the ED is best treated first, as this may resolve both ED and PE. Alternatively, a combination of drugs to treat ED and PE may be required.	Strong
	8. Couples may be advised to try different sexual positions to see if some positions result in better ejaculatory control.	Weak
	9. On-demand dapoxetine can be used as the first line of pharmacotherapy because it has fewer side effects, though it has lower efficacy than long-acting SSRIs.	Weak
	10. Topical anesthetics are another treatment option. It is important to identify the suitable candidate for their use and instructions are needed to prevent to avoid complete anesthesia of the glans, and to avoid affecting the partner.	Strong
	11. In refractory PE cases, a combination of pharmacotherapeutic drugs, together with psycho-sexual therapy if appropriate, should be considered.	Strong
	12. On-demand tramadol may be used for treating PE in men who have not responded to other pharmacotherapeutic drugs. However, its availability is restricted in some countries due to the potential risk of addiction.	Weak
	13. The ideal time frame for gradual withdrawal of daily use oral SSRIs is 2 to 4 weeks, depending on the drug and the individual patient response.	Weak
	14. The role of surgical interventions in treating PE cases is still uncertain and is not supported by guidelines. If utilized, there should be extensive patient counselling about the uncertain positive results and possible side effects.	Strong
	15. The criteria for successful PE treatment are based on the subjective report of patient and partner satisfaction, associated with an increase in duration of intercourse.	Strong

PE: premature ejaculation, ISSM: International Society of Sexual Medicine, IELT: intravaginal ejaculatory latency time, ED: erectile dysfunction, SSRI: selective serotonin reuptake inhibitor.

GAF RECOMMENDATIONS FOR PE: A DELPHI-BASED FRAMEWORK

Expert recommendations for the diagnosis and treatment of PE were formulated through collaboration among senior members of the GAF. A total of 15 statements encompassing the critical aspects of PE diagnosis and treatment were developed and subsequently subjected to a consensus process using the Delphi method.

The 15 statements were circulated among 57 GAF experts with significant expertise in male sexual dysfunction (MSD) management. Of these, 32 experts (56.0%) had more than 10 years of clinical experience, while the remaining 25 experts (44.0%) had less than 10 years of experience. The group comprised 33 urologists (57.9%), 23 andrologists (40.3%), and one endocrinologist (1.7%) representing diverse geographical regions.

The Delphi process achieved robust consensus in the first round, as over 80% of the experts rated all 15 statements with a score greater than 7, meeting the predefined threshold for approval. This rapid consensus highlights the shared understanding and agreement among global experts regarding the essential principles of PE management.

Additionally, the statements underwent a grading process. A total of 29 GAF experts assessed the final recommendations using the GRADE Working Group methodology, categorizing them as either "Strong" or "Weak." These experts, comprising andrologists and urologists with substantial clinical experience in MSD, represented a broad geographic distribution. Among them, 20 (69.0%) had over 10 years of experience in MSD management, while 9 (31.0%) had less than 10 years of experience. Notably, 10 out of 15 recommendations were graded as "Strong," and the remaining 5 as "Weak," by over 80% of the experts. Detailed responses from the Delphi survey and the grading of recommendations are provided in Table 2 and Supplement File 5.

DISCUSSION

PE presents a complex therapeutic challenge for several reasons, including physiological, psychological, and interpersonal factors due to different diagnostic criteria, its inherent complexity due to varying causes and comorbidities, geographical differences in medical resources and treatment availabilities, and regional genetic variations. Although the global prevalence of PE is described between 3.4% and 31%, it is frequently underreported, can significantly impair sexual and psychological health, and can lead to considerable embarrassment and dissatisfaction among the affected individuals. Previous global observational studies have been published on the prevalence of patients with PE [34-37]. However, this study represents the first global survey on the diagnosis and management of PE as reported by professionals specializing in MSD.

There are multiple definitions of PE, often lacking robust scientific evidence and specific diagnostic criteria, highlighting the need for standardized, research-based definitions. Current definitions are limited to heterosexual relationships involving vaginal intercourse, excluding other sexual practices. The DSM-V defines PE as ejaculation within approximately 1 minute of vaginal penetration, with symptoms persisting for at least 6 months on most (75%–100%) sexual occasions, and categorizes severity into mild (30 sec to 1 min), moderate (15–30 sec), and severe (prior to or within 15 sec of penetration). The ISSM distinguishes between lifelong PE (ejaculation within 1 minute) and acquired PE (reduced latency to 3 minutes or less), both leading to significant distress and inability to delay ejaculation. The AUA/SMSNA guidelines set a different criterion, defining PE as ejaculation within approximately 2 minutes. The EAU, following the ICD-11, uses the term "early ejaculation" without a definitive time cut-off.

The results of our global survey indicated that the ISSM definition is utilized by more than half of the respondents (54.2%, 142/262). This is followed by the ICD-11 MMS definition, selected by 9.2% (24/262 respondents), and the DSM-V definition, was chosen by 6.5% (17/262 respondents). Interestingly, and possibly based on the unclear recommendation in all the guidelines, 16.0% of respondents opt to use all of them. The GAF recommendation also suggests that many couples with an ejaculatory time of >1 minute may also be dissatisfied and could be offered treatment to delay ejaculation, though the upper limit is yet to be defined.

The majority of participants did not assess family history in patients with PE suggesting a general neglect in considering family history as a relevant factor in PE, with only a small proportion of practitioners routinely incorporating it into their assessments.

It has been shown that PE is approximately one-

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third more often associated with a higher risk for ED, with an odds ratio of 3.68, but is higher for older men [38-40]. Similarly, in the current survey, the majority of participants reported that PE was associated with DM and metabolic syndrome suggesting an underlying potential pathophysiology. However, in another study on men with PE, comorbidities were significantly associated with PE when associated with ED, but this significance was not established when ED was excluded from the analysis, denoting that this association is not related to PE per se [41]. This is why it is essential to acknowledge that PE may be a secondary condition to ED, as substantial evidence has demonstrated a bidirectional psychosexual association between these different types of sexual dysfunction.

Hence, a multi-modal approach might be appropriate [4]; the GAF recommendations suggest treating ED first when ED and PE co-exist. When all participants in this survey were asked how they would distinguish the condition of PE from ED, the majority of participants indicated that they would differentiate based on patient satisfaction with erection strength, identifying PE (100/261 respondents, 38.3%) and not ED. Further distinctions were noted, with PE being the primary complaint over ED (69/261 respondents, 26.4%), the ability to penetrate signifying PE (49/261 respondents, 18.8%), and complaints regarding erection strength being indicative of the ED (43/261 respondents, 16.5%). Surprisingly, in the current study, more than half (60.7%) found distinguishing PE from ED to be challenging. This confusion regarding differentiating PE from ED was also acknowledged by previous studies [42]. This can be attributed to the fact that men tend to be less ashamed of PE than confessing having ED or maybe also due to the high co-existence of both conditions in up to one third of cases [43]. Assessing and relying solely on the erection hardness score can make it challenging to diagnose PE and distinguish it from ED. More than 60% of the participants recommended the use of a PDE5 inhibitor in addition to treatment with different SSRIs, which not only underlies the simultaneous presence of two different patterns within the spectrum of MSD but also reflects the clinical experience that both disorders can be successfully treated with pharmacological therapy using PDE5 inhibitors.

An interesting point is that the professional participants pointed out that the couples may find that some sexual positions could offer better ejaculatory control. The majority of the respondents (34.1%) identified that the "man on top" position (the missionary position), provided the most time before ejaculation. The "woman on top" position was the second most preferred (29.5%), allowing for better control of the pace of intercourse by the partner. The "doggy style" position ranked third (6.9%), followed by the "spooning" position (6.5%) whereas 23.0% of the respondents indicated that their patients did not find any specific sexual position as significantly prolonging the time to ejaculation. Along with their study, Raveendran et al. [28] proposed alternate sex position as one of the behavioral techniques.

Over the past few decades, the therapeutic armamentarium for PE has expanded from behavioral psychotherapy to pharmacological treatments and surgical interventions. A global online sexuality survey indicated that oral treatments for PE are more frequently used and effective compared to local anesthetics, especially among those with lifelong PE [36]. Our study found that participants used medications (34.3%), exercise (22.6%), herbal remedies (17.5%), nutritional approaches (14.3%), and spiritual practices (11.3%) to treat PE. Behavioral therapy consists of using the squeeze technique and 59.2% of respondents reported an improvement in 20% of PE cases with this technique.

Preferred medications for treating PE in the current survey were dapoxetine (37.9%), paroxetine (24.8%), sertraline (12.3%), fluoxetine (11.5%), clomipramine (5.1%), escitalopram (5.1%), and citalopram (3.3%). The participants reported that pharmacotherapy is often discontinued due to lower-than-expected efficacy (35.6%), adverse effects (24.6%), cost (21.2%), loss of interest in sex (5.7%), and a combination of reasons (12.9%). Withdrawal syndrome after stopping SSRIs needs to be monitored since 53.8% of responding physicians report this effect within 1 to 3 days. Withdrawal symptoms can be minimized by withdrawing the drug gradually (GAF recommendation 13). Among the non-SSRI medications, 44.0% of participants prescribed local topical anesthetics, followed by oral PDE5 inhibitors by 36.2%, tramadol by 10.6%, and other non-SSRI medications by 2.1%.

The role of surgery for PE remains controversial since its longer-term outcomes are unknown, and the risk of ED, glans hypo or hyperesthesia are serious consequences [16]. In the present study, the majority of participants (61.3%) stated that they do not use surgical methods to treat PE. If surgical therapies are employed,

they include frenuloplasty (21.3%), circumcision (16.4%), selective penile dorsal nerve neurotomy (13.4%), glandular augmentation with hyaluronic acid gel (11.7%), penile prosthesis implantation (5.2%), inner condom technique (4.9%), and cryoablation and radiofrequency (4.9). In our study, the success of PE treatment was defined by various criteria: patient satisfaction (55.9%), IELT measurement (20.7%), patient-reported outcome measures (19.2%), and clinical judgment or others (4.2%).

An interesting finding in the current global survey was that most respondents were in the younger age group (25–44 years). This was also reported by a meta-analysis on response rate to online surveys in published research who found a negative correlation between age of the participants and response rate with the lowest response rate being in participants 40 years and above [44]. This can be attributed to the fact that younger researchers are more acquainted to internet technology and are using and responding more to online material.

However, as the first global survey of its kind, our survey possesses some limitations. While it is intended as a worldwide survey, one-fourth of our respondents are from Turkey, and only a few or no responses were received from large countries such as the United States, China, and Russia.

The survey also revealed a lack of respondents from the sub-Saharan region, indicating no representation from Africa. This might be a significant limitation in this survey, since, for example, in Somalia, a 37.1% higher prevalence was reported compared to other regions in the world [45]. This study additionally stratified the prevalence of PE in relation to the mono- or polygamous state, whereby with increased wives, the prevalence of PE decreased to 22% for two women, 20% for men with three wives, and 12% for men with four wives [41,45]. In the Global Study of Sexual Attitudes and Behaviors study, the South Africa data were included in the Non-European West category, along with Australia, Canada, New Zealand, and the US, yielding a strictly defined early ejaculation of 27.4% compared to 12.4% in the Middle East population [38], which highlights that there is a lack of data acquisition in some countries, and even the present study may be missing important insights from some countries.

The use of English language in the survey may have restrict the participation of non-English speaking countries. Therefore, the results of the survey may not be representative in those under represented countries. Furthermore, the number of respondents is relatively small, even when compared to the previous Korean nationwide survey on PE management that received 527 respondents [46]. Consequently, no subgroup analysis can be conducted due to the limited number of responses. Nevertheless, our study discusses the most up to date practice patterns on PE that include 264 clinicians from 41 countries. Though the survey questionnaire was not validated it was developed by a global group of experts to ensure the comprehensiveness of the data collected.

Despite these limitations, the present study highlighs the diversity and important issues in the prevalence and diagnostic approach to the treatment of PE globally. The variability in the prevalence of PE is due to the different definitions used among clinicians. Moreover, the subjectivity aspect of PE can also affect the perception of patients. Such diversity was also depicted in two previous nationwide surveys in South Korea [46] and the United States [20].

There was also no unified pathway for evaluating men with PE and what should be considered a routine assessment, aside from IELT. Physicians may end up using their clinical judgment to evaluate multifaceted factors of PE. In terms of treatment, further studies are crucial to provide a higher LOE, especially given the different recommendations on treatment approaches that exist among the guidelines. While the use of dapoxetine is unanimously recommended in many guidelines as the first-line treatment, the second- and third-line treatments were varied. Additionally, the use of surgical treatment for PE is also controversial, with the majority of published articles being from Asian countries which may cause bias. Several other non-pharmacological and non-surgical treatments for PE, such as electrical stimulation are also emerging, but the available evidence of their efficacy is limited and flawed due to several drawbacks. With the reported adverse effects of medications, the off-label use, and varied responses to treatment (including for behavioral therapy), future studies should be conducted to identify which patients will benefit from a specific approach. A well-designed, multicenter trial will be beneficial to find the optimal treatment for PE.

CONCLUSIONS

PE is defined by 2 important criteria namely the lack

of control with a short time to ejaculation during sexual penetration and the ensuing psychosexual distress experienced by the patient. While several definitions are available, most clinicians adopt the definition by ISSM. To date, most of the medications are prescribed off-label, without the approval of governmental regulatory agencies, except for dapoxetine in many countries. The role of surgery as an effective (and safe) treatment for PE remains controversial since its longer-term outcomes are unknown and the risk of ED and glans numbness or hyperesthesia has serious consequences. In this first global survey of its kind, there was considerable diversity in the diagnostic approaches and treatment strategies in PE. It is likely a multi-modal therapy with specific emphasis on the patient's needs and demand will provide the optimal treatment for PE. Further scientific research to improve our understanding of the neurobiology and novel molecules that delay ejaculation in an effective and safe manner is needed to manage this common MSD.

Conflict of Interest

The authors have nothing to disclose.

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Author Contribution

Conceptualization: AA, RS. Statistical analysis: BS. Supervision: AS, RS, TM. Writing – original draft: TM, RS, AS, EC, MAH, MA, SC, AR, WA, BS, OR, GMP. Writing – review & editing: all authors. All authors have read and agreed to the published version of the manuscript.

Supplementary Materials

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REFERENCES

1. Abdo CH. The impact of ejaculatory dysfunction upon the sufferer and his partner. Transl Androl Urol 2016;5:460-9.
2. Liu J, Bao T, Wang Q, Jiang H, Zhang X. Stigma and its associations with self-confidence and sexual relations in 4 types of premature ejaculation. Basic Clin Androl 2024;34:11.
3. McCabe MP, Sharlip ID, Atalla E, Balon R, Fisher AD, Laumann E, et al. Definitions of sexual dysfunctions in women and men: a consensus statement from the fourth international consultation on sexual medicine 2015. J Sex Med 2016;13:135-43.
4. Serefoglu EC, McMahon CG, Waldinger MD, Althof SE, Shindel A, Adaikan G, et al. An evidence-based unified definition of lifelong and acquired premature ejaculation: report of the second International Society for Sexual Medicine Ad Hoc Committee for the Definition of Premature Ejaculation. J Sex Med 2014;11:1423-41.
5. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. American Psychiatric Publishing, Inc.; 2013.
6. Waldinger MD, Schweitzer DH. The use of old and recent DSM definitions of premature ejaculation in observational studies: a contribution to the present debate for a new classification of PE in the DSM-V. J Sex Med 2008;5:1079-87.
7. Althof SE, Abdo CH, Dean J, Hackett G, McCabe M, McMahon CG, et al. International Society for Sexual Medicine's guidelines for the diagnosis and treatment of premature ejaculation. J Sex Med 2010;7:2947-69.
8. First MB, American Psychiatric Association. Diagnostic and statistical manual of mental disorders: DSM-5-TR. 5th ed. American Psychiatric Association; 2022.
9. World Health Organization (WHO). International classification of diseases 11th revision for mortality and morbidity statistics (ICD-11-MMS): The global standard for diagnostic health information. WHO; 2023.
10. Spector IP, Carey MP. Incidence and prevalence of the sexual dysfunctions: a critical review of the empirical literature. Arch Sex Behav 1990;19:389-408.

11. Serefoglu EC, Yaman O, Cayan S, Asci R, Orhan I, Usta MF, et al. Prevalence of the complaint of ejaculating prematurely and the four premature ejaculation syndromes: results from the Turkish Society of Andrology Sexual Health Survey. J Sex Med 2011;8:540-8.
12. McMahon CG, Jannini E, Waldinger M, Rowland D. Standard operating procedures in the disorders of orgasm and ejaculation. J Sex Med 2013;10:204-29.
13. Waldinger MD. The pathophysiology of lifelong premature ejaculation. Transl Androl Urol 2016;5:424-33.
14. Rowland D, Perelman M, Althof S, Barada J, McCullough A, Bull S, et al. Self-reported premature ejaculation and aspects of sexual functioning and satisfaction. J Sex Med 2004;1:225-32.
15. Gul M, Bocu K, Serefoglu EC. Current and emerging treatment options for premature ejaculation. Nat Rev Urol 2022;19:659-80.
16. Salonia A, Bettocchi C, Capogrosso P, Carvalho J, Corona G, Dinkelman-Smit M, et al. EAU Guidelines on Sexual and Reproductive Health. European Association of Urology (EAU); 2024.
17. Waldinger MD, Zwinderman AH, Olivier B. On-demand treatment of premature ejaculation with clomipramine and paroxetine: a randomized, double-blind fixed-dose study with stopwatch assessment. Eur Urol 2004;46:510-5; discussion 516.
18. Wang H, Bai M, Zhang HL, Zeng A. Surgical treatment for primary premature ejaculation with an inner condom technique. Medicine (Baltimore) 2019;98:e14109.
19. Hu QB, Zhang D, Ma L, Ng DM, Haleem M, Ma Q. Progresses in pharmaceutical and surgical management of premature ejaculation. Chin Med J (Engl) 2019;132:2362-72.
20. Shindel AW, Althof SE, Carrier S, Chou R, McMahon CG, Mulhall JP, et al. Disorders of ejaculation: an AUA/SMSNA Guideline. J Urol 2022;207:504-12.
21. Cormio L, Massenio P, La Rocca R, Verze P, Mirone V, Carrieri G. The combination of dapoxetine and behavioral treatment provides better results than dapoxetine alone in the management of patients with lifelong premature ejaculation. J Sex Med 2015;12:1609-15.
22. Abu El-Hamd M, Abdelhamed A. Comparison of the clinical efficacy and safety of the on-demand use of paroxetine, dapoxetine, sildenafil and combined dapoxetine with sildenafil in treatment of patients with premature ejaculation: a randomised placebo-controlled clinical trial. Andrologia 2018. doi: 10.1111/and.12829.
23. Eysenbach G. Improving the quality of Web surveys: the Checklist for Reporting Results of Internet E-Surveys (CHERRIES). J Med Internet Res 2004;6:e34.
24. Dalkey N, Helmer O. An Experimental Application of the DELPHI Method to the Use of Experts. Manag Sci 1963;9:458-67.
25. Guyatt GH, Oxman AD, Kunz R, Falck-Ytter Y, Vist GE, Liberati A, et al. Going from evidence to recommendations. BMJ 2008;336:1049-51.
26. Palmer NR, Stuckey BG. Premature ejaculation: a clinical update. Med J Aust 2008;188:662-6.
27. Kalejaiye O, Almekaty K, Blecher G, Minhas S. Premature ejaculation: challenging new and the old concepts. F1000Res 2017;6:2084.
28. Raveendran AV, Agarwal A. Premature ejaculation - current concepts in the management: a narrative review. Int J Reprod Biomed 2021;19:5-22.
29. Sansone A, Aversa A, Corona G, Fisher AD, Isidori AM, La Vignera S, et al. Management of premature ejaculation: a clinical guideline from the Italian Society of Andrology and Sexual Medicine (SIAMS). J Endocrinol Invest 2021;44:1103-18.
30. Althof SE, McMahon CG, Rowland DL. Advances and missteps in diagnosing premature ejaculation: analysis and future directions. J Sex Med 2022;19:64-73.
31. Colonnello E, Ciocca G, Limoncin E, Sansone A, Jannini EA. Redefining a sexual medicine paradigm: subclinical premature ejaculation as a new taxonomic entity. Nat Rev Urol 2021;18:115-27.
32. Saleh R, Majzoub A, Abu El-Hamd M. An update on the treatment of premature ejaculation: a systematic review. Arab J Urol 2021;19:281-302.
33. Althof SE, McMahon CG, Waldinger MD, Serefoglu EC, Shindel AW, Adaikan PG, et al. An update of the international society of sexual medicine's guidelines for the diagnosis and treatment of premature ejaculation (PE). Sex Med 2014;2:60-90.
34. Cote-Leger P, Rowland DL. Global perspectives on the three criteria for premature ejaculation: An observational study of ejaculatory latency, ejaculatory control and bother/distress. Andrologia 2020;52:e13796.
35. Althof S, Rosen R, Harty B, Osterloh IH, Muirhead GJ, McMahon C. Objective and subjective measures of premature ejaculation: how closely do they correspond and how well are the subjective measures recalled? J Sex Med 2020;17:634-44.
36. Shaeer O. The global online sexuality survey (GOSS): The United States of America in 2011 Chapter III—Premature ejaculation among English-speaking male Internet users. J Sex Med 2013;10:1882-8.
37. Waldinger MD, Quinn P, Dilleen M, Mundayat R, Schweitzer

DH, Boolell M. A multinational population survey of intravaginal ejaculation latency time. J Sex Med 2005;2:492-7.
38. Laumann EO, Nicolosi A, Glasser DB, Paik A, Gingell C, Moreira E, et al. Sexual problems among women and men aged 40-80 y: prevalence and correlates identified in the global study of sexual attitudes and behaviors. Int J Impot Res 2005;17:39-57.
39. Corona G, Rastrelli G, Limoncin E, Sforza A, Jannini EA, Maggi M. Interplay between premature ejaculation and erectile dysfunction: a systematic review and meta-analysis. J Sex Med 2015;12:2291-300.
40. McMahon CG, Lee G, Park JK, Adaikan PG. Premature ejaculation and erectile dysfunction prevalence and attitudes in the Asia-Pacific region. J Sex Med 2012;9:454-65.
41. Porst H, Montorsi F, Rosen RC, Gaynor L, Grupe S, Alexander J. The Premature Ejaculation Prevalence and Attitudes (PEPA) survey: prevalence, comorbidities, and professional help-seeking. Eur Urol 2007;51:816-23; discussion 824.
42. Jannini EA, Lombardo F, Lenzi A. Correlation between ejaculatory and erectile dysfunction. Int J Androl 2005;28 Suppl 2:40-5.
43. Corona G, Petrone L, Mannucci E, Jannini EA, Mansani R, Magini A, et al. Psycho-biological correlates of rapid ejaculation in patients attending an andrologic unit for sexual dysfunctions. Eur Urol 2004;46:615-22.
44. Wu MJ, Zhao K, Fils-Aime F. Response rates of online surveys in published research: a meta-analysis. Comput Hum Behav Rep 2022;7:100206.
45. Mohamed AH, Mohamud HA, Yasar A. The prevalence of premature ejaculation and its relationship with polygamous men: a cross-sectional observational study at a tertiary hospital in Somalia. BMC Urol 2021;21:175.
46. Yang DY, Ko K, Lee WK, Park HJ, Lee SW, Moon KH, et al. Urologist's practice patterns including surgical treatment in the management of premature ejaculation: a korean nationwide survey. World J Mens Health 2013;31:226-31.