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Authors Information;

Dr. Shivananda Manohar J, Associate Professor, Department of Psychiatry, JSS Medical College and Hospital (JSSMCH), JSS Academy of Higher Education & Research (JSSAHER)
Mysore, Karnataka, India

Dr. Donthu Raj Kiran, Professor, Department of Psychiatry, NRI Medical College, Guntur, Andhra Pradesh, India

Dr. M. Aleem Siddiqui, Professor and Head, Department of Psychiatry, Era's Lucknow Medical College

Lucknow, Uttar Pradesh, India

Corresponding Author Name: Dr. Shivananda Manohar J, Department of Psychiatry, JSS Medical College and Hospital (JSSMCH), JSS Academy of Higher Education & Research (JSSAHER), Mysore, Karnataka, India

Email: drshivman@gmail.com

Phone: 8105438462

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Assessment & Management of Premature Ejaculation

Shivananda Manohar J¹, Donthu Raj kiran², M Aleem Siddiqui³

1. Associate Professor, Department of Psychiatry, JSSMCH, JSSAHER, Mysore

2. Professor, Department of Psychiatry, NRI Medical College, Guntur

3.. Professor and Head, Department of Psychiatry, Era's Lucknow Medical College

Executive Summary

This guidelines attempts to provide evidence-based, culturally adaptable recommendations for assessment and management of premature ejaculation. It also prioritises feasible, practical interventions tailored for psychiatrists practising in outpatient settings. The three core criteria in the definition of premature ejaculation include short ejaculatory latency, perceived lack of control and significant distress for the individual as well as their partner. Clinical classification into lifelong, acquired, variable, and subjective is essential for selecting an appropriate management strategy. Detailed sexual and medical history is essential for assessment and diagnosis of premature ejaculation. A detailed history that focuses on culturally specific syndromes, as well as comorbid medical and psychiatric disorders, is essential. A combined approach incorporating pharmacotherapy and relaxation techniques, including the start-stop technique, squeeze technique, and pelvic muscle training, yields optimal outcomes. On-demand dapoxetine is the first-line option along with topical anaesthetics. Off-label use of selective serotonin inhibitors like paroxetine or tricyclic antidepressants like clomipramine serves as second-line choices. The dependence risk of tramadol makes it reserved strictly for refractory cases. Transparent documentation and open communication should be emphasised when prescribing off label medications. Treatment outcomes should be measured by patient and partner satisfaction rather than strict intravaginal ejaculatory latency time.

Introduction

Premature ejaculation (PE) is considered the most common sexual disorder in men; up to 30% report PE. (1)Lack of a standardised universal definition of PE has led to ambiguity in interpreting research on premature ejaculation. (2)Sociocultural perceptions regarding normal ejaculation time have hampered efforts to establish a universal definition. (3)In recent decades, there has been an increased awareness of sexual dysfunction that has challenged the traditional paradigm about PE. (4)Previously understood as a psychological disorder, PE is now understood to have multiple etiological factors.(5)

The previous Indian Psychiatric Society (IPS) guidance dealt with PE within a single, combined document covering all sexual dysfunctions. Since then the field has moved on: the definition has been placed on a firmer footing, dapoxetine has become widely available in India, and the major international bodies — the International Society for Sexual Medicine (ISSM), the American Urological Association together with the Sexual Medicine Society of North America (AUA/SMSNA), and the European Association of Urology (EAU) — have issued and revised dedicated recommendations. This chapter attempts to provide evidence-based guidelines to help psychiatrists practice in different settings, including teaching hospitals, district clinics or private chambers. (6)

Definition and Diagnostic Criteria

Premature ejaculation was first reported in medical literature in 1887. (7)Several definitions have been proposed; the first recognisable definition was proposed by Masters and Johnson in 1970. They defined PE as “The inability of a man to delay ejaculation long enough for his partner to reach orgasm on 50% of intercourse attempts”. This definition encompasses the role of female partners but is confounded by women's ability to reach climax. (8)Later, many professional bodies and organisations gave different definitions which lacked operational criteria and specificity.(9) Use of ambiguous terminology, such as " reasonable voluntary control in the definition by the Diagnostic and Statistical Manual-3, was subject to interobserver variability, and rendered it ineffective to use

as a research tool. Even the definition in the Diagnostic and Statistical Manual-IV lacked specificity to recommend an actual cut-off time for 'short ejaculation time'. (10) The first definition to propose a time limit as part of the definition was the International Statistical Classification of Diseases, 10th edition (ICD-10). (11) This definition proposed that ejaculation less than fifteen seconds after penetration constituted PE. The evidence supporting this cut-off was unclear. (12,13) The absence of operational criteria in these definitions increased the pressure on regulatory authorities, including the United States Food and Drug Administration (FDA). The International Society of Sexual Medicine convened a committee comprising internationally recognised experts to develop a definition that addresses the criticism of the previous one. It was acknowledged that, although acquired and lifelong PE are different entities, they share the same underlying constructs. Since they share the same construct, it is possible to work out a unifying definition. They identified three major underpinnings that were common in all definitions. 1) Short ejaculatory latency 2) Perceived lack of control 3) Negative personal consequences, including frustration, distress, interpersonal issues and avoidance of intercourse. (14)

For an operational definition to be applied uniformly, the inclusion of ejaculatory latency is essential. (15) Previous literature suggests the use of intravaginal ejaculatory latency time (IELT). Studies by Waldinger et al. have demonstrated that individuals with lifelong premature ejaculation are characterised by an IELT of one minute or less. In another paper, the same author examined IELT using a stopwatch in a group of randomly selected men across five countries. Upon examination, it was found that the 0.5th and 2.5th percentiles corresponded to IELTs of 0.9 and 1.3 minutes, respectively. (16) Another important factor postulated to be important in PE is the inability to delay or control ejaculation. Low ratings for control over ejaculation were linked to shorter IELT. Compared with their non-PE counterparts, subjects with PE were more likely to have poor control. Among patients with an IELT of ≤ 1 minute, nearly 70% reported poor control, compared with only 10% of those with an IELT > 1 minute. (17) Many studies have demonstrated moderate or no correlation between reported ejaculatory time and IELT. Byers and Grenier demonstrated a weak correlation between IELT and control, supporting the notion that they were independent risk factors. (18,19)

Premature ejaculation clearly affects the psyche of its sufferers as well as their partners. A community-based study examining 1,587 subjects, which used DSM-IV-TR to diagnose PE, found that more than 60% of individuals with PE had distress when compared to 4% in the non-PE group. (20) In the year 2008, after assimilation of data, an evidence-based definition of lifelong PE was formulated;

- (i) Ejaculation that always or nearly always happens within one minute of vaginal penetration or a bothersome and clinically significant reduction in latency time of about three minutes or less.
- (ii) Inability to delay ejaculation on all or nearly all vaginal penetration
- (iii) Negative personal consequence, such as frustration, distress, bother and avoidance of sexual intimacy.

This definition has its own limitations and faults. It focuses only on vaginal penetration and disregards other activities like anal/oral sex and masturbation. This also ignores the needs of men who have sex with men. Furthermore, this definition excludes men who had PE intermittently or only during a period of their lives. (21) Table 1 summarises the views of different classification systems on premature ejaculation.

System	Core criteria	Latency anchor
ISSM (lifelong)	Short latency + poor control + negative personal consequences, from first sexual experience	~1 min
ISSM (acquired)	Clinically significant, bothersome reduction in latency from a previously normal level; poor control; distress	~3 min or less
AUA/SMSNA	Poor ejaculatory control with associated bother; lifelong present since debut	~2 min
DSM-5-TR	Ejaculation within ~1 min of penetration; ≥6 months; on 75–100% of occasions; distress; specify lifelong/acquired, generalised/situational, severity	~1 min
ICD-11 (HA03)	Ejaculation with minimal stimulation before/at/very shortly after penetration, before the person wishes, with distress; no fixed time	Not specified

Table 1. Comparison of major definitions of premature ejaculation. The clinician should read the latency anchor alongside perceived control and personal/partner distress rather than as an isolated threshold.

Classification of PE

Clinical subtypes are now recognised, and separating them is not an academic exercise — it changes what we offer the patient. Lifelong (primary) PE has been present from the first sexual encounters and tends to have a neurobiological basis, so it usually needs pharmacological help, often combined with behavioural work. Acquired (secondary) PE develops after a period of normal function and frequently points to a treatable cause — erectile dysfunction (ED), prostatitis or other genitourinary infection, thyroid disturbance, a new medication, or acute relationship or performance anxiety — which should be sought and addressed first. Variable PE describes inconsistent early ejaculation that falls within normal variation and generally needs reassurance and education rather than drugs. Subjective PE refers to men who complain of PE but whose measured latency is normal; here the problem is usually one of perception, expectation or anxiety, and the correct response is psychoeducation, not a prescription. Recognising the last two categories protects a substantial number of men from unnecessary medication.(22) (23).(24)

Epidemiology and Clinical Significance

PE is consistently reported as the most common male sexual complaint across Indian and international clinic samples. The wide gap between self-reported prevalence and stopwatch-defined prevalence reflects the central role of perception and distress. What is clinically important is the impact: PE is associated with reduced sexual self-confidence, avoidance of intimacy, interpersonal and marital difficulty, and secondary anxiety or low mood, and the distress commonly extends to the partner. In the Indian context two features recur — frequent overlap with erectile dysfunction and with culture-bound presentations such as Dhat syndrome and pre-marital “apprehension about potency” — and these shape both assessment and the order in which problems are treated.(25)

Assessment

Assessment of PE is clinical. It rests on a careful sexual, medical and psychosocial history, and only rarely requires investigation. The first task, often, is simply to make it possible for the man to speak.

Creating the conditions for disclosure

Men find it hard to raise ejaculatory problems and frequently feel ashamed or abnormal. A brief, matter-of-fact opening that normalises the difficulty and assures confidentiality does much of the work: an acknowledgement that many men find these things awkward to discuss, that the conversation is private, and that the purpose is to understand the problem so that it can be helped. Involving the partner — not necessarily at the first visit, but early — improves both assessment and outcome, because PE is an interpersonal problem as much as an individual one.

History

The history should establish the three defining domains and then place them in context. The clinician should ask, in plain language, roughly how long ejaculation takes from penetration (an estimated IELT is adequate; a stopwatch is a research tool, not a clinic requirement), whether the man feels any control over the timing, and how much the problem distresses him and his partner. Around this core, the elements outlined in Table 2 should be addressed..(26)

Domain	What to ask / why
Onset and course	Lifelong or acquired; situational or generalised; stable or worsening — this determines the treatment pathway
Core symptoms	Estimated IELT, perceived control, sexual satisfaction, distress and interpersonal difficulty
Comorbid sexual problems	Screen actively for erectile dysfunction and for Dhat syndrome; both commonly coexist with PE and, if present, are usually treated first
Partner and relationship	Partner’s perspective and distress; quality and stability of the relationship; whether PE is secondary to discord
Medical and drug history	Thyroid symptoms, prostatitis/urinary symptoms, diabetes; current medication including any that may reduce or increase latency; substance and alcohol use

Domain	What to ask / why
Psychiatric history	Anxiety, depression, performance anxiety; whether these are primary or secondary to the sexual problem

Table 2. Focused history in premature ejaculation.(27)

Validated instruments

Structured tools are not essential for diagnosis but are useful for documentation and for tracking change, particularly in teaching settings. The Premature Ejaculation Diagnostic Tool (PEDT), a five-item questionnaire assessing control, frequency and distress, is the best validated for screening. The Premature Ejaculation Profile (PEP) and the Index of Premature Ejaculation (IPE) capture control, satisfaction, distress and interpersonal difficulty and are convenient for follow-up. No substitute for the clinical interview.(28)

Examination and investigations

In lifelong PE with no other complaint, physical examination is usually normal and extensive testing is unnecessary. Examination and targeted investigation are reserved for acquired PE or when the history points to an organic contributor — for example, a genital or prostatic examination and urine analysis where infection is suspected, thyroid function where the picture fits, and appropriate evaluation of erectile function where ED coexists. Quantitative sensory testing and neurophysiological studies remain research procedures and have no place in routine care.(29) Clinicians use Quantitative sensory testing to measure the sensory threshold of the penis. Few of the painless, non-invasive tests include:

Biothesiometry: This is a commonly used vibratory testing device which is placed on different parts of the penis. It begins with a low-frequency vibration, followed by a gradual increase in frequency. The client reports to the doctor when he can feel the vibration. Men with lifelong PE may sometimes feel the vibration sooner than men without PE. (30)

Thermal testing: These devices apply varying temperatures to the penis to measure how quickly the nerve registers temperature. (31)

Tactile sensitivity: Here, the therapist uses fine nylon fibres pressed against the skin of the penis to measure the lightest touch the client can perceive. (32)

Somatosensory evoked potentials; In highly specialised cases, to check whether the pathways from the penis to brain is functioning, mild electrical pulses are used. (33)

#	Assessment Domain	Key Assessment Question	Clinical Rationale & Treatment Implications
1	Diagnostic Subtype	Does the patient present with true PE, or with variable or subjective PE?	Differentiates clinical dysfunction from normal variations; variable and subjective PE are managed primarily with psychoeducation and reassurance rather than pharmacotherapy.

#	Assessment Domain	Key Assessment Question	Clinical Rationale & Treatment Implications
2	Onset & Etiology	Is the condition lifelong or acquired? If acquired, is there a reversible underlying cause?	Guides etiology-specific management; acquired PE requires screening and treatment for reversible underlying conditions (e.g., prostatitis, thyroid dysfunction).
3	Comorbid Sexual Dysfunction	Is there comorbid erectile dysfunction (ED) or Dhat syndrome that should be prioritized?	Dictates treatment sequencing; comorbid ED or culture-bound distress (e.g., Dhat syndrome) should generally be treated prior to or concurrently with PE.
4	Psychiatric Comorbidity	Is there a comorbid psychiatric disorder, and is it primary or secondary to the sexual dysfunction?	Determines therapeutic focus; primary psychiatric disorders require independent psychiatric management, whereas secondary distress may resolve with PE treatment.
5	Relational Context	Is interpersonal or relationship discord driving or maintaining the problem?	Identifies whether couple therapy or relationship counseling is required alongside individual medical or psychological interventions.
6	Preferences & Feasibility	What are the patient's and couple's expectations, motivation, treatment preferences, and financial resources?	Promotes shared decision-making and improves treatment adherence by selecting a tailored, realistic, and affordable therapeutic regimen.

Table 4; Questions to settle before treatment

Principles of Management

Management is patient-centred and, wherever the man has a partner, couple-centred. Three principles govern everything that follows. First, sequence matters: comorbid conditions are addressed in a deliberate order. If erectile dysfunction, Dhat syndrome or a genitourinary infection coexists with PE, that condition is treated first, because doing so often improves the ejaculatory complaint and because treating PE alone in the presence of untreated ED can worsen matters. If a comorbid psychiatric disorder is primary or severe, it is stabilised first, with attention to choosing an

agent that will not aggravate the sexual problem. If PE is secondary to relationship discord, the discord is addressed before or alongside specific treatment. Second, expectations are set honestly: except the treatable acquired causes, current treatments control PE rather than cure it, and the complaint commonly returns when medication is stopped. Third, choice is shared: the clinician lays out the realistic options, their benefits, adverse effects and costs, and the couple chooses. The primary measure of success is not a stopwatch reading but the satisfaction of the man and his partner.

A further practical point specific to psychiatry deserves emphasis. Almost all pharmacological options for PE, other than dapoxetine, are used off-label. The patient should be told this clearly, and the discussion documented. This is both good ethics and sensible medico-legal practice.

General and Behavioural Measures

These are the foundation of treatment and, in many men, sufficient on their own; they are also the first-line choice where the couple prefers to avoid medication, in variable and subjective PE, and in men with prominent performance anxiety.

Education and correction of myths

Simple, accurate information about normal sexual response, the range of normal ejaculatory latency, and the role of anxiety relieves a surprising number of men, particularly those with subjective PE or unrealistic expectations. Correcting the common myths encountered in Indian practice — that any early ejaculation is a disease, that it reflects “weakness” or lost semen, that masturbation has caused permanent damage — is part of treatment, not a preliminary to it.

Relaxation techniques

Relaxation techniques help in managing premature ejaculation by lowering anxiety and releasing pelvic floor muscle tension.

Behavioural therapy (BT)(34): Studies have included a variety of techniques such as Squeeze/ Stop-start, functional-sexological treatment, start-stop using a handheld device and web-based sex therapy (sensate focus).

Figure 1; Picture depicting start and stop technique

===== Insert figure 1 =====

In the stop-start technique, the male stimulates the penis until he feels the urge to ejaculate, then stops until the sensation passes. This is repeated a few times before allowing ejaculation to occur. Here the aim is to recognise the arousal cues and improve control. In a study this was achieved by using a vibrating stimulation device.

In squeeze technique, the female partner stimulates the partners' penis until the he feels the urge to ejaculate, at this point the stimulation is stopped by a gentle squeeze over the glans to reduce the arousal. Functional-sexological therapy involves education on sensuality, movement of body, speed of sexual activity, muscular tension and breathing.

Figure 2: Picture depicting how the squeeze technique is done.

===== Insert figure 2 =====

Efficacy: the evidence for BT alone is mixed. Studies evaluating the functional-sexological technique and self-help book with/ without therapist found to have improved IELT compared to waitlisted individuals. Stop-start using a handheld device did not improve the ejaculatory latency compared to those who were waitlisted over a period of 6 weeks, but IELT improved by 1.7 times after 6 months from baseline. Self-help book with/ without therapist noted an improvement in IELT between 7 to 9 minutes compared to those in waitlisted. A web-based therapy format did not show improvement with waitlist at 12 weeks, but improvements were noted at 3 and 6 months after cessation of treatment.

Pelvic floor muscle training(35–38) (PFMT): It is also known as pelvic floor rehabilitation, and has roots from rehabilitation techniques used in urinary and faecal incontinence.

Theoretical basis: It is based on strengthening the pelvic floor musculature, which is involved in ejaculation. Training aims is to improve the voluntary control of these muscles. Various pelvic floor muscles coordinate in semen expulsion, and studies have found their increased activity throughout the ejaculatory phase. The principal components involved are: structured physiotherapy (isometric and isotonic exercises to strengthen pelvic floor muscles), biofeedback and electrical stimulation. PFMT also trains the patients to recognise and consciously regulate these muscles during the sexual activity.

Efficacy: A prospective study that evaluated the efficacy of PFMT over a period of 12 weeks, and found that IELT improved from 31.7 seconds (pre-intervention) to 146.2 seconds (post intervention). Another study explored its efficacy in an eight-week programme and found PFMT to significantly improve ejaculatory control.

Compared with other methods: A meta-analysis comparing PFMT and SCT had a smaller effect on IELT compared to dapoxetine (MD -54.09; 95% CI: -92.13 to -16.05) and combination therapies (MD -81.44; 95% CI: -127.54 to -35.34). They concluded that dapoxetine or PFMT combination with other therapies may be superior in improving IELT.

Cognitive behavioural therapy (CBT)(39–41): It evolves from BT and incorporates a broader psychotherapeutic model by integrating cognitive restructuring, behavioural training, psychosexual education, sexual skills training, and couple communication.

Virtual reality (VR) and digital-based applications: these interventions have been studied as an adjunct to mainstay/ above discussed methods. Initial studies used headset-based immersive VR, which has now evolved to broader digital interventions such as smartphone applications, biofeedback training devices etc. these have found to improve access to services, motivation, and compliance.

A study used a smartphone coaching app to deliver psychodynamic psychotherapy, and found that it significantly improved the pre and post scores and the number of patients meeting PE criteria post intervention compared to treatment as usual. CLIMACS study compared home-based digital approach to control and found intervention group had significantly improved the PE scores.

Currently there is a lack of head-to-head comparisons with pharmacological agents and behavioural techniques.

Safety data from the studies utilising VR and digital applications is limited. Published studies have not reported any specific adverse events. However studies using head-mounted VR have commonly reported nausea, dizziness, disorientation, postural instability and fatigue.(42)

Pharmacotherapy

Where drug treatment is indicated, the agents below are ordered as they are actually used in Indian practice, with the international recommendations and their evidence grades noted. The consolidated options and the points of agreement and disagreement among the ISSM, AUA/SMSNA, and EAU are presented in Tables 4 and 5.

Agent	Typical dose / regimen	Line	Notes for Indian practice
Dapoxetine	30–60 mg on-demand, 1–3 h before sex	First-line	Only licensed agent; widely available; FDCs with PDE5I
Topical lidocaine–prilocaine	Cream ~20 min before; wash or use condom	First-line	Cream/spray available manage partner transfer
Paroxetine / other SSRIs	e.g. Paroxetine 20 mg daily (off-label)	First / second-line	Daily > on-demand; screen for depression; effect wanes on stopping
Clomipramine	Daily or on-demand a few hours before sex	First / second-line	TCA cautions; nausea common
Tramadol	Low-dose on-demand	Later-line	Controlled drug; dependence and

			serotonin-syndrome ²⁹² risk; avoid with SSRIs ²⁹³ ²⁹⁴
PDE5 inhibitor	On-demand (per ED practice)	PE + ED	Use mainly when ED coexists

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Table 3. Pharmacological options for premature ejaculation, ordered by practical priority in Indian settings.

Table 5. Table depicting the details of systemically used pharmacological interventions.

Drug/class	Dose/regimen studied	Efficacy signal	Key cautions
Alpha-adrenergic blockers Silodosin, tamsulosin, terazosin, doxazosin(43)	Mostly on-demand; silodosin 4 mg about 2 h before sex. Some studies used continuous 2–8 week regimens.	Silodosin shows the strongest signal; comparable to dapoxetine 30 mg in one RCT and better than other alpha-blockers in limited studies.	Evidence remains limited; on-demand studies report no major serious adverse effects, but monitor hypotension/dizziness.
Tricyclic antidepressants Clomipramine; limited amitriptyline data	Clomipramine 15–50 mg/day or 25 mg on-demand a few hours before sex; nasal spray evidence inconclusive.	Clomipramine improves IELT versus placebo; some evidence suggests dose-related benefit and superiority to on-demand paroxetine in one RCT.	More adverse events than placebo; anticholinergic, gastrointestinal, cardiovascular and next-day effects need counselling.(44)
Duloxetine	30–40 mg daily for at least 1 month in small RCTs.	Improves IELT; broadly similar to paroxetine in limited comparative data. Benefit may return to baseline after discontinuation.	Mild dizziness reported; evidence base small, so not a routine first-line option.(45)
Levosulpride	25–75 mg/day, usually continuous treatment for about 60 days.	Limited RCT evidence suggests IELT improvement versus placebo; paroxetine performed better in one Indian comparison.	Risk of reduced libido and hyperprolactinaemia; reserve for selected cases, not standard treatment.(46)
PDE5 inhibitors Sildenafil, tadalafil, vardenafil	Sildenafil 50–100 mg on-demand; tadalafil 5 mg daily or 20 mg on-demand; vardenafil 10 mg on-demand.	Improves IELT versus placebo and is most useful when ED coexists. Combination with SSRIs may outperform either alone.	Headache, flushing, dizziness, dyspepsia and nasal congestion; avoid unsafe combinations and assess cardiovascular risk.(47)
SSRIs	Dapoxetine 30–60 mg on-demand; paroxetine	Strongest oral evidence. SSRIs improve IELT, perceived	Most are off-label except dapoxetine. Counsel about nausea,

Dapoxetine, paroxetine, sertraline, fluoxetine, citalopram	commonly 20 mg daily; other SSRIs studied daily or on-demand.	control and satisfaction; paroxetine shows large IELT gains, while dapoxetine is licensed and practical for on-demand use.	somnolence, sexual side effects, withdrawal and relapse after stopping.(46)
Tramadol	25–100 mg studied; 50 mg on-demand is commonly evaluated and reaches peak levels after about 1.6–1.9 h.	Improves IELT versus placebo and may outperform paroxetine in some analyses, but benefit must be weighed against safety concerns.	Reserve for refractory cases. Dependence, tachyphylaxis, dizziness, nausea, constipation and serotonin-syndrome risk; avoid with SSRIs/SNRIs.(48)

Topical(49): These agents are applied locally and have minimal side effects when compared to oral agents. Oral agents, on the other hand, can be taken either daily or on-demand (may compromise efficacy), whereas topical agents have the advantage of being effective on an on-demand basis. The main adverse effect of topical agents is the risk of an allergic reaction at the site of application. While using the topical agents, the important considerations are: active anaesthetic agents and the mode of delivery.

Background	Application details	Efficacy	Precautions/ Adverse effects
Eutectic Mixture of Local Anaesthetics (EMLA)			
This cream is a mixture of two local anaesthetics, namely lidocaine and prilocaine (both at 2.5%). A eutectic mixture contains a 1:1 ratio of these anaesthetics; this combination creates an emulsion with a low melting point. This allows a higher concentration of absorbable medication (50,51).	Studies have compared different application times, ranging from 20 to 45 minutes; an optimal time of application is 20 minutes before sex. An application time of 45 minutes leads to penile numbness and erectile dysfunction. EMLA 2.5 g applied to entire glans and shaft in combination with a condom was found to improve sexual satisfaction. The combination at 5% was also found to be effective when applied 20 minutes before sex.	In a study, EMLA cream use resulted a 5.6-fold increase in IELT. Being a combination of two anaesthetic agents, it can be effective in treating penile hypersensitivity as well. A meta-analysis found EMLA fared better over placebo (MD 6.44; 95% CI: 6.01 to 6.87).	Penis should be washed before intercourse to avoid the risk of transference of medication to sexual partner or wearing a condom is recommended.
Eutectic Lidocaine and Prilocaine spray (TEMPE/ PSD502)			
This is a metered dose of lidocaine and prilocaine, and is available as Topical Eutectic Mixture for Premature Ejaculation (TEMPE). It contains 7.5 mg of lidocaine and 2.5 mg of prilocaine in a non-aqueous solution with a base, which serves as a solvent and spray propellant. (52,53).	It is a non-aqueous solution, it does not penetrate keratinised skin, but penetrates the poorly keratinised glans penis, thus leading to targeted drug delivery. This retains the sensitivity of the shaft of the penis, thus improving sexual satisfaction. As it contains only the non-ionised forms of local anaesthetic, it penetrates the deeper tissue to reach	A RCT compared TEMPE with placebo and found there is improvement in IELT, ejaculatory control, and sexual satisfaction. The IELT increased to 3.8 minutes, a 6.3-fold increase compared to a 1.7-fold increase with placebo. In a meta-analysis, use of TEMPE was associated with a significantly improvement compared	usually well tolerated with no systemic side effects and a lower incidence of localised effects.

	the targeted neuronal membranes. Along with these, the distribution and delivery properties of the drug reduce the time required for the onset of action and penis hypoesthesia. Due to these properties, there is no requirement for a condom (to prevent transference of medication to sexual partner) after application	to placebo (MD 2.26; 95% CI: 1.47 to 6.80).	
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Combination Therapy

Combining a behavioural method with pharmacotherapy is more effective than either alone and is the approach we recommend for most men with lifelong PE, who tend to need the pharmacological effect but benefit from the durable skills that behavioural work provides. Drug–drug combinations — a topical anaesthetic with an oral agent, or a PDE5 inhibitor with dapoxetine where ED coexists — can help selected patients, but they add cost and adverse effects and should be built up one step at a time rather than started together.

Compared to other methods: studies have compared BT with pharmacotherapy (combined) versus pharmacotherapy alone; and BT versus pharmacotherapy. Combined were better than drug alone, the pharmacotherapeutic agents combined with BT were chlorpromazine (MD 1.11; 95% CI: 0.86 to 1.36), paroxetine (MD 0.40; 95% CI: 0.18 to 0.62) and citalopram (MD 0.46; 95% CI: 0.04 to 0.88). The BT techniques included: stop-start technique, squeeze technique, sensate focus, acupoint taping and Qigong. Few studies have compared BT with pharmacotherapy, the agents compared were citalopram (20 mg), clomipramine (25 mg), dapoxetine (30 or 60 mg on-demand), paroxetine (20 mg), sertraline (50 mg), and sildenafil (50 mg). Among these comparisons, other than sertraline and clomipramine, all other drugs fared better than BT alone.

- Adverse effects: None of the studies have reported any adverse effects. However, dropout rates were higher for self-help material alone compared to groups with therapist contact.

- Efficacy: most effective when used in combination with pharmacotherapy rather than stand-alone. A meta-analysis evaluated the efficacy of CBT combined with SSRIs versus SSRIs alone, and found the combination resulted in significantly higher IELT (SMD 1.38; 95% CI: 0.91 to 1.85). further subgroup comparing with individual SSRI such as dapoxetine (SMD 1.76; 95% CI: 0.83 to 2.68), paroxetine (SMD 1.34; 95% CI: 0.75 to 1.92), citalopram (SMD 0.54; 95% CI: 0.04 to 2.12) and fluoxetine (SMD 1.00; 95% CI: 0.00 to 2.00) yielded similar findings. The findings remained consistent even with different variations of CBT (group psychotherapy, or behavioural training alone), but the cognitive component resulted in longer IELT (SMD 4.37; 95% CI: 3.63 to 5.11). The combination also resulted in significant improvement in: sexual satisfaction (SMD 1.28; 95% CI: 0.63 to 1.93); and spousal satisfaction (SMD 1.58; 95% CI: 0.51 to 2.65).

- Adverse effects: there was no significant difference in adverse effects between the CBT combined with SSRIs versus SSRIs alone (RR 0.99; 95% CI: 0.73 to 1.34); PE-related distress (WMD 0.12; 95% CI: -0.33 to -0.57); and treatment compliance (RR 0.68; 95% CI: 0.43 to 1.09). Yoga(48,54–56)It is a holistic mind-body discipline that integrates physical postures (asanas), breathing techniques, meditation, relaxation and mindfulness. When used for PE, it leads to overall physical health improvement, autonomic balance, emotional regulation, and body awareness.

•Theoretical basis: Yoga is documented to have effects on various systems, which include neurological, psychological, hormonal, autonomic and musculoskeletal. It suppresses sympathetic system and enhances the parasympathetic tone; this is believed to improve voluntary ejaculatory control and delay ejaculation. By enhancing serotonergic activity, it improves ejaculatory control. Asanas, specifically the sitting ones have been thought to produce greatest effects on pelvic musculature.

•Efficacy: a meta-analysis found pooled effect favouring yoga (SMD 1.74; 95% CI: 1.27 to 2.22) compared to other methods (included stop-start technique, non-sitting yoga and naturopathy). A pilot study compared yoga was compared to paroxetine (25 to 75 mg) and found that both lead to improvement in IELT from the baseline, but there was a delay in the onset of effect with yoga. Another study compared different types of yoga, sitting and non-sitting type and found that seated yoga produced greater IELT improvement.

A Practical Stepwise Approach

The following sequence is intended as a usable clinic algorithm rather than a rigid protocol (Figure 3).

1. Confirm that this is PE, and establish the subtype (lifelong, acquired, variable, subjective). Reassure and educate in variable and subjective PE; treat reversible causes in acquired PE.
2. Screen for and address comorbidity in order: treat coexisting erectile dysfunction, Dhat syndrome or genitourinary infection first; stabilise a primary or severe psychiatric disorder; address significant relationship discord.
3. Begin treatment with education, myth-correction and a behavioural method, offered to every couple willing to use it.
4. For lifelong PE, or when behavioural measures are insufficient or the couple prefers medication, add first-line pharmacotherapy — on-demand dapoxetine or a topical anaesthetic, choosing between them on the basis of preference, tolerability and cost.
5. If the response is inadequate, switch within first-line options or move to a daily off-label SSRI (paroxetine) or clomipramine; consider combining a topical agent with an oral drug.
6. Reserve tramadol for men who have failed the above, on-demand and at low dose, and never alongside a serotonergic antidepressant.
7. Where PE coexists with ED, treat the ED (PDE5 inhibitor); a dapoxetine–PDE5I fixed-dose combination is a practical option with appropriate counselling.
8. Review at four to six weeks; measure success by the man's and partner's satisfaction; plan for relapse and for gradual withdrawal of medication where feasible.

===== Insert figure 3 here =====

Special Considerations in the cultural context

Several features of Indian practice deserve explicit attention because they change how these recommendations are applied.

- **Overlap with Dhat syndrome and “apprehension about potency”.** Many men frame ejaculatory complaints in terms of semen loss or fear of failure on the wedding night. Where Dhat syndrome coexists, it is addressed first, chiefly through sex education and correction of myths; only then is any residual PE re-assessed and treated.
- **Single and pre-marital men.** A substantial number present before marriage, without a partner, and anxious about future performance. Education, relaxation and graded self-directed behavioural assignments are the mainstay, with medication reserved for genuine lifelong PE.

- **Partner and family involvement.** Partner participation improves outcome, but privacy, consent and cultural context must be respected; the partner is involved with the patient's agreement and at a pace the couple can manage.
- **Stigma and under-reporting.** Because men rarely volunteer the complaint, a brief, routine, non-judgemental enquiry about sexual function — particularly in men on psychotropics — will uncover cases that would otherwise be missed.
- **Availability and affordability.** Dapoxetine and topical lidocaine–prilocaine are widely available and inexpensive; the metered lidocaine–prilocaine spray often is not. Cost and continuity of supply should guide the choice, especially where daily medication is being considered.
- **Off-label use and consent.** Apart from dapoxetine, PE pharmacotherapy is off-label; this should be explained and documented.
- **Treatment-emergent PE and drug-induced sexual dysfunction.** Psychotropics can both cause and, in the case of serotonergic agents, be exploited to treat ejaculatory symptoms. This overlaps with the companion guideline on treatment-emergent sexual dysfunction and should be considered whenever the history is temporally linked to a psychotropic.
- **When to refer.** Refer to urology or andrology where an organic acquired cause is suspected, where ED is prominent or refractory, or where specialist investigation is needed; and involve a mental-health colleague with sexual-health expertise for entrenched relationship or psychological difficulty.

Follow-up, Relapse and Termination

Follow-up is individualised; a review at about four to six weeks, then at intervals, is usually adequate. The couple should be prepared from the outset for the likelihood of relapse, particularly when medication is stopped, and reassured that recurrence is expected and manageable rather than a failure. Where behavioural skills have been learned, they can be re-deployed, and medication can often be tapered rather than continued indefinitely. Setting a realistic time frame at the start improves adherence and reduces the sense of disappointment if progress is gradual.

Key Recommendations

The strength descriptors below follow the international PE guidelines; the CPG committee may map them to the grading scheme adopted across the guideline set.

Recommendation	Strength
Diagnose PE clinically using latency, perceived control and personal/partner distress together; distinguish lifelong, acquired, variable and subjective subtypes	Strong
Treat coexisting ED, Dhat syndrome or genitourinary infection, and any primary/severe psychiatric disorder or relationship discord, before or alongside specific PE treatment	Strong
Offer education, myth-correction and a behavioural method to every willing couple; combine with pharmacotherapy for lifelong PE	Strong
Use on-demand dapoxetine or a topical anaesthetic as first-line drug treatment	First-line
Use daily off-label SSRIs (paroxetine) or clomipramine where first-line options fail or are unsuitable	First / second-line
Reserve tramadol for refractory cases; never combine with serotonergic antidepressants; be alert to dependence	Later-line, conditional

Recommendation	Strength
Use PDE5 inhibitors principally when ED coexists	Conditional
Explain and document off-label use; judge success by patient and partner satisfaction; plan for relapse	Good practice

Table 6. Summary of key recommendations.(57)

Research Gaps and Future Directions

Indian data on PE remain thin. Most treatment evidence is generated abroad, and the few Indian studies are small, often open-label and rarely randomised. There is a clear need for well-designed Indian trials — of dapoxetine in routine practice, of topical agents, of behavioural and combination approaches, and of yoga and pelvic floor training, which are culturally acceptable and locally popular but under-evaluated. Validated Hindi and regional-language versions of the standard instruments would strengthen both practice and research. Finally, the frequent coexistence of PE with Dhat syndrome, with erectile dysfunction and with treatment-emergent sexual dysfunction is characteristically Indian. It deserves dedicated study rather than extrapolation from Western samples.

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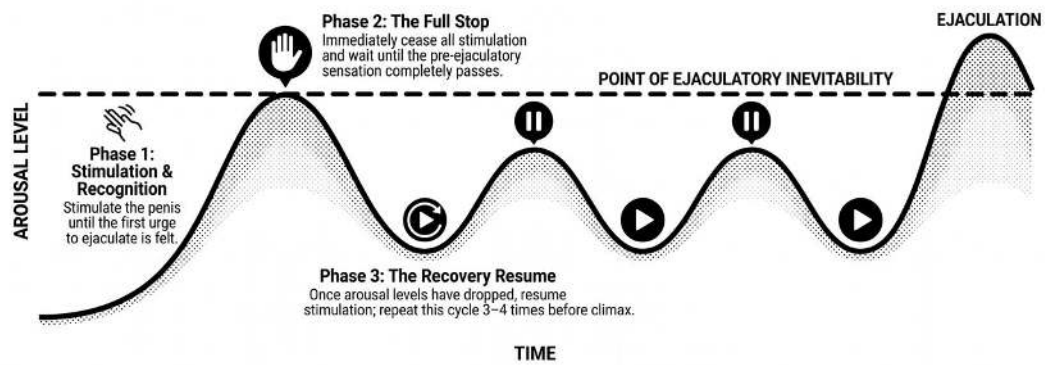
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Assessment & Management of Premature Ejaculation

Figure 1: Picture depicting start and stop technique

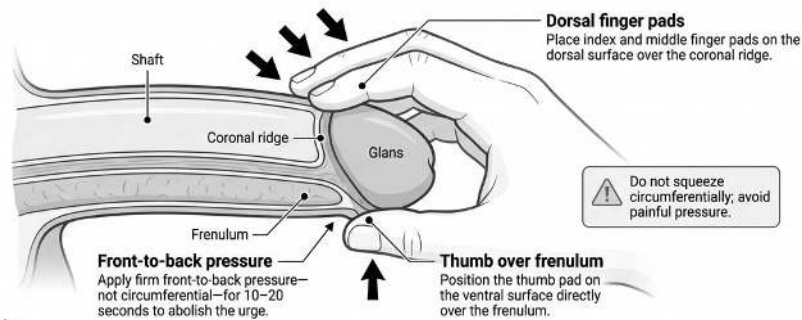


Assessment & Management of Premature Ejaculation

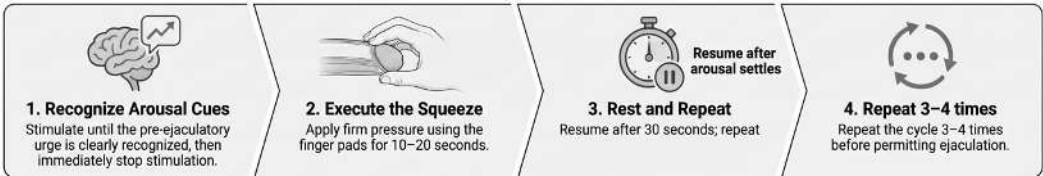
Figure 2: Picture depicting how the squeeze technique is done.

Digit Placement for the Squeeze Technique: Lateral Schematic

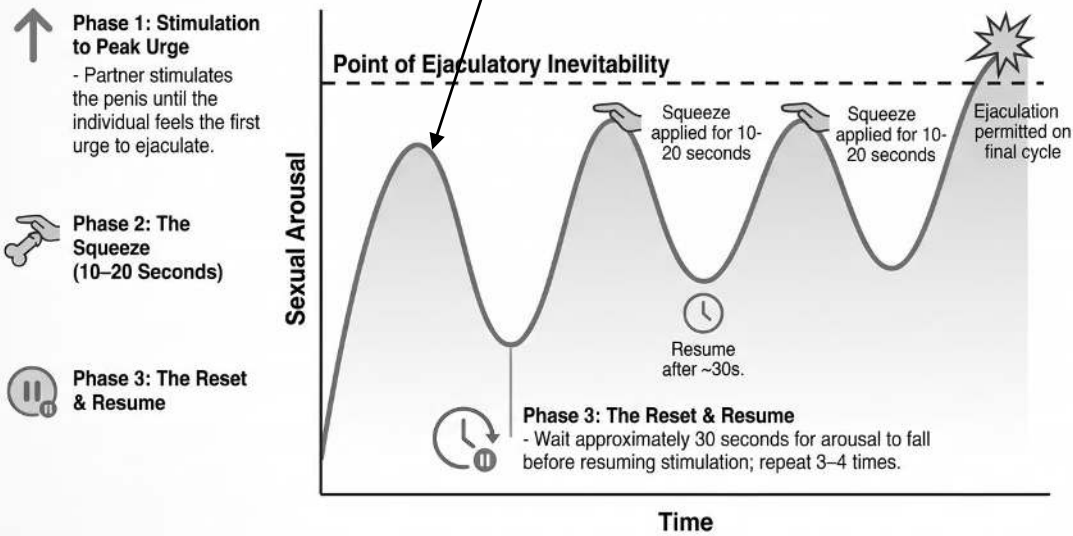
A clinical guide for correct digit placement and procedural steps in managing premature ejaculation.



The 4-Step Clinical Cycle



The Three-Phase Cycle



598 **Figure 3: A Practical Stepwise Approach**

