ORIGINAL PAPER

The importance of inquiring the ejaculation function in men with premature ejaculation who do not actively seek treatment

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Summary
Purpose: To evaluate the clinical characteristics of men presenting for other complaints whose ejaculatory function inquiry indicated premature ejaculation (PE).
Methods: The data of 536 PE patients, including those who presented with the complaint of PE (group 1) and those presenting with other complaints who were diagnosed with PE (group 2) as a result of ejaculatory function inquiry using estimated intravaginal ejaculation latency time (IELT) and Premature Ejaculation Diagnostic Tool (PEDT), were retrospectively evaluated. Age, PE type, comorbidities, recommended treatments, and treatment acceptance status of all patients were recorded. These characteristics were compared for each group.
Results: Among all the patients, those who presented with PE complaints constituted 22.4%. Among the patients with both PE and ED, 98.1% applied with ED complaint and only 1.9% with PE complaint. The percentage of patients with one comorbidity was significantly higher in group 2 (p = 0.032). 90.1% of all patients and 88.5% of patients in group 2 accepted the recommended treatment for PE. The mean age and comorbidities were significantly higher in patients that refused the treatment. The most common reason for treatment refusal was the patients' lack of expectation for treatment.
Conclusions: This study shows that men more frequently tend to seek treatment for ED than PE, and treatment acceptance rate may be higher when the patients with PE complaints who don't seek treatment are reached through ejaculatory function inquiry. The presence of comorbidities negatively affects the treatment expectation and acceptance as well as treatment seeking behavior of men with PE.

KEY WORDS: *Sexual attitude; Ejaculatory function inquiry; Premature ejaculation; Treatment seeking; Comorbidity.*

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INTRODUCTION

One of the main purposes of human sexuality is pleasure and this has led men to learn to control ejaculation in order to increase both their partner's and their own pleasure. Over time, the ability to control ejaculation has become one of the most important indicators of a couple's sexual health (1). In 1970, *Masters and Johnson* defined *premature ejaculation* (PE) as "*the inability to achieve the ejaculation period that will enable the partner to reach orgasm*

in at least half of sexual intercourses" (2). Most recently, *International Society for Sexual Medicine* (ISSM) has defined PE as a male sexual dysfunction condition that has significant negative consequences for the man, his partner, and the couple as a whole, creates difficulties in interpersonal relationships, and is associated with a decrease in quality of life (3, 4). Despite this, most men do not seek help for PE, and most doctors do not sufficiently question this issue (5, 6).

There are few studies and limited information on men's attitudes towards sexual problems and their seeking help for this. The *Global Study of Sexual Attitudes and Behaviors* (GSSAB), which surveyed 13625 men, reported that a large proportion of men (77.8%) did not consult a doctor or other healthcare professional about their sexual problems, and only 18.0% of the participants sought medical help (7). In the same study, 23.7% of men have reported PE and some of the reasons why men with a sexual dysfunction, including PE, did not consult a doctor were not taking it seriously and thinking that sexual dysfunction is an age-appropriate and acceptable condition. Patients may be reluctant to discuss their PE complaint with a doctor due to the feeling of embarrassment and stigma associated with sexual dysfunction and disabilities (8). The *Premature Ejaculation Prevalence and Attitudes* (PEPA) survey study reported that despite awareness of prescription treatments for PE, only 9.0% of men consulted a doctor regarding their PE complaints (9). Moreover, some studies have revealed that 45% of men expect their doctors to initiate the discussion about sexual problems (10) and 60% believe that doctors should routinely ask about patients' sexual health (11).

In this study, we evaluated men whose ejaculatory function inquiry indicated presence of PE. We aimed to evaluate their clinical characteristics, factors affecting their attitude towards the recommended treatment, and the effect of presence of comorbidity on treatment seeking behavior and treatment acceptance in these patients. We also compared these characteristics with those of men presenting with spontaneous complaint of PE.

MATERIALS AND METHODS

After the approval of the local ethics committee (Protocol No: 2020/138), the data of male patients aged 18-75

years who presented to the urology outpatient clinic between January 2015 and March 2020 were retrospectively reviewed. A total of 536 patients diagnosed with PE for the first time were included in the study. To avoid that our treatment proposal could be affected by the patient's previous treatment experiences we excluded from the study patients who had previously applied to any health institution due to PE or received previous treatment for PE. We also excluded patients who had delayed ejaculation or anejaculation, who were not sexually active or had multiple partners, and whose full data could not be accessed in the records.

The patients were divided into two groups. Group 1 consisted of patients that applied to the urology outpatient clinic with complaints of PE. Group 2 included patients that presented with another urological complaint and were found to have PE when ejaculatory function was actively questioned. The ejaculatory functions of patients who reported having problems were evaluated using international questionnaires.

The study was based on the estimated *intravaginal ejaculation latency time* (IELT) reported by the patients. Patients were classified as lifelong PE and acquired PE based on the definition of PE made by ISSM in 2014 (3, 12), where lifelong PE is defined as ejaculation within approximately 1 minute before or after vaginal penetration all the time or almost all the time since the first sexual experience, while acquired PE was defined as a clinically significant and disturbing reduction in IELT and ejaculation of about 3 minutes or less. In addition, men with incidental and situational experiences of decreased ability to delay ejaculation, and men with normal and even long ejaculation time were considered as subtypes of natural variable PE and *premature-like ejaculatory dysfunction* (PLED), respectively (13).

Validated Turkish version of *Premature Ejaculation Diagnostic Tool* (PEDT) was used in the evaluation of PE (14). PEDT score was calculated according to the answers of the patients. Those with a total score > 9 were considered to have PE.

The erectile status of those who reported *erectile dysfunction* (ED) was evaluated with the *International Index of Erectile Function* (IIEF-5) questionnaire which was translated and validated by the *Turkish Andrology Association* in 2002 (15). Total score < 22 was considered as ED.

Patients' age, PE type, smoking status, comorbidities, the recommended treatment for PE (medical or psychotherapy), the names of the medical agents, their acceptance of the treatment, and if not, the reasons for refusal were recorded. The relationship between the characteristics of PE and the factors affecting treatment acceptance according to the reasons for presentation was evaluated using appropriate statistical methods.

Statistical methods

Research data were evaluated using SPSS software (*ver.21.0 for Windows; SPSS Inc, Chicago, IL, USA*).

The compliance of continuous variables to normal distribution was investigated using visual (histogram and probability graphs) and analytical methods (*Kolmogorov-Smirnov/Shapiro-Wilk tests*). The descriptive statistics of the study were shown as mean and standard deviation for data

conforming to the normal distribution and as median, minimum and maximum for data that did not conform to the normal distribution. The chi-square test was used to show whether there was a difference between categorical variables. When comparing independent groups, Student-t test was used to compare continuous variables with parametric properties, while Mann Whitney U test was used to compare continuous variables with nonparametric properties. P value of < 0.05 was considered statistically significant.

RESULTS

Of the 536 PE patients evaluated in the study, 22.4% (n: 120/536) were in group 1 and 77.6% (n: 416/536) were in group 2. The mean age of all patients was 43.06 ± 12.3 years and the mean age of group 1 (39.49 ± 11.29 years) was significantly lower than that of group 2 (44.09 ± 12.49 years) (p < 0.001) (Table 1).

The PE type analysis showed that 41.8% of the patients (n: 224/536) had lifelong PE, 54.1% (n: 290/536) had acquired PE, and 4.1% had PE subtypes of natural variable PE (n: 14/536) and PLED (n: 8/536). The mean age of patients with lifelong PE was significantly lower than that of the acquired group (p < 0.001) and PE subtypes (p = 0.006) (Figure 1). The most common PE type in both groups 1 and 2 was acquired PE. IELT was < 1 min in 82.1% of patients with lifelong PE (n: 184/224) and between 1-2 min in 17.9% (n: 40/224). In total, 39.9% of the patients (n:214/536) had both ED and PE: 3.3% in group 1 (n: 4/120) and 50.5% in group 2 (n: 210/416). ED was the most common reason for application to the urology outpatient clinic, followed by infertility and *lower urinary tract symptoms* (LUTS) (Figure 2). As a result, while 98.1% (n: 210/214) of the patients with both ED and PE presented with ED complaints, only 1.9% (n: 4/214) gave priority to PE.

Table 1.

Comparison of groups according to application complaint.

	Total (n = 536)	Group 1 (n = 120)	Group 2 (n = 416)	P value
Age (year) (Mean ± SD)	43.06 ± 12.3	39.49 ± 11.29	44.09 ± 12.49	**< 0.001**
PE type (n, %)				0.982
Lifelong	224 (41.8)	51 (42.5)	173 (41.6)	
Acquired	290 (54.1)	64 (53.3)	226 (54.3)	
Natural variant	14 (2.6)	5 (4.2)	9 (2.2)	
PLED	8 (1.5)	-	8 (1.9)	
Treatment status (n, %)				**0.017**
Accept	483 (90.1)	115 (95.8)	368 (88.5)	
Reject	53 (9.9)	5 (4.2)	48 (12.5)	
Smoking (n, %)	101 (18.8)	18 (15)	83 (20)	0.222
Comorbidities (n, %)				
Single comorbidity	226 (42.1)	32 (26.7)	194 (46.6)	**0.032**
Cardiovasculary diseases	85 (37.6)	12 (37.5)	73 (37.6)	0.046
Oncological diseases	12 (5.3)	2 (6.2)	10 (5.2)	1.000
Neurological diseases	15 (6.6)	5 (15.6)	10 (5.2)	0.344
Endocrinological diseases	7 (3.1)	-	7 (3.6)	1.000
Chronic systemic diseases	30 (13.3)	6 (18.8)	24 (12.4)	0.747
Psychiatric disorder	5 (2.2)	-	5 (2.6)	0.592
DM	72 (31.9)	7 (21.9)	65 (33.4)	**0.006**
Multiple comorbidities	56 (10.4)	9 (7.5)	47 (11.3)	**0.028**

SD: Standard deviation; PE: Prematüre ejaculation; PLED: Prematüre like ejaculatory dysfunction; DM: Diabetes mellitus.

Figure 1.
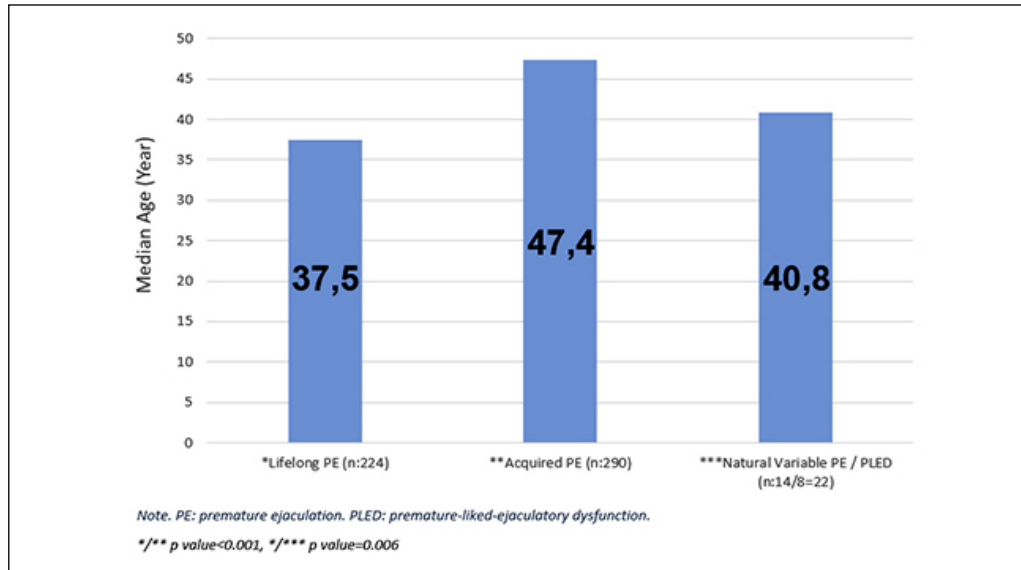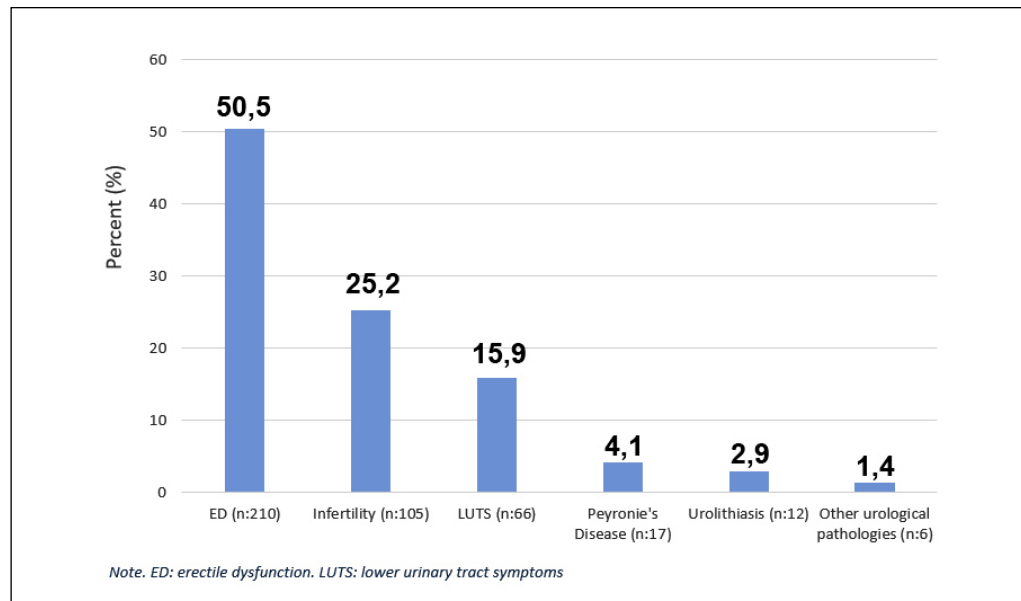*Comparison of mean ages of premature ejaculation types.*

Note. PE: premature ejaculation. PLED: premature-liked-ejaculatory dysfunction.
*/** p value<0.001, */*** p value=0.006

Figure 2.
The most common non-PE reasons for application to the urology outpatient clinic.

Note. ED: erectile dysfunction. LUTS: lower urinary tract symptoms

Among all patients, 18.8% (n: 101/536) were smokers and 14.1% (n: 76/536) had a concomitant disease such as *diabetes mellitus* (DM) and hyperthyroidism, which are risk factors for PE. At least one comorbidity was present in 42.1% (n: 226/536) of all patients, while 10.4% (n: 56/536) had multiple comorbidities. Among all comorbidities, the most common were *cardiovascular system* (CVS) diseases (37.6%) such as coronary artery disease, hypertension, hyperlipidemia and heart failure. The percentage of patients with a comorbidity was significantly higher in group 2 (46.6%) than in group 1 (26.7%) (p = 0.032). The increase in CVS disease (p = 0.046) and DM (p = 0.006) was statistically significant. In addition, the incidence of CVS diseases (p < 0.001) and DM (p < 0.001) was significantly higher in patients with acquired PE compared to the other groups.

The percentage of patients that complied with the recommended treatment for PE was 90.1% (n: 483/536). While at least one medical agent was given as PE treatment to 86% of these patients, psychotherapy was recommended to 4.1% of them. The most common medical agent recommended to the patients was Dapoxetine (Figure 3).

Fifty-three patients (9.9%) refused the recommended treatment. In group 1, 95.8% of the patients (n: 115/120) accepted the recommended treatment, while in group 2 this number was 88.5% (n: 368/416).

The number of patients that accepted the treatment in both groups was significantly higher than those who did not accept it (p = 0.017).

The mean age of the patients that accepted the treatment (42.5 + 12 years) was significantly lower than the mean age of those who did not accept the treatment (47.3 + 14 years) (p = 0.017) (Table 2). As the age got older, the rate of accepting the treatment decreased.

The age range with the lowest treatment acceptance rate was 60 years and over (p = 0.019). The percentage of
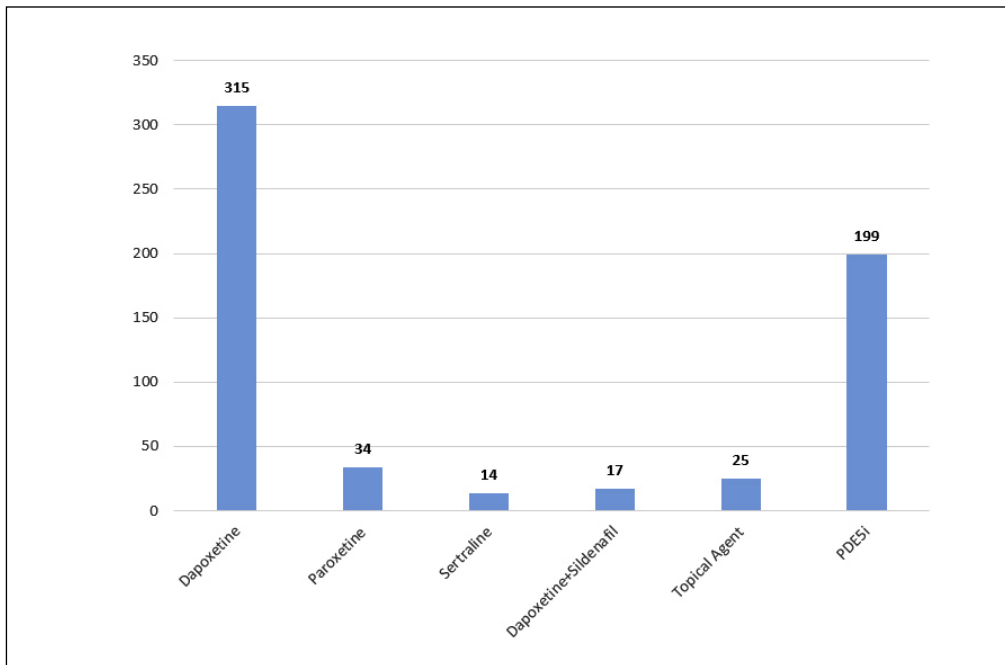
Figure 3.
Recommended medical agents for treatment.

presence of CVS (p < 0.001), oncological (p < 0.001), neurological disease (p = 0.011) and endocrine disorders (p = 0.027) except hyperthyroidism in patients who refused treatment was significantly higher than the group that accepted the treatment. When asked about the reasons for not accepting the treatment, 66% of the patients (n: 35/53) stated that they did not care to prolong their ejaculation time with treatment, so there was no treatment expectation for PE and 13.2% (n: 7/53) did not want a new medical treatment due to the use of multiple

drugs for their comorbidities (Figure 4). In group 1, 4.2% of the patients (n: 5/120) that thought that the treatment might be effective and sought treatment for PE, did not accept the treatment due to high drug cost and concerns about drug side effects.

Discussion

Premature ejaculation is considered the most common male sexual dysfunction with a prevalence rate of 20-30% (9, 16, 17). Despite this, patients suffering from PE do not easily seek medical treatment. They are mostly detected in epidemiological studies because of the use of the broad definition of sexual dysfunction. The very low help-seeking behavior of men who reported PE in previous prevalence studies indicates that referral to physician is much lower than reported (9). As a matter of fact, only 22.4% of our PE cases applied with the complaint of PE. It has been reported that cultural factors and health-related beliefs rather than socioeconomic factors such as education levels and income levels may play a more determining role in the frequency of seeking medical help for sexual problems (7). The belief that sexual problems are not medical problems, the thought that ejaculatory problems are temporary or caused by the daily stress of life, lack of information about current treatment strategies or confusion about which medical specialist to consult are listed as factors that may reduce the patient's desire to seek treatment (8). Embarrassment about discussing the situation with anyone, doubting that any medication could help them control their ejaculation, and worrying about being addicted to a drug have also been shown as reasons for not seeking treatment. In addition, nowadays there is a scientific understanding that assumes that ejaculation control is not a natural but a cultural phenomenon. *Puppo V and Puppo G* (18) reported that PE, in which ejaculation and orgasmic physiology is not impaired, is

Table 2.
Comparison of groups according to treatment acceptance.

	Total (n = 536)	Group 1 (n = 483)	Group 2 (n = 53)	P value
Age (year) (Mean ± SD)	43.06 ± 12.3	42.5 + 12	47.3 + 14	**0.017**
Age groups (year) (n, %)				**0.019**
< 30	100 (18.6)	93 (19.3)	7 (13.2)	
30-60	389 (72.6)	353 (73.1)	36 (67.9)	
> 60	47 (8.8)	37(7.7)	10 (18.9)	
PE type (n, %)				0.833
Lifelong	224 (41.8)	202 (41.8)	22 (41.5)	
Acquired	290 (54.1)	262 (54.2)	28 (52.8)	
Natural variant	14 (2.6)	14 (2.9)	-	
PLED	8 (1.5)	5 (1.1)	3 (5.7)	
Smoking (n, %)	101 (18.8)	88 (18.2)	13 (24.5)	0.265
Comorbidities (n, %)	226 (42,1)	177 (36.6)	49 (92.4)	
Cardiovasculary diseases	85 (15.8)	66 (13.7)	19 (35.8)	**< 0.001**
Oncological diseases	12 (2.3)	6 (1.2)	6 (11.3)	**< 0.001**
Neurological diseases	15 (2.8)	10 (2.1)	5 (9.4)	**0.011**
Endocrinological diseases				
- Hyperthyroidism	4 (0.7)	3 (1.9)	1 (0.6)	0.341
- Others	3 (0.6)	1 (0.2)	2 (3.8)	**0.027**
Chronic systemic diseases	30 (5.6)	25 (5.2)	5 (9.4)	0.204
Psychiatric disorder	5 (0.9)	4 (0.8)	1 (1.9)	0.407
DM	72 (13.4)	62 (12.8)	10 (18.9)	0.222

SD: Standard deviation; PE: Prematüre ejaculation; PLED: Prematüre like ejaculatory dysfunction; DM: Diabetes mellitus.

Figure 4.
Reasons for patients to refuse treatment.
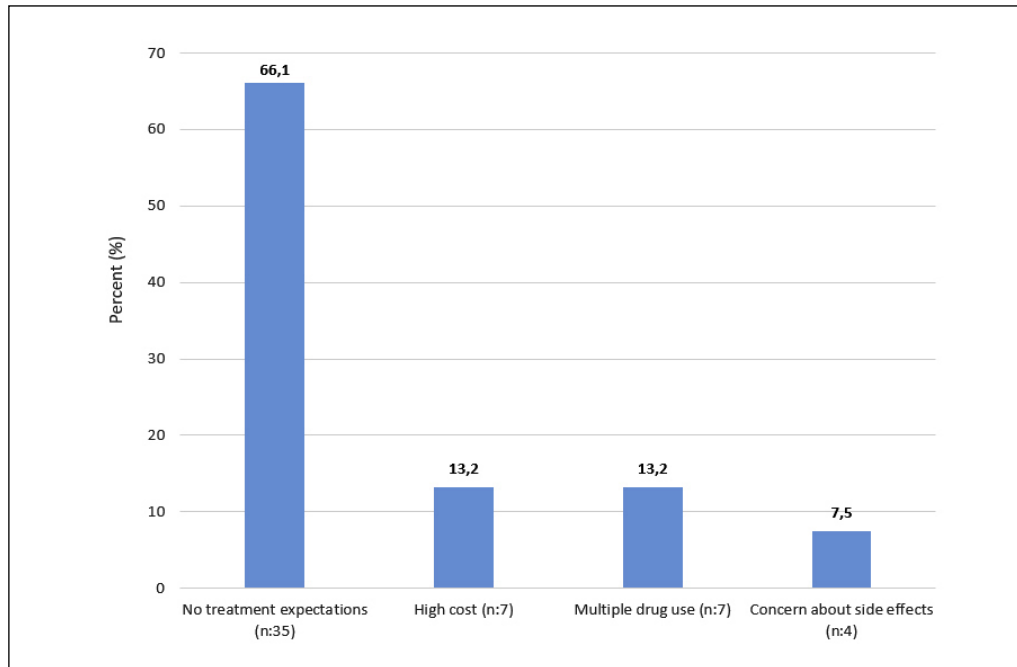
not a disease, and female orgasm can be achieved by continuing non-coital sexual acts after male ejaculation. *Jannini et al.* (1) stated that PE should be considered as a symptom rather than a disease. Consequently, 37% of men with PE reported that they have learned to live with this condition (9). *Serefoglu et al.* (19) evaluated 512 men with PE complaints and reported that 10.0% of them sought treatment for PE, 27.9% of them planned to receive treatment, and 66% did not think to consult a doctor. In the same study, the proportion of patients seeking treatment was higher in men with acquired PE (26.53%) and lifelong PE (12.77%), while it was lower in males with natural variable PE (6.47%) and PLED (1.75%). *Gao et al.* (20) showed that men with acquired PE seek more treatment (17.12% *vs* 14.58%) and plan to seek treatment (36.30% *versus* 27.08%) compared to men with lifelong PE. On the other hand, in another study *Serefoglu et al.* (21) reported that patients with lifelong PE (62.5%) seek more PE treatment than those with acquired PE (16.1%). *Zhang et al.* (22) supported this finding by reporting that the majority of 1,988 patients who applied to the outpatient clinic had lifelong PE (35.6%). These data reveal important evidence that the majority of patients seeking treatment for PE complaints are lifelong and acquired PE patients and that there is a difference in the prevalence of PE subtypes. In our study, the majority of patients seeking treatment had acquired (53.3%) and lifelong (42.5%) PE, followed by natural variable PE (4.2%) group. None of the patients presenting with PLED sought the treatment.

In the GSSAB study, 23.7% of men reported PE and 17.0% reported ED (7). Although self-reported PE is more common than self-reported ED in the literature (23) and PE is considered to be the most common self-reported male sexual dysfunction, men seek far more medical help for ED than PE (7, 24). In our study, we found that 98.1% of the patients with both PE and ED applied to the clinic due to

ED and only 1.9% due to PE. Therefore, ED appeared as a sexual problem requiring more medical help.

Various studies have shown that the presence of a comorbidity such as hypertension, obesity, DM, coronary artery disease, and stroke is associated with sexual dysfunction such as decreased libido, ED and ejaculatory dysfunction in men (25, 26). *Serefoglu et al.* (19) reported that men with PE complaints had more comorbidities compared to those without, and the incidence of all comorbidities except for neurological disorders is significantly higher in patients with acquired PE. Other studies have also revealed that men with acquired PE have a high incidence of comorbid diseases such as high mean *body mass index* (BMI), DM, hypertension, chronic prostatitis, sexual desire disorder, and ED (20, 21, 27, 28). Similarly, mean age is higher in patients with acquired PE compared to other PE subtypes (21, 22, 27). In our study, age, presence of CVS diseases and DM were significantly higher in patients with acquired PE.

The PEPA study reported that although men with PE see PE as a problem for themselves or their partners, a significant portion of them think that PE is a normal part of aging or that the problem will be solved with increasing sex frequency, therefore these patients do not seek treatment (9). In our study, the mean age of patients that applied with the complaint of PE was lower, and as the patients got older, the treatment seeking behavior and treatment acceptance rate for PE decreased significantly.

In this study, we evaluated the effects of comorbidities on seeking treatment and accepting the recommended treatment for PE and observed that people seeking treatment for PE had less comorbidities. In addition, we found that the rate of acceptance of treatment decreased significantly in the presence of CVS, neurological, oncological, and endocrine diseases. We think that decrease in treatment expectation and treatment seeking behavior for PE in presence of comorbidities is associated with unwilling-

ness to use multiple medications and possible side effects. Although majority of men do not seek help for PE, one study reported that 45% of men expected their doctors to initiate the discussion about sexual problems (10), and 60% believed that physicians should routinely question the sexual health of patients (11). While this is the case, in order to increase their general well-being, sexual health, and quality of life, it is apparent that men should be more active participants of the conversation with their physicians. As a matter of fact, we questioned the ejaculatory function of patients who applied for reasons other than PE, identified PE in 416 patients and treated PE in 88.5% of them. The majority of those who did not want treatment for PE were people who did not expect treatment to be beneficial. Although 4.2% of the patients applied to the clinic with complaints of PE, they did not accept the recommended medical treatment due to high drug cost and concern for drug side effects. To the best of our knowledge, this study is the first study in the literature that investigated the importance of ejaculation function inquiry in the detection of patients not seeking help for PE, and the effect of comorbidity on treatment seeking behavior as well as acceptance of treatment for PE. However, our study had some limitations. It is not a routine procedure of our clinic to question the sexual function of every male patient who applies to the outpatient clinic for reasons other than sexual function complaints. Physicians who do not deal with andrology do not tend to question sexual health. This situation prevented us from detecting more PE patients. There are studies suggesting that the partner should also be evaluated so that PE treatment can be optimized and results can be measured accurately (29).

The absence of an evaluation about the partner can be considered as a limitation. In addition, retrospective design of the study, the fact that some of the patients who were given treatment were not followed up regularly, and the inability to evaluate the treatment compliance and treatment results can be considered as the limitations of the study.

CONCLUSIONS
The results of this study show that men tend to seek more treatment for ED compared to PE. The treatment acceptance rate may be higher if patients that did not seek treatment for their PE complaints are reached through sexual health inquiry that include PE. This reveals the importance of such inquiry. In addition, the presence of comorbidity emerges as a factor that negatively affects the treatment-seeking behavior of men with PE, as well as treatment expectation and acceptance. Therefore, we find it useful and recommend that every patient who applies to the andrology or even urology outpatient clinic is questioned about their ejaculatory function.

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