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Premature Ejaculation in Cotonou

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Abstract

Objectives: Premature ejaculation is the most common sexual disorder whose definition is still very controversial. The purpose of this study is to assess its incidence, social impact and support in our population.

Methodology: It was a descriptive and cross-cutting study which took place in CNHU HKM and Ménontin district hospital over a period of one month from 15th May to 15th June 2016.

Outcomes: 42.2% of the study population are faced with premature ejaculation. The average age of premature ejaculators was 39.0 years ± 13.5. The average intravaginal ejaculation latency time (IELT) among premature ejaculators was 7.8 min ± 8.4 against 11.95 min ± 8.9 for non-premature ejaculators. 74.9% of respondents' partners were satisfied with the intravaginal ejaculation latency time of their spouse. Only 28.1% of premature ejaculators resorted to treatment at least once to improve their intravaginal ejaculation latency time.

Conclusion: Premature ejaculation is a cross-cutting issue in the population but the absence of consensus on its parameters prevents a satisfactory research.

Keywords: Premature ejaculation; Sexuality; Ejaculation; Sexual disorders; Sex; Erection

Introducton

Premature ejaculation (PE) is the most widespread [1] sexual disorder among men. It affects 5 to 40% of sexually active men, with age-based variations [2]. Its diagnosis involves several parameters such as intravaginal ejaculatory latency time, personal satisfaction and the impact on the couple [3]. The difficulty of obtaining unanimity in the definition of premature ejaculation explains the poverty of epidemiological data on this affection [3,4]. It is a very embarrassing medical condition which is based on the patient's medical history and self-diagnosis. It should be stressed from the outset that, not all men who ejaculate early are sufferers. Furthermore, the determinants of the suffering remain poorly known [5]. Rarely do we make the distinction between primary and secondary PE, yet the clinical form determines the choice of the therapeutic strategy and its effectiveness. The objective of this study is to assess the magnitude of this medical condition in our population as well as its impact on the quality of life in Benin population.

Methodology

It was a multicenter study conducted at Ménontin district hospital (second-rank hospital) and Hubert KOUTOUKOU MAGA teaching hospital (national referral hospital) based on national health pyramid. This cross-cutting and descriptive study was conducted for one month, from 15th May to 15th June 2016. The study population included all sexually active men who were present on the different healthcare centers during the study period. Sampling technique was essentially a comprehensive census. All sexually active men present in the healthcare centers irrespective of the purpose of their consultation were included in this study. Studied variables related to epidemiological aspects, its impact on the couples and the different therapeutic approaches.

Conduct of the survey

This survey was conducted with the consent of the different authorities of healthcare centers involved in our study and urology residents (n=4). These residents were well trained on the basis of a survey form established and tested for the purpose of its reliability and understanding by the respondents. The items on this survey form helped to assess: Patients' age, The level of understanding of the population with regards to premature ejaculation, Respondents' intravaginal ejaculation latency time, Premature ejaculation impact a on the couple. During the 30-day study, the trained physicians were dispatched in the different healthcare centers to administer the questionnaires to every man meeting the inclusion criteria. Patients with proven level of education filled the questionnaire themselves, while the illiterate were supported by the trained physician. After data collection conducted on the field, daily data check was carried out by the collection team in order to prevent duplicates and questionnaire completion errors. The main difficulties of this study were primarily the inaccessibility of the spouse and the lack of objective measure. However, anonymity allowed achieving expected results.

Data processing and analysis

Our analysis consisted in making a simple description (Tables 1) of incidence, average, standard deviation, median, graphs) of different variables taken into account in our study. Statistical tests were CHI2 or Fisher depending on the case. Tolerated statistical significance is 5%. Data editing and processing were conducted using MS Word 2007, Excel 2010 and SPSS21.

		Patients with PE		Total	
		Yes	No	Undetermined	
Group age	19-29	34	52	1	87
	30-40	43	55	0	98
	41-51	26	26	0	52
	>51	25	41	0	66
Total		128	174	1	303

Table 1: Distribution of age groups on the basis of PE incidence: There is a predominance of PE in the class of 30 to 40 years.

Ethical consideration

Each respondent gave his informed consent prior to responding to the questionnaire. Compliance with anonymity was observed. We also obtained the hospitals' consent. There is no conflict of interest in the realization of this study.

Outcomes

Epidemiological features

Three hundred and three men responded to our questionnaire. The average age was 39.02 years ± 14.40 with extremes of 19 and 85 years. The average age of those who identified themselves as premature ejaculators was 39.0 years ± 13.5. Half of our respondents were civil servants (52.5%), followed by pupils/students (13.9%). The least represented were traders (5%). A survey on the general knowledge of respondents revealed that 51.2% were able to respond appropriately to the definition of ejaculation, while 63.4% were able to define premature ejaculation.

Diagnostic Features

Types of premature ejaculation

Among patients who identify themselves as PE, 45.7% have been experiencing this condition since their first sexual intercourse. 50.4% had a secondary premature ejaculation. In our study, the medium IELT among PE was 7.8 min ± 8.4 against 11.95 min ±8.9 for non-PE. Among those who identify themselves as PE, 34% had ejaculation latency time between 0-3 min, 62.5% higher than 3 min and 3.1% were not been able to precise (vertical analysis) (Table 2).

	Number of respondents (n)	Percentage (%)
Identify themselves to suffer from PE	128	42.2
Do not identify themselves to suffer from PE	174	57.4
Undetermined	1	0.4
Total	303	100

Table 2: Distribution of patients based on existence or non-existence of premature ejaculation: All performances combined, 42% of respondents identify themselves suffering from PE.

Impact on the couple's life

210 (69.3%) partners out of 303 respondents were satisfied with their spouse's IELT. Spouses of 11.9% of respondents had an IELT between 0-3 min. 83.8% had an IELT above 3 min. Out of 303 respondents, 227 were satisfied with their sexual intercourse. Among those satisfied, 12.3% had an IELT between 0-3 min; 84.1% had an IELT above 3 min.

Therapeutic and scalable modality

Seventeen percent (or 52) of the respondents and 28.1% (or 36) of those who identify themselves as PE (or 128) underwent at least once a treatment to improve their IELT. 76.9% (out of 52) performed self-medication and the most frequently used drugs were herbal treatment and sildenafil in respectively 35% and 27.5% cases. 23.1% went for medical consultation and their primary prescription was sildenafil in 50% of cases. The efficacy of medical treatment was considered satisfactory in 41.7% of cases.

Discussion

PE has always been a worrying condition whose research of the mechanism has raised several theories: psychogenic, neurobiological, genetic and hormonal [6]. Among our respondents (303), 42.2% identified themselves as PE while 57.4% did not. Based on a limit IELT of 3 min, only 19.5% were PE against 75.5%. But yet, among respondents whose intravaginal ejaculation latency time is above 3 min, 62.5% complained of PE. Waldinger et al. reported that premature ejaculation affected 5 to 40% of sexually active men [7]. Some authors consider an ejaculation occurring one to seven minutes after penetration as pathology. Others define PE based on the number of movements of the erect penis, considering that 15 movements or less constitute PE (Tables 3 and 4) [7,8]. Another definition is the inability to willfully delay ejaculation before the partner's orgasm in at least 50% of sexual intercourse.

	Number of respondents (n)	Percentage (%)
PE	59	19.5
Non PE	229	75.5
Undetermined	15	5
Total	303	100

Table 3: Distribution of respondents based on intravaginal ejaculation latency time (3 min): Considering a satisfactory of intravaginal ejaculation latency time of 3 min, 19.5% of the respondents then recognize themselves suffering from PE.

			Patients identifying themselves as PE			Total
			Yes	No	Undetermined	
Duration	0-3 min	**Total**	44	14	1	59
		% included in PE according to latency time	74.6%	23.7%	1.7%	100.0%
		% included in patients with PE	34.4%	8.1%	100.0%	19.5%
	>3 min	Total	80	149	0	229
		% included in PE according to latency time	34.9%	65.1%	0.0%	100.0%
		% included in patients with PE	62.5%	86.1%	0.0%	75.8%
	Undetermined	Total	4	10	0	14
		% included in PE according to latency time	28.6%	71.4%	0.0%	100.0%
		% included in patients with PE	3.1%	5.8%	0.0%	4.6%
Total		Total	128	173	1	302
		% included in PE according to latency time	42.4%	57.3%	0.3%	100.0%
		% included in patients with PE	100.0%	100.0%	100.0%	100.0%

Table 4: Distribution of respondents who identify themselves as premature ejaculators based on intravaginal ejaculation latency time: For an intravaginal ejaculation latency time of less than or more than 3 minutes, there are still some respondents who think they are suffering from PE.

PE can also be defined as the recurrent or persistent inability to voluntarily delay ejaculation [5]. Given that there is no consensus on the definition [9], criteria for the classification of PE and non-PE remain ambiguous. This would then involve the cultural and sociological aspects of each individual. The average age of respondents was 39.02 years ± 14.40 with 19 and 85 years as extremes. Respondents who identify themselves as premature ejaculators were aged 39.0 years ± 13.5. Most of the time, PE among young patients is psychogenic. It is associated with the first sexual intercourse which was precipitated and the vicious cycle which settles down afterward. Psychological problems play an important role in the onset or persistence of premature ejaculation including anxiety and depression [10]. PE could also relate to having multiple partners with different experiences or the desire to accomplish pornographic scenes performance. Among elderly patients, organic causes are predominant: sexually transmitted diseases and prostatitis. According to Raymond et al. coll, among NHSLS respondents, the answer as to ejaculate prematurely or reach the peak did not differ across the studied age groups (approximately 18 to 29 years, 30 to 39 years, 40 to 49 and 50 to 59 years) [11]. PE prevalence, diagnostics based on PEDT (Premature Ejaculation Diagnostic Tool) score and self-declaration increased with age, according to Lee et al. [12]. Apart from age, other risk factors were mentioned such as lack of exercise, obesity and tobacco and alcohol consumption [13]. Based on diagnosis, the difficulty associated with the definition of PE makes it difficult to confirm PE clinically. In this case, the diagnosis would be inherently subjective in the absence of measurement tools. The optimization of this diagnostic involves IELT. In our study, the medium IELT among PE was 7.8 min ± 8.4 against 11.95 min ± 8.9 for non-PE. In a population of rats, ejaculation latency time follows a continuum according to Pattij et al. graph. The same pattern is found among men (from 0.55 to 44 minutes through an average of 5.4 minutes), asserting the existence of ejaculation latency time endophenotypes [14]. This overlapping of IELT among PE and non PE is attributed to the absence of consensual IELT. Out of 128 respondents who identify themselves as PE (on the basis of their IELT, and or their satisfaction and their partner's satisfaction), 34% have IELT between 0-3 min, 62.5% above 3 min and 3.1% were unable to precise. Giuliano F. et coll reported that in their PE population, 20% had IELT below one minute; 31% had IELT between one to two minutes; 21% two to four minutes [8]. Deok and Coll reported 28% of respondents ejaculating in less than 3 min [15]. The result of our study could be explained by the fact that our respondents referred much more to their personal

satisfaction and/or that of their partner to define premature ejaculation. They have no standard IELT. In our study, less than half of the partners (37.8%) was dissatisfied with the IELT (0-3 min). This result remains subjective because emanating from respondents. With regards to respondents' personal satisfaction, 227 were satisfied with their sexual activity. Among those satisfied, 12.3% had IELT between 0-3 min; 84.1% had IELT above 3 min. Two hundred and ten (69.3%) partners out of the 303 respondents were satisfied with their spouse's IELT. Spouses of 11.9% had IELT between 0-3 min. 83.8% had IELT above 3 min. The partner's sexual satisfaction is reported as low or very low among 61.8% against 10.1% among non PE [16]. The low rate of dissatisfied men and women would no doubt be associated with the low rate of identified PE or latency time, and also the subjective nature of the answers provided because female partners were not questioned. Several treatment approaches have been proposed taking into account the different theories supporting the occurrence of PE. Behavioral, psychological and medicinal therapies [4,17]. During our study, 17.1% (or 52) of respondents and 28.1% (or 36) of those who identify themselves as PE (or 128) underwent at least once a treatment to improve their IELT. The low treatment rate among PE is probably linked to the belief that intake of sexual performance-enhancing drugs would be detrimental to health in long-term. This fear is even greater in the so-called modern treatments. 76.9% (out of 52) performed self-medication and the most frequently used drugs were herbal treatment and sildenafil in respectively 35% and 27.5% cases. Self-medication provided sound improvement in 47.5% of cases against no improvement in 32.5%. Self-medication recorded higher rating than medical consultation because sexual dysfunction is a taboo subject owing to cultural considerations. Patients dare not discuss such issue with physicians and physicians themselves rarely ask this question [18]. Therefore, they tend to rely upon pieces of advice from their acquaintances. Most of them resort to herbal medicine because it is easily accessible and sometimes in total discretion. Drugs used in the treatment of erectile dysfunction also have an interest in PE treatment. First, through a possible specific action on ejaculation, a study having revealed the presence of IPDE5 in the vas deferens [19,20]. Secondly, their use decreases performance-related anxiety and the advantage of delay before ejaculation is almost constant. Finally, by reducing the refractory period, these treatments allow a second sexual intercourse in case of premature ejaculation, and in general it lasts longer [19,20] [Table 5 and 6].

			Partner's satisfaction			Total
			Yes	No	Undetermined	
Duration	0-3 min	Total	25	34	0	59
		% included in PE according to latency time	42.4%	57.6%	0.0%	100.0%
		% included in partner's satisfaction	11.9%	37.8%	0.0%	19.5%
	>3 min	Total	176	52	1	229
		% included in PE according to latency time	76.9%	22.7%	0.4%	100.0%
		% included in partner's satisfaction	83.8%	57.8%	50.0%	75.8%
	Undetermined	Total	9	4	1	14
		% included in PE according to latency time	64.3%	28.6%	7.1%	100.0%
		% included in partner's satisfaction	4.3%	4.4%	50.0%	4.6%
Total		Total	210	90	2	302
		% included in PE according to latency time	69.5%	29.8%	0.7%	100.0%
		% included in partner's satisfaction	100.0%	100.0%	100.0%	100.0%

Table 5: Distribution of partners' satisfaction based on respondents' intravaginal ejaculation latency time.

			Personal satisfaction			Total
			Yes	No	Undetermined	
PE according to latency time	0-3 min	Total	28	31	0	59
		% included in PE according to latency time	47.5%	52.5%	0.0%	100.0%
		% included in personal satisfaction	12.3%	42.5%	0.0%	19.5%
	>3 min	Total	191	37	1	229

		% included in PE according to latency time	83.4%	16.2%	0.4%	100.0%
		% included in personal satisfaction	84.1%	50.7%	50.0%	75.8%
	Undetermined	Total	8	5	1	14
		% included in PE according to latency time	57.1%	35.7%	7.1%	100.0%
		% included in personal satisfaction	3.5%	6.8%	50.0%	4.6%
Total		Total	227	73	2	302
		% included in PE according to latency time	75.2%	24.2%	0.7%	100.0%
		% included in personal satisfaction	100.0%	100.0%	100.0%	100.0%

Table 6: Distribution of respondents' satisfaction according to their intravaginal ejaculation latency time.Personal satisfaction is more important in the case the intravaginal ejaculation time is greater than 3 min.

Conclusion

Premature ejaculation is a serious issue prevailing in the population, but the absence of consensus on its parameters prevents an appropriate exploration. The challenge is to determine clear diagnostic standards, known to all and specific to each type of population according to their socio-cultural considerations.

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