

Premature ejaculation among men attending in the sex clinic of a tertiary level psychiatric hospital

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Summary

Premature Ejaculation (PE) has been considered as the most common male sexual dysfunction having significant adverse effects on the quality of life of the men and their sexual partners. The objective of the study was to determine the proportion of PE among men attending in the sex clinic of National Institute of Mental Health (NIMH), Dhaka, Bangladesh. This was a descriptive cross-sectional study conducted from August 2017 to June 2018 among the purposively selected 280 patients. The patients were of 18 to 60 year, and sexually active during at least the past 6 months. A semi-structured self-administered questionnaire, containing socio-demographic and clinical variables and Bangla version of Premature Ejaculation and Diagnostic Tool (PEDT) were used to assess PE. Results showed that mean (\pm SD) age of the respondents was 38.8 (\pm 8.44) years. 26.4% of the respondents were found to have Premature Ejaculation. Among the PE subtypes, lifelong PE, acquired PE, natural variant PE, and premature-like ejaculatory dysfunction, was 20.3%, 24.3%, 25.7% and 29.7% respectively. Presence of PE was slightly higher among the younger age (aged 20-40 years) group (51.1%) than the older age (aged 41-60 years) group (48.9%). Intra-vaginal ejaculatory latency time (IELT) of 51.1% of men was >3 minutes, 38.2% of men in the range of 2-3 minutes and that of 10.7% men was <1 minute. The high prevalence and adverse consequences illustrate the need for promoting awareness and standardized methods of PE diagnosis, assessment and treatment.

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Introduction

Premature ejaculation (PE) has been considered as the most common male sexual dysfunction.¹ The impact of PE is mostly felt psychologically and in interpersonal relationships² and it can have a significant adverse effect on the quality of life for the patient and his sexual partner's. Throughout history, PE has been defined in many ways by several professional organizations and individuals.³⁻⁶ The Diagnostic and Statistical Manual of Mental Disorders, 4th edition, text revision (DSM-IV-TR) by the American Psychiatric Association (APA) defines PE as persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it, with the disturbance causing marked distress or interpersonal difficulty and is not due exclusively to the direct effects of a substance (e.g., withdrawal from opioids).⁵ Most of these definitions are considered to be authority based rather than evidence based.⁷ To overcome the shortcomings of former definitions, the International Society for Sexual Medicine (ISSM) Ad Hoc Committee of international experts in PE adopted a completely new evidence-based definition of PE in 2014. They classified premature ejaculation as lifelong or acquired, and proposed inclusion of an objective, quantifiable time to ejaculation, which is referred to as the intra-vaginal ejaculatory latency time (IELT). The IELT is defined as the time from vaginal penetration to ejaculation. Lifelong premature ejaculation is characterized by an IELT of <1 minute since first intercourse, whereas IELT of <3 minutes at any point in a man's life is considered to be acquired premature ejaculation.⁸ But in reality, two more PE subtypes are present named 'natural variable PE' and 'premature-like ejaculatory dysfunction' which are considered to be authority based rather than evidence-based. Men with natural variable PE experience coincidental and situational rapid ejaculations, whereas men with premature-like ejaculatory dysfunction complain of PE in spite of normal, or even long ejaculation latency time.⁹ So, with the varying definitions of PE the prevalence of PE differs. On average, most studies reported a prevalence ranging from 20 % to 31.6%.¹⁰⁻¹⁵ There are very few published literatures on psychosexual dysfunction in Bangladesh and there is no established data regarding the prevalence of PE in Bangladesh, so far. Based on this fact, this study was designed to determine the prevalence of PE among men attending in sex clinic, NIMH, Dhaka, Bangladesh.

Materials and methods

This was a descriptive cross-sectional study conducted from August 2017 to June 2018, among men attending in Sex clinic of NIMH, Dhaka, Bangladesh. A sample size was calculated using a single proportion formula to determine the prevalence of PE.¹⁶ Considering the prevalence of men with confirmed PE of 20.3%¹⁷ and precision of .05 with 95% confidence interval, the minimum required sample size was 267. After considering a non-response rate of 5%, a total sample size of 280 men was needed. Men aged 18-60 years who were sexually active for at least 6 months prior to the study were selected by purposive sampling technique. Those with unstable psychiatric illnesses, mental retardation, illiteracy were excluded. Before data collection, the patients were provided with information related to the study along with an information and consent form. Confidentiality was ensured, and written informed consent was taken. For data collection, a semi-structured questionnaire in Bengali prepared by the researcher containing socio-demographic and other variables was distributed to the respondents. The Bengali version of Premature Ejaculation Diagnostic Tool (PEDT) was applied to diagnose premature ejaculation (PE). The PEDT has a high level of agreement with the clinical diagnosis (according to DSM-IV-TR) and good test-retest reliability with an interclass correlation co-efficient of 0.888.^{17,18} It consists of 5 items with 5 domains (ejaculatory control, frequency, minimal stimulation, distress and interpersonal difficulty) with 5- Likert scale (0-4) and the score-range from 0 to 20. A score of < 8 indicates no PE; 9 & 10 indicates probable PE; and >11 indicates confirmed PE. In this study, the PE cases included confirmed and probable cases of PE based on a Premature Ejaculation and Diagnostic Tool (PEDT) score of >9.¹⁹ The English version of PEDT was translated and validated into Bengali by a local psychiatrist and consent was taken from him to use the tool in this study. After proper processing and handling, data were encoded. Analysis was done by Statistical Package Social Sciences (SPSS) for windows version 16. After thorough cleaning and editing of data, descriptive analyses were done and findings were presented by frequency tables and graphs.

Results

The study identified socio-demographic and clinical characteristics of the respondents including age, religion, habitat, education, occupation, self-estimated IELT. A total of 280 men out of 290 eligible men responded with a response rate of 96.6%. The prevalence of PE among the men attending in sex clinic of NIMH, Dhaka, Bangladesh was 26.42% (n=74) (Figure 1). The prevalence of PE subtypes, namely, lifelong PE, acquired PE, natural variant PE, and premature-like ejaculatory dysfunction, were 20.3% (n=15), 24.3% (n=18), 25.7% (n=19) and 29.7% (n=22) respectively. (Figure 2). The mean (\pm SD) age of the respondents was 38.8 (\pm 8.44) years and mean (\pm SD) duration of relationship was 10.35 (\pm 8.44) years. 51.1% of the respondents were in age group of 20-40 years and 48.9% of them were in age group of 41-60 years. 52.1% of them studied upto primary and secondary level. Majority (74.5%) of the respondents resided in urban area and rest (25.5%) of them resided in rural area. Most of the respondents were Muslim (95%) and (5%) was found as Hindu. Almost two-third of the respondents (68.6%) were employed (Table 1).

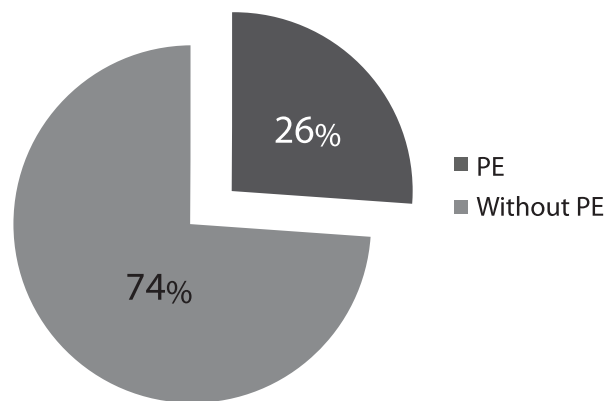


Figure 1: Proportion of the respondents with PE (n=280)

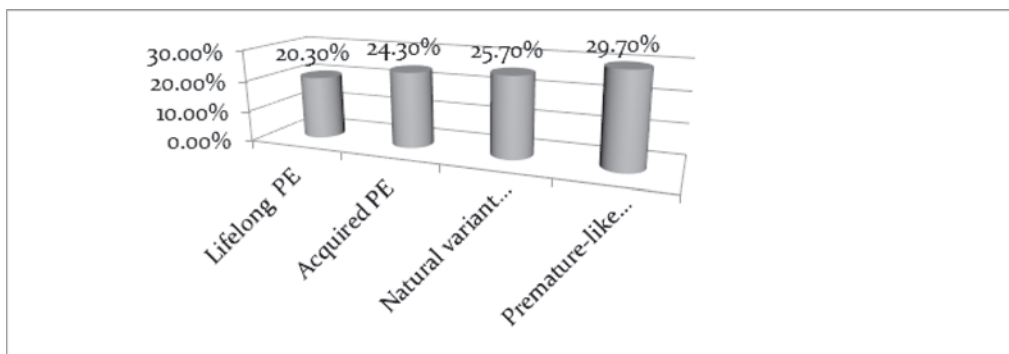


Figure 2: Proportion of PE subtypes among men with PE (n=74)

Table 1: Socio-demographic characteristics of the respondents (n=280)

Characteristics	Frequency	Percentage
Age (years)		
20-40	143	51.1
41-60	137	48.9
Habitat		
Rural	70	25.5
Urban	210	74.5
Religion		
Islam	266	95
Hindu	14	5
Education		
Primary and secondary	146	52.1
Graduation and post-graduation	134	47.9
Occupation		
Employed	192	68.6
Unemployed	88	31.4

Discussion

Due to the absence of universally accepted PE definition, many prevalence studies conducted in the past reported conflicting results.^{20,21} In this study, the PE cases included confirmed and probable cases of PE based on a Premature Ejaculation and Diagnostic Tool (PEDT) score of > 919 and proportion of premature ejaculation was found 26.4% (74 out of 280 men), which was consistent with previously reported majority of the study findings.¹⁰⁻¹⁵ Due to the unavailability of published data on premature ejaculation among men in Bangladesh, we could not compare the results in Bangladesh context. In Malaysia, studies have reported prevalence of PE of 29.0%²² and 49.1%.¹⁷ First one is almost consistent with our study findings and the later study, which applied a similar methodology, a PEDT questionnaire, an operational definition, and was conducted in a clinical setting, but involved diverse ethnic groups, showed a much higher prevalence. Variations in culture and religion may contribute to this difference. In the present study, the proportion of PE subtypes, namely, lifelong PE, acquired PE, natural variant PE, and premature-like ejaculatory dysfunction, was 20.3%, 24.3%, 25.7% and 29.7% respectively. A well conducted study among men attending in a primary healthcare clinic in Kelantan, Malaysia using the same scale and similar methods detected those of the PE subtypes, 7.9%, 15.9%, 58.7%, and 17.5% respectively. This big difference may be explained by the difference in the study population, sample size and the study place. A recent epidemiological study conducted in Turkey found the prevalence of lifelong, acquired and natural variable PE, and premature-like ejaculatory dysfunction 2.3%, 3.9%, 8.5% and 5.1%, respectively.²³ This difference in proportion of PE-subtypes may be explained by the fact that this Turkish study was acquired a different approach i.e. they collected data from randomly selected 17 provinces of Turkey, they didn't apply any scale to diagnose PE and collected data by asking both partners. Whereas our study was conducted in 1 purposively selected Tertiary care hospital, Bengali version of PEDT was applied for diagnosis of PE. In our study, 51.1% of the respondents were in age group of 20-40 years and 48.9% of them were in age group of 41-60 years. Although data on the prevalence of PE according to age are limited, there is a widespread belief that the prevalence of PE decreases with age. Data from the 2004 survey of more than 11,500 men in the United States, Germany and Italy showed that the prevalence of self-reported PE was constant across age groups ranging from 18 to 70 years.²⁴ These studies had limitations

because they did not follow men longitudinally to assess changes in IELT with age. In another study of the Italian Society of Andrology with a sample of 12,558 men attending the Andrology Prevention Week 2001, it was shown that men with PE were younger than those without, but after adjusting for concomitant erectile dysfunction the risk of PE significantly decreased with aging.²⁶ So, it appears that the belief that the prevalence decreases with age is not fully supported by current data and more study is needed. In our study, 52.1% of them studied up to primary and secondary level and 47.9% studied up to graduate and post-graduate level. Illiterate people were excluded. Almost two-thirds of the respondents (68.6%) were employed and rest of them were un-employed. Different studies in other countries reported mixed findings with regard to socio-demographic factors, such as educational and economic status.²⁵ In another study, it was found that men who are more educated had a slightly increased risk. It was also found that stress related to socioeconomic status also increase the risk for PE.²⁶ In our study, majority (74.5%) of the respondents resided in urban area and rest (25.5%) of them resided in rural area. Most of the respondents were Muslim (95%) and rest of them (5%) was found as Hindu. Data regarding the association between habitat and religion with PE is scarce. So more study needed regarding these issues. Though optimum care had been taken by the researcher, still there are some limitations. The study was conducted in one purposively selected hospital in one city of Bangladesh. So, there might be some selection bias which limits the generalization of the results of all PE patients of Bangladesh. Moreover, in this study, patients with unstable psychiatric illnesses, mental retardation, illiteracy were excluded. But, in these groups of patients there might have some PE patients. So, there was a probability of underestimation of PE prevalence.

Conclusion

In this study, proportion of premature ejaculation was found 26.4% (74 out of 280 men) and the proportion of PE subtypes, namely, lifelong PE, acquired PE, natural variant PE, and premature-like ejaculatory dysfunction, were 20.3%, 24.3%, 25.7% and 29.7% respectively. Despite of a number of limitations, this study will provide a brief report on the area of sexual health and serve as a basis for further analytical epidemiological studies in this area.

References

1. Montorsi F. Prevalence of premature ejaculation: a global and regional perspective. *J Sex Med* 2005;2 Suppl 2(s2):96-102.
2. Symonds T, Robin D, Hart K, Althof S. How does premature ejaculation impact a man's life? *J Sex Marital Ther* 2003;29:361-70.
3. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Text Revision*. Washington, DC: American Psychiatric Publishing Inc.;1980.
4. World Health Organization. *International Classification of Diseases and Related Health Problems*. 10th ed. Geneva: World Health Organization;1994.
5. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Text Revision*. 4th ed. Washington, DC: American Psychiatric Publishing Inc.;2000.
6. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Arlington,VA: American Psychiatric Association;2013.
7. McMahon CG, Althof S, Waldinger MD, Porst H, Dean J, Sharlip I, et al. An evidence-based definition of lifelong premature ejaculation: report of the International Society for Sexual Medicine Ad Hoc Committee for the Definition of Premature Ejaculation. *BJU Int* 2008;102:338-50.
8. 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. *Sex Med* 2014;2:41-59.
9. Waldinger MD. Recent advances in the classification, neurobiology and treatment of premature ejaculation. *Adv Psychosom Med* 2008;29:50-69.

10. Porst H, Montorsi F, Rosen RC, Gaynor L, Grupe S, Alexander J. The Premature Ejaculation Prevalence and Attitudes (PEPA) survey: prevalence, co-morbidities and professional help-seeking. *Eur Urol* 2007;51(3):816-24.
11. Adaikan PG, Lim P, Ng KK, Fock EL. Asian perspective: premature ejaculation prevalence and attitudes (PEPA) among Singaporean men. *J Men's Health* 2011;8(S1):884-6.
12. Park HJ, Park JK, Park K, Lee SW, Kim SW, Yang DY, et al. Prevalence of premature ejaculation in young and middle-aged men in Korea: a multicenter internet-based survey from the Korean Andrological Society. *Asian J Androl* 2010;12(6):880-9.
13. Silangcruz JMA, Chua ME, Morales ML. Prevalence and factor association of premature ejaculation among adult Asian males with lower urinary tract symptoms. *Prostate Int* 2015;3(2):65-9.
14. Quek KF, Sallam AA, Ng CH, Chua CB. Prevalence of sexual problems and its association with social, psychological and physical factors among men in a Malaysian Population: a cross-sectional study. *J Sex Med* 2008;5(1):70-6.
15. Gao J, Xu C, Liang C, Su P, Peng Z, Shi K, et al. Relationships between intra-vaginal ejaculatory latency time and National Institutes of Health-Chronic Prostatitis Symptom Index in the four types of premature ejaculation syndromes: a large observational study in China. *J Sex Med* 2014;11(12):3093-101.
16. Daniel WW. Determination of sample size for estimating proportion. *Biostatistics: a foundation for analysis in the Health Science*. 8th ed. Hoboken, NJ: John Wiley & Sons; 2005.
17. Tang WS, Khoo EM. Prevalence and correlates of premature ejaculation in a primary care setting: a preliminary cross-sectional study. *J Sex Med* 2011;8(7):2071-8.
18. 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. *J Sex Med* 2014;11(6):1392-1422.
19. Symonds T, Perelman MA, Althof S, Giuliano F, Martin M, May K, et al. Development and validation of a premature ejaculation diagnostic tool. *Eur Urol* 2007;52(2):565-73.
20. Waldinger MD. The neurobiological approach to premature ejaculation. *J Urol* 2002;168: 2359-67.
21. 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.
22. 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(2):454-65.
23. Serefoglu EC, Yaman O, Cayan S, Asci R, Orhan I 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;8:1177-85.
24. Porst H. Factors related to seeking treatment for premature ejaculation: results from the Premature Ejaculation Prevalence and Attitudes (PEPA) Survey. Presented at 7th Congress of the European Society for Sexual Medicine, London, United Kingdom, December 5-8, 2004.
25. Laumann EO, Paik A, Rosen RC. Sexual dysfunction in the United States: prevalence and predictors. *JAMA* 1999;281(6):537-44.
26. Fasolo CB, Mirone V, Gentile V, Parazzini F, Ricci E. Andrology Prevention Week centers; Premature ejaculation: prevalence and associated conditions in a sample of 12,558 men attending the andrology prevention week 2001- a study of the Italian Society of Andrology (SIA). *J Sex Med* 2005;2(3):376-82.