CASE REPORT

Premature Ejaculation: Response to Increasing the Frequency of Ejaculation. Report of a Case.

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Abstract

Background: Premature ejaculation (PE) is currently the most common form of sexual dysfunction in men. A good clinical history remains the best diagnostic method. Increasing the frequency of sexual intercourse between couples who experience PE has not been previously known to increased their self-reported Intravaginal ejaculation latency time. **Case presentation**: A case is reported of a couple who had been diagnosed with acquired premature ejaculation of 3 years duration with self-reported intravaginal ejaculatory latency time of 2 to 3 minutes. While participating in a study on the effect of increasing frequency of ejaculation on the serum prostate specific antigen level which required their having sexual intercourse 2 to 3 times a week, their self-reported intravaginal ejaculation latency time increased to 30 minutes. **Conclusions**: Increasing the frequency of sexual intercourse may be an additional armamentarium in the treatment of couples who have acquired premature ejaculation.

Key Words: Acquired premature ejaculation, Intravaginal ejaculatory latency time, Frequent ejaculation.

Introduction

Premature ejaculation (PE) is the most prevalent sexual dysfunction in men.[1] The definition of PE has remained controversial but it is now widely accepted that three features must be included, namely: short interval between vaginal penetration and ejaculation, lack of control over ejaculation and distress felt by one or both partners.[2] Based on the presumed etiologic factors in PE which have included penile hypersensitivity, rapid serotonin reabsorption at synaptic junctions, hormonal factors, urologic comorbidities, behavioural and psychogenic factors[3], a number of investigative tools came into use in the evaluation of patients with PE. These have included the use of patient reported outcome (PRO) questionnaire (Rowland et al)[4], Index of penile erection (IPE) (Althof et al) [5], Premature ejaculation detection tool (PEDT) (Symonds et al)[6], Premature ejaculation profile (PEP) (Patrick et al)[7], Intravaginal ejaculation latency time (IELT) (Waldinger et al)[8], and Penile biotensiometry[2] among others.

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However, because of the pre-existing and lingering inconsistencies in the definition of PE, none of these gives a result that is absolutely diagnostic of the condition.

The available methods of treatment have included behavioural modifications, psychotherapy, pharmacotherapy with topical application of agents to reduce penile hypersensitivity, Selective serotonin reuptake inhibitors and surgical ablation of the dorsal penile nerves[2]. However, all current treatment methods available for PE have their limitations and complications and other novel drugs and procedures require further studies to determine their efficacy and safety profile.[2] We report a case of PE which became corrected by increasing the frequency of sexual intercourse.

Case Presentation

Mr A.A. is a 60year old who presented with a 3-year history of premature ejaculation associated with mild storage lower tract urinary symptoms. He had had occasional sexual intercourse in the preceding 3 years each of which ended in frustration of the couple due to ejaculation which occurred within 2 to 3 minutes of intromission. He had tried the stop and start method of treating the PE and had used tricyclic antidepressants without must success. He could not afford Dapoxetine. He had no comorbidities. The findings on general physical examination were normal. Digital rectal examination revealed a moderately enlarged benign prostate gland. His international prostate symptom score was 5. His

serum prostate specific antigen (PSA) was 13.4ng/ml Following a 3 week course of a quinolone, his PSA dropped by over 75%. Based on this, he was considered for recruitment into an ongoing study into the effect of increasing frequency of ejaculation on the serum PSA levels of patients whose serum PSA decreased significantly following a course of antibiotics.

As part of obtaining an informed consent from his wife before enrolling the couple into the study, she was called on the phone as was detailed in the ethically approved study protocol and was duly informed about the study and the need to secure her cooperation to participate. She was initially reluctant. Her reason was that her husband had PE and she had not engaged him much in sexual intercourse in the preceding 3 years because of the frustration she experienced each time she did. However, after some persuasion that increasing the frequency of ejaculation was expected to keep her husband's serum PSA below the grey zone that would raise the suspicion of possible carcinoma of the prostate gland, she consented. Her role in the study was to surreptitiously engage her husband in sexual intercourse 2 to 3 times a week without telling him why she was doing it since he was blinded in the study as in the approved study protocol.

His initial serum PSA level was 13.4ng/ml. This dropped to 2.9ng/ml following a 3 week course of a quinolone. At the end of the first month of participating in the study, his serum PSA dropped to 1.3ng/ml and further to 1.13ng/ml at the end of the second month. However, it rose slightly to 1.17ng/ml at the end of the third month. His wife was contacted on the phone to find out why the serum PSA rose in the 3rd month. She complained that her husband now takes sometimes up to 30 minutes after intromission to ejaculate and she often gets tired before he does. Therefore, for the past month, she had not had sexual intercourse with him. She then agreed to reduce the frequency of sexual intercourse to once or twice a week from the 2 to 3 time a week hitherto, instead of stopping completely. Her husband's serum PSA subsequently dropped to 1.1ng/ml at his last visit 2 months later.

Although PE is currently the most common sexual dysfunction, it is underdiagnosed and could actually be more common than thought, especially in locations where fast ejaculation is seen as a sign of masculinity[10]. A good clinical history remains the best diagnostic method. All current methods of treatment have their limitations and complications and their beneficial effects are not sustained.

Our patient's initial problem was acquired PE with a self-reported IELT of less than 3 minutes, causing a distress for both him and his wife. Because of the accompanying frustration, they only engaged in sexual activity occasionally. They had tried some of the available methods of treating this without much success and were unable to afford Dapoxetine which cost the equivalent of a month's minimum wage per dose in this country.

When they started participating in a study which required them to be having sexual intercourse 2 to 3 times a week, the patient developed delayed ejaculation by the 2nd month with self-reported ejaculation latency time (IELT) of up to 30minutes. When they reduced their frequency of sexual intercourse to 1 to 2 times a week, they were able to achieve a mutually convenient balance in their self-reported intravaginal ejaculatory latency time.

Conclusion

It would appear from this case reported, that increasing the frequency of sexual intercourse between couples who experience PE could be a way of treating it. A formal case controlled study will be required to confirm this finding.

List of abbreviations:
PE: Premature ejaculation.
IELT: Intravaginal ejaculatory latency time.
PRO: Patient reported outcome questionnaire.
IPE: Index of penile erection.
PEDT: Premature ejaculation detection tool.
PEP: Premature ejaculation profile.
PSA: Prostate specific antigen.

References

1. Pereira-Lourenco M, Vieira e Brito D, Pereira BJ. Premature ejaculation: From physiology to treatment. J. Fam. Reprod. Health. 2019; 13(3): 120-31
2. Hu QB, Zhang D, Ma L, Ng DM, Haleem M, Ma Q. Progress in pharmaceutical and surgical management of premature ejaculation. Chin Med J. 2019; 132: 2362-2372. Doi: 10,1097/CM9.0000000000000433.
3. McMahon CG, Jannini EA, Serefoglu EC, Hellstrom WJ. The pathophysiology of acquired premature ejaculation. TranslAndrolUrol 2016; 5(4): 434-449. doi: 10. 21037/tau.2016.07.06
4. Rowland D, Perelman M, Althof S, et al. Self-reported premature ejaculation and aspects of

sexual functioning and satisfaction. J sex Med 2004; 1: 225-32
5. Althof S, Rosen R, Symonds T, et al. Development and validation of new questionnaire to assess sexual satisfaction, control, and distress associated with premature ejaculation. J Sex Med 2006; 3: 465-75.
6. Symonds T, Perelman MA, Althof S, et al. Development and validation of a premature ejaculation diagnostic tool. EurUrol 2007; 52: 565-73.
7. Patrick DL, Guiliano F, Ho KF, et al. The premature ejaculation profile: validation of self-reported outcome measure for research and practice. BJU Int 2009; 103:358-64.
8. Waldinger MD, Hengeveld MW, Zwinderman AH. Paroxetine treatment of premature ejaculation: a double blind, randomized, placebo-controlled study. Am J Psychiatry 1994; 151: 1377-9.
9. Wei S, Wu C, Yu B, Ma M, Qin F, Yuan J. Advantages and limitations of current premature ejaculation assessment and diagnostic methods: a review. TranslAndrolUrol 2020; 9(2); 743-757. doi: 10.21037/tau.2019.12.08
10. Waldinger MD, Quinn P, Dilleen M, Mundayat R, Schweitzer DH, Boolell M. A multinational population survey of intravaginal ejaculation latency time. J Sex Med 2005; 2: 492-7.