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)

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ABSTRACT

Introduction. Premature ejaculation (PE) is the most frequent sexual complaint.

Aim. To investigate prevalence of PE and its associated conditions.

Methods. We analyzed information gathered from men attending a free andrologic consultation in 186 Italian medical centers, in the setting of a project focused on andrologic prevention.

Main Outcome Measure. Risk factors for PE.

Results. Five hundred sixty-nine men suffered from lifelong PE; 1,855 had previously normal ejaculation; and 234 had PE not specified. Men with PE were younger than those without, but after adjusting for concomitant erectile dysfunction the risk of PE significantly decreased with aging. Men more educated, or who had experienced a divorce had a slightly increased risk. Also, lifestyle and occupational status affected the risk of PE. Concerning medical history, a decreased risk of PE emerged in men with treated diabetes, and no association was found with hypertension, cardiopathy, hypercholesterolemia, and peripheral or central neuropathy.

Conclusions. The results of the analysis of a large dataset show that subjects with PE who are seeking treatment either have experienced stress-related problems or have a physical condition predisposing to this dysfunction (genital anomalies, prostate inflammation).

Key Words. Premature Ejaculation; Risk Factor; Medical History

Introduction

Premature ejaculation (PE) has been described as a common form of male sexual dysfunction. However, both its definition and prevalence are not clearly defined. Some investigators have based the diagnosis on the quantitative dimensions of intercourse [1], while others have considered partner satisfaction [2]. The DSM-IV categorization of the American Psychiatry Association defined PE as "persistent or recurrent ejaculation with minimal sexual stimulation before, or shortly after penetration, and before the person wishes" [3]. Few studies used well-defined criteria, so that the prevalence estimates range from 4% to 66% across studies in community samples [4–9], or among patients in family practice [10,11]. However, most definitions implied the inability to exert voluntary control over ejaculation.

Functional factors related to the etiology of lifelong PE (LPE, PE since first intercourse) are suggested to be penile hypersensitivity, greater cortical penile representation, and a disturbance of central serotonergic neurotrasmission [12–15]. Both anxiety and depression have been associated with PE, although this may be a consequence of the condition rather than a cause [16]. Acquired PE (APE, developing in men with previously normal ejaculation) is associated with recognizable organic pathology in many cases: neurological disorders affecting the conus medullaris [17], acute bacterial prostatitis [18], and drugs [19].

In order to offer further data on risk factors for PE, we have analyzed information collected from 2,658 men with PE and 9,900 without PE attending a free andrologic consultation in 186 Italian medical centers, in the setting of a project focused on andrologic prevention in Italy.

Methods

During the 1st Italian Andrology Prevention Week (September 19–24, 2001) males of any age from the general population were invited to attend a free-of-charge visit for counseling about urologic or andrologic conditions in 186 Italian medical centers affiliated to the Italian Society of Andrology (Società Italiana di Andrologia—SIA). (See list of participating centers and responsible clinicians in Appendix 1.) Each man underwent a physical examination and was asked about his sexual activity and possible related problems.

Data were recorded with a simple questionnaire in all participating centers. Its first section, investigating age, weight, height, marital, educational and professional status, and life habits (smoking, drinking, drug assumption, physical activity, frequency of sexual intercourse), was to be filled in by the patient. History of hypertension, diabetes, cardiovascular diseases, and other medical conditions, as well as evaluation of anomalies of the penis, testicles, and prostate, were recorded by the physician.

A man was diagnosed as suffering from PE if he had "persistent or recurrent ejaculation with minimal sexual stimulation before, or shortly after penetration, and before the person wishes" (DSM-IV categorization of the American Psychiatric Association). The presence of this disorder was asked directly to the patient during the visit. Subjects were also asked "about their ability to achieve and maintain an erection sufficient for satisfactory sexual performance." If they answered they were dissatisfied, they were considered as having erectile dysfunction (ED).

Odds ratios (OR) as estimators of the relative risk of PE and the corresponding 95% confidence interval (CI) were computed by using unconditional multiple logistic regression. The terms included in the logistic regression equations are indicated in the footnotes to the tables.

Results

Of the 2,658 subjects (21.2%) with PE, 569 (mean age 39 years) suffered from LPE; 1,855 (mean age 50 years) had APE; and 234 (mean age 46 years) did not specify. The distribution of subjects with and without PE is shown in Table 1. Cases with PE had a mean age lower than those without (47.7 years, range 17–81 years, and 48.7 years, range 17–98 years, respectively).

The frequency of PE did not markedly change with aging; in comparison with men under 30 years, men aged 30–49 years were at risk (OR 1.3, 95%, CI 1.1–1.4), and the OR declined in subjects 50–69 years and over 70 years (respectively, 1.1, 95% CI 0.9–1.3, and 0.8, 95% CI 0.7–0.9). When men with ED-associated PE were compared with men suffering from PE only, the main risk factor was increasing age: in comparison with men aged less than 40 years, those aged 40–49, 50–59, and over 60 years had ORs, respectively, of 1.9, 2.1, and 1.6 (95% CI 1.5–2.4, 1.6–2.6, 1.3–2.1, respectively). Among subjects with PE, men smoking more than 10 cigarettes per day were at risk of ED (OR 1.3, 95% CI 1.1–1.5). The risk factors for ED in men with PE did not seem different from those in the general population (data not shown).

Considering lifestyle, smoking habits, and physical activity did not affect the risk of PE, and a slight increase of risk was found in men with moderate consumption of alcoholic drinks. Occupational status seemed to have a strong influence on PE: after adjusting for age and ED, employed and unemployed men were shown to be at risk (respectively 1.6 and 1.7, 95% CI 1.3–2.0 and 1.2–2.3) in comparison with men retired from work.

Concerning medical history, a decreased risk of PE was found in men with treated diabetes (OR 0.6, 95% CI 0.5–0.8), and no association with hypertension, cardiovascular disease, hypercholesterolemia, and peripheral or central neuropathy (Table 2).

Relationship between the anomalies of the testicles, penis, scrotum, and prostate and PE are