

Primary Care guidance for prescribing SSRIs for premature ejaculation

Background

Premature ejaculation is a common condition affecting approximately 20-30% of men. (1) Its aetiology is largely unknown (2) but acquired premature ejaculation may be caused by conditions such as prostatitis, anxiety, erectile dysfunction and hyperthyroidism. (3)

There have been various attempts in the literature to define premature or “early” ejaculation. (3) The international society for sexual medicine (4) defines this as: -

- *“Ejaculation that always or nearly always occurs prior to or within about 1 minute of vaginal penetration (lifelong PE) or a clinically significant and bothersome reduction in latency time, often to about 3 minutes or less (acquired PE);*
- *Inability to delay ejaculation on all or nearly all vaginal penetrations.*
- *Negative personal consequences, such as distress, bother, frustration, and/or the avoidance of sexual intimacy.*

There is a quick reference guide to diagnosis which can be found on the website :

<https://www.issm.info/media/attachments/2021/08/17/03-clinical-guidelines---issm-quick-reference-guide-to-pe--vjan2015.pdf>

Treatment

First Option: Non-pharmacological First line treatment includes psychosexual and behavioural counselling if available locally.

Second Option: Pharmacological (5)

- **Paroxetine** 10mg -40 mg daily. **Usual dose 20mg.**
<https://www.medicines.org.uk/emc/product/9582/smpc>
- **Sertraline** 50-200mg a day, **usual dose 50-100mg daily**
<https://www.medicines.org.uk/emc/product/13524/smpc>
- Topical anaesthetic preparations (off label use)
 - Available to purchase over the counter

There are no formal NICE guidelines on this subject except an evidence summary for Dapoxetine (1) and a BNF summary for PE which mentions the selective serotonin re-uptake inhibitors (SSRIs): Citalopram, Escitalopram, Paroxetine, Fluoxetine and Sertraline. These are all *off licence*. (5) Clinical guidelines can be found from the International Society of Sexual Medicine (6) and the European Association of Urology. (3) Dapoxetine is the only licensed medication for this indication but it is expensive and can have significant orthostatic hypotensive side effects therefore is not recommended as a 1st line therapy.

- In clinical trials, Paroxetine (7) has been shown to be superior to Sertraline (8) due to the longer intravaginal latency time, with some evidence for Sertraline and Fluoxetine (8). Sertraline is suggested locally as a 2nd line treatment as it is cost effective, and a familiar medicine prescribed in primary care.

SSRIs are to be taken once daily. After 1 month of use, Paroxetine specifically can be also used on a PRN basis.

- Caution should be taken in young adolescents and men with a history of depression due to the increased risk of suicidal ideation with all SSRIs. (5)
- Medication may take 1-2 weeks to take effect, medication should be reviewed at 4 weeks and again at 6 months when an attempted reduction in dose should be considered.

References

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