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The Premature Ejaculation Prevalence and Attitudes (PEPA) Survey: Prevalence, Comorbidities, and Professional Help-Seeking

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Abstract

Objectives: This study evaluated the associated comorbidities and patient satisfaction with treatment options for premature ejaculation (PE), a common sexual dysfunction.
Methods: A comprehensive, Internet-based survey (the PE Prevalence and Attitudes [PEPA] survey) was conducted among men ages 18–70 in the United States, Germany, and Italy ($n = 12{,}133$). Men were classified as having PE based on self-report of low or absent control over ejaculation, resulting in distress for them or their sexual partner or both.
Results: The prevalence of PE was 22.7% (24.0% in the United States, 20.3% in Germany, and 20.0% in Italy) and did not vary significantly with age among men over age 24 yr. Men with PE were more likely to self-report other sexual dysfunctions (e.g., anorgasmia, low libido, erectile dysfunction) and psychological disturbances (e.g., depression, anxiety, excessive stress) than men without PE ($p < 0.05$ for all). Men with PE were most aware of (>70%) and most likely to have used (>50%) special positions during sex, interrupted stimulation, masturbation, and having intercourse more often than usual to manage their PE. Only 9.0% of men with PE reported having consulted a physician for the condition; 81.9% had to initiate the conversation about PE and 91.5% reported little or no improvement as a result of seeking treatment.
Conclusion: PE is a highly prevalent sexual problem, with significant sexual and psychological comorbidities. Most men with PE do not seek assistance from their physician, and most of those who do are not satisfied with the results.

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1. Introduction

Results of large population-based surveys have frequently shown that premature ejaculation (PE) is a common male sexual dysfunction [1–4]. However, these surveys applied different approaches to the classification of men with PE. The National Health and Social Life Survey (NHSLS) estimated the prevalence of PE based on latent class analysis of results from 90-minute, in-person interviews of a representative 1992 cohort of US adults (n = 1243), in which respondents were matched on various social attributes [3], whereas the Global Study of Sexual Attitudes and Behaviors (GSSAB) estimate was based on response to a single item among 27,500 men and women worldwide, using telephone, door-to-door, and mailed questionnaires [4].

The *Diagnostic and Statistical Manual of Mental Disorders*, edition 4 (DSM-IV), 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 [5]; other definitions include the similar concepts of limited intravaginal ejaculatory latency and decreased ejaculatory control [6–8]. Applying these concepts of low control and associated distress to the classification of men with PE may affect the observed prevalence of the condition. For example, 32.5% of men ≥21 yr of age (n = 1158) reported in an Internet survey that they ejaculated before they wished at least 50% of the time; 16.3% of men also reported that it was "very much" or "somewhat" of a problem for them, whereas 16.2% reported that it was not a problem or only a little bit of a problem for them [9].

Studies exploring attitudes and behaviours about PE have generally been small and focused on the impact of PE on individual men's lives. For instance, a report by Symonds and colleagues provided details about the impact of PE on self-image, sex life, relationship with partner, and everyday life among 28 men who reported having had PE for at least 2 yr [10]. Although such small studies are informative, large surveys are required to examine the attitudes and behaviours of the broader population of men with PE. Moreover, little is known about the risk factors or comorbid conditions associated with PE in the general population. Studies that have evaluated comorbidity have only focused on the population of men with PE who have sought treatment for the condition (e.g., at a sexual dysfunction clinic) [11,12] or those who presented for treatment of a specific condition (e.g., hyperthyroidism) [13].

To address this need for information on PE in the general population, an in-depth survey was developed based on a series of qualitative, one-on-one interviews in the United States, Germany, and Italy among men with PE and women whose partners suffer from PE (n = 65). Following analysis of results obtained from these interviews, the multinational, quantitative Premature Ejaculation Prevalence and Attitudes (PEPA) survey was conducted via the Internet in these countries. Here, we present the overall results of the PEPA survey, with the goal of exploring the prevalence of PE, comorbid conditions, and current methods of treatment.

2. Materials and methods

2.1. Participants

Men aged 18–70 yr were recruited to participate in the online survey; men were excluded if they were not or had not been involved in a sexual relationship at the time of recruitment or in the previous 2 yr nor planned to be in the future. The study sample was recruited from two large, pre-existing Internet panels (Greenfield On-Line Internet Panel in the United States and Ciao Internet Survey Solutions in Germany and Italy; both panels are now owned by Greenfield On-Line, www.greenfieldonline.com). Participants opted in to join an online community and Web portal and were asked to participate in

Table 1 – Questions used to classify men with PE in the PEPA survey

Criterion	Question	Responses indicative of PE	Other possible responses
Low or absent control over ejaculation	"Do you feel that your control over your ejaculation during sexual intercourse is:"	• Fair • Poor	• Excellent • Very good • Good
Ejaculatory latency that is a problem for the man or his partner	"Which one of these four statements best describes how your typical length of time from penetration to climax has affected your relationship?"	• A problem for me, but is not for my partner • Not a problem for me, but it is for my partner • A problem for both me and my partner	• Not a problem for me or my partner

PE = premature ejaculation; PEPA = Premature Ejaculation Prevalence and Attitudes.

confidential market research studies. The panel members were then sent an e-mail inviting them to participate in a confidential survey, with a unique URL, and collected points, cash incentives, or were entered into prize drawings if they agreed to participate. Panel members could not be invited more than twice per month or answer more than one survey per month. At the time of this study, the US panel had about 1,000,000 members, the German panel had about 300,000 members, and the Italian panel had about 60,000 members.

2.2. Procedures

This Web-based study was conducted from March to May 2003 and in August 2004 (for men 25–70 and 18–24 yr, respectively). The PEPA survey encompassed 82 questions: questions 1–54 (administered to all men) assessed general and sexual health, attitudes towards medical treatment, and demographics; questions 55–82 (administered to all men classified with PE and about 20% of heterosexual men without PE but who indicated a desire to prolong ejaculatory latency time) identified PE-related attitudes and behaviours. Men were classified as having PE if they answered two questions that addressed the common concepts of low or absent control over ejaculation that is viewed as a problem by men or their partners (Table 1). Results for each question were weighted by country and age to represent the general male population (weighting strategy available on request). Differences between groups of men were compared using pair-wise *t* tests.

3. Results

3.1. Subject demographics

There was a 12% response rate to the e-mail survey invitation, and the sample of men ($n = 12,133$; Table 2) was representative of the overall male population of each country, based on census data (not shown). Characteristics of these randomly sampled men from the United States ($n = 8009$), Germany ($n = 2433$), and Italy ($n = 1691$) were similar to those reported in census data with respect to marital status, employment, religion, education, and smoking rates for each country (data not shown). Overall, respondents were of mean (±SD) age 41.59 ± 13.57 yr; men with a partner reported their partner's age as mean (± SD) 38.98 ± 12.87 yr. The majority of men identified themselves as Caucasian, Western European, or Eastern European (83.0%, 97.6%, and 96.6% of men in the United States, Germany, and Italy, respectively). Most respondents (80.5%) reported that they were currently in a sexual relationship, and 63.1% of respondents were married or living with their partner; 91.0% of respondents identified themselves as heterosexual, and 9.0% of respondents identified themselves as homosexual or

Table 2 – Subject demographics

Category		All Men	Men with PE	Men without PE
n (%)	Total	12,133 (100.0)	2754 (100)	9379 (100)
Age, yr, mean ± SD		41.59 ± 13.57	42.32 ± 13.13	41.38 ± 13.69
Age group, %	18–24 yr	14.0%	10.9*%	14.9%
	25–34 yr	20.3%	21.0%	20.1%
	35–44 yr	23.2%	23.6%	23.1%
	45–54 yr	20.6%	21.7%	20.2%
	55–70 yr	21.9%	22.8%	21.6%
Relationship status, %	Currently in sexual relationship	80.5%	80.0%	80.7%
	Not currently in a sexual relationship, but have been in the past 2 yr	9.1%	9.3%	9.1%
	Not in a sexual relationship in the past 2 yr, but hope to be in the future	10.3%	10.6%	10.2%
Age of partner, yr (mean ± SD)		38.98 ± 12.87	39.57 ± 12.50*	38.80 ± 12.97
Marital status, %	Married or living together	63.1%	68.3*%	61.5%
	Single	25.9%	20.2%	27.6%
	Separated or divorced	9.9%	10.6%	9.8%
	Widowed	1.1%	0.9%	1.1%
Sexual orientation, %	Heterosexual	91.0%	91.7%	90.8%
	Bisexual or homosexual	9.0%	8.3%	9.2%
Caucasian, Western European, or Eastern European, %	United States	83.0%	85.0*%	82.4%
	Germany	97.6%	97.8%	97.5%
	Italy	96.6%	97.4%	96.4%
Smoke every day or almost every day, %		25.1%	27.7*%	24.4%
Exercise frequency, %	A few times a week or more	46.5%	37.0*%	49.3%
	A few times a month or less	53.5%	63.0*%	50.7%

PE = premature ejaculation; SD = standard deviation.
Numbers may not sum to totals due to rounding.
* $p < 0.05$ vs men without PE.

bisexual (approximately 5% and 4% identified as homosexual and bisexual, respectively).

3.2. *The prevalence and demographics of PE*

Based on the two classification questions that were derived from established clinical definitions for PE, the prevalence of PE among men in the PEPA survey was 22.7% and was similar across countries (24.0% in the United States, 20.3% in Germany, and 20.0% in Italy) and age groups (Fig. 1); the prevalence of erectile dysfunction (ED; ''where the penis does not get or stay hard'') was 16.4% overall (18.3% in the United States, 14.6% in Germany, and 9.7% in Italy). Approximately one in two men with PE (49.6%) reported that they had experienced PE since the first time they had sex, and 34.6% reported that PE had started more recently; 15.8% of men indicated that PE had been present when they first began having sex, then went away, and then returned again more recently. Although intravaginal ejaculatory latency time (IELT), the time from vaginal intromission to intravaginal ejaculation, was not used to classify men with PE, 25.8% of men who were classified with PE self-reported an estimated IELT of $\leq$2 min the last time that they had sex, and an additional 32.4% self-reported an estimated IELT of 2–5 min. The majority of men with PE (83.9%) reported that their time to ejaculation was usually the same as or shorter than these reports.

3.3. *Comorbid conditions*

Among men with PE, only 35.6% reported that their current state of health was ''excellent'' or ''very good'' compared to 49.4% of men without the condition ($p < 0.05$). Very few men with PE (7.2%) reported that they ''agree completely'' or ''agree somewhat'' that their PE was related to another medical condition. Men with PE were more likely to self-report several conditions (Table 3), including other sexual dysfunctions (e.g., anorgasmia, low libido, ED), and psychological disturbances (e.g., depression, anxiety, excessive stress) compared with men without PE ($p < 0.05$ for all).

Because ED has several recognised comorbidities, and a significant proportion of men with PE also reported ED (31.9%), the rate of comorbid conditions among men with PE was examined when men with ED were excluded (Table 3). Previous studies have also demonstrated a high prevalence of comorbid PE and ED [14]. A similar profile of comorbidities was observed when men with ED were excluded from the analysis ($p < 0.05$ for all). Cardiovascular comorbidities (i.e., hypertension, heart disease) and diabetes, which are known to be associated with ED, were not significantly more common in men with PE when men with ED were excluded.

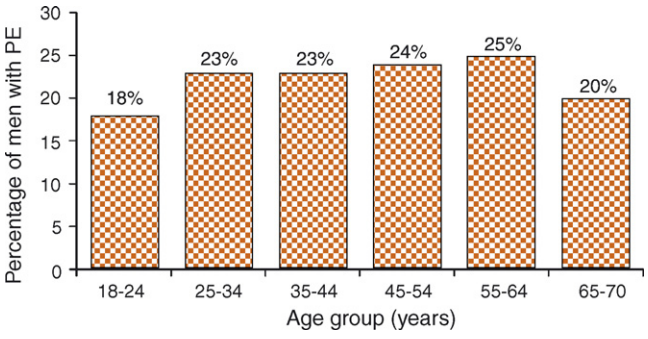

Fig. 1 – The prevalence of premature ejaculation (PE) by age group.

3.4. *Current treatment of PE*

Of the various treatment options available for PE, men with PE were most aware of (>70%) and most likely to have used (>50%) special positions during sex, interrupted stimulation, masturbation, focusing on something else, and having intercourse more often than usual. Most men with PE were aware of topical creams or ointments (73.1%); however, few reported having used them (24.9%). A large percentage of men with PE had used alcohol (41.2%) or recreational drugs (15.6%) to address their condition. Most men with PE (59.9%) were aware that prescription pharmacologic treatment options existed, but very few reported having used them (12.9%). Awareness of specific pharmacologic treatment options was not ascertained.

Despite awareness of prescription treatments for PE, only 9.0% and 4.2% of men with PE reported having consulted a physician or psychologist/sex therapist, respectively, about their problem. Over half of the men with PE (52.2%) who did not talk to a physician about their PE indicated that they had never considered speaking to a physician about PE. Among men with PE who recalled speaking to a physician about PE, most (69.5%) had consulted their physician for another reason, and 30.5% made a special appointment to discuss PE. The majority of men (81.9%) had initiated the conversation about PE. Most men with PE who sought treatment for their condition were not satisfied with the results; little or no improvement was reported by 91.5% and 95.9% of men who sought treatment from a physician or therapist, respectively. It is not known if patients had used the prescribed treatments consistently or according to instructions.

Table 3 – Percentages of men reporting comorbid conditions

Condition	Men with PE (n = 2754)	Men without PE (n = 9379)	Excluding men with ED	
			Men with PE* (n = 1110)	Men without PE* (n = 8270)
Arthritis	21.9†	16.8	16.6‡	13.9
High blood pressure (hypertension)	27.2†	20.7	19.0	17.2
Heart disease or stroke	7.1†	5.8	4.2	4.3
High cholesterol	26.4†	20.8	21.5‡	18.0
Diabetes	10.0†	7.1	5.2	5.0
Enlarged prostate (not cancer)	6.1	5.2	2.5	3.7
Prostate cancer	0.5	0.4	0.2	0.2
Lack of orgasm (not climaxing at all)	15.7†	4.4	4.2‡	1.6
Allergies	40.0†	37.0	39.7‡	36.8
Low libido (little interest in sex)	25.7†	9.1	13.8‡	5.2
Heartburn or gastro-oesophageal reflux disease	28.8†	21.7	25.7‡	19.8
Erectile dysfunction (''where the penis does not get or stay hard'')	31.9†	11.8	0.0	0.0
Insomnia	21.9†	14.4	17.5‡	12.2
Depression	20.4†	12.4	15.5‡	11.1
Excessive stress	28.2†	18.7	25.6‡	17.9
Anxiety	24.4†	12.9	18.9‡	11.9
Weight gain	39.0†	27.2	34.5‡	24.8
Other	13.3†	10.9	9.6	9.8

ED = erectile dysfunction; PE = premature ejaculation.
* Excluding men who self-reported ED.
† $p < 0.05$ vs men without PE.
‡ $p < 0.05$ vs men without PE or ED.

3.5. *Factors contributing to treatment-seeking for PE*

Men with PE self-reported several reasons why they would seek treatment for PE (Table 4), including if their partner suggested it and if they knew of a pill to treat the condition. A large majority of men with PE (87.9%) wished that they had more control over climax. Although most men with PE reported an IELT of <5 min (58.2%), they indicated that the ''ideal'' IELT (i.e., how long ''should'' the average man last?)

Table 4 – Factors associated with professional help-seeking for PE

	% of men
A. Men with PE	**(n = 2033)**
Response of ''agree completely'' or ''agree somewhat'' to:	
When I have a health problem, I try to get as much information as possible about it.	78.5
I would talk to a doctor if I knew a pill to control ejaculation were available.	57.6
I think my PE is preventing me from finding or keeping a partner.	11.6
I am willing to pay almost anything for a treatment that works.	17.1
I would talk to a doctor about being able to last longer if my partner suggested it.	57.2
I worry about the future of my sex life.	50.6
I will try anything if there is a chance it will solve this problem for me.	40.3
I wish I had more control over when I climax.	87.9
It is important to me that my partner reaches orgasm.	91.9
I wish my time to ejaculation were consistently longer.	87.2
B. Men with PE who spoke to a doctor about the condition	**(n = 199)**
Positive response to ''what reasons encouraged you to speak to a doctor?''	
I wanted to increase my own personal pleasure during sex.	61.1
My partner was concerned, upset, or angry when I climax quickly.	21.2
My partner asked me to.	14.9
I wanted to rule out an underlying medical condition.	38.8
I became very depressed or upset about my climaxing quickly during sex.	31.4
Coming too soon began to happen too frequently.	36.7
I wanted to better satisfy my partner sexually.	74.6

PE = premature ejaculation.

Table 5 – Factors discouraging men from seeking treatment

	% of men with PE (n = 2754)
Response of "agree completely" or "agree somewhat" to:	
My doctor is the best source of information about health issues.	51.1
I don't like taking pills.	38.8
Less control over ejaculation is a natural part of aging.	20.6
I doubt any medicine can help me control when I climax.	20.1
I would rather discuss my sexual concerns with a doctor who is not my regular physician.	24.5
I worry about becoming dependent on a medication to perform sexually.	43.8
I have learned to live with the fact that I climax too soon.	37.1
I am not comfortable discussing sexual issues with my partner.	23.7
Reason for response of "slightly interested" or "not at all interested" in a medication for PE:	
I do not want to have to talk to a physician to get the medication.	17.0
I am too embarrassed to discuss this with anyone.	12.0
I don't think anything can help.	11.5
Positive response to "The main cause of my climaxing too soon is:"	
Performance anxiety.	26.6
Being too aroused sexually.	48.7
Being too sensitive to touch.	31.9
Having sex too infrequently.	30.6
A consequence of another medical condition.	5.4
PE is a medical condition.	6.6
Psychological or emotional issues.	10.4
Getting older.	23.6

PE = premature ejaculation.

would be 15.77 ± 10.33 min, and estimated the average IELT (i.e., how long does the average man last?) to be 8.78 ± 6.71 min. These results are similar to those reported by an observational study in which men who were classified as having PE based on the DSM-IV criteria had a stopwatch-measured mean IELT of 3.0 min (vs. 9.2 min for men without PE) [15].

Although most men (~80%) reported that they try to get as much information as possible about health problems (Table 4), only one in two men agreed that their doctor was the best source of information about health issues (Table 5). Fewer men with PE reported feeling comfortable discussing sensitive issues with their doctor (68.6% vs. 75.6% of men without PE; $p < 0.05$). Other reasons men had not sought treatment for their condition included embarrassment at discussing the condition with anyone, doubt that any medication could help them control their ejaculation, worry about becoming dependent on a medication to perform sexually, and resignation—37% of men with PE reported that they had learned to live with the condition.

4. Discussion

Consistent with findings of previous reports [1–4], PE was a common sexual problem among men in the PEPA study, and the prevalence (~23%) was similar in the United States, Germany, and Italy. Elements common to clinical diagnosis definitions for PE were used to classify men with PE, based on low or absent control over ejaculation that resulted in distress for the man or his partner; this Internet-based approach was not intended to substitute for a clinical diagnosis by a physician. Previous studies have demonstrated that results from Internet surveys on sexual health, including the Men's Attitudes to Life and Sexuality (MALES) study and the GSSAB, were not different from those obtained using other methods, such as telephone surveys or mailed questionnaires [16,17]. Although the response rate was lower than that reported in other studies, this level of response is not unexpected for an e-mail survey request. A recent study compared the response rates of surgeons to a questionnaire sent via e-mail or standard mail and reported a significantly lower response rate with e-mail solicitation [18]; however, the responses to questions obtained using the two survey methods were not different. In the PEPA study, the population of men who responded to the survey was representative of the male population in each country, and the sample size was large enough to adequately represent each age group.

The prevalence of PE reported here is similar to that observed in an earlier analysis of this data set, in which different criteria for the classification of PE were used. In that earlier analysis, the observed prevalence of PE was about 25%, based on self-reported IELT of typically $\leq$2 min, or self-reported IELT of $>$2 min and at least two of the following

criteria: ejaculate before desired, fair/poor control over ejaculation, and the man or partner has a problem with the time to ejaculation [19]. The similar results obtained from these two PE classification methods suggests that the high prevalence of PE is not an artifact of the analysis methodology and that PE is a multifactorial dysfunction that is not adequately described by any single factor. This is supported by evidence from a recent observational study that identified IELT, control over ejaculation, and the sexual satisfaction of the man and his partner as important interrelated determinants of PE [15].

Similar to what has been reported previously [3], no relationship between age and the prevalence of PE among men >24 yr of age was observed. In contrast, the prevalence of erection problems in men has been shown to increase dramatically with age [3]. Most large surveys have not reported on the younger population of men with PE (<25 yr), which appeared to have a lower prevalence of PE. It is possible that younger men with short latencies may have a higher threshold for defining rapid ejaculation as a lack of ejaculatory control. However, little is known about the other aspects of sexual function in this group of men and, therefore, definitive conclusions cannot be drawn.

This is one of the first surveys to include men who were not currently in a relationship and who were not heterosexual. In previous studies, single men with PE have reported avoidance of pursuing relationships [9,10,19,20]. Excluding men who are not currently in a sexual relationship may exclude a significant proportion of men with PE (nearly 20% of men with PE, based on these results). In addition, there is no sound rationale for excluding homosexual or bisexual men, particularly because the prevalence of PE remains relatively constant across most other demographic categories (such as age, race, country of origin, etc). Men with PE in the PEPA survey were just as likely to self-identify as homosexual or bisexual as men without PE. The only men excluded from the study were those who had not been and did not desire to be in a sexual relationship, for whom sexual dysfunction was not likely to be a concern.

Men with PE were more likely to report other forms of sexual dysfunction and psychological distress (including excessive stress, depression, and anxiety) compared to men without the condition, even when men with ED were excluded. A recent study of 755 men attending an outpatient clinic for sexual dysfunction for the first time reported that symptoms of anxiety, hyperthyroidism, and low fasting plasma glucose concentrations were more common among men with symptoms of PE [12]. Because the population of men studied was derived from a sexual dysfunction clinic, 95% of men in the sample had self-reported ED. Similar to the results from the PEPA study, the comorbidities associated with PE were still apparent, even when men with concomitant ED were excluded. Results from a recent small study of men with hyperthyroidism ($n = 34$) and hypothyroidism ($n = 14$) seeking treatment at endocrinology and andrology clinics demonstrated that 50% and 7.1%, respectively, of these men could be classified as having PE, based on the DSM-IV-TR definition [13]. Interestingly, the prevalence of PE among men with hyperthyroidism decreased to 15% following thyroid hormone normalisation with methimazole. Other studies have suggested that PE is associated with chronic pelvic pain syndrome [11] and prostatic infection and prostatitis [21,22].

Similar to previous reports, very few men with PE reported that they had sought treatment from a physician or therapist, and the majority of those who did were not satisfied with the treatment they received. In the GSSAB, 43% of sexually active men indicated that they had experienced at least one sexual problem; only 18.0% had attempted to seek medical help [4]. In another survey, only 1% of men ≥40 yr of age reported having received treatment for PE, even though 18% of men reported that they "always/almost always" or "usually" ejaculated prematurely [1]. These results suggest that men are far less likely to seek treatment for PE than for erection problems. Therefore, new treatment options for PE are required that will encourage men to seek treatment and provide effective management of the condition.

This is the first large survey to report on the reasons why men do not seek treatment specifically for PE. Men with PE did not view their physician as the best source of health information, and many (~30%) were not comfortable discussing sensitive issues with their regular physicians. In addition, even though men with PE reported that it was a problem for them or their partner, a significant number reported that PE was a normal part of aging or felt that increased frequency of sex would solve the problem. However, a majority of men with PE (~60%) stated that they would seek treatment for PE if their partner suggested it, and nearly 75% of men with PE who did seek treatment did so based on a desire to increase the sexual satisfaction of their partner. Based on these findings, involving the partner in discussions of sexual health and asking female patients about their sexual satisfaction or their partner's sexual health may be useful approaches to encourage men to seek treatment for PE.

5. Conclusions

In conclusion, PE is a highly prevalent male sexual dysfunction, with important comorbidities, and most men with the condition do not seek treatment. Furthermore, men who sought treatment were generally dissatisfied with the results. Physicians should inquire about the sexual health of their male patients during routine visits to create an environment in which men may be more comfortable reporting PE and other common sexual problems. Physicians and patients should be more proactive in the maintenance of sexual health, which may lead to improved management of PE. However, the negative expectations of most patients towards current treatment options need to be addressed if patients are to be encouraged to seek professional help.

Conflicts of interest

The authors declare the following potential conflicts of interest. Drs. Porst and Montorsi are consultants/advisors and lecturers for Johnson & Johnson, and Dr. Rosen is a consultant/advisor and lecturer for Johnson & Johnson and Ortho Women's Health & Urology. Dr. Gaynor, Ms. Grupe, and Mr. Alexander are employees of Johnson & Johnson Pharmaceutical Services LLC, Raritan, NJ. This study was funded by Johnson & Johnson Pharmaceutical Services LLC, Raritan, NJ.

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Editorial Comment

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Dr. Porst and colleagues are working in the right direction. Any attempt to "medicalise" a symptom traditionally considered as psychogenic (and thus underdiagnosed and undertreated) is more than welcome in sexual medicine. The cure of premature ejaculation (PE) begins with awareness of its epidemiologic importance (from the Premature Ejaculation Prevalence and Attitudes [PEPA] study we now know that more than one in five, if not one in four, of sexually active men is unable to perfectly control his ejaculation). The second step is to understand organic and nonorganic etiologies and risk factors and to create a diagnostic flowchart. A consensus conference on the definition of PE is then needed. This taxonomic effort is essential and will lead to the availability and widespread use of new drugs specifically designed for PE.

This paper reports results of an Internet-based survey. PE is always a self-diagnosis, but clinical experience indicates that the final diagnosis often changes after a careful interview with the patient. As correctly pointed out by the authors, an Internet survey cannot fully replace the physician–patient interaction and clinical examination in obtaining a diagnosis.

Another very important insight in the paper is the demonstration that the prevalence of lifelong PE versus acquired PE is about 50%. This is both surprising and interesting (and roughly corresponds to my own clinical practice and experimental experience). In fact, a large number of literature studies and clinical trials have unfortunately been performed only in men with lifelong PE, giving the impression that PE is always lifelong. In light of the results presented here, this seems incorrect. Although the absence of a full sexual history limits this result, it is now clear that there are more patients with acquired PE than previously thought.

The final take home message from this study is that most men with PE do not seek assistance from their physicians, and most of those who do are not satisfied with the results. In the past 10 yr, we have succeeded in convincing patients that impotence is a body and mind symptom that can be cured with drugs. The next challenge for sexual medicine will be to do the same for the most prevalent sexual symptom, PE.

Editorial Comment

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The paper by Porst et al really focuses on three major issues regarding Premature Ejaculation (PE), (1) high prevalence, (2) common comorbidities, and (3) professional attitudes and help-seeking patterns that makes the topic much closer and better understood, not just by urologists, the main target of this journal, but for every healthcare professional who works in the field of sexual health.

Due to the lack of a universally accepted definition for PE, scarce "reliable" data exists on its real prevalence. This study shows a figure (22.7% among men 18–70 years) in accordance with some previous studies. So the prevalence rate is high, even higher than that reported for ED (16.8%), regardless the definition/criterion used to characterize the condition. So it is not an "artifact" as it is clearly stated by authors.

The demographic data presented here undermine the "myth" of PE being just a dysfunction in young people. Please note that though the mean age for PE sufferers is 42.32 ± 13.13 years, the prevalence across age groups is fairly constant, meaning just a younger onset of PE in comparison to ED, which occurs later and dramatically increases with age while the PE rate remains constant.

Regarding comorbid conditions, it is worth highlighting that men with PE significantly self-report a poorer health status than do men without PE, although only a low proportion (7.2%) correlates PE with a medical condition. Furthermore, men with PE self-report more frequently than those without PE other sexual dysfunctions and psychological disturbances. Table 3 outlines a wide range of medical and psychological conditions related to PE, indicating that PE must be put along biological and psychological coordinates. The exact role of each dimension is to be further addressed.

It cannot be ignored, according to this study, (1) that very few PE sufferers seek help (9%), (2) that of those who seek help, 91.5% reports little or no improvement as a result of seeking treatment, and (3) in the vast majority of occasions (81.9%), it is the sufferer himself who needs to initiate the conversation.

Definitely, attitudes towards PE's meaning and help provision has a lot of room for improvement.