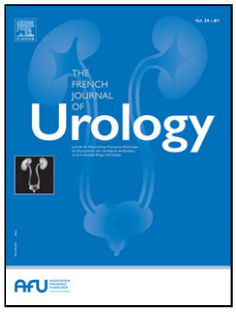


# Recommendations for the diagnosis and evaluation of premature ejaculation

Eric Huyghe Laure Grellet Antoine Faix Thierry Almont Béatrice Cuzin Carol Burte

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# Recommendations for the diagnosis and evaluation of premature ejaculation

Eric HUYGHE [1,2,3], Laure GRELLET [4], Antoine FAIX [5], Thierry ALMONT [6], Béatrice CUZIN [7,8] Carol BURTE [4]

[1] : Médecine de la Reproduction, CHU de Toulouse, site de Paule de Viguier, Toulouse, France
[2] : Département d'urologie, transplantation rénale et andrologie, Hôpital Rangueil, CHU de Toulouse, France
[3] : UMR DEFE INSERM 1203, université de Toulouse III, université de Montpellier, France
[4] : Cabinet de sexologie, 19 bis Rue Magnol, 34000 Montpellier
[5] : Cabinet d'Urologie, 265 Avenue des Etats du Languedoc, Montpellier, France
[6] : Service d'oncologie, CHU de Martinique, Fort de France, France
[7] : Service d'Urologie, chirurgie de la transplantation, Hôpital Edouard Herriot, CHU de Lyon, France

[8] : Service de médecine de la reproduction, Hôpital Femme Mère Enfant, HCL, Bron, France
[9] : Cabinet de médecine sexuelle, 4 rue des Etats-Unis, Cannes, France

# Recommendations for the diagnosis and evaluation of Premature Ejaculation

**Objectives :**
The Association Inter-disciplinaire Post-Universitaire de Sexologie (AIUS) has brought together a panel of experts to draw up French recommendations for the management of premature ejaculation. This article presents the recommendations for the diagnosis and evaluation of premature ejaculation.
**Methods :**
Systematic review of the literature between 01/1995 and 02/2022. Using the method of recommendations for clinical practice (RPC).
**Results :**
We recommend using the SIAMS definition for everyday clinical practice.
PE is defined as: (i) a persistent and recurrent subjective perception of loss of control (management) of the ejaculatory mechanism in the presence of appropriate erotic stimuli; (ii) subjective, PE-related distress induced in the patient and sexual dissatisfaction or PE-related anorgamy in the partner; (iii) a short intravaginal ejaculatory latency time, whether subjectively perceived by the patient and the. partner or objectively measured as less than 180 seconds (generally).
We suggest that the same definition be applied to practices other than vaginal penetration, such as masturbation, oral or anal intercourse, as well as to non-heterosexual contexts
We suggest using information reported by the patient, possibly supplemented by assessment tests/questionnaires (IPE, PEP, PEDT).
We recommend investigating the presence of other sexual dysfunctions, in particular erectile dysfunction (ED), as well as any sexual dysfunctions of partners.
We recommend taking a medical and psychosexological history, and carrying out a targeted physical examination in patients complaining of PE.
**Conclusion :**
These recommendations should help to improve the management of PE.
Key words: premature ejaculation, sexual dysfunction, sexology
**Mots-clés** : éjaculation prématurée, dysfonction sexuelle, sexologie

# I. Introduction

Epidemiological data indicate that a significant number of men are dissatisfied with their control over ejaculation and its precocity. Nevertheless, compared with other sexual dysfunctions, such as erectile dysfunction, premature ejaculation (PE) appears to be a relatively new topic in sexual medicine. For this reason, Sansone et al. recently remarked that "patients and the media are only partially aware of the solid body of evidence produced in the context of the diagnosis, pathogenesis and treatment of PE".

For this reason, the Association Interdisciplinaire Post Universitaire de Sexologie (AIUS) set up a multidisciplinary working group to produce a clinical practice guide for healthcare professionals in the French-speaking community. The aim of this article is to summarize the main points of the arguments and recommendations concerning the definition, epidemiology and assessment of PE. The Comité d'Andrologie et de Médecine Sexuelle (CAMS) of the Association Française d'Urologie recommends the use of these recommendations for the practice of urologists.

# II. Methodology

These professional recommendations have been drawn up in accordance with the recommendations for clinical practice (RPC) method, published by ANAES (1999), and updated in 2013 by the French National Authority for Health (HAS). (1).

The recommendations were drawn up by the **working group**, following an analysis of the scientific literature and a synthesis of the opinions of the professionals consulted. The working group was made up of professionals from a wide range of disciplines, from both public and private practice settings, and from a variety of geographical backgrounds. They identified, selected, analyzed and synthesized the scientific literature used to draw up the arguments and recommendations.

A **literature search was** carried out using the Pubmed and Psycinfo bibliographic databases for the period from January 1995 to February 2022, limiting the search to literature in English and French.

A critical analysis of the literature based on the methodology proposed by HAS (Table 1) was used to analyze the selected articles, and enabled a level of scientific evidence to be assigned to each. Based on this analysis of the literature, the working group proposed recommendations wherever possible. Depending on the level of evidence of the studies on which they are based, the proposed recommendations were classified as grades A, B, C or AE.

A **reading group was** consulted by letter and gave its opinion on the content and form of the recommendations, in particular on their readability and applicability. The comments of the reading group were analyzed by the working group and taken into account wherever possible in the drafting of the recommendations.

# III. Definitions

- All recent definitions take into account (i) the delay in the onset of ejaculation; (ii) the inability to defer the onset of ejaculation; and (iii) the negative personal and interpersonal consequences (worry and suffering) associated with PE. They recognize that PE is a multi-faceted sexual dysfunction, which may be present from the start of sexual life (permanent, primary) or after a period of satisfactory ejaculatory control (acquired).
- The definitions most commonly used today are those of the International Society of Sexual Medicine (ISSM (2)), the Diagnostic and Statistical Manual of Mental Disorders, 5th revision (DSM-5 (3)), and the 11th revision of the International Classification of Diseases for Morbidity and Mortality Statistics (ICD-11) (4). All the above definitions are limited to intra-vaginal sexuality (5).
- More recently, the Italian Society of Andrology and Sexual Medicine (SIAMS) has proposed a definition for everyday practice applicable to sexual stimuli other than intravaginal intercourse, such as masturbation, oral or anal intercourse, as well as to non-heterosexual contexts (6). **Table 2** summarizes the main definitions of PE.

# IV. Epidemiology

It seems difficult to conclude on a prevalence of PE, given the diversity of definitions between studies (7-11). However, it seems reasonable to think that the prevalence of PE (primary and acquired) would be around 5% of the general population, consistent with epidemiological data indicating that around 5% of the population has an ejaculation latency of less than 2 minutes.

## A. Risk factors

Numerous biological and psychological risk factors have been proposed, but the methodology used (cross-sectional) does not allow a causal link to be established:

- Hypersensitivity of the glans penis (12) and penile sheath (13)
- Cortical overrepresentation of the pudendal nerve (14),
- Disorders of central serotonergic neurotransmission (15, 16),
- hypofunction of brain networks involved in behavioral inhibition (17, 18)
- Erectile dysfunction and other sexual comorbidities (19-22),

- Withdrawal from certain medications (23, 24),
- Recreational drugs (25),
- Psychological and sleep disorders (20, 26-28),
- anxiety and depression (27, 29)
- Lower urinary tract symptoms (30, 31)
- Chronic pelvic pain syndrome (32) or chronic prostatitis (20, 33-38)
- Hyperthyroidism (39-42)

None of the proposed etiologies has been confirmed, and the etiology of PE remains unknown. What's more, the statistical effects appear rather moderate, meaning that the association between PE and these risk factors is modest.

On the other hand, there is consensus that performance anxiety and interpersonal difficulty arising from PE aggravate the situation (43, 44).

### B. Link between erectile dysfunction and PE

There is strong evidence to suggest that erectile dysfunction (ED) and PE are frequently intertwined, with the two symptoms coexisting in up to 50% of cases (22, 45, 46).

The exact mechanisms have not been fully elucidated, but, in addition to performance anxiety, it is generally assumed that some PE patients may develop ED or erectile difficulties in trying to reduce their arousal (47) and that patients with ED or ED may develop PE by excessively increasing their arousal in order to achieve erection (22, 45).

# V. Evaluation

## A. Ejaculation control

Ejaculatory control integrates both the possibility of prolonging intercourse by delaying ejaculation and the feeling of ejaculatory control (48).

Inability to control ejaculation is a major feature of PE (49-51). However, several authors have shown that impaired control of ejaculation is not only present in men with PE (52, 53).

Perception of ejaculatory control is influenced by orgasmic latency and the partner's perception of ejaculation, as well as satisfaction and overall sexual functioning (54). There is therefore a proven interest in assessing control, as well as sexual satisfaction and relational difficulties in relation to PE (55-57).

Assessment of ejaculation control is based on patient-reported outcomes (PROs), ideally using validated standardized questionnaires (6, 48, 58).

## B. Assessment of intravaginal ejaculatory delay (IED)

**Intravaginal ejaculatory delay (IED)** is the time elapsed between the start of vaginal penetration and the onset of ejaculation (3, 6, 9, 48, 56, 59).

The use of chronometric benchmarks (i.e., DEI) to determine the nature of the disorder remains controversial (60, 61). IED benchmarks (1 to 3 minutes, depending on the case) have been used to distinguish between "disorders" and "non-disturbances", and between different forms of the problem. THE SIMS (2, 7) first, then the APA (DSM-5) (3) have adopted these benchmarks. Tending towards a certain objectivity, these definitional systems nevertheless had the disadvantage of (1) keeping ejaculation delays in situations other than heterosexual coitus vague, and (2) being of little use in terms of clinical heuristics. Two studies (55, 56) also highlighted EP/non-EP overlaps in IED values between 2 and 4 minutes, and the fact that low IED values are far less specific for the disorder than is a feeling of lack of control. Consequently, more flexibility was called for in the assessment of the ejaculatory rapidity criterion (60, 62-64). Since then, in its approach to the issue, the WHO has refused to appeal to precise duration criteria (ICD-11, 2018). IED values are no longer used to define the disorder; at most, they are used to determine a gradient of severity. Note that WHO (4) and the American Psychiatric Association (3) have followed completely opposite paths in their diagnostic thinking. Whereas, in the ICD-11 (2018) (4) the WHO repudiated the duration criteria that prevailed in the previous version (ICD-10), the APA took the opposite path, adopting, in DSM-5 (2013) (3)a diagnostic criterion of a maximum of one minute of IED, absent from the previous version (DSM-IV-TR) (65). The question therefore remains as to the place of the temporal criterion (earliness) of ejaculation (61).

In addition to IELT (Intravaginal ejaculation latency time), SIAMS has defined a number of ejaculatory delays according to sexual practice: masturbation (MELT, masturbation ejaculation latency time), oral sex (OELT, oral ejaculation latency time) and anal sex (AELT, anal ejaculation latency time). (6).

We suggest that in current clinical practice, ejaculatory delay can be applied to other types of sexual stimulation than intra-vaginal intercourse, such as masturbation, oral sex, anal intercourse and also during non-heterosexual sex.

Despite the potential benefit of obtaining an objective measurement, the disadvantage of the stopwatch is that it is intrusive and can disrupt the spontaneity of intercourse and sexual pleasure (48, 66). It is therefore reserved for research (67).

Self-estimation by the patient or his or her partner can be used to estimate ejaculatory delay, as it correlates well with stopwatch measurement (sensitivity = 80%, specificity = 80%) (59, 68-70).

## C. Anamnesis

The aim of the assessment is to identify the sexual problem(s), delineate possible contributing factors and clarify treatment goals for the patient and partner.

It must be based on the biopsychosocial model, and be multidimensional in order to synthesize rather than categorize etiological and contributory factors. (2, 6, 48, 71).

The diagram proposed by Hatzichristou et al. shows sexual dysfunction as a multifactorial problem, with interacting contributing factors and taking into account the dynamic and interactive potential of the various factors presented (72).

The assessment should include (but not be limited to) the following elements:

- PE characterization
- Organic aspects
- Psychological aspects
- Relationship/partner aspects
- Aspects relating to sexuality
- Contextual aspects

## D. PE characterization

The anamnesis will therefore make it possible to identify 4 categories: primary, acquired, variable (situational) and subjective PE (Table 3) (73):

Only primary and acquired PE are considered sexual dysfunctions. However, every patient's suffering and need for care must be welcomed and supported. Indeed, even in the case of subjective PE, therapeutic support may be indicated and proposed.

Particular attention should be paid to (71, 74):

- Ejaculation delay
- The intensity of sexual stimulation
- The impact of PE on sexuality and quality of life
- The presence of other sexual dysfunctions
- Consumption or abuse of psychoactive substances
- The presence of past or present sexual violence

A few simple questions make it easier for the practitioner to conduct the interrogation (Table 4) (2):

## E. Assessment tools

There are 2 main types of standardized PE assessment tools: self-assessment questionnaires and stopwatch measurement of IED.

These tools should not, however, replace the clinical history and examination (2, 58, 71, 72).

Among the questionnaires developed with an appropriate methodology in this field, 3 validated in French are recommended. They can be used for diagnosis, follow-up and assessment of response to treatment (2, 58).

### 1. The *Premature Ejaculation Profile* (PEP) (7, 59)

The *Premature Ejaculation Profile* consists of four questions that gather information on the three dimensions on which the definitions are based (7, 59) ejaculatory delay, control over ejaculation and any relationship difficulties within the couple caused by premature ejaculation. An additional question explores patients' satisfaction with their sexuality. The questionnaire is short and easy to use. Its French version is available in **Appendix 1**.

### 2. The "Index of Premature Ejaculation" (IPE) (58, 75).

Developed in 2006 by Pfizer Laboratories, the IPE aims to assess perceived control of ejaculation, sexual satisfaction and distress in patients suffering from PE (58, 75). It has been translated into 19 languages. Its French version is available in **Appendix 2**.

3. The Premature Ejaculation Diagnostic Tool (PEDT).

Developed by Pfizer Laboratories in 2005, the PEDT assesses the presence or absence of premature ejaculation according to DSM-IV classification criteria (76, 77). It has been translated into 33 languages. Its French version is available in **Appendix 3**.

4. Other tools

Several other self-assessment tools have been developed internationally, including:

- Chinese Index for Premature Ejaculation (78, 79),
- the Checklist for Early Ejaculation Symptoms (80-82),
- the Arabic Index of Premature Ejaculation (83, 84).

These instruments have been used by a number of researchers, but to date there is no validated French translation.

## F. Clinical examination

Depending on the initial assessment, a targeted clinical examination will be performed (6).

Clinical examination can identify anatomical anomalies, comorbidities and risk factors that may favor PE (2, 71) :

- Shortness of the frenulum, pathology of the prepuce (phimosis) or glans (balanitis)
- Other anatomical anomalies of the urogenital system
- Examination of the perineum and prostate (prostatitis)
- Search for signs of dysthyroidism

## G. Further tests

No further investigations are routinely recommended unless prompted by specific clinical findings (thyroid, prostate) detected during the history or clinical examination (71).

An algorithm summarizing the evaluation of PE recommended by the AIUS is available in **Figure 1**.

# **VI.** Recommendations

**Recommendation 1**. For clinical research, we recommend using the International Society of Sexual Medicine (ISSM) definition of PE (GR A)

**Recommendation 2**. For everyday clinical practice, we suggest using the definition of the Italian Society of Andrology and Sexual Medicine (SIAMS), which defines PE as: (i) a persistent and recurrent subjective perception of loss of control (management) of the ejaculatory mechanism in the presence of appropriate erotic stimuli; (ii) subjective, PE-related distress induced in the patient and sexual dissatisfaction or PE-related anorgasmia in the,partner; (iii) a short intravaginal ejaculatory latency time, whether subjectively perceived by the patient and the.partner or objectively measured as less than 180 seconds (usually) (GR C).

- Note that the order (i), (ii) and (iii) mentioned here reflects the clinical importance of each aspect of the three-dimensional definition of PE.

**Recommendation 3**. For everyday clinical practice, we suggest that the same definition be applied to practices other than vaginal penetration, such as masturbation, oral or anal intercourse, as well as to non-heterosexual contexts (GR C).

**Recommendation 4.** The three criteria that characterize PE, namely (1) rapidity of ejaculation, (2) lack of control and (3) distress, should be systematically assessed**.**

**Recommendation 5**. In daily clinical practice, we suggest using patient-reported information (PROs), including ejaculation latency in different contexts, possibly supplemented by assessment tests/questionnaires (IPE, PEP, PEDT) (GR C).

**Recommendation 6.** We recommend investigating all patients with PE for the presence of other sexual comorbidities, in particular erectile dysfunction (ED) (GR A).

**Recommendation 7.** We suggest investigating possible sexual dysfunctions in partners (GR C).

**Recommendation 8.** We recommend taking a medical and psychosexological history, and performing a targeted physical examination in patients complaining of PE (GR A).

**Recommendation 9.** In a patient with PE and symptoms suggestive of hyperthyroidism, we recommend prescribing a TSH assay (GR B).

**Recommendation 10.** We suggest investigating prostatic pathology/chronic pelvic pain syndrome in men complaining of PE, especially if acquired (GR B).

**Recommendation 11.** We suggest studying the sexual function and psychological health of male patients in infertile couples. (GR A).

# VII. References

1. Haute Autorité de Santé (HAS). Niveau de preuve et gradation des recommandations de bonne pratique [Internet]. Available from: https://www has-sante fr/upload/docs/application/pdf/2013-06/etat_des_lieux_niveau_preuve_gradation pdf. 2013.

2. 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 (PE). The journal of sexual medicine. 2014;11(6):1392-422.

3 American Psychiatric Association. Diagnostic and statistical manual of mental disorders, fifth edition (DSM-5). Am Psychiatric Assoc. 2013.

4 World Health Organization. International classification of diseases 11th revision for mortality and morbidity statistics (ICD-11-MMS). https://icd.who.int/browse11/l-m/fr. World Health Organization, Geneva. 2018.

5. Serefoglu EC, Yaman O, Cayan S, Asci R, Orhan I, Usta MF, 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. The journal of sexual medicine. 2011;8(2):540-8.

6. Sansone A, Aversa A, Corona G, Fisher AD, Isidori AM, La Vignera S, et al. Management of premature ejaculation: a clinical guideline from the Italian Society of Andrology and Sexual Medicine (SIAMS). J Endocrinol Invest. 2021;44(5):1103-18.

7. 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. The journal of sexual medicine. 2010;7(9):2947-69.

8. Waldinger MD, Quinn P, Dilleen M, Mundayat R, Schweitzer DH, Boolell M. A multinational population survey of intravaginal ejaculation latency time. The journal of sexual medicine. 2005;2(4):492-7.

9 Waldinger MD, McIntosh J, Schweitzer DH. A five-nation survey to assess the distribution of the intravaginal ejaculatory latency time among the general male population. The journal of sexual medicine. 2009;6(10):2888-95.

10. Verze P, Arcaniolo D, Palmieri A, Cai T, La Rocca R, Franco M, et al. Premature Ejaculation Among Italian Men: Prevalence and Clinical Correlates From an Observational, Non-Interventional, Cross-Sectional, Epidemiological Study (IPER). Sex Med. 2018;6(3):193-202.

11. Barbonetti A, D'Andrea S, Cavallo F, Martorella A, Francavilla S, Francavilla F. Erectile Dysfunction and Premature Ejaculation in Homosexual and Heterosexual Men: A Systematic Review and Meta-Analysis of Comparative Studies. The journal of sexual medicine. 2019;16(5):624-32.

12. Xin ZC, Choi YD, Rha KH, Choi HK. Somatosensory evoked potentials in patients with primary premature ejaculation. J Urol. 1997;158(2):451-5.

13. Guo L, Liu Y, Wang X, Yuan M, Yu Y, Zhang X, et al. Significance of penile hypersensitivity in premature ejaculation. Sci Rep. 2017;7(1):10441.

14. Fanciullacci F, Colpi GM, Beretta G, Zanollo A. Cortical evoked potentials in subjects with true premature ejaculation. Andrologia. 1988;20(4):326-30.

15 Waldinger MD, Berendsen HH, Blok BF, Olivier B, Holstege G. Premature ejaculation and serotonergic antidepressants-induced delayed ejaculation: the involvement of the serotonergic system. Behavioural brain research. 1998;92(2):111-8.

16. Giuliano F. 5-Hydroxytryptamine in premature ejaculation: opportunities for therapeutic intervention. Trends in neurosciences. 2007;30(2):79-84.

17. Yang X, Gao M, Zhang L, Liu L, Liu P, Sun J, et al. Central Neural Correlates During Inhibitory Control in Lifelong Premature Ejaculation Patients. Front Hum Neurosci. 2018;12:206.

18. Zhang B, Lu J, Xia J, Wang F, Li W, Chen F, et al. Functional insights into aberrant brain responses and integration in patients with lifelong premature ejaculation. Sci Rep. 2017;7(1):460.

19. Rastrelli G, Cipriani S, Corona G, Vignozzi L, Maggi M. Clinical characteristics of men complaining of premature ejaculation together with erectile dysfunction: a cross-sectional study. Andrology. 2019;7(2):163-71.

20. Culha MG, Tuken M, Gonultas S, Cakir OO, Serefoglu EC. Frequency of etiological factors among patients with acquired premature ejaculation: prospective, observational, single-center study. Int J Impot Res. 2020;32(3):352-7.

21. Chia S. Management of premature ejaculation -- a comparison of treatment outcome in patients with and without erectile dysfunction. International journal of andrology. 2002;25(5):301-5.

22 Jannini EA, Lombardo F, Lenzi A. Correlation between ejaculatory and erectile dysfunction. International journal of andrology. 2005;28 Suppl 2:40-5.

23. Adson DE, Kotlyar M. Premature ejaculation associated with citalopram withdrawal. The Annals of pharmacotherapy. 2003;37(12):1804-6.

24. O'Flynn R, Michael A. Reboxetine-induced spontaneous ejaculation. Br J Psychiatry. 2000;177:567-8.

25. Peugh J, Belenko S. Alcohol, drugs and sexual function: a review. J Psychoactive Drugs. 2001;33(3):223-32.

26. Liu T, Jia C, Peng YF, Zhong W, Fang X. Correlation between premature ejaculation and psychological disorders in 270 Chinese outpatients. Psychiatry Res. 2019;272:69-72.

27 Yang Y, Lu Y, Song Y, Chen H, Liu X. Correlations and stratification analysis between premature ejaculation and psychological disorders. Andrologia. 2019;51(8):e13315.

28 Fiala L, Lenz J, Konecna P, Zajicova M, Cerna J, Sajdlova R. Premature ejaculation and stress. Andrologia. 2021;53(7):e14093.

29 Figueira I, Possidente E, Marques C, Hayes K. Sexual dysfunction: a neglected complication of panic disorder and social phobia. Archives of sexual behavior. 2001;30(4):369-77.

30. Chierigo F, Capogrosso P, Boeri L, Ventimiglia E, Frego N, Pozzi E, et al. Lower urinary tract symptoms and depressive symptoms among patients presenting for distressing early ejaculation. Int J Impot Res. 2020;32(2):207-12.

31. Sihotang RC, Alvonico T, Taher A, Birowo P, Rasyid N, Atmoko W. Premature ejaculation in patients with lower urinary tract symptoms: a systematic review. Int J Impot Res. 2021;33(5):516-24.

32. Gonen M, Kalkan M, Cenker A, Ozkardes H. Prevalence of premature ejaculation in Turkish men with chronic pelvic pain syndrome. Journal of andrology. 2005;26(5):601-3.

33. Li HJ, Kang DY. Prevalence of sexual dysfunction in men with chronic prostatitis/chronic pelvic pain syndrome: a meta-analysis. World journal of urology. 2016;34(7):1009-17.

34. Liang CZ, Zhang XJ, Hao ZY, Shi HQ, Wang KX. Prevalence of sexual dysfunction in Chinese men with chronic prostatitis. BJU international. 2004;93(4):568-70.

35. Screponi E, Carosa E, Di Stasi SM, Pepe M, Carruba G, Jannini EA. Prevalence of chronic prostatitis in men with premature ejaculation. Urology. 2001;58(2):198-202.

36. Shamloul R, el-Nashaar A. Chronic prostatitis in premature ejaculation: a cohort study in 153 men. The journal of sexual medicine. 2006;3(1):150-4.

37 La Vignera S, Condorelli RA, Vicari E, Favilla V, Morgia G, Calogero AE. Acquired premature ejaculation and male accessory gland infection: relevance of ultrasound examination. Asian journal of andrology. 2016;18(5):769-72.

38. La Vignera S, Condorelli R, Vicari E, D'Agata R, Calogero AE. High frequency of sexual dysfunction in patients with male accessory gland infections. Andrologia. 2012;44 Suppl 1:438-46.

39. Carani C, Isidori AM, Granata A, Carosa E, Maggi M, Lenzi A, et al. Multicenter study on the prevalence of sexual symptoms in male hypo- and hyperthyroid patients. The Journal of clinical endocrinology and metabolism. 2005;90(12):6472-9.

40. Corona G, Petrone L, Mannucci E, Jannini EA, Mansani R, Magini A, et al. Psycho-biological correlates of rapid ejaculation in patients attending an andrologic unit for sexual dysfunctions. European urology. 2004;46(5):615-22.

41 Waldinger MD, Zwinderman AH, Olivier B, Schweitzer DH. Thyroid-stimulating hormone assessments in a Dutch cohort of 620 men with lifelong premature ejaculation without erectile dysfunction. The journal of sexual medicine. 2005;2(6):865-70.

42. Cihan A, Demir O, Demir T, Aslan G, Comlekci A, Esen A. The relationship between premature ejaculation and hyperthyroidism. J Urol. 2009;181(3):1273-80.

43. Rajkumar RP, Kumaran AK. The association of anxiety with the subtypes of premature ejaculation: a chart review. Prim Care Companion CNS Disord. 2014;16(4).

44 Pyke RE. Sexual Performance Anxiety. Sex Med Rev. 2020;8(2):183-90.

45. Corona G, Rastrelli G, Limoncin E, Sforza A, Jannini EA, Maggi M. Interplay Between Premature Ejaculation and Erectile Dysfunction: A Systematic Review and Meta-Analysis. The journal of sexual medicine. 2015;12(12):2291-300.

46. Kamnerdsiri WA, Rodriguez Martinez JE, Fox C, Weiss P. Clinical correlation between erectile function and ejaculatory function in the Czech male population. PLoS One. 2018;13(7):e0199588.

47. Jannini EA, Lenzi A, Isidori A, Fabbri A. Subclinical erectile dysfunction: proposal for a novel taxonomic category in sexual medicine. The journal of sexual medicine. 2006;3(5):787-94.

48. 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. The journal of sexual medicine. 2014;11(6):1423-41.

49 Kaplan HS, Kohl RN, Pomeroy WB, Offit AK, Hogan B. Group treatment of premature ejaculation. Archives of sexual behavior. 1974;3(5):443-52.

50. Zilbergeld B. Male sexuality. New York, Bantam. 1978.

51 McCarthy BW. Cognitive-behavioral strategies and techniques in the treatment of early ejaculation. Principles and practice of sex therapy: Update for the 1990s, 2nd ed. New York, NY, US: Guilford Press; 1989. p. 141-67.

52 Grenier G, Byers ES. The relationships among ejaculatory control, ejaculatory latency, and attempts to prolong heterosexual intercourse. Archives of sexual behavior. 1997;26(1):27-47.

53 Grenier G, Byers ES. Operationalizing premature or rapid ejaculation. The Journal of Sex Research. 2001;38(4):369-78.

54. Burri A, Buchmeier J, Porst H. The Importance of Male Ejaculation for Female Sexual Satisfaction and Function. The journal of sexual medicine. 2018;15(11):1600-8.

55. Patrick DL, Althof SE, Pryor JL, Rosen R, Rowland DL, Ho KF, et al. Premature ejaculation: an observational study of men and their partners. The journal of sexual medicine. 2005;2(3):358-67.

56 Giuliano F, Patrick DL, Porst H, La Pera G, Kokoszka A, Merchant S, et al. Premature ejaculation: results from a five-country European observational study. European urology. 2008;53(5):1048-57.

57. Rowland D, Perelman M, Althof S, Barada J, McCullough A, Bull S, et al. Self-reported premature ejaculation and aspects of sexual functioning and satisfaction. The journal of sexual medicine. 2004;1(2):225-32.

58 Giuliano F. [Questionnaires in sexual medicine]. Progres en urologie: journal of the Association francaise d'urologie and the Societe francaise d'urologie. 2013;23(9):811-21.

59. McMahon CG, Althof SE, Waldinger MD, Porst H, Dean J, Sharlip ID, et al. An evidence-based definition of lifelong premature ejaculation: report of the International Society for Sexual Medicine (ISSM) ad hoc committee for the definition of premature ejaculation. The journal of sexual medicine. 2008;5(7):1590-606.

60. Kempeneers PD, M. The premature ejaculation 'disorder': questioning the criterion of one minute of penetration. Sexologies. 2014;23(3):59-63.

61 Rowland DL, Althof SE, McMahon CG. The Unfinished Business of Defining Premature Ejaculation: The Need for Targeted Research. Sex Med Rev. 2022;10(2):323-40.

62. Kempeneers P, Andrianne R, Cuddy M, Blairy S. Sexual Cognitions, Trait Anxiety, Sexual Anxiety, and Distress in Men With Different Subtypes of Premature Ejaculation and in Their Partners. J Sex Marital Ther. 2018;44(4):319-32.

63 Perelman MA. Reexamining the Definitions of PE and DE. J Sex Marital Ther. 2017;43(7):633-44.

64 Rowland DL, Kolba TN. Understanding the effects of establishing various cutoff criteria in the definition of men with premature ejaculation. The journal of sexual medicine. 2015;12(5):1175-83.

65 Shabsigh R, Rowland D. The Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision as an appropriate diagnosis for premature ejaculation. The journal of sexual medicine. 2007;4(5):1468-78.

66 Althof SE, McMahon CG. Contemporary Management of Disorders of Male Orgasm and Ejaculation. Urology. 2016;93:9-21.

67. Hatzimouratidis K, Amar E, Eardley I, Giuliano F, Hatzichristou D, Montorsi F, et al. Guidelines on male sexual dysfunction: erectile dysfunction and premature ejaculation. European urology. 2010;57(5):804-14.

68. Althof SE. Evidence based assessment of rapid ejaculation. Int J Impot Res. 1998;10 Suppl 2:S74-6; discussion S7-9.

69 Pryor J, Broderick G, Ho K, Jamieson C, Gagnon D. Comparison of estimated versus measured intravaginal ejaculatory latency time in men with and without premature ejaculation. The journal of sexual medicine. 2005;3:54.

70. Rosen RC, McMahon CG, Niederberger C, Broderick GA, Jamieson C, Gagnon DD. Correlates to the clinical diagnosis of premature ejaculation: results from a large observational study of men and their partners. J Urol. 2007;177(3):1059-64; discussion 64.

71. Hatzimouratidis K, Eardley I, Giuliano F, Hatzichristou D, Moncada I, Salonia A. Guidelines on male sexual dysfunction: erectile dysfunction and premature ejaculation. European Association of Urology Website http://uroweborg/guideline/male-sexual-dysfunction/ European Association of Urology Website Updated 2015. 2015.

72. Hatzichristou D, Kirana PS, Banner L, Althof SE, Lonnee-Hoffmann RA, Dennerstein L, et al. Diagnosing Sexual Dysfunction in Men and Women: Sexual History Taking and the Role of Symptom Scales and Questionnaires. The journal of sexual medicine. 2016;13(8):1166-82.

73. Serefoglu EC, Saitz TR. New insights on premature ejaculation: a review of definition, classification, prevalence and treatment. Asian journal of andrology. 2012;14(6):822-9.

74. Montorsi F, Adaikan G, Becher E, Giuliano F, Khoury S, Lue TF, et al. Summary of the recommendations on sexual dysfunctions in men. The journal of sexual medicine. 2010;7(11):3572- 88.

75. Althof S, Rosen R, Symonds T, Mundayat R, May K, Abraham L. Development and validation of a new questionnaire to assess sexual satisfaction, control, and distress associated with premature ejaculation. The journal of sexual medicine. 2006;3(3):465-75.

76. Symonds T, Perelman MA, Althof S, Giuliano F, Martin M, May K, et al. Development and validation of a premature ejaculation diagnostic tool. European urology. 2007;52(2):565-73.

77. Symonds T, Perelman M, Althof S, Giuliano F, Martin M, Abraham L, et al. Further evidence of the reliability and validity of the premature ejaculation diagnostic tool. Int J Impot Res. 2007;19(5):521-5.

78. Yuan YM, Xin ZC, Jiang H, Guo YJ, Liu WJ, Tian L, et al. Sexual function of premature ejaculation patients assayed with Chinese Index of Premature Ejaculation. Asian journal of andrology. 2004;6(2):121-6.

79. Cui YD, Hu SB, Wu B, Li SJ, Xiang K, Liao ZL, et al. Efficacy of combined traditional Chinese medicine spray with premature ejaculation desensitization therapy for the treatment of primary premature ejaculation. Afr Health Sci. 2017;17(3):603-13.

80. Jern P. Evaluation of a behavioral treatment intervention for premature ejaculation using a handheld stimulating device. J Sex Marital Ther. 2014;40(5):358-66.

81. Jern P, Piha J, Santtila P. Validation of three early ejaculation diagnostic tools: a composite measure is accurate and more adequate for diagnosis by updated diagnostic criteria. PLoS One. 2013;8(10):e77676.

82. Ventus D, Gunst A, Arver S, Dhejne C, Oberg KG, Zamore-Soderstrom E, et al. Vibrator- Assisted Start-Stop Exercises Improve Premature Ejaculation Symptoms: A Randomized Controlled Trial. Archives of sexual behavior. 2020;49(5):1559-73.

83. Albakr A, Arafa M, Elbardisi H, ElSaid S, Majzoub A. Premature ejaculation: An investigative study into assumptions, facts and perceptions of patients from the Middle East (PEAP STUDY). Arab J Urol. 2021;19(3):303-9.

84 Arafa M, Shamloul R. Development and evaluation of the Arabic Index of Premature Ejaculation (AIPE). The journal of sexual medicine. 2007;4(6):1750-6.

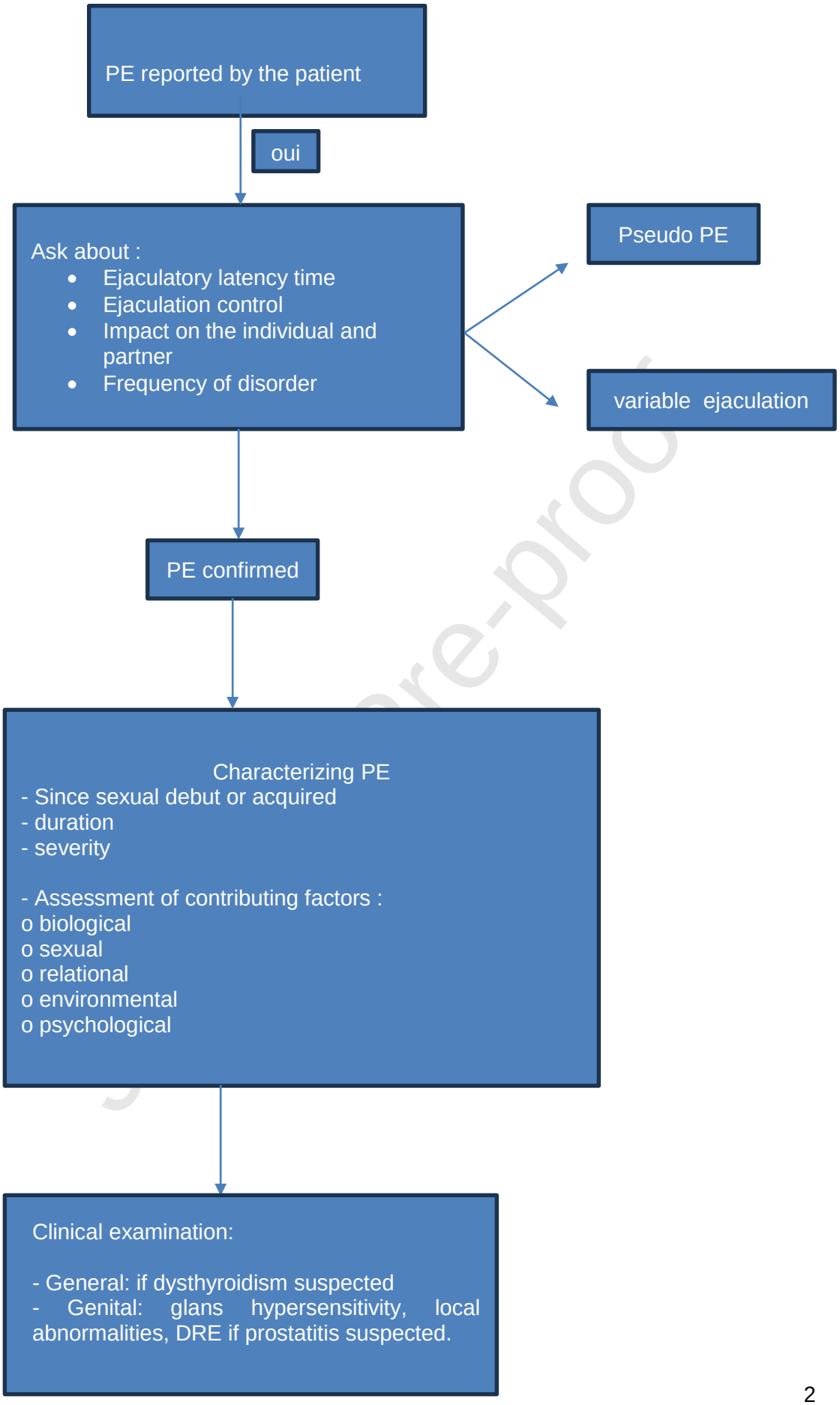

*Table 1 Levels of overall scientific evidence provided by the literature and Grade of recommendations.*

| **Level of scientific evidence provided by the literature (HAS grid)** | | **Grade of recommendations** |
|---|---|---|
| **Level 1** | • High-power randomized controlled trials<br>• Meta-analysis of randomized controlled trials<br>• Decision analysis based on well-conducted studies. | **A**<br>Established scientific proof |
| **Level 2** | • Low-power randomized controlled trials<br>• Well-conducted non-randomized comparative studies<br>• Cohort studies | **B**<br>Scientific presumption |
| **Level 3** | • Case-control studies. | **C**<br>Low level of evidence |
| **Level 4** | • Comparative studies with significant bias<br>• Retrospective studies<br>• Case series<br>• Descriptive epidemiological studies (cross-sectional, longitudinal) | |
| **Expert agreement** | • In the absence of studies, recommendations are based on agreement between experts on the working group, after consultation with the reading group. The absence of a gradation does not mean that the recommendations are not relevant and useful.<br>• On the other hand, it should encourage further studies. | **AE**<br>Expert agreement |

*Table 2 Main definitions of PE.*

| | |
|---|---|
| **DSM-5 (3).** | *"Male sexual dysfunction characterized by a persistent or recurrent pattern of ejaculation occurring during sexual activity in a couple within about 1 min after vaginal penetration and before the individual wishes to do so. Symptoms must have been present for at least 6 months and be experienced on almost all (> 75-100%) occasions of sexual activity (situational or generalized contexts). The symptoms cause clinically significant distress to the individual and the sexual dysfunction is not better explained by a non-sexual mental disorder or as a consequence of severe relational distress and is not attributable to a substance/medication or other medical condition.*" |
| **SIMS (2)** | "*male sexual dysfunction characterized by ejaculation that always or almost always occurs before or within about 1 min after vaginal penetration on first sexual experience (primary PE), OR a clinically significant reduction in latency, often to about 3 min or less (acquired PE); inability to delay ejaculation on all or almost all vaginal penetrations; and negative personal consequences, such as distress, embarrassment, frustration, and/or avoidance of sexual intimacy.*" |
| **ICD-11 (4).** | *"Ejaculation that occurs before or very soon after the onset of vaginal penetration or other sexual stimulation, with ejaculation control perceived as nil or poor.* Premature ejaculation occurs episodically or persistently over a period of at least several months, and is associated with clinically significant distress."<br>• ICD-11 identifies five categories: (1) permanent, generalized; (2) permanent, situational; (3) acquired, generalized; (4) acquired, situational; (5) unspecified (as a residual category).<br>• With regard to degrees of severity, ICD-10 classifies PE as severe, when it occurs before penetration (ante portas) or with an intra-vaginal ejaculation delay (IED) ≤ 15 s, moderate, when the IED is between 15 s and 1 min, and mild, when the IED is between 1 and 2 min (85). ICD-11 removed the thresholds while introducing the category "subjective or relational PE" when the loss of voluntary control is experienced with distress by the |

| | |
|---|---|
| | man or partner, but the IED is "normal" (up to about 6 min) (4). |
| **SIAMS (6)** | "(i) a persistent and recurrent subjective perception of loss of control of the ejaculatory mechanism in the presence of appropriate erotic stimuli; (ii) subjective distress, related to PE, induced in both the patient and the partner; (iii) a short IED (<180s) from penetration to ejaculation, whether the IED is subjectively perceived or objectively measured by the patient or the partner." |

*Table 3 Description of the four PE syndromes used in the classification of men complaining of premature ejaculation.*

| **EP Primary** | **EP Acquired** | **EP Variable** | **EP Subjective** |
|---|---|---|---|
| In most cases (80%) within 30-60 seconds or between 1 and 2 min (20%) | The IED is short (less than 2 minutes) | The IED can be short or normal | The IED is within the normal range or may even be longer. |
| PE has been present since the earliest sexual experiences | PE appears at a given moment in a man's life | PE is not constant and occurs irregularly | Subjective perception of PE, constant or irregular |
| With almost all women | The man had normal ejaculation experiences before | The ability to delay ejaculation may be diminished or absent | The ability to delay ejaculation may be diminished or absent |
| Ejaculation occurs too early, almost every time you have sex. | Onset is either sudden or gradual | The impression of a reduced ability to control ejaculation. | Imaginary EP or lack of ejaculation control |
| PE persists throughout human life (neurobiological/genetic cause) | PE may be the result of a urological/thyroid disorder, or psychological or relationship problems. | Psychotherapy should be considered as a first-line treatment | Man's preoccupation not best explained by another mental disorder |

*Table 4 A few simple questions to guide your interrogation (2).*

| | |
|---|---|
| **For diagnosis :** | Can you delay ejaculation?<br>Do you feel embarrassed, annoyed or frustrated by your EP?<br>What is the time between penetration and ejaculation? |

| | |
|---|---|
| **To characterize PE :** | When did you first experience this problem?<br>Do you have an EP on almost every attempt?<br>and with all the partners or not? |
| **To assess erectile function** | Is your erection rigid enough to penetrate?<br>Do you have difficulty maintaining your erection until ejaculation during intercourse?<br>Did you rush penetration to avoid losing your erection? |
| **To assess relational impact** | Is your partner upset by your EP?<br>Is your partner avoiding sex?<br>Does your EP affect your overall relationship? |
| **About previous treatments** | Have you ever received treatment or care for your PE? |
| **About the impact on quality of life** | Do you avoid sexual relations because of PE?<br>Do you feel anxious, depressed or embarrassed about your PE? |
| **Concluding question (suggested):** | Would you like to add anything about your sex life? |

# Premature Ejaculation Profile (PEP)

Veuillez répondre aux questions en pensant à votre activité sexuelle actuelle

**Q1 En qui concerne vos rapports sexuels au cours du dernier mois, vous diriez que votre satisfaction a été :**

1 = Très mauvaise
2 = Mauvaise
3 = Correcte
4 = Bonne
5 = Très bonne

**Q2 Au cours du dernier mois votre contrôle de l'éjaculation au cours de vos rapports sexuels a été :**

1 = Très mauvais
2 = Mauvais
3 = Correct
4 = Bon
5 = Très bon

**Q3 Au cours du dernier mois, la rapidité avec laquelle vous avez éjaculé lors de vos rapports sexuels avec pénétration vous-a-t-elle contrarié ?**

1 = Pas du tout
2 = Un peu
3 = Modérément
4 = Beaucoup
5 = Extrêmement

**Q4 Au cours du dernier mois, la rapidité avec laquelle vous avez éjaculé lors de vos rapports sexuels avec pénétration a-t-elle compliqué vos relations avec votre partenaire ?**

1 = Pas du tout
2 = Un peu
3 = Modérément
4 = Beaucoup
5 = Extrêmement

## Index of Premature Ejaculation©

Ces questions portent sur les effets que vos problèmes sexuels ont eus sur votre vie sexuelle pendant les 4 dernières semaines.
S'il vous plait, répondez aux questions suivantes aussi honnêtement et clairement que possible. Dans ce questionnaire, les définitions suivantes seront utilisées :
- Un **rapport sexuel** est défini comme une pénétration sexuelle (vous pénétrez votre partenaire)
- **Ejaculation** : l'éjection de sperme du pénis
- **Contrôle** : éjaculer quand vous y êtes prêts
- **Perturbé** : signifie de quelle façon vous êtes frustré, déçu ou ennuyé par votre éjaculation prématurée.

Cochez une seule case par question.

1. Pendant les quatre dernières semaines, lorsque vous avez eu des rapports sexuels, combiende fois avez-vous **contrôlé** le moment de votre éjaculation ?

- ☐ Pas de rapport sexuel (sans objet)
  - ☐ Presque toujours ou toujours
  - ☐ Plus de la moitié du temps
  - ☐ Environ la moitié du temps
  - ☐ Moins de la moitié du temps
  - ☐ Presque jamais ou jamais

2. Pendant les quatre dernières semaines, quand vous avez eu des rapports sexuels, quelle étaitvotre **confiance** en votre contrôle de l'éjaculation ?

- ☐ Pas de rapport sexuel (sans objet)
  - ☐ Confiance élevée
  - ☐ Confiance modérément élevée
  - ☐ Confiance ni élevée ni faible
  - ☐ Confiance modérément faible
  - ☐ Faible confiance

3. Pendant les quatre dernières semaines, quand vous avez eu des rapports sexuels, à quellefréquence cela a-t-il été satisfaisant pour vous ?

- ☐ Pas de rapport sexuel (sans objet)
  - ☐ Presque toujours ou toujours
  - ☐ Plus de la moitié du temps
  - ☐ Environ la moitié du temps
  - ☐ Moins de la moitié du temps
  - ☐ Presque jamais ou jamais

4. Pendant les quatre dernières semaines, quand vous avez eu des rapports sexuels, quel étaitvotre degré de satisfaction concernant votre **contrôle** de l'éjaculation ?

- ☐ Pas de rapport sexuel (sans objet)
- ☐ Très satisfait
- ☐ Quelque peu satisfait
- ☐ Ni satisfait ni insatisfait
- ☐ Quelque peu insatisfait
- ☐ Très insatisfait

5. Pendant les quatre dernières semaines, quand vous avez eu des rapports sexuels, quel étaitvotre degré de satisfaction concernant la **durée du rapport** avant l'éjaculation ?

- ☐ Pas de rapport sexuel (sans objet)
- ☐ Très satisfait
- ☐ Quelque peu satisfait
- ☐ Ni satisfait ni insatisfait
- ☐ Quelque peu insatisfait
- ☐ Très insatisfait

6. Pendant les quatre dernières semaines, quelle satisfaction avez-vous retirée de **votre** viesexuelle dans l'ensemble ?

- ☐ Très satisfait
- ☐ Quelque peu satisfait
- ☐ Ni satisfait ni insatisfait
- ☐ Quelque peu insatisfait
- ☐ Très insatisfait

7. Pendant les quatre dernières semaines, quelle satisfaction avez-vous retirée des relationsintimes **avec votre partenaire** ?

- ☐ Très satisfait
- ☐ Quelque peu satisfait
- ☐ Ni satisfait ni insatisfait
- ☐ Quelque peu insatisfait
- ☐ Très insatisfait

8. Au cours des quatre dernières semaines, quel plaisir vous ont procuré vos rapports sexuels ?

- ☐ Pas de rapport sexuel (sans objet)
- ☐ Plaisir élevé
- ☐ Plaisir modérément élevé
- ☐ Plaisir ni élevé ni faible
- ☐ Plaisir modérément faible
- ☐ Faible plaisir

| |
|---|
| 9. Pendant les quatre dernières semaines, dans quelle mesure avez-vous été perturbé (frustré)par le temps que vous avez tenu avant d'éjaculer ?<br><br>☐ Pas de rapport sexuel (sans objet)<br>☐ Extrêmement perturbé<br>☐ Très perturbé<br>☐ Modérément perturbé<br>☐ Peu perturbé<br>☐ Pas perturbé du tout |
| 10. Pendant les quatre dernières semaines, dans quelle mesure avez-vous été perturbé (frustré)par votre contrôle de l'éjaculation ?<br><br>☐ Pas de rapport sexuel (sans objet)<br>☐ Extrêmement perturbé<br>☐ Très perturbé<br>☐ Modérément perturbé<br>☐ Peu perturbé<br>☐ Pas perturbé du tout |

**Système de notation IPE (Items, Total, Domaines)**

Items individuels
L'EPI contient 10 items et chaque item a 5 options de réponse possibles.

Les items 1 à 8 sont notés de 5 à 1 (par ordre décroissant), la catégorie "pas de rapport sexuel, non applicable" étant définie comme "manquante".

Par exemple
Au cours des quatre dernières semaines, lorsque vous avez eu des rapports sexuels, à quelle fréquence avez-vous contrôlé le moment de l'éjaculation ?

Pas de rapports sexuels, non applicable [manquant].
Presque toujours/tout le temps [5]
Beaucoup plus de la moitié du temps [4].
Environ la moitié du temps [3]
Beaucoup moins de la moitié du temps [2].
Presque jamais/jamais [1]

Les items 9 et 10 sont notés de 1 à 5 (par ordre croissant), la catégorie "pas de rapport sexuel, non applicable" étant définie comme "manquante".
Par exemple

Au cours des quatre dernières semaines, quel a été votre degré de détresse (frustration) concernant le contrôle de votre éjaculation ?

Pas de rapports sexuels, sans objet [Manquant].
Extrêmement angoissé(e) [1]
Très angoissé(e) [2]
Moyennement angoissé [3]
Légèrement angoissé(e) [4]
Pas de détresse du tout [5]

Scores des domaines
L'analyse factorielle a permis d'identifier trois domaines.

1

Domaine Nombre d'items Gamme de scores des items
Sexuel

Satisfaction sexuelle 4 3, 6, 7, 8 0-100*
Contrôle 4 1, 2, 4, 5 0-100*
Détresse 2 9, 10 0-100*

*Standardisation de la notation sur l'échelle 0-100
Chaque domaine doit ensuite être standardisé sur une échelle de 0-100 en utilisant la formule suivante :

Domaine du contrôle : (score non standardisé - 4) x 100/16 Satisfaction sexuelle : comme ci-dessus
Détresse (score non standardisé - 2) x 100/8

Un score plus élevé = plus de contrôle, plus de satisfaction, moins de détresse.

# Premature Ejaculation Diagnostic Tool (PEDT)

Ce questionnaire analyse la présence d'éjaculation précoce pendant les rapports sexuels. L'éjaculation précoce est la dysfonction sexuelle masculine la plus répandue. Ce questionnaire ne remplace pas un examen médical et ne doit pas être considéré comme définitif. Les résultats du test doivent toujours être discutés avec un professionnel de santé.

**Q1 : À quel point vous est-il difficile de retarder votre éjaculation ?**

- Pas facile du tout
- Un peu difficile
- Assez difficile
- Très difficile
- Extrêmement difficile

**Q2 : Votre éjaculation se produit-elle avant que vous ne le souhaitiez ?**

- Jamais ou presque jamais (0%)
- Quelques fois (25%)
- La moitié du temps (50%)
- La plupart du temps (75%)
- Presque toujours ou toujours (100%)

**Q3 : Éjaculez -vous suite à une très faible stimulation ?**

- Jamais ou presque jamais (0%)
- Quelques fois (25%)
- La moitié du temps (50%)
- La plupart du temps (75%)
- Presque toujours ou toujours (100%)

**Q4 : Vous sentez -vous frustré d'éjaculer avant le moment souhaité ?**

- Pas du tout
- Légèrement
- Modérément
- Beaucoup
- Extrêmement

**Q5 : Vous sentez -vous affecté par l'insatisfaction sexuelle générée chez votre partenaire ?**

- Pas du tout
- Légèrement
- Modérément
- Beaucoup
- Extrêmement

**SCORE :**
0-8 absence d'éjaculation précoce
9-10 éjaculation précoce probable
11-22 éjaculation précoce