Considerations for an Evidence-Based Definition of Premature Ejaculation in the DSM-V

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ABSTRACT

Introduction. The Diagnostic and Statistical Manual of Mental Disorders, 4th Ed., text revision (DSM-IV-TR) criteria for premature ejaculation (PE) have been criticized on multiple grounds including that the criteria lack precision, that the requirement of marked distress is inappropriate, and that the specification of etiological subtypes should be deleted. Since these criteria were originally adopted, there has been a tremendous gain in knowledge concerning PE.

Aim. The goal of this manuscript is to review evidence relevant to diagnostic criteria for PE published since 1990.

Method. Medline searches from 1990 forward were conducted using the terms PE, rapid ejaculation, ejaculatory disorder, and intravaginal ejaculatory latency. Early drafts of proposed alterations in diagnostic criteria were submitted to advisors.

Main Outcome Measure. Expert opinion was based on review of evidence-based medical literature.

Results. The literature search indicated possible alterations in diagnostic criteria for PE.

Conclusions. It is recommended that the Diagnostic and Statistical Manual committee adopt criteria similar to those adopted by the International Society of Sexual Medicine. It is proposed that lifelong PE in heterosexual men be defined as ejaculation occurring within approximately 1 minute of vaginal penetration on 75% of occasions for at least 6 months. Field trials will be necessary to determine if these criteria can be applied to acquired PE and whether analogous criteria can be applied to ejaculatory latencies in other sexual activities. Serious consideration should be given to changing the name from PE to rapid ejaculation. The subtypes indicating etiology should be eliminated.

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Key Words. Premature Ejaculation; Rapid Ejacualtion; Diagnostic Criteria

The Diagnostic and Statistical Manual of Mental Disorders, 4th Ed., text revision (DSM-IV-TR) definition of premature ejaculation (PE) has been criticized on multiple grounds, especially that the criteria sets lack precision and that the diagnosis is highly dependent upon clinician judgment [1]. There is considerable evidence that studies using DSM-IV-TR diagnostic criteria have included men with widely varying ejaculatory latencies. The lack of agreement concerning the definition of what constitutes PE has hampered research concerning the etiology and treatment of this disorder. The purpose of this manuscript is to critically review the DSM-IV-TR criteria for PE in view of recent controlled studies of the syndrome.

This diagnostic entity was first introduced into the DSM-III [2]. In subsequent editions of the Diagnostic and Statistical Manual, there have been minor alterations in criteria sets. In DSM-III, PE was defined as "ejaculation which occurs before the person wishes it, because of recurrent and persistent absence of reasonable control of ejaculation and orgasm during sexual activity." The criteria of control was removed in DSM-III-R [3]. The following wording was substituted: "persistent or recurrent ejaculation with minimal sexual stimulation or before, upon, or shortly after penetration and before the person wishes it." Similar wording was retained in DSM-IV [4] and DSM-IV-TR [5]. In DSM-IV and DSM-IV-TR, an additional criterion of the disorder causing "marked personal or

interpersonal distress" was added. The concept of distress was added to insure that variations in sexual behavior unassociated with impairment nor distress would not be diagnosed as a disorder. Precise time parameters were not included and the clinician was instructed to use clinical judgment in making this diagnosis. The clinician was instructed to take into account factors which might influence duration of the excitement phrase, such as age, novelty of the sex partner, and recent frequency of sexual activity when making this diagnosis.

Perhaps, the most serious criticism of the DSM-IV-TR definition of PE is the absence of clear criteria or an objective operational definition. For example, the criterion of "ejaculation before or shortly after vaginal penetration" is subjective and has been variously interpreted by different investigators. Proposed objective criteria for PE have varied widely. Some investigators have defined PE as ejaculation which occurs within 1 minute of penetration, whereas others have defined ejaculation occurring within 7 minutes as premature [6]. Other clinicians have proposed operational definitions based on the number of thrusts between vaginal penetration and ejaculation, sense of control over ejaculatory latency, and sexual satisfaction [7–11]. Others have proposed definitions based on a combination of direct measures and patient-reported outcomes [12]. Two separate studies employing DSM-IV-TR criteria for the diagnosis of PE have found quite heterogeneous populations of men defined as having PE. For example, data from a study by Patrick [13] were reanalyzed by Waldinger and Schweitzer [14]. In the original study, men were diagnosed by expert clinicians as meeting or not meeting DSM-IV-TR criteria for PE. Subsequently, they measured intravaginal ejaculatory latency time (IELT) by stopwatch. Stopwatch measures of IELT were compared between 190 men diagnosed with PE and 1,215 assessed as not having PE. As might be expected, men diagnosed with PE have shorter IELTs than men not so diagnosed. Men with PE had a median IELT of 1.8 minutes and men without PE had a median IELT of 7.3 minutes. However, considerable overlap occurred between the two groups of men. Both groups had a range on 0–25 minutes. Half of the men diagnosed with PE had IELTS exceeding 2 minutes. Thirty-five percent had IELTs between 2 and 5 minutes and 13% had IELTs between 5 and 25 minutes. In a somewhat similar study, 201 men were diagnosed as having PE according to DSM-IV-TR criteria and 1,115 men were diagnosed as not having PE [15]. Again, IELTs were separately measured. Waldinger and Schweitzer [16] reanalyzed the data and found that there was considerable overlap between the two groups. Only about 20% of men who were diagnosed as PE ejaculated within 1 minute after penetration, whereas about 35% ejaculated between 1 and 2 minutes; 19% had an IELT between 2 and 4 minutes, and 25% ejaculated between 4 and 25 minutes. In the non-PE group, 12.1% had an IELT of less than 2 minutes. It is obvious that the DSM-IV-TR criteria are nonspecific and that this results in heterogenous research populations.

Several lines of converging date suggest that a more precise definition of PE is possible. Waldinger et al. [17] advocated the measurement of intravaginal ejaculatory time (IELT) as measured by stopwatch in an attempt to operationalize the definition of PE. IELT is defined as the time between vaginal intromission and intravaginal ejaculation. In a study of 110 heterosexual men with lifelong PE, Waldinger et al. [18] found that 40% had IELTs of less than 30 seconds, 70% within 40 seconds, and 90% within 60 seconds. McMahon is a study of 1,346 consecutive heterosexual males with both lifelong and acquired PE reported similar results, with an average IELT of 43.4 seconds [19]. Seventy-seven percent of the men in that study ejaculated within 1 minute of vaginal penetration. In another study of heterosexual men with PE [20], 92% of men reported that they ejaculated within 1 minute of penetration without having used a stopwatch. A stopwatch study of IELT in an unselected sample of 491 men in the Netherlands, United Kingdom, Spain, Turkey, and Spain found that the general population had an IELT of 5.4 minutes [21]. In this study, the 0.5 percentile cutoff was approximately 1 minute and the 2.5% cutoff was 1.5 minutes. The authors suggested that the 0.5 percentile be used as a cutoff to define an abnormal IELT. This cutoff was 0.9 minutes. This convergence of data led to the adoption of a 60-second cutoff for the definition of PE by the International Society Sexual Medicine [6].

It is recommended that the DSM-V subcommittee on sexual dysfunctions consider adopting the approximately 1-minute criteria for intravaginal ejaculatory latency to define PE. Issues with this criteria are (i) that we only have data concerning intravaginal ejaculatory latency; (ii) that most data concern lifelong PE; (ii) that there are no data available for the diagnosis of PE in homosexual men or for heterosexual men who choose activities

other than coitus; and (iv) that in clinical practice, estimated ejaculatory latency would have to serve as a proxy to measured ejaculatory latency. It should be noted that investigation has indicated a reasonable correlation between measured and estimated ejaculatory latency time. The definition would clearly have to specify that the 1 minute latency can only be applied with certainty to intravaginal ejaculatory latency and that data are required regarding normative ejaculatory latencies in other sexual activities. One advantage of a specific time threshold for the diagnosis of PE is that men with excessive expectancies but normative ejaculatory latencies would be excluded from this diagnosis. A clearly specified time duration would eliminate men with excessive expectations but normative ejaculatory latencies from being diagnosed with a psychiatric disorder.

Another definitional issue is how long a symptom should persist until it reaches diagnostic criteria. One study in the United Kingdom found whereas 11.7% of the population reported premature orgasm that lasted 1 month, whereas only 2.9% reported this problem lasting for as long as 6 months [22]. This suggests that using a 6 months criterion would restrict the diagnosis to those men with persistent problems.

Also, one needs to specify the frequency with which PE occurs before this behavior reaches diagnostic threshold. There has been minimal study of the frequency with which ejaculation must be rapid in order to reach a diagnostic threshold. Clearly, the difficulty must be frequent in order to be considered a disorder. Whereas Waldinger and his associated [23] have proposed that ejaculation be premature on at least 90% of occasions, most of the epidemiological studies have employed terms such as never, occasionally, or frequently. The International Society for Sexual Medicine definition states that ejaculation must be premature on all or nearly all occasions [6]. A minimal standard would be to designate that ejaculation be rapid on at least 75% of occasions before a diagnosis of PE can be made.

The DSM-IV-TR also instructs the physician to take into consideration factors such as "age, novelty of the sexual partner, and recent sexual activity" in making this diagnosis. Research has not found a consistent relationship between age and the incidence and severity of PE. In the study of sexual behavior and attitudes in a representative sample of the United States population ages 18 to 59 years, Laumann et al. [24] reported a higher frequency of complaints of rapid ejaculation in men under 40 years as compared to men over 40 years. However, in the Global Study of Sexual Behavior [25] there was a tendency for complaints of rapid ejaculation to be more common in older men than younger men. In a multinational population survey of intravaginal ejaculation latency time [21], it was found that intravaginal ejaculation latency times appeared to decrease with age. In addition, in a study of the interrelationship of various measures of PE in heterosexual men ages 21 to 61 years, Waldinger and his coworkers [26] found no evidence of an increase in IELT with age. Similarly, there is minimal evidence that novelty of the sexual partner is to ejaculatory latency in men with lifelong PE. In a study of men with PE and with relationship durations varying from 1.5 to 37 years, there was no evidence of relationship of relationship duration and IELT. If relationship duration can be used as an indicator of partner novelty, this would suggest that the DSM-IV-TR recommendation that partner novelty be taken into consideration may be unnecessary. There is some evidence that frequency of sexual activity may have a small relationship to IELT. In one study, it was found that less than 10% of the variability in IELT could be explained by frequency of sexual activity [27].

Starting with the DSM-III-R, all of the sexual dysfunctions including PE were subtyped as lifetime vs. acquired, global vs. situational, and psychogenic or of mixed etiology. In practice, the global vs. situational distinction has been rarely used and the etiological designation of psychogenic vs. mixed might be criticized as implying greater knowledge about etiology than exists. However, the lifetime vs. acquired subtype distinction has been accepted by most professionals [28]. Whereas lifelong PE has been postulated to reflect a hereditary tendency, acquired PE has been postulated to result from various injuries or disease processes. Anecdotal data suggest that acquired PE might result from multiple sclerosis or peripheral neuropathies [29]. There have also been case reports of rapid ejaculation being associated with thyroid abnormalities [30,31], although in contrast, lifelong PE appears not to be related to thyroid dysfunction [32]. Among organic etiologies, there have been a number of case reports and clinical series suggesting that PE may be associated with prostatitis [33–38] and that successful treatment of prostatitis in men with acquired PE may reverse the complaint [39,40]. Case reports and clinical series also suggest a relationship between acquired PE and psychological factors especially anxiety and anxiety disorders [41–45]. It is unclear that subtyping by etiology should be

retained as there is little if any definitive evidence regarding etiology. It has been postulated that lifelong PE is a neuropsychiatric phenomena related to hereditary factors [27]. One recent study by Santtila et al. [46] reported findings which are supportive of the Waldinger hypothesis. In this study, 3,186 male twins and their siblings completed items concerning sexual function on first coital experience. Genetic influences were found to account for approximately 22% of the variance in PE. More direct evidence of genetic involvement was recently reported by Waldinger and colleagues in a study in 89 men with lifelong PE. In this stopwatch study, in which 92% of men ejaculated within 1 minute, serotonin-transporter-linked promoter region (5-HTTLPR) polymorphism was significantly associated with the duration of the intravaginal ejaculatory larency time (IELT). Men with LL genotypes had 100% and 90% shorter IELTs than men with short (SS) and long (SL) polymorphic variants genotypes [47]. Clearly, evidence of a hereditary influence on ejaculatory latency does not preclude other etiological factors. Although different etiologies have proposed for PE, there is little definitive information available concerning etiology.

In DSM-IV, there was the added criterion that rapid ejaculation causes marked distress or interpersonal consequences before it could be diagnosed as PE [48] Some studies have found distress to be associated with PE and that PE can be associated with negative psychological consequences for patients and their partners [19,49,50]. There is debate about the choice of words to describe the negative psychological consequences. Qualitative research used in the development of patient-reported outcomes for pharmaceutical research indicates that words such as bother, frustration, and annoyance more accurately reflect patient experiences [51]. A more important issue is whether the negative consequence of a disorder should be included in the definition of the diagnostic entity. For example, one could argue that the entity of PE should be defined simply in terms of IELT. Waldinger et al. [26] cogently makes this argument by using the analogy of a migraine headache. A migraine headache is diagnosed by its clinical presentation, not by the amount of distress it causes the patient.

Other Issues

If one accepts the proposal that PE be defined by a specific IELT, there remains the issue of how this will be measured in clinical practice. The normative data available concern IELT as measured by stopwatch. In clinical practice, estimated IELT would probably be the proxy measure in common usage. There are some data concerning the correlation of measured and estimated IELT. Pryor et al. [52] reported a study in which estimated IELT was compared with IELT measured by stopwatch in 1,587 men. A correlation of 0.69 was observed between estimated IELT and IELT measured by stopwatch in men with PE, suggesting that estimated IELT could be used as a proxy for stopwatch-measured IELT in clinical practice. In another study, Waldinger et al. [18] studied the interrelationship of various measures of ejaculatory latency with IELT measured by stopwatch. The correlation between estimated and directly measured IELT was only 0.56. Men tended to slightly overestimate their IELTs but were more accurate than their partners. Most men with PE estimated their IELTs to be less than 1 minute. They concluded that estimated IELT was acceptable in clinical practice.

As mentioned previously, normative data are available primarily for lifetime PE in heterosexual activities. We lack normative data for acquired PE and for ejaculatory latencies in sexual activity other than vaginal intercourse. Waldinger introduced the concept of a masturbatory ejaculation latency time, an oral ejaculation latency time, and an anal ejaculatory latency time as measures for research in homosexual men and for other types of sexual activity in heterosexual men [20].

A subject of considerable debate is whether the concept of control of ejaculatory control should be part of the definition of PE [53] As mentioned above, the concept of control over ejaculation was present in DSM-III and removed in DSM-IIIR and has never been reintroduced into subsequent DSM series. It, however, is present in the ICD-10 definition of PE. Some investigators have found that sense of control distinguishes men with PE from normals [9,13,54], whereas other authors [10,18] have found minimal relationship between sense of control over ejaculation and ejaculatory latency. One author even found that certain interventions could improve subject's sense of control over ejaculation without modifying ejaculatory latency [53]. Ultimately, the issue is whether the addition of a self-reported or questionnaire measured cognitive variable of ejaculatory control to the measurable variable of IELT adds anything of value. Clearly, the use of this variable in addition to the IELT variable complicates clinical research

and epidemiological studies. For example, it is unclear how one would classify a man who ejaculated within 20 seconds of vaginal penetration yet reported a strong sense of ejaculatory control as well as how one would classify a man lasting 6 minutes who reported a sense of lack of ejaculatory control. In this author's opinion, there are insufficient data to warrant the reintroduction of the concept of control into the DSM-V definition of PE. Other investigators disagree with this position [51].

Specific Recommendations

It is specifically recommended that the DSM-V adopt the definition that PE as a repetitive pattern of ejaculation occurring within approximately 60 seconds on 75% of occasions and present for at least 6 months. Wording concerning clinician taking into account the patient's age and novelty of the sex partner should be removed from the definition. Current evidence supports this deletion. It should be stated that there is insufficient evidence to determine if this time limit should also apply to sexual activities not involving vaginal intercourse.

An additional advantage of this definition is that it parallels the definition recently adopted by the International Society for Sexual Medicine. In 2007, the International Society for Sexual Medicine convened an ad hoc committee to review current evidence concerning ejaculatory latency and to recommend an evidence-based definition. This committee recommend that PE be defined as a male sexual dysfunction in which "ejaculation always or nearly always occurs prior to or within 1 minute of vaginal penetration . . . on all or nearly all vaginal penetrations with negative personal consequences" [6].

The 60-second time limit can be also applied to acquired PE, but with less certainty. In a large study of ejaculatory latencies in men both with acquired and lifetime PE, McMahon [55] reported that approximately 77% ejaculated within 1 minute of vaginal penetration. At this time, there are insufficient data to determine the duration before the symptoms reach the threshold for the diagnosis of acquired PE. For example, one needs to distinguish between normal variability in ejaculatory threshold from acquired PE. This author would prefer to err on the side of under diagnosis and require a 6-month duration for the diagnosis of acquired PE. The subtype by etiology should either be eliminated or an idiopathic subtype should be added.

DSM-IV-TR also requires the specification of subtypes for sexual disorders on three separate dimensions: lifelong vs. acquired, generalized vs. situational, and due to psychological factors vs. due to combined factors. The lifelong vs. acquired designation has been widely used and clearly has clinical utility. It is proposed that this designation remain in DSM-V. The designation of global vs. situational has been minimally utilized and could easily be eliminated. DSM-IV-TR also requires the use of etiological subtypes. Clinicians and investigators have noted that subtype implies a knowledge of etiology which simply does not exist [48].

It is recommended that this subtype be deleted. To expedite research concerning comorbidities, an optional designation of associated features could be utilized. One dimension could be associated psychological issues such as life stress or interpersonal discord. Another dimension could be associated medical disorders. For acquired PE, associated medical conditions might include prostatitis or thyroid abnormalities.

DSM-IV-TR requires that an individual has to have marked distress or interpersonal difficulty to be diagnosed. These criteria have been problematic for several reasons. First, marked distress and interpersonal difficulty have various meanings to different clinicians. Second, distress implies misery or severe suffering, terms which usually do not apply to men with PE. A recommendation is that this part of the definition be replaced with the terms "discomfort or worry." A third more complicated issue is whether the possible consequence of a disorder should be part of its definition. A proposed solution is to define the phenomenon of rapid ejaculation by ejaculatory latency alone. However, the clinical diagnosis would require personal discomfort. Clearly, few men seek treatment for rapid ejaculation if it is of little significance to them or their sexual partner(s). The separation of the syndrome from the designation of personal discomfort should facilitate the study of the neurobiology of ejaculatory latency independent of distress which may related to multiple and varied psychosocial and cultural factors.

A specification of severity of the disorder would facilitate measurement of improvement. A suggested 4-point scale is as follows: prior to penetration, at time of penetration, less than 15 seconds after penetration, within 30 seconds, and within 45 seconds of penetration.

Lastly, serious consideration should be given to the name PE and whether it appropriately

designates the syndrome. The term premature usually is used to designate that an event is occurring before its proper time such as premature labor or a premature hear beat. From a strictly biological perspective, one could argue that PE should only be used in cases of anteportal ejaculation. From an interpersonal perspective, one could argue for various definitions as to what constitutes PE. The term premature has inappropriate pejorative connotations. A rather radical proposal would be to change the name of the clinical syndrome to rapid ejaculation.

Field Trials

A major issue is the lack of normative data on sexual activity other than vaginal intercourse. It is recommended that we consider a field trial of these diagnostic criteria in an unselected group of men with PE of mixed sexual orientations. Measures of ejaculatory latency should include oral, vaginal, and anal sexual activities.

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Comments on "Considerations for an Evidence-Based Definition of Premature Ejaculation in the DSM-V"

The author of this article is to be congratulated for the impeccable timing and the issues that he brings for consideration. For some of us with long memories in the field of sexual medicine, it appears that the understanding of the pathophysiology, diagnosis, and therapeutics of premature ejaculation (PE) is at the developmental stage of knowledge that erectile dysfunction (ED) was at the time of the National Institutes of Health Consensus Development Conference on Impotence in 1992 [1,2]. From semantics to diagnostic techniques and from definition to therapy, the similarities are conspicuous. The definition of the condition itself is under question, the diagnostic paraphernalia primitive or inconsistent producing conflicting results [3] and the treatments that are largely nonspecific [4].

Extreme care must be exercised in the definition of PE. The stringent criterion of an IELT of $\leq$60 seconds is appropriate for research purposes, particularly in order to maintain objectivity in the assessment of efficacy of new therapies. Such strictness is wholly unsuitable in clinical practice. The danger here is that new treatments might be assigned restricted indications and become unavailable for couples dissatisfied with the male's ejaculatory performance if their fulfillment is beyond this arbitrary limit. How often do clinicians base their current therapeutic decisions for treating PE on the stopwatch technique? It is not even standardized! The concept of biological and analytical variation, largely ignored in diagnosing PE, must be seriously considered and the use of reference intervals must be treated with special caution, particularly when current tools are as imperfect and inaccurate as the stopwatch method.

The discrepancies in observations from reputable investigators cited in the article, regarding issues of ejaculatory control, is another example of our anemic understanding of the physiology of PE. The author has dealt astutely with this issue. I share his/her view that information in this regard is too sparse and contradictory to consider its inclusion in a new definition of PE.

Referring to the etiological categories, it is stated in the article that "subtype implies a knowledge of etiology which simply does not exist." Regretfully, this statement is unreservedly accurate and at the crux of our problems with definitions, diagnosis, and therapeutic approaches in dealing with PE.

Perhaps, a retrospective look at the developments in ED over the last 30 years will provide valuable insights. The availability of adequate diagnostic instruments capable of revealing the severity of the condition [5], together with effective and safe treatments [6,7] based on sound physiological and pharmacological principles, allowed real clinical progress. When the field of PE reaches a similar point, issues related to the ejaculatory circumstances, intravaginal or otherwise (oral, manual, etc.), will lose much of its relevance.

As indicated in the article, a proposal was advanced a few years ago to rename the "syndrome" (it is not clear that it truly constitutes a syndrome since there is no aggregate of concurrent symptoms) as rapid—instead of PE. The main argument is that "premature" is considered as pejorative as "impotence" once was. I do not agree with this idea. Fortunately, it has failed to prosper and for good reasons: rapid and premature are different concepts. Rapid implies velocity, swiftness (a river runs rapid), while premature refers to timing, happening before the natural or proper period (a birth). "Impotence" was both erroneous and derogatory: it was appropriate to dismiss the term. Premature, in relation to ejaculation, is accurate, descriptive, and fitting.

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There are several issues with the recommendations to the DSM-V subcommittee on sexual dysfunctions. Definition of PE in DSM-IV and DSM-V proposal suffer from the same problem of being authority-based rather than evidence based. In the DSM-V proposal, PE has been defined as a repetitive pattern of ejaculation occurring within 1 minute on 75% of occasions and present for at least 6 months. The three studies that lead to the International Society for Sexual Medicine (ISSM)'s adoption of the 1 minute cutoff were inadequate; in one study, 110 men were recruited by an advertisement. The second study was never published as an article; in the third study, a stopwatch was not used [8]. Most recent studies on PE have selected a cutoff point of ≤2 minutes, implying failure of the ISSM's 1-minute cutoff to be widely accepted. In response, some have claimed that the goal of adopting the 2 minutes cutoff is to increase the patients' pool for the pharmacologic industry. I have no industry involvement at all; in my large experience with 3,458 patients over 12 years, intravaginal ejaculatory latency times (IELTs) of ≤1 minute and ≤2 minutes were reported by 59.5% and 75.5%, respectively. IELTs of >2 minutes and ≤5 minutes collectively comprised 20.6% of all patients [9]. Excluding those having IELTs of more than 1 minute would miss more than third of patients for whom PE was of enough importance to seek treatment for it.

The recommendation that ejaculation be rapid on at least 75% of occasions is not evidence based. The cutoff point of 6 months is supported by only one study.

In the present proposal, it has been stated that "there is little if any definitive evidence regarding etiology." This is a step forward compared with a former DSM-V proposal [10], in which a "new" categorization of PE was presented based on pure speculations about etiology, pathophysiology, prevalence, and treatment. In that proposal, aimed at persuasion when evidence was lacking, conditional assertions were switched imperceptibly to the indicative case to calm the reader into feeling that the speculations have a more definite basis than in fact they do. Primary lifelong PE, that is by far the most common variety of PE [9], was claimed to be rare. Men with "normal" and "long" IELTs were included into the so-called "premature-like ejaculatory dysfunction"; the same authors stated that "treatment of longer IELTs is similar to unnecessary cosmetic surgery for completely normal physical features," and that "men with complaints of PE but with normal or long IELT durations are able to delay ejaculation but may suffer from psychological problems that interfere with an adequate judgment of sexual performance." In absence of consensus on normal and abnormal IELT based on truly international, large studies, it is unacceptable to overemphasize the results of small studies in a few countries, and to accuse the patients of "psychological problems" just because they do not "fit" into the proposed cutoffs.

The sexual medicine community should reach a consensus on the approach to those patients with IELTs of more than 1–2 minutes who consider themselves as premature ejaculators and actively seek treatment. A release of the final DSM-V is expected in 2012. Thus, there is enough time for the ISSM to conduct an international study in as many countries as reasonably possible, to determine the IELT both in general population and in clinical PE patients. Many important questions will be answered by that study, and its results and recommendations will be accepted by all.

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It is evident that recent research on premature ejaculation (PE) has substantially increased knowledge about the condition itself, as well as different aspects of its treatment. However, several issues are still topics of vigorous debate, and rightly so. The root of these issues is usually, as the author points out, that quite much is still unknown about the etiology of PE. This, in turn, makes it difficult to formulate definitions, diagnostic criteria, and agree on treatment methods.

Intravaginal ejaculatory latency time (IELT) has become one of the most popular methods to measure and operationalize PE in recent years. Stopwatch measurement of IELT certainly holds several advantages, especially method-wise, as it generates a continuous variable well suited for statistical analysis. However, in relying on (a <60-second) IELT for diagnosis of PE, one must also make assumptions that are not necessarily valid. First, at the present stage, it is assumed that it can be generalized to any form of sexual activity, even though very little is known about ejaculation latency time (ELT) in other sexual activities (than vaginal intercourse; although there is some evidence for—at least—anal sex being associated with longer ELTs [11]). Hence, peculiarly, exclusively homosexual men could not be diagnosed with PE

if an IELT of <60 seconds is strictly employed as the chief diagnostic criterion. Second, any cutoff latency is ultimately an arbitrary choice that can only separate a certain proportion of the population from the rest in terms of IELT. With 60 seconds as diagnostic cutoff, how should a deeply distressed man who always ejaculates in two, but not within one, minutes be treated? Should a man who happens to have an IELT of <1 minute receive diagnosis and treatment if both he and his partner are pleased with every aspect of their sex life? IELT does hold the advantage that it can distinguish patients with rather normal IELTs but nevertheless express dissatisfaction with their ejaculatory performance and seek treatment [12]; hence, the IELT provides remedy to some clinical and theoretical problems, but in doing so, it does not abolish the very similar problems at the other end of the IELT distribution.

Third, as the author also points out, it appears that no IELT cutoff can clearly separate between men who perceive themselves to be in control of their ejaculation, and men who do not (ELT has also been shown to have a very weak correlation with variables measuring ejaculatory control; e.g. [13]). Hence, a man who has complete control of his ejaculation and ejaculates rapidly after penetration by choice would be perceived as dysfunctional, although he would certainly strongly disagree with this himself. Furthermore, the fact that some studies (e.g. [14]) have found a "minimal relationship between sense of control over ejaculation and ejaculatory latency" is no better or more valid an argument for the exclusion of aspects of ejaculatory control from diagnostic criteria than it is for the exclusion of IELT. While there are problems related to operationalizing it, I do believe that some measure of ejaculatory control should be included as a diagnostic criterion of PE.

The author also raises the notion that *premature* may be an inadequate term, as it refers to something which occurs sooner than it should. This is a very interesting comment because it yields an important question that cannot be eliminated by simply changing the term to "rapid": when, and why, does an IELT become *dysfunctional* on an ultimate level of explanation? For something to be dysfunctional, it must be disruptive of its purpose. Whether the purpose of ejaculation is to impregnate the egg (as the evolutionist would certainly have it), bring pleasure to the ejaculator, or both, it is hard to conceive of an ELT so rapid that it directly obstructs any of the above—unless it is so rapid, that ejaculation always occurs prior to penetration. However, it is very conceivable that, for example, a short IELT may be distressful and frustrating for a sexual partner, which in turn can cause distress in the quickly ejaculating man. While this may certainly be a problem warranting treatment (or at least scientific attention), a short ELT could actually be perceived as "normal" and advantageous from an evolutionary perspective [15]. This, then, calls into question what, and why, exactly we are looking to diagnose and treat—and whether IELT alone really can guide us right.

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The authors are to be congratulated on their erudite approach and efforts in simplifying this difficult topic. Premature ejaculation (PE) is a unique sexual disorder, because, despite the high prevalence of the problem, only half of the men with PE are bothered. Complicating its characterization are ambiguities in the definition and classification based on anachronistic notions. The authors challenge the vagaries of the previous DSM definitions based on evidence-based medicine where it exists. An evidence-based objective definition of PE based on intravaginal ejaculatory latency time (IELT) is proposed. PE is defined as a self-reported IELT of less than 1 minute with duration of at least 6 months and a frequency arbitrarily determined to be on 75% of occasions. Current evidence supports the deletion of wording taking into account the patient's age and novelty of the sex partner in the definition.

The authors challenge the DSM-IV-TR requirement of the specification of subtypes for sexual disorders on three separate dimensions: (i) lifelong vs. acquired; (ii) generalized vs. situational; and (iii) due to psychological factors vs. due to combined factors. Adoption of the "lifelong vs. acquired" distinction is widely used, clinically useful and recommended, supported by significant differences in IELT between the groups, and recent genetic studies demonstrating 5-HTTLPR polymorphism was significantly associated with the men with an IELT of less than 1 minute. The generalized vs. situational subtypes are not utilized and are not evidence based and were recommended to be deleted. Although the DSM-IV-TR requires the use of etiological subtypes, those etiologic subtypings are beyond our evidence-based knowledge. The authors suggest deleting this

subtype and using a designation of "associated features" such as life stress or interpersonal discord and associated medical disorders such as prostatitis or thyroid abnormalities. Current supportive data are lacking for clear cause and effect between etiologies. Much of the evidence supporting etiologic factors is anecdotal at best.

DSM-IV-TR currently requires that an individual has to have marked distress or interpersonal difficulty to be diagnosed. A bother component to the definition is recommended, although the terms "distress and interpersonal consequences" are recommended to be changed to "discomfort or worry."

The authors stray from evidence base when they propose a 4-point severity scale as follows: 1: prior to penetration; 2: at time of penetration; 3: less than 15 seconds after penetration; 4: within 30 seconds and within 45 seconds of penetration. The proposed 4-point severity scale is not evidence based and needs to be validated prior to its implementation.

The pejorative connotations of the PE label are challenged suggesting the adoption of the term rapid ejaculation, much like impotence was replace by erectile dysfunction. Finally the authors call for more field trials looking at PE outside heterosexual vaginal intercourse, an area heretofore unexplored.

In summary, the recommendations proposed by the authors are a quantum leap in the simplification of the diagnosis of PE and will serve as the foundation more much needed high level clinical research.

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The establishment of any medical condition mandates an agreed-upon universal definition. Further development and research brings about an evolution in knowledge in diagnosis and treatment. Such as in the case after the first publication on premature ejaculation (PE) in 1887 [16]. Advances in treatment(s) often necessitate a more precise definition, as was the case with the introduction of clomipramine for the treatment of PE in 1973 [17]. A number of confirmatory clinical studies with selective serotonin reuptake inhibitors followed.

PE, as a diagnostic entity, was first introduced into the Diagnostic and Statistical Manual (DSM)-III in 1980. Subsequent updates and revisions (DSM-III-R in 1987, DSM-IV in 1994, and DSM-IV-TR in 2000) have added the criteria of ejaculating before the person wishes (control) and distress into the definition of PE. The most recent criticisms suggest that the current operational definition lacks precision in regard to time (ejaculatory latency) and relies too heavily on clinician judgment in making the diagnosis of PE using the DSM-IV-TR definition.

As expected, men diagnosed with PE have shorter IELTs compared to men without PE; however, there is considerable overlap between the two groups [18]. Using a specified time duration (e.g., 1 or 2 minutes) eliminates men with excessive expectations and normal ejaculatory latencies from being misdiagnosed as having PE. Likewise, by incorporating the concepts of ejaculatory control and personal distress into the definition, this prevents men without these secondary subjective two criteria from incorrectly being diagnosed with a "disorder" based on ejaculatory time alone.

In 2007, the International Society Sexual Medicine convened an ad hoc committee and recommended that "PE be defined as a male sexual dysfunction in which ejaculation always or nearly always occurs prior to or within one minute of vaginal penetration . . . on all or nearly all vaginal penetrations . . . with negative personal consequences." [19]

It is not uncommon to have men with longer latencies to still complain and self-label as having PE, although they do not meet the appropriate criteria. This is a dilemma for clinical management. Understandably, one can expect further refinements in the development of an evidence-based definition of PE in the upcoming DSM-V. Concepts to still be addressed include acquired PE, ejaculatory latencies in sexual activities other than vaginal intercourse (e.g., masturbatory, oral, and anal), further definition of anteportal ejaculation, and elaboration of the female perspective on this problem, hence the natural evolution as witnessed in any medical condition.

Consideration is made for a name change from premature to rapid or early ejaculation because of the pejorative connotations that PE implies. During the 5th Annual Fall Research Meeting of the Sexual Medicine Society of North America (SMSNA) in 2004, a Scientific Working Group convened to debate the need to rename the condition [20]. A representative panel of American and European sexual health specialists reviewed the information presented at the 2nd International Consultation and proposals of the American Uro-

logical Association (AUA) PE guidelines document. A representative research study on the term PE was presented from four U.S. and two European cities with 184 respondents.

The results of this study demonstrated that the term PE was universally recognized and accurately understood by men with PE and their partners. Although "rapid ejaculation" has been used, patients, partners, and clinicians found it less precise than premature. Most important, the stigma is associated with the condition of PE, not with its name [20].

The SMSNA Scientific Working Group recommended that the term PE continue to be used. Adoption of a new name may result in confusion, require extensive reeducation, and delay efforts to increase awareness and discussion of PE [20].

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Despite being the most common male sexual dysfunction, an evidence-based, accurate definition of rapid ejaculation (RE) is absent. As clearly described by the current article, RE definitions proposed by the DSM-IV [21] and DSM-IV-TR [22] lack objectivity, specificity, and emphasize factors, such as age, novelty of sexual partner, and recent sexual activity, that have not been proven to affect the development and the severity of RE. A more recently developed definition of PE was introduced by a subcommittee of the International Society For Sexual Medicine (ISSM) [8]. Indeed, this latter definition constitutes the first evidence-based definition of RE; however, it is only limited to lifelong RE, does not address the duration or the frequency of the problem, and may be limited by the fact that it is based on data from heterosexual men only.

The current proposed modifications to the DSM-IV-TR terminology and classification of RE adequately address many of its past criticisms. We certainly agree with the authors that a specific intravaginal ejaculation latency time (IELT) should be incorporated in the new definition; a cutoff time of 60 seconds is appropriate and harmonizes with the ISSM's definition. Also, specifying problem duration (at least 6 months) and frequency (at least 75% of times) clearly adds to the specificity and accuracy of the definition. However, the absence of a component that recognizes the importance of ejaculatory control limits the proposed new definition.

Assessment of the sense of ejaculatory control is an important factor during evaluation of RE [23]. Patients who are able to exercise some degree of control over their ejaculation, i.e., delaying their IELT for a few seconds, are expected to be more responsive to medical and/or psychological treatment of RE than patients who have minimal control of their IELT [24]. It is therefore advisable, as eloquently phrased in the ISSM's definition of PE, to acknowledge the importance of ejaculatory control in new definition of RE.

Historically, RE has been associated with worry, distress, anxiety, bother, and frustration. This is equally true for lifelong RE and acquired RE as well. These psychological symptoms can affect both the male and his partner to various degrees. While we do recognize the complexity the inclusion of such symptoms brings to the definition of RE, adequate assessment of the severity of RE and the patient's treatment response cannot be made without considering the psychological manifestations of RE. Contrary to the current authors' viewpoint, we hesitate toward relying on the IELT as the sole tool to define and assess the severity of RE as it does not solve the nomenclature problem. In fact, it makes it more difficult. By limiting RE to a time-dependent disease, the various underlying neurobiological and psychological issues that may have contributed to the pathophysiology of this disease, especially in lifelong RE, are ignored. Also, it makes the measurement of the disease severity and future improvement more complex and potentially unclear. For example, would a patient with IELT of 30 seconds and mild distress be considered as having more severe disease than a patient with an IELT of 45 seconds and marked distress? Also, would a patient with RE that has a longer IELT after treatment but still suffers distress and discomfort be considered "improved"? Certainly, severity and overall improvement in cases of RE should be assessed based on both the IELT and the RE-related psychological symptoms. This cannot be performed without using valid and reliable indices or questionnaires that can help in accurately identifying, measuring the severity and improvement of RE. A number of these indices have been recently developed and are used mainly for research purposes [25,26]. The authors should be commended for stressing the need to abolish the term *premature ejaculation*, as it is inaccurate, very subjective, and indeed considered derogatory.

The proposed modifications of the DSM-IV-TR definition of RE are certainly a significant

step forward. We hope that current and future research can help reach a universal definition of RE that incorporates vaginal and nonvaginal intercourse, as well as the various psychobiological components of RE.

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The author presents a very important issue in exposing the need of an updated evidence-based definition of premature ejaculation (PE) for the upcoming DSM-V and individualizes and discusses the main items to be changed.

The first issue discussed is the time to ejaculation, which was not present on the latest DSM definitions and proposes the threshold of 60 seconds of intravaginal ejaculatory latency time (IELT). This threshold is also present on the International Society for Sexual Medicine (ISSM) definition of lifelong PE and I think that the wording of "about 1 minute" as expressed on the ISSM definition is important to be added in order to be more inclusive with patients with borderline IELTs [8,27]. The author also discusses the need of including the frequency of the symptom and proposes that it should be present on 75% of the times as opposed to the term "always or nearly always" expressed on the ISSM definition. I find this proposal to be arbitrary and nonevidence based. Also, the duration of the symptom is considered and a minimal duration of 6 months is proposed. If one considers that the symptom should occur always or nearly always, we are already ruling out occasional PE so a minimum duration might be unnecessary.

A classification of PE, although interesting, does not need to be present when elaborating the definition since robust evidence-based data are only present for lifelong PE.

The author also discusses the issue of renaming premature ejaculation, proposing the use of the term "rapid ejaculation." The term premature ejaculation is widely used in studies and clinical trials and is widely accepted in the medical community. I think that changing the name to rapid ejaculation will bring more confusion with other issues such as speed of emission or perineal contractions.

The author questions the need of using the wording of negative personal consequences in the definition. Why would a patient consult for PE if this does not cause negative personal consequences for him or his partner? It is known that many patients with a short IELT do not consider themselves suffering from a medical condition, and hence do not consult. If the patient or his partner is not bothered by this condition, it is not a medical problem [28].

The issue of ejaculatory control, which was removed on the recent DSMs but included on the ISSM definition, is also discussed in this article. I think that if a person ejaculates intentionally with a short IELT, this does not make him a PE sufferer. One could argue with the design of some questionnaires to define ejaculatory control, but although not unanimously, the literature favors the inclusion of lack of control to define a patient with PE [14,29].

Finally, the author clearly defines the deficiencies of the current definitions in identifying men with acquired PE, with noncoital sexual activities and homosexuals, but there is currently a significant lack of evidence-based information, and certainly, further research is needed in this field. I applaud the need of an updated definition of lifelong PE on the new DSM-V and I am sure that efforts like this author's will make it happen.

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The proposal of this manuscript is to accept the intravaginal ejaculatory latency time (IELT) of 1 minute or less as the sole criterion for diagnosis of premature ejaculation (PE). The distress criterion is rejected because conditions such as migraine should be "diagnosed by its clinical presentation, not by the amount of distress it causes the patient" and, the voluntary control criterion is set aside on with the rational that including it "complicates clinical research and epidemiological studies." In a single opinion article, Segraves sets aside the considerations of the International Society for Sexual Medicine ad doc committee to include time, ability to delay, and negative consequences in the diagnosis and erroneously states that this committee agreed on the 1-minute criterion for the definition of PE when in fact, it was accepted only for the lifelong subtype [8]. Segraves suggests that we should change the name of the condition because "from a strictly biological perspective, one could argue that premature ejaculation should only be used in cases of anteportal ejaculation." The main argument to limit the diagnosis of PE to the

1-minute criterion is that not having it leads to diagnosis of a heterogeneous group.

Sexual medicine is populated with heterogeneous groups sharing a condition. The best example is erectile dysfunction that in fact has a large number of possible etiologies. Psychogenic erectile dysfunction is indeed different from the diabetes mellitus-related erectile dysfunction. Notwithstanding, the use of medications that are effective in improving erectile function in both cases is now clearly accepted.

The 1-minute criterion appears after the successful characterization of a subgroup of patients suffering from short IELTs by Waldinger and coworkers ([14,27,30]). There is evidence that this group might have hereditary components [31] and some partial evidence points to genetic polymorphism (the difference appeared only among lifelong PE patients but it the polymorphism was not different in PE patients when compared to normal controls) [32].

The clinical presentation of PE cannot be predicted with IELT alone. IELT has a very low sensitivity when attempting to identify PE patients, especially if the 1-minute criterion is used. Table 1 was built with the published data of the Patrick et al. [18] and Giuliano et al.'s [28] studies. These patients did complain of rapid ejaculation and had negative impacts in their lives. IELT set at 1 minute has, if one agrees that PE is an heterogeneous condition in a fashion similar to what sexual medicine does with erectile dysfunction, a sensitivity to detect PE as understood by a large numbers of clinicians today of only 6% to 26%.

Perhaps the most important conceptual issue is absent in the Segraves article relates to what makes PE a problem. Premature or rapid ejaculation cannot be classified as a problem or disease just because it is a statistical rarity (0.5 percentile of IELTs) [27]. If normative statistics were useful to define functionality in sexual medicine, erectile inability would not be a dysfunction because it occurs in the majority on men above 40 years of age [33]. There is a need to specify why this is considered a problem and why it causes so much distress in some patients. The reason why PE is considered a problem by patients is not related to statistics but related to the failure to obtain a satisfactory sexual interaction.

Table 1 Percentage of patients with the PE diagnosis by IELT in two observational studies

	% of patients with the diagnosis if IELTs chosen for diagnosis is the one in first column	
IELT in minutes	Patrick et al. [7] n = 190	Giuliano et al. [8] n = 182
0.5	08.00	00.41
1	25.71	06.50
1.5	40.86	19.84
2	52.19	37.15
2.5	63.71	51.63
3	68.29	57.80
3.5	74.00	63.41
4	79.71	70.08
4.5	82.95	73.41

IELT = intravaginal ejaculatory latency time.

The reason why a rapid ejaculation might be frustrating is clear: it can deprive the partner of the process of receiving stimulation at a different, much slower pace. We lack evidence of what is the adequate time to accompany the partner, but lack of evidence does not equate to inexistence. Some proxy measures, however, give us an idea: Men not complaining of PE have a median of 7.3 to 8.8 minutes [18,28]. Sex therapist in the United States and Canada estimated that the desirable time varied from 7 to 13 minutes [34]. In an unpublished study, Ellen Laan recently reported that the average time to reach orgasm by women under laboratory conditions and stimulation with vibrator is 10 minutes [35].

The identification of a subgroup of patients that have PE with characteristics that very likely indicate that they do have a neurobiological basis for their dysfunction is very good news. Attempting to limit the condition known to practitioners of sexual medicine and sexual psychotherapy to this subtype that is probably neurobiologically determined remind me of the time a protocol in erectile dysfunction required absence of morning and nocturnal erections to include the patient in the protocol. One minute is clearly not enough, not only to prevent sexual satisfaction to partners and possibly the patient, but also to characterize the condition or PE.

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Nomenclature: Conversations continue about renaming premature ejaculation (PE) in order to destigmatize both the condition and the men with the diagnosis. However, U.S. regulatory authority (Food and Drug Administration) eventual approval of a drug for PE will trigger pharmaceutical direct to the consumer advertising, resulting in PE being relabeled "PE" as erectile dysfunction

was successfully relabeled "ED." No doubt, that process will be repeated for PE, making further discussion moot.

Etiology: The etiology of sexual function and dysfunction is always "mental and physical." Our understanding of etiology must recognize that identifying biological predetermination does not negate the existence of additional etiologic factors. Additionally, there is need to recognize that all characteristics of sexual capacity exist on a multidimensional continuum rather than categorically. Recognizing the difference between biological variability and biologically determined pathology must also be appreciated. PE complicates that conversation given the overlapping range of intravaginal ejaculatory latency times (IELTs) present in both "normal" men, men who self-define and deny, and those defined by others as suffering PE.

The DSM-V draft correctly notes that hereditary influence on ejaculatory latency does not preclude other etiological factors. Yet, the interaction of both hereditary and nonhereditary variables may also result in the expression or lack of expression of PE symptoms. IELT may be predisposed to be more rapid in one man than another by a variety of hereditary and other organic factors, yet there will be a variability of response, albeit within a predetermined range, due to the impact of psychosocial–behavioral–cultural factors (PSBCFs). While it is highly likely that every man has a biologically predetermined range of response, the contributory weighting of biology and PSBCFs will vary between men and within any given individual's experience. Therefore, the sexual response itself, whether functional or dysfunctional, is always a net/net result of all these factors.

Diagnosis: Diagnosing PE would be improved by using the same modifiers typically applied to ED: mild, moderate, and severe. All three subtypes would require the second and third criteria of the International Society for Sexual Medicine definition (inability to delay, and bother) [8]. The only difference between the subtypes would be the variation in the reported IELT range. This subtyping would provide researchers needed objective categories, allowing for cross-center comparison while also providing the diagnostic flexibility needed for the majority of practitioners who treat men for this condition.

All involved in treating and researching this disorder realize that IELT "cutoff time" arguments have created considerable controversy and tension between supporters of alternative views. Practitioners and scientists may be seeing different cohorts depending on their setting, resulting in the views of fellow colleagues seeming naïve, or extreme, not capturing what appears self-evident. This is, of course, a function of the reality that IELT, like most human characteristics, is variable and on a continuum.

I propose these PE subtypes: "Mild" based on a reported IELT of 2–4 minutes, "Moderate" 1–2 minutes, and "Severe" for "less than 1 minute." Arguing the rationale for the specific temporal range of each sub-type is beyond this 500-word commentary. However, IELT population studies could provide guidance in establishing a consensus, which minimizes both type I and type II errors.

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The International Society for Sexual Medicine (ISSM) definition for premature ejaculation (PE) is the suggested basis for defining evidence-based lifelong PE [8]. One would think that the consideration for the evidence-based definition of PE in the proposed DSM-V would parallel this.

The author states that precise time parameters are not included in DSM-IV-TR. Objective (stopwatch) criteria have varied and it is reassuring that investigation has found a reasonable correlation between measured (objective) and estimated (subjective) ejaculatory latency times. The ISSM recommends this time to be 60 seconds or less.

The author has an issue with "how long a symptom should persist" and also the "frequency" of PE. His recommendation that DSM-V adopt his definition "PE is a repetitive pattern of ejaculation occurring within approximately 60 seconds" fits in with the above paragraph. However the concept of ". . . on 75% of occasions and present for at least 6 months" is too constricting and dogmatic. The ISSM statement that ejaculation must be premature on all, or nearly all, occasions appears more sensible and practical.

The concept of control of ejaculation, certainly in clinical practice, is pertinent. Men may not use the term "control" pretreatment but commonly use it with successful results, viz, "I now have control. . . ." I disagree with the author on this point which is borne out by other investigators on perceived control and associated personal distress and satisfaction with sexual intercourse [36,37].

Following this, the author's statement that marked distress and interpersonal difficulty be

replaced with the terms "discomfort or worry" trivializes the psychological effects of PE. A recent Canadian report underlines the association of significant distress as well as considerable documented impacts on partners and relationships [38,39].

The proposal to change the name from PE to rapid ejaculation is challenging. The dictionary definition of premature is "before customary/correct time/unexpectedly" and of rapid is "with great speed." PE does occur before its "correct/proper time" despite what the author asserts. In the older patient, often, his ejaculation is described as "slow" but occurs before its "correct/proper time," i.e., premature—hardly rapid. Premature has a medical connotation, whereas rapid is a general term for speed.

Field trials recommended for PE other than vaginal intercourse is a valid concept. As suggested, diagnostic criteria being evaluated for men of mixed sexual orientation, as well as oral, vaginal, anal and masturbatory sexual activities. The logistics would be challenging and take some time to implement, and should not hold up development of DSM-V, pro tem.

Having said that, I am puzzled as to why PE is considered a mental disorder. Whether primary (lifelong) or secondary (acquired), it has a mostly organic etiology, although there may be psychological sequelae (performance anxiety, isolation, poor self-esteem, depression, etc.). These latter occur with other organic illnesses such as migraine, cardiovascular disease, stroke etc. Is it, in fact, time to delete PE from "Diagnostic and Statistical Manual of Mental Disorders" as was done with homosexuality when it was not considered, correctly, a mental disorder?

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The primary recommendation of this author is the revision of the diagnostic criteria for PE to include only one construct, intravaginal ejaculatory latency time (IELT), with a threshold value of "within 45 seconds" of penetration. The role of negative consequences in his proposal is somewhat ambiguous and is not addressed here. There are at least three concerns with this proposed definition: (i) PE is multifactorial; (ii) the deletion of control; and (iii) a 45 seconds threshold for IELT.

An International Society for Sexual Medicine (ISSM) Ad Hoc Committee reviewed definitions of PE in 2007. The committee cited extensive evidence for inclusion of three constructs to define PE including "ejaculatory latency time which always or nearly always occurs within about one minute of vaginal penetration, the inability to delay ejaculation on all or nearly all vaginal penetrations and negative personal consequences, such as distress, bother, frustration and/or the avoidance of sexual intimacy" [8]. Althof and Rowland (2008) support this definition and note that using multiple factors to define criteria for any biobehavioral and/or medical disorder is likely to reduce errors of classification [40].

The author proposes to exclude inability to delay ejaculation, i.e., control, from future definitions of PE despite compelling evidence that this is an important mediator of IELT from the patient's perspective. For example, in one U.S. study, among men diagnosed with PE, IELT explained very little of the variance in negative consequences (ejaculation related distress and dissatisfaction with sexual intercourse) when included in a stepwise regression analysis, while the addition of control greatly enhanced the explained variance [29]. When IELT, control, and negative consequences were included in a path model, IELT had no significant direct effect on negative consequences. These findings, which were supported in a second European study [41], suggest that a man's perception of control rather than latency time, impacts his assessment of the negative consequences of PE.

Finally, the proposed IELT threshold of within 45 seconds is not empirically supported. Most experts appear to agree that PE is associated with a low latency time. The evidence that there is a precise threshold, i.e., 45 seconds, is less compelling and does not provide for clinical judgment in borderline cases or measurement error, which is presumably why the ISSM definition states "about" 1 minute. In large part, this is due to the variability surrounding the assessment of IELT which may be influenced by several factors, e.g., culture, psychological response to the procedure differences in measurement.

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