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Disorders of Ejaculation: An AUA/SMSNA Guideline

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Abbreviations and Acronyms

AUA = American Urological Association
BPH = Benign prostatic hyperplasia
CNS = Central nervous system
DE = Delayed ejaculation
DSM-V = American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders 5th edition
ED = Erectile dysfunction
ELT = Ejaculation latency time
GABA = Gamma aminobutyric acid
IELT = Intravaginal ejaculatory latency time
ISSM = The International Society of Sexual Medicine
LUTS = Lower urinary tract symptoms
MSM = Men who have sex with men
PE = Premature ejaculation
RCT = Randomized controlled trial
SMSNA = Sexual Medicine Society of North America
SNRI = Serotonin noradrenaline reuptake inhibitors
SSRI = Selective serotonin reuptake inhibitors
T = Testosterone
TCA = Tricyclic antidepressants

Purpose: Men who ejaculate before or shortly after penetration, without a sense of control, and who experience distress related to this condition may be diagnosed with premature ejaculation (PE), while men who experience difficulty achieving sexual climax may be diagnosed with delayed ejaculation (DE). The experience of many clinicians suggest that these problems are not rare and can be a source of considerable embarrassment and dissatisfaction for patients. The role of the clinician in managing PE and DE is to conduct appropriate investigation, to provide education, and to offer available treatments that are rational and based on sound scientific data.

Materials and Methods: The systematic review utilized to inform this guideline was conducted by a methodology team at the Pacific Northwest Evidence–based Practice Center. A research librarian conducted searches in Ovid MEDLINE (1946 to March 1, 2019), the Cochrane Central Register of Controlled Trials (through January 2019) and the Cochrane Database of Systematic Reviews (through March 1, 2019). An update search was conducted on September 5, 2019. Database searches resulted in 1,851 potentially relevant articles. After dual review of abstracts and titles, 223 systematic reviews and individual studies were selected for full-text dual review, and 8 systematic reviews and 59 individual studies were determined to meet inclusion criteria and were included in the review.

Results: Several psychological health, behavioral, and pharmacotherapy options exist for both PE and DE; however, none of these pharmacotherapy options have achieved approval from the United States Food and Drug Administration and their use in the treatment of PE and DE is considered off-label.

Conclusion: Disturbances of the timing of ejaculation can pose a substantial impediment to sexual enjoyment for men and their partners. The

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Panel recommends shared decision-making as fundamental in the management of disorders of ejaculation; involvement of sexual partner(s) in decision making, when possible, may allow for optimization of outcomes.

Key Words: Premature Ejaculation, Delayed Ejaculation, Orgasm, Sexual Function, Mental Health

It is typical for men to be able to exert at least partial control of if and when they ejaculate during partnered sexual encounters and masturbation. If a man does not feel that he has control of when ejaculation occurs, and if there is distress on the part of the man or his sexual partner(s), either premature ejaculation (PE) or delayed ejaculation (DE) may be present (Supplemental Material A, https://www.jurology.com). The diagnosis is determined by application of specified time-based criteria to when/if ejaculation occurs. Disorders of the timing of ejaculation can pose a major impediment to sexual satisfaction for both men and their partners. In the most extreme cases, an ejaculatory disorder may lead to relationship stress or marked trepidation about starting new relationships for men afflicted with the condition.

Although the reported prevalence of clinical PE and DE is less than 5%,[1, 2] the experience of many clinicians suggest that these problems are not at all rare. The perception of rarity may stem from the frequency with which other disabling disorders of sexual function, primarily erectile dysfunction (ED), are present in men with comorbid disruption of ejaculation.

Although few treatments have achieved regulatory approval, several interventions can be considered for management of distressing disruptions of ejaculation latency time (ELT), defined as the time between penetration and ejaculation (see Supplemental Material A, https://www.jurology.com). Education and referral to colleagues with experience in the psychological health evaluation and treatment of sexual problems are essential elements of care for these patients.

GUIDELINE STATEMENTS

Premature Ejaculation

1. Lifelong premature ejaculation is defined as poor ejaculatory control, associated bother, and ejaculation within about 2 minutes of initiation of penetrative sex that has been present since sexual debut. (Expert Opinion)

Lifelong PE, sometimes referred to as primary PE, is a bothersome pattern of ejaculation that occurs much earlier than desired and that has been present for all or most of a man's sexual life. Bother referable to the condition and lack of self-efficacy regarding ejaculatory control are both necessary for a PE diagnosis. Bother in particular should be interpreted broadly. It may refer to consequences to the patient himself, the patient's partner, and/or aspects of the relationship.

For men who have had short ejaculatory latencies for most or all of their sexual lives, the average estimated ELT during partnered sex should be 2 minutes or less, measured from the time of penetration to ejaculation. This 2-minute criterion differs from ISSM and DSM-V definitions that use a threshold of 60 seconds. While ejaculation latency of less than 60 seconds is common among men presenting for management of PE, about 20% of men seeking treatment for PE ejaculate after more than 60 seconds.[3] A more permissive time-based criterion allows for appropriate treatment of patients with distress and short ejaculation latencies.

2. Acquired premature ejaculation is defined as consistently poor ejaculatory control, associated bother, and ejaculation latency that is markedly reduced from prior sexual experience during penetrative sex. (Expert Opinion)

Acquired PE, sometimes known as secondary PE, typically denotes a later life onset. Men with acquired PE experience a period of sufficient ejaculatory control and lack of distress prior to developing shortened latency. As with lifelong PE, men with acquired PE should meet the criteria of poor ejaculatory control, diminished sexual satisfaction with intercourse, and negative personal or interpersonal consequences.

The Panel suggests two temporal criteria regarding ELT for diagnosing acquired PE. First, for men who have had normative, non-bothersome ELT for much of their sexual lives, but who later develop a shorter latency time coupled with lack of control and negative consequences, the average estimated ELT during partnered sex should fall under about 2-3 minutes. Alternatively, ELT should be reduced by about 50% or more from prior estimations. The Panel recognizes that these criteria are limited by lack of evidence; clinicians should exercise their own best judgement when making the diagnosis of acquired PE.

3. Clinicians should assess medical, relationship, and sexual history, and perform a focused physical exam to make the diagnosis of premature ejaculation. (Clinical Principle)

A detailed history is an essential element of good medical practice for any condition. A query on the absence or loss of ejaculatory control, personal or interpersonal bother, and short ejaculatory latency time is essential. A psychological health assessment should also be obtained, which may include questions about ongoing or persistent anxiety, mood disorders such as major depression and bipolar affective disorder, or significant psychiatric problems over the past 6-12 months. Assessment by a mental health professional may be of benefit, or even a necessity, depending on severity of mood disorder. A physical examination is typically an essential standard in medical practice; however, physical examination rarely contributes to the evaluation of PE. While it seldom changes management, a focused physical examination is reassuring to patients and may identify issues meriting consideration so should be conducted if/when possible.

4. Clinicians may use validated instruments to assist in the diagnosis of PE. (Conditional Recommendation; Evidence Level: Grade C)

While validated patient-reported questionnaires are useful for research purposes, their value in clinical diagnosis is uncertain. Questionnaires may be useful as an adjunct to diagnosis or as an "ice breaker" to facilitate a conversation about ejaculatory issues but are not required to make the diagnosis of PE.

5. Clinicians should not use additional testing for the evaluation of a patient with lifelong premature ejaculation. (Conditional Recommendation; Evidence Level: Grade C)

High serum testosterone (T),[4] hyperthyroidism,[5] elevated serum glucose or HbA1c, and presence of inflammatory cells or infection in the urine or expressed prostatic secretions may be associated with increased likelihood of PE.[6, 7] With the possible exception of high serum T occurring with onset of sexual maturation, these conditions are generally acquired rather than lifelong. It is therefore not clear how these conditions are relevant to the diagnosis of lifelong PE. Adjunctive tests may be informative in making the diagnosis of lifelong PE, but the nature and strength of association is ambiguous. The clinical application of adjunctive testing is unclear; therefore, additional laboratory testing is not routinely necessary for the diagnosis of lifelong PE.

6. Clinicians may utilize additional testing as clinically indicated for the evaluation of the patient with acquired premature ejaculation. (Conditional Recommendation; Evidence Level: Grade C)

Acquired PE generally manifests later in life, often in association with one or more comorbid conditions. Serefoglu et al.,[8] Zhang et al.,[9] and Gao et al.[10] reported that men with acquired PE have a higher mean body mass index and a greater incidence of comorbid diseases including hypertension, sexual desire disorder, diabetes mellitus, chronic prostatitis, and ED compared to men with lifelong PE. Many of these conditions are risk factors for ED, making ED an important consideration when diagnosing PE. Acquired PE in this context may be conceptualized as an adaptive practice in a man who lacks confidence in his ability to maintain penile erection; "speeding up" the process may be a means to achieve climax before loss of tumescence. If a man with PE is diagnosed with concomitant ED, evaluation should proceed according to the AUA Guidelines on Erectile Dysfunction.[11]

Laboratory tests, particularly tests related to the hypothalamic-pituitary-testicular axis, thyroid function, glucose metabolism, and prostatitis or chronic pelvic pain syndrome should be employed when there is clinical suspicion of these conditions in men with acquired PE.

7. Clinicians should advise patients that ejaculatory latency is not affected by circumcision status. (Conditional Recommendation; Evidence Level: Grade C)

A systematic review of 12 studies on circumcision and premature ejaculation[12] found no association between circumcision and increased risk of premature ejaculation (OR: O.90; 95% CI: 0.72-1.13). In the absence of compelling data to the contrary, the Panel concludes that circumcision status does not exert a significant intrinsic influence on ejaculation latency in the general population.

8. Clinicians should consider referring men diagnosed with premature ejaculation to a mental health professional with expertise in sexual health. (Moderate Recommendation, Evidence Level: Grade C)

Clinical experience suggests that psychological and interpersonal factors may precipitate and exacerbate PE and generate additional psychological and interpersonal symptoms for the man, partner, and couple. Psychological and interpersonal factors associated with PE include depression, anxiety, history of sexual abuse, decreased emotional intimacy, and conflict within the relationship.[1] It is important to note that these are associations, and that causality is unclear. Compared to men without PE, men with PE have significantly lower self-esteem and self-confidence,[13] more interpersonal conflict, and more anxiety in

sexual situations.[14] PE may be a barrier to seeking out and becoming involved in new relationships and hence may pose a particular challenge to men without a partner(s).[15]

Psychotherapy for men and couples suffering from PE may be useful even when no clear psychological or physiological etiology is apparent. Most psychological therapies for PE represent the integration of psychodynamic, systematic, behavioral, and cognitive approaches within a short-term psychotherapy model. Treatment may be provided in an individual, couples, group, or on-line format.

9. Clinicians should recommend daily SSRIs; on demand clomipramine or dapoxetine (where available); and topical penile anesthetics as first-line agents of choice in treatment of premature ejaculation. (Strong Recommendation; Evidence Level: Grade B)

Off-label selective SSRIs and clomipramine

Daily treatment with off-label paroxetine 10-40 mg, sertraline 50-200 mg, fluoxetine 20-40 mg, citalopram 20-40 mg and clomipramine 12.5-50 mg is effective in delaying ejaculation (Table 1). A meta-analysis of published data suggests that daily paroxetine exerts the strongest ejaculation delay, increasing ELT a mean of 8.8-fold over baseline.[16]

On-demand administration of clomipramine, paroxetine, sertraline and fluoxetine 3-6 hours before intercourse is modestly efficacious and well tolerated but is associated with substantially less ejaculatory delay than daily treatment in most studies.[17-21] On-demand treatment may be combined with either an initial trial of daily treatment or concomitant low dose daily treatment.[17]

Serotonin Syndrome is a potentially serious complication most often associated with simultaneous use of multiple serotonergic drugs (e.g., SSRI, TCA, and recreational drugs such as amphetamine or cocaine). Common symptoms include clonus (i.e., cyclic relaxation and contraction of muscles), tremor, hyperreflexia, agitation, mental status changes, diaphoresis, fever. Severe cases may be associated with seizure and rhabdomyolysis. Treatment includes cessation of serotonergic agents. Benzodiazepines may be used in the short-term to manage symptoms.[22-24]

Treatment with SSRIs should be avoided in men with a history of bipolar depression due to risk of mania.[25] The use of off-label SSRIs is favored over the TCA clomipramine because of a better side effect profile.[26]

A systematic review (70 studies; n=18,526 patients) did not identify a significant difference (OR: 1.21; 95% CI: 0.84-1.74) in suicidal ideation in adult men treated with anti-depressants versus placebo.[27] A small increase in the risk of suicidal ideation or suicide attempts was noted in patients under age 18. Elevated risk of suicidal ideation has not been found in trials with SSRIs in non-depressed men with PE. Nevertheless, caution is suggested in prescribing SSRIs to adolescents with PE and to men with PE and a comorbid depressive disorder, particularly when associated with suicidal ideation.[28]

Patients are often reluctant to begin off-label treatment of PE with SSRIs. Salonia et al. reported that 40% of patients either refused to begin or discontinued paroxetine within 12 months of beginning treatment due to concern about taking an antidepressant, treatment effects below expectations, and cost.[29] Patients should be advised to avoid sudden cessation or rapid dose reduction of daily dosed SSRIs as this may precipitate SSRI withdrawal syndrome.[30]

Table 1. *Pharmacotherapies for the treatment of Premature Ejaculation*

Drug	Daily Dose	On-demand dosing
First Line:		
Paroxetine	10—40 mg	20 mg (+/-10 mg daily)
Clompramine	12.5—50 mg	25—50 mg
Sertraline	50—200 mg	50—100 mg
Fluoxetine	20—40 mg	
Citalopram	20—40 mg	
Second Line:		
Tramadol		25—100 mg
Terazosin	5 mg	
Alfuzosion	6—10 mg	
Sildosin	4 mg	
Tamsulosin	0.4 mg	
Doxazosin	4 mg	

Topical Anesthetics

The use of topical anesthetics such as lidocaine and prilocaine is well established and is moderately effective in delaying ejaculation.[31, 32] Topical anesthetics may be associated with significant penile hypoesthesia and possible absorption by the receptive partner, resulting in discomfort and/or numbness.[33] Use of a condom or thorough washing of the penis prior to penetration may help prevent these bothersome effects.

10. Clinicians may consider on-demand dosing of tramadol for treatment of premature ejaculation in men who have failed first-line therapy pharmacotherapy. (Conditional Recommendation; Evidence Level: Grade C)

Tramadol is a centrally acting synthetic opioid analgesic and weak inhibitor of re-uptake of GABA, norepinephrine, and serotonin. The efficacy of on-demand tramadol in the treatment of PE has been reported by several authors.[34-36] The potential of tramadol for addiction or abuse appears low in most

patient populations but has not been assessed in men with PE.[37] Adams et al. reported abuse rates of 0.7% for tramadol compared with 0.5% for non-steroidal anti-inflammatory drugs and 1.2% for hydrocodone, based on application of a dependency algorithm as a measure of persistence of drug use.[38] These data are reassuring but in light of the ongoing opioid crisis in many nations, caution should be exercised in prescribing an analgesic medication with opioid-like properties for management of PE.

11. Clinicians may consider treating men with premature ejaculation who have failed first-line therapy with α1-adrenoreceptor antagonists (Expert Opinion)

α1-Adrenoceptor antagonists are widely used in the treatment of LUTS associated with or without BPH. Several published studies have investigated α1-adrenoceptor antagonists for the treatment of PE;[39-43] however, existing efficacy data remains very limited. Additional controlled studies are required to determine the true role of α1-blockers for management of PE.

12. Clinicians should treat comorbid erectile dysfunction in patients with premature ejaculation according to the AUA Guidelines on Erectile Dysfunction. (Expert Opinion)

Epidemiological data on the coincidence of clinical PE and ED are scant. Based on published data and clinical experience, it is the Panel's opinion that in some cases, acquired PE may be secondary to ED, whereas some men with lifelong PE may develop ED related to performance anxiety. Clinicians should thoroughly evaluate patients with both ED and PE to gauge temporal relationships between the conditions and determine whether they should be managed concomitantly or sequentially.

13. Clinicians should advise men with premature ejaculation that combining behavioral and pharmacological approaches may be more effective than either modality alone. (Moderate Recommendation; Evidence Level: Grade B)

Behavioral strategies have been studied in combination with pharmacological approaches to increase ELT and sexual satisfaction beyond that resulting from pharmacological treatment alone. Inclusion of behavioral therapy for PE leads to a significantly greater increase in ELT compared to pharmacological therapy alone.[44] Combination therapy is also associated with greater improvement in scores on validated instruments for assessment of PE.[44]

14. Clinicians should advise patients that there is insufficient evidence to support the use of alternative therapies in the treatment of premature ejaculation. (Expert Opinion)

Intracavernous self-injection treatment of PE is currently without strong evidence-based support for efficacy or safety. In addition, intracavernous injection does not address issues of PE but rather medically induces erection that is not reversed by ejaculation. Legitimate concerns exist about the risk of priapism in men without ED who utilize injectable agents to induce erections. Other treatments such as duloxetine (40 mg/day), venlafaxine (75 mg/day), herbal therapies, acupuncture, botulinum toxin, modafanil, and oxytocin antagonists all have limited evidence base as management options for clinical PE.

15. Clinicians should inform patients that surgical management (including injection of bulking agents) of premature ejaculation should be considered experimental and only be used in the context of an ethical board-approved clinical trial. (Expert Opinion)

Several authors have reported the use of surgically induced penile hypo-anesthesia via selective dorsal nerve neurotomy, pulsed radiofrequency ablation of dorsal penile nerves, or hyaluronic acid gel glans penis augmentation in the treatment of lifelong PE refractory to behavioral and/or pharmacological treatment. Invasive treatment may be associated with permanent loss of penile sensation; as such, the Panel recommends that surgical intervention for PE only be considered in the context of an ethical board-approved trial for patients who have failed or cannot tolerate alternative management strategies for PE.

Delayed Ejaculation

16. Lifelong delayed ejaculation is defined as lifelong, consistent, bothersome inability to achieve ejaculation, or excessive latency of ejaculation, despite adequate sexual stimulation and the desire to ejaculate. (Expert Opinion)

17. Acquired delayed ejaculation is defined as an acquired, consistent, bothersome inability to achieve ejaculation, or an increased latency of ejaculation, despite adequate sexual stimulation and the desire to ejaculate. (Expert Opinion)

DE is arguably the least studied, least reported, and least understood male sexual dysfunction and is of particular concern when procreation is desired. Regardless of the desire for procreation, the impact of failure to achieve orgasm is significant in that it typically results in a lack of sexual fulfilment for both

the man and his partner. DE is meant to describe any and all of the ejaculatory disorders resulting in a delay or absence of ejaculation and concomitant impairment of orgasm (Supplemental Material A, https://www.jurology.com).

The median ELT in Western countries is between 5-6 minutes following intromission.[45] Men with latencies beyond 25 or 30 minutes who report distress, or men who simply cease sexual activity due to their partners request, fatigue or a sense of ejaculatory futility qualify for this diagnosis. Such symptoms, together with the fact that a man and/or his partner decide to seek help for the problem, are usually sufficient for a DE diagnosis.

EVALUATION AND DIAGNOSIS

18. Clinicians should assess medical, relationship, and sexual history and perform a focused physical exam to evaluate a patient with delayed ejaculation. (Clinical Principle)

A general medical history should include an assessment of conditions associated with neuropathy, metabolic derangements, and traumas to the nervous system or pelvis. A sexual history should be obtained, assessing factors such as relationship status, relationship quality, partner feelings on the acute issue, and on sexuality in general. The patient should be queried on whether the problem of DE is situational or generalized. An assessment of time of onset, chronicity, frequency, and associated factors, such as alleviating and exacerbating should also be obtained. There are no physical exam findings that have been clearly linked to DE; however, a focused physical exam is often reassuring to patients and may yield clues to conditions that may be comorbid or even related to DE.

19. Clinicians may utilize additional testing as clinically indicated for the evaluation of delayed ejaculation. (Conditional Recommendation; Evidence Level: Grade C)

The utility of additional testing in the management of DE is unclear, in large part because the etiology of the disorder is incompletely understood. Predisposing factors can generally be elicited with a careful history. Considering the prevalence of symptoms consistent with DE can increase with progressively lower serum T levels,[46] the Panel supports morning T testing as recommended by the AUA Guideline on the Management of Testosterone Deficiency.[47] Basic serum studies including electrolytes, lipids, and glycosylated hemoglobin may be informative of medical conditions that could predispose to neuropathy or vascular disease, which may contribute to sexual dysfunction, including DE.

Table 2. *Agents known to be associated with Delayed Ejaculation*

Alcohol	Clomipramine	Mebanizine	Phenelzine Sulfate
Alprazolam	Demethylimpiramine	Mesoridazine	Prazosin
Amiocaproic Acid	Fluoxetine	Methadone	Protriptyline
Amitriptyline	Fluvoxamine	Methyldopa	Reserpine
Amoxapine	Guanadrel	Naproxen	Sertraline
Baclofen	Guanethidine	Nortriptyline	Thiazides
Bethanidine	Haloperidol	Pargyline	Thioridazine
Butaperazine	Hexamethonium	Paroxetine	Trazodone
Chlordiazepoxide	Imipramine	Perphenazine	Trifluoperazine
Chlorimipramine	Iproniazid	Phenotiazine	
Chloropromazine	Isocarboxazid	Phenoxybenzamine	
Chlorprothixene	Lorazepam	Phentolamine	

TREATMENTS

20. Clinicians should consider referring men diagnosed with lifelong or acquired delayed ejaculation to a mental health professional with expertise in sexual health. (Expert Opinion)

Psycho-behavioral strategies are unlikely to directly alter the ejaculatory threshold but may enhance psychosexual arousal and/or remove barriers and inhibitions that interfere with psychosexual excitement. One of the most significant factors in DE is age, which likely combines psychological and physiological processes. Age-related increases in latency may be managed with psychological and behavioral approaches (e.g., increasing the repertoire of behaviors) aimed at increasing physical and psychological arousal. These approaches avoid the risks of pharmacotherapies for DE that also have a very limited evidence basis and carry some risk of treatment-related adverse events.

21. Clinicians should advise men with delayed ejaculation that modifying sexual positions or practices to increase arousal may be of benefit. (Expert Opinion)

Behavioral interventions are a low-risk option that may help some men with DE enhance arousal and trigger orgasmic response. This may include incorporation of alternative sexual practices, scripts, and/or incorporation of sexual enhancement devices. At a minimum, a discussion about sexual needs and desires may help open lines of communication between partners and help facilitate treatment.

PHARMACOTHERAPY

22. Clinicians should suggest replacement, dose adjustment, or staged cessation or of medications that may contribute to delayed ejaculation. (Clinical Principle)

Table 3. *Pharmacotherapies with potential efficacy for the treatment of Delayed Ejaculation*

Drug	PRN Dosage	Daily Dosage
Oxytocin	24 IU intranasal/SL during sex	—
Pseudoephedrine	60—120 mg (120—150 minutes prior to sex)	—
Ephedrine	15—60 mg (1 hour prior to sex)	—
Midodrine	5—40 mg daily (30—120 minutes prior to sex)	—
Bethanecol	20 mg daily	
Yohimbine	—	5.4 mg TID
Cabergoline	—	0.25—2 mg BIW
Imipramine	—	25—75 mg Daily

BIW: twice a week; IU: international units; PRN: pro re nata; SL: sublingual; TID: three times a day

A variety of medications have been clearly linked to disruption of orgasmic function. Examples include SSRI, SNRI, TCA, opioids, CNS-acting agents, and various others.[48, 49] Table 2 (adapted from Sadowski et al.) highlights agents known to be associated with DE.[49] Cessation of these medications should be considered in patients who present with troublesome DE, particularly if the onset of DE coincides with initiation of the medication. When cessation is not possible, dose adjustment or substitution may yield benefit.

The majority of drugs associated with DE are not commonly utilized in urological practice; the practicing urologist is unlikely to be fully familiar with indications and particular considerations regarding dose adjustment and cessation. The prescribing physician(s) and possibly a pharmacist should be advised of the potential issue with the prescribed medication; the decision on cessation and dose adjustment must be made using shared decision-making involving all parties after careful consideration of risks and benefits.

23. Clinicians should inform patients that there is insufficient evidence to assess the risk-benefit ratio of oral pharmacotherapy for the management of delayed ejaculation. (Expert Opinion)

There are no FDA approved pharmacotherapies for DE and the body of literature on DE pharmacotherapy is scant. The bulk of published studies consisting of case reports and non-randomized, non-placebo-controlled case series. The Panel is supportive of clinicians offering appropriately selected pharmacotherapies that have a physiologic rationale for benefit in DE treatment (Table 3). Patients should be counseled on the weak evidence base and the potential for both known and unknown side effects. The benefit of enhanced orgasmic function must be weighed by the patient against the potential risks; an individualized decision can then be made based on the patient's own personal values. The majority of these drugs are not commonly utilized in urological practice; the urologist who is not comfortable prescribing these medications should consider referral of the patient for discussion of these management options.

24. Clinicians may offer treatment to normalize serum testosterone levels in patients with delayed ejaculation and testosterone deficiency. (Expert Opinion)

Ejaculatory dysfunction is increasingly common with age, which is itself associated with declining serum T levels. It is logical to hypothesize that the androgenic milieu has an influence on ejaculation and orgasm. This study and understanding of the relevance of T to ejaculation and orgasm supports checking T level in men with delayed orgasm and ejaculation. In men with biochemically low T and symptoms, clinicians may consider T replacement therapy as per the 2018 AUA Guideline on the Management of Testosterone Deficiency.[47]

25. Clinicians should treat men who have delayed ejaculation and comorbid erectile dysfunction according to the AUA Guidelines on Erectile Dysfunction. (Expert Opinion)

ED and DE are oftentimes comorbid and share a number of common risk factors, including medications, endocrine conditions, penile sensation loss, and psychological factors. The critical step in evaluating patients with concomitant ED and DE is to define the chronology of their relationship. When DE precedes the onset of ED the focus should be on defining the etiologies of DE and trying to determine if they have played a role in the development of ED and address any etiological factors appropriately. When ED precedes the onset of DE, common etiological factors should be sought and addressed. When no overt etiological factors are present for DE, careful attention should be focused on the secondary psychological sequela of the presence of ED.

26. Clinicians should counsel patients with delayed ejaculation that no currently available data indicates that invasive non-pharmacological strategies are of benefit. (Expert Opinion)

Given the paucity of effective treatments for DE, some clinicians have explored non-pharmacological strategies such as pudendal nerve release, intracavernosal injections, platelet rich plasma, and surgical interventions. No published, peer-reviewed data exists supporting any of these approaches.

Given the risks and potential expense the panel does not recommend use of any invasive procedure for DE outside the context of an ethical board-approved clinical trial in which participants give informed consent for participation in research.

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