Editorial Comments

This paper represents another one on the topic of pharmacological management of premature ejaculation among a plethora of papers within the last four years, devoted to the therapeutical impact of serotonin re-uptake inhibitors in this indication and with many of them being cited in this article. Similar to many other recent papers in this field the authors reduce their efforts in terms of evaluation of the efficacy of this treatment towards pure mechanical aspects to say the measurements of the ejaculation latency times before and after treatment. This attitude encountered in many publications on this topic does not meet the real psychological impact of this entity both in the patient and female partner. We all know that premature ejaculation represents a purely psychologic phenomenon apart from these very rare cases based on anatomical anomalies. Therefore in all these papers like this one, it is more than reasonable and desirable that the therapeutic outcome of any treatment of premature ejaculations is evaluated by stratified and therefore reliable inventories both for the patients and their partners. In addition this paper leaves some open questions. Why do 32% of the males fail in the on demand group after chronic doses? Is this a special group with special psychopathological features and if yes which characteristics could be found? For these men with significant improvement of premature ejaculation after serotonin re-uptake inhibition is this a life-long treatment or is there a chance for continuing improvement if the drug is withdrawn after several months of treatment? This issue is of special importance as this medication represents a very expensive one and therefore not affordable for many afflicted patients.

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I would like to comment on Hartmut Porst's editorial comment

Dr Porst suggests that 'we all know that premature ejaculation represents a purely psychological phenomenon . . .'. There is no doubt that many patients have PE due to performance anxiety. However, there is mounting data suggesting that some PE may have a biogenic basis. Berendson and Szele have both demonstrated in animals that responses to SSRIs are identical to those seen after selective activation of 5-HT_{2C} receptors. Ahlenius has reported that activation of 5-HT_{1A} receptors with a specific agonist shortens the ejaculatory latency time. Furthermore, this 5-HT_{1A} receptor response is either attenuated or blocked by simultaneous stimulation of 5-HT_{2C} receptors. Waldinger has speculated that PE in humans is due to either hypersensitive 5-HT_{1A} receptors or hyposensitive 5-HT_{2C} receptors. As such, PE may not always be psychogenic—there may be a biogenic basis. Accordingly, both the treatment and the research methodology of PE can justifiably diverge, in some respects, from the 'psychological model' of PE. Studies focusing on the pivotal defect in PE, namely too brief an ejaculatory interval, are entirely valid. Whilst the level of ejaculatory and/or orgasmic satisfaction in men and their partners is clearly important and can potentially be assessed by a validated inventory, no validated patient/partner inventories specifically for ejaculatory dysfunction have been published at this stage. Failure of 'on demand' treatment after initial successful chronic treatment was more common in men with lifelong PE. This was also the case in men who failed to respond to chronic paroxetine and initial 'on demand' treatment. Their treatment failure appears associated with the presumed increased severity of lifelong PE as opposed to acquired PE. Follow-up of both patient groups suggest that approximately 70% of patients taking chronic or 'on demand' paroxetine are able to suspend medication and maintain improved ejaculatory control after a mean of six months treatment. Similar observations were made with earlier published work on sertraline (*J Urol*, May, 1998). The retention of improved ejaculatory control after cessation of medication is more likely in men with acquired PE and in men who have more frequent intercourse. Drug treatment of ejaculatory dysfunction is an exciting new area in sexual health and, in as much as PE is the most common male sexual disorder, may represent the next new focus of clinical research.

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