International Journal of Impotence Research (2006) 18, S1–S2
 0955-9930/06 $30.00
www.nature.com/ijir

EDITORIAL

International Journal of Impotence Research (2006) **18,** S1–S2. doi:10.1038/sj.ijir.3901515

The field of male sexual dysfunction remains enigmatic. While significant advances have been made in the understanding and treatment of erectile dysfunction (ED), topics such as libido, hypogonadism and ejaculation remain fertile areas of research.

This supplement focuses on the broad area of male ejaculation. A variety of ejaculatory disorders exist. Two of the ejaculatory disorders are characterized by nomenclature without specific time intervals. While rapid ejaculation and delayed ejaculation imply an 'early' and 'late' ejaculatory time, the exact time interval by which 'early' and 'late' are defined is not universally accepted. Further, time ranges for the diagnosis of rapid or delayed ejaculation are also not well established. Adding to the puzzle is the multifaceted nature of the ejaculatory response. Both physical and psychogenic influences appear to have a contributory role to the ejaculation cascade, adding a level of complexity to this problem.

Use of the terminology, 'rapid' ejaculation and 'delayed' ejaculation imply that a normal range for ejaculatory latency has been established. Yet, no such universally accepted time frame exists. The methodology needed to acquire such data remains controversial as well. Intravaginal ejaculation latency time (IELT) appears to have emerged as a leading candidate for determination of the ejaculatory time-frame. In an elegant study, Waldinger *et al.*[1] used IELT in an attempt to gauge a range of normal ejaculatory responses. A total of 500 couples were recruited from five countries: the Netherlands, United Kingdom, Spain, Turkey and the United States. Men enrolled in the study were 18 years or older, had a stable heterosexual relationship for at least 6 months, with regular sexual intercourse. The distribution of the IELT in all the five countries was positively skewed, with a median IELT of 5.4 min (range, 0.55–44.1 min). The median IELT decreased significantly with age, from 6.5 min in the 18–30 years group, to 4.3 min in the group older than 51 years ($P<0.0001$). The median IELT varied between countries, with the median value for Turkey being the lowest, that is, 3.7 min (0.9–30.4 min), which was significantly different from each of the other countries. These data also introduce the possibility that age-specific ranges may exist, further complicating this area.

Notwithstanding, the relatively new time-frame offered by Waldinger above, others have used an arbitrary time frame of 1–2 min to define rapid ejaculation. Additionally, the definition of rapid ejaculation has also included an element of bother or distress.[2] This broader definition of rapid ejaculation implies that bother should be an integral part of the diagnosis. This comprehensive definition has been used in a variety of epidemiologic surveys, which have demonstrated that rapid ejaculation is the most common male sexual disorder.[3] Gunn and Carson[4] and Segraves,[5] noted authorities in the area of sexual medicine, provide an update of the definition and epidemiology in their respective papers.

Newer data suggests that delayed ejaculation may be related to lower urinary tract symptoms (LUTS),[6,7] suggesting that local influences, such as the prostate, can have a wide-ranging impact on ejaculation. Treatment for delayed ejaculation remains problematic.

The far end of the delayed ejaculation spectrum includes anejaculation, the total lack of ejaculation. Anejaculation is seen post-radical prostatectomy as this operation removes the prostate gland, which contributes approximately 30% of the ejaculation, and the seminal vesicles, which contributes approximately 70% to the total ejaculate. Beyond post-prostatectomy anejaculation, anejaculation may have a neurologic origin, such as in patients with spinal cord injury, or who may be psychogenic, wherein a man may actually be able to retard ejaculation based on a variety of psycho-social issues. To this end, Orr and Seidman[8] address this multifaceted process with a thorough and insightful look into the potential comment mechanisms involved in orgasm, depression, sexual dysfunction, as well as treatment strategies.

New therapies are in development and treatment of rapid ejaculation has recently received a great deal of attention. There is no currently available Food and Drug Administration (FDA) approved therapy for rapid ejaculation or delayed ejaculation. Historical therapies for rapid ejaculation have included psychotherapy and off-label selective serotonin reuptake inhibitor (SSRI) use.[9] Recently, dapoxetine,[10] a novel treatment for rapid ejaculation, received a great deal of attention as a potential therapeutic agent. Dapoxetine will require further study prior to use as an FDA-approved treatment.[11]

The basic physiology of ejaculation has come under intense study. The multifaceted pathways, the

complex animal models, the neurotransmitters involved in ejaculation have been the subject of research by several laboratories. Waldinger *et al.*[12] provide a thorough overview of the animal models and the issues surrounding the entire animal model pathway as it pertains to human ejaculatory behavior. Development of animal models that mimic human ejaculatory patterns may allow for novel therapies to be developed for the entire gamut of ejaculatory disorders.

It is hoped that this supplement enlightens the reader as to the newer concepts regarding ejaculatory disorders. I am delighted to have Culley Carson, a noted expert in the field of sexual medicine serve as the guest editor of this supplement on ejaculation. Dr Carson's introductory comments, continue to highlight the problems clinicians and patients alike face in the area of premature ejaculation.

A Seftel
Department of Urology, Case Western Reserve University, University Hospitals of Cleveland, Cleveland, OH, USA
E-mail: adseftel@aol.com

References

1 Waldinger MD, Quinn P, Dilleen M, Mundayat R, Schweitzer DH, Boolell M. A multinational population survey of intravaginal ejaculation latency time. *J Sex Med* 2005; **2**(4): 492–497.
2 American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, DSM IV.* American Psychiatric Press: Washington, DC, 1994.
3 Laumann EO, Paik A, Rosen RC. Sexual dysfunction in the United States: prevalence and predictors. *JAMA* 1999; **281**(6): 537–544.
4 Gunn K, Carson CC. Premature ejaculation: definition and prevalence. *Int J Impot Res* 2006 **18**(Suppl 1): S5–S13.
5 Segraves RT. Rapid ejaculation: a review of nosology prevalence, and treatment. *Int J Impot Res* 2006 **18**(Suppl 1): S24–S32.
6 Rosen R, Altwein J, Boyle P, Kirby RS, Lukacs B, Meuleman E *et al.* Lower urinary tract symptoms and mal sexual dysfunction: the multinational survey of the aging male (MSAM-7). *Eur Urol* 2003; **44**(6): 637–649.
7 Braun M, Wassmer G, Klotz T, Reifenrath B, Mathers M, Engelmann U. Epidemiology of erectile dysfunction: results of the 'Cologne Male Survey'. *Int J Impot Res* 2000; **12**(6): 305–311.
8 Orr G, Seidman S. Ejaculatory dysfunction and depression: pharmacological and psychobiological interactions. *Int J Impot Res* 2006 **18**(Suppl 1): S33–S38.
9 Arafa M, Shamloul R. Efficacy of sertraline hydrochloride in treatment of premature ejaculation: a placebo-controlled study using a validated questionnaire. *Int J Impot Res* advance online publication, 23 March 2006; doi:10.1038/sj.ijir.3901469.
10 Dresser MJ, Desai D, Gidwani S, Seftel AD, Modi NB. Dapoxetine, a novel treatment for premature ejaculation, does not have pharmacokinetic interactions with phosphodiesterase-5 inhibitors. *Int J Impot Res* 2006; **18**(1): 104–110.
11 http://www.jnj.com/news/jnj_news/20051026_164127.htm. accessed, July 1, 2006.
12 Olivier B, Chan JSW, Pattij T, de Jong TR, Oosting RS, Veening JG *et al.* Psychopharmacology of male rat sexual behavior: modeling human sexual dysfunctions? *Int J Impot Res* **18**(Suppl 1): S14–S23.