Editorial comment

Treatment of premature ejaculation with sertraline hydrochloride — a single blind placebo controlled cross over study — by CG McMahon

Premature ejaculation (PE) represents a very frequently encountered sexual disorder in many physicians' offices and its prevalence is reported to affect between 22 and 38% of all males.[1] Although there is no world-wide accepted and standardized scientific definition of PE available, there is general agreement that this sexual disorder concerns both the male and female to more or less the same extent. It is also true so far that no predominant cause of PE is documented in the literature and past publications go so far as to claim that PE may be attributed to a potentially serious neurosis.[2] Presently there seems to be general acceptance that PE is associated to a distinct degree with generalized anxiety and based on this concept several behavioral approaches were recommended with the stop/start- or squeeze-technique representing the most popular ones. Although many psychiatrists, who proclaimed and exclusively used behavioral and psychoanalytic approaches to PE, reported success-rates as high as 90% a considerable number of publications with pharmacotherapeutic approaches to PE appeared in the course of the last 20 y with increasing tendency in the last 5 y. This indicates without any doubt that despite the confirmations of the psychiatrists many males failed with the aforementioned behavioral approaches and consulted other physicians for a second opinion and in order to solve their problem. Therefore numerous publications were dealing with the more or less beneficial effects of several drugs on PE including alpha adrenoceptor blocking agents (phenoxybenzamine) or tricyclic antidepressants (clomipramine) as well as beta adrenoceptor blocking agents (propranolol) or local anasthetic creams (prilocaine). Although with most of these pharmacotherapeutic approaches successes were reported the results did not indicate a breakthrough in the pharmacological management of PE. With the development and approval of the novel generation of serotonin re-uptake inhibitors like fluoxetine, paroxetine and recently sertraline for the treatment of psychic diseases, especially concerning depression, one of the frequently encountered adverse effects were disturbances of ejaculation especially a delay or loss of ejaculation. Therefore the use of these drugs for the treatment of PE seemed reasonable. In the meanwhile several studies with these agents were conducted in the indication PE with promising results.[3–5]

Although the study design of the present series with sertraline in PE reveals some obvious shortcomings that are not double blinded and placebo-controlled design and the non-involvement of the female partners concerning the assessment of success- and satisfaction-rates, the outcome of the study provided evidence that sertraline especially in the dosage of 50 mg seems to become a first choice option for the management of PE. In this context the question raises whether sertraline also yields the same favorable success-rates if used on an on demand ('as needed') basis, an approach, which should be preferred to a continuing daily administration. A second issue concerning the usefulness of sertraline in PE is whether this drug also shows a comparable efficacy in premature ejaculation and simultaneous erectile dysfunction.

Although this article is not able to provide the answers to these questions in my opinion the novel serotonin re-uptake inhibitors including sertraline may considerably simplify the management of PE. In this fashion these new agents may contribute to the abandonment of 'novel heroic' surgical procedures like selective neurotomy, as was suggested by Tullii *et al*,[6] and may preserve the affected males from such questionable therapies.

References

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