

# Medical management of premature ejaculation

Neil Baum, MD, and Bradley Spieler, BA

**ABSTRACT** Premature ejaculation is the most prevalent condition of all male sexual problems, a fact that has been obscured by the increased attention to erectile dysfunction. In the past, most of the help given to men suffering from ejaculatory problems (and their partners) was by referral to a sex therapist. Currently, several medical options are available and more are on the horizon that can be prescribed in the primary care setting. Specifically, evidence has shown the serotonergic antidepressants as a successful first-line therapy for premature ejaculation, but careful consideration of the drugs' side effects profile is necessary. Other therapies include anesthetic agents, topical creams, and a mouth wash spray. The best approach to treatment is one that combines medical therapy with one of the behavioral methods for retraining the ejaculatory reflex.

The advent of a drug treatment for erectile dysfunction has focused the attention of the medical community on that condition, moving erectile problems to front stage and obscuring the reality that ejaculatory problems, specifically premature ejaculation, are the most prevalent conditions among male sexual disorders. Last month, Dr Elliott elaborated on how to take the sexual history of ejaculatory problems. This month we focus on the approach to treatment in primary care, combining drug and nondrug options.

## Prevalence

Premature ejaculation is defined as persistent or recurrent ejaculation with minimal sexual stimulation before, upon, or shortly after penetration and before it is wished by the man or his partner. It is considered the most commonly experienced male sexual dysfunction, affecting tens of millions of American men.<sup>1</sup> Estimates suggest that as many as one third of all sexually active men suffer from premature ejaculation.

Premature ejaculation is the most frequently encountered sexual complaint of men and couples. This condition could have profound effects on the psychosexual relationship of a couple, and in its most severe form can lead to secondary impotence or even to male infertility.

## Causes of premature ejaculation

Premature ejaculation is most common among adolescents, young adults, and men who lack sexual experience and frequency. It is associated with low

## Practice Tips

‡ A thorough history is key to the assessment of patients presenting with ejaculatory problems. Be sure to include a voiding and sexual history when taking the history of these patients.

‡ During the physical exam check the external genitalia, especially the urethral meatus, for evidence of urethral discharge. Perform a digital rectal exam to check for prostate tenderness, which may indicate prostatitis.

‡ Laboratory investigations should include a urinalysis, especially in the patient who has any associated urinary symptoms.

‡ All SSRIs may result in erectile dysfunction, therefore do not prescribe them for patients with a history of this condition.

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**TABLE 1** Medical conditions that can contribute to premature ejaculation

<ul style="list-style-type: none"> <li>▫ Arteriosclerosis</li> <li>▫ Benign prostatic hyperplasia</li> <li>▫ Cardiovascular disease</li> <li>▫ Diabetes</li> <li>▫ Injury to the sympathetic nervous system</li> <li>▫ Pelvic injuries</li> <li>▫ Prostate cancer</li> <li>▫ Prostatitis</li> <li>▫ Urethritis</li> <li>▫ Urinary incontinence</li> <li>▫ Polycythemia</li> <li>▫ Polyneuritis</li> </ul>
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or lack of self-confidence or with a psychological trauma. Experts suggest the etiology is rooted in some psychological issues, such as early sexual experiences, performance anxiety, low arousal levels, or decreased sexual desire<sup>2,3</sup>; another cause that is sometimes mentioned and is still debatable is hypersensitivity of the penile skin.

Early sexual experiences that involve frequent rapid masturbation or a quick sexual experience can form poor sexual habits. Increased risk of premature ejaculation is associated with lack of sexual experience, lack of knowledge regarding male and female sexual responses, and with men who associate psychological stress (fear, guilt, anxiety) with sexual activity. Another significant cause may sometimes be the man's decreased sexual desire or lack of arousal. Relationship or partner issues can also be a contributing factor, especially when there is a deterioration in the relationship or lack of open communication.

Although most men who complain of premature ejaculation have psychogenic causes, rarely are there purely physiologic explanations (Table 1) for this condition.

**Patient evaluation**

**The history.** A thorough history is key to the assessment of patients presenting with ejaculatory problems. Be sure to include a voiding and sexual history when taking the medical history. The questions in Table 2 will help foster an atmosphere that allows the patient to comfortably discuss his sexuality. A positive response to any of the questions requires a more thorough urologic investigation to rule out any physiologic cause for the ejaculatory problem.

**Physical exam.** When performing the physical examination check the external genitalia, especially the ure-

**TABLE 2** Ruling out associated urologic conditions

<ul style="list-style-type: none"> <li>▫ Do you have any problems obtaining or maintaining an erection?</li> <li>▫ Do you have pain or problems with ejaculation?</li> <li>▫ Do you have any blood in the seminal fluid?</li> <li>▫ Do you have any difficulty with urination?</li> <li>▫ Do you have any pain with urination?</li> <li>▫ Do you have any blood in your urine?</li> </ul> <p>These questions will help to rule out any urologic involvement that may be contributing to the ejaculatory problem. A positive response to any of these questions requires a more thorough urologic investigation for potential associated conditions.</p>
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thral meatus, for any evidence of a urethral discharge (Figure 1). Perform a digital rectal exam to check for prostate gland tenderness, which may indicate prostatitis. Also use a focused neurologic examination of the lower extremities and the genital and perineal areas, examining the bulbocavernosus reflex and the ability to discern light touch and pinprick in the genital area.

**Lab studies.** Laboratory investigations should include a urinalysis, especially in the patient who has any associated urinary symptoms. If such problems exist, they must be addressed before prescribing any drug treatment for the ejaculatory problem.

**Drug therapy with serotonin reuptake inhibitors**

For many years, premature ejaculation had been considered a predominately psychological disorder, and its treatment fell into the realm of the psychiatrist, clinical psychologist, or sex therapist. Early studies in the 1970s and 1980s indicated a possible role for antidepressants in the treatment of premature ejaculation, suggesting that the adverse sexual effects caused by some antidepressants could reverse rapid ejaculation. Focusing on serotonin reuptake inhibitor antidepressants, evidence has shown them useful in delaying ejaculation or anejaculation.<sup>4</sup> None of the antidepressants is currently indicated for premature ejaculation, but clinical use has proven effective, although their general adverse effects profile renders them less-than-ideal solutions (Table 3).

**Clomipramine.** Clomipramine (Anafranil®) is a tricyclic antidepressant that inhibits the reuptake of norepinephrine as well as serotonin and was the first to be investigated in men who suffered from premature ejaculation with no connection to depression.<sup>5,6</sup> Although the exact mechanism of action for this treatment has not been elucidated, the mechanism of the serotonin reuptake inhibitors appear to improve ejacu-

latory control by decreasing the alpha-adrenergic tone or by increasing the serotonin levels in the blood.<sup>7</sup>

Clomipramine has been shown to produce a significant delay in time to orgasm. In a prospective placebo-controlled trial, use of clomipramine, 12 to 24 hours before intercourse, resulted in a significant improvement in intravaginal latency time. Clomipramine has been effective in approximately 70% to 80% of men with this ejaculatory condition.<sup>8</sup>

Reported side effects were not sufficient to discourage those who suffered from premature ejaculation. A significant advantage of clomipramine is that it can be taken several hours before sexual activity, as needed.

Our clinical experience has shown beneficial effect with clomipramine, 25 mg on an on-demand basis. When this dose has been ineffective, increasing the dose to 50 mg has again shown beneficial results. However, it is only occasionally necessary to increase the dose to 50 mg.

We must remember that most patients experience a return of symptoms following discontinuation of this or any drug treatment for premature ejaculation.

**Fluoxetine.** The selective serotonin reuptake inhibitor (SSRI) with the longest use for this purpose, fluoxetine (Prozac<sup>®</sup>) has also been beneficial for the treatment of premature ejaculation. A dosage of 20-mg daily for 1 week, followed by 40-mg daily thereafter for 4 weeks has produced significant benefit.<sup>9</sup> Fluoxetine has also been shown to increase the penile sensory threshold of the dorsal nerve,<sup>10</sup> thereby delaying time to orgasm.

**Paroxetine.** A more recent SSRI, use of paroxetine (Paxil<sup>®</sup>) several hours before coitus has also been shown effective.<sup>11</sup> In addition to the common SSRI side effects, paroxetine produces frequent bursts of intense yawning. However, these sexual side effects could decrease or disappear after an extended use.<sup>12</sup> A potential side effect for all the SSRIs, retarded ejaculation or even anejaculation has been specifically documented with paroxetine.<sup>13</sup> In the context of premature ejaculation, this adverse effect becomes beneficial treatment.

**Advantages.** The SSRIs may offer a good pharmacologic treatment option for premature ejaculation in patients who have no other psychopathology because of their dramatic postponement of ejaculation, the rapidity of the improvement, relatively small impact on sexual desire, and a general low incidence of side effects. The SSRIs may have some effect on sexual desire, but it is seldom a reason to discontinue use of medication for premature ejaculation. The down side is that the benefits of such drug treatment depend on continuing

## FIGURE 1 The physiology of ejaculation

Ejaculation is a spinal reflex different from the primarily vascular changes associated with an erection.<sup>1</sup> The normal act of ejaculation is a well-synchronized event requiring input from both the autonomic and somatic nervous systems. With sexual activity, the events of emission and ejaculation are closely related. The emission phase, which momentarily precedes ejaculation, is mediated by the sympathetic efferent nerve fibers that originate between the T10–L2 spinal cord segments.<sup>2</sup> Initially, the prostatic smooth muscle contracts, thereby expressing the prostatic secretions. This is followed by contraction of the distal vasa deferentia and the seminal vesicles. Immediately following emission, the bladder neck begins to close under the control of the sympathetic nervous system. The actual act of ejaculation then results from the rhythmic contractions of the ischiocavernosus, bulbocavernosus, and pelvic musculature, with subsequent relaxation of the external genitourinary sphincter. In a coordinated fashion the deposited seminal fluid is forcibly ejected in an antegrade fashion through the anterior urethra.

1. Seftel AD, Althof SE. Rapid Ejaculation. *Sexual Dysfunction* 2:10–13, 2000.

2. Murphy JB, Lipshultz LI. Abnormalities of ejaculation. *Urol Clin N Amer* 14:583,1987.

use of the drug. When discontinued, the positive effects are lost and ejaculatory latencies return to pretreatment level.<sup>14</sup> None of the antidepressants is presently indicated for this condition.

**Side effects.** Remember that all SSRIs have potential side effects; before prescribing these drugs you must be aware of their pharmacology. These drugs are well absorbed from the gastrointestinal tract and are metabolized by the liver and excreted by the liver and kidneys. Therefore, the dose should be adjusted downward in men with hepatic or renal impairment. Also, all SSRIs may result in erectile dysfunction and should therefore not be given to patients with a history of this condition.<sup>8</sup>

**Contraindications.** All the SSRIs are absolutely contraindicated in combination with the monoamine oxidase inhibitors (MAOIs). Use of an SSRI in combination with an MAOI has precipitated a serotonin crisis, which consists of confusion, agitation, poor concentration, rigidity, myoclonus, involuntary movements, orthostatic hypotension, or hyperreflexia. The SSRI should also not be prescribed to men with prior or active seizure disorders, anxiety disorders, or recent myocardial infarctions.

## Topical treatments

**SS-cream.** Another pharmacologic treatment option is

**TABLE 3** Drug treatment for premature ejaculation

Drug	Dose	Side effects	Comments
<b>TRICYCLIC ANTIDEPRESSANT</b> (and a serotonin reuptake inhibitor)			
<b>Clomipramine</b> (Anafranil)	25 mg, 12–24 hr before intercourse, as needed; if ineffective, increase to 50 mg	Dry mouth, fatigue, lethargy, dizziness, decreased libido, delayed orgasm	Promotes ejaculatory delay Need not be taken continuously Prolonged use may result in constipation or weight gain <sup>1</sup>
<b>SSRIs</b>		Nausea, headache, anxiety, insomnia	Most SSRIs decrease sexual desire, but this effect may diminish when used for prolonged periods SSRIs' ability to delay ejaculation is beneficial for premature ejaculation <sup>2</sup> Contraindicated with use of MAOIs
<b>Fluoxetine</b> (Prozac)	20 mg/d for 1 wk, then 40 mg/d for 4 wk	Urinary incontinence, priapism, decreased libido, delayed orgasm	
<b>Paroxetine</b> (Paxil)	20 mg a few hr before intercourse	Fatigue, bursts of intense yawning, decreased libido, delayed orgasm	
<b>TOPICAL CREAMS</b>			
<b>SS-cream</b>	Applied to glans penis 1 hr before intercourse	Mild penile burning and pain	Not available in the United States
<b>Anesthetic creams</b> <b>Prilocaine-lidocaine</b> (EMLA cream)	Apply 2.5 mg, PRN	Penile numbness	Condom use will resolve partner's concerns of genital numbness
<b>MOUTHWASH</b>			
<b>Chloraseptic</b>	PRN, just before intercourse	Good safety profile	Retards sexual stimulation, inexpensive

SSRIs=selective serotonin reuptake inhibitors

1. Crenshaw, TL, Goldberg, PG. *Sexual Pharmacology: Drugs that Affect Sexual Functioning*. New York: WW Norton, 1996, p 291.

2. *Ibid.*, pp 289–94.

the topical SS-cream. This new agent, made from the extracts of nine natural products, has not yet been approved by the FDA and is not available in this country. In placebo-controlled, double-blind studies, this cream was found to significantly improve or increase ejaculatory latency and sexual satisfaction<sup>15</sup>; it increases the penile sensory threshold in a dose-dependent manner.<sup>15</sup> Once available in this country, you may wish to suggest it to your patient if the SSRIs' side effects are a concern.

**Desensitizing creams.** Anesthetics are therapeutic for this condition because of their ability to retard the ejaculatory process by their numbing or desensitizing effects; these desensitizing creams should be applied directly to the penis. Among the most effective agents is the local topical anesthetic combination of prilocaine-lidocaine (EMLA<sup>®</sup> cream). This agent has been successfully used off-label for treating premature ejaculation.<sup>16</sup>

The down side of topical desensitizing creams is the unpleasant effect of penile numbness. Also, some men

report that their partners complain of vaginal or clitoral anesthesia, especially if the man does not use a condom. Using a condom would prevent the cream from being applied to his partner's genitalia and may avoid this effect on the partner.<sup>16</sup>

**A mouthwash spray?**

Another anesthetic product that can be used as a novel treatment option is the practical and inexpensive over-the-counter mouthwash spray—Chloraseptic<sup>™</sup>. This spray has a local anesthetic effect; it should be used by the man just before intercourse to retard the effect of sexual stimulation.<sup>17</sup> It has a good safety profile since it evaporates quickly, which lessens the likelihood of producing anesthesia in the partner.

**Nonpharmacologic treatment options**

Although antidepressants have proven effective in controlling premature ejaculation, both physicians and pa-

tients are often reluctant to resort to drug use because of their side effects profile. In such cases, or when drug therapy is contraindicated and the other options mentioned are not sufficient, nonpharmacologic therapies must be considered. Such options should also be considered as supplemental therapy; all these options take practice and motivation to get results but do not have long-term effects, unlike the pharmacologic options.

Several innovative treatments are available. They include the Masters and Johnson start-stop method, the squeeze-stop technique, Kegel exercises, and several behavioral-psychological strategies, including changing sexual positions, masturbation, and sex therapy.

**The start-stop technique.** The Masters and Johnson method emphasizes the notion that premature ejaculation can be reduced by the patient's understanding of and command over his own bodily sensations that proceed to orgasm. This method consists of trials of masturbation transitioning to penetrative sex. The man should systematically attempt to bring himself as close to orgasm as possible, then stopping, relaxing, and beginning again, until he can no longer control the climactic state (Patient information). The underlying theme of this method is that the patient will identify his point of imminent climax, such that he will be able to guide his partner to stop all movement and thus halt the ascent toward orgasm. The main disadvantage of this method is the length of time involved. Many patients take weeks and even months to achieve control over their ejaculatory reflex. For best results, this method usually requires the guidance of a sex therapist.<sup>18</sup>

**Squeeze-stop technique.** A slight variation on the Masters and Johnson technique is the squeeze-stop technique. It involves the man bringing himself to the boundary immediately preceding ejaculation, or the point of ejaculatory inevitability, then halting the process by applying pressure in squeezing the glans penis, thereby delaying the orgasm. For best results the patient should have his hand encircle the head of the penis. The central idea of this method is that the external pressure created by the squeeze forces the blood away from the penis, thereby decreasing erection and preventing early ejaculation. Moreover, the goal of this method is for the man to develop an awareness of his physiologic feelings preceding orgasm and in essence acquire a control over these sensations.

**Kegel exercises.** These exercises, which have little risk and virtually no side effects, are a series of conditioning of the pelvic floor muscles that have most com-

monly been used in patients suffering from urinary incontinence. However, it has recently been demonstrated that Kegel exercises are an effective treatment for premature ejaculation.<sup>19</sup> These exercises consist of contracting the pelvic floor muscles or the pubococcygeus muscles for variable intervals of time (Patient information) and are usually first attempted during urination; by starting and stopping the urinary stream, the man learns to identify the pubococcygeus muscles. The goal of the technique is to strengthen the pubococcygeus muscles in order to augment control during orgasmic response. Make sure your patient understands that it takes 3 to 6 months for this technique to make a significant change in the latency period.

Such alternatives may not offer a successful resolution to the ejaculatory problem as quickly as that offered by any of the SSRIs, but these are less expensive and less risky approaches. When used in combination with drug therapy, they may assist the patient to gradually regain control over the ejaculatory problem while allowing him to achieve sexual satisfaction during that period of time, which in turn may enhance and expedite the recovery process.

### Psychological intervention

Frequently, premature ejaculation can be associated with personal and domestic problems. Specifically, it can be caused by psychological factors such as feelings of guilt, fear, performance anxiety, or simply difficulty relating to or communicating with a partner. In these cases, it is advisable to consider referral to sexual therapy<sup>20</sup> in combination with any medical therapy. Sex therapists can be useful adjuncts to help patients with premature ejaculation of mixed etiology relieve their anxiety or other psychological issues while receiving specific medical therapy.

### A practical approach to treatment

A cost-effective approach would be to recommend the use of the Chloraseptic spray while also prescribing one of the SSRIs, such as fluoxetine, 20-40 mg, to be taken a few hours before engaging in sexual intimacy. This could be supplemented by suggesting to the patient to practice the start-stop or the squeeze-stop technique and Kegel exercises to enhance his gradual control of the sexual act.

If this "as-needed" strategy does not increase the latency time from penetration to ejaculation, consider prescribing one of the SSRIs for use on a daily basis. With improvement of the latency time, the SSRI could

Patient information

**Techniques to delay ejaculation**

Inform your patient that he can learn to control the moment of ejaculation by controlling his sensations before orgasm. The following methods take time and much practice but are very effective.

**The Start-Stop Technique**

1. First you need to bring yourself close to orgasm (this can be done through self-stimulation or masturbation, without the involvement of your partner) and then stop and relax before recommencing. Each time, bring yourself closer to orgasm until finally you reach the point of ejaculatory inevitability. If you do this often enough, you will eventually learn how to identify your point of climax. Knowing this point is helpful when interacting with your partner.
2. Next, practice reaching your climax point with your partner by engaging in nonpenetrative sex so that when you feel you are nearing ejaculation, you will signal your partner to stop, to allow your erection to subside. Repeat this until you and your partner are familiar with the procedure.
3. Once you feel you are ready for intercourse, it is best to start by lying on your back so that you can guide your partner during penetration. When you are near ejaculation, give your partner a signal to stop, and allow yourself to relax for a few seconds or minutes, then begin again.
4. Once you have familiarized yourself with this method, which may take several weeks or months, premature ejaculation can be controlled.

**The Squeeze-Stop Technique**

A variant of this method that can supplement the start-stop technique involves you or your partner squeezing the tip of the penis between the thumb and index finger just before orgasm (this is the “squeeze technique”). This pushes blood out of the penis and reduces the erection.

**Kegel exercises for premature ejaculation**

These exercises, although primarily used for controlling urinary incontinence in men and women, have recently been found to be beneficial in treating premature ejaculation. These exercises are easy to perform and lack side effects, thus making it a widely acceptable therapeutic option. And unlike any drug therapy, the benefits are long term.

1. Pelvic floor muscles are used during urination. To isolate the muscles, go to the bathroom and try to stop the flow of urine midstream. Do this several times so that you know what these muscles feel like. These muscles can also be isolated if you insert a finger into your rectum and pretend that you are holding back urine. You should feel some muscles contracting.
2. To begin the exercises, you must have an empty bladder. Tightly contract the muscles you have just identified and hold them tight for 10 seconds. Then relax the muscles for 10 seconds.
3. Repeat this procedure 10 times, approximately 3 times a day. It is important to identify correctly the involved muscle group; otherwise these exercises will not be useful.

be discontinued and the patient may continue using the Chloraseptic spray and the physical exercises.


If this approach is unsuccessful in the primary care setting and the ejaculatory problem persists, then referral to a sex therapist or a counselor is appropriate, for a more thorough review of any potential underlying psychological or relationship issues.

For men who have severe psychological problems that may be contributing to their ejaculatory problem, counseling is recommended from the very beginning of treatment. However, remember that many sex therapists are of the opinion that extensive analysis would not benefit the man unless there is some retraining of the ejaculatory reflex. Most sex therapists agree that the primary care clinician can treat the majority of men with premature ejaculation by following the approach outlined here, and that most men will respond to it without sex therapy, once they have achieved a new sense of control over the ejaculatory

reflex.<sup>21</sup> Although the initial results of most psychological treatment efforts are quite good, hovering around 75%, 3 years after treatment the success rates decrease to 25%.<sup>14</sup> These data suggest that patients, and perhaps their physicians, have failed to recognize the need for ongoing, periodic booster sessions to solidify the initial improvement.

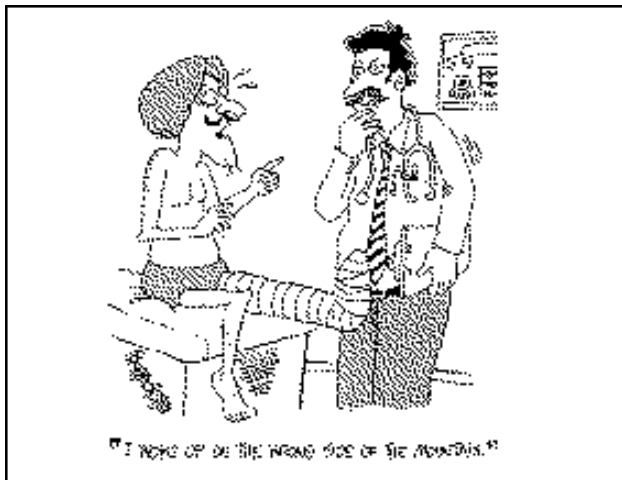
**The best approach to treatment is one that uses several strategies concomitantly.**

To date, no studies have investigated the combination of pharmacologic with psychologic interventions to treat this condition. Theoretically, pharmacologic interventions may, in the short term, help the man to regain his sexual confidence, while psychotherapeutic sessions, appropriately spaced over a long period up to several years, might enable him to maintain any sexual gains.<sup>14</sup>

With increasing pharmacologic and behavioral options, it is becoming apparent that premature ejaculation could be treated in the primary care setting and that the best approach to treatment is the one that combines several strategies concomitantly. 

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