

Initiators and Barriers to Discussion and Treatment of Premature Ejaculation Among Men and Their Partners in Asia Pacific – Results From a Web-based Survey



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ABSTRACT

Introduction: Premature ejaculation (PE) is one of the most prevalent yet under-reported sexual disorders. Differing sociocultural norms across the Asia-Pacific region provide unique challenges in PE management.

Methods: This web-based study collected data from 5,038 men and women across 11 countries in the Asia-Pacific region. Respondents were recruited from an existing database.

Main Outcome Measures: The initiators and barriers for PE discussions and for seeking professional management following self-treatment, as well as their choices and expectations of healthcare professionals (HCPs).

Results: More than two-thirds of respondents have discussed PE with their partners, and men are more likely to initiate the discussion. Top drivers were for both partners to attain sexual satisfaction and greater fulfillment in the relationship. Emotional insecurity was the top barrier for men as they did not want to feel hurt or inadequate. Before consulting an HCP, more than two-thirds of men self-treated their PE for at least 20 months. The primary reason for stopping self-treatment and seeking medical management was a lack of improvement in sexual satisfaction. The ideal attributes that men seek in their HCP included trust and being knowledgeable about PE management.

Conclusion: Attitudes and barriers to PE and its treatment in the Asia-Pacific region are poorly understood. Many men are reluctant to seek professional advice and therefore resort to self-treatment for extended periods. HCPs can play a key role to empower PE sufferers and partners to understand the prevalence, medical relevance, treatability, and negative impacts of PE on sexual and overall relationships. Greater awareness of the diverse cultural and social norms, education of both partners and HCPs, and the involvement of HCPs through a patient-centric approach are all pivotal in managing PE optimally across the Asia-Pacific region.

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Key Words: Premature Ejaculation; Asia-Pacific; Attitudes; Drivers; Barriers; Sociocultural Norms; HCP; Self-Treatment; Female Partner

INTRODUCTION

Premature ejaculation (PE) is defined by the International Society for Sexual Medicine (ISSM) as a male sexual dysfunction that is characterized by: “ejaculation that always or nearly always occurs prior to or within about 1 minute of vaginal penetration from the

first sexual experience (lifelong premature ejaculation [LPE]), or a clinically significant reduction in latency time, often to about 3 minutes or less (acquired premature ejaculation [APE]); the inability to delay ejaculation on all or nearly all vaginal penetrations; and negative personal consequences such as distress, bother, frustration, and/or the avoidance of sexual intimacy.”^{1,2}

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PE, when viewed across all age groups, countries and ethnicities, is likely to be one of the most prevalent of male sexual disorders.^{1,3–7} However, PE is a condition that is often not reported by patients or recognized by healthcare professionals and therefore can go undiagnosed and untreated.^{1,8}

Prior to 2013, the reported prevalence of PE was as high as 20% to 30%, which may be due to a lack of a standardized definition and different diagnostic criteria.^{1,6,8,9} Based on the 2014 ISSM definition, the prevalence of APE and LPE in general populations is now an estimated 5% globally.¹ A China study of the general male population reported the prevalence of LPE to be 3% and APE 4.8%.¹ In a recent study of PE in Korean men, the prevalence when using the PE diagnostic tool (PEDT) was found to be 11.3% for definite PE and 15.6% for possible PE.⁹ In the same study when using an intravaginal ejaculation latency time (IELT) of ≤ 1 minute, the prevalence was 3%; when an IELT ≤ 2 min was used, the prevalence was reported to be 16.6%.⁹

Despite the large variation reported globally on the prevalence of PE, the condition is still associated with significant distress, anxiety, and depression. This has a negative impact on the emotional wellbeing and quality of life of individuals as well as their partners and their relationships.^{8,10–13}

In a 2011 European survey involving 9 countries, 57% of men with PE and 44% of partners of men with PE were dissatisfied with their sex life, compared to 26% in the general population. The negative emotional impact was due to feelings of less confidence during sex, guilt or failure, anger, shame, depression, and lower confidence outside of the bedroom.^{14,15} The main reasons for sexual distress in partners of men suffering from PE were the male's lack of attention and focus on performance, the short time between penetration and ejaculation, and the lack of ejaculatory control.¹⁶

Culture, ethnicity and religion have been reported to cause marked variability in the distress related to early ejaculation experienced by individual men.^{1,11–13,17} In the Asia-Pacific region, PEDT survey results showed that 86% of respondents with PE were very or extremely concerned that their time to ejaculation left their partner sexually unfulfilled.¹²

Globally, reasons for the under-treatment of PE are well documented and include concerns of social stigmatization and embarrassment, resulting in men refraining from discussing the issues with their healthcare professional (HCP).^{1,8,10,15} Furthermore, many men believe that PE is their fault and that there is no treatment for the condition, and therefore have not considered seeking medical assistance.^{14,18} On the other hand, HCPs themselves may lack the knowledge or be uncomfortable with discussing sexual problems, resulting in even fewer treatment opportunities for patients.⁸

In the Asia-Pacific region, differing sociocultural and economic factors may further prevent individuals from seeking medical help for sexual dysfunction.^{13,17,19} In general, there is

a conservative attitude toward discussing sexual concerns with physicians.^{13,20} Men expect straightforward solutions when faced with sexual dysfunctions and the traditional masculine social norms discourage them from seeking assistance.^{11,20} Additionally, clinicians rarely initiate discussions with their patients about their sexual health during routine consultations.

Many men with PE also will have tried self-help remedies before they present to an HCP, creating further barriers to appropriate care. Despite modern pharmacotherapy being available in many parts of the Asia-Pacific region, traditional medicines and alternative treatments are still used frequently in the belief that they are more effective than conventional medicine, have fewer side effects, and are more accessible and affordable. It also avoids the perceived embarrassment of having to visit medical specialists.^{11,13}

Behavioral self-help processes that have been employed to treat PE include masturbation prior to intercourse, distracting thoughts, short foreplay, gentle thrusting, interrupted thrusting, and withdrawal. However, due to varying religious and cultural beliefs across the Asia-Pacific region, there may be reluctance in certain populations to use behavioral processes that involve masturbation.²⁰ Behavioral approaches with retraining that are most widely used are the squeeze technique and the stop-start methodology.²¹ Other remedies include the use of alcohol, desensitizing agents, and thick condoms.^{4,21}

Information on PE across Asia-Pacific is generally sparse and outdated compared with global data.^{11,13} The diverse cultural differences and varying initiators and barriers to discussing PE and its treatment also pose additional challenges for patients, their partners, and HCPs in the region. Studies with an Asia-Pacific focus on the sufferers and partners, namely the push and pull factors to seeking treatment and their perception of HCPs, will provide valuable insights to overcome future challenges in treating patients with PE.

AIM

To identify current initiators and barriers to PE discussion, as well as barriers and drivers for seeking PE treatment in 11 countries and regions across Asia-Pacific.

METHODS

Subjects

This web-based survey recruited heterosexual men with their respective partners, aged 18–64 years, who had sexual intercourse at least once per month in the past 6 months. Respondents were selected from a panel of subjects from commercial market research databases. The subjects were predominantly educated, computer literate, having a higher income, and from an urban background. Multiple recruiting emails were

sent to all potential participants of all participating countries until the quota was met.

Study Design

A 30-minute quantitative online survey was carried out from July 30 to August 23 2014 using proprietary panels for market research purposes. The survey questions were categorical in nature rather than open-ended queries, to allow standardization. Patients also were presented with a list of “self-treatments” when addressing the issue. The survey questionnaire was administered in English in Australia, Philippines, and Singapore, and in the local language in other countries/regions.

The questionnaire determined the respondent’s age, gender, and the frequency of sexual intercourse/month (respondents who had sexual intercourse > 40 times/month were excluded). Respondents were also screened for PE using the PEDT and through self-reporting. The PEDT is a validated 5-question unidimensional tool that captures the essence of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* definition of PE. Sensitivity/specificity analyses suggest that scores ≥ 9 indicate probable or definite PE.²² For self-reported PE, respondents were asked to acknowledge whether or not they or their partners had experienced PE, and if so, for how long and when PE was first experienced.

Based on their responses to the PEDT and self-reporting of PE, respondents were classified as: (1) probable/definite PE based on PEDT and who acknowledged having PE; and (2) probable/definite PE based on PEDT who did not acknowledge having PE but were concerned or frustrated about ejaculation. Responses from female partners were placed into similar groups; partners answered the survey questions based on the perceptions of their partner’s PE.

Study Analyses

Responses to individual questions in the survey were collected through an online portal and were analyzed using SPSS version 22.0 (SPSS Inc, Chicago, IL, USA) for the total population and also by geographic location. The data for each country were consolidated only as the highlights of those responses that were most often expressed.

MAIN OUTCOME MEASURES

The main outcome measures reported here are initiators and barriers to PE discussions, self-treatment of PE across the Asia-Pacific region, type of HCP managing PE, and the respondents’ experience with HCPs.

RESULTS

Demographics

A total of 5038 participants (2676 males and 2362 females), aged 18 to 64 years were surveyed across 11 countries/regions and 35 geographic locations in the Asia Pacific region (Figure 1). China, Australia, and South Korea had the largest representation, with 21%, 13%, and 12%, respectively. Overall, 36% of respondents were 26 to 35 years of age and 29% were 36 to 45 years of age (Table 1).

The percentage of men with probable/definite PE based on PEDT and who also acknowledge having experienced PE was 48% across the Asia-Pacific region. The highest percentages of men in this group were from Australia (58%) and China (56%), whereas Singapore (38%) and Vietnam (38%) had the lowest percentage. For respondents with probable/definite PE based on PEDT, the percentage of men who however did not acknowledge having experienced PE was 15% across the Asia-Pacific

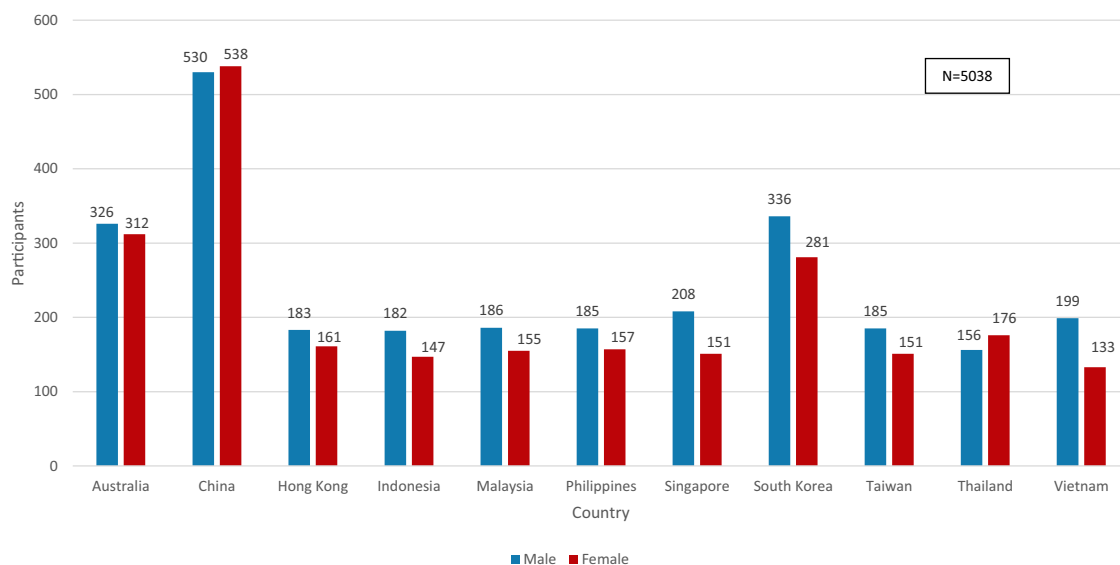


Figure 1. Asia Pacific survey participants.

Table 1. Age groups of survey participants

Age Groups	Regional	East							South			
		Australia	China	Hong Kong	Indonesia	Malaysia	Philippines	Singapore	Korea	Taiwan	Thailand	Vietnam
18–25 years old	653	96	89	27	47	50	69	45	44	14	44	128
26–35 years old	1813	206	436	104	130	141	126	97	156	125	140	152
36–45 years old	1454	158	338	109	84	91	83	112	212	120	108	39
46–55 years old	780	106	140	76	57	34	52	65	147	62	31	10
56–64 years old	338	72	65	28	11	25	12	40	58	15	9	3
Total	5038	638	1068	344	329	341	342	359	617	336	332	332

region. The highest percentages of men in this group were from Singapore (25%) and Malaysia (22%), whereas China (9%) had the lowest percentage (Figure 2).

Likelihood of PE Discussions

Among the group with/acknowledge PE, most men (range: 60% to 93%) and women (range: 68% to 95%) across the Asia-Pacific region have discussed PE with one another. The percentage of men who had discussed PE with their partner was highest in Thailand (91%) and China (93%). Men from Singapore (60%), Hong Kong (68%) and Taiwan (68%) were least likely to discuss PE with their partner.

Partners of men with/acknowledge PE from Thailand, China and Taiwan were most likely to have discussed PE (95% for all 3 countries/regions). In all countries/regions included in this study, the women were as likely or more likely than the men to discuss PE with their partners, with the exception of South Korea.

Initiators of PE Discussions by Men

With the exception of Indonesia (39%), more than half (range: 51% to 63%; regional average: 56%) of all men

with/acknowledge PE stated that they were the initiator of PE discussions with their partner; the highest percentages were observed for South Korea (63%) and Vietnam (63%), followed by Hong Kong and Taiwan (59%). Furthermore, in all countries/regions, men in this group stated that PE discussion was more likely initiated by them than by their partner (5% to 24%) or as a couple (14% to 36%).

Main reasons for initiating the PE discussion by men with/acknowledge PE and their partners were partner-driven, self-driven, or relationship driven (Figure 3). For men in all countries, the top partner-driven reason for initiating the discussion was to find a solution to help their partner feel sexually satisfied. The highest response was in Taiwan (73%), followed by Indonesia (71%); and lowest in Australia (49%), Hong Kong (51%), and China (51%).

The main self-driven reason for initiating PE discussion reported by men with/acknowledge PE in Australia (45%), Hong Kong (51%), Indonesia (62%), Singapore (49%), South Korea (64%), and Taiwan (59%) was self-sexual satisfaction. In Malaysia (58%), Philippines (61%), Thailand (54%), and Vietnam (61%), the main self-driven reason was to find a solution for PE; whereas in China (45%) the main reason was that the PE bothered them a lot.

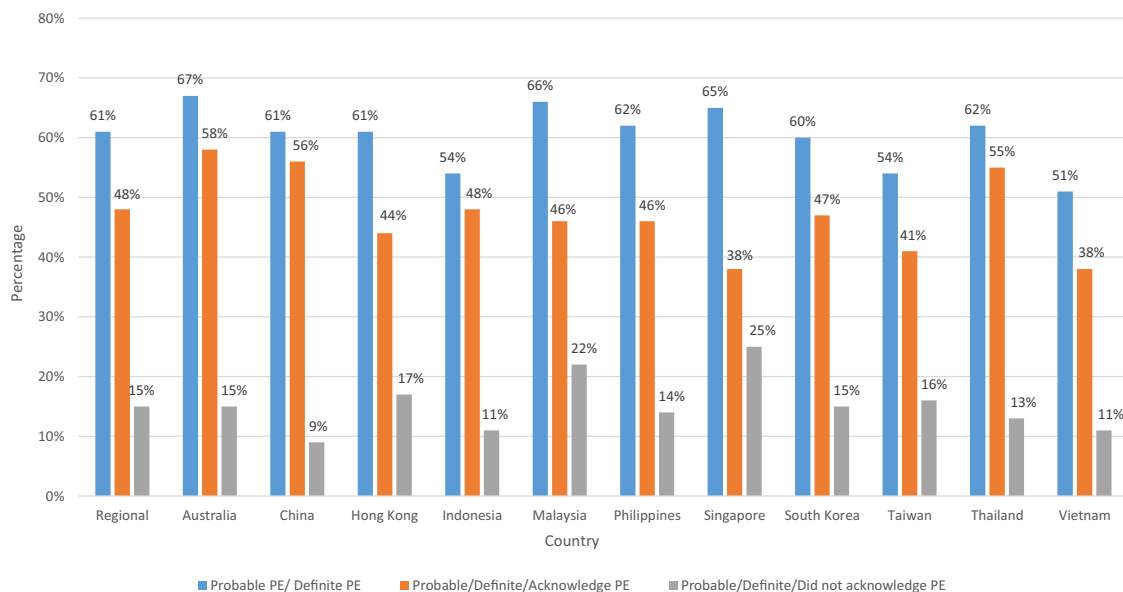


Figure 2. Survey participants with PE.

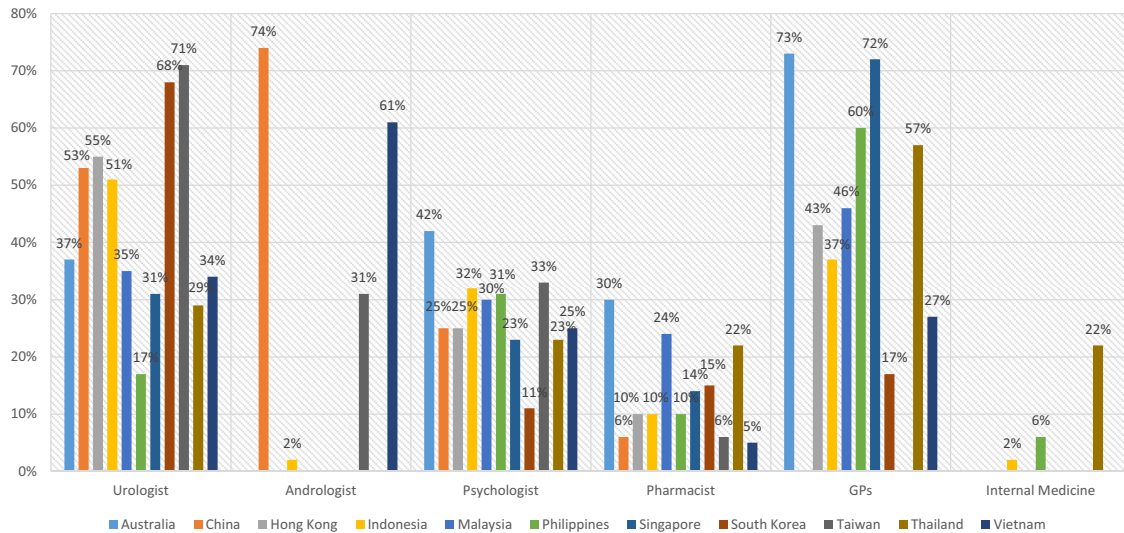


Figure 3. HCPs seen by men with/acknowledge PE.

The main relationship-driven reason for men initiating a PE discussion in China (42%), Hong Kong (41%), Thailand (51%), and Vietnam (61%) was that they were afraid that PE would negatively affect their relationship. In Indonesia (71%), Malaysia (50%), Singapore (51%), and Taiwan (51%), the main relationship-driven reason was to achieve greater fulfillment in their relationship. The main reason in Australia (41%), Philippines (65%), and South Korea (52%) was that they wanted to fulfill their role as the man in the relationship.

Barriers to PE Discussions for Men

Emotional insecurity was the main barrier for men to initiate a PE discussion. Fear of appearing inadequate to their partner was the main concern by men in China (60%), Hong Kong (45%), Indonesia (56%) and Vietnam (67%). In Australia (38%), Malaysia (57%), Philippines (33%), Singapore (30%), South Korea (60%), and Taiwan (38%), the main barrier was the fear of having their feelings hurt by their partners. In Thailand, the males did not seem to be affected by emotional security; rather, it was their lack of understanding PE’s significant impacts as well as their passive attitude that prevented them from raising the topic of PE, with 54% of men believing that PE is a common condition and that it would resolve over time. In addition, across the Asia-Pacific region, 38.5% of men indicated that one of the main partner-driven reasons for not initiating a PE discussion was that they did not want to hurt their partner’s feelings. Furthermore, 11% to 45% of men said that the discussion of PE was difficult from a cultural perspective.

Self-Treatment of PE Across Asia-Pacific Region

A high proportion of all respondents stated that they have self-treated PE. The countries with the highest prevalence of self-treatment were China (90%), Indonesia (90%), and Vietnam

(91%). Self-treatments most often used were either behavioral in nature, applied topically, or by oral treatment.

Among the behavioral self-treatment methods employed in the Asia-Pacific region, the Start-Stop technique was favored in Australia (33%), Indonesia (38%), Malaysia (33%), Singapore (29%) and Thailand (35%); whereas condom wearing was preferred in China (43%), Hong Kong (28%), South Korea (34%), Taiwan (29%), and Vietnam (49%). By comparison, the method of choice in the Philippines was masturbation (29%), followed by the Start-Stop technique (25%) and condom wearing (21%). More than 25% of respondents in Indonesia, Thailand, and Vietnam used Kegel exercises; however, this method was used the least in Australia (9%).

All respondents surveyed have also employed topically applied treatments and oral treatments. In China, desensitizing cream or spray (25%) was the topical/oral treatment of choice; whereas traditional medicine or herbal medicine (31%) was preferred in Malaysia. By comparison, alcohol consumption was the topical/oral treatment of choice in both Australia (16%) and South Korea (26%). Respondents from Hong Kong indicated that nutritional supplements and alcohol consumption predominate as self-treatment and were used equally (14%). Alcohol consumption is lowest in Indonesia and Malaysia, with only 9% of respondents using this self-treatment method.

The average duration of PE self-treatment before seeing an HCP across the Asia-Pacific region was 29.6 months. Respondents in China (21.9 months) and Malaysia (20.8 months) were more likely to seek help earlier than in other countries, whereas in Australia respondents waited the longest (36.8 months) before consulting an HCP. Reasons given for stopping self-treatment and going to see an HCP included a lack of efficacy, inconvenience, cost, and side effects. The primary response across the Asia-Pacific region regarding the lack of efficacy was

that there was no improvement in sexual satisfaction (range: 32% to 53%). The main inconvenience reason cited by respondents was the fear of becoming dependent on the treatment after long-term use (range: 33% to 51%). The high cost of treatment was a key driver for stopping self-treatment in Malaysia (44%), Indonesia (35%), Philippines (35%), and Vietnam (34%). The country with the least concern over cost of treatment was China (11%). Side effects of self-treatment were cited as a key driver for consulting an HCP in Vietnam (37%), Indonesia (28%), Australia (26%), and Thailand (26%). South Korean men showed least concern about side effects, with only 10% stopping self-treatment for this reason.

HCPs Who Manage Patients with PE

Variations existed in countries across the Asia-Pacific region as to which HCP specialty was consulted for the management of PE (Figure 3). More than half of men in Hong Kong, Indonesia, South Korea, and Taiwan who have visited a HCP for PE primarily saw a urologist. In China the largest percentage of respondents were seen by either an andrologist (74%) or a urologist (53%). Andrologists also were commonly consulted in Taiwan (31%) and Vietnam (61%). This contrasted with men from Australia (73%), Malaysia (46%), Philippines (60%), Singapore (72%), and Thailand (57%), who primarily sought medical advice from their GP. Other HCPs who were consulted by all respondents in the survey were pharmacists and psychologists. Between 5% and 30% of men with PE visited pharmacists (Australia 30%; Vietnam 5%) whereas 11% to 42% consulted a psychologist (Australia 42%; South Korea 11%).

Respondents' Experience with HCPs

All men who had an interest in seeking help from a HCP looked for specific attributes in the individual they wished to

consult. The key HCP attribute looked for in China (68%), Hong Kong (44%), Singapore (54%), Taiwan (59%), and Vietnam (65%) was that they wanted the HCP to be knowledgeable in diagnosing PE. In addition to this, in China (68%) and Malaysia (53%) they wanted the HCP to be knowledgeable in explaining the benefits and side effects of PE treatments. In Australia, Indonesia, Philippines, South Korea, Thailand, and Vietnam, ≥50% of the men were looking for an HCP they could trust; and in Taiwan, 59% of men also wanted the HCP to make them feel comfortable when discussing PE.

The most positive experience of male respondents with/acknowledge PE when visiting their HCP varied across the region. In Australia (44%), China (56%), Hong Kong (44%), Indonesia (72%), and Vietnam (77%) men felt reassured by their HCP explaining that PE is a common condition. In Malaysia (55%), Singapore (65%), South Korea (59%), and Taiwan (74%) reassurance came from the HCP explaining that PE is one of the most common male sexual issues, affecting up to 1 in 3 men. In Australia (44%), Hong Kong (44%), Philippines (75%), and Singapore (65%) the men liked that their HCP asked questions about their sexual health as part of a general health screening. One additional positive experience noted in Australia (44%), Indonesia (72%), Malaysia (55%), and Vietnam (77%) was that the respondents liked the fact that their HCP provided more information on the pros and cons of PE treatment (Figure 4).

Across the Asia-Pacific region, ≥15% of all men who visited a HCP received encouragement from their partner to do so. The highest level of encouragement was in China (31%), Hong Kong (31%) and Vietnam (37%); and the lowest in Indonesia (15%) and South Korea (19%). The main reason for all female partners from Australia (48%), Hong Kong (48%), Indonesia (63%), Philippines (54%), Singapore (46%), and Taiwan (48%) who

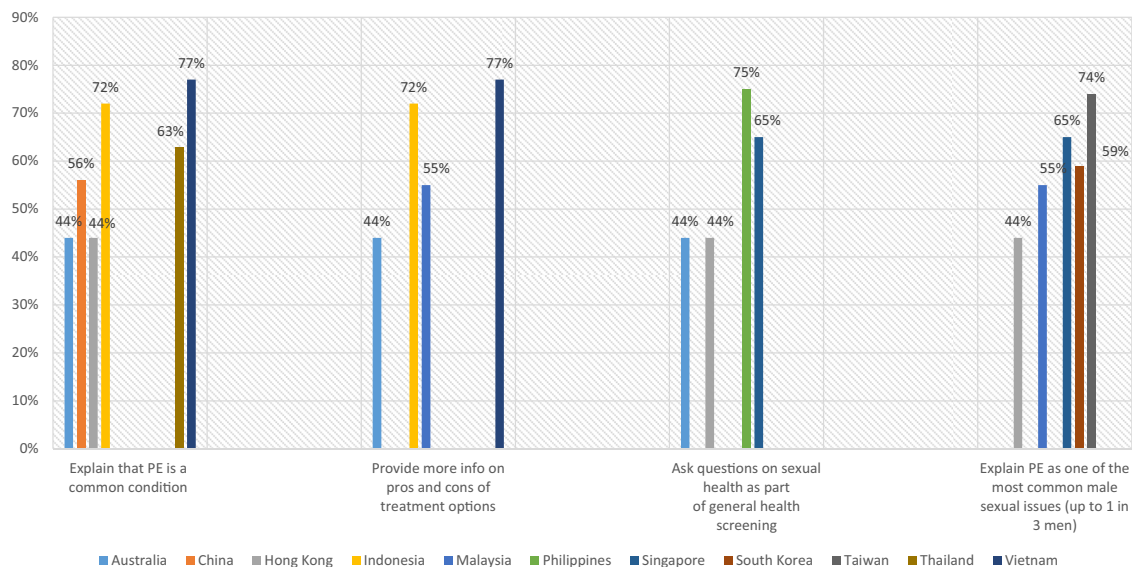


Figure 4. Most positive HCP experience by men with/acknowledge PE.

encouraged their partner to visit their HCP was self-driven, in that they wanted to find a solution for PE. In China (49%) and South Korea (44%), female partners stated that the main reason for encouraging HCP visits was relationship-driven, as they wanted the man and themselves to feel a greater sense of fulfillment in their relationship. In Malaysia, 49% of women stated that they wanted to feel sexually satisfied; and in Vietnam, 63% of women wanted the man to feel sexually satisfied. Awareness of an available treatment for PE was the reason given by 40% of women in Thailand for encouraging their male partners to visit an HCP.

DISCUSSION

In the Asia-Pacific region, differing sociocultural and economic factors may prevent individuals from seeking medical help for sexual dysfunction^{13,17,19}; however, there has been increasing interest in assessing the prevalence of sexual dysfunction and PE in the Asia-Pacific region, but there is little knowledge regarding the initiators and barriers to the disorder and its management.^{6,11,17,19} The Asia-Pacific region is heterogeneous, with differing religious, social, and cultural beliefs. Masculinity is considered to be central to male social standing and may be a deterrent to seeking medical help for any sexual-health issues.^{11,23} Even when medical help is sought, PE is often undertreated because many Asian men generally believe that erectile function is the hallmark of the male sexual prowess and may even mistakenly believe that improving the strength of their erections can help resolve their PE condition.

This study was the first large, multinational investigation in the Asia-Pacific region designed to identify the initiators and barriers to PE and its treatment among men and their partners.

There was a wide discrepancy between respondents who acknowledged having experienced PE and those diagnosed with the condition using the PEDT. Probable/definite PE based on the PEDT was high in the Asia-Pacific region, with a prevalence of 61%. This was 30% higher than the prevalence of probable/definite PE found in a similar demographic group in a 2012 survey.¹² The reasons behind such high prevalence may be due to the backgrounds of the participants — who were predominantly urbanite, educated, having a higher income, and possessing more knowledge of sexual dysfunction. The web recruitment method from the database also can induce self-selection bias. Another factor that may play a role is that there has been an increase in awareness of PE and its treatment in the years subsequent to this survey.

The percentages for respondents who acknowledged experiencing PE were higher, and ranged from 71% to as high as 91% in China, which may have skewed the overall data. When the percentage of individuals with probable/definite PE based on PEDT and who acknowledged PE were combined, the prevalence dropped to 44%. It should be noted that this figure may be higher than in other studies reporting PE prevalence, as IELT

was not taken into consideration.^{1,6,8,9} Additionally, as this was a web-based study, the proportion may be an overestimation compared to the general population. Notwithstanding that, it is clear from this study that PE has a negative impact on these men as well as on their partners and their relationship.

The main initiator for men to open up discussion is mainly to improve sexual satisfaction and their relationship. Men claimed they were the most likely initiators of PE discussion compared with their female partners. This trend may reflect the patriarchal society in countries across the Asia-Pacific region. For the majority of men and women in all countries, their main reasons for initiating a PE discussion were similar in that they were driven by the desire for greater sexual satisfaction for both partners and for a fulfilling relationship. The only partner-driven reason for women in the region that was different was in South Korea, where females initiated the conversation because they did not want to continue hurting their partners' feelings. In addition to this, men in Australia, the Philippines, and South Korea stated a desire to fulfill their role as the man in the relationship, reflecting that the image of the man may be central to the relationship.

The main barriers for men to initiate a PE discussion were largely emotional in that they did not want to feel inadequate or were afraid of either being hurt or hurting their partner's feelings. The negative emotional impact was due to feelings of low confidence during sex. Furthermore, guilt or failure, anger, shame, depression, and lower confidence outside of the bedroom also may prevent open discussion of the issues with partners.^{14,15} It is likely that the growing influence of the Internet and social media will further educate and raise awareness on sensitive topics surrounding PE that couples currently find difficult to discuss. This would help to liberalize couples and particularly women to improve communication and for them to be a key part of a joint decision-making process regarding sexual issues in the relationship.

In Asia Pacific, due to cultural and traditional influences, many men with PE will have tried self-help remedies before they present to an HCP. This study revealed that more than two-thirds of men with PE in the Asia-Pacific region tended to initiate self-treatments that are predominantly behavioral in nature or are administered topically or orally. The 2 most popular behavioral techniques employed were wearing of condoms and the Start-Stop technique. Of the topical/oral treatments commonly used, alcohol consumption was predominant in Australia and South Korea, which may be part of the sociocultural norms for men in those countries. This contrasted with Indonesia and Malaysia, two predominantly Muslim countries, where the use of alcohol was very low. This finding illustrates the diversity of cultural and religious influences on attitudes to PE treatment in the region.

The self treatment approach toward PE is common. In China and Malaysia, men who had self-treated were more likely to seek treatment from an HCP earlier. In these 2 countries, men preferred seeing an HCP based on their knowledge of PE and its

treatment rather than for emotional reasons. This may be one reason for seeking treatment earlier, in that they were less embarrassed to discuss PE with the HCP. By comparison, the men who self-treated for longer periods also were those who looked for trust in their HCP, indicating that the resistance to seek advice from a HCP may be emotionally driven; this may be a factor related to the masculine role model in those countries, in that they wanted to avoid exposure and embarrassment.

The role of the HCP in the treatment of men with PE also unveiled interesting observations. Men refraining from discussing the issues with their HCP, or even from finding the appropriate HCP, have concerns of social stigmatization and embarrassment.^{1,8,10,15} The large variation observed across the Asia-Pacific region in choosing a preferred HCP for PE management may be due to country-specific norms as well as the healthcare and referral systems in place in specific countries. The specific attributes that men looked for in their HCP were emotional or rational in nature, with either a higher desire to have an HCP they could trust, or the desire to consult someone who was knowledgeable about PE, including treatment options and possible side effects. Men also felt reassured when their HCP told them that PE is a common problem in males, and liked the fact that they were questioned about their sexual health as part of a general health screening. The latter could be used effectively to start the discussion of sensitive sexual topics, especially in male-dominant societies in the Asia-Pacific region, where the man may be reluctant to discuss these matters with the HCP. In Australia, Malaysia, and Thailand the pharmacist plays an important role in providing information on PE and its treatment. It may be that pharmacists could be an increasingly important link in the HCP network in the future, especially in countries where clinicians are particularly pressed for time.

The experience in treating men with other sexual dysfunctions such as erectile dysfunction (ED) has provided valuable lessons in reducing barriers for the treatment of PE. HCPs should be encouraged to utilize self-administered questionnaires, provide patient information literature, and practice routine sexual enquiry during routine consultations. Such measures can empower both sufferers and partners to understand the prevalence, medical relevance, treatability, and negative impacts of PE on sexual and overall relationships.

Although this study has provided important insights for initiators and barriers to the treatment of PE, the utilization of self-treatment, and the role of HCP in Asia Pacific, the investigation also has a number of limitations. Being a web-based study that used proprietary panels, the findings may not be representative of the general population. The panel sizes also were different in different countries, and some of the sub-group sample sizes were small. Participants also were grouped based on self-reported PE and PEDT-diagnosed PE and could not be validated with medical records or HCP discussions. In addition, the PEDT has not been validated for female partners, nor has it been validated in some of the local languages used.

CONCLUSION

This study was the first large multinational investigation in the Asia-Pacific region designed to identify initiators and barriers towards the treatment of PE among men and their partners. This study is unique, as the vast majority of the respondents felt that they suffer from PE. Analyses of this subgroup of patients can unearth issues to encourage dialogue between couples and the HCP.

The study revealed most couples initiate discussion to improve sexual satisfaction and intimacy. Many lessons can be learnt from the data to improve communications. Men were more likely to initiate discussions with their partners regarding PE. The main initiator for men is predominantly partner driven, to find a solution for better sexual satisfaction, and the main barriers were that they did not want to be hurt or to hurt their partners. For partners, the main obstacle was a lack of knowledge.

Self-treatment for PE is common and there may be a significant time lapse before men seek help from an HCP they can trust who is knowledgeable about PE. Such data can help to reveal potential supportive roles of partners and the complex mindset of treatment-seeking behavior for men suffering from PE.

Analyses of the perceptions of HCP further provide important regional-focused data. The regional-specific data can provide respective useful understanding, as the role of HCP in the treatment varies in different Asia Pacific countries. Greater awareness of country-specific initiators and barriers towards PE revealed by this study can facilitate the involvement of HCPs through a patient-centric approach — this is pivotal for the optimal management of PE. HCPs should be encouraged to utilize self-administered questionnaires, provide patient information literature, and practice routine sexual enquiry during consultations. Such measures may empower the sufferers and partners to understand the prevalence, medical relevance, treatability, and the negative impacts of PE on sexual and overall relationships.

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Conflicts of Interest: GL, HJ and PL do not have a conflict of interest. CGM is a consultant, speaker, and investigator for Menarini. MMcC is a member of the Menarini Advisory Board. SWL is a board member of the Menarini Advisory Panel. BPJ has acted as an investigator, speaker, and advisor for Eli-Lily, Bayer, Menarini, and Pfizer.

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(c) Analysis and Interpretation of Data

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Category 2

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(b) Revising It for Intellectual Content

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Category 3

(a) Final Approval of the Completed Article

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