

Immediate Curative and Permanent Treatment for Premature Ejaculation (Alaa Aglan Operation)

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Abstract: Premature ejaculation (PE) is a common male sexual disorder, although there is some medications used for this problem but there is no definite medical treatment and current surgical options is not so effective with high recurrence and low success rate. The present study shows the effectiveness of cutting bulbospongiosus muscle bilaterally and frenular delta excision for treatment of premature ejaculation and delay time of ejaculation in normal persons this study was started since 6/4/2011 to 6/4/2016 (60) patient underwent this study and were operated with success rate 96.6% with immediate result after 1st intercourse usually 3weeks after surgery, the intra – vaginal ejaculation latency time increased up to (200 – 1000 %), patients with time less than 2 minutes usually reach 8 minutes some of them reach 20 minutes, patients time more than 5 minutes increased up to 15 – 20 minutes and some of them up to 30 minutes the result is permanent, in this study we explain also why some patients not respond to local anesthesia applied to glans and approved that clinically .

1. Introduction

Premature ejaculation (PE) occurs when a man experiences orgasm and expels semen soon after sexual activity and with minimal penile stimulation . it has also been called early ejaculation rapid ejaculation , rapid climax premature climax , and (historically) ejaculation praecox there is no uniform cut-off defining Premature , but a consensus of experts at the international Society for Sexual Medicine endorsed a definition including ejaculation which always or nearly always occurs Prior to or within about one minute [1] the international classification of Diseases (Icd-10) applies a cut-off of 15 seconds from the beginning of sexual intercourse [2]

2. Materials and Methods

The study took place at Hamad Specialized hospital and Alaa Clinic hospital between April 2011 and April 2016, 60 patients were included in this study, inclusion criteria was married heterosexual patients and age varies between 17 and 87 years old

Surgical technique:

All the patients received spinal anesthesia before Peno – scrotal incision and dissection of

bulbospongiosus muscle bilaterally and cutting it completely,(Figures 1-7)then closure in layers followed by identification of frenular delta (frenular rough surface area) and excision of frenular delta (elliptical). Suturing and dressing at the end of operation.

In the patient with penile abscess and frenular skin loss we apply split thickness graft.

Intravaginal Ejaculation Latency Time (IELT) is calculated equal to the mean of 3 times done by the same way of sex practice for each individual pre and post-operative; evaluation of cases was done after 1,2,3,6 months then yearly.

3. Results

58 patients improved dramatically after the 1st intercourse (3weeks after surgery) time of ejaculation continued to increase till the 3rd month after surgery then the time is constant. (Tables 1-3)

All cases with time less than 2 Minutes (except 2) showed gradual increase in time during the first three months, most of them jumped to 4 – 5 minutes after 3weeks (1st intercourse) then 6 minutes after 2 months and 8 minutes after 3 months without change after that.

3 patients showed improvement directly, 1st patient was 2 minutes and changed to 20 minutes 2nd patient was 3 minutes and changed to 30 minutes (with 5years constant value in both patients)

Two patients did not respond to surgery, in 1st patient time was about 20 second but they were not respond to Antidepressant and drugs that treat premature ejaculation and time was not exceed 20 second with drugs but after surgery time increase in 1st patient up to 7.40 minutes and second patient increased from 30 second up to 8.5 minutes with the effect of operation and drug together (clomipramine 50mg)

Two patients complained from anejaculation up to around 90 minutes leading to interruption of intercourse. The condition improved after 40 days of operation and time increased from 10,12 minutes to 30 , 35 minutes respectively .

4. Discussion

Ejaculation is initiated as brain stimulus then has two stages: first stage is static stage which mainly

nervous, second stage is dynamic stage which is motor due to contraction of muscles (bulbospongiosus mainly) and smooth muscles of seminal vesicles and ampulla of vater.

Frenulur delta is the most sensitive area in penis (diagrams: A .B) as it contains fine touch receptors and main axon bundles count in this area is 17.9 bundles / mm ventrally and the other areas varies between 6.2 – 8.6 axon bundles / mm[3] .

During our study we found that pressure on glans has important role in premature ejaculation as pressure on glans during sex causes hyper excitability to bulbospongiosus muscle this is known as bulbospongiosus reflex which is a diagnostic test used to diagnose spinal cord lesions, in this test if we apply pressure on glans the muscle contracts and pressure on glans by partner actually happens during intercourse, the hyper-excitability of pelvic muscles also occurs during prostatic massage which cause premature ejaculation[4].

Most people are surprised to learn that the glans penis is one of the least sensitive parts of the entire body [5] the glans is insensitive to light touch , heat cold , and even pinpricks , as researches at the Department of pathology in the Health Scientists center at the University of Manitoba discovered [6] the corona of the glans contains scattered free nerve endings , genital end bulbs , and pacinian corpuscles , which transmit sensations of pain and deep pressure . The glans is nearly incapable of detecting light touch.

Brain role in premature ejaculation is very important in ejaculation during sleep. When the brain is the only factor in sexual operation , some cases was done 5 years ago and results is permanent with some cases improved up to 1000% increase in time of ejaculation permanently. We think this gradual increase is due to psychological effect of increase in time in 1st month.

In some patients with normal time who want to increase time (beyond this study) without cutting the muscle we do simple test, we apply local anesthesia (procomail®) at frenulur delta 15 minutes before intercourse and if result is satisfactory frenulur delta excision under local anesthesia at clinic is done.

The re-innervation of grafted frenulum area (1×1cm) may be the reason of improvement in the patient with such graft.

5. Conclusion

Surgical technique to treat and improve ejaculation time, muscle cutting could be done

The combined effect of cutting of bulbospongiosus and frenular delta excision is the best although frenular delta excision alone or the opposite could be done

This technique was used in cases of penoplasty and penile implant and even in penile curvature and penile abscess with the same result in all cases.

In some cases (beyond this study) we excise frenular delta and leave it as raw area some cases had good result and some complained of neuroma and excision and suturing improve the condition.

The size of muscle is not related to severity of premature ejaculation as found clinically that muscle may be atrophied or hypertrophied.

6. References

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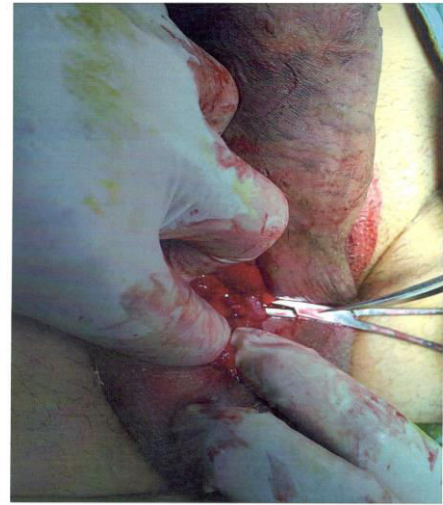
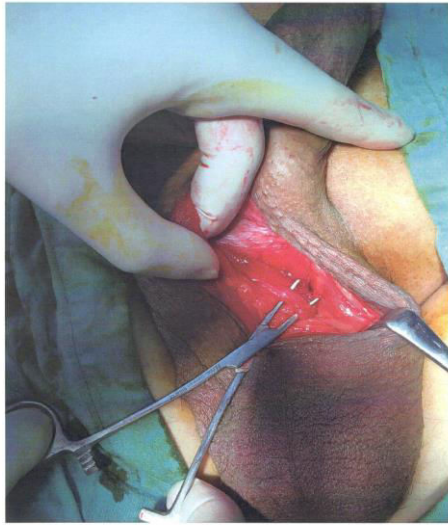


Figure no., 1, 2
Identification of the muscles

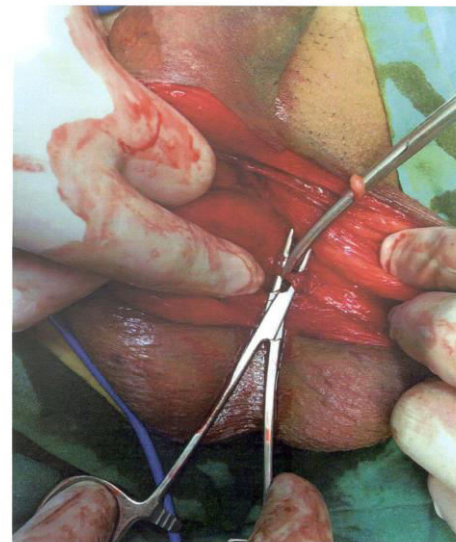
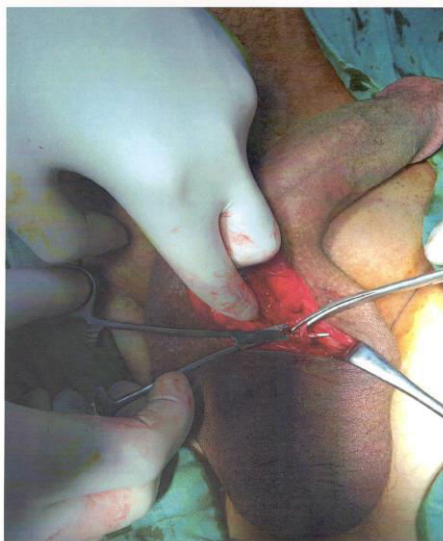


Figure no., 3, 4
Bilateral cutting of the muscles



Figure no., 5
Closure in layers



Figure no., 6
Excision of frenular delta



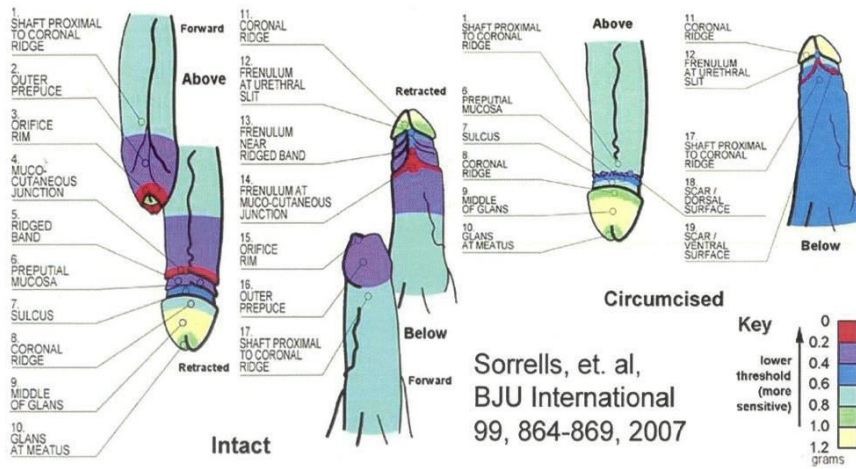
Figure no., 6
Suturing and dressing

Tables No. 1,
2, 3
Patients Data
and Results

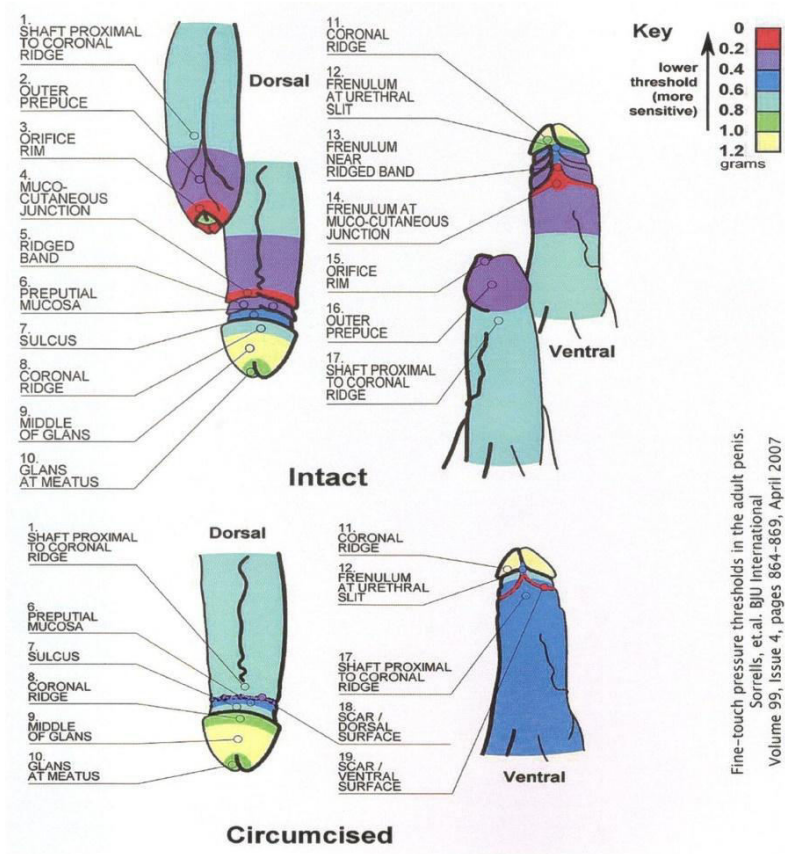
Pt number	notes	age	time preoperative	Time post-operative
1		29	3:10	30
2	diabetic	44	15:10	45:17
3		17	2:12	8:20
4		23	5:02	12:30
5		27	4:19	11:02
6	penile curvature	31	7:40	15:16
7	previous Penile abscess and frenular graft	52	5:12	25 then regress to 20:14 (permanent)
8		22	2:07	6:29
9	temporary <u>anejaculation</u>	32	10:59	30:10
10	temporary <u>anejaculation</u>	29	12	35:13
11	with clomipramine 50 mg	27	0:33	7:40
12	with clomipramine 50 mg	26	0:5	8:30
13		31	2:39	6:31
14		24	3:41	8:55
15		27	15:31	30:33
16		41	2:13	20:05
17		34	3:27	7:43
18		21	1:33	4:04
19		64	2:15	8:17
20		55	2:57	9:16

patient number	notes	age	time preoperative	Time post-operative
21	with penile implant	43	2:23	10:14
22		67	3	11:24
23		21	1:15	6:23
24		59	5:07	12:52
25		19	1:39	8:19
26		31	2:30	6:44
27		33	7:18	15:26
28	with penile implant	41	3:22	8:49
29		24	0:33	3:40
30		37	1:31	4:15
31		50	4:22	8:30
32	penile curvature	21	3:29	7:50
33		26	1:50	4:50
34		34	2:21	5:11
35		47	7:13	13:23
36		29	2:40	7:19
37		44	1:20	5:30
38		23	1:50	8:07
39		31	2:05	6:45
40		57	3:33	8:12

patient number	notes	age	time pro operative	time post-operative
41		39	5:33	11:42
42		46	6:33	12:14
43		36	7	21
44	with penoplasty and fat injection	21	2:20	5:14
45		28	3:10	7:40
46		48	9:17	17:53
47		67	2:05	4:30
48	with implant	70	1:30	10:10
49	penoplasty and fat injection	87	1:40	6:14
50		24	1:10	3:17
51	<u>hypospedias</u>	22	2:20	6:01
52	<u>vitiligo</u> at penis	39	1:11	7:15
53	history of fracture penis With split thickness skin graft of <u>peins</u>	44	3:20	7:15
54		47	5:14	11:55
55		18	2:10	7:14
56	history of inter sex and correction surgery	27	1:20	6:10
57		53	7:05	13:44
58	<u>Peyronie's</u> disease and implant	43	4:13	9:17
59		51	2:30	6:47
60		33	5:10	9:56



A



B

Diagram A, B
 Penile sensitivity areas