Procedia of Engineering and Medical Sciences
Volume: 08 | 2023

To verify Questionnaire of the "Uzbek Index of Premature Ejaculation"

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Abstract : 200 male patients who complaint PE were asked to fill Uzbek Index of Premature Ejaculation (UIPE) Questionnaire and separated control group (30 patients) who gather between 13 and 16 score from questionnaire. They were tested for additional concomitant diseases and treated. After treatment control group was asked to fill questionnaire. It is proved that after treating concomitant diseases, patients who gathered 13 score in control group showed a significant increase in IELT (intravaginal ejaculation latency time). However, the IELT did not change in 14-16 scored patients. It means 13 score cannot indicate PE, it is enough to treat concomitant diseases to remove PE symptoms.

Keywords: Uzbek index of premature ejaculation (UIPE), Premature ejaculation (PE), Premature Ejaculation Diagnostic Tool (PEDT), Intra-vaginal ejaculatory latency time (IELT).

INTRODUCTION

Premature ejaculation (PE) is an ejaculatory disorder with a highly variable estimated prevalence which is partly explained by the lack of standardized definitions and diagnostic tools [5]. There are various definitions of premature ejaculation in literature. In the Diagnostic and Statistical Manual of Mental Disorders-IV-Text Revision (DSM-IV-TR), PE was defined according to patient description and clinician assessment of a few other factors [6]. The International Society for Sexual Medicine (ISSM) adopted the first evidence-based objective definition of PE [7]. Premature ejaculation (lifelong and acquired) is a male sexual dysfunction with following features:

1. Ejaculation that always occurs before or within about one minute of vaginal penetration (lifelong PE) or a clinically reduced in latency time, to about three minutes or less (acquired PE).
2. Unable to delay ejaculation on all or nearly all-vaginal penetrations.
3. Negative personal consequences, such as distress, bother, frustration, and/or the avoidance of sexual intimacy.

Uzbek Index of Premature Ejaculation Questionnaire (UIPE) includes eight questions investigating control, frequency, duration, anxiety, partner's opinion and satisfaction during sexual activity: a score of 0 to 4 points can be assigned to each question, producing a total score ranging from 0 to 32. There are two unscored question at the beginning and ending of the UIPE, and they can help to identify which type of PE males have. According to the final score, PE can be classified as patient have not PE (0-12), patient have PE but additional diagnostic methods are necessary to exact diagnose (13-16) (gray zone), or patient have PE (17-32). This eight-question set is internally consistent and reliable, is sensitive to treatment response. The recommended questions establish the diagnosis and direct treatment consideration and the optional questions gather detail for implementing treatment. Often patients are too embarrassed, shy, and uncertain to mention sexual complaints in the health care professional’s office. UIPE can avoid face to face connection between patient and doctor, therefore patients are able to response all questions on their own. Additionally, it is very brief and easy to administer and may be valuable for use in a clinic setting as a measure of treatment responsiveness.

Methods:

This cross-sectional study was conducted on base of Uromed clinic, Fergana for three years duration, from October 2020 to April 2023. In our study 200 patients, aged 20 to 50 year males, who were in a stable sexual relationship for a minimum duration of six months, were asked to fill the UIPE Questionnaire.

All patients with age 20 to 50 years, who were in a stable sexual relationship for a minimum duration of six months, visiting the Uromed Clinic that agreed to participate in the study were included. Study participants were given information about the study procedure and informed written consent was obtained.

The UIPE questionnaire was accurate in diagnosing PE and the questions were easy to read and understand by the participants. Data was collected for demographics including age, frequency of intercourse, marital status, duration of the relationship, self-reported IELT, type of PE (lifelong vs acquired).

Results:

Initially, 200 eligible participants filled all the questionnaires at the first interview. Among them 20 (10%) patients gathered from 0 to 12 score in questionnaire and according to the UIPE scoring system they did not have PE. An average score of 150 (75%) participants was between 17-32score and they had an exact PE. Other remain 30 (15%) patients gathered from 13 to 16 score and were considered as a gray zone. It means they may have PE but to put an exact diagnose other additional diagnostic methods are necessary. (Table 1.)

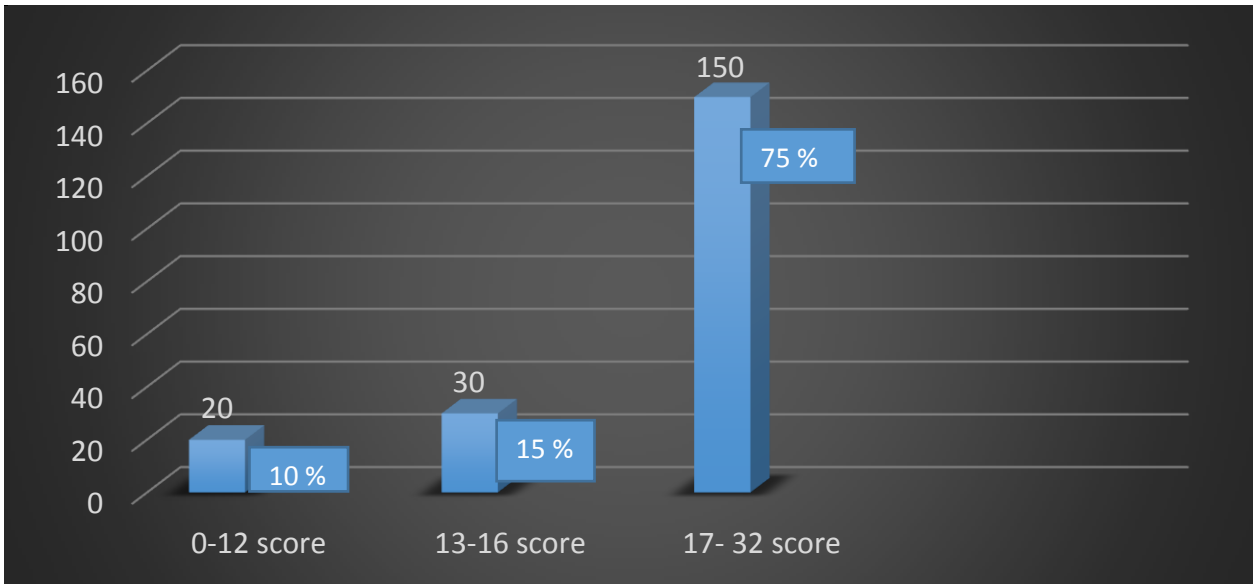


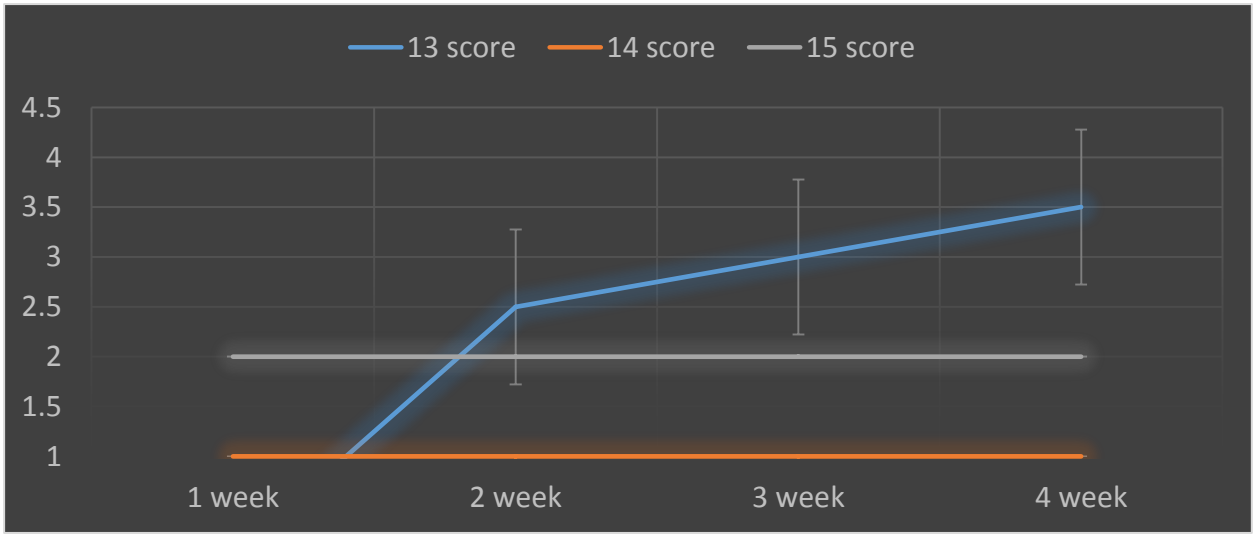
Table 1.

In the second step of our study we separated 30 patients in the gray zone and tested them other concomitant diseases that can make PE symptoms. We tested Testosterone, Estrogen, Follicle stimulating hormone(FSG), Luteinizing hormone(LH), Meares and Stamey 4-glass test and ultrasound(US) of the prostate. The results showed that all hormone level in all patients were normal but they all had an inflammation and bacteria in their 3-glass in Meares and Stamey test. It means they had chronic bacterial prostatitis (CBP). Table 2.

Analysis	Results
Testosterone	Normal
Estrogen	Normal
FSH	Normal
LH	Normal
US of prostate gland	Slightly enlarged
Meares and Stamey 4-glass test	3-glass indicated inflammation and bacteria.

Table 2.

After finding out concomitant disease (CBP) we treated it with Levofloxacin 500 mg oral tablet for 4 weeks according to European Association of Urology guidelines 2020. After treatment we asked control group to fill UIPE questionnaire. We witnessed that the IELT (intravaginal ejaculation latency time) increased noticeably in patients who gathered 13 score in the first interview. However, IELT did not change in other patients (14-16 score) report. (Line 3.) It is proved that 13 and above score cannot be considered or diagnosed PE and it ca be enough to treat concomitant disease. And 14-16 scored patients also should not request additional diagnostic method because those patients are diagnosed as PE.



Line 3.

Discussion:

Premature ejaculation evaluation with UIPE is an excellent tool that helps clinicians in objectively defining and quantifying the condition. PE possess a highly variable estimated prevalence worldwide and very limited literature is available from local studies performed on sexual dysfunction.

There have been variety of studies concerning the validity of premature ejaculation diagnostic tool (PEDT) in the diagnosis of PE. One of these studies Development and validation of a premature ejaculation diagnostic tool. The questionnaire development involved three stages: (1) Five focus groups and six individual interviews were conducted to develop the content; (2) psychometric validation using three different groups of men; and (3) generation of a scoring system. For psychometric validation/scoring system development, data was collected from (1) men with PE based on clinician diagnosis, using DSM-IV-TR, who also had IELTs < or =2 min (n=292); (2) men self-reporting PE (n=309); and (3) men self-reporting no-PE (n=701). Standard psychometric analyses were conducted to produce the final questionnaire. Sensitivity/specificity analysis was used to determine an appropriate scoring system [10].

Urdu translational and validation of premature ejaculation diagnostic tool. This cross-sectional study was conducted at the urology section of the Aga Khan University Hospital, Karachi, for six months duration, from July 2018 to December 2018. In their study 108 subjects, aged 20 to 50 years, who were in a stable sexual relationship (heterosexual) for a minimum duration of six months, were asked to fill the Urdu version of PEDT, 61 with PE and 47 without PE [8].

Additionally, Yan- Ping Huang MD, PhD and his colleague tried to validate A Chinese version of PEDT. A Chinese version of PEDT was confirmed by andrologist and bilingual linguist. Participants were recruited among seven different communities of Shanghai from 2011 to 2012, and their information regarding self- reported PE, self- estimated IELT, expert diagnosis of PE, and PEDT scores were collected [9]. A total of 143 patients without PE (mean age 55.11 ± 7.65 years) and 100 men with PE (mean age 53.07 ± 8.08 years) were enrolled for validation. Of the patients in PE group, the number of men reporting self- estimated IELTs of ≤1, 1–2, and >2 minutes were 34 (34.0%), 22 (22.0%), and 44 (44.0%), respectively. The Cronbach's alpha score ($\alpha = 0.77$) showed adequate internal consistency, and the test–retest correlation coefficients of each item ($r \geq 0.70$, $P < 0.001$) indicated excellent stability over time. The frequency of agreement showed that there was excellent concordance between PEDT diagnosis and clinician diagnosis when the

PEDT scores ≥11. An adequate correlation was found between total PEDT score and self-estimated IELT ($\rho = -0.396$, $P < 0.001$), and sensitivity and specificity analyses suggested a score of ≤8 indicated no time- defined PE (self- estimated IELT ≤1 minute) [9].

However, perfect PEDT should have additional parts. For example, our study resulted in development of reliable and valid questionnaire for assessing PE. Sensitivity and specificity of the tool as well differences in the gained scores between men with PE and without PE, so it may vouch for good discriminant ability of the tool. Moreover, thanks to its ability to discriminate lifelong and acquired PE it also may be useful in decision making between indication of pharmacotherapy only for lifelong PE or pharmacotherapy and/or behavioral therapy for acquired PE. In addition, removing gray zone from questionnaire can improve its sensitivity toward diagnosing an exact PE.

Study limitations. Our study had limitation which should be declared. The main limitation was small number of respondents. Therefore, this study demands large number of respondents to improve sensitivity of our questionnaire.

Conclusion:

Initially it was considered that patients who gather 13 score in UIPE questionnaire may have PE. However, after study it was proved 13 score does not indicate PE, in order to mitigate PE symptoms physicians should pay attention to concomitant diseases on them. It is proved that 13 and above score cannot be considered or diagnosed PE and it should not request additional diagnostic methods. And 14-16 scored patients also should not request additional diagnostic method because those patients are diagnosed as PE.

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