

Premature Ejaculation (PE): Causes, Diagnosis, Treatment and the Unani Approach to Better Ejaculatory Control

Understanding Sur'at-i-Inzāl through Modern Sexual Medicine and Unani Medicine

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Introduction

When a man comes to me and says, **“Doctor, I ejaculate very quickly and I am unable to control it,”** I first explain something that often reduces a great deal of anxiety:

Premature ejaculation is common, treatable, and it does not mean that a man has permanently lost his sexual strength or masculinity.

Premature ejaculation, commonly abbreviated as **PE**, is one of the most frequent male sexual complaints. However, simply ejaculating sooner than desired on an occasional occasion does not automatically mean that a person has a medical disorder.

Modern sexual medicine defines PE using several dimensions together: ejaculation occurs unusually early, the man has little ability to delay it, and the pattern causes meaningful distress, frustration, avoidance of intimacy or relationship difficulty. The International Society for Sexual Medicine describes lifelong PE as ejaculation occurring before or within approximately one minute of vaginal penetration from the beginning of sexual life. Acquired PE develops after a period of satisfactory control and usually involves a clinically significant shortening of ejaculation time, often to around three minutes or less.

Importantly, **time alone is not enough to diagnose PE.**

A patient may ejaculate in two or three minutes and be completely satisfied, while another may last longer but feel that he has virtually no control and experience considerable distress.



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Contemporary European guidelines therefore assess ejaculation time together with perceived control, distress and interpersonal consequences.

From my perspective as a physician working with sexual disorders and infertility, the most productive question is not simply:

“How many minutes do you last?”

It is:

“What is happening, why is it happening, how much control do you have, and how is it affecting you and your relationship?”

That approach allows treatment to address the person rather than just a stopwatch.

What Is Premature Ejaculation?

Premature ejaculation—called **Sur‘at-i-Inzāl** in Unani medical terminology—is a condition in which ejaculation repeatedly occurs earlier than the individual wishes and is accompanied by inadequate control and significant distress.

The three most important features are:

- **short ejaculation latency**, meaning ejaculation occurs unusually early;
- **difficulty controlling or delaying ejaculation**;
- **negative consequences**, such as anxiety, frustration, reduced sexual satisfaction or relationship difficulty.

The International Classification of Diseases, 11th Revision, uses the term **male early ejaculation** and describes a persistent or recurrent pattern of ejaculation occurring before or within a very short period after penetration or relevant sexual stimulation, with little perceived control and clinically significant distress.

This is a much better way of understanding PE than the popular idea that every man must continue intercourse for a certain fixed number of minutes.

How Common Is Premature Ejaculation?

The answer depends greatly on how PE is defined.

Older surveys using broad questions such as “Do you ejaculate sooner than desired?” sometimes produced estimates approaching 20–30%. Strict medical definitions produce considerably lower figures.



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Current sexual-medicine literature commonly estimates clinically relevant PE at approximately **5–15% of men**, depending on population and diagnostic criteria.

The older ISSM evidence-based criteria suggested that strict lifelong PE may affect fewer than 4% of the general population, while broader variable and subjective patterns are more frequent.

This difference is important because not every episode of rapid ejaculation represents a disease.

Different Types of Premature Ejaculation

I find it very useful to determine **which type of PE a patient has**, because different types may require different treatment.

1. Lifelong Premature Ejaculation

In lifelong PE, rapid ejaculation has been present from the man's first or earliest sexual experiences.

He may report:

- ejaculating before penetration,
- ejaculating within approximately one minute,
- having very little ability to delay ejaculation,
- and experiencing this pattern with most partners and sexual encounters.

Biological mechanisms, including central neurotransmitter pathways, genetic susceptibility and individual ejaculatory reflex characteristics, have been investigated in lifelong PE. No single cause explains every patient.

2. Acquired Premature Ejaculation

Acquired PE is different.

The patient previously had satisfactory ejaculatory control but later began ejaculating substantially earlier.

When I see acquired PE, I pay particular attention to possible underlying causes such as:

- erectile dysfunction,
- sexual performance anxiety,
- relationship stress,



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- psychological distress,
- prostatitis or other genitourinary symptoms,
- thyroid disease, particularly hyperthyroidism,
- poor sleep,
- and other health problems.

Current European guidance recommends that the underlying condition be treated first when acquired PE is secondary to another problem.

This is an extremely important clinical point.

If erectile dysfunction is making a man hurry intercourse because he is afraid his erection will disappear, simply giving a medicine to delay ejaculation may fail to address the real problem.

3. Variable Premature Ejaculation

Some men occasionally ejaculate very quickly but at other times have normal or prolonged control.

This is called **variable PE**.

Current guidelines regard variable PE largely as a normal variation in sexual performance rather than necessarily a disease.

Stress, excitement, a long period of abstinence, a new relationship or changes in sexual stimulation may all influence ejaculation from one occasion to another.

4. Subjective Premature Ejaculation

A man may believe that he ejaculates abnormally quickly even when his actual ejaculation time is within the normal range.

This is sometimes called **subjective PE**.

Such patients often compare themselves with pornography, internet claims or unrealistic expectations about how long intercourse “should” last.

In these cases, sexual education, counselling and correcting expectations can sometimes be more valuable than increasing medication.

Ejaculation Is a Biological Process, Not Simply a Matter of Willpower



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A common misunderstanding is that a man who ejaculates quickly simply lacks discipline. That is not correct.

Ejaculation involves interaction between:

- the brain,
- spinal cord,
- sensory nerves,
- autonomic nervous system,
- genital stimulation,
- pelvic muscles,
- psychological arousal,
- neurotransmitters,
- relationship circumstances,
- and learned sexual responses.

Serotonergic pathways in the central nervous system appear especially relevant because medicines that increase serotonergic activity can delay ejaculation in many patients.

However, the exact biology of PE is complex, and current guidelines explicitly state that its aetiology is not fully understood.

This is why telling a patient merely to “control himself” is often unhelpful.

What Causes Premature Ejaculation?

There is rarely one universal cause.

A combination of biological, psychological, sexual and relationship factors may be involved.

Psychological Factors

Psychological contributors can include:

- performance anxiety,
- fear of sexual failure,
- excessive focus on ejaculation time,
- previous embarrassing sexual experiences,
- depression,



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- chronic stress,
- low sexual confidence,
- relationship tension,
- guilt surrounding sexual activity.

Some men enter intercourse already thinking:

“I must not ejaculate.”

Every change in sensation then becomes a warning sign.

The more desperately he tries to suppress ejaculation, the more anxious and hyper-alert he may become.

This can create a self-perpetuating cycle.

Performance Anxiety and PE

Performance anxiety deserves special attention.

Imagine that a man ejaculates quickly once.

At the next encounter he thinks:

“What if it happens again?”

Instead of enjoying touch, affection and arousal, he starts monitoring every sensation.

His anxiety rises.

He may rush penetration, become excessively stimulated or lose erection confidence.

Ejaculation again occurs quickly.

He then concludes:

“I have become permanently weak.”

The next sexual encounter becomes even more stressful.

Modern European guidance recognizes anxiety, relationship problems and sexual performance anxiety among important contributors particularly to acquired PE.

Breaking this cycle is sometimes as important as slowing the ejaculation itself.

Erectile Dysfunction and Premature Ejaculation Often Occur Together

This relationship is frequently misunderstood.



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A man with erectile dysfunction may deliberately hurry intercourse because he is afraid that his erection will disappear.

He may therefore develop what appears to be premature ejaculation.

Alternatively, repeated PE may cause such intense performance anxiety that erection subsequently becomes difficult.

European guidelines recommend specifically distinguishing PE from ED and treating coexisting erectile dysfunction appropriately.

Therefore, when a patient tells me:

“Doctor, I finish very quickly,”

I also ask:

“Is your erection fully hard? Does it remain hard until ejaculation? Do you hurry because you are frightened of losing it?”

That can completely change the treatment plan.

Prostate and Urinary Problems

Acquired PE has been associated in some patients with prostatitis and other genitourinary symptoms.

A patient who has newly developed PE together with:

- pelvic pain,
- urinary burning,
- painful ejaculation,
- urinary frequency,
- genital discomfort,

requires assessment for an underlying urinary or prostate-related condition rather than assuming the problem is purely psychological.

Thyroid Disease

Hyperthyroidism is another important but often overlooked association.



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A systematic review and meta-analysis found higher rates of sexual dysfunction, including PE, among men with hyperthyroidism and noted improvement in sexual function after successful treatment of the thyroid disorder.

This does not mean every man with PE needs thyroid testing.

It means that **tests should be guided by clinical history and symptoms.**

Stress, Depression and Sleep

Sexual response does not operate independently of general health.

Chronic stress, mood disturbance and poor-quality sleep can alter sexual confidence, arousal and ejaculatory control.

European guidelines include emotional problems, stress, depressive symptoms and poor sleep among factors associated with PE.

This is why treating sexual health sometimes means discussing a patient's sleep schedule, workload and emotional state—not simply prescribing a tablet.

Relationship Factors

PE is not exclusively an individual problem.

It may affect both partners.

A man may withdraw from intimacy because he feels ashamed.

His partner may interpret this avoidance as lack of attraction.

The man becomes more anxious, and sexual communication deteriorates.

PE has been associated with lower sexual satisfaction, relationship strain, embarrassment, anxiety and reduced self-confidence for affected men and can also negatively affect partner satisfaction.

Whenever possible and acceptable to the patient, constructive partner involvement can be valuable.

Does Masturbation Cause Premature Ejaculation?

Masturbation itself does not automatically cause PE.

However, sexual habits can influence learned arousal patterns.



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For example, someone who has repeatedly trained himself to reach ejaculation extremely rapidly because he fears being interrupted may develop a pattern of rushing stimulation.

This does not mean the reproductive system has been damaged.

The more useful approach is to understand the sexual behaviour and, where appropriate, retrain arousal and control without guilt or frightening claims about semen loss.

Does Testosterone Deficiency Cause PE?

Not usually.

Patients sometimes assume that every sexual problem means testosterone is low.

Premature ejaculation is not generally diagnosed by measuring testosterone.

Hormonal testing is appropriate only when the clinical history suggests a particular endocrine problem.

Routine blood tests are not recommended for every man with PE. Current guidelines advise investigations only when the history or examination provides a reason for them.

How Is Premature Ejaculation Diagnosed?

There is no single blood test, ultrasound or scan that confirms PE.

The diagnosis is mainly **clinical**.

During assessment I want to understand four central areas:

Ejaculation time

Approximately how long does intercourse usually continue before ejaculation?

Exact stopwatch timing is generally unnecessary in routine practice. Patient-estimated timing is normally sufficient.

Ejaculatory control

Can you recognize increasing arousal?

Can you slow or pause stimulation?

Can you delay ejaculation when you want to?

Distress

Does the problem bother you significantly?

Does it make you anxious, embarrassed or reluctant to have sexual contact?

Relationship effect

Is PE creating dissatisfaction, avoidance or tension between you and your partner?

That combination provides much more useful clinical information than time alone.

Questions I Commonly Ask During Consultation

A patient should be prepared to discuss:

- When did PE begin?
- Has it been present since your first sexual experiences?
- Did you previously have normal control?
- Does it happen every time or only sometimes?
- Does it occur with every partner?
- How long approximately does penetration continue?
- Do you feel you can delay ejaculation?
- Is your erection fully satisfactory?
- Is there pain or burning?
- Are there urinary symptoms?
- Is sexual desire normal?
- Are you anxious before intercourse?
- Are there relationship difficulties?
- Which medicines or supplements are you using?
- Have you previously used PE medicines?
- Are you and your partner trying to conceive?

These questions often provide more information than a laboratory panel.

Does Every PE Patient Need Tests?

No.



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Current EAU guidance specifically recommends against routine laboratory or physiological testing for every PE patient. Investigations should be selected according to the medical and sexual history and examination findings.

For example:

A man with lifelong PE and no other symptoms may need little or no laboratory investigation.

A man with newly developed PE, weight loss, tremor and rapid heartbeat may warrant thyroid assessment.

A patient with pelvic pain and urinary symptoms may require urological evaluation.

A patient with erectile dysfunction needs assessment of the factors contributing to ED.

Testing should answer a clinical question.

Treatment of Premature Ejaculation

Successful treatment usually begins by identifying whether PE is lifelong, acquired, variable or primarily subjective.

There is no single treatment suitable for every man.

Management may combine:

- education,
 - psychosexual counselling,
 - behavioural training,
 - pharmacological treatment,
 - pelvic-floor rehabilitation,
 - treatment of erectile dysfunction,
 - management of an underlying medical condition,
 - lifestyle improvement,
 - and appropriately selected traditional or Unani treatment.
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Education and Sexual Counselling

One of the simplest but most valuable treatments is correct information.



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I explain to patients that:

A man does not have to perform for 20 or 30 minutes to be sexually healthy.

Sexual intimacy is not an examination.

A partner's satisfaction is not determined solely by penetration time.

Intimacy includes affection, communication, touch, stimulation, emotional security and mutual pleasure.

Reducing unrealistic expectations can itself reduce performance pressure.

The Start–Stop Technique

The start–stop technique is one traditional behavioural method.

The principle is simple.

Sexual stimulation continues until the individual feels that ejaculation is approaching.

Stimulation is then reduced or paused.

Once the level of arousal falls, stimulation is resumed.

Repeated practice can help some men become more familiar with different stages of sexual arousal.

Behavioural approaches can be useful, although research findings have historically been inconsistent when such methods are used alone. Current guidelines generally see psychosexual and behavioural interventions as particularly valuable when combined with other treatment.

The Squeeze Technique

The squeeze technique was historically developed as another way of temporarily reducing the urge to ejaculate.

Today, many patients find start–stop training, communication exercises and structured psychosexual therapy easier to integrate into normal sexual activity.

No patient should feel that one particular behavioural technique is compulsory.

Cognitive Behavioural Therapy (CBT)

CBT can be particularly useful when PE is associated with:



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- performance anxiety,
- negative thoughts about sexuality,
- fear of disappointing the partner,
- catastrophizing after one unsuccessful sexual encounter,
- low self-confidence,
- or excessive monitoring during intercourse.

CBT helps the patient recognize the thought patterns that increase anxiety and replace them with more realistic interpretations and behaviours.

A 2025 meta-analysis involving **15 randomized controlled trials and 1,243 participants** reported that CBT or behavioural therapy combined with SSRIs produced better outcomes than SSRIs alone across several measures, including ejaculation latency, perceived control and sexual satisfaction, without a significant increase in adverse effects.

This supports an important principle:

Medication and psychological treatment do not have to compete with each other. For suitable patients they can complement each other.

Pelvic Floor Exercises: What Does the Latest Research Show?

Patients frequently hear about Kegel exercises.

The pelvic-floor muscles participate in sexual and ejaculatory function, so pelvic-floor rehabilitation has been investigated for PE.

However, pelvic-floor exercises should not be presented as a guaranteed cure.

A **2026 systematic review and meta-analysis of randomized trials** evaluated pelvic-floor muscle training for PE. Five studies were included. Isolated pelvic-floor training showed less improvement in ejaculation latency than dapoxetine or some combined interventions, although pelvic-floor rehabilitation may still have a role within multimodal treatment.

This research gives us a more balanced message than simply telling every patient to “do Kegels.”

The quality of exercise, correct muscle identification and patient selection matter.

Also, pelvic-floor exercises are **not specifically a Unani treatment**; they are a contemporary rehabilitation approach that may be integrated with other therapies where appropriate.



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Modern Medicines Used for Premature Ejaculation

Medication can be particularly useful for true lifelong PE and selected cases of acquired PE.

It should be prescribed after considering medical history, other medicines and treatment goals.

Dapoxetine

Dapoxetine is a short-acting SSRI specifically designed for on-demand use in PE and is approved in many countries.

European guidelines identify on-demand dapoxetine as one of the established first-line pharmacological options for lifelong PE. Clinical trials have shown improvement not only in ejaculation latency but also in perceived control, distress and sexual satisfaction.

Common adverse effects may include:

- nausea,
- dizziness,
- headache,
- diarrhoea.

It is not appropriate for every patient and should not be self-prescribed simply because someone has occasional rapid ejaculation.

Topical Local Anaesthetics

Certain lidocaine/prilocaine preparations can reduce penile sensitivity and thereby delay ejaculation.

Clinical evidence supports their effectiveness, and contemporary European guidance recognizes an approved lidocaine/prilocaine spray as a first-line option for lifelong PE where available.

Possible disadvantages include:

- penile numbness,
- reduced sexual sensation,
- transfer of anaesthetic to the partner,
- partner genital numbness,
- irritation in some individuals.



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Correct use is therefore important.

Daily SSRIs

Certain antidepressants can delay ejaculation as a side effect and are consequently used **off-label** for PE.

Examples include:

- paroxetine,
- sertraline,
- fluoxetine,
- citalopram.

Paroxetine has generally demonstrated one of the strongest ejaculation-delaying effects among commonly studied daily SSRIs.

These medicines can produce adverse effects such as nausea, tiredness, sweating, gastrointestinal symptoms, reduced libido or other sexual effects. They should not be suddenly discontinued after regular use without medical advice.

Clomipramine

Clomipramine is another antidepressant that can delay ejaculation and may be prescribed in selected patients either regularly or according to a particular treatment protocol.

Like SSRIs, it is not a general sexual tonic.

The decision should be individualized.

PDE5 Inhibitors and Erectile Dysfunction

Medicines such as sildenafil or tadalafil are primarily used for erectile dysfunction.

Their role in PE depends on the individual patient.

They can be particularly relevant where PE and erection difficulties coexist, because improving erection confidence may reduce the tendency to rush intercourse.

Current European guidance includes PDE5 inhibitors among possible PE strategies in appropriate patients and notes evidence for combination treatment in selected situations.

Patients should never combine prescription sexual medicines indiscriminately.

Why I Am Cautious About Tramadol for PE

Tramadol can delay ejaculation, but it is an opioid-related medicine and carries significant safety concerns, including dependence and addiction potential.

European guidelines therefore place it well behind more established treatments and recommend caution.

I do not consider a potentially habit-forming medicine an appropriate casual solution to sexual anxiety.

The Unani Perspective on Premature Ejaculation

In classical Unani medicine, premature ejaculation is generally discussed as **Sur'at-i-Inzāl**.

Unani medicine developed from ancient Greek medical traditions and was extensively enriched by Arab, Persian and later South Asian physicians.

The system views health through several interconnected concepts, including:

- **Mizaj** – temperament,
- **Akhlat** – humours,
- faculties or functional powers,
- organs,
- lifestyle and environmental influences.

The four classical humours are:

Dam – blood

Balgham – phlegm

Safra – yellow bile

Sauda – black bile.

Official Ministry of Ayush and CCRUM material describes health in classical Unani theory as depending on an appropriate balance of these humours and the individual's temperament.

These traditional concepts should be understood as the conceptual framework of Unani medicine; they are not interchangeable with modern laboratory diagnoses such as neurotransmitter levels, thyroid function or testosterone concentration.

How Classical Unani Medicine Explains Sur'at-i-Inzāl



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Classical Unani texts describe several possible mechanisms for rapid ejaculation.

Traditional terminology includes concepts such as:

- **Du‘f-i-Quwwat-i-Māsika** – weakness of the retentive faculty,
- increased genital sensitivity,
- altered temperament affecting the reproductive organs,
- abnormalities attributed traditionally to semen consistency,
- excessive sexual stimulation,
- psychological excitement,
- and general weakness or disturbance of reproductive function.

Modern Unani literature continues to discuss Sur‘at-i-Inzāl within this traditional framework.

However, I believe it is essential to make a distinction for patients:

A classical description can guide traditional clinical reasoning, but modern PE must still be assessed for conditions such as ED, prostatitis, thyroid disease, anxiety and medication effects according to contemporary medical standards.

Asbab-e-Sitta Zarooriya: A Useful Unani Framework

One of the most practical concepts in Unani healthcare is **Asbab-e-Sitta Zarooriya**, the six essential factors of life.

They include broadly:

- air and environment,
- food and drink,
- physical movement and rest,
- mental activity and repose,
- sleep and wakefulness,
- retention and elimination.

The Ministry of Ayush identifies these six essential factors as central to preservation of health within the Unani system.

In my clinical practice, this framework is particularly useful in PE because sexual function can indeed be influenced by:



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- inadequate sleep,
- chronic stress,
- sedentary lifestyle,
- poor general health,
- nutritional imbalance,
- excessive mental pressure.

This does not mean that lifestyle modification alone will cure every case of lifelong PE.

It means that treatment should not ignore the health of the whole person.

Unani Dietary Management

Dietary guidance in Unani medicine is traditionally individualized according to the patient's condition and temperament.

From a contemporary clinical perspective, however, I would discourage the idea that one food—milk, dates, nuts, eggs, saffron or any other food—can permanently cure PE.

Instead, diet should support:

- healthy body weight,
- metabolic health,
- adequate nutrition,
- cardiovascular health,
- energy,
- sleep,
- and overall reproductive wellbeing.

Patients with diabetes, obesity or other chronic illness require diets appropriate to those conditions rather than excessive “strength-giving” foods.

Unani Pharmacotherapy for Premature Ejaculation

Unani pharmacotherapy has traditionally included compound formulations described as having **Mumsik** or retentive properties and other actions intended to support ejaculatory control.



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There is some emerging clinical research, but it is important to describe the evidence accurately.

A 2023 clinical validation study evaluated **Majoon-e-Piyaz** in patients with Sur'at-i-Inzāl. Of 105 enrolled participants, 80 completed the study. Six were classified as achieving complete remission, 47 partial remission and 27 poor remission; 25 patients dropped out. Laboratory safety monitoring in that study did not identify reported hepatotoxicity or nephrotoxicity during the study period.

This study is encouraging from a Unani research perspective, but it does **not** establish that Majoon-e-Piyaz is a universally proven cure. The absence of a strong placebo-controlled comparison and the dropout rate limit the conclusions that can be drawn.

That distinction is important when discussing traditional medicine scientifically.

Current Unani Research Is Continuing

The **CCRUM Annual Report 2024–2025** lists comparative clinical validation of **Majoon-e-Mughalliz versus Majoon Piyaz for Sur'at-i-Inzāl (premature ejaculation)** among its research activities.

This is encouraging because the best way to strengthen traditional medicine is not through exaggerated claims but through:

- standardized formulations,
- clearly defined diagnoses,
- controlled clinical trials,
- validated outcome measures,
- safety monitoring,
- and publication of transparent results.

As a practitioner of Unani medicine, I consider this scientific evaluation essential for the future of the system.

How I Use Unani Principles Responsibly in PE

In my approach, Unani treatment is not simply:

“You ejaculate quickly, therefore take a strengthening medicine.”

I first try to determine why PE is occurring.



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An individualized plan may therefore address:

General health

Sleep, exercise, metabolic health, digestion, nutrition and chronic illness.

Psychological health

Anxiety, performance pressure, fear, excessive sexual monitoring and relationship stress.

Sexual technique and education

Understanding arousal, slowing stimulation, improving communication and reducing unrealistic expectations.

Associated sexual dysfunction

Particularly erectile dysfunction, reduced libido or other ejaculatory disorders.

Appropriate traditional treatment

Carefully selected Unani therapy may be considered according to the individual's condition, medical history and traditional assessment.

Modern investigation or treatment where indicated

A patient with thyroid disease needs thyroid treatment.

A patient with infection needs appropriate investigation and therapy.

A patient with clinically significant anxiety may benefit from counselling.

A patient with ED deserves an ED evaluation.

Integrative treatment should mean using the right approach for the right problem—not rejecting one medical system in favour of another.

Role of Dr. Nizamuddin Qasmi and Saira Health Care

At **Saira Health Care**, my focused clinical work includes sexual disorders and infertility.

My training includes:

BUMS – Hamdard University, Delhi

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Certificate in Infertility – MGBIMS, Delhi

Certificate in Urology – London, UK

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When a patient consults me for premature ejaculation, my objective is not merely to increase the number of minutes before ejaculation.

I want to understand:

- Is the problem lifelong or acquired?
- Is the patient actually experiencing medical PE?
- Is erection satisfactory?
- Is anxiety driving the problem?
- Are there urinary or prostate symptoms?
- Is thyroid disease suspected?
- Is there a relationship problem?
- Is the patient also concerned about fertility?
- Has he already become dependent on self-prescribed sexual medicines?
- Which aspects can be addressed through Unani care?
- Which need modern pharmacological, psychological or specialist intervention?

This comprehensive assessment is particularly important because men frequently arrive after trying multiple “delay” products without ever receiving a proper diagnosis.

Saira Health Care's Contribution to Sexual Disorders and Infertility

Sexual-health problems remain surrounded by embarrassment, misinformation and exaggerated advertising.

At Saira Health Care, an important part of our work is therefore **patient education**.

I believe patients should understand:

- PE is not evidence of reduced masculinity;
- intercourse duration is not the only measure of sexual satisfaction;
- ED and PE are different disorders, although they can coexist;
- fertility and ejaculation time are not the same thing;
- psychological treatment does not mean that symptoms are imaginary;
- Unani treatment should be individualized;
- modern medicines should not be self-prescribed;



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- and genuine medical conditions should not be hidden behind labels such as “sexual weakness.”

An informed patient is much better equipped to participate in his own treatment.

A Practical Treatment Strategy

For many patients I explain the treatment pathway in a simple sequence.

First: define the actual problem

Is this lifelong PE, acquired PE, variable PE or mainly unrealistic expectations?

Second: identify associated conditions

Particularly ED, anxiety, relationship problems, prostatitis symptoms, thyroid problems or other medical illness.

Third: educate the patient

Explain normal sexual response and realistic expectations.

Fourth: improve modifiable lifestyle factors

Sleep, stress, activity and overall health.

Fifth: introduce behavioural or psychological techniques when appropriate

Start–stop training, anxiety reduction, CBT, couple communication and other psychosexual approaches.

Sixth: consider pharmacological treatment when clinically appropriate

Dapoxetine, topical anaesthetic therapy or selected off-label medicines may be considered after medical review.

Seventh: integrate suitable Unani care

Dietary, lifestyle and individualized pharmacotherapeutic principles may complement treatment where appropriate.

Eighth: review the response

Did control improve?

Did distress decrease?

Did sexual satisfaction improve?

Were there side effects?



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A treatment that simply adds two minutes but leaves the patient frightened and dissatisfied has not solved the entire problem.

What About “Permanent Cure”?

Patients naturally ask:

“Doctor, can PE be cured permanently?”

The answer depends on the type and cause.

Acquired PE caused by another treatable problem may improve considerably when the underlying issue is corrected.

Lifelong PE may require longer-term management, and some men experience recurrence after stopping medication.

Current European guidelines note that long-term outcomes for many pharmacological PE treatments remain incompletely defined.

Responsible medicine should therefore promise **appropriate treatment and improvement**, not guarantee a permanent cure to every patient.

Frequently Asked Questions

Is ejaculation within one minute always premature ejaculation?

Not automatically.

For lifelong PE, ejaculation within about one minute is an important diagnostic feature, but lack of control and distress must also be considered.

I sometimes ejaculate quickly. Do I have PE?

Not necessarily.

Occasional early ejaculation can be normal, particularly with excitement, stress, a new relationship or a long period without sexual activity.

Variable early ejaculation is recognized as a normal variation for many men.

Does PE mean that I am impotent?

No.



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Premature ejaculation concerns ejaculation timing and control.

Erectile dysfunction concerns the ability to obtain or maintain an erection.

They are different conditions, although they can occur together.

Does PE mean my sperm are weak?

No.

Ejaculation time does not determine sperm count, motility or morphology.

A man may have PE and normal fertility.

Likewise, a man can have normal ejaculation timing but abnormal semen parameters.

Can PE cause infertility?

PE usually does not directly cause male infertility if semen is deposited appropriately inside the vagina.

Very severe ejaculation occurring consistently before penetration may interfere with natural conception, but this is different from abnormal sperm production.

Couples experiencing fertility difficulty should be evaluated appropriately rather than assuming PE is the only reason.

Does masturbation cause PE?

Masturbation does not automatically cause PE.

Sexual habits and anxiety can influence arousal patterns, but this is not equivalent to permanent reproductive damage.

Can Kegel exercises cure PE?

Pelvic-floor rehabilitation may help selected patients, but it should not be promoted as a guaranteed cure.

A 2026 meta-analysis found that isolated pelvic-floor exercise was less effective for ejaculation latency than dapoxetine or some combined interventions.

Is CBT useful?



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Yes, particularly where anxiety, negative expectations and performance pressure contribute.

A recent meta-analysis found better outcomes when CBT/behavioural treatment was combined with SSRIs than with SSRIs alone.

Can Unani medicine help?

Unani medicine can contribute through an individualized holistic approach involving lifestyle, diet, psychological wellbeing and carefully selected traditional treatment.

Some Unani formulations have preliminary clinical data, and CCRUM continues research in this field. However, current evidence does not justify claiming that one Unani medicine is a guaranteed cure for every patient.

When Should You Consult a Doctor?

Seek professional evaluation when:

- ejaculation repeatedly occurs much sooner than desired;
 - you have little ability to control ejaculation;
 - the problem causes significant distress;
 - PE has suddenly developed after previously normal sexual function;
 - erection is also weak;
 - ejaculation is painful;
 - there are urinary or pelvic symptoms;
 - sexual anxiety is interfering with your relationship;
 - you have symptoms suggesting thyroid or other medical disease;
 - or self-treatment has not helped.
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A Message From Dr. Nizamuddin Qasmi

When you come to me with premature ejaculation, I do not judge your masculinity by a stopwatch.

I want to understand your **control, confidence, physical health, emotional health, relationship and expectations.**



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Many men suffer for years because they remain embarrassed to discuss the problem. Others repeatedly purchase delay sprays, tablets, capsules and herbal products without ever discovering whether they have lifelong PE, erectile dysfunction, performance anxiety or another medical condition.

Please understand that PE is **not a moral weakness and not evidence that you are less of a man.**

The objective of treatment is also not simply to make intercourse as long as possible.

The objective is to help you develop satisfactory control, reduce anxiety, improve confidence and create a better sexual experience for you and your partner.

For some men, counselling and behavioural training may be central.

For others, medication is useful.

For some, an underlying condition must be treated.

And for appropriately selected patients, principles of Unani medicine can be integrated with modern sexual-health assessment to support a more comprehensive approach.

The best treatment is therefore individualized—not the strongest medicine, but the treatment that addresses the actual cause of your problem.

About the Author

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Medical Disclaimer

This article is provided for **medical education and public awareness** and does not replace individual diagnosis or treatment.



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Premature ejaculation has several possible causes, and the appropriate treatment depends on whether it is lifelong or acquired and whether other physical, psychological or relationship problems are present.

Prescription medicines, topical anaesthetics and Unani/herbal preparations should be used only after appropriate professional advice. Patients should not discontinue prescribed medicines or begin antidepressants, sexual medicines or herbal products independently.

The clinical evidence for conventional PE treatments is substantially stronger than the evidence currently available for individual Unani formulations. Unani medicine is best used responsibly, with standardized products, appropriate diagnosis, safety monitoring and integration with evidence-based medical or psychological care when required.



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