Premature Ejaculation: Causes, Diagnosis, Treatment and the Role of Unani Medicine

Introduction

Premature ejaculation (PE) is one of the most frequently reported male sexual concerns. In simple terms, it means that ejaculation repeatedly occurs earlier than a man wishes, he finds it difficult to delay or control ejaculation, and the problem causes distress, frustration, reduced sexual satisfaction or difficulty within a relationship.

Modern sexual medicine no longer defines premature ejaculation simply by counting the number of minutes during intercourse. The **2026 European Association of Urology (EAU) Sexual and Reproductive Health Guidelines** emphasize that PE is a multidimensional condition involving three particularly important features:

- A shortened time to ejaculation
- Reduced ability to control or delay ejaculation
- Personal or interpersonal distress resulting from the problem

The EAU's 2026 guideline update included a full revision of its disorders-of-ejaculation section after reviewing newly available scientific evidence.

This distinction is important because an occasional episode of early ejaculation is extremely common and does not necessarily represent disease. Fatigue, excitement, anxiety, a new partner, a long period of sexual abstinence, emotional stress or other temporary circumstances may sometimes result in faster ejaculation.

A medical diagnosis becomes more appropriate when early ejaculation is **persistent or recurrent, difficult to control and sufficiently troublesome to affect the man's sexual or emotional well-being or his relationship**.

Premature ejaculation should therefore not be a source of shame. It is a recognized sexual-health condition, and several treatment approaches are available.

What Is Premature Ejaculation?

The World Health Organization's ICD-11 uses the term **male early ejaculation**, while premature ejaculation remains the most commonly used clinical and public term.

The current EAU guideline incorporates the ICD-11 concept of early ejaculation as ejaculation occurring before or within a very short period after relevant sexual stimulation, with little perceived control, recurring over at least several months and being associated with clinically significant distress.

This means that simply ejaculating in two, three or four minutes does not automatically mean a man has a disease.

The question is not only:

“How many minutes does intercourse last?”

Doctors must also ask:

- Can the man delay ejaculation when he wishes?
- Does the problem happen almost every time or only occasionally?
- Has it been present since his earliest sexual experiences?
- Did it begin only recently?
- Is it causing distress or relationship difficulty?
- Is there associated erectile dysfunction?
- Are psychological or medical conditions contributing?

There is **no single ideal duration of intercourse** that applies to every man or couple.

International Definitions of Premature Ejaculation

Different professional organizations use slightly different criteria.

International Society for Sexual Medicine Definition

The International Society for Sexual Medicine (ISSM) describes lifelong PE as ejaculation occurring always or nearly always before or within approximately **one minute of vaginal penetration**, together with inability to delay ejaculation and negative consequences such as distress, frustration or avoidance of sexual intimacy.

For acquired PE, the ISSM emphasizes a significant reduction from a previously satisfactory ejaculation time, often to approximately **three minutes or less**, combined with reduced control and distress.

AUA/SMSNA Definition

The American Urological Association and Sexual Medicine Society of North America use a somewhat broader criterion.

Their guideline defines lifelong PE by consistently poor ejaculatory control, associated bother and ejaculation within approximately **two minutes after penetrative sexual activity begins**, with the problem having been present since sexual debut.

Acquired PE is defined by poor control and distress together with a marked reduction from the person's previous ejaculation latency.

As of 2026, the AUA continues to list its Disorders of Ejaculation guideline among its current male sexual-dysfunction guidelines.

The Practical Meaning

These slightly different numerical definitions should not confuse patients.

All major frameworks agree on the central concept:

Premature ejaculation involves early ejaculation plus reduced control plus clinically important distress—not a stopwatch measurement alone.

How Common Is Premature Ejaculation?

PE has often been described as one of the most common male sexual complaints.

Older population surveys reported that around **20–30% of men** experienced ejaculation they considered too early. However, these surveys often asked only a simple question such as whether ejaculation occurred sooner than desired.

When stricter modern diagnostic criteria are applied, true persistent PE appears considerably less common.

The 2026 EAU guideline reports that observational studies found approximately:

- **2.3–3.2%** for lifelong PE
- **3.9–4.5%** for acquired PE

Larger numbers of men fall into variable or subjective PE categories rather than having persistent lifelong or acquired disease.

This difference is important because it prevents normal variations in sexual performance from being unnecessarily labelled as disease.

Understanding Normal Ejaculation

Ejaculation is much more complex than a simple penile reflex.

It involves coordination between:

- Brain
- Spinal cord
- Autonomic nerves
- Peripheral nerves
- Prostate
- Seminal vesicles
- Vas deferens
- Pelvic-floor muscles
- Hormonal influences
- Multiple neurotransmitters

The EAU describes ejaculation as having two coordinated stages: **emission and expulsion**, controlled through interconnected neurological, hormonal and anatomical pathways.

Emission

During emission, sperm and secretions from the reproductive glands are transported into the posterior urethra.

Expulsion

Rhythmic contractions of pelvic and genital muscles then propel semen outward through the urethra.

The entire process is coordinated by the nervous system.

This helps explain why premature ejaculation can involve biological, psychological and relationship-related influences at the same time.

What Causes Premature Ejaculation?

There is no single cause that explains every patient.

Modern research increasingly considers PE a **biopsychosocial disorder**, meaning that biological, psychological, sexual and interpersonal factors may interact.

The 2026 EAU guideline states that the exact cause remains incompletely understood and discusses several proposed biological and psychological mechanisms.

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1. Serotonin and Brain Regulation of Ejaculation

Serotonin is an important neurotransmitter in the brain.

Research suggests that serotonergic pathways help regulate the ejaculation reflex. Certain medicines that increase serotonergic signaling commonly delay ejaculation, which provides strong pharmacological evidence that serotonin pathways are involved.

However, it would be inaccurate to say that every patient with PE simply has a “serotonin deficiency.”

The nervous system is considerably more complex, and serotonin is only one component.

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2. Genetic and Biological Predisposition

Lifelong PE sometimes appears to have a biological predisposition.

Research has explored:

- Genetic influences
- Differences in serotonin receptors
- Central nervous-system processing
- Dopamine pathways
- Oxytocin pathways

- Sensory processing
- Differences in ejaculatory-reflex threshold

No single genetic or biochemical abnormality has yet been shown to explain all cases.

3. Psychological and Performance Anxiety

Psychological factors can substantially influence ejaculation.

These may include:

- Performance anxiety
- Fear of disappointing a partner
- Excessive focus on sexual timing
- Chronic stress
- Depression
- Low confidence
- Relationship conflict
- Previous negative sexual experiences
- Unrealistic expectations created by pornography or misinformation

A common cycle can develop:

Early ejaculation → anxiety about the next encounter → increased monitoring of sexual performance → greater tension → another episode of early ejaculation → greater anxiety.

Breaking this cycle may be an important part of successful treatment.

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4. Erectile Dysfunction

Premature ejaculation and erectile dysfunction can occur together.

Some men who fear losing an erection begin to rush sexual intercourse. Over time, this can establish a pattern of rapid ejaculation.

The opposite may also occur: repeated PE produces anxiety that subsequently interferes with erection quality.

For this reason, doctors should determine which condition appeared first.

Both EAU and AUA/SMSNA guidance emphasize appropriate assessment and treatment of accompanying erectile dysfunction. The EAU specifically recommends treating ED and other relevant sexual or genitourinary disorders when they contribute to PE.

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5. Prostatitis and Pelvic Symptoms

Prostate inflammation and chronic pelvic symptoms have been associated with acquired PE in some patients.

A patient who develops rapid ejaculation together with:

- Pelvic discomfort
- Pain during ejaculation
- Urinary burning
- Urinary frequency
- Perineal discomfort

may require evaluation for a urological condition rather than receiving ejaculation-delaying treatment alone.

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6. Thyroid Disease

Hyperthyroidism has been associated with acquired PE.

This does **not** mean every patient needs thyroid testing.

Routine laboratory investigation is generally unnecessary in lifelong PE. Thyroid evaluation may be appropriate when the patient's symptoms or medical history suggest thyroid disease.

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7. Diabetes and Metabolic Health

Some observational research has linked PE with:

- Diabetes
- Obesity

- Metabolic syndrome
- Poor overall health
- Reduced physical activity

These associations do not prove that diabetes directly causes every case of PE, but they emphasize the importance of considering the patient's overall health.

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8. Poor Sleep and Chronic Stress

Poor sleep can influence:

- Mood
- Stress hormones
- Sexual desire
- Nervous-system function
- Emotional stability

Acquired PE has been associated with poor sleep quality in observational research.

Improving sleep alone may not cure PE, but healthy sleep is an important component of general sexual health.

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9. Penile Sensitivity

Penile hypersensitivity has long been proposed as one possible mechanism.

The fact that topical local anaesthetics can delay ejaculation indicates that reducing sensory input can help certain patients.

However, research has not established excessive penile sensitivity as the universal cause of PE.

Therefore, telling every patient that his “nerves are too sensitive” is an oversimplification.

Types of Premature Ejaculation

Correct classification is important because treatment differs according to the type.

1. Lifelong Premature Ejaculation

Lifelong PE:

- Begins from the earliest sexual experiences
- Occurs during most sexual encounters
- Usually occurs with different partners and situations
- Is associated with consistently reduced control

Biological predisposition appears particularly important in this group.

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2. Acquired Premature Ejaculation

Acquired PE develops **after a period of previously normal ejaculatory control**.

For example, a man may previously have had satisfactory intercourse for many years but later begin ejaculating much sooner than before.

Potential contributing factors include:

- Erectile dysfunction
- Prostatitis or pelvic problems
- Hyperthyroidism
- Anxiety
- Depression
- Relationship stress
- Medication or substance factors

- General health changes

Identifying and treating the underlying cause is particularly important in acquired PE.

The EAU recommends addressing the underlying condition first when possible.

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3. Variable Premature Ejaculation

Variable PE means ejaculation is sometimes very rapid but normal at other times.

This is generally considered a **normal variation in sexual performance**, not necessarily a disease.

Stress, excitement, a prolonged period without intercourse and other temporary circumstances can influence ejaculation.

The EAU specifically distinguishes variable PE from persistent pathological PE.

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4. Subjective Premature Ejaculation

Some men believe that they ejaculate abnormally quickly even though their actual ejaculation time falls within a normal or even prolonged range.

This is known as **subjective PE**.

The problem may arise because of:

- Unrealistic expectations
- Comparison with pornography
- Anxiety
- Misunderstanding of normal sexual physiology
- Partner expectations
- Excessive focus on penetration duration

Education and counselling may be more useful than medicine in many such cases.

Generalised and Situational PE

PE can also be described as:

Generalised

The problem occurs with almost all partners and sexual situations.

Situational

The problem occurs only:

- With a particular partner
- In a particular environment

- During certain sexual activities
- Under certain psychological circumstances

This distinction can provide valuable clues regarding the underlying cause.

Symptoms of Premature Ejaculation

Common features include:

- Ejaculating sooner than desired
- Difficulty delaying ejaculation
- Feeling that ejaculation becomes uncontrollable very rapidly
- Ejaculation before penetration in severe cases
- Ejaculation soon after penetration
- Anxiety before sexual intercourse
- Fear of sexual failure
- Avoidance of intimacy
- Reduced sexual confidence
- Dissatisfaction after intercourse
- Partner frustration
- Relationship tension

The most important symptom is not simply “short timing.”

It is **lack of satisfactory control together with distress**.

Premature Ejaculation and Relationship Health

PE can affect both members of a couple.

The 2026 EAU guideline reports that affected men may have:

- Lower sexual satisfaction
- Lower relationship satisfaction
- Difficulty relaxing during intercourse

- Reduced self-confidence
- Anxiety
- Embarrassment
- Depression or emotional distress

Partner sexual satisfaction may also decline as the severity of the condition increases.

Sexual-health treatment should therefore consider the couple whenever appropriate rather than viewing ejaculation solely as an isolated male problem.

Does Premature Ejaculation Cause Infertility?

PE and infertility are **not the same condition**.

A man can have severe premature ejaculation while producing completely normal sperm.

Likewise, a man can have normal ejaculation timing but abnormal sperm count, motility or morphology.

However, very severe PE can interfere with natural conception when ejaculation repeatedly occurs before semen can be deposited inside the vagina.

Couples trying to conceive should also tell their doctor about their fertility plans because certain PE treatments require additional consideration during pregnancy planning.

How Is Premature Ejaculation Diagnosed?

In most patients, diagnosis does not require complicated machines or expensive investigations.

A detailed, confidential sexual and medical history is the most important diagnostic tool.

The EAU strongly recommends diagnosis based on medical and sexual history, including assessment of:

- Ejaculatory latency
- Perceived control
- Distress

- Interpersonal difficulty

It recommends against routine laboratory or physiological testing unless specific findings suggest that testing is needed.

Important Questions During Consultation

A doctor may ask:

- When did the problem begin?
- Was ejaculation normal previously?
- Does it happen every time?
- Does it occur with every partner?
- Approximately how quickly does ejaculation occur?
- Can you delay ejaculation?
- Do you have normal erections?
- Do you have morning erections?

- Is sexual desire normal?
- Do you have pelvic or urinary symptoms?
- Are you experiencing anxiety or depression?
- Are there relationship difficulties?
- Are you taking medications?
- Do you use alcohol or recreational drugs?
- Are you trying to achieve pregnancy?

These questions are medically important and should be discussed openly.

Intravaginal Ejaculatory Latency Time — IELT

The term **IELT** means the time between vaginal penetration and ejaculation.

Stopwatch measurement is frequently used in clinical research.

However, most patients do not need to time intercourse with a stopwatch.

Self-estimated IELT is generally adequate for routine clinical assessment, and the EAU emphasizes that IELT by itself is inadequate for fully characterizing PE.

Excessive timing can actually increase anxiety in some patients.

Premature Ejaculation Diagnostic Tool — PEDT

The **Premature Ejaculation Diagnostic Tool (PEDT)** is a short validated questionnaire.

It evaluates:

- Control over ejaculation
- Frequency of early ejaculation
- Ejaculation with minimal stimulation
- Personal distress
- Interpersonal difficulty

According to the EAU guideline:

- A score **above 11** supports PE
- **9–10** suggests possible PE
- A lower score makes PE less likely

A questionnaire helps assessment but does not replace clinical judgment.

Physical Examination

A focused physical examination may be appropriate, especially in acquired PE.

Depending on the history, the doctor may assess:

- Genital anatomy
- Signs of infection
- Prostate or pelvic symptoms
- Thyroid abnormalities
- Neurological signs
- Erectile dysfunction
- Other relevant medical conditions

Physical examination alone usually cannot diagnose lifelong PE, but it can identify another condition that requires treatment.

Are Blood Tests Required?

Not routinely.

Tests may be ordered only when medically indicated.

Examples include:

- Thyroid tests when hyperthyroidism is suspected
- Blood glucose or HbA1c if diabetes is suspected
- Hormonal tests when endocrine symptoms are present
- Urological tests when infection or pelvic disease is suspected

Routine semen analysis is also **not required simply because a patient has PE** unless fertility evaluation is needed.

Treatment of Premature Ejaculation

There is no single treatment that is ideal for every patient.

Treatment should be based on:

- Lifelong versus acquired PE
- Severity
- Erectile function
- Psychological health
- Medical conditions
- Relationship factors
- Previous treatment
- Fertility plans
- Patient preference

The treatment goal should not merely be to add minutes.

The larger goals are:

Better control, lower distress, greater confidence and improved sexual satisfaction.

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1. Treat the Underlying Cause

This is especially important in acquired PE.

If the problem is related to:

- Erectile dysfunction
- Prostatitis
- Hyperthyroidism
- Significant anxiety
- Relationship difficulty
- Another medical condition

the underlying problem should receive appropriate treatment.

The 2026 EAU guideline makes this a central treatment principle.

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2. Sexual Education and Counselling

Many patients benefit simply from learning what constitutes normal sexual function.

Important counselling points include:

- There is no mandatory intercourse duration.
- Pornographic performances are not a realistic medical standard.
- Occasional early ejaculation is normal.
- Masculinity is not measured in minutes.
- Satisfaction depends on more than penetration duration.
- Anxiety itself can worsen control.

Correcting misconceptions can significantly reduce distress.

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3. Behavioural Treatment

Behavioural methods aim to help the individual recognize increasing arousal and develop better control before reaching the point at which ejaculation becomes inevitable.

Stop–Start Technique

During sexual stimulation:

1. Stimulation is paused as ejaculation approaches.
2. The man waits until arousal decreases.
3. Stimulation begins again.
4. The cycle is repeated.

Over time, this can improve awareness of the stages of arousal.

Squeeze Technique

The squeeze technique also involves stopping stimulation near ejaculation and briefly applying pressure before resuming sexual activity.

It may be useful for selected couples but should not be considered a guaranteed standalone cure.

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4. Cognitive Behavioural and Psychosexual Therapy

Psychological treatment can address:

- Performance anxiety
- Fear of failure
- Catastrophic thinking
- Sexual communication
- Relationship conflict
- Excessive monitoring
- Unrealistic expectations

The 2026 EAU guideline notes that psychosexual approaches incorporating behavioural, cognitive, couple-based and mindfulness strategies can improve symptoms and associated distress. Combination with medical treatment may provide greater benefit than medication alone for some patients.

A 2025 systematic review also evaluated cognitive-behavioural therapy combined with SSRIs, reflecting continued research into combined treatment approaches.

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5. Dapoxetine

Dapoxetine is a short-acting selective serotonin reuptake inhibitor specifically designed for on-demand management of premature ejaculation.

It is approved for PE in many countries, although regulatory approval varies internationally.

Clinical trials reviewed by the EAU show improvement in:

- Ejaculatory latency
- Perceived control
- Distress
- Sexual satisfaction

Common side effects may include:

- Nausea
- Headache
- Dizziness
- Diarrhoea

Dapoxetine should be used following appropriate medical assessment because patient health, concurrent medicines and the possibility of dizziness or fainting must be considered.

It is also important to understand that medication generally manages symptoms while it is being used; it should not be advertised as permanently “resetting” ejaculation after a single course.

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6. Other Selective Serotonin Reuptake Inhibitors

Several antidepressant SSRIs can delay ejaculation.

Examples studied include:

- Paroxetine
- Sertraline
- Fluoxetine
- Citalopram

These are generally used **off-label** for PE.

The AUA/SMSNA guideline includes daily SSRIs among its recommended first-line pharmacological options, while the EAU considers daily SSRIs an effective alternative after approved on-demand therapies.

Potential adverse effects include:

- Nausea
- Fatigue
- Drowsiness
- Sweating
- Gastrointestinal symptoms
- Reduced libido
- Delayed orgasm
- Erectile difficulty in some men

Daily antidepressants should not be abruptly discontinued without professional advice.

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7. Clomipramine

Clomipramine is an older antidepressant with strong serotonergic action.

Clinical studies have shown that it can delay ejaculation in selected patients.

It is usually used off-label and requires medical assessment because adverse effects can occur.

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8. Topical Anaesthetic Treatment

Local anaesthetic preparations containing agents such as **lidocaine and prilocaine** reduce penile sensory stimulation.

They can significantly delay ejaculation for some patients.

Clinical evidence supports their efficacy, and the EAU recommends approved lidocaine/prilocaine spray as a first-line treatment option for lifelong PE.

Possible problems include:

- Excessive penile numbness
- Reduced sexual sensation

- Transfer to the partner
- Partner genital numbness or burning
- Occasional erection difficulty

Correct application is therefore important.

Depending on the formulation, residual medication may need to be removed or a condom used to reduce transfer to a partner.

Couples actively trying to conceive should discuss topical anaesthetic use with their clinician.

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9. Treatment of Coexisting Erectile Dysfunction

When erectile dysfunction and PE occur together, treating ED may improve the overall sexual situation.

PDE5 inhibitors such as sildenafil or tadalafil are primarily erectile-dysfunction medicines.

Some research suggests they may also improve confidence, perceived ejaculation control and sexual satisfaction in PE, particularly in selected patients or combination treatment.

The 2026 EAU guideline includes PDE5 inhibitors among possible options alone or in combination, whereas treatment should remain individualized.

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10. Tramadol

Tramadol can delay ejaculation because it affects opioid and serotonin/noradrenaline pathways.

However, it carries important risks, including:

- Sedation
- Drug interactions
- Dependence
- Addiction
- Breathing complications

The EAU therefore places tramadol as a later-line treatment and advises caution because long-term safety evidence for PE is limited.

Tramadol should **never be treated as an ordinary sexual "timing tablet" for unsupervised use.**

11. Pelvic-Floor Rehabilitation

Pelvic-floor muscles participate in ejaculation.

Some small studies suggest that appropriately supervised pelvic-floor rehabilitation may improve control in selected men.

This area remains promising but has a smaller evidence base than established drug treatments.

Importantly, pelvic-floor treatment should not simply mean performing hundreds of Kegel exercises.

Some men may have excessive pelvic-floor tension rather than weakness.

Professional assessment may therefore be preferable.

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12. Experimental and Invasive Treatments

Several procedures have been investigated, including:

- Hyaluronic-acid glans injections
- Neuromodulation
- Electrical stimulation
- Botulinum toxin
- Penile sensory procedures
- Selective dorsal penile neurectomy

These treatments do not have the same established evidence base as first-line medical approaches.

The EAU advises caution with hyaluronic-acid injection and specifically recommends **against dorsal neurectomy** because the procedure is irreversible and adequate long-term safety evidence is lacking.

Patients should therefore be cautious about clinics promising a “permanent cure” through nerve cutting or unvalidated injections.

Premature Ejaculation in the Unani System of Medicine

Sur‘at-i-Inzāl — The Unani Concept

Premature ejaculation has long been recognized within the Unani system of medicine.

The Central Council for Research in Unani Medicine (**CCRUM**), an autonomous research organization under India's Ministry of AYUSH, uses the term:

Sur'at-i-Inzāl / Sur'a al-Inzāl

for premature ejaculation.

CCRUM's official Unani Treatment Guidelines describe Sur'at-i-Inzāl as ejaculation occurring earlier than normal, sometimes shortly after penetration or even during sexual stimulation before penetration.

This demonstrates that premature ejaculation is not a newly recognized complaint within traditional medicine; it has been discussed and treated within Unani medical literature for generations.

The Traditional Unani Understanding

Unani medicine approaches health through an individualized understanding of:

- **Mizaj** — temperament
- **Akhlat** — humoral balance
- Organ function
- Diet
- Digestion
- Sleep
- Psychological state
- Physical activity
- General bodily strength

Classical Unani concepts should be understood in their historical medical framework rather than treated as direct equivalents of modern neurotransmitters, hormones or neurological pathways.

CCRUM's standard guideline describes several traditional mechanisms of Sur'at-i-Inzāl, including changes involving **Burudat** (coldness), **Rutubat** (moisture) and weakness of **Quwwat Masika**, traditionally understood as the retentive faculty. It also recognizes other possible temperament-based mechanisms rather than assigning every patient to one identical cause.

Quwwat Masika — Retentive Faculty

Within classical Unani terminology, **Quwwat Masika** refers broadly to a retaining faculty.

Weakness of this faculty has traditionally been associated with inability to retain seminal discharge adequately.

This concept is not the biomedical equivalent of a serotonin receptor or pelvic nerve. Rather, it represents a traditional functional explanation within Unani medical theory.

Responsible modern Unani practice can preserve this traditional framework while also ensuring that medical conditions such as:

- Erectile dysfunction
- Thyroid disease
- Diabetes
- Prostatitis
- Anxiety
- Depression

are not overlooked.

Unani Treatment Philosophy for Premature Ejaculation

A major strength of Unani clinical practice is its emphasis on **individualized rather than one-size-fits-all treatment**.

Traditional management can include:

Ilaj bil-Ghiza

Dietary management

Ilaj bit-Tadbir

Regimenal or lifestyle management

Ilaj bid-Dawa

Treatment through medicinal formulations

The formulation chosen traditionally depends on the patient's:

- Mizaj

- General health
- Associated sexual symptoms
- Digestive function
- Sleep
- Mental stress
- Sexual history
- Physical strength
- Other diseases

This individualized approach is particularly relevant to PE because modern medicine also recognizes that the condition has several different subtypes and causes.

Mumsik and Mughalliz-e-Mani in Unani Pharmacology

Traditional Unani literature uses pharmacological terms including:

Mumsik — medicines traditionally intended to improve retention or delay discharge.

Mughalliz-e-Mani — medicines traditionally described as influencing the consistency of seminal material.

These are Unani pharmacotherapeutic concepts and should not be mistaken for modern pharmacological mechanisms.

The current National Formulary material continues to list Unani preparations with traditional **Mumsik** action and Sur'at-i-Inzāl among their therapeutic uses.

Scientific Research on Unani Treatment of Premature Ejaculation

The role of Unani medicine in PE is not limited to historical literature.

The **Central Council for Research in Unani Medicine**, Ministry of AYUSH, has conducted and continues to support scientific investigation into traditional formulations for Sur'at-i-Inzāl.

CCRUM describes itself as India's apex government organization for scientific research into Unani medicine, working in clinical research, drug standardization and other areas.

Clinical Validation of Majoon-e-Piyaz

A CCRUM annual report described clinical validation of the Unani pharmacopoeial formulation **Majoon-e-Piyaz** in patients with Sur'at al-Inzāl.

In that programme, 114 patients were studied and 103 completed treatment. Among the completers, the report classified 39 as relieved, 42 as partially relieved and 22 as showing no response; no adverse effect was reported during the programme.

A separate clinical-validation publication in 2023 studied 105 patients, of whom 80 completed the trial, and reported varying degrees of improvement without detected hepatotoxicity or nephrotoxicity during the study period.

These findings are **encouraging**, but they should be interpreted correctly.

Such studies do not establish that every patient will respond, nor are they equivalent to large multicentre, placebo-controlled trials.

They provide clinical evidence supporting continued research into traditional Unani formulations.

Continuing CCRUM Research

Research remains active.

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

Furthermore, CCRUM's 2026 research material continues to list **Sur'a al-Inzāl** among the male uro-genital disorders relevant to Unani research.

This ongoing work is important because it moves Unani therapeutics from historical experience toward increasingly systematic evaluation.

What Does the Evidence Mean for Patients?

The scientifically responsible conclusion is neither:

"Unani medicine has no role,"

nor:

"Every Unani medicine permanently cures PE."

A more accurate conclusion is:

Unani medicine has a long-established therapeutic tradition for Sur'at-i-Inzāl, government-recognized treatment guidelines and an expanding body of clinical research. Some studied formulations have shown encouraging clinical results, but larger and methodologically stronger trials are still needed to determine precisely which treatments are most effective for which patients.

This is particularly important because "Unani treatment" is not one single drug.

Different formulations can have:

- Different ingredients
- Different doses
- Different indications
- Different safety profiles
- Different levels of clinical evidence

Therefore, results from one studied formulation cannot automatically be applied to every herbal or Unani medicine marketed for PE.

There Is No Scientifically Established Universal Success Rate

No responsible medical system—Unani or modern—should promise that PE will be cured in a fixed percentage of every patient without defining:

- Patient type
- Treatment used
- Duration
- Outcome measure
- Follow-up period
- Whether treatment benefits remained after stopping therapy

For PE, "success" itself can mean different things:

- Longer ejaculation latency
- Improved control
- Lower PEDT score
- Reduced anxiety

- Greater patient satisfaction
- Greater partner satisfaction
- Improvement maintained after treatment

For this reason, there is currently **no scientifically defensible universal cure percentage for Unani treatment of premature ejaculation**.

Individual outcomes vary.

Why an Integrative Approach Can Be Valuable

A thoughtfully delivered Unani approach can be particularly useful because it encourages clinicians to consider the patient as a whole.

A comprehensive evaluation may include:

- Sexual history
- Lifestyle
- Diet
- Digestion
- Sleep
- Stress
- General health
- Mizaj
- Erectile function
- Fertility concerns
- Existing diseases

Modern sexual medicine similarly emphasizes individualized treatment and recognition of biological, psychological and relationship factors.

The two frameworks use different theoretical languages, but both can contribute to a **patient-centred approach when appropriately practiced**.

A responsible integrative model does not reject modern diagnosis. Instead, it uses appropriate investigation where necessary while retaining individualized Unani assessment and treatment.

Dr. Nizamuddin Qasmi and the Saira Health Care Approach

Dr. Nizamuddin Qasmi is the founder and chief physician associated with Saira Health Care, Barabanki, Uttar Pradesh.

According to Saira Health Care's official professional profile, his listed qualifications include:

- **BUMS — Bachelor of Unani Medicine and Surgery**
- **MD**
- **CGO**
- **Certificate in Infertility**

The clinic's official profile identifies his focused field of practice as **sexual disorders and infertility** and lists premature ejaculation, erectile dysfunction and multiple male and female fertility disorders among the conditions addressed in his clinical work.

The profile also describes clinical experience at institutions including:

- Hakeem Abdul Hameed Centenary Hospital
- Majeedia Unani Hospital
- Dr. Hedgewar Arogya Sansthan
- Pt. Madan Mohan Malviya Hospital
- Life Rays Hospital
- District Hospital, Barabanki

These professional details are those published by Saira Health Care in its official physician biography.

Specialized Focus on Sexual Disorders and Infertility

Sexual disorders require a particularly sensitive approach because patients may delay professional consultation for months or years because of embarrassment.

Dr. Qasmi's clinical focus, as described by Saira Health Care, includes areas such as:

Male Sexual Disorders

- Premature ejaculation
- Erectile dysfunction

- Loss of libido
- Other ejaculation-related complaints

Male Infertility

- Azoospermia
- Oligospermia
- Asthenospermia
- Teratospermia
- Necrospermia
- Increased pus cells in semen
- Varicocele
- Epididymal cyst

Female Reproductive Health

The clinic also reports work involving selected female fertility and reproductive-health conditions.

This focused exposure to sexual and reproductive-health complaints is particularly relevant because premature ejaculation frequently overlaps with erectile problems, fertility concerns, anxiety and relationship stress.

Special Treatment Approach at Saira Health Care

Saira Health Care describes its consultation model as involving:

- Detailed history taking
- Evaluation of symptoms
- Assessment of **Mizaj**
- Review of associated conditions
- Individualized prescription planning

Its current service information explicitly lists **premature ejaculation and timing problems** among its male sexual-health services and states that consultation includes history taking, Mizaj assessment and an individualized prescription plan.

This is an important distinction.

A specialist approach to PE should not mean giving every patient the same "timing medicine."

A man with lifelong PE since his first sexual experience may require a different plan from:

- A diabetic man who recently developed PE
- A man whose PE began after erectile dysfunction
- A patient with prostatitis
- Someone with severe performance anxiety
- A couple attempting pregnancy
- A man with normal ejaculation time but unrealistic expectations

Individualized treatment is therefore medically appropriate.

Combining Traditional Assessment With Appropriate Modern Investigation

For a patient with PE, a responsible consultation may consider:

The Sexual Problem

- Duration of PE
- Lifelong versus acquired
- Ejaculation timing
- Ejaculatory control
- Sexual satisfaction
- Partner concerns

Erectile Health

- Quality of erection
- Ability to maintain erection
- Morning erections

General Medical Health

- Diabetes
- Thyroid disease
- Urological symptoms

- Medication history
- Sleep
- Mental health

Unani Assessment

- Mizaj
- Diet
- Digestion
- Lifestyle
- General strength
- Associated traditional symptom patterns

This approach allows traditional Unani treatment to be used without ignoring an underlying medical disorder.

Contribution of Saira Health Care to Sexual-Health Awareness

Sexual-health misinformation remains widespread.

Common myths include:

- Every early ejaculation means permanent sexual weakness.
- PE means infertility.
- PE proves low testosterone.
- Masturbation permanently destroys sexual power.
- A “strong” herbal medicine can cure every patient.
- Intercourse must last a fixed number of minutes.

These misconceptions can make patients anxious and vulnerable to unregulated sexual-performance products.

Saira Health Care describes a broader mission involving patient education, individualized consultation and sexual- and fertility-health awareness in addition to clinical treatment. Its official profile also documents extensive educational activity through its digital platforms.

Education is an important contribution because understanding the difference between PE, ED and infertility can help patients seek appropriate professional care rather than rely solely on advertisements or myths.

Why Specialist Consultation Matters

Premature ejaculation may appear to be a simple timing problem, but the same symptom can arise in very different patients.

Consider these examples:

Patient A

A 25-year-old has ejaculated within approximately one minute during almost every intercourse since his first sexual experience.

This pattern may be consistent with lifelong PE.

Patient B

A 48-year-old previously had normal control but recently developed both erection difficulty and rapid ejaculation.

His ED and cardiovascular or metabolic health may require assessment.

Patient C

A man has normal intercourse duration but believes that sexual intercourse should last 30–60 minutes because of online videos.

He may primarily require counselling rather than medicine.

Patient D

A man suddenly develops PE together with palpitations, sweating and weight loss.

Thyroid disease may require evaluation.

Patient E

A patient develops rapid ejaculation together with pelvic pain and urinary symptoms.

Urological evaluation may be appropriate.

Giving all five patients the same medicine would not represent good clinical practice.

Lifestyle Measures That Support Sexual Health

Lifestyle changes alone cannot be guaranteed to cure lifelong PE.

However, healthy habits can improve overall physical and psychological sexual health.

Helpful measures include:

- Regular physical activity
- Adequate sleep
- Maintaining a healthy body weight
- Good diabetes control
- Limiting excessive alcohol
- Avoiding recreational drugs
- Stopping tobacco use
- Managing stress
- Treating depression or anxiety
- Maintaining open communication with a partner

These measures may be particularly useful when PE is associated with stress, metabolic disease, ED or general poor health.

Communication With the Partner

A partner should not be viewed as merely an observer of treatment.

Open communication can reduce:

- Pressure
- Misunderstanding
- Blame
- Fear of failure

Sexual intimacy does not depend solely on penetration.

Reducing pressure to “perform for a certain number of minutes” can itself improve confidence for some men.

Couple-based counselling may therefore be valuable when relationship distress has developed.

SAIRA HEALTH CARE
An ISO Certified Clinic
SEXUAL DISORDERS & INFERTILITY CENTER

Common Myths About Premature Ejaculation

Myth 1: Every Man Who Ejaculates Quickly Has PE

Fact: Occasional early ejaculation is normal. Persistent lack of control and distress are important for diagnosis.

Myth 2: Premature Ejaculation Means a Man Is Infertile

Fact: Ejaculation timing and sperm quality are different issues.

Myth 3: PE Is Always Due to Weak Nerves

Fact: PE is multifactorial. Neurological signaling, psychological factors, associated ED and other health issues can contribute.

Myth 4: Low Testosterone Is the Main Cause

Fact: PE does not automatically indicate testosterone deficiency.

Myth 5: Circumcision Automatically Cures PE

Fact: Current AUA guidance states that ejaculatory latency is not determined simply by circumcision status.

Myth 6: Stronger Penile Numbing Is Always Better

Fact: Excessive anaesthetic can cause numbness, partner transfer and reduced sexual sensation.

Myth 7: Surgery Provides a Guaranteed Permanent Cure

Fact: Major guidelines advise caution with invasive sensory procedures and do not recommend routine dorsal neurectomy because of safety concerns.

When Should You Consult a Doctor?

Professional evaluation is advisable when:

- Early ejaculation occurs repeatedly
- Control is consistently poor
- The problem causes significant distress
- Sexual confidence is decreasing
- Relationship problems are developing
- Sexual activity is being avoided
- PE suddenly appears after years of normal function
- Erectile dysfunction is present
- Pelvic or urinary symptoms are present
- Thyroid symptoms are suspected
- Fertility is a concern
- Previous treatment has not helped
- You are considering long-term medication

When Is Further Investigation Particularly Important?

Acquired PE should receive additional attention when accompanied by:

- New erectile dysfunction
- Major change in sexual desire
- Pelvic pain
- Painful ejaculation
- Urinary symptoms
- Symptoms of thyroid disease
- Significant depression or anxiety
- Newly diagnosed diabetes
- Major medication changes

Tests should then be selected according to the suspected condition.

Frequently Asked Questions

Is premature ejaculation curable?

PE can often be managed successfully, and substantial improvement in control, distress and sexual satisfaction is possible.

However, the word **“cure”** should be used carefully.

Some treatments work primarily while they are being used, while behavioural, psychological and management of underlying causes may produce longer-lasting benefits in selected patients.

Individual outcomes vary.

What is a normal ejaculation time?

There is no single ideal time.

A diagnosis should not be based solely on minutes.

Control and distress are equally important.

Is one minute always abnormal?

Not automatically.

For lifelong PE, approximately one minute forms part of the ISSM definition, but clinical diagnosis also requires poor control and negative consequences.

Can stress cause PE?

Yes.

Stress and anxiety can contribute to PE or worsen an existing biological tendency.

Can erectile dysfunction cause premature ejaculation?

Yes.

Some men hurry intercourse because they fear losing their erection.

Treating associated ED may therefore be an important part of PE management.

Does diabetes cause PE?

Diabetes has been associated with sexual dysfunction and PE in observational research, but not every diabetic patient develops PE.

Does masturbation cause permanent premature ejaculation?

There is no good evidence that masturbation itself inevitably causes permanent PE.

Some individuals may develop a habit of rushing ejaculation during masturbation, but such behavioural patterns are different from claiming permanent physical damage.

Are Kegel exercises useful?

Pelvic-floor rehabilitation may help selected patients, but unsupervised excessive strengthening is not appropriate for everyone.

Can Unani medicine help premature ejaculation?

Unani medicine has a long-established framework for **Sur'at-i-Inzāl**, including individualized Mizaj assessment, dietary and regimenal principles and traditional medicinal formulations.

CCRUM treatment guidelines formally recognize the condition, and government research programmes have evaluated Unani pharmacopoeial formulations for PE. Some clinical-validation findings are encouraging, and comparative validation research continues.

However, the effectiveness of individual formulations should be judged according to their specific evidence, and treatment should not delay diagnosis of another underlying disease.

Is herbal treatment completely free from side effects?

No.

"Natural" does not automatically mean risk-free.

Herbal and traditional medicines may:

- Produce adverse effects
- Interact with other medicines
- Influence blood sugar or blood pressure
- Be unsuitable for particular diseases
- Vary in quality

Professional supervision is therefore important.

Prognosis

The overall outlook for PE is generally favourable.

Many patients experience meaningful improvement through one or more of the following:

- Education
- Treatment of underlying disease
- Pharmacotherapy
- Behavioural training
- Psychological care
- Couple-based intervention
- Individualized traditional or Unani management

Treatment success should be defined by the patient's own meaningful goals rather than by an arbitrary stopwatch target.

For one person, meaningful improvement may mean increasing ejaculation time.

For another, the greatest improvement may be:

- Feeling in control
- No longer fearing sexual activity
- Better communication with a partner
- Improvement in associated ED
- Reduced distress

A Balanced Modern and Unani Approach

Premature ejaculation provides a good example of why medicine should avoid extremes.

It is inappropriate to dismiss centuries of traditional clinical experience without investigation.

It is equally inappropriate to claim that historical use alone proves that every traditional formulation is effective.

The strongest approach is:

Traditional knowledge + individualized assessment + modern diagnostic awareness + scientific research + responsible safety monitoring.

This approach allows Unani medicine to retain its authentic philosophy while benefiting from modern methods of clinical evaluation.

CCRUM's continuing research programme demonstrates that formal scientific investigation of Unani treatment for Surʻat-i-Inzāl remains active in India.

Role of Dr. Nizamuddin Qasmi and Saira Health Care

At Saira Health Care, the stated clinical model under **Dr. Nizamuddin Qasmi** focuses particularly on sexual disorders and infertility.

Saira Health Care's official information lists Dr. Qasmi's professional qualifications as **BUMS, MD, CGO and Certificate in Infertility** and describes previous clinical experience in several hospitals before establishing his focused practice in Barabanki.

The clinic states that patients are evaluated through detailed history taking, Mizaj assessment and individualized prescription planning rather than being offered a single standard treatment simply because they report early ejaculation.

This personalized model can be especially useful in premature ejaculation because correct management depends on determining whether the problem is:

- Lifelong
- Acquired
- Situational
- Variable
- Subjective
- Associated with ED
- Related to another health disorder
- Predominantly psychological
- Complicated by fertility concerns

Saira Health Care's broader contribution has also included public education concerning sexual disorders and infertility—subjects about which many patients remain reluctant to seek reliable information.

Conclusion

Premature ejaculation is not simply a disease of "short timing."

It is a recognized male sexual dysfunction characterized by a combination of:

- Earlier-than-desired ejaculation
- Difficulty controlling or delaying ejaculation
- Associated distress or relationship consequences

Current evidence recognizes several different forms of PE.

Lifelong PE is generally present from the earliest sexual experiences, whereas **acquired PE** appears after previously satisfactory control and may be associated with conditions such as erectile dysfunction, prostatitis, hyperthyroidism or psychological stress.

Diagnosis should primarily be based on a careful medical and sexual history rather than unnecessary laboratory testing.

Evidence-based treatment can include:

- Management of underlying disorders
- Psychosexual counselling
- Behavioural approaches
- Dapoxetine
- Other SSRIs
- Clomipramine
- Topical anaesthetics
- Selected combination treatment
- Pelvic-floor rehabilitation in appropriate patients

Invasive or poorly validated interventions require greater caution.

The **Unani system of medicine** recognizes premature ejaculation as **Sur'at-i-Inzāl** and offers a structured tradition of individualized treatment based on Mizaj, diet, lifestyle, regimenal care and medicinal formulations. CCRUM under the Ministry of AYUSH has formally published Unani treatment guidance for the condition and has conducted clinical-validation research into traditional formulations. Research remains active, including comparative clinical validation programmes listed in recent CCRUM reports.

This scientific activity supports the continued investigation of Unani medicine while also demonstrating why claims should remain specific to the formulation and evidence being discussed.

Within Saira Health Care, Dr. Nizamuddin Qasmi's official professional profile lists **BUMS, MD, CGO and Certificate in Infertility**, together with a focused clinical practice in sexual disorders and infertility. The clinic describes its approach as individualized Unani assessment combined with attention to diagnosis, lifestyle and relevant modern diagnostic information.

The most important message for patients is straightforward:

Premature ejaculation is common, it is not a measure of masculinity, it should not be a source of shame, and meaningful improvement is possible when the type and underlying contributing factors are correctly identified and treatment is individualized.

Key Points for Patients

- Occasional early ejaculation is normal.
- PE is not diagnosed from intercourse duration alone.
- Lifelong and acquired PE are different conditions.
- Erectile dysfunction and PE frequently coexist.
- Acquired PE may require evaluation for another underlying problem.
- Complex laboratory testing is not routinely necessary for lifelong PE.
- Several evidence-supported medical and behavioural treatments are available.
- Unani medicine has a recognized traditional framework for Surʻat-i-Inzāl and is the subject of continuing CCRUM research.
- No treatment—modern, herbal or Unani—should promise the same result for every patient.
- Individualized professional consultation is preferable to unsupervised use of sexual-performance products.

Medical Disclaimer

This article is intended for **general health education and public awareness** and is not a substitute for individual medical diagnosis or treatment.

Premature ejaculation can have biological, psychological, relationship-related and medical causes. Treatment should therefore be selected according to the patient's clinical history, subtype of PE, associated medical conditions, concurrent medicines and reproductive plans.

Traditional Unani concepts presented here describe the established theoretical framework of the Unani system of medicine and should not be interpreted as substitutes for scientifically established neurological, endocrine or urological mechanisms.

Research into Unani treatments for Sur'at-i-Inzāl is ongoing. Results reported for one Unani formulation should not be assumed to apply to every traditional or herbal product.

Patients should consult an appropriately qualified healthcare professional before beginning, stopping or changing prescription medicines, topical anaesthetics, antidepressants, herbal formulations, supplements or other treatments.

Newly acquired PE, particularly when accompanied by erectile dysfunction, pelvic or urinary symptoms, major psychological distress or other systemic symptoms, deserves professional medical evaluation.