Volume 3, Issue 12, December 2025 ISSN (E): 2938-3765

IMPROVE OF "UZBEK INDEX OF PREMATURE EJACULATION

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Abstract
A questionnaire developed to test the "Uzbek Premature Ejaculation Index". The main goal is to exclude the gray zone (13-16 points) from the scoring system of the Uzbek Index of Premature Ejaculation. The study was conducted from October 2020 to April 2023 at the Republican Specialized Scientific and Practical Medical Center of Urology in partnership with the Department of Urology of the Tashkent Medical Academy. In our study, 200 male patients aged 20 to 50 years who had been in a stable sexual relationship for at least six months completed the Uzbek Index of Premature Ejaculation Questionnaire. They were monogamous. A group of 30 patients, each with a score between 13 and 16, was randomly assigned to the UIPE Questionnaire, which was filled out by 200 male patients who had experienced premature ejaculation. Other accompanying illnesses were examined and treated for them. The treatment control group was prompted to complete the questionnaire. Treatment-free patients with concomitant diseases who scored 13 in the control group demonstrated a significant increase in IELT. The IELT of patients with 14 16 scores showed no change. Despite the fact that a 13 score is not indicative of PE, it can be used to treat concurrent diseases and alleviate symptoms of early childhood illness. It has been determined that a score of 13 or higher is not diagnosticable in PE and should not be sought through further diagnosis. "Uzbek Index of Premature Ejaculation" is the validated measure for outcomes measured by the patient.

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

Introduction

Epidemiology: Premature ejaculation (PE) is very common among sexually active men. There are several definitions developed with various organizations regarding PE. It is considered as an inability to consciously control the ejaculatory reflex or as a condition in which a man reaches orgasm and ejaculates earlier than he desires. [1]. The World Health Organization (WHO) describes premature ejaculation as "the inability to delay ejaculation sufficient to enjoy lovemaking, which is manifested by either an occurrence of ejaculation before or very soon after the beginning of intercourse or ejaculation occurring in the absence of sufficient erection to make intercourse possible [1].

During the last decade, the prevalence of PE is increasing in all countries. Prevalence of PE as a 'sexual dysfunction' according to the modified International Society of Sexual Medicine (ISSM) definition of was 3.3% (n=81), whereas the prevalence of PE as a 'sexual complaint' (i.e., men who estimated their time to ejaculation was occasionally very short, suffered to some extent from PE and had a lack of ejaculation control) was 14.5% (n=356). Men attributed PE predominantly to

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particularly high sexual arousal (75%) or a long time since the last sexual intercourse (53%), but less than one third of all men with PE (30%) considered PE a 'disease'. Potential self-reported risk factors showed significant differences PE [2].

The overall age-adjusted prevalence of self-identified PE increased from 19.0% in 2006 to 21.6% in 2016; however, the result was not statistically significant (P = .244). The overall age-adjusted prevalence of PE increased from 1.8–4.0% in 2006 and 2016, respectively (P = .012). [3].

Additionally, 30% of men with premature ejaculation also report experiencing erectile dysfunction; in this case, early ejaculation occurs in the absence of a full erection [1]. Furthermore, prevalence of PE proportionally increased with age. 64.6% of patients presented lifelong PE vs 35.4% of patients who reported acquired PE. Estimated prevalence of coexisting PE and erectile dysfunction was 7.0% [4].

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

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

The UIPE's eight questions investigate premature ejaculation and include questions on control, frequency, duration, anxiety, partner'd opinion, and sexual satisfaction. A score of 0 to 4 points can be given to each question, with a range of between 0-32. The UIPE begins with two unscored question at the end and can help determine PE males' gender. Why. The score for PE can be adjusted to indicate patient have not PE (0,01), patient having PE requiring further diagnosis (13 16) (gray zone), or patient had PE (17 32). There is internal consistency and reliability in the eight question set that are sensitive to treatment response. Questioning methods include those that establish the diagnosis and consider specific treatment options, as well supplementary questions that gather information for administering treatments. The health care practitioner's office often experiences patients with embarrassing, timid, and hesitant reactions when they bring up their sexual complaints. Through UIPE, patients can avoid the need for face-to-face contact with doctors and instead answer all questions independently. Why is this so. The short duration and simplicity of its administration make it a valuable tool for measuring treatment effectiveness in clinch.

Methods:

This cross-sectional study was conducted on base of Republican Specialized Scientific and Practical Medical Center of Urology, Tashkent Medical Academy, for three years duration, from October 2020 to April 2023. In our study 200 patients, aged 20 to 50 year males, who were in a stable sexual relationship for a minimum duration of six months, were asked to fill the UIPE Questionnaire. All

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patients with age 20 to 50 years, who were in a stable sexual relationship for a minimum duration of six months, visiting the Republican Specialized Scientific and Practical Medical Center of Urology that agreed to participate in the study were included. Study participants were given information about the study procedure and informed written consent was obtained. The UIPE questionnaire was accurate in diagnosing PE and the questions were easy to read and understand by the participants. Data was collected for demographics including age, frequency of intercourse, marital status, duration of the relationship, self-reported IELT, type of PE (lifelong vs acquired).

Results:

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

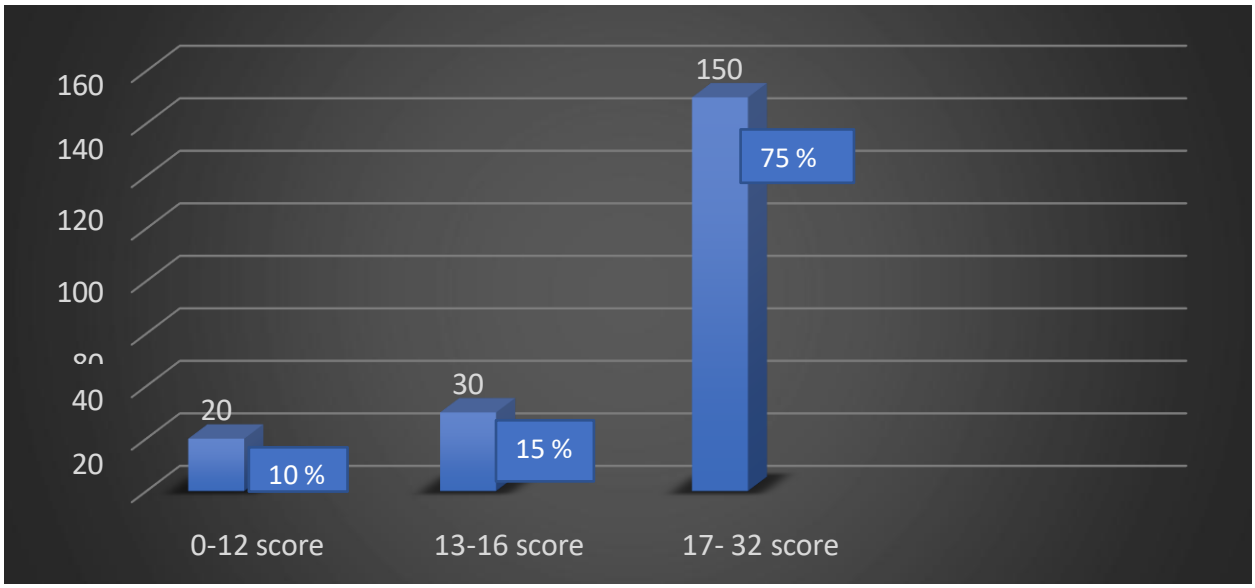

Table 1.

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

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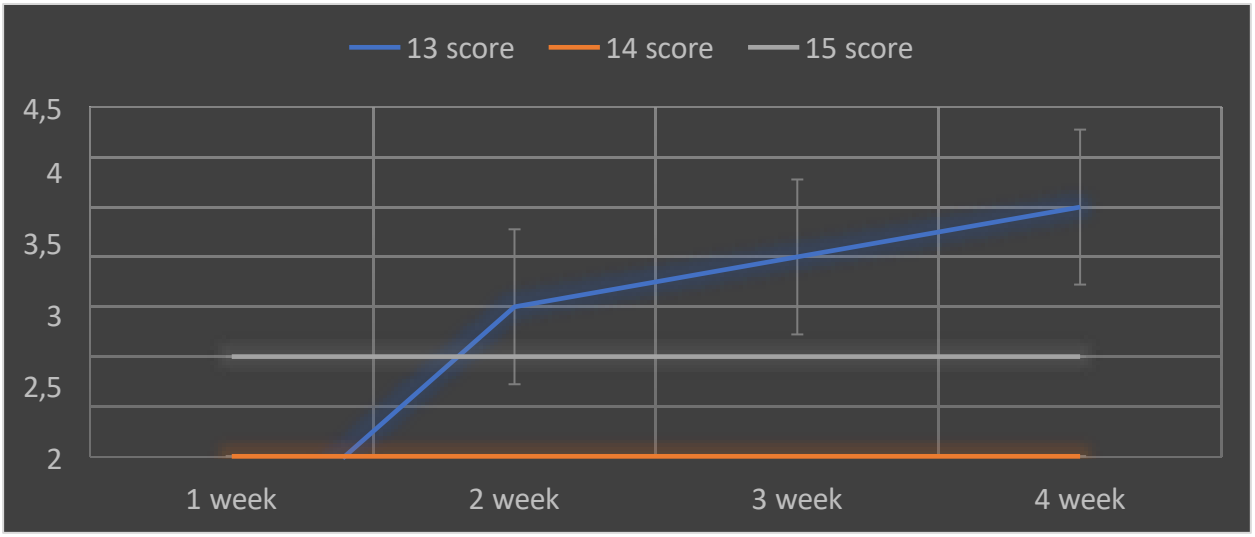
Table 2.

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

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



Line 3.

Discussion

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

There have been variety of studies concerning the validity of premature ejaculation diagnostic tool (PEDT) in the diagnosis of PE. One of these studies Development and validation of a premature ejaculation diagnostic tool. The questionnaire development involved three stages: (1) Five focus groups and six individual interviews were conducted to develop the content; (2) psychometric validation using three different groups of men; and (3) generation of a scoring system. For

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psychometric validation/scoring system development, data was collected from (1) men with PE based on clinician diagnosis, using DSM-IV-TR, who also had IELTs < or =2 min (n=292); (2) men self-reporting PE (n=309); and (3) men self-reporting no-PE (n=701). Standard psychometric analyses were conducted to produce the final questionnaire. Sensitivity/specificity analysis was used to determine an appropriate scoring system [10].

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

Additionally, Yan-Ping Huang MD, PhD and his colleague tried to validate A Chinese version of PEDT. A Chinese version of PEDT was confirmed by andrologist and bilingual linguist. Participants were recruited among seven different communities of Shanghai from 2011 to 2012, and their information regarding self-reported PE, self-estimated IELT, expert diagnosis of PE, and PEDT scores were collected [9]. A total of 143 patients without PE (mean age 55.11 ± 7.65 years) and 100 men with PE (mean age 53.07 ± 8.08 years) were enrolled for validation. Of the patients in PE group, the number of men reporting self-estimated IELTs of ≤1, 1–2, and >2 minutes were 34 (34.0%), 22 (22.0%), and 44 (44.0%), respectively. The Cronbach's alpha score ($\alpha = 0.77$) showed adequate internal consistency, and the test– retest correlation coefficients of each item ($r \geq 0.70$, $P < 0.001$) indicated excellent stability over time. The frequency of agreement showed that there was excellent concordance between PEDT diagnosis and clinician diagnosis when the PEDT scores ≥11. An adequate correlation was found between total PEDT score and self-estimated IELT ($\rho = -0.396$, $P < 0.001$), and sensitivity and specificity analyses suggested a score of ≤8 indicated no time-defined PE (self-estimated IELT ≤1 minute) [9].

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

Study limitations. Our study is conducted in a small number of respondents and has limitations that we need to state. Therefore, in future research, a large number of respondents are required to increase the sensitivity of our questionnaire.

Conclusion

It was thought that patients who scored 13 on the UIPE questionnaire might have PE. The study proved that 13 points is not an indicator of PE, and physicians should pay attention to their comorbidities to clarify PE.

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