MIMS

Guidelines on Premature Ejaculation by Society for Men's Health (Singapore)

SINGAPORE 2013

A special edition supported by an educational grant from A. Menarini Singapore

Society for Men's Health
(Singapore)

ABOUT US

The Society for Men's Health (Singapore) was formed initially named as the Society for the Study of Aging Males Singapore on 9 July 1999 by a group of concerned clinicians. In the course of the years and changing perspective, in 5 October 2005 the Society was renamed the Society for Men's Health (Singapore) in keeping with the objective to focus on the clinical and related issues of the healthy male as he grows and matures from boyhood to manhood and not just aging alone.

The Society for Men's Health (Singapore) SMHS develops and implements training programmes for medical professionals, nurses and others to promote men's health and aging. Having been around for 14 years, The Society for Men's Health (Singapore) has been very beneficial to public especially to men in older years. It provides different activities to share the society's commitment to education, and has developed and presented programmes that also helps numerous medical practioners through seminars and lectures.

ACTIVITIES

The society organises training programmes and CME courses to equip our members with latest knowledge and skills in the management of men's health and development. As part of our effort, this year the society has put together a series of comprehensive guidelines for clinicians in the field of men's health.

To find out more about our membership, CME Courses and to get a copy of our guidelines, kindly contact us .

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Contents

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Society for Men's Health (Singapore)

Introduction

Definition

Premature ejaculation (PE) is a condition where a man ejaculates earlier than he or his partner would like him to. Premature ejaculation is also known as rapid ejaculation, rapid climax, premature climax, or early ejaculation.

With the social stigma attached to the nomenclature of 'premature ejaculation', there is a trend and preference towards the term Rapid Ejaculatory Dysfunction (RED), akin to how the term Erectile Dysfunction (ED) swung the stigma away from Impotence.

Prevalence

PE is one of the most common male sexual disorders affecting 20%-30% of men.[1] Thirty percent of men with PE have concomitant ED.[2] A study in Singapore on 243 men aged 18-55 years old noted that 20% of the respondents have PE, which is similar to the prevalence in Caucasian population.[3] Current evidence supports an average Intravaginal Ejaculation Latency Time (IELT) of 6.5 minutes in 18-30 year old men.

Diagnosis

The Second International Consultation on Sexual and Erectile Dysfunction defines PE as "ejaculation with minimal stimulation and earlier than desired before or soon after penetration, which causes bother or distress, and over which the sufferer has little or no voluntary control".[4] The International Society for Sexual Medicine defines lifelong PE as "a male sexual dysfunction characterized by ejaculation which always or nearly always occurs prior to or within about one minute of vaginal penetration; and inability to delay ejaculation on all or nearly all vaginal penetrations; and negative personal consequences, such as distress, bother, frustration and/or the avoidance of sexual intimacy".[5] In the DSM-5 published by the American Psychiatric Association, premature (early) ejaculation is defined as "a persistent or recurrent pattern of ejaculation occurring during partnered sexual activity within approximately 1 minute following vaginal penetration and before the individual wishes it".[6]

Note the common themes in these definitions:

- The time to ejaculation
- Inability to control or delay ejaculation
- Negative consequences like bother or distress from PE

History

PE can be divided into lifelong (primary) or acquired (secondary).[7] Lifelong PE is characterized by onset from the first sexual experience and remains a problem throughout life. For lifelong PE, ejaculation can happen very fast, before vaginal penetration or very shortly after. For patients with acquired PE, they have normal ejaculation prior to the onset of the problem. Time to ejaculation is short but is not usually as fast as in lifelong PE.

PE should also be classified as being situational (under specific circumstances or with a specific partner) or consistent.

Time to ejaculation and degrees of sexual stimulation should also be noted.

Besides establishing the nature of PE, it is important to find out how PE affects sexual life.

Physical Examination

In most men with PE, physical examination is likely to be normal. However, a complete physical examination may be useful to screen for other sexual dysfunction. This includes a rough endocrinological, neurological, vascular examination, and the examination of the external genitalia.

For endocrinological examination, virility can be assessed to look for signs of hypogonadism. For neurological examination, lower limb strength and reflexes, including plantar and anal reflexes, should be assessed. Lower limb vascularity should be examined to look for signs of vascular disease.

For the external genitalia, the glans should be examined for any deformities. The examiner should palpate the shaft of the penis to feel for plaques which is suggestive of Peyronie's disease. The testes should also be felt for the presence of nodules and size.

Instrument

To help diagnose as well as monitor therapy for PE, various instruments have been formulated. Intravaginal Ejaculatory Latency Time (IELT) has been used for a long time but may be cumbersome for clinicians to use. Premature Ejaculation Diagnostic Tool (PEDT) is a more recent instrument, which could be more convenient as it involves the use of a self-administered questionnaire. Other instruments include Premature Ejaculation Profile (PEP),[8] the Index of Premature Ejaculation (IPE), and the Male Sexual Health Questionnaire Ejaculatory Dysfunction (MSHQ-EjD).[9]

IELT

IELT or Intravaginal Ejaculatory Latency Time refers to the time between penetration into the vagina and ejaculation. Ideally, it should be timed with a stop watch. As it takes two persons to perform sexual intercourse, the timing can be done by the man or his partner. Certain studies have shown that IELT timed by the partner tend to be shorter than that done by the man himself, sometimes by as much as half.

In everyday clinical practice, self-estimated IELT is sufficient.

The value of IELT by which PE is diagnosed has not been agreed upon as there is significant overlap of IELT between men with and men without PE. Most studies use IELT of 1 or 2 minutes for the diagnosis of PE, but Waldinger[10] found that some studies use an IELT of as high as 5 minutes.

Going back to the definitions of PE, IELT reflects only time, which is only one of the three components in the statements. The other 2 aspects – inability to control and negative impact on quality of life, are equally important.

PEDT

Premature Ejaculation Diagnostic Tool (PEDT) is a self-administered questionnaire to help clinicians screen and assess PE and its treatment (Appendix I). The use of PEDT has been validated in a study by Symonds.[11]

Investigation

Laboratory investigations are generally not necessary for assessment of PE. Specific investigations can be ordered based on findings from history or physical examination, for example, endocrinopathies.

Treatment

The principles of therapy are essentially:

Lifelong PE – pharmacotherapy. In lifelong PE, behavioural techniques are not recommended for first line treatment because they are time-intensive, require the support of a partner, and can be difficult to do.

Acquired or Situational PE – pharmacotherapy and/or behavioural therapy. In particular men with significant contributing psychogenic or relationship factors may benefit from concomitant behavioural therapy.

Behavioural Techniques

Fifty to sixty percent success rates have been reported in the short term for behavioural therapy.[12] A double-blind, randomized, crossover study showed that drug treatment resulted in greater prolongation of IELT than behavioural therapy.[13] Improvements with behavioral techniques may not persist.[14] However, both behavioural techniques and pharmacotherapy can be combined to optimize the treatment of PE.[15]

Sexual Counseling

Patients with PE frequently have performance anxiety. Sexual counseling attempts to relieve the underlying performance pressure on the man. If PE occurs at intercourse, the couple should be instructed that intercourse should not be attempted until PE is treated.

If the man always experiences ejaculation with initial sexual excitement or early foreplay, this probably indicates primary or lifelong PE and should be treated as such.

Sexual Therapy

Several techniques have been used to help delay ejaculation:

Stop and Start Method

This technique involves sexually stimulating the man until he feels like he is about to reach orgasm. The stimulation is then stopped for about 30 seconds and then started again. This pattern is repeated until the man wants to ejaculate. The stimulation is continued until the man reaches orgasm.

Squeeze Technique

The man is sexually stimulated until he recognizes that he is about to ejaculate. At that point, the man or his partner gently squeezes the glans of the penis for several seconds. The sexual stimulation is then stopped for about 30 seconds and then started again. The couple may repeat this pattern until the man wants to ejaculate.[16]

Pre-coital Masturbation

This is useful if the man is relatively young and can achieve another erection in a few minutes following an episode of PE. The man is advised to masturbate (or be stimulated by his partner) 1 to 2 hours before sexual relations are planned. After which, the interval for achieving a second climax often includes a much longer period of latency, and the man can usually exert better control in this setting. This strategy may be less effective in an older man, as he may have difficulty in achieving a second erection after his first rapid sexual release.

Pharmaceutical Treatment

Dapoxetine

The most effective pharmacologic modality found to aid a man with PE is the Selective Serotonin Reuptake Inhibitors (SSRIs) class of drugs, which are used normally as antidepressants in the clinical setting. These agents have been found to cause a significant delay in reaching orgasm in both male and female patients. For this reason, medications with SSRI side effects have been used in men who experience PE.

Dapoxetine is a short acting SSRI developed specifically for the treatment of PE. An integrated analysis of two randomized clinical trials reported that Dapoxetine, 30 and 60 mg, improved IELT significantly compared with placebo.[17] It has been documented that Dapoxetine, in the recommended doses of 30 mg and 60 mg taken 30-60 minutes prior to an intercourse, significantly increased the IELT duration to 3.03 minutes and 3.15 minutes respectively, compared to placebo (1.66 minutes). Additionally, it also improved other parameters of sexual satisfaction. It is an approved SSRI for treatment of PE in Singapore by Health Science Authority (HSA) in 2010.[18] Approval for the indication of PE has also been given in several European Union countries, South Korea, Australia, New Zealand, Philippines and Malaysia.

Dapoxetine is rapidly absorbed (T_{max} 1.5 hrs) following oral administration. It acts by inhibiting neuronal reuptake of serotonin and the subsequent potentiation of the neurotransmitter's action at pre- and postsynaptic receptors. Dapoxetine may be effective at first dose (i.e. on demand) for PE when given 1-3 hours prior to sexual intercourse.

Dapoxetine is rapidly excreted. Dapoxetine plasma concentrations at 24 hours are <5% of peak levels. There are no specific pharmacodynamic data about the duration of effect of Dapoxetine. However, clinical data indicates that it is effective when intercourse occurs 3 hours after taking it.

The recommended starting dose for all men is 30 mg, taken as needed approximately 1-3 hours prior to sexual activity.

One side effect of Dapoxetine is postural hypotension and/or syncope. Patients should be advised to take Dapoxetine with at least one full glass of water and not to take it if they are dehydrated. Other common side effects are nausea, dizziness, diarrhea and headache. However, these side effects only led to discontinuation of the drug in very few patients (1.3%, 3.9% and 8.2% of patients on placebo, Dapoxetine 30 mg and Dapoxetine 60 mg respectively).

If the effect of 30 mg is insufficient and the drug is well tolerated, the dose may be increased to the maximum recommended dose of 60 mg. If the man has postural hypotension on the 30 mg dose, dose escalation should not be performed.

In a double-blind placebo-controlled trial by McMahon, Dapoxetine showed significant improvements in IELT compared to placebo, beginning at 4 weeks after treatment, and more improvements up to week 12.[19] For optimized individual response, the patient should continue with therapy up to 12 weeks to observe for efficacy.

Other Serotonin Reuptake Inhibitors (SRIs)

Other serotonin reuptake inhibitors have been used for treatment of PE, but these are used off-label. Various doses and dosing regimens have been used and evaluated. Some studies have employed continuous daily dosing while others use a situational dosing regimen whereby the medication is only taken prior to sexual activity.[20] Common side effects include fatigue, drowsiness, yawning, nausea, vomiting, dry mouth, diarrhea and perspiration. They are usually mild and gradually improve after 2-3 weeks. Decreased libido, anorgasmia, anejaculation and ED have also been reported.

Non Selective Serotonin Reuptake Inhibitor

Clomipramine (Anafranil®) 25-50 mg/day or 25 mg 4-24 hours pre-intercourse

Selective Serotonin Reuptake Inhibitors (SSRIs)

Fluoxetine (Prozac®) 5-20 mg/day

Paroxetine (Paxil®) 10, 20, 40 mg/day or 20 mg 3-4 hours pre-intercourse

Sertraline (Zoloft®) 25-200 mg/day or 50 mg 4-8 hours pre-intercourse

Topical Therapies

Topical therapies involve the use of creams or gels to numb the glans penis, desensitizing it with the effect of delaying ejaculation.

Local anaesthetic creams like Lidocaine 2.5%, EMLA cream or Prilocaine 2.5% are applied 20-30 minutes pre-intercourse. Prolonged use of local anaesthetic creams (30-45 minutes) may result in loss of erection due to numbness of penis. A condom is required to avoid diffusion of the local anaesthetic cream into the vaginal wall, causing numbness in the partner.

In Korea and other areas of the Far East, SS cream (a combination of nine ingredients, mainly herbal; SS stands for Super Secret) has been shown to desensitize the penis, decrease the vibratory threshold, and help men with premature ejaculation to significantly delay their ejaculatory response.[21]

Phosphodiesterase Type 5 Inhibitors (PDE5i)

The treatment of Erectile Dysfunction (ED) has been revolutionalized with the advent of PDE5i. ED and PE frequently overlap. When both are present, ED should be treated first. In the PE patient with a definite etiological cause, the etiology should be cured first. The choices for therapeutic approach of ED and PE are:

PDE5i

PDE5i + SSRIs or topical therapy

Pharmaceuticals + sex therapy (behavioural therapy)

PDE5i can be used in older patients with PE or those with concomitant ED. A randomized clinical trial compared the use of PDE5i (Sildenafil) on PE[22], and found that IEFT was not significantly improved. However, Sildenafil increased confidence, perception of ejaculatory control and overall sexual satisfaction as well as reduced anxiety and decreased refractory time to achieve a second erection after ejaculation.

Intracavernosal Prostaglandin E_1 Injection

Intracavernosal prostaglandin E_1 (PGE_1) or Alprostadil has been an effective treatment for ED. Very little is known whether PGE_1 per se can delay ejaculation in lifelong PE patients. PGE_1 relaxes the cavernosal smooth muscles and inhibits anti-erectile adrenergic neurotransmission in the cavernosum. By this mechanism, PGE_1 does not directly overcome PE but rather, it facilitates erection. Studies have shown that men suffering from ED and PE have a longer erection duration with PGE_1, and they felt encouraged by being able to satisfy their partners at that critical time when they needed to continue with a few more strokes for their partners' orgasm.[23] Most men in this group were referring to their ability to hold several intravaginal strokes after the ejaculation rather than delaying the ejaculation per se. Older small-scale studies[24] have described the use of PGE_1 as primary treatment for PE, but there is a risk of priapism.

Surgical Treatment

No recommended surgical treatment per se exists for PE. However, chronic preputial infection or inflammation/balanitis or an uncorrected phimosis may occasionally be found and correction of the latter may help resolve PE. Abnormal penile curvatures can contribute to the condition if left uncorrected. A urological opinion under these circumstances is mandated. Denervation techniques are still largely experimental and not currently deemed appropriate.

Appendix I – PEDT (Premature Ejaculation Diagnostic Tool)

This is a questionnaire to help identify men who have a problem with ejaculating too soon during sexual activity. Even if you do not have difficulties, please answer all the questions.

- Please ☒ mark the box that best represents your answer for each of the questions below.
- Please mark only one box for each question.
- Remember there are no right or wrong answers to these questions.
- While your experiences may change from time to time, what we're interested in here is your general experience with intercourse.

Definition:
Ejaculation here refers to ejaculation (release of semen) after penetration (when your penis enters your partner)

	Not difficult at all	Somewhat difficult	Moderately difficult	Very difficult	Extremely difficult
1. How difficult is it for you to delay ejaculation?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4

	Almost never or never 0%	Less than half the time 25%	About half the time 50%	More than half the time 50%	Almost always or always 100%
2. Do you ejaculate before you want to?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4
3. Do you ejaculate with very little stimulation?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4

	Not at all	Slightly	Moderately	Very	Extremely
4. Do you feel frustrated because of ejaculating before you want to?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4
5. How concerned are you that your time to ejaculation leaves your partner sexually unfulfilled?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4

Pfizer LTD ©; 27 July 2005

A PEDT score is obtained by adding the total numbers of these 5 questions.

- PEDT score ≥ 11 : Has PE
- PEDT score = 9 or 10 : Probable PE
- PEDT score ≤ 8 : No PE

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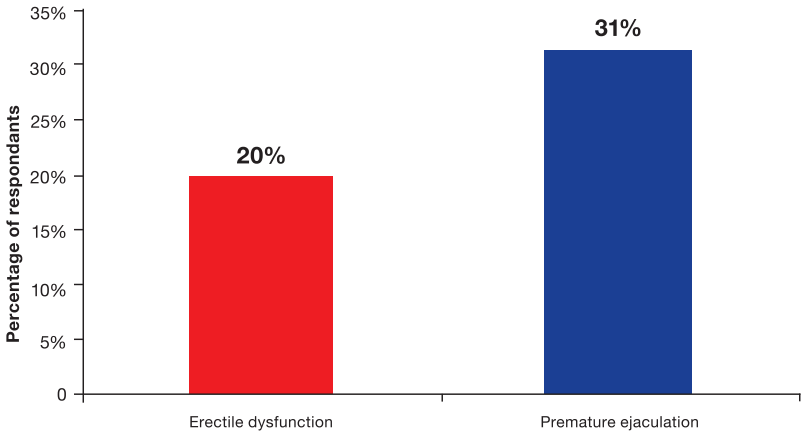
Premature ejaculation: The most common sexual dysfunction in men[1]

31% prevalence in Asia Pacific[2]

Premature ejaculation is more prevalent than erectile dysfunction[2]



Data shown from the Premature Ejaculation and Erectile Dysfunction Prevalence and Attitudes in the Asia-Pacific Region study, a 48-question survey of 4,997 heterosexual males aged 18–65 years old, in Australia/New Zealand, China, Hong Kong, Indonesia, Malaysia, Philippines, South Korea, Taiwan, and Thailand. 20% of men have SHIM diagnosed "mild-to-moderate", "moderate" or "severe" erectile dysfunction. 31% of men have PEDT diagnosed premature ejaculation or probable premature ejaculation.[2]

PEDT: Premature Ejaculation Diagnostic tool; SHIM: Sexual Health Inventory for Men.

Premature ejaculation is underdetected and undertreated[3]

"It came to a point that I was like nagging him already to go see a doctor because I really don't get satisfied."
– Partner of man with premature ejaculation

"I felt my needs cannot be satisfied."
– Partner of man with premature ejaculation

"We're unhappy and dissatisfied."
– Man with premature ejaculation

Premature Ejaculation Diagnostic Tool (PEDT)[4,*]

- The PEDT is a simple tool to facilitate the diagnosis of premature ejaculation.[4]
- Identified as a validated, self-reported screening tool to classify men at risk of premature ejaculation.[4]

*Refer to the PEDT tool insert

Premature ejaculation affects both the man and his partner[6]

Premature ejaculation has a negative impact on quality of life[7,8]

Men with premature ejaculation have:

- Poor control over ejaculation: 90%[9]
- Personal distress: 75%[9]
- Dissatisfaction: 78%[9]
- Interpersonal difficulty: 50%[9]

Premature ejaculation affects partners too[10]

	Partners of men	
	With premature ejaculation	Without premature ejaculation
Satisfied	38%[10]	90%[10]

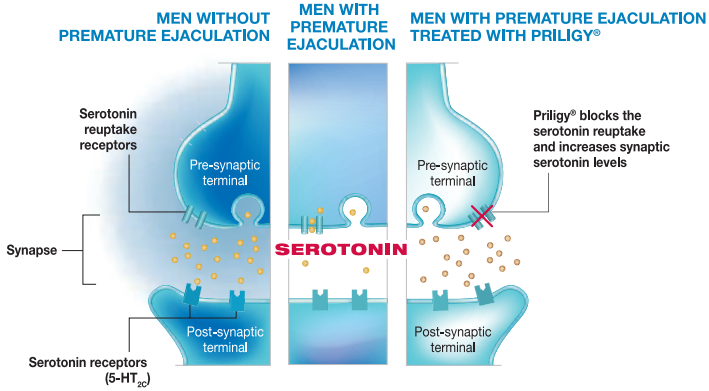
Couples affected by premature ejaculation have relationship problems, a reduced quality of life and low sexual satisfaction[11]

- 90% of men in Asia Pacific reported poor or very poor control of their ejaculation[9]
- 75% of men in Asia Pacific reported “quite a bit” to “extremely” personal distress related to ejaculation[9]
- 78% of men in Asia Pacific reported “poor” to “very poor” satisfaction with sexual intercourse[9]
- 50% of men in Asia Pacific reported “quite a bit” to “extremely” interpersonal difficulty related to ejaculation[9]
- 38% of partners of men with premature ejaculation in USA reported “good” or “very good” satisfaction with sexual intercourse compared to 90% of partners of men without premature ejaculation[10]

Priligy® is the first and only drug specifically developed for the treatment of premature ejaculation

Premature ejaculation is associated with lower levels of serotonin[12]

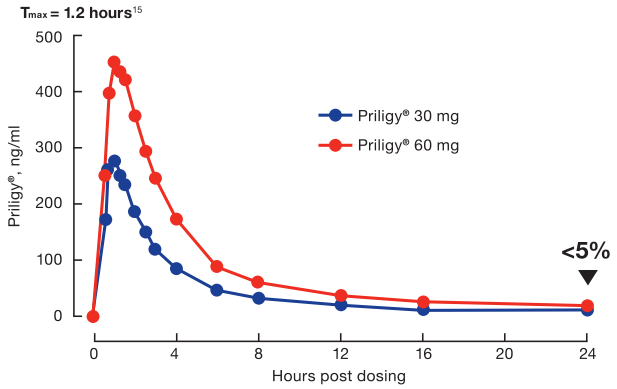
Mechanism of action of Priligy®



Priligy® (dapoxetine) quickly increases the synaptic levels of serotonin, improving the symptoms of premature ejaculation[1,13]

Priligy® is suitable for on-demand dosing[11]

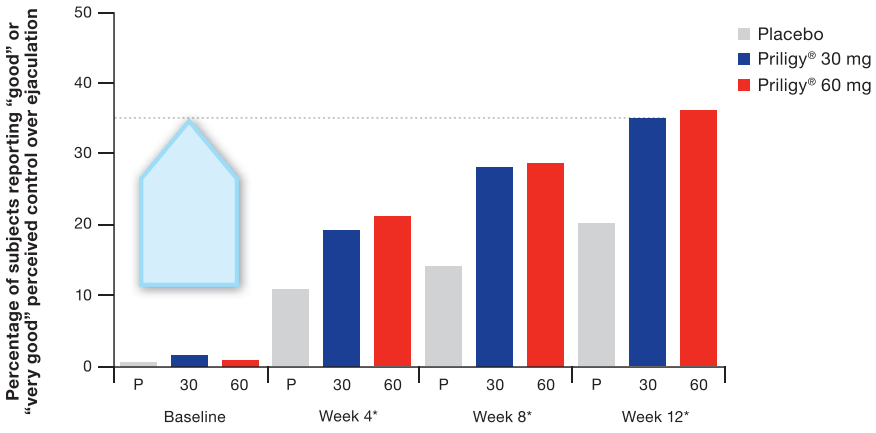
Plasma concentration over time after oral administration of Priligy®[14]



Priligy® is quickly absorbed and rapidly cleared, avoiding accumulation[1,13]

Priligy® significantly improves all measures of premature ejaculation

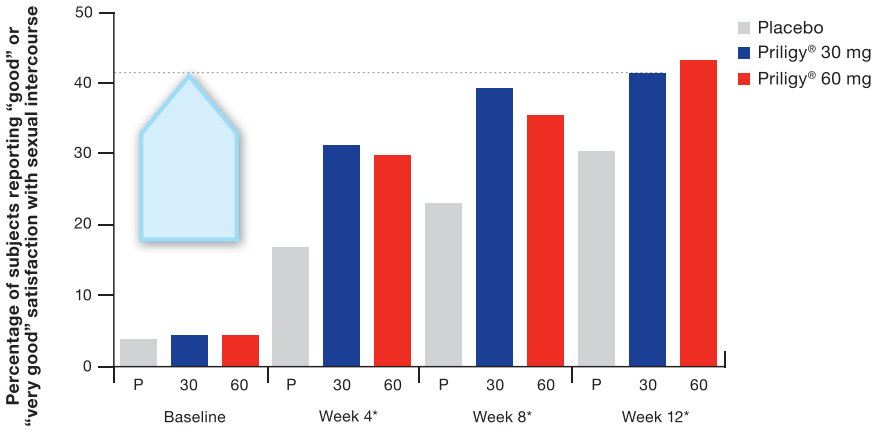
Priligy® significantly improves control over ejaculation[16]



*Significant improvement over placebo P<0.05

Results from a randomized, double-blind, placebo-controlled trial of 1,067 men with premature ejaculation from the Asia Pacific region.[16]

Priligy® significantly improves sexual satisfaction[16]

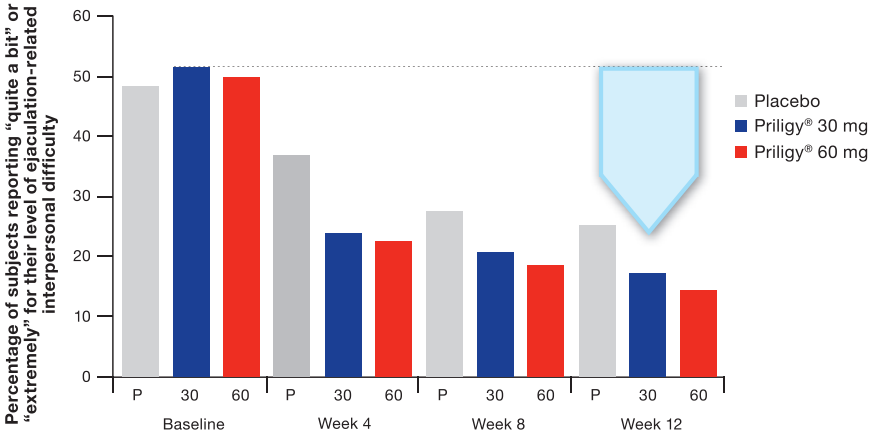


*Significant improvement over placebo P<0.05

Results from a randomized, double-blind, placebo-controlled trial of 1,067 men with premature ejaculation from the Asia Pacific region.[16]

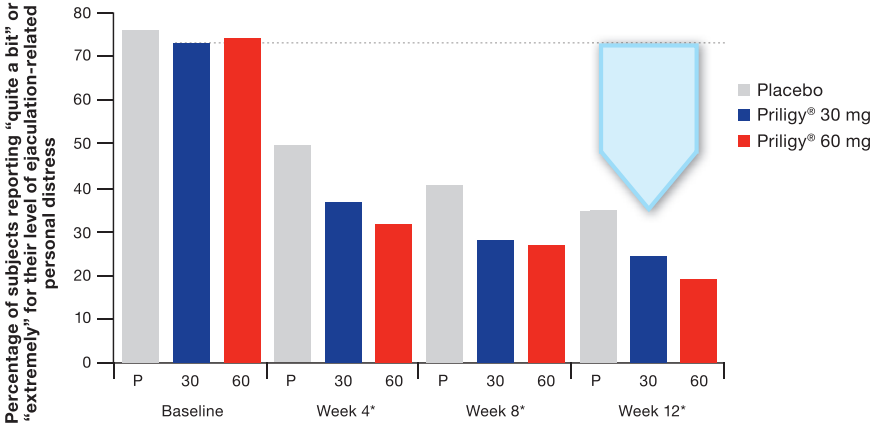
Priligy® significantly improves all measures of premature ejaculation

Over 65% of men who experienced interpersonal difficulty reported improvement with Priligy®[16]



Results from a randomized, double-blind, placebo-controlled trial of 1,067 men with premature ejaculation from the Asia Pacific region. At baseline, 51.9% of men before receiving Priligy® 30 mg reported "quite a bit" or "extremely" for their level of ejaculation-related interpersonal difficulty; this decreased to 17.9% by study endpoint, showing that 65% of men had improvement. P < 0.005 vs. placebo.[16]

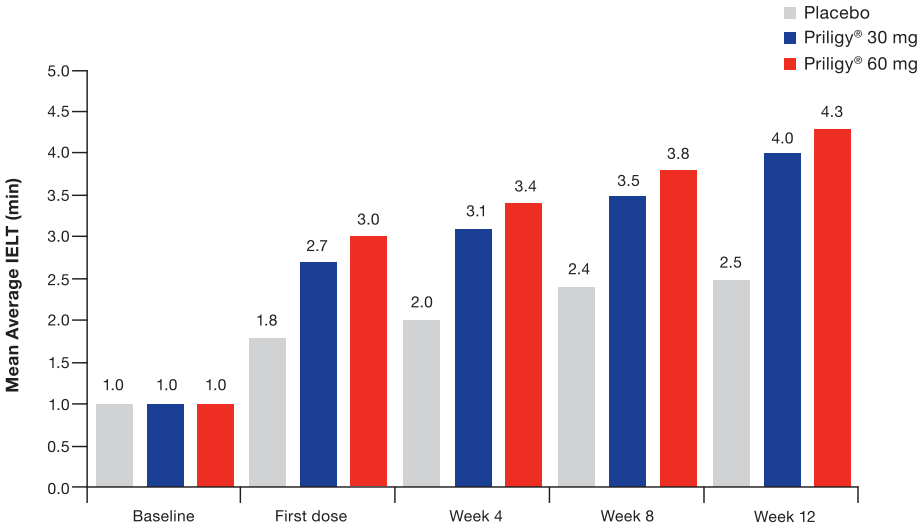
Over 65% of men who experienced personal distress reported improvement with Priligy®[16]



Results from a randomized, double-blind, placebo-controlled trial of 1,067 men with premature ejaculation from the Asia Pacific region. At baseline, 73.5% of men before receiving Priligy® 30 mg reported "quite a bit" or "extremely" for their ejaculation-related personal distress; this decreased to 25.2% by study endpoint, showing that 65% of men had improvement. P < 0.001 vs. placebo.[16]

Priligy® significantly improves IELT[9,11]

Priligy® is effective from the first dose[16]



Mean IELT after 12 weeks of treatment with Priligy® from a randomized, multicenter, double-blind, placebo-controlled trial conducted on 1,067 men with premature ejaculation in the Asia Pacific region. Mean IELT was significant vs placebo for Priligy® at all time points ($P < 0.001$).[16]

IELT: Intravaginal Ejaculation Latency Time

Priligy® significantly improves all measures of premature ejaculation[16]

- Improved control over ejaculation
- Improved sexual satisfaction
- Decreased interpersonal difficulty
- Decreased personal distress
- Increased IELT

Priligy® is clinically proven to be well-tolerated[9,11]

- Adverse events associated with Priligy® are dose-dependent and tend to be non-severe and non-serious[9,11]
- The most common adverse events included nausea, dizziness, and headache[9]

Treatment-emergent adverse events occurring in at least 2% of subjects[9]

Adverse event	Placebo (N=1,857) %	PRILIGY® 30 mg on-demand (N=1,616) %	PRILIGY® 60 mg on-demand (N=2,106) %
Nausea	2.2	11.0	22.2
Dizziness	2.2	5.8	10.9
Headache	4.8	5.6	8.8
Diarrhea	1.7	3.5	6.9
Somnolence	0.5	3.1	4.7
Fatigue	1.2	2.0	4.1
Insomnia	1.5	2.1	3.9
Nasopharyngitis	2.3	3.2	2.9

Treatment-emergent adverse events occurring in at least 2% of subjects treated with Priligy® 30 mg or 60 mg on-demand, or placebo. Results from an integrated analysis of the efficacy and the safety data from five randomized, double-blind placebo-controlled, phase 3 studies, on 6,081 men with premature ejaculation.[9]

According to results from clinical trials, side effects due to Priligy® are usually mild to moderate and are more frequent at the first dose or in the first week of treatment.

As men continue taking Priligy® over time, side effects decrease in frequency and severity.[9]

Priligy®
Dapoxetine

Premature ejaculation is the most common male sexual dysfunction resulting in reduced sexual satisfaction and quality of life for men and their partners[11]

Priligy® is the first and only drug specially developed for the treatment of premature ejaculation and now approved in over 50 countries

- Improved control over ejaculation[16]
- Improved sexual satisfaction[16]
- Well tolerated, based on robust clinical trials involving over 6,000 men worldwide[9]

Priligy® works effectively on the first dose and should be taken for at least six doses or four weeks before evaluating individual response[9,17]

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PRILIGY
A. Menarini
[Zuellig]
Regulatory Class: POM
C: Dapoxetine
I: Treatment of premature ejaculation (PE) in men 18-64 yr.
D: Adult men 18-64 yr Recommended starting dose: 30 mg, as needed, approx 1-3 hr prior to sexual activity. Max: 60 mg/day.
A: : Swallow whole w/ at least a full glass of water.
CI: Hypersensitivity. Significant pathological cardiac conditions eg heart failure (NYHA class II-IV); conduction abnormalities (2nd- or 3rd-degree AV block or sick sinus syndrome) not treated w/ a permanent pacemaker; significant ischemic heart disease or valvular disease. Concomitant use of MAOIs, thioridazine, serotonin re-uptake inhibitors or other medicinal/herbal products w/ serotonergic effects or w/in 14 days of discontinuing treatment; potent CYP3A4 inhibitors, recreational drugs, antidepressants. Moderate & severe hepatic impairment (Child-Pugh class B & C); history of mania/hypomania or bipolar disorder; psychiatric disorders eg schizophrenia, co-morbid depression. Rare hereditary problems of galactose intolerance, Lapp lactase deficiency or glucose-galactose malabsorption. Use in women. Childn & adolescents <18 yr & elderly >64 yr.
SP: Concomitant use w/ alcohol, medicinal products w/ vasodilatation properties, moderate CYP3A4 or potent CYP2D6 inhibitors; drugs known to affect platelet function or anticoagulants (eg warfarin). Maintain adequate hydration & warn patients of the risk of syncope. Perform orthostatic test prior to therapy. Underlying structural CV disease (eg documented outflow obstruction, valvular heart disease, carotid stenosis and CAD); history or suspected orthostatic reaction; suicidal tendencies; seizure or unstable epilepsy; history of bleeding or coagulation disorders. Mild or moderate & severe renal impairment. May impair ability to drive or operate machinery.
AR: Dizziness, headache; nausea. Insomnia, anxiety, agitation, restlessness, decreased libido, abnormal dreams; somnolence, disturbance in attention, tremor, paraesthesia; blurred vision; tinnitus; flushing; sinus congestion, yawning; diarrhoea, dry mouth, vomiting, constipation, abdominal pain & distention, upper abdominal pain, dyspepsia, flatulence, stomach discomfort; hyperhidrosis; erectile dysfunction; fatigue, irritability; increased BP.
DI: Potential serious reactions w/ MAOIs. Inhibits metabolism of thioridazine. Risk of serotonergic-associated effects w/ serotonergic medicinal/herbal products (including L-tryptophan, triptans, tramadol, linezolid, SSRIs, SNRIs, lithium & St. John's wort prep). CNS-active medicinal products. Possible reduction of clearance w/ CYP2D6, CYP3A4 & flavin monooxygenase 1 inhibitors. Increased exposure w/ potent (eg ketoconazole, itraconazole, ritonavir, saquinavir, telithromycin, nefazodone, nelfinavir & atazanavir) & moderate (eg erythromycin, clarithromycin, fluconazole, amprenavir, fosamprenavir, aprepitant, verapamil, diltiazem) CYP3A4 inhibitors; potent CYP2D6 inhibitors. Possible reduced orthostatic tolerance w/ PDE-5 inhibitors & α-adrenergic receptor antagonists. Increases plasma conc of desipramine & other drugs metabolized by CYP2D6. Decreases $AUC_{0-\infty}$ of midazolam. Warfarin (chronic therapy). Alcohol.
P/P: FC tab 30 mg x 3's, 6's. 60 mg x 3's, 6's.

Please contact A. Menarini Singapore Pte Ltd for Priligy full prescribing information.

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