Wiley
Andrologia
Volume 2025, Article ID 9527433, 7 pages
https://doi.org/10.1155/and/9527433

WILEY

Research Article

A Retrospective Study of Selective Dorsal Neurectomy for Lifelong Premature Ejaculation: Erectile and Ejaculatory Functions, Sensory Correlation, and Safety Evaluation

Yaşar Başağa,[1] Ahmet Tevfik Albayrak, [2,3] Doğukan Sökmen,[2,3] and Zülfü Sertkaya[2]

[1]*Urology Department, Nişantaşı University, Istanbul, Türkiye*
[2]*Andrology Department, Andro Expertise Men's Health and Aesthetic Clinic, Istanbul, Türkiye*
[3]*Istanbul Kent University, Istanbul, Türkiye*

Correspondence should be addressed to Ahmet Tevfik Albayrak; atevfikalbayrak@gmail.com

Received 3 April 2025; Revised 22 September 2025; Accepted 5 November 2025

Academic Editor: Mohamed Arafa

Introduction: Premature ejaculation (PE) is a common male sexual dysfunction and a subset of patients with lifelong PE remain unresponsive to pharmacologic and behavioral therapies. Although selective dorsal neurectomy (SDN) is practiced in certain regions, its safety and efficacy remain underexplored in Western guidelines.
Objective: The main aim of this study is to evaluate the clinical outcomes, sensory changes, and safety profile of SDN in patients with lifelong PE who failed conventional treatments.
Methods: In this retrospective cohort study, we reviewed 82 patients with lifelong PE who underwent SDN between January and October 2024. Patients were selected based on strict clinical criteria, including failed response to medical therapy and evidence of penile hypersensitivity, which was objectively assessed using a biothesiometer. SDN involved preserving at least one dorsal penile nerve <1 mm in each of the three anatomical zones. Pre and postoperative assessments included intravaginal ejaculatory latency time (IELT), the International Index of Erectile Function-5 (IIEF-5), the PE diagnostic tool (PEDT), and biothesiometry scores.
Results: At 6 months postoperatively, mean IELT increased by 241.04 ± 134.02 s (559.12%, $p < 0.001$), PEDT scores decreased by 6.98 ± 1.66 points (48.07%, $p < 0.001$), and IIEF-5 improved by 1.51 ± 0.79 points (6.63%, $p < 0.001$). A strong negative correlation was observed between preoperative sensory thresholds and postoperative improvement in sensory thresholds (Spearman $r = -0.83$ to -0.70, all $p < 0.001$). No major complications, including glans numbness or anorgasmia, were reported.
Conclusion: SDN appears to be a safe and effective surgical option for selected patients with lifelong PE who are unresponsive to conservative treatments. The procedure resulted in significant improvements in ejaculatory control with minimal risk when performed using a nerve-preserving approach.

Keywords: biothesiometry; ejaculatory control; lifelong premature ejaculation; selective dorsal neurectomy; sensory thresholds

1. Introduction

Premature ejaculation (PE) is one of the most common male sexual dysfunctions, with an estimated prevalence of 20%–30% among sexually active men [1]. Lifelong PE, a distinct subtype, affects ~3%–5% of men and is defined by ejaculation that consistently occurs within 1 min of vaginal penetration from the first sexual experience onward [2]. Despite its high prevalence and impact, PE remains underdiagnosed and undertreated, largely due to patient embarrassment, inconsistent diagnostic criteria, and limited awareness among healthcare providers [3]. The consequences of lifelong PE extend beyond sexual dissatisfaction, often impairing self-esteem, straining intimate relationships, and contributing to psychological comorbidities such as anxiety and depression [4, 5].

The pathophysiology of lifelong PE is multifactorial, involving both central and peripheral mechanisms. Central dysfunction of the serotonergic system has been implicated, particularly abnormalities in the 5-hydroxytryptamine receptors [6]. Peripheral factors, especially glans penis hypersensitivity, also play a significant role in some patients. Notably, studies have demonstrated that individuals with lifelong PE exhibit significantly lower penile vibratory thresholds compared to healthy controls [7–9]. Animal studies further support this concept; for example, dorsal penile nerve transection in male marmosets delayed or inhibited ejaculation, suggesting a causal link between sensory input and ejaculatory reflex modulation [10].

Current management strategies for PE include behavioral therapy, selective serotonin reuptake inhibitors (SSRIs), topical anesthetics, and phosphodiesterase type 5 (PDE5) inhibitors [11]. While these treatments have shown varying degrees of efficacy in prolonging intravaginal ejaculatory latency time (IELT), their effectiveness is often limited by adverse effects, poor long-term adherence, and recurrence of symptoms after treatment discontinuation. Dapoxetine, the only approved on-demand SSRI for PE, is associated with common side effects such as nausea and dizziness, and high dropout rates have been observed in clinical practice [12]. Surveys indicate that up to 25% of patients remain dissatisfied with conventional therapies [13].

Given these limitations, surgical interventions such as selective dorsal neurectomy (SDN) have gained attention as a potential treatment option, particularly in East Asian countries and Turkey. SDN aims to reduce penile sensitivity by partially transecting the dorsal penile nerve, thereby delaying the ejaculatory reflex [14, 15]. However, major urological and sexual medicine associations, including the European Association of Urology (EAU) [11] and the International Society for Sexual Medicine (ISSM) [2], have not endorsed SDN due to concerns about irreversible complications such as glans numbness, anorgasmia, and the limited availability of high-quality evidence.

Despite these reservations, SDN continues to be performed in clinical practice, especially among patients who are refractory to or intolerant of pharmacologic treatments and who prefer a long-term solution. Preliminary studies from Asia have shown promising results, but the procedure remains controversial due to variability in technique, outcomes, and complication rates [14, 15]. Furthermore, no study has examined the relationship between baseline penile sensitivity and postoperative outcomes, which could help refine patient selection and predict treatment success.

This study aims to address these gaps by evaluating the clinical efficacy, safety profile, and sensory changes associated with SDN in a cohort of men with lifelong PE who have failed conventional therapies. We assess the correlation between preoperative penile sensitivity and postoperative erectile and ejaculatory (functional) improvements to better understand the neurophysiological mechanisms underlying SDN and to identify predictors of surgical success.

2. Methods

2.1. Ethical Conduct. This study was approved by the Kanuni Sultan Suleyman Training and Research Hospital Institutional Review Board (IRB) under protocol number 267783510 (Istanbul, Turkey). All patients provided informed consent for the use of their anonymized clinical data in accordance with ethical standards.

2.2. Study Design and Patients. This was a retrospective analysis of prospectively collected data from patients with lifelong PE who underwent SDN between January and October 2024. In our clinic, such patients are routinely evaluated using a structured protocol that includes validated questionnaires and biothesiometer testing at both preoperative and scheduled postoperative intervals. For this study, we reviewed the records of 82 men aged 19–68 years. All procedures were performed by a single high-volume microsurgeon at a tertiary care center.

The inclusion criteria were as follows:

1. Diagnosis of lifelong PE is defined as an IELT of less than 1 min in more than 70% of sexual encounters since the first sexual experience, based on ISSM criteria.
2. International Index of Erectile Function-5 (IIEF-5) score > 21, indicating normal erectile function.
3. PE diagnostic tool (PEDT) score > 11.
4. Circumcision performed at least 3 months prior to SDN.
5. Stable sexual partner for at least 6 months.
6. Refractory to standard pharmacological and psychobehavioral therapies, including SSRIs, dapoxetine, topical anesthetics, clomipramine, and PDE5 inhibitors.
7. Penile sensory threshold <4 volts as measured by biothesiometry.

Exclusion criteria included conditions such as balanitis, bleeding disorders, keloid formation, or the use of psychiatric medications. Patients with acquired PE were also excluded.

2.3. Measurements and Data Collection. Patients completed the IIEF-5, PEDT, and IELT assessments preoperatively and at postoperative months 1, 3, and 6. IELT was recorded using a stopwatch by the female partner during three separate sexual encounters over a 2-week period; the geometric mean was calculated for analysis.

Penile vibratory sensitivity thresholds were measured using a Kilde Medic Digital Biothesiometer (Graested, Denmark), as previous research has validated biothesiometry as a reliable tool for evaluating penile sensitivity [16, 17]. The device operates at a constant frequency of 100 Hz, while the vibration amplitude is adjustable and recorded in volts [18]. Thresholds were determined using the staircase method: stimulation began at 0 volts and was gradually increased until the participant first perceived the vibration. Measurements were obtained at three anatomical sites: left penile shaft, right penile shaft, and frenulum. For each site, three readings were taken, and the average value was used. Postoperative sensitivity was recorded at 1, 3, and 6 months. Sensory assessments and clinical evaluations were performed by assessors blinded to the surgical status.

2.4. Surgical Technique (SDN). All procedures were performed under local anesthesia with 1% lidocaine. A

Figure 1: Intraoperative views of penile dissection and neurovascular bundle mobilization during SDN.

circumferential incision was made ~1 cm proximal to the coronal sulcus, followed by full degloving of the penile shaft to expose the dorsal nerve complex. The deep fascia was incised, and dorsal nerve branches were isolated and lifted with 5-0 surgical filaments (Figures 1 and 2). Each patient's dorsal penile nerve anatomy was divided into three zones (11–1 o'clock, 1–5 o'clock, and 7–11 o'clock), and 1–2 nerve branches were preserved in each zone. Nerve branches less than 1 mm in diameter were spared. On average, 6–8 nerve branches were resected per patient (Figure 3). The fascia and skin were closed using absorbable 5-0 sutures.

Patients were advised to abstain from sexual activity for 2 weeks postoperatively. At 3 and 6 months, structured interviews assessed postoperative complications, including altered glans sensation, numbness, or anorgasmia.

2.5. Statistical Analysis. All statistical analyses were performed using SPSS version 27. The Wilcoxon signed-rank test was used to compare changes in IELT, IIEF-5, and PEDT scores across time points. The Spearman rank correlation test was used to evaluate the relationship between preoperative penile sensitivity and postoperative sensory gain or functional improvements. A two-sided p-value of <0.05 was considered statistically significant to account for multiple comparisons across time points.

3. Results

A total of 82 patients with lifelong PE were included in the study. The mean age was 36.87 ± 11.34 years (range: 19–68), and the mean body mass index (BMI) was 27.21 ± 3.21 kg/m^2 (range: 19.52–35.06). Preoperatively, the mean IIEF-5 score was 22.79 ± 0.84, the IELT was 43.11 ± 16.7 s, and the PEDT score averaged 14.51 ± 1.53. Biothesiometric assessment demonstrated baseline penile sensory thresholds of 5.5 ± 1.5 V on the right side of the penile shaft, 5.32 ± 1.54 V on the left side, and 5.92 ± 1.44 V at the frenulum (Table 1). Comorbidities included diabetes mellitus in five patients (6.1%) and hypertension in three patients (3.7%). All patients had previously failed at least two standard pharmacologic treatments, including SSRIs and topical anesthetics. The mean duration of PE symptoms was 13.2 ± 5.7 years.

3.1. Functional Outcomes. At postoperative follow-up, patients demonstrated significant improvements across all measured outcomes. The mean IELT increased from 43.11 ± 16.70 s preoperatively to 241.83 ± 131.94 s at 1 month, 273.54 ± 140.93 s at 3 months, and reached 284.15 ± 138.71 s at 6 months, reflecting a 559.1% increase from baseline ($p < 0.001$ for all timepoints). Correspondingly, 94% of patients achieved an IELT of at least 60 s, and 71% exceeded 120 s by the 6-month mark. The PEDT score showed a progressive decline from a baseline of 14.51 ± 1.53 to 8.15 ± 1.08 at 1 month, 7.63 ± 1.13 at 3 months, and 7.54 ± 1.15 at 6 months ($p < 0.001$),

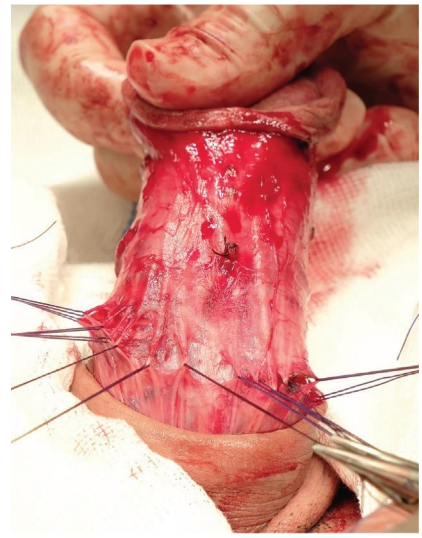

Figure 2: Intraoperative exposure demonstrating penile shaft dissection and careful mobilization of the neurovascular bundle as part of the SDN procedure.

Figure 3: Intraoperative demonstration of transected dorsal penile nerve fibers following SDN.

Table 1: Demographic and clinical data of the patients.

Variables	Mean ± SD
Age (year)	36.87 ± 11.34
Height (cm)	177.93 ± 8.04
Weight (kg)	86.1 ± 11.44
BMI	27.21 ± 3.21
IIEF-5 (s)	22.79 ± 0.84
IELT	43.11 ± 16.7
PEDT	14.51 ± 1.53
R (volt)	5.5 ± 1.5
L (volt)	5.32 ± 1.54
F (volt)	5.92 ± 1.44

Note: *F*, preoperative frenulum of the penis biothesiometer value; *L*, preoperative left side of the penile shaft biothesiometer value; *R*, preoperative right side of the penile shaft biothesiometer value.
Abbreviations: IELT, intravaginal ejaculatory latency time; IIEF-5, International Index of Erectile Function-5; PEDT, premature ejaculation diagnostic tool.

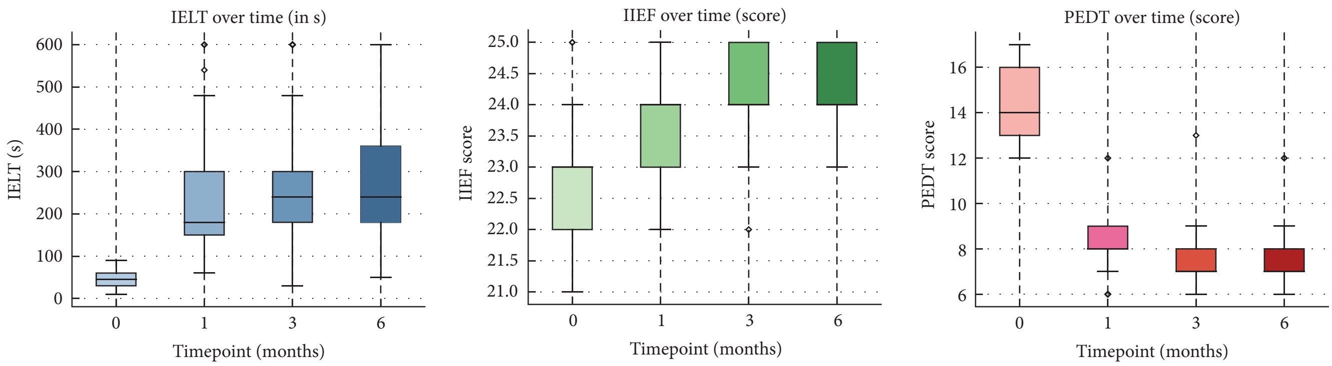

FIGURE 4: Longitudinal comparison of ejaculatory latency, erectile function, and premature ejaculation scores at key postoperative intervals.

TABLE 2: Comparison of preoperative and postoperative characteristics.

Variables	Pre-op	1st month (±%)	3rd month (±%)	6th month (±%)	*p*-Value
IIEF-5	22.79 ± 0.84	23.85 ± 0.79 (+4.65%)	24.17 ± 0.77 (+6.05%)	24.3 ± 0.68 (+6.63%)	<0.001
IELT (s)	43.11 ± 16.7	241.83 ± 131.94 (+460.96%)	273.54 ± 140.93 (+534.51%)	284.15 ± 138.71 (+559.12%)	<0.001
PEDT	14.51 ± 1.53	8.15 ± 1.08 (−43.87%)	7.63 ± 1.13 (−47.39%)	7.54 ± 1.15 (−48.07%)	<0.001
R (volt)	5.50 ± 1.50	11.76 ± 1.13	11.76 ± 1.11	11.79 ± 1.03	<0.001
L (volt)	5.32 ± 1.54	11.50 ± 1.10	11.52 ± 1.03	11.58 ± 0.98	<0.001
F (volt)	5.92 ± 1.44	11.82 ± 1.17	11.87 ± 1.07	11.85 ± 1.04	<0.001

Note: *F*, preoperative frenulum of the penis biothesiometer value; *L*, preoperative left side of the penile shaft biothesiometer value; *R*, preoperative right side of the penile shaft biothesiometer value.
Abbreviations: IELT, intravaginal ejaculatory latency time; IIEF-5, International Index of Erectile Function-5; PEDT, premature ejaculation diagnostic tool.

TABLE 3: Comparison of postoperative effects.

Variables	1st month change	3rd month change	6th month change	*p*-Value
IIEF-5	1.06 ± 0.78 (+4.65%)	1.38 ± 0.86 (+6.05%)	1.51 ± 0.79 (+6.63%)	<0.001
IELT (s)	198.72 ± 127.14 (+460.96%)	230.43 ± 136.38 (+534.51%)	241.04 ± 134.02 (+559.12%)	<0.001
PEDT	−6.37 ± 1.80 (−43.87%)	−6.88 ± 1.74 (−47.39%)	−6.98 ± 1.66 (−48.07%)	<0.001
R (volt)	6.26 ± 1.41 (+113.91%)	6.26 ± 1.42 (+113.89%)	6.29 ± 1.35 (+114.49%)	<0.001
L (volt)	6.18 ± 1.45 (+116.09%)	6.20 ± 1.47 (+116.57%)	6.26 ± 1.45 (+117.65%)	<0.001
F (volt)	5.90 ± 1.28 (+99.69%)	5.95 ± 1.20 (+100.54%)	5.93 ± 1.23 (+100.19%)	<0.001

Note: *F*, preoperative frenulum of the penis biothesiometer value; *L*, preoperative left side of the penile shaft biothesiometer value; *R*, preoperative right side of the penile shaft biothesiometer value.
Abbreviations: IELT, intravaginal ejaculatory latency time; IIEF-5, International Index of Erectile Function-5; PEDT, premature ejaculation diagnostic tool.

indicating a substantial reduction in PE symptom severity. Erectile function also improved, with the IIEF-5 score increasing from 22.79 ± 0.84 at baseline to 24.30 ± 0.68 at 6 months ($p < 0.001$), representing a 6.6% improvement. These gains were consistent across all follow-up points and suggest that SDN led to both statistically and clinically meaningful improvements in ejaculatory control without negatively affecting erectile function (Figure 4A–C), (Tables 2 and 3).

Correlation analysis revealed a strong inverse relationship between preoperative penile sensitivity and postoperative sensory gain, as measured by biothesiometry. Specifically, lower baseline sensitivity thresholds were associated with greater reductions in sensory perception following surgery. This was evident across all anatomical sites assessed, with Spearman correlation coefficients of −0.83 for the left penile shaft ($L0$ vs. ΔL), −0.80 for the right penile shaft ($R0$ vs. ΔR), and −0.70 for the frenulum ($F0$ vs. ΔF), all statistically significant at $p < 0.001$ (Table 4). These findings suggest that patients with heightened preoperative sensitivity may benefit most in terms of desensitization after SDN. In contrast, no significant correlations were observed between preoperative sensory thresholds and changes in functional outcomes. Improvements in IELT ($r = +0.12$, $p = 0.18$), PEDT scores ($r = +0.06$, $p = 0.34$), and IIEF-5 scores ($r = -0.04$, $p = 0.45$) appeared largely independent of baseline sensory levels (Table 5). This indicates that while SDN effectively reduces penile sensitivity, the magnitude of functional benefit is not strictly dependent on the initial sensory threshold.

Table 4: Sensory gain correlations.

Variables	Spearman coefficient	p-Value
L vs. ΔL	−0.83	<0.001
R vs. ΔR	−0.8	<0.001
F vs. ΔF	−0.7	<0.001

Note: F, preoperative frenulum of the penis biothesiometer value; L, preoperative left side of the penile shaft biothesiometer value; R, preoperative right side of the penile shaft biothesiometer value; Δ, the change between the preoperative value and the 6th-month postoperative value.

Table 5: Functional outcome correlations.

Variables	Spearman coefficient	p-Value
R vs. ΔIIEF-5	−0.04	> 0.05
R vs. ΔIELT	0.16	> 0.05
R vs. ΔPEDT	0.2	> 0.05
L vs. ΔIIEF-5	0.0	> 0.05
L vs. ΔIELT	0.1	> 0.05
L vs. ΔPEDT	0.22	> 0.05
F vs. ΔIIEF-5	−0.01	> 0.05
F vs. ΔIELT	0.08	> 0.05
F vs. ΔPEDT	0.15	> 0.05

Note: F, preoperative frenulum of the penis biothesiometer value; L, preoperative left side of the penile shaft biothesiometer value; R, preoperative right side of the penile shaft biothesiometer value; Δ, the change between the preoperative value and the 6th-month postoperative value.
Abbreviations: IELT, intravaginal ejaculatory latency time; IIEF-5, International Index of Erectile Function-5; PEDT, premature ejaculation diagnostic tool.

3.2. Safety and Complications. No major complications were reported. Specifically, there were no cases of permanent glans numbness, anorgasmia, infection, or hematoma. Structured follow-up interviews were conducted at 3 and 6 months to assess for adverse events, and all patients denied experiencing abnormal glans sensation or orgasmic dysfunction. Two patients (2.4%) reported mild, transient penile tingling that resolved within 4 weeks postoperatively without intervention (Clavien–Dindo Grade I).

These findings support the favorable safety profile of SDN when performed using a nerve-sparing technique by an experienced surgeon.

4. Discussion

Our study demonstrates that SDN significantly improves IELT, PEDT scores, and IIEF-5 outcomes in patients with lifelong PE who have failed to respond to conventional treatments. These findings support the role of penile hypersensitivity as a major contributing factor in the pathophysiology of lifelong PE and reinforce the clinical rationale for SDN as a surgical intervention aimed at modulating sensory input.

It is now widely recognized that the biological factors contributing to PE include penile hypersensitivity, a hyperexcitable ejaculatory reflex, heightened sexual arousability, potential hormonal imbalances, genetic predisposition, and dysfunction of central 5-hydroxytryptamine receptors. Additionally, studies have shown that individuals with PE have significantly lower penile vibration thresholds compared to men without PE, indicating an abnormally heightened sensory response to penile stimulation [19]. Given this evidence, it is reasonable to suggest that reducing penile sensitivity could effectively help delay ejaculation. Our study shows that the improvement in postoperative IELT, over 500% at six months after SDN, aligns with previous studies [14, 18, 20, 21]. Our approach to nerve preservation, with retention of branches <1 mm in diameter, likely contributed to the absence of complications such as glans numbness or anorgasmia, which have been reported in other studies where more aggressive resections were performed [15]. While our cohort experienced no major adverse events, studies from Korea have reported complication rates between 10% and 12%, including transient sensory loss [14]. This disparity may stem from differences in surgical technique, anatomical variability, or definitions of complications. Although recurrence of symptoms was noted in 10% of the cases, other complications were reported to be rare [14]. The recurrence may be attributed to nerve regeneration after transection or the inadvertent preservation of nerve trunks that should have been resected [22].

Additionally, the consistent satisfaction rates reported in international surveys suggest that, for certain patient populations, the benefits of SDN outweigh the risks, if nerve preservation is prioritized and patients are appropriately counseled [20].

Furthermore, the strong negative correlation between preoperative sensory thresholds and sensory gain postoperatively suggests that patients with lower baseline penile sensitivity benefit the most in terms of desensitization. Interestingly, this sensory gain did not correlate strongly with functional outcomes like IELT or PEDT, implying that mechanisms beyond local sensitivity, possibly central modulation or altered sensory feedback loops, may also play a role in ejaculatory control.

Although SDN is not recommended in current international guidelines for the management of PE, the procedure was offered strictly as an investigational treatment within the framework of IRB approval [2, 11]. All patients were fully informed of its nonguideline status and provided written informed consent acknowledging that the procedure was experimental in nature. This ethical consideration is crucial in contextualizing our findings and underscores the need for further controlled studies before broader clinical adoption.

This study has several limitations that should be acknowledged. First, all surgeries were performed by a single high-volume surgeon, limiting the generalizability of our findings. Second, although short-term outcomes are promising, our follow-up was limited to 6 months. The potential for symptom recurrence due to nerve regeneration remains unknown and warrants long-term surveillance. Third, our study did not assess psychological contributors to PE, such as anxiety or depression, which could confound the observed improvements. Fourth, the lack of a control group and blinding introduces the possibility of placebo effects or reporting bias. Lastly, we did not establish the optimal number of dorsal penile nerve branches that should be selectively resected to achieve maximum prolongation of IELT for each patient. While it is reasonable to assume that resecting a greater number of nerve branches may result in longer IELT, removing too many could increase the risk of excessive sensory loss in the penis, potentially leading to erectile dysfunction. Therefore, further research is needed to explore the relationship between the extent of dorsal nerve resection and the degree of IELT prolongation to determine a safe and effective balance.

5. Conclusion

SDN has been shown to effectively improve lifelong PE by significantly prolonging IELT and enhancing ejaculatory control, with minimal postoperative complications. As such, SDN presents a promising treatment option for lifelong PE, particularly in patients who have had limited response to medical therapies or prefer to avoid long-term use of oral medications, although further prospective controlled studies are warranted.

Data Availability Statement

The datasets generated and analyzed during the current study are not publicly available due to institutional restrictions and patient confidentiality. Still, deidentified data are available from the corresponding author upon reasonable request.

Ethics Statement

This study was approved by the Institutional Review Board of Kanuni Sultan Suleyman Training and Research Hospital, Istanbul, Turkey (Protocol Number: 267783510). Written informed consent was obtained from all participants prior to inclusion in the study.

Consent

All patients provided written informed consent for the anonymized publication of their clinical data.

Conflicts of Interest

The authors declare no conflicts of interest.

Author Contributions

Yaşar Başağa: conceptualization, methodology, surgical supervision, data interpretation, critical revision of the manuscript for important intellectual content. **Ahmet Tevfik Albayrak**: study design, data curation, formal analysis, writing – original draft, statistical analysis, project administration, corresponding author responsibilities. **Doğukan Sökmen**: patient recruitment, data acquisition, literature review, visualizations, manuscript editing. **Zülfü Sertkaya:** biothesiometric assessment coordination, ethical compliance oversight, validation of data, manuscript review and approval.

Funding

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

References

[1] J. Gao, X. Zhang, P. Su, et al., "Prevalence and Factors Associated With the Complaint of Premature Ejaculation and the Four Premature Ejaculation Syndromes: A Large Observational Study in China," *Journal of Sexual Medicine* 10, no. 7 (2013): 1874–1881.

[2] S. E. Althof, C. G. McMahon, M. D. Waldinger, et al., "An Update of the International Society of Sexual Medicine's Guidelines for the Diagnosis and Treatment of Premature Ejaculation (PE)," *Journal of Sexual Medicine* 11, no. 6 (2014): 1392–1422.

[3] M. T. Rosenberg and R. Sadovsky, "Identification and Diagnosis of Premature Ejaculation," *International Journal of Clinical Practice* 61, no. 6 (2007): 903–908.

[4] T. Symonds, D. Roblin, K. Hart, and S. Althof, "How Does Premature Ejaculation Impact a Man s Life?" *Journal of Sex & Marital Therapy* 29, no. 5 (2003): 361–370.

[5] D. Rowland, M. Perelman, S. Althof, et al., "Self-Reported Premature Ejaculation and Aspects of Sexual Functioning and Satisfaction," *The Journal of Sexual Medicine* 1, no. 2 (2004): 225–232.

[6] C. G. McMahon, C. Abdo, L. Incrocci, et al., "Disorders of Orgasm and Ejaculation in Men," *The Journal of Sexual Medicine* 1, no. 1 (2004): 58–65.

[7] G-X. Zhang, L-P. Yu, W-J. Bai, and X-F. Wang, "Selective Resection of Dorsal Nerves of Penis for Premature Ejaculation," *International Journal of Andrology* 35, no. 6 (2012): 873–879.

[8] M. G. Wyllie and W. J. G. Hellstrom, "The Link Between Penile Hypersensitivity and Premature Ejaculation," *BJU International* 107, no. 3 (2011): 452–457.

[9] J.-D. Xia, L.-H. Zhou, Y.-F. Han, Y. Chen, R. Wang, and Y.-T. Dai, "A Reassessment of Penile Sensory Pathways and Effects of Prilocaine-Lidocaine Cream in Primary Premature Ejaculation," *International Journal of Impotence Research* 26, no. 5 (2014): 186–190.

[10] A. F. Dixson, "Effects of Dorsal Penile Nerve Transection Upon the Sexual Behaviour of the Male Marmoset (*Callithrix jacchus*)," *Physiology & Behavior* 43, no. 2 (1988): 235–238.

[11] A. Salonia, C. Bettocchi, L. Boeri, et al., "European Association of Urology Guidelines on Sexual and Reproductive Health-2021 Update: Male Sexual Dysfunction," *European Urology* 80, no. 3 (2021): 333–357.

[12] G.-J. Zhao, Q. Guo, Y.-F. Li, and Y.-G. Zhang, "Efficacy and Safety of Dapoxetine for Premature Ejaculation: An Updated Systematic Review and Meta-Analysis," *Sexual Health* 16, no. 4 (2019): 301–313.

[13] H. Porst, F. Montorsi, R. C. Rosen, L. Gaynor, S. Grupe, and J. Alexander, "The Premature Ejaculation Prevalence and Attitudes (PEPA) Survey: Prevalence, Comorbidities, and Professional Help-Seeking," *European Urology* 51, no. 3 (2007): 816–823; discussion 824.

[14] H. S. You, "The Partial Neurectomy of the Dorsal Nerve of the Penis for Patient With Premature Ejaculation," *Korean Journal of Andrology* 18, no. 2 (2000): 143–148.

[15] Q. Liu, S. Li, Y. Zhang, et al., "Anatomic Basis and Clinical Effect of Selective Dorsal Neurectomy for Patients With Lifelong Premature Ejaculation: A Randomized Controlled

Trial," *The Journal of Sexual Medicine* 16, no. 4 (2019): 522–530.

[16] G. Breda, D. Xausa, A. Giunta, A. Tamai, P. Silvestre, and L. Gherardi, "Nomogram for Penile Biothesiometry," *European Urology* 20, no. 1 (1991): 67–69.

[17] B. J. Hill, E. Janssen, P. Kvam, E. E. Amick, and S. A. Sanders, "The Effect of Condoms on Penile Vibrotactile Sensitivity Thresholds in Young, Heterosexual Men," *The Journal of Sexual Medicine* 11, no. 1 (2014): 102–106.

[18] C-Y. Zhang, X-H. Li, T. Yuan, H-F. Zhang, J-H. Liu, and Z-Q. Ye, "[Regional Anatomy of the Dorsal Penile Nerve and Its Clinical Significance]," *Zhonghua nan ke xue = National Journal of Andrology* 15, no. 2 (2009): 130–133.

[19] Z. C. Xin, W. S. Chung, Y. D. Choi, D. H. Seong, Y. J. Choi, and H. K. Choi, "Penile Sensitivity in Patients With Primary Premature Ejaculation," *Journal of Urology* 156, no. 3 (1996): 979–981.

[20] D. Y. Yang, K. Ko, W. K. Lee, et al., "Urologist's Practice Patterns Including Surgical Treatment in the Management of Premature Ejaculation: A Korean Nationwide Survey," *The World Journal of Men's Health* 31, no. 3 (2013): 226–231.

[21] W.-G. Shi, X.-J. Wang, X.-Q. Liang, et al., "[Selective Resection of the Branches of the Two Dorsal Penile Nerves for Primary Premature Ejaculation]," *Zhonghua nan ke xue = National Journal of Andrology* 14, no. 5 (2008): 436–438.

[22] M. R. Nangle, J. Proietto, and J. R. Keast, "Impaired Cavernous Reinnervation After Penile Nerve Injury in Rats With Features of the Metabolic Syndrome," *The Journal of Sexual Medicine* 6, no. 11 (2009): 3032–3044.