Original Article

Open Access

Low-Dose Silodosin for Premature Ejaculation: A Clinical Evaluation

Sajid Mahmood Khan,[1] Asif Imran,[2] Muhammad Shafi Ghori,[3] Asif Shehzad,[4] Irfan Ul Haq[5]

ABSTRACT

BACKGROUND & OBJECTIVE: Premature ejaculation (PE) is one of the most common male sexual disorders and may occur alone or in association with erectile dysfunction. Various psychological, behavioral, local, and pharmacological treatment options are available; however, an ideal and universally accepted treatment regimen remains unavailable. This study aimed to evaluate the efficacy of silodosin 4 mg in the management of premature ejaculation.

METHODOLOGY: This comparative study included 120 patients with PE, who were equally divided into two groups. Group A comprised 60 patients who received silodosin 4 mg two hours before sexual intercourse, while Group B comprised 60 patients who received a placebo capsule. The study period was six months, with patients followed for three months. Pre- and post-treatment intravaginal ejaculation latency time (IELT), Premature Ejaculation Profile (PEP), and Clinical Global Impression of Change (CGIC) were recorded. Treatment-related adverse effects were also documented. Informed consent was obtained, and ethical considerations were observed.

RESULTS: The mean age was 29.6 ± 4.8 years in Group A and 29.8 ± 2.44 years in Group B. In Group A, 54 (90%) patients had lifelong PE and 6 (10%) had acquired PE, whereas in Group B, 52 (86.6%) patients had lifelong PE and 8 (13.3%) had acquired PE. In Group A, IELT increased significantly from less than one minute at baseline to 8.2 minutes after treatment with silodosin 4 mg. Significant improvement was also observed in PEP and CGIC scores among patients receiving silodosin.

CONCLUSION: Silodosin 4 mg appears to be an effective treatment option for patients with premature ejaculation, with negligible side effects. Its safety, affordability, and availability may make it a useful alternative therapeutic option for PE.

KEY WORDS: Premature ejaculation; Silodosin; Intravaginal ejaculation latency time; Premature Ejaculation Profile; Clinical Global Impression of Change; Alpha-1A blocker.

How to cite: *Khan SM, Imran A, Ghori MS, Shehzad A, Haq I. Low-Dose Silodosin for Premature Ejaculation: A Clinical Evaluation. J Allam Iqbal Med Coll. 2026; 24(3): 28-33*

INTRODUCTION

Premature ejaculation (PE) is the most common male sexual disorder, with a prevalence of approximately 30%. Its prevalence varies across cultures.[1] In a cross-sectional observational study conducted in 2021, polygamous men were reported to have a lower prevalence and incidence of PE and greater sexual satisfaction than monogamous men.[2] Premature ejaculation was first reported approximately a century ago.[3] Over the past few decades, several changes have been made to its definition and classification. The first evidence-based definition of PE was established in 2014.[4]

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) renamed premature ejaculation as early ejaculation and defined it as a pattern of ejaculation occurring within approximately one minute of vaginal penetration, persisting for at least six months, and occurring during 75–100% of sexual encounters. Premature ejaculation has also been categorized as mild when ejaculation occurs approximately 30 seconds to one minute after vaginal penetration, moderate when it occurs within approximately 15–30 seconds, and severe when it occurs before sexual activity, during foreplay, or within approximately 15 seconds of vaginal penetration.[5]

The International Society for Sexual Medicine (ISSM) defines PE as a male sexual dysfunction characterized by ejaculation that always or nearly always occurs before or within approximately one minute of vaginal penetration, or by a clinically significant reduction in ejaculatory latency time. Premature ejaculation is classified as lifelong when it has been present since the first sexual encounter and acquired when it develops later in life.[6]

Various treatment modalities are available, including psychotherapy, behavioral therapy, topical treatments, oral medications, and surgical interventions such as dorsal nerve neurotomy, glans penis augmentation with hyaluronic acid, the inner condom technique, cryoablation, radiofrequency ablation, implantation of an autologous decellularized matrix, and frenulectomy. However, a universally accepted standard approach to PE management remains lacking.

Dapoxetine 30 mg, a short-acting selective serotonin reuptake inhibitor (SSRI), is currently one of the most commonly used pharmacological treatments for PE. Although it has not been approved by the United States Food and Drug Administration, it is used for PE in Europe and the United Kingdom. Its adverse effects include dizziness, headache, nausea, vomiting, dry mouth, decreased sexual desire, ataxia, and drowsiness. Abrupt discontinuation of SSRIs may also produce symptoms known as SSRI discontinuation syndrome.[7]

Correspondence:
Dr Sajid Mahmood
Associate Professor of Urology, Mayo Hospital / KEMU, Lahore.
Email: dhmsk71@gmail.com

* Received for Publication: April 05, 2026
* Revision Received: July 12, 2026
* Accepted for Publication: September 01, 2026

Serotonin functions as a central inhibitory neurotransmitter in sexual activity, whereas dopamine has a central excitatory role. SSRIs inhibit the reuptake of serotonin into presynaptic serotonergic neurons, thereby increasing its concentration within the synaptic cleft. This reduction in serotonin reuptake has been proposed as the principal mechanism through which SSRIs delay ejaculation.

Silodosin is a highly uroselective α_1A-adrenergic receptor antagonist with a well-established role in the management of benign prostatic hyperplasia.[8] Silodosin 4 mg is now being evaluated as a potential treatment for PE. Unlike dapoxetine, which acts through a central mechanism, silodosin acts peripherally on the seminal vesicles, vas deferens, prostate gland, and associated smooth muscles, all of which contain abundant α_1A-adrenergic receptors. By blocking these receptors, silodosin may inhibit seminal emission and delay ejaculation. Silodosin 4 mg is generally well tolerated; reported adverse effects include nasal congestion, reduced semen volume, and, rarely, excessively delayed ejaculation or anorgasmia.[9]

The therapeutic role of silodosin is also being investigated in several other urological conditions, including distal ureteric calculi, chronic prostatitis, chronic pelvic pain syndrome, overactive bladder, acute urinary retention, prostate cancer, post-brachytherapy urinary symptoms, and premature ejaculation.[10] In the present study, we evaluated the role of silodosin 4 mg in the management of PE.

Historically, PE received limited attention in modern medicine. However, research interest has increased considerably over recent decades, extending to the genetic basis of the condition. The SLC6A4 gene, located on chromosome 17, encodes the serotonin transporter responsible for serotonin reuptake, and polymorphisms within this gene have been associated with PE.[11] Nevertheless, the pathophysiology of PE remains complex and incompletely understood, warranting further research to develop more effective management strategies.

The situation may be particularly concerning in developing countries such as Pakistan, where the misconception that allopathic medicine has no effective treatment for PE remains widespread. This culturally embedded misconception has partly been reinforced by traditional healers and unqualified practitioners. Consequently, patients with PE may initially seek treatment from traditional healers or unqualified practitioners, subsequently consult a qualified medical practitioner, and approach a urologist only when specialist services are accessible. Therefore, there is a pressing need to establish effective, accessible, and evidence-based strategies for the management of PE.

METHODOLOGY

The study was conducted in urology department, Nishtar medical college, Multan .The study duration was six months commencing from 1st of September 2025. Prior permission was taken from the ethical committee. Ethical issues were taken into account. 120 patients who reported premature ejaculation were included in the study. Informed consent was taken 120 patients were randomly divided into two groups. Group A and group B, each group comprised of 60 patients, group A patient received the silodosin 4mg, 2 hours before sexual activity. Group B patients received the placebo. Only male partner was included in the study due to our social constrains. The sample size calculation and statistical analysis were done with the consultation of biostat department. IELT, PEP (Four domains of PEP, Patrick et al, Study design was Comparative longitudnal study perceived control over ejaculation, satisfaction with sexual intercourse, personal distress with sexual intercourse and interpersonal difficulty related to ejaculation) and CGIC (Clinical global impression of change, a 7-point response scale Very much improved, much improved, minimally improved, no change, minimally worse, much worse and very much worse) were recorded prior to the start of the treatment and after the treatment. Any adverse effects of the silodosin reported by the patients were recorded. All concerned variable were recorded. Quantitative data expressed as mean, median and standard deviation. Qualitative data were expressed as frequency and percentage. Data analysis was done by applying student t test and chi square tests using statistical package for social sciences SPSS version 17. The p value less than 0.05 was taken as significant. P-value less than 0.001 was taken as highly significant and p-value more than 0.05 was taken as not significant. The advantage of telemedicine was taken to facilitate the patients from far flung areas. The patients were instructed how to record the IELT with stop watch or with cell phone. The study duration was six months and patients were followed for three months. The relevant Performa were printed in Urdu language. History taking and examination was conducted.

Patients Diagnosed according to (DSM-IV TR) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision and married male, age 20 to 45 years were included in this study.

Following were excluded

1 Age above 45 years.
2 hypotensive patients.
3 Drug abuse or alcohol abuse.
4 psychological or mental disorders
5 Diabetics
6 Patients taking sex hormones.
7 Patients who has taken PE treatment in last three months.
8 Patients on anti-depressive therapy.
9 Patients using local anesthetic spray or intracavernous injections.
10 Patients with BPH
11 Patients with urethral stricture.

12 Urological malignancy.

RESULTS

Average age in group A was 29.6 + 2.83. average age in group B was 31.2 + 2.44(as shown in Table I). In group A, 54 patients (90%) had lifelong PE, 6 patients (10%) had acquired PE. No statistically significant difference in age in two groups. In group B, 52 patients (86.6%) had lifelong PE and 8 patients (13.3%) had acquired PE (as shown in Table II).

Table I: Age of Patients in Group A & B

Average Age in Years	Group A	Group B
	29.6 ± 4.8	31.8± 3.2

We measured intravaginal ejaculatory latency time (IELT) in minutes. In group A before treatment it was 0.9 ± 0.4 and after treatment it became 8 ± 0.2 and this difference statistically is highly significant. In group B, IELT pretreatment was 0.8 ± 0.3 and post treatment it became 1.4 ± 0.3 which is statistically not significant as shown in the Figure 1.

Table II: Types of PE

	Group A, n= 60		Group B, n= 60	
Lifelong PE	54	90%	52	86%
Acquired PE	6	10%	8	13.30%

We used PEP-4 domain premature ejaculation assessment tool, develop and validated by Patrick et al in 2009.[12] In perceived control over ejaculation domain before treatment 38 patients (63.3%) had very poor control and 22 patients (36.6%) had poor control, after treatment 19 patients (31.6%) had very good control and 37 patients (61.6%) had good control and this difference is statistically significant. In satisfaction with intercourse domain before treatment, 25 patients (41.6%) were very poorly satisfied, 26 patients (43.3%) poorly satisfied and 9 patients (15%) were fairly satisfied, but after treatment 19 patients

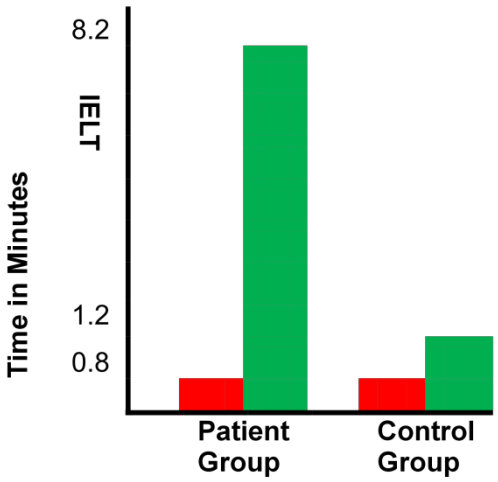
Table III: Table of Side Effects

Side Effects	Patient n=60	% age	Control n=60	%age
Decreased Semen Volume	8	13.30%	0	0
Uncomfortably Delayed Ejaculation	5	8.30%	0	0
Anejaculation	1	1.60%	0	0
Anorgasm	0	0%	0	0

(31.6%) satisfaction level was very good, 28 patients (46.6%) good, 7 (11.6%) fair and 4 patients (6.6%) poor, and 2 patients (3.3%) very poor level of satisfaction.

In ejaculation related distress domain before treatment, 24 patients (40%) had extreme ejaculation distress, 22 patients (36.6%) had quite a bit, 14 patients (23.3%) had moderate level of ejaculation related distress and after treatment 45 patients (75%) had little bit distress, 12 patients (20%) had moderate distress, 1 patient (1.6%) quite a bit and 2 patients (3.3%) had extreme distress. This difference in pre and post treatment is statistically significant. In last domain of ejaculation related difficulty in interpersonal relationship before treatment 11 patients (18.3%) had extreme difficulty, 17 patients (28.3%) quite a bit, 20 patients (33.3%) moderately and 12 patients (20%) had a little bit difficulty and after treatment 23 patients (38.3%) had no difficulty at all, 29 patients (48.3%) had little bit, 2 patients (3.3%) moderate, 1 patient (1.6%) quite a bit, and 5 patients (8.3%) had extreme difficulty. Once again this difference pre and post treatment is highly significant, results of all four domains are shown in Table IV.

Clinical global impression of change (CGIC), is a 7-points response scale to measure CGIC of PE. The 7-points are very much improved, much improved, minimally improved, no change, minimally worse, much worse and very much worse. Before treatment 9 patients (15%) minimally improved and 51 patients (85%) showed no change. After treatment 9 patients (15%) very much improved, 34 patients (56%) much improved and 17 patients (28.3%) minimally improved. This difference in pre and post treatment CGIC points found statistically significant as shown in the Table V. We found decreased semen volume in 8 patients (13.3%), uncomfortably



delayed ejaculation in 5 patients (8.3%), and these two side effects are statistically significant. In one patient (1.6%) there was an ejaculation, as shown in Table III.

Figure 1: Graphic Representation of IELT Pre & Post Treatment Red bar showing IELT before treatment in patient and control group. Green bar showing IELT after treatment in patient and control group.

DISCUSSION

Premature ejaculation (PE) is the most common male

Table IV: Premature Ejaculation Profile (PEP)

Group A (Patient Group)		Pre-Treatment		Post-Treatment	
		n=60 % age		n=60 % age	
Perceived Control Over Ejaculation	Very Poor	38	63.30%	1	1.80%
	Poor	22	36.60%	3	5%
	Fair	0	0	0	0
	Good	0	0	37	61.60%
	Very Good	0	0	19	31.60%
Satisfaction with Intercourse	Very Poor	25	41.60%	2	3.30%
	Poor	26	43.30%	4	6.60%
	Fair	9	15%	7	11.60%
	Good	0	0	28	46.60%
	Very Good	0	0	19	31.60%
Personal Distress with Ejaculation	Extremely	24	40%	2	3.30%
	Quite a Bit	22	36.60%	1	1.60%
	Moderately	14	23.30%	12	20%
	A Little bit	0	0	45	75%
	Not at All	0	0	0	0
Inter Personal Difficulty Related to Ejaculation	Extremely	11	18.30%	5	8.30%
	Quite a Bit	17	28.30%	1	1.60%
	Moderately	20	33.30%	2	3.30%
	A Little bit	12	20%	29	48.30%
	Not at All	0	0	23	38.30%

Table V: Clinical Global Impression of Change, A-7 points response scale

CGIC	Patients n= 60		Control n= 60	
Very Much Improved	9	15%	0	0
Much Improved	34	56%	0	0
Minimaly improved	17	28.30%	9	15%
No Changed			51	58%
Minimaly Worse				
Much Worse				
Very Much Worse				

sexual dysfunction. In the United States, approximately one in three men aged 18–59 years experiences PE. Depression, anxiety, stress, guilt, lack of confidence, a history of sexual repression, relationship problems, and unrealistic expectations about sexual activity are among its possible causes. Premature ejaculation can occur at any age. Although ageing is not a direct cause, PE may occur at an advanced age, possibly because of low testosterone levels. Nevertheless, the association between testosterone levels and PE remains unclear, as both excessively high and low testosterone levels have been implicated.[13]

Numerous treatments have been prescribed for PE; however, none has been universally accepted as completely satisfactory or as the definitive gold-standard treatment. Therefore, identifying an effective and well-tolerated treatment for PE remains challenging. At present, dapoxetine is a mainstay of pharmacological treatment. It delays ejaculation by inhibiting the ejaculatory reflex and has been reported to be safe and effective.[14] However, selective serotonin reuptake inhibitors may produce psychiatric and neurological adverse effects.

In a Chinese study, cumulative dapoxetine discontinuation rates at 4, 8, and 12 weeks after treatment were 12.0%, 41.3%, and 62.7%, respectively. The reported reasons for discontinuation included unrealistically high expectations regarding efficacy (30.9%), recurrence of symptoms following drug withdrawal (26.6%), high treatment cost (25.5%), adverse effects (9.6%), fear of drug dependence (4.3%), loss to follow-up (2.1%), and preference for other treatments (1.1%).[15] In addition to its adverse effects and high discontinuation rate, dapoxetine is unavailable in many countries, including Pakistan. These limitations have encouraged researchers to investigate more suitable therapeutic options for PE.

Silodosin is generally well tolerated following oral

administration and may produce fewer adverse effects than conventional SSRIs such as dapoxetine. In 2016, Sato and Otani compared the efficacy of silodosin with that of naftopidil, a comparatively weak α_1-adrenergic receptor antagonist used as the control drug. Silodosin significantly prolonged intravaginal ejaculatory latency time (IELT) compared with the control treatment. Premature Ejaculation Profile (PEP) and Clinical Global Impression of Change (CGIC) scores also improved compared with baseline and the control group. However, 12 patients (46%) experienced reduced semen volume.[16] The frequency of reduced semen volume reported in that study was higher than that observed in the present study; nevertheless, the improvements in IELT, PEP, and CGIC were consistent with our findings.

In another study conducted by Bhat and Shastri in 2016, silodosin 4 mg was found to be an effective treatment option for PE, with relatively few adverse events, particularly among patients who were dissatisfied with dapoxetine 30 mg because of its adverse effects.[17] Hodeeb et al. evaluated the effectiveness and safety of silodosin for PE in 2019 and reported statistically significant increases in IELT as well as improvements in PEP and CGIC scores following treatment. These findings are consistent with those of the present study. The authors concluded that silodosin 4 mg administered two hours before sexual intercourse represented a promising, effective, affordable, safe, and readily available treatment option for PE in Egypt.[18]

Maladkar et al. reported in 2024 that, among α-adrenergic receptor antagonists, silodosin was highly effective and well tolerated and produced fewer adverse effects than SSRIs traditionally used for PE, such as dapoxetine.[19] Similarly, a meta-analysis by Fauzan et al. identified silodosin as a potential new therapeutic strategy for PE.[20] In a randomized controlled trial conducted in 2022, Sharma and Darshi concluded that silodosin 4 mg was as effective as dapoxetine 30 mg but had a more favourable adverse-effect profile in the management of PE.[21] Saleh et al. also reported in their 2021 review that silodosin 4 mg was effective in improving PEP scores and prolonging IELT.[22]

In the present study, reduced semen volume was observed in eight patients (13.3%), while uncomfortably delayed ejaculation occurred in five patients (8.3%) in Group A. These adverse effects were statistically significant. They may potentially be managed by reducing the silodosin dose to 2 mg; however, further clinical trials are required to evaluate the efficacy and safety of this approach. Reduced semen volume and delayed ejaculation have also been reported in previous studies, including that conducted by Sato and Otani.[16]

CONCLUSION

We concluded that silodosin 4mg is significantly effective in the management of PE with negligible side effects. It is also suitable for those patients who cannot take dapoxetine due to its side effects. We recommend silodosin 4mg, two hours before sexual intercourse as it is safe, cheap, effective and easily available. However further multicenter trials are needed to further elucidate the role of 4mg silodosin especially with dose reduction to 2mg.

Ethical approval:

Ethical approval was taken from institutional review board of Nishtar Medical University with the IRB number 14454/NMU Dated 08-08-2025.

Conflict of Interest:

Authors declare no conflict of interest.

Financial Disclosure:

None

REFERENCES

1. Coskuner ER, Ozkan B. Premature ejaculation and endocrine disorders: a literature review. World J Mens Health. 2022;40(1):38-51. doi:10.5534/wjmh.200184.
2. Mohamed AH, Mohamud HA, Yasar A. The prevalence of premature ejaculation and its relationship with polygamous men: a cross-sectional observational study at a tertiary hospital in Somalia. BMC Urol. 2021;21(1):175. doi:10.1186/s12894-021-00942-0.
3. Raveendran AV, Agarwal A. Premature ejaculation-current concepts in the management: a narrative review. Int J Reprod Biomed. 2021;19(1):5-22. doi:10.18502/ijrm.v19i1.8176.
4. Romano L, Arcaniolo D, Spirito L, Quattrone C, Bottone F, Pandolfo SD, et al. Comparison of current international guidelines on premature ejaculation: 2024 update. Diagnostics (Basel). 2024;14(16):1819. doi:10.3390/-diagnostics14161819. 1
5. Shindel AW, Althof SE, Carrier S, Chou R, McMahon CG, Mulhall JP, et al. Disorders of ejaculation: an AUA/SMSNA guideline. J Urol. 2022;207(3):504-512. doi:10.1097/-JU.0000000000002392.
6. Saleh R, Majzoub A, Abu El-Hamd M. An update on the treatment of premature ejaculation: a systematic review. Arab J Urol. 2021;19(3):281-302. doi:10.1080/2090598X.-2021.1943273.
7. Gul M, Bocu K, Serefoglu EC. Current and emerging treatment options for premature ejaculation. Nat Rev Urol. 2022;19(11):659-680. doi:10.1038/s41585-022-00639-5.
8. Sathianathen NJ, Hwang EC, Mian R, Bodie JA, Soubra A, Lyon JA, et al. Selective serotonin re-uptake inhibitors for premature ejaculation in adult men: a Cochrane systematic review. World J Mens Health. 2022;40(2):257-263. doi:10.5534/wjmh.210155.
9. Liu G, Yin Y, Zhang L, He D, Yang L. Efficacy of dapoxetine in the treatment of patients with lifelong premature ejaculation as an alternative to sertraline therapy. Sex Med. 2022;10(1):100473. doi:10.1016/j.esxm.2021.100473.
10. Mohseni Rad H, Zahirian Moghadam T, Hosseinkhani A, Soluki N, Amani F. Comparison of dapoxetine/tadalafil and paroxetine/tadalafil combination therapies for the treatment of premature ejaculation: a randomized clinical trial. Urol J. 2022;19(2):138-143. doi:10.22037/uj.v18i.6644.
11. Lee HY, Pyun JH, Kim JY. Efficacy of various treatments in premature ejaculation: a systematic review and network

meta-analysis. World J Mens Health. 2024;42(2):338-346. doi:10.5534/wjmh.230030.

12. Fauzan MI, Daryanto B, Budaya TN, Makkaraka MAG, Fakhri M, Rahman IA. Promising selective alpha-1 blocker silodosin as a new therapeutic strategy for premature ejaculation and analysis of its adverse effects: a systematic review and meta-analysis of randomized controlled trials. Arch Ital Urol Androl. 2024;96(4):12984. doi:10.4081/aiua.2024.12984.
13. Abdellatif A, Elbatanouny A, Ragheb A, Abdelbary A, Eid A, Lotfy AM, et al. Comparative evaluation of safety and efficacy of dapoxetine, silodosin, and citalopram in the management of premature ejaculation: a randomized clinical trial. BMC Urol. 2025;25:273. doi:10.1186/s12894-025-01973-7.
14. Shaher H, Kandil W, Elatreisy A. On-demand silodosin 4 mg versus dapoxetine 60 mg in the treatment of primary premature ejaculation: a prospective randomized study. Arab J Urol. 2025. doi:10.1080/20905998.2025.2573579.
15. Abdel-Hamid IA, Abo-Aly M, Mostafa T. Phosphodiesterase type 5 inhibitors and premature ejaculation: an overview of systematic reviews and meta-analyses using AMSTAR 2, ROBIS, and GRADE. Sex Med Rev. 2023;11(1):23-51. doi:10.1093/sxmrev/qeac003.
16. Gharib TM, Abdel-Al I, Elatreisy A, Kandeel W, El-Shaer W, Abdrabuh AM, et al. Short- and long-term follow-up results of daily 5-mg tadalafil as a treatment for erectile dysfunction and premature ejaculation. Arab J Urol. 2022;20(1):49-53. doi:10.1080/2090598X.2021.2024695.
17. Shah MDA, Shah S, Nusrat NB, Zafar N, Rehman A. Topical anesthetics and premature ejaculation: a systematic review and meta-analysis. Cureus. 2023;15(8):e42913. doi:10.7759/cureus.42913.
18. Cai T, Gallelli L, Verze P, Salonia A, Palmieri A. Prilocaine/lidocaine spray for the treatment of premature ejaculation: a dose- and time-finding study for clinical practice. Int J Impot Res. 2023;35(4):378-384. doi:10.1038/s41443-022-00554-8.
19. Zheng L, Wei LT, Song C, Liu W, Jiang H, Jiang T, et al. The effect of local anesthetic on hypersensitive and nonsensitive penile areas in primary premature ejaculation: a pilot study. Sex Med. 2024;12(2):qfae020. doi:10.1093/sexmed/qfae020.
20. Pizzol D, López Sánchez GF, Ilie PC, Bertoldo A, Trott M, Tully MA, et al. Non-pharmacological approaches for treatment of premature ejaculation: a systematic review. Trends Urol Mens Health. 2023;14(2):15-20. doi:10.1002/tre.903.
21. Li L, Geng H, Chen M, Hu W, Ye Q. Cognitive behavioural therapy combined with selective serotonin reuptake inhibitors for premature ejaculation: a systematic review and meta-analysis. Andrology. 2025;13(6):1646-1660. doi:10.1111/andr.13787.
22. Shebl SE, Ali S, Shokr M. Hyaluronic acid injection in the glans penis for the treatment of refractory premature ejaculation: a prospective controlled study. Andrologia. 2021;53(6):e14084. doi:10.1111/and.14084

Authors' Contributions:

AI & SMK: Conceptualization and study design

MSG& AS: Data Collection and manuscript drafting.

IUH, AS& SMK: Data Analysis and critical review.

IUH, AI & MSG: Supervision & Manuscript drafting & proof reading.

All authors have read and approved the final version of the manuscript and are responsible and accountable for the accuracy and integrity of the work.

1. Sajid Mahmood Khan
   Associate Professor of Urology, Mayo Hospital / KEMU, Lahore.
2. Asif Imran
   Professor HOD, Urology Department, Nishter Medical University, Multan.
3. MUHAMMAD SHAFI GHORI
   Assistant Professor of Urology, Mayo Hospital/ KEMU, Lahore.
4. ASIF SHEHZAD
   Senior Registrar, Urology Department, Mayo Hospital/ KEMU, Lahore
5. IRFAN UL HAQ
   Senior Registrar Urology Unit -II, Mayo Hospital/ KEMU, Lahore.