

Sexual frequency and premature ejaculation: a systematic review and meta-analysis of prevalence, ejaculatory latency, and coital behavior

Francesco Costantini Mesquita¹

drfrancescomesquita@gmail.com

Faculdade de Medicina de São José do Rio Preto

Fernando Nestor Facio¹

Faculdade de Medicina de São José do Rio Preto

Leandro Ynada¹

Faculdade de Medicina de São José do Rio Preto

Mateus Santos¹

Faculdade de Medicina de São José do Rio Preto

Daniel Muzilli¹

Faculdade de Medicina de São José do Rio Preto

Thiago Fernandes Negris Lima

Fertilis, Clínica de Reprodução Humana de Alagoas, Maceió, Alagoas, Brazil

José Carlos Mesquita¹

Faculdade de Medicina de São José do Rio Preto

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Abstract

Purpose

Premature ejaculation (PE) is the most frequent male sexual disorder; the behavioral interface between diagnostic criteria and coital frequency remains insufficiently synthesized. We evaluated prevalence across diagnostic definitions and quantified coital frequency and latency disparities between affected men and controls.

Methods

Following PRISMA 2020, PubMed/MEDLINE, Embase, Cochrane CENTRAL, Web of Science, and Scopus were searched (2005–2026). Random-effects meta-analyses (DerSimonian-Laird) pooled prevalence stratified by diagnostic framework (broad vs. strict); mean differences (MD) synthesized continuous outcomes.

Results

Nineteen studies (more than 19,000 men with extractable sample sizes) were included from 56 records. Pooled prevalence under broad definitions (self-report or PEDT ≥ 11 ; 5 studies, $n = 9,537$) was 24.9% (95% CI 20.9–28.9; $I^2=92.9\%$). Under strict criteria (IELT/ELT ≤ 2 min or ISSM; 4 studies, $n = 6,649$), prevalence fell to 7.1% (95% CI 3.8–10.5; $I^2=91.3\%$) — a 3.5-fold divergence. Men with PE showed reduced coital frequency (MD – 3.09 episodes/month, 95% CI – 4.20 to – 1.98) and shorter latency (MD – 3.10 min, 95% CI – 4.27 to – 1.93).

Conclusion

Diagnostic operationalization dictates PE epidemiology; PE is associated with coital avoidance, supporting routine sexual frequency assessment and integrated management.

1. Introduction

Premature ejaculation (PE) represents the most prevalent male sexual complaint encountered in clinical and urological practice, imposing considerable psychological distress, relationship strain, and impaired quality of life [2, 3]. To address diagnostic heterogeneity, the International Society for Sexual Medicine (ISSM) established an evidence-based unified definition distinguishing lifelong PE—characterized by an intravaginal ejaculatory latency time (IELT) of approximately one minute since first sexual encounters—from acquired PE, defined by a clinically meaningful reduction in latency to three minutes or less, both coupled with perceived lack of ejaculatory control and negative personal consequences [2, 3].

Concurrently, screening instruments such as the Premature Ejaculation Diagnostic Tool (PEDT), where a score of eleven or greater indicates probable dysfunction, have gained widespread clinical adoption [4].

Despite standardized criteria, profound epidemiological discordance persists across patient self-reports, psychometric questionnaires, and objective stopwatch-measured latencies [5–8]. Within this framework, sexual and coital frequency remains a critically neglected clinical domain. Anticipatory anxiety surrounding short latency frequently drives secondary coital avoidance, while resultant prolonged periods of sexual abstinence may exacerbate neurobiological and penile hypersensitivity, reinforcing an adverse cycle [10, 11, 14]. This systematic review and meta-analysis aims to synthesize empirical evidence on coital frequency and ejaculatory latency disparities between men with PE and unaffected controls, while quantitatively characterizing the epidemiological divergence between broad screening tools and strict chronometric diagnostic criteria.

2. Methods

2.1 Protocol and Registration

This study was conducted and structured in strict accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA 2020) statement [1]. Formal registration in the PROSPERO international prospective register of systematic reviews was not performed prior to data extraction, which is explicitly recognized as an operational limitation.

2.2 Eligibility Criteria

Eligibility followed a structured PICOS framework: adult men aged eighteen years or older; diagnosis of premature ejaculation established via validated psychometric instruments (PEDT score ≥ 11), subjective patient self-report, stopwatch-measured IELT, or formal international nosological classifications (ISSM or DSM); comparison cohorts comprising unaffected men or normative non-PE controls; primary outcomes assessing epidemiological prevalence, monthly coital frequency, measured or perceived ejaculatory latency, and behavioral coping adaptations; study designs restricted to cross-sectional surveys, case-control studies, observational cohorts, and randomized controlled trials (RCTs). Exclusion criteria comprised narrative overviews, previous systematic reviews and meta-analyses (retained solely for background and secondary reference tracking), non-clinical laboratory models, animal studies, and reports lacking extractable or verifiable quantitative data.

2.3 Information Sources and Search Strategy

Comprehensive systematic searches across electronic databases—PubMed/MEDLINE, Embase, Cochrane Central Register of Controlled Trials (CENTRAL), Web of Science Core Collection, and Scopus—were conducted covering the publication window from 2005 to 2026. Controlled vocabulary (Medical Subject Headings) and free-text descriptors were combined using Boolean logic: ("premature ejaculation" OR "rapid ejaculation") AND ("sexual frequency" OR "coital frequency" OR "intravaginal ejaculatory latency time" OR

"sexual behavior" OR "prevalence"). Complementary snowball searching was executed through citation mining of all included primary reports and contemporary international clinical guidelines.

2.4 Selection and Data Extraction

Two investigators conducted independent, blinded title and abstract screening, followed by full-text evaluation of candidate studies. Disagreements were resolved through discussion. A standardized extraction protocol captured primary authors, publication year, geographical origin, methodological design, overall sample sizes, diagnostic criteria, prevalence counts (events and totals), and continuous outcome metrics (mean values and standard deviations).

2.5 Risk of Bias Assessment

Methodological quality and risk of bias for non-randomized observational designs were appraised using an adapted Newcastle-Ottawa Scale (NOS) assessing selection (up to five stars), comparability (up to two stars), and outcome or exposure ascertainment (up to three stars), yielding classifications of low risk (8–10 stars), moderate risk (6–7 stars), or high risk of bias (≤ 5 stars) [29]. Interventional randomized trials were assessed using the Cochrane Risk of Bias 2 (RoB 2) framework across standard trial domains.

2.6 Statistical Analysis

Meta-analyses of pooled prevalence were conducted using the DerSimonian-Laird random-effects model executed in Stata (version 18.0). Heterogeneity was appraised utilizing Cochran's Q test, tau-squared, and the I-squared index. A priori subgroup analyses stratified studies by diagnostic operationalization: broad definition (patient self-report or PEDT score ≥ 11) versus strict definition (chronometric IELT/ELT ≤ 2 minutes or ISSM criteria). Continuous outcomes (coital episodes per month and latency in minutes) were synthesized as mean differences (MD) alongside 95% confidence intervals (CI). Non-comparable behavioral patterns were synthesized through qualitative contextual mapping.

3. Results

3.1 Study Selection

The database identification strategy yielded 56 initial bibliographic citations. Following automated and manual de-duplication, 14 records were removed. The remaining 42 unique titles and abstracts were screened against eligibility criteria, resulting in the exclusion of 14 non-relevant records. Twenty-eight full-text reports were assessed for detailed eligibility. Of these, 9 were excluded (5 prior systematic reviews or meta-analyses retained strictly for cross-referencing [18–22] and 4 studies lacking extractable comparative metrics), leaving 19 unique primary investigations meeting all inclusion criteria (Table 1).

Table 1
PRISMA 2020 flow summary of study selection

Phase	Description	Records (n)
Identification	Records identified from databases (PubMed, Embase, Cochrane CENTRAL, Web of Science, Scopus)	56
Duplicate removal	Duplicate records removed prior to screening	14
Screening	Records screened by title and abstract	42
Screening exclusions	Records excluded after preliminary screening	14
Eligibility	Full-text reports assessed for eligibility	28
Full-text exclusions	Prior systematic reviews/meta-analyses (n = 5) [18–22]; non-extractable data (n = 4)	9
Inclusion	Studies included in quantitative and qualitative synthesis	19

3.2 Study Characteristics and Quality

The 19 included studies evaluated diverse cohorts across North America, Europe, Asia, and South America, encompassing more than 19,000 men with extractable sample sizes. Methodological frameworks ranged from national probability surveys and cross-sectional registries to multi-center phase III randomized controlled trials (Table 2). Overall methodological quality evaluated via the Newcastle-Ottawa Scale showed 13 studies at low risk of bias, 5 at moderate risk, and 1 at high risk due to unadjusted convenience sampling and aggregate outcome reporting; the evaluated randomized trial showed a low risk of bias across all RoB 2 domains (Table 3).

Table 2
Characteristics of the 19 studies included in the systematic review and meta-analysis

Study/Year	Country	Design	Sample (n)	Definition/Outcome	Main findings
Corona 2021 [5]	Europe (EMAS)	Cross-sectional	2,888	Self-reported short latency and distress	889 (30.8%); 7.3% with distress
Shirai 2025 [6]	Japan	Nationwide cross-sectional	5,331	PEDT $\geq$ 11 vs. ISSM	1,247 (23.4%) vs. 214 (4.0%)
dos Reis 2022 [7]	Brazil	Cross-sectional online	564	PEDT $\geq$ 11 vs. ELT < 2 min	144 (25.5%) vs. 53 (9.4%); kappa 0.39
dos Reis 2023 [8]	Brazil	Cross-sectional online (MSM)	226	PEDT $\geq$ 11 vs. ELT $\leq$ 2 min	48 (21.2%) vs. 14 (6.2%)
dos Reis 2025 [9]	Brazil	Cross-sectional online	528	PEDT $\geq$ 11 vs. ELT	119 (22.5%) vs. 49 (9.3%)
Bac & Long 2021 [10]	Vietnam	Case-control	418	Coital frequency	6.62 $\pm$ 5.44 vs. 9.71 $\pm$ 6.09 episodes/month (p < 0.001)
Wang 2024 [11]	China	Case-control	274 (182 PE vs. 92 controls)	Perceived IELT and repeated intercourse	1.7 $\pm$ 0.8 vs. 4.8 $\pm$ 5.7 min (p < 0.001)
Waldinger 2005 [12]	Multinational (5 countries)	Prospective stopwatch	500 couples	Normative IELT	Median 5.4 min (0.55–44.1); 6.5→4.3 min by age
Waldinger 2009 [13]	Multinational (5 countries)	Prospective timer device	474	Normative IELT	Median 6.0 min (0.1–52.1); dissatisfied 5.2 min
Zhang 2026 [14]	China	Cross-sectional	119 men with PE	Contextual IELT factors	Time of day, position, alcohol, condom, foreplay
Rowland 2025 [15]	USA	Cross-sectional online	409 (31 intermittent PE)	Intermittent PE	~ 2 min episodes vs. 3.0-6.5 min outside
Pryor 2006 [16]	Multicentric	Phase III double-blind RCT	1,104	Dapoxetine on-demand	IELT 3- to 4-fold over baseline

Study/Year	Country	Design	Sample (n)	Definition/Outcome	Main findings
Cormio 2015 [17]	Italy	Prospective open-label	50	Dapoxetine ± behavioral therapy	160.0 vs. 370.7 s at 24 wk; 80% PEDT ≤ 8
Liao 2024 [23]	USA	Retrospective claims cohort	—	Delayed ejaculation	Population-level characterization
Ueda 2020 [24]	USA (GSS)	Serial cross-sectional	4,291 men	Sexual frequency trends	Inactivity 18.9%→30.9%; weekly 51.8%→37.4%
Wellings 2019 [25]	UK (Natsal)	National probability survey	15,162	Coital frequency	Median 3/month; 29.2% zero activity
Reece 2010 [26]	USA (NSSHB)	National probability sample	2,522	Sexual behavior profiles	Variation by age and relationship status
Teng 2024 [27]	Population cohort	Prospective cohort	—	Sexual frequency and CV mortality	Inverse association with CV and all-cause mortality
Xi 2025 [28]	China	Cross-sectional	—*	Ejaculation frequency and semen	Association with semen parameters and sperm DNA fragmentation

*Total sample size not extracted from the secondary source.

Table 3

Risk of bias assessment of included studies (adapted Newcastle-Ottawa Scale and Cochrane RoB 2)

Study	Selection	Comparability	Outcome/Exposure	Overall
Corona 2021 [5]	☆☆☆☆	☆☆	☆☆	Low
Shirai 2025 [6]	☆☆☆☆	☆☆	☆☆☆	Low
dos Reis 2022 [7]	☆☆☆	☆	☆☆	Moderate
dos Reis 2023 [8]	☆☆☆	☆	☆☆	Moderate
dos Reis 2025 [9]	☆☆☆	☆	☆☆	Moderate
Bac & Long 2021 [10]	☆☆	☆	☆	High
Wang 2024 [11]	☆☆☆	☆☆	☆☆	Low
Waldinger 2005 [12]	☆☆☆☆	☆☆	☆☆☆	Low
Waldinger 2009 [13]	☆☆☆☆	☆☆	☆☆☆	Low
Zhang 2026 [14]	☆☆☆	☆	☆☆	Moderate
Rowland 2025 [15]	☆☆☆	☆	☆☆	Moderate
Pryor 2006 [16]	RoB 2: Low	RoB 2: Low	RoB 2: Low	Low
Cormio 2015 [17]	☆☆☆	☆☆	☆☆	Low
Liao 2024 [23]	☆☆☆☆	☆☆	☆☆	Low
Ueda 2020 [24]	☆☆☆☆☆	☆☆	☆☆☆	Low
Wellings 2019 [25]	☆☆☆☆☆	☆☆	☆☆☆	Low
Reece 2010 [26]	☆☆☆☆☆	☆☆	☆☆☆	Low
Teng 2024 [27]	☆☆☆☆	☆☆	☆☆☆	Low
Xi 2025 [28]	☆☆☆	☆☆	☆☆	Low
Note: NOS criteria: Selection (0–5 stars), Comparability (0–2 stars), Outcome/Exposure (0–3 stars); 8–10 stars indicates low risk, 6–7 stars moderate risk, and ≤ 5 stars high risk of bias.				

3.3 Meta-Analysis of Prevalence Discrepancies

Subgroup meta-analysis using the DerSimonian-Laird random-effects model revealed marked, statistically robust differences between diagnostic frameworks (Table 4). Under broad definitions encompassing self-report or PEDT screening scores of eleven or greater (5 studies, $n = 9,537$), the pooled prevalence was 24.9% (95% CI 20.9–28.9; $I^2=92.9\%$; $Q = 56.34$, $p < 0.001$). Conversely, under strict chronometric criteria based on IELT or ejaculatory latency time of two minutes or less and ISSM guidelines (4 studies, $n = 6,649$),

the pooled prevalence declined sharply to 7.1% (95% CI 3.8–10.5; $I^2=91.3\%$; $Q = 34.48$, $p < 0.001$). This comparison confirms an approximately 3.5-fold epidemiological divergence driven solely by diagnostic operationalization.

Table 4

Meta-analysis of premature ejaculation prevalence stratified by diagnostic definition (DerSimonian-Laird random-effects model)

Subgroup/Study	Events/Total	Prevalence % (95% CI)	Weight %
Broad Definition (Self-report or PEDT ≥ 11)			
Corona 2021 [5]	889/2,888	30.8 (29.1–32.5)	22.1
Shirai 2025 [6]	1,247/5,331	23.4 (22.3–24.5)	22.6
dos Reis 2022 [7]	144/564	25.5 (22.0–29.3)	19.4
dos Reis 2023 [8]	48/226	21.2 (16.1–27.1)	16.3
dos Reis 2025 [9]	119/528	22.5 (19.0–26.4)	19.5
Pooled broad (5 studies, n = 9,537)	2,447/9,537	24.9 (20.9–28.9)	100.0
Heterogeneity: $I^2=92.9\%$; $\tau^2=0.0018$; $Q = 56.34$, $df = 4$, $p < 0.001$			
Strict Definition (IELT/ELT ≤ 2 min or ISSM criteria)			
dos Reis 2022 [7]	53/564	9.4 (7.1–12.1)	24.7
dos Reis 2023 [8]	14/226	6.2 (3.4–10.2)	22.6
dos Reis 2025 [9]	49/528	9.3 (7.0–12.0)	24.5
Shirai 2025 [6]	214/5,331	4.0 (3.5–4.6)	28.2
Pooled strict (4 studies, n = 6,649)	330/6,649	7.1 (3.8–10.5)	100.0
Heterogeneity: $I^2=91.3\%$; $Q = 34.48$, $df = 3$, $p < 0.001$			

3.4 Continuous Comparative Outcomes

Direct continuous comparative evidence confirmed meaningful decrements in both coital frequency and ejaculatory latency among men suffering from PE relative to controls (Table 5). Bac and Long [10] demonstrated an average monthly coital frequency of 6.62 ± 5.44 episodes among affected men versus 9.71 ± 6.09 in unaffected controls, corresponding to a significant reduction of over three coital episodes monthly (MD – 3.09 episodes/month, 95% CI – 4.20 to – 1.98, $p < 0.001$). Concurrently, Wang et al. [11] documented perceived IELT of 1.7 ± 0.8 minutes in clinical cases compared with 4.8 ± 5.7 minutes among control subjects (MD – 3.10 minutes, 95% CI – 4.27 to – 1.93, $p < 0.001$).

Table 5

Continuous outcomes: coital frequency and ejaculatory latency in men with premature ejaculation versus controls

Study	Outcome	PE mean ± SD	Control mean ± SD	MD (95% CI)	p
Bac & Long 2021 [10]*	Coital frequency (episodes/month)	6.62 ± 5.44	9.71 ± 6.09	-3.09 (- 4.20 to - 1.98)	< 0.001
Wang 2024 [11]	Ejaculatory latency (perceived IELT, minutes)	1.7 ± 0.8	4.8 ± 5.7	-3.10 (- 4.27 to - 1.93)	< 0.001

*Balanced group allocation assumed (~ 209 per arm) due to aggregate reporting in the source publication.

3.5 Behavioral Adaptations and Contextual Modulators

Qualitative synthesis of behavioral strategies highlighted repeated same-day intercourse with markedly prolonged IELT during the second encounter compared with the first [11]. In contrast, pre-coital masturbation was rejected by the majority of men, citing fatigue, psychogenic distress, or concerns about losing erectile turgidity [11]. The physiological post-ejaculatory refractory period demonstrated extreme inter-individual variance, extending up to 330 ± 296.6 minutes in older cohorts compared to 20.16 ± 8.93 minutes among younger cohorts [11]. Rowland et al. [15] characterized intermittent PE, showing that during symptomatic episodes latencies drop to approximately two minutes, contrasting with 3.0 to 6.5 minutes outside episodes (409 men, 31 intermittent). Furthermore, contextual determinants—including time of day, sexual position, alcohol consumption, condom usage, and foreplay duration—heavily modulated episodic ejaculatory latency (n = 119) [14].

3.6 Normative Baselines and Therapeutic Impact

Normative stopwatch surveys establish population median IELTs of 5.4 minutes [12] and 6.0 minutes [13], exhibiting age-dependent declines from 6.5 to 4.3 minutes [12]. Broader epidemiological registries demonstrate shifting baselines: the British Natsal survey observed a median of 3 episodes per month, with 29.2% reporting zero monthly activity [25], while the US General Social Survey (GSS) documented an increase in past-year sexual inactivity from 18.9% to 30.9% alongside a decline in weekly coitus from 51.8% to 37.4% [24]. In interventional trials, on-demand dapoxetine produced three- to fourfold IELT prolongations over baseline [16]. Combining dapoxetine with behavioral therapy extended latency from 160.0 to 370.7 seconds at 24 weeks, yielding an 80% normalization rate ($\text{PEDT} \leq 8$) [17], supported by an SMD of 1.6 favoring multimodal intervention [20]. Network meta-analyses across 59 RCTs and 10,474 subjects confirm pharmacotherapeutic efficacy [19, 21]. Finally, sexual and ejaculatory frequency correlate directly with systemic cardiovascular survival [27] and sperm DNA integrity [28] (Table 6).

Table 6

Therapeutic interventions and systemic contexts of regular sexual activity in premature ejaculation

Intervention/Domain	Evidence/Design	Effect on IELT and clinical outcomes
Dapoxetine 30/60 mg on-demand	Integrated phase III double-blind RCTs (n = 1,104) [16]	IELT 3- to 4-fold over baseline; improved control, satisfaction, distress
Dapoxetine + sexual behavioral therapy	Prospective open-label study (n = 50) [17]	IELT 160.0 s vs. 370.7 s at 24 weeks; 80% PEDT ≤ 8; no difference in adverse events
Combined pharmacotherapy + behavioral	Systematic review and meta-analysis [20]	SMD 1.6 (95% CI 0.5–2.8) favoring combination
Broad pharmacological regimens (SSRIs, tramadol, clomipramine, topicals, PDE5 inhibitors)	Network meta-analysis (59 RCTs, 10,474 patients) [19]; overview [21]	Consistent IELT prolongation [19]; improvements of 1–5 minutes [21]
Systemic and reproductive context	Prospective cohort [27]; cross-sectional study [28]	Regular sexual frequency inversely associated with CV and all-cause mortality [27]; ejaculation frequency associated with semen parameters and sperm DNA fragmentation [28]

4. Discussion

This systematic review and meta-analysis quantitatively demonstrates an approximately 3.5-fold divergence in pooled PE prevalence depending on whether broad screening tools (24.9%) or strict chronometric criteria (7.1%) are applied. This divergence suggests that up to 70% of individuals categorized as having PE through subjective screening capture non-pathological variants, including natural-variable and subjective premature ejaculation [6, 7]. These findings expand the three-dimensional construct evaluated by Opolony et al. [18] (reporting a global prevalence of 14.2% across 79 studies and 319,468 participants) by demonstrating how diagnostic overreach occurs in web-based surveys lacking stopwatch verification.

Furthermore, the continuous synthesis confirms that men with PE engage in significantly fewer monthly coital encounters (MD – 3.09 episodes/month) and experience marked latency deficits (MD – 3.10 minutes). These results support the existence of a bidirectional behavioral cycle: performance distress triggers coital avoidance, leading to prolonged sexual abstinence that heightens penile sensitivity and sympathetic reactivity, precipitating even faster ejaculation during subsequent attempts [10, 14]. Consequently, routine clinical assessment of sexual frequency is essential. Relying on spontaneous coping strategies, such as repeated coitus, is constrained by age-related increases in refractory periods and erectile vulnerability [11, 15], reinforcing the clinical superiority of integrated multimodal protocols combining on-demand pharmacotherapy with behavioral sex therapy [16, 17, 20].

5. Limitations

The findings of this systematic review and meta-analysis should be interpreted within the context of several limitations:

1. The study protocol was not prospectively registered in PROSPERO.
2. High residual statistical heterogeneity ($I^2 > 90\%$) was observed, reflecting international variations in study sampling.
3. Several included investigations relied on online convenience cohorts, predisposing to selection bias.
4. Latency times in select epidemiological studies were based on self-reported estimates rather than prospective stopwatch validation.
5. In the continuous analysis by Bac and Long [10], balanced group allocation was assumed due to aggregate data reporting.
6. Formal comparative synthesis of monthly coital frequency was derived from a single primary case-control study [10].

6. Conclusions

Diagnostic operationalization drives an approximately 3.5-fold disparity in premature ejaculation prevalence, while affected men experience a significant reduction of more than three coital encounters monthly. Clinicians should routinely evaluate sexual frequency and implement multimodal treatment combining pharmacotherapy with behavioral modification.

Declarations

Ethics approval and consent to participate: Not applicable (secondary synthesis of published, de-identified data).

Consent for publication: Not applicable.

Availability of data and materials: All data are included in this article; the PRISMA 2020 checklist is provided alongside the submission files.

Competing interests: The authors declare no competing interests.

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Single editable Word file – all 6 tables with captions placed in the body where referenced. Main text ~1,500-1,600 words + 6 tables (1,500 words) – within/slightly above the WJU 3,000-word limit (abstract and references excluded), as accepted by the authors.