References:

1. Barsukov D. B. Orthopedic-surgical therapy of children with Legg-Calve-Pertes disease: abstract of doctoral diss. …CMD: 14.00.22/D. B. Barsukov. – 2003. – 28 p.
2. Gerasimenko M. A. Post-constructive remodeling of hip joint in children with aseptic necrosis of caput femori and Legg-Calve-Pertes' disease/M. A. Gerasimenko, A. V. Beletski//Journal "Medical news". – 2004. – № 3. –P. 40–42.
3. Mayorov A. N. Modern principles of surgical treatment of the pathology of hip joint in children and teenagers: abstract of doctoral diss... MD. – M., 2009. – 35 p.
4. Korolko A. N. Legg-Calve-Pertes' disease//Orthopedics, traumatology and prosthetics.– 2008. – № 2. – P. 111–120.
5. Kruchok V. G. Early diagnostics and complex therapy of Legg-Calve-Pertes' disease: diss. CMD. – M., 1999. P. – 202.
6. Surgical treatment of Pertes disease/Z. K. Radjabov et al.//Materials of the I meeting of traumatologists – orthopedists of Tajikistan with international participants – Dushanbe, 2009. – Annex to a journal № 1. – P. 241.

Makhmudov Azamjon Talatovich,
Tashkent Medical Academy, Department of Urology, assistant
E-mail: mbshakur@mail.ru

The role of self-assessment in evaluation of severity of premature ejaculation

Abstract: Ejaculatory control issues have been documented for more than 1,500 years. Today, PE is relevant and significant problem, and the most common male sexual disorder, affecting about 30–40% of sexually active men. The data about PE prevalence contradict each other; furthermore, there is different prevalence of PE in different regions, countries or climatic zones. Because of the variability in time required to ejaculate and in partners' desired duration of sex, exact prevalence rates of PE are difficult to determine. The etiopathogenesis of PE is poor understood as well. Development of diagnostic tools, guidelines and questionnaires for PE is an evolutionary process that continually reviews data and requires the best new researches. However, there is still no universal agreement on how to define or to diagnose PE. Development of any diagnostic tool and questionnaire for PE should be based on criteria of easily recognizable criteria of the disease. According to the analysed literature and recommendations of the ISSM, it is strongly recommended the diagnostic tools be updated and improved.

Keywords: premature ejaculation, diagnostic tools, criteria for premature ejaculation.

Introduction. Recently, knowledge of premature ejaculation (PE) has significantly advanced because of progress in understanding the physiology of ejaculation, clarifying the real prevalence of PE in population-based studies, reconceptualizing the definitions and diagnostic criterion of the disorder, assessing the psychosocial impact on patients and partners, designing validated diagnostic and outcome measures, proposing new pharmacological strategies and examining the efficacy, safety and satisfaction of these new and established therapies [1].

PE is the most common male sexual disorder, affecting 30–40% of sexually active men [2], and perhaps as many as 75% of men at some points in their lives [3]. Like erectile dysfunction (ED), PE also could impact a man's life in many aspects, such as self-esteem and relationship with the opposite sex [4]. About 10% of patients receive ineffective or unreasonable treatment. However, there is still no universal agreement on how to define or to diagnose PE.

Ejaculatory control issues have been documented for more than 1,500 years. The Kamasutra, the 4th century Indian sex handbook, declares: "Women love the man whose sexual energy lasts a long time, but they resent a man whose energy ends quickly because he stops before they reach a climax" [5].

PE occurs when a man experiences orgasm and expels semen soon after sexual activity and with minimal penile stimulation. It has also been called "early ejaculation", "rapid ejaculation", "rapid climax", "premature climax", and (historically) "ejaculation praecox". Sex researcher Alfred Kinsey did not consider rapid ejaculation a problem, but viewed it as a sign of "masculine vigor" [6]. There is no uniform cut-off defining "premature", but a consensus of experts at the International Society for Sexual Medicine (ISSM) endorsed a definition including "ejaculation which always or nearly always occurs prior to or within about one minute" [7]. The International Classification of Diseases (ICD-10) applies a cut-off of 15 seconds from the beginning of sexual intercourse [8].

Definition. In 2007, an expert committee of the International Society for Sexual Medicine (ISSM) concluded formulate a definition can only for the primary form of PE, arising at the moment of sexual debut. The ISSM defined PE as a male sexual dysfunction characterized by ejaculation that always or nearly always occurs prior to or within one minute of vaginal penetration, and the 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 [9]. This definition applies only to intravaginal sexual activity and does not define PE in the context of other sexual behaviors or men having sex with men. Therefore, this definition has insufficient information about PE in other groups. According to the recently edited recommendations of ISSM (2010) for the diagnosis and treatment of PE, these criteria may be relevant for the diagnosis of secondary (acquired) form of the disease [1]. Additionally, there are poor published objective data propose a new evidence-based definition of acquired PE, although it believed the proposed criterion for lifelong PE might be applied to acquire PE as well.

In 2007, the Russian experts conducted large-scale survey in RuNet among 1248 Russian-speaking respondents; final results of the study were analyzed in 2012. After temporal border, as well as a number of other diagnostic criteria had been determined, they formulated a new definition of the disease. According to that, PE is ejaculation that always or intermittently occurs without proper control over it prior to introduction of the penis into the vagina (ejaculatio ante portas), or within less than 2 minutes after introjection (ejaculatio praecox), and by male's negative consequences of the state of ejaculatory function, partner's sexual frustration and interpersonal conflicts [10]. PE has been defined according to five essential criteria: (1) continuous or periodical ejaculation prior to or within two minutes of vaginal penetration; (2) continuous or periodical loss of control over ejaculation; (3) psychological distress in man for ejaculatory dysfunction; (4) continuous or periodical inability to deliver sexual satisfaction of sexual partner; (5) the presence of conflicts between partners due to existing copulative disorders [10].

Epidemiology. In the Global Study of Sexual Attitudes and Behaviors (GSSAB), including 13 618 men from 29 countries, accelerated ejaculation was also marked on the average every third respondent. The highest prevalence of PE (30.5%) was registered in the countries of South-East Asia and the lowest (12.4%) in the countries of the Middle East [2].

According to a survey on the Premature Ejaculation Prevalence and Attitudes (PEPA), conducted in the U. S., Germany and Italy among 12 133 men aged from 18 to 70 years, the total prevalence of PE was close to 23% [11]. Thus, the number of PE patients in these countries was approximately the same and amounted to 24; 20.3 and 20%, respectively, which contradicts the results of GSSAB.

In Russia were noted 32.6% of men with PE. The overall incidence of primary and secondary forms of PE in the male Russian population surveyed corresponded to 20.1% and 7.6%, respectively; i. e., the total accelerated ejaculation frequency was 27.7%. In 15% of cases, according to history, was recorded ejaculatio ante portas, and in 85% of cases occurred ejaculatio praecox. Thus, the occurrence of these options of accelerated ejaculation in the population studied was 4.2% and 23.6%, respectively. Among the 251 surveyed with primary form of PE ejaculatio ante portas and ejaculatio praecox were ascertained in 17.1% and 82.9% of men, respectively. In 95 respondents with secondary form of the disease and prepenetration intracoital options of ejaculatory disorders were observed in 9.5% and 90.5% of cases, respectively [10].

According to Kulchavenya Y. V. et al. (2010), who surveyed 543 men aged from 17 to 73 years living in the southern regions of Siberia and the Russian Federation, the prevalence of PE was 33.5% and 43.6%, respectively [10].

Montorsi F. (2005), who had conducted a meta-analysis of epidemiological data, concluded that the prevalence of PE significantly varies, depending on ethnic, demographic, and geographic origins of the respondents [2].

Etiopathogenesis. Many theories have been suggested, including that PE was the result of masturbating quickly during adolescence to avoid being caught by an adult, of performance anxiety, of an unresolved Oedipal conflict, of passive-aggressiveness, and having too little sex — but there is little evidence to support any of these theories [18]. Several physiological mechanisms have been hypothesized to contribute to causing premature ejaculation including serotonin receptors, a genetic predisposition, elevated penile sensitivity, and nerve conduction atypicalities [8]. The nucleus paragiganto-cellularis of the brain has been identified as involved in ejaculatory control [12]. Scientists have long suspected a genetic link to certain forms of PE. In one study, 91% percent of men who have had PE for their entire lives also had a first-relative with lifelong PE. Other researchers have noted that men who have PE have a faster neurological response in the pelvic muscles. PE may be caused by prostatitis or as a drug side effect [1]. Along with that, Freudian theory postulated that rapid ejaculation was a symptom of underlying neurosis. It stated that the man suffers unconscious hostility toward women, so he ejaculates rapidly, which satisfies him but frustrates his lover, who is unlikely to experience orgasm that quickly [6].

Present-day theories of PE etiology focus on the combination and interaction of psychological and organic factors. Although, to date, no single etiological theory has universal acceptance, there is a general shift toward the acceptance of the condition as one in which psychologically mediated processes exacerbate an underlying organic component. The identification of a common cause of PE is nevertheless complicated by the fact that most researchers differentiate between two forms of PE: a primary (lifelong) and secondary (acquired) form, which may have distinct etiologies [2].

Classification. It is important for physician to distinguish PE as a "complaint" versus PE as a "syndrome" [13]. About 20 years ago, PE was classified into "lifelong PE" and "acquired PE". Recently, a new classification of PE was proposed based on controlled clinical and epidemiological stopwatch studies, and it included two other PE syndromes: "natural variable PE" and "premature-like ejaculatory dysfunction" [15].

Diagnosis.

Recently, an updated proposal for PE definition and diagnosis has been provided after the second consultation on

sexual dysfunctions [14]. PE has been defined according to three essential criteria: (i) brief ejaculatory latency; (ii) loss of control; and (iii) psychological distress in the patients and/or partner. Ejaculatory latency of 2 minutes or less may qualify a man for the diagnosis, which should include consistent inability to delay or control ejaculation, and marked distress about the condition [16].

Questionnaire measures or brief symptom scales are available for assessing PE; however, the majority are not well standardized to date. In 2004, Yuan et al. presented the Chinese Index of Premature Ejaculation (CIPE-5) and described it as a useful method for the evaluation of sexual function of patients with PE [17].

In the opinion of experts ISSM (2010), described "differences" can not be associated with objective epidemiological differences, and the diagnostic criteria that are used by researchers in detection of the disease. More precisely — with the lack of a unified system of diagnosis of PE. Therefore, the highest priority in similar activities is appropriate evaluation criteria discussed ejaculatory disorder codes definition of PE. In 2008, Patrick D. L. et al. developed profile "Profile of premature ejaculation" (PEP), which contains 4 questions. The authors of the questionnaire set the task to characterize patients 4 accelerated ejaculation recognized criteria listed in DSM–IV (the degree of control over ejaculation, sexual satisfaction, concern about the state of their male sexual function and the presence of interpersonal complications between the partners) [16]. Importantly, experts ISSM established a significant correlation between the total score and the duration of PEP coitus. However, due to the lack of clear boundaries rules applying this questionnaire in the diagnosis of primary rapid ejaculation considered unwise. Similar views on the PEP holds and the European Association of Urology (EAU). However, given the questionnaire, along with PEDT, recommended for the quantitative assessment of the impact of the original form of the treatment of PE. There are individual literary references to Arabic and Chinese indices rapid ejaculation (AIPE and CIPE), which indicates a lack of limited validity and diagnostic unit. There are literary references to Arabic and Chinese indices rapid ejaculation (AIPE and CIPE), which indicates a lack of limited validity and diagnostic sensitivity [1].

Patients expect clinicians to inquire about their sexual health. Often patients are too embarrassed, shy, inquiry into sexual health gives patients permission to discuss their sexual concerns and also screens for associated health risks (e. g., cardiovascular risk and ED) [1].

Recommended and optional questions to establish the diagnosis of PE and direct treatment (ISSM, 2010) [1]:

Recommended questions for diagnosis:

— What is the time between penetration and ejaculation?

— Can you delay ejaculation?

— Do you feel bothered, annoyed, and/or frustrated by your premature ejaculation?

Optional questions to differentiate lifelong and acquired PE:

— When did you first experience premature ejaculation?

— Have you experienced premature ejaculation since your first sexual experience on every/almost every attempt and with every partner?

Optional questions to assess erectile function:

— Is your erection hard enough to penetrate?

— Do you have difficulty in maintaining your erection until you ejaculate during intercourse?

— Do you ever rush intercourse to prevent loss of your erection?

— Optional questions to assess relationship impact:

— How upset is your partner with your premature ejaculation?

— Does your partner avoid sexual intercourse?

— Is your premature ejaculation affecting your overall relationship?

— Optional question for previous treatment

— Have you received any treatment for your premature ejaculation previously?

Optional questions for impact on quality of life:

— Do you avoid sexual intercourse because of embarrassment?

— Do you feel anxious, depressed, or embarrassed because of your premature ejaculation?

Since patient self-report is the determining factor in treatment seeking and satisfaction, it has been recommended that self-estimation by the patient and partner of ejaculatory latency be routinely assessed in clinical practice when PE is present. The PEP or IPE are currently the preferred questionnaire measures for assessing PE, particularly in the context of monitoring responsiveness to treatment.

For lifelong PE, a physical examination is highly advisable but not mandatory and should be conducted in most if not all patients. For acquired PE a targeted physical examination is mandatory to assess for associated/causal diseases such as ED, thyroid dysfunction, or prostatitis [1].

The Russian Criteria for premature ejaculation (CriPE), in which the term "ejaculation" means the release of seminal fluid (sperm) from the external opening of the urethra, accompanied by voluptuous sensations (orgasm), has the following questions describing sexual function for the last 4 weeks [10]:

1. Does your ejaculation occur intermittently or continuously until the introduction of the penis into the vagina or less than 2 minutes from the initiation of sexual intercourse?

2. Do you note persistent or periodical lack of control over ejaculation?

3. Do you feel anxious of your state of ejaculatory function?

4. Do you feel persistent or periodical inability to deliver sexual satisfaction for sexual partner?

5. Is your disturbed premature ejaculation affecting your relationship with sexual partner?

It should be noted that for a simplified assessment of treatment modalities have been successfully applied

certain one-item questionnaires, including a question about the overall treatment satisfaction and characterization of impressions resulting from changes after therapy.

References:

1. Althof S. E., Abdo C., Dean J., Carmitta H. N. et al. International Society for Sexual Medicine's Guidelines for the diagnosis and treatment of premature ejaculation//J Sex Med. – 2010. – Vol. 7. – P. 2947–2969.
2. Montorsi F. Prevalence of premature ejaculation: A global and regional perspective//J Sex Med. – 2005. – Vol. 2 (s2). – P. 96–102.
3. McMahon C. G. Treatment of premature ejaculation with sertraline HCL: a single-blind placebo controlled crossover study//J Urol. – 1998. – Vol. 159. – P. 1935–1938.
4. Arafa M., Shamloul R. Development and evaluation of the Arabic Index of Premature Ejaculation (AIPE)//J Sex Med. – 2007. – Vol. 4. – P. 1750–1756.
5. Vatsyayana M., Doniger W., Kakar S./Kamasutra. – 2009. – Oxford University Press.
6. Kaplan H. S. The New Sex Therapy//Brunner Mazel/New York Times, 1974. – P. 292.
7. Sharlip I. D., Hellstrom W. J., Broderick G. A. The ISSM definition of premature ejaculation: A contemporary, evidence-based definition//J Urology. – 2008. – Vol. 179 (suppl. 340) – P. 988.
8. Althof S. E. Treatment of rapid ejaculation: Psychotherapy, pharmacotherapy, and combined therapy/In S. R. Leiblum (Ed.), Principles and practice of sex therapy (4th ed.), NY: Guilford. – 2007. – P. 212–240.
9. McMahon C. G., Althof S. E., Waldinger M. D., Porst H., Dean J. et al. An evidence-based definition of lifelong premature ejaculation: Report of the International Society for Sexual Medicine (ISSM) ad hoc committee for the definition of premature ejaculation//J Sex Med. – 2008. – Vol. 5. – P. 1590–1606.
10. Vinarov A. Z., Akhvlediani N. D., Verce P. Premature Ejaculation//Urology today. – 2013. – №.4 (26). – www.urotoday.ru
11. Porst H. et al. The premature ejaculation prevalence and attitudes (PEPA) Survey: Prevalence, Co-morbidities, and Professional Help-Seeking//European Urology. – 2007. – Vol. 51 (3). – P. 816.
12. Strassberg D. S., Perelman M. A. Sexual dysfunctions/In P. H. Blaney, T. Millon (Eds.), Oxford textbook of psychopathology (2nd ed.). – NY: Oxford University Press, 2009. – P. 399–430.
13. Coolen L. M., Olivier B., Peters H. J., Veening J. G. Demonstration of ejaculation-induced neural activity in the male rat brain using 5-HT1A agonist 8-OH-DPAT//Physiol. Behav. – 1997. – Vol. 62 (4). – P. 881–891.
14. McMahon CG, Abdo C, Incrocci L, et al. Disorders of orgasm and ejaculation in men. J Sex Med 2004 Jul;1 (1):58–65. Godpodinoff M. L. Premature ejaculation: clinical subgroups and etiology//J Sex Marital Ther. – 1989. – Vol. 15. – P. 130.
15. Lue T. F., Giuliano F., Montorsi F., Rosen R. C., Andersson K. E., Althof S., Christ G., Hatzichristou D., Hirsch M., Kimoto Y., Lewis R., McKenna K., Mac-Mahon C., Morales M., Mulcahy J., Padma-Nathan H., Pryor J., de Tejada I., Shabsigh R., Wagner G. Summary of the recommendation on sexual dysfunctions in men//J Sex Med. – 2004. – Vol. 1. – P. 6–23.
16. Patrick D., Althof S., Pryor J., Rosen R., Rowland D., Ho K., McNulty P., Rothman M., Jamieson C. Premature ejaculation: An observational study of men and their partners//J Sex Med. – 2005. – Vol. 2. – P. 358–367.
17. Yuan Y. M., Xin Z. C., Jiang H. et al. Sexual dysfunction of premature ejaculation patients assayed with Chinese Index of Premature Ejaculation//Asian J Androl. – 2004. – Vol. 6. – P. 121–126.

Nazhmetdinova Dilfuza Farhatovna,
Senior Research Scientist — researcher,
State Medical Institute. Abu Ali Ibn Sina,
Department of Obstetrics and Gynecology, Ministry of Health
of the Republic of Uzbekistan Bukhara
E-mail: farhod.ahmedov.77@mail.ru

Features of change of lipid spectrum of blood serum at prolonged pregnancy

Abstract: In women with prolonged post-term pregnancy and notes mixed form dislipoproteinemia characterized by hypertriglyceridemia, hypercholesterolemia, and increased levels of cholesterol in lipoproteins of very low and low density, due to lower his level of HDL cholesterol, causing a high risk of atherogenic with a forecast for the development of placental insufficiency.

Keywords: Prolonged pregnancy, lipid metabolism, placental insufficiency.