JRAS

10.5005/jp-journals-10064-0018

RESEARCH ARTICLE

Management of Premature Ejaculation (*Shukragata vata*) with *Erandamoola basti* and *Vanari kalpa*: A Clinical Study

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ABSTRACT

Introduction: Premature ejaculation (PE) is one of the most common sexual dysfunctions in men. Premature ejaculation is characterized with a short ejaculatory latency time, lack of ejaculatory control, decreased satisfaction with sexual intercourse causing interpersonal distress, negative impact on man's self-esteem, reduced sexual function, and reduced quality of life. In Ayurveda, the problem is discussed under *Shukragata vata*. Functional approximation *Shukra* and *Vata* are quite evident in *Ayurvedic* principles. *Erandamoola* is described as the best *Vrishya* and *Vatahara* in *Charaka Samhita*, and *Vanari gutika* is mentioned for treatment of PE in *Bhavprakash Samhita*.

Objective: To evaluate the efficacy of *Erandamoola basti* and *Vanari kalpa* (granules) in the management of PE.

Materials and methods: Forty-five patients with PE were treated with *Vanari kalpa* granules for 2 months with milk (group II), *Erandamoola basti* for 16 days followed by *Vanari kalpa* granules for 2 months with milk (group III), and placebo control with wheat granules for 2 months with milk (group I). Psychological counseling was given to the patients in all the three groups.

Results: Patients treated with *Erandamoola basti* and *Vanari kalpa* showed significant results against placebo in all the parameters, namely intravaginal ejaculation latency time (IELT), voluntary control over ejaculation, patient's and partner's satisfaction, and performance anxiety.

Conclusion: The overall effect of therapy was higher in group III (*Erandamoola basti* followed by *Vanari kalpa* granules) with a better percentage of complete remission and marked improvement followed by groups II and I.

Keywords: *Erandamoola basti*, Premature ejaculation, Sexual disorder, *Shukragata vata*, *Vanari gutika*.

How to cite this article: Shah AB, Thakar A, Radhakrishnan P. Management of Premature Ejaculation (*Shukragata vata*) with *Erandamoola basti* and *Vanari kalpa*: A Clinical Study. J Res Ayurvedic Sci 2017;1(3):157-164.

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Source of support: Nil

Conflict of interest: None

INTRODUCTION

Ayurveda mentions *Ahara*, *Nidra*, and *Brahmacharya* as the tripods of life.[1] Sex is a basic instinct, but sexual behavior is a learned ability. Premature ejaculation is one of the most common sexual dysfunctions in men with prevalence rates ranging from 21 to 31%.[2] A man is considered to ejaculate prematurely if his partner was not orgasmic in at least 50% of the coital episodes.[3] Premature ejaculation occurs when a man experiences orgasm and expels semen soon after sexual activity and with minimal penile stimulation.[4] There is no uniform cut-off defining "premature," but a consensus of experts at the International Society for Sexual Medicine endorsed a definition including "ejaculation which always or nearly always occurs prior to or within about 1 minute." The International Classification of Diseases 10th revision applies a cut-off of 15 seconds from the beginning of sexual intercourse. Ayurvedic classics state that neurological functions are under the control of *Vata*. *Apana vata*, a variety of *vata*, is responsible for the control of erection, ejaculation, orgasm, and spermatogenesis.[5]

AIMS AND OBJECTIVES

To evaluate the efficacy of *Erandamoola basti* and *Vanari kalpa* (granules) in the management of PE.

MATERIALS AND METHODS

Patients attending the outpatient department of the Department of Panchakarma, Institute of Post Graduate Teaching & Research in Ayurveda, Gujarat Ayurved University, Jamnagar, India, having genuine complaints of PE fulfilling the criteria for inclusion were selected irrespective of race, caste, and religion, who were between the age group of 21 and 60 years. Pre-entry examination was simple and brief and tried to include an interview of the wife, wherever it was possible.

Inclusion Criteria

Patients who were having ejaculation prior to 10 penile thrusts and those with ejaculation before, on, or within

1 minute of sexual act after penetration were included. Patients who were unable to satisfy partner in at least 50% of the coital incidences and unable to delay ejaculation till the person wishes it were also included. The problem should be persistent or recurrent and cause marked distress or Interpersonal difficulties.

Exclusion Criteria

Factors that affect the duration of the excitement phase of sexual act, such as novelty of the partner or situation and recent frequency of sexual act were taken into account. The problem should not be due exclusively to the direct effect of a substance (e.g., withdrawal of opioids). Persons having very short postejaculatory refractory period were excluded. Patients with major psychiatric illness were excluded. Routine pathological and biochemical investigations were done to exclude any other major pathology.

Investigation

- Urine—routine
- Semen analysis

Study Design

Group I

Patients in this group were given wheat granules (placebo control) in a dose of 7.5 gm twice a day after lunch and supper with milk for 2 months.

Group II

Patients in this group were given *Vanari kalpa* (granules of *Vanari gutika*, Table 1)[6] in a dose of 7.5 gm twice a day after lunch and supper for 2 months with milk.

Table 1: Drugs required for *Vanari kalpa* granules

Content name	*Latin name*	*English name*	*Quantity (%)*
Kapikachhu	*Mucuna prurita hook*	Cowhage	11.4
Sarkara	*Saccharum officinarum*	Sugar	37.5
Go-Ghrita	*Butyrum depuratum*	Cow ghee	5.7
Go-Ksheera	–	Cow milk	45.5

Group III

Patients in this group were administered *Erandamoola basti* (Table 2) for 16 days followed by *Vanari kalpa* (granules of *Vanari gutika*) in a dose of 7.5 gm twice a day after lunch and supper for 2 months with milk. For *Bastikarma*, *Kalabasti* was selected. In the sequence, first *Anuvasana basti* has administered. From the next day, six *Niruha* and six *Anuvasna basti* were administered alternatively, and lastly three *Anuvasna basti* was given.

- All the patients were directed to keep the frequency of sexual act and duration of foreplay as usual, so that a change in them will not make error in the evaluation of therapy. A generalized moderate *Pathyapathya* was advised to all patients.
- To assess the effect of *Erandamoola basti* and *Vanari kalpa* in PE, wheat granules was selected as the placebo control drug.
- Psychological counseling was done in all groups.

Criteria of Assessment

Improvement in the patient was assessed mainly based on the relief in the sign and symptoms of the disorder. To assess the effect of therapy objectively, all signs and symptoms were given a score depending upon their severity. Related sign and symptoms were recorded from the first day—starting on the day of treatment followed by weekly or daily observation during the course of treatment. Gradation of the symptoms was done depending on the severity and specific symptom score prior to treatment and after completion of the treatment, and their difference was assessed.

Gradation of Cardinal Symptoms

1. IELT less than 1 minute:

A	Mere thought, sight, or voice of partner	5
B	Immediately after penetration	4
C	Within 30 sec of penetration	3
D	Within 2 min	2
E	Within 2–5 min	1
F	More than 5 min	0

Table 2: Contents of *Erandamoola basti*

Content name	*Latin name*	*English/chemical name*	*Quantity (for one dose)*
Niruha Basti			
Makshika	*Mal depuratum*	Honey	150 mL
Saindhava	*Sodii chloridum*	Rock salt	12 gm
Tila Taila	*Sesamum orientale* Linn	Sesamum oil	220 mL
Erandamoola Kalka	*Ricinus communis* Linn	Paste of castor oil plan (root part)	070 gm
Erandamoola Kwatha	*Ricinus communis* Linn	Decoction of castor oil plant (root part)	300 mL
Anuvasna Basti			
Erandamoola Taila	*Ricinus communis* Linn	Oil processed with castor oil plant (root part)	144 mL

2. Voluntary control over ejaculation:

A	Never	5
B	Lack of control on most occasions	4
C	Less than 25% encounters	3
D	Less than 50% encounters	2
E	Less than 75% encounters	1
F	Full control over ejaculation	0

3. Patient satisfaction:

A	No orgasm at all	5
B	Lack of enjoyment	4
C	Satisfaction during 25% sexual acts	3
D	Satisfaction during 50% sexual acts	2
E	Satisfaction during 75% sexual acts	1
F	Satisfaction during every sexual act	0

4. Partner's satisfaction:

A	No orgasm at all	5
B	Lack of enjoyment	4
C	Satisfaction during 25% sexual acts	3
D	Satisfaction during 50% sexual acts	2
E	Satisfaction during 75% sexual acts	1
F	Satisfaction during every sexual act	0

5. Performance anxiety:

A	Anxiety that hampers all encounters	5
B	Anxiety that hampers sexual act in 75% encounters	4
C	Anxiety that hampers sexual act in 50% encounters	3
D	Anxiety that hampers sexual act in 25% encounters	2
E	Slight anxiety that does not disrupt the sexual act	1
F	No anxiety at all	0

6. Number of penile thrusts:

A	None, discharge before penetration	5
B	Less than 5	4
C	Less than 10	3
D	Less than 15	2
E	Less than 20	1
F	More than 25	0

Total Effect of Therapy

Considering the relief of major symptoms and improvement in the quality of sexual functioning, the subjects were divided into the following five groups to assess the total efficacy of each therapy.

1. Cured (100%)—achievement of certain reasonable voluntary control over ejaculation, sufficient length of sexual act according to wish, with both partners satisfied.
2. Markedly improved (>75–100%)—sufficient length of sexual act according to wish, with both partners satisfied, but no voluntary control over ejaculation.
3. Moderately improved (>50–75%)—improvement in duration of sexual act more than 1 minute or more than 10 penile thrusts with partner's satisfaction in at least 50% of incidents.
4. Improved (25–50%)—duration of sexual act less than 1 minute or less than 10 penile thrusts.
5. Unchanged (<25%)—no change or worsening of duration of sexual act and or other sexual health parameters like erection, rigidity, etc.

OBSERVATION AND RESULT

Total 45 patients were registered. In groups I and II, 15 patients were registered in each group and all 30 patients completed treatment. In group III, 15 patients were registered, out of which 1 dropped out and 14 completed treatment.

In group III, IELT improved by 61%, voluntary control over ejaculation improved by 61%, and patient satisfaction improved by 71%. Improvement of IELT, voluntary control over ejaculation, and patient satisfaction was statistically significant ($p < 0.01$). Partner's satisfaction improved by 69%, performance anxiety reduced by 71%, and number of penile thrusts improved by 68%. Improvement of partner's satisfaction, performance anxiety, and number of penile thrusts was also statistically significant at the level of $p < 0.01$ (Table 3).

In group II, IELT improved by 57%, while voluntary control over ejaculation improved by 55%. Improvement of IELT and voluntary control over ejaculation were statistically significant ($p < 0.01$). Patient satisfaction improved by 58%, partner's satisfaction improved by 57%, performance anxiety reduced by 66%, and number of penile thrusts improved by 57%. Improvement in patient satisfaction, partner's satisfaction, performance anxiety, and number of penile thrusts was also statistically significant ($p < 0.01$; Table 4).

Table 3: Improvement in cardinal symptoms of PE in group III (*Erandamoola basti* followed by *Vanari kalpa* granules)

	Mean score								
Cardinal symptoms	*BT*	*AT*	*Difference*	*% of relief*	*SD*	*SE*	*W*	*n*	*p-value*
Intravaginal ejaculatory latency time	4.35	1.64	2.71	61	1.20	0.32	91.00	13	<0.01
Voluntary control over ejaculation	4.42	1.64	2.78	61	1.42	0.38	91.00	13	<0.01
Number of penile thrusts	4.36	1.43	2.93	68	0.92	0.25	105.0	14	<0.01
Performance anxiety	1.93	0.64	1.29	71	0.61	0.16	91.00	13	<0.01
Patient satisfaction	1.93	0.54	1.36	71	0.63	0.16	91.00	13	<0.01
Partner's satisfaction	2.0	0.64	1.35	69	0.74	0.98	91.00	13	<0.01

Table 4: Improvement in cardinal symptoms of PE in group II (*Vanari kalpa* granules)

	Mean score								
Cardinal symptoms	*BT*	*AT*	*Difference*	*% of relief*	*SD*	*SE*	*W*	*n*	*p-value*
Intravaginal ejaculatory latency time	4.2	1.87	2.3	57	0.72	0.18	120.0	15	<0.01
Voluntary control over ejaculation	4.20	1.93	2.26	55	0.59	0.15	120.0	15	<0.01
Number of penile thrusts	4.20	1.87	2.33	57	0.82	0.21	120.0	15	<0.01
Performance anxiety	3.07	1.67	1.40	42	1.18	0.31	78.00	12	<0.01
Patient satisfaction	3.27	1.33	1.93	58	1.16	0.31	120.0	15	<0.01
Partner's satisfaction	3.53	1.40	2.13	57	0.99	0.26	120.0	15	<0.01

Table 5: Improvement in cardinal symptoms of PE in group I (placebo group)

	Mean score								
Cardinal symptoms	*BT*	*AT*	*Difference*	*% of relief*	*SD*	*SE*	*W*	*n*	*p-value*
Intravaginal ejaculatory latency time	3.93	2.26	1.66	42	0.81	0.21	105.0	14	<0.01
Voluntary control over ejaculation	3.93	2.60	1.33	33	0.97	0.25	66.00	11	<0.01
Number of penile thrusts	3.93	2.40	1.53	38	0.99	0.25	78.0	12	<0.01
Performance anxiety	3.46	1.20	2.27	66	1.22	0.31	105.0	14	<0.01
Patient satisfaction	2.93	1.87	1.07	38	1.10	0.28	55.00	10	<0.01
Partner's satisfaction	3.20	1.93	1.27	42	1.03	0.27	78.00	12	<0.01

Table 6: Effect of placebo (group I) on modified scale for PE based on GRISS questionnaire

	Mean score								
GRISS questionnaire	*BT*	*AT*	*Difference*	*% of relief*	*SD*	*SE*	*W*	*n*	*p-value*
Are you able to delay ejaculation during intercourse if you think you may be coming too quickly?	2.93	1.93	1.00	35	0.84	0.22	55.00	10	<0.01
Can you avoid ejaculation too quickly during intercourse?	2.93	2.00	0.93	32	0.80	0.21	55.00	10	<0.01
Do you ejaculate without wanting to almost as soon as your penis enters your partner's vagina?	1.80	2.67	−0.87	30	1.19	0.31	−41.0	15	<0.05
Do you ejaculate by accident just before your penis is at least to enter your partner's vagina?	2.33	3.53	−1.20	33	0.68	0.17	−91.0	13	<0.01

Table 7: Effect of *Vanari kalpa* granules (group II) on modified scale for PE based on GRISS questionnaire

	Mean score								
GRISS questionnaire	*BT*	*AT*	*Difference*	*% of relief*	*SD*	*SE*	*W*	*n*	*p-value*
Are you able to delay ejaculation during intercourse if you think you may be coming too quickly?	3.00	1.5	1.46	48	0.74	0.19	91.00	13	<0.01
Can you avoid ejaculation too quickly during intercourse?	2.87	1.40	1.47	50	0.83	0.21	78.00	12	<0.01
Do you ejaculate without wanting to almost as soon as your penis enters your partner's vagina?	1.73	3.26	−1.53	42	1.06	0.27	−101	15	<0.01
Do you ejaculate by accident just before your penis is at least to enter your partner's vagina?	2.33	3.67	−1.53	40	0.64	0.17	−105	14	<0.01

In group I, IELT time improved by 42%, voluntary control over ejaculation improved by 33%, patient satisfaction improved by 38%, partner's satisfaction improved by 42%, performance anxiety reduced by 42%, and number of penile thrusts improved by 38%. Improvement of all above cardinal symptoms was statistically significant ($p < 0.01$; Table 5).

The effect of therapy on modified scale for PE based on GRISS questionnaire has shown significant improvement in all three groups (Tables 6 to 8).

The effect of therapy on Hamilton's Anxiety Rating scale showed statistically significant improvement ($p < 0.01$) in all the three groups (Table 9).

In group III, 14.19% patients and in group II 6.67% patients got complete relief, while no patient in group I (placebo) was completely cured. Maximum patients in group II (40%) and in group III (42%) were markedly improved. About 46.67 and 35.71% patients were moderately improved in groups II and III respectively. However, 13.13% patients were markedly improved and

Table 8: Effect of *Erandamoola basti* followed *Vanari kalpa* granules (group III) on modified scale for PE based on GRISS questionnaire

	Mean score								
GRISS questionnaire	*BT*	*AT*	*Difference*	*% of relief*	*SD*	*SE*	*W*	*n*	*p-value*
Are you able to delay ejaculation during intercourse if you think you may be coming too quickly?	2.79	0.78	2.00	66	0.68	0.18	105.00	14	<0.01
Can you avoid ejaculation too quickly during intercourse?	2.4	1.07	1.33	55	0.82	0.21	78.00	12	<0.01
Do you ejaculate without wanting to almost as soon as your penis enters your partner's vagina?	1.71	3.28	−1.57	47	0.64	0.17	−91.0	13	<0.01
Do you ejaculate by accident just before your penis is at least to enter your partner's vagina?	2.14	3.79	−1.64	43	0.74	0.20	−91.0	13	<0.01

Table 9: Effect of therapy on Hamilton's Anxiety Rating scale

	Mean score								
Group	*BT*	*AT*	*Difference*	*% of relief*	*SD*	*SE*	*W*	*n*	*p-value*
Group I (n = 15)	10.4	5.87	4.53	44	1.81	0.47	105.0	14	<0.01
Group II (n = 15)	11.8	5.53	6.27	52	2.82	0.73	120.0	15	<0.01
Group III (n = 14)	10.5	4.14	6.35	58	1.78	0.47	105.0	14	<0.01

Table 10: Overall effect of therapy in 44 patients

Groups	*Complete remission (%)*	*Markedly improved (%)*	*Moderately improved (%)*	*Unchanged (%)*
Group I—Placebo (n = 15)	0.0	13.13	53.33	33.33
Group II—*Vanari kalpa* (n = 15)	6.67	40.00	46.67	6.67
Group III—*Basti* followed by *Vanari kalpa* (n = 14)	14.29	42.85	35.71	7.14

53.33% patients were moderately improved in placebo group (group I). On the contrary, 33.33% patients in placebo group (group I), 6.67% patients in group II, and 7.14% patients in group III remained unchanged after the treatment Table 10.

DISCUSSION

The voluntary control over ejaculation in all groups (I, II, and III) was improved statistically significantly ($p < 0.01$). The percentage of improvement was almost double in group III than in group I. Mean IELT improved by 42% in group I, 57% in group II, and 61% in group III, which was statistically significant ($p < 0.01$). It may be because of aphrodisiac and *Vatahara* property of *Erandamoola*[1] and aphrodisiac, strengthening, nervine tonic, ante-impotent, and psychotropic properties of *Vanari kalpa*.[7] Since the disorder has huge psychological component, counseling has a big role to play.

The self-satisfaction was improved by all selected therapies at significant level ($p < 0.01$), but a distinct advantage was noted in group III. It means that the quality of orgasm was better in this group probably because of the direct effect of *Basti* on *Vata* (which is the root of *Harsha*). The effect of therapy in the satisfaction of the female partner was also considerably positive in all groups at significant level ($p < 0.01$); again, advantage was noted in the third group. The fact that the subject is taking treatment makes the spouse feel that her partner is having a problem and makes her to compromise a little during the act due to which the patient feels that he is improving, this could be the reason that the placebo group also showed statistically significant results. But the percentage of improvement was almost 20% in group II and 30% in the group III more than that in group I.

The improvement in mean number of penile thrusts was statistically significant ($p < 0.01$) in all the groups. Considering the number of penile thrusts, the effect of therapy in group III was 30% and in group II it was almost 20% more than placebo group. It may be because of the cowhage (main ingredient of *Vanari kalpa*), which possess *Vrishya* (aphrodisiac), *Balya* (strengthening), *Brimhana* (anabolic), *Nadidourbalyahara* (nervine tonic), *Klaibyahara* (ante-impotent), and *Medhya* (psychotropic) properties.

The performance anxiety was considerably reduced in groups II and III than psychological counseling along with placebo group. The additional effects gained in groups II and III can be attributed to the psychotropic effects of *Erandamoola basti* and *Vanari kalpa*. The reduction in the performance anxiety and improvement in the ejaculatory performance were coinciding, which shows their strong positive correlation.

Table 11: Effect of therapy on seminal parameters

Group	Mean score			% of relief	SD	SE	T	p-value
	BT	AT	Difference					
Sperm count								
Group II (n = 15)	48.33	50.40	−2.07	54	32.81	8.47	−0.24	>0.05
Group III (n = 14)	36.00	40.71	−4.71	14	36.78	9.83	0.479	>0.05
Motility (%)								
Group II (n = 15)	57.67	49.67	8.0	−4.0	26.24	6.78	1.18	>0.05
Group III (n = 14)	53.57	53.21	0.36	−4.0	21.17	5.66	0.063	>0.05
Actively progressive motile								
Group II (n = 15)	41.0	34.67	6.33	−18.0	21.42	5.53	1.15	>0.05
Group III (n = 14)	37.28	35.14	2.14	5	18.96	5.07	0.423	>0.05
Sluggishly progressive motile								
Group II (n = 15)	23.67	18.0	5.67	−13	11.48	2.96	1.91	>0.05
Group III (n = 14)	22.71	20.71	2.0	−11	10.59	2.83	0.707	>0.05
Nonmotile								
Group II (n = 15)	35.33	42.40	−7.07	61	22.53	5.81	−1.22	>0.05
Group III (n = 14)	34.29	32.46	1.43	−11	22.05	5.89	0.242	>0.05

The ability to delay ejaculation and the severity of the problem were assessed with the four-itemed subscale of GRISS questionnaire for high reliability and good validity. The first criterion enquired the "ability to delay ejaculation during intercourse when he may think he may be coming too quickly." This was aimed to understand the maintenance of internal cue, identification of ejaculatory inevitability, and voluntary control over ejaculation. Almost all the subjects answered "never." Statistically highly significant improvements of 35% ($p < 0.01$), 48% ($p < 0.01$), and 66% ($p < 0.01$) were noted in groups I, II, and III respectively. From the foregoing observations it may be assumed that *Erandamoola basti* provides certain degree of significant voluntary control over ejaculation in comparison with oral medication or placebo. This may be due to the direct effect of *Basti* on *Vata* especially in the *Apana vata* which is responsible for ejaculation. The advantage effect may be the result of reduction in the shortness of nerve latency time or decrease in the rapidity of reflexes.

The second item was to examine whether the subject is enjoying the sexual act for a sufficient length of time without early ejaculation. Improvements of 32, 50, and 55% were noted in groups I, II, and II respectively, on a statistically significant level ($p < 0.01$).

The third item was to enquire the incidence of ejaculation immediately after penetration, and highly significant improvement was noticed in all groups (30, 42, and 47% respectively ($p < 0.01$).

The last item analyzes the incidence of ejaculation before penetration, which also was relieved by 33, 40, and 43% respectively, at a significant level ($p < 0.01$).

Hence, in a nutshell, it can be conceptualized that an ejaculation before penetration or just after penetration and when purely psychological factors are operating, it can be managed by even placebo, whereas oral medication and *Basti* considerably increase the duration of sexual act, with an advantage effect in *Basti* therapy by imparting certain degree of voluntary control on ejaculation.

The effect of therapy in the Hamilton's Anxiety Rating scale was also falling in same fashion with 44, 52, and 58% significant ($p < 0.01$) improvement in groups I, II, and III respectively.

The effect of therapy in the seminal parameters was assessed only in groups II and III by retrospectively confirming that placebo is not having any marked effect on seminal parameters Table 11. The effect on seminal parameters with the selected therapies in groups II and III were inconsistent and varied largely. Certain parameters were improved, while certain were not. The sperm count was improved in both groups (statistically insignificant), whereas motility was decreased. After treatment, the actively progressive motile was better in group III, whereas worse in group II. However, except one all other data were statistically insignificant, so no definite conclusions can be drawn from this. This may be due to the fact that the sampling and management were planned for managing PE in a short duration and without proper purificatory procedures, which failed to make any significant influence in the seminal parameters.

The therapies selected for all three groups provided relief to the patients with improving the treatment advantage toward group III. Since the treatment was planned as add-on, succession manner advantage effect on group III is not so promising compared with group II. But the quality of the effect was obviously different. *Basti* in group III has imparted certain voluntary control over ejaculation. The duration of sexual act and the number of

penile thrusts were considerably improved in group III in comparison with others. The effects were uniformly consistent in all the groups. As the difference between the effect of performance anxiety, Hamilton's Anxiety Rating scale in groups II and III was not too varied, and the result can be more attributed to psychotropic effect of *Vanari kalpa.* The selected design of treatment improved considerably the self and partner's satisfaction but failed to make any significant change in seminal parameters.

CONCLUSION

Erandamoola basti followed by *Vanari kalpa*—group III is more effective in PE because of aphrodisiac and *vata* balancing property of *Erandamoola* and direct effect of *Basti* on *Vata* especially on the *Apana vata* which is responsible for ejaculation. *Vanari kalpa* by virtue of its properties biologically acts as a psychotropic and improves the duration of sexual act and reduces the performance anxiety. Placebo and psychological counseling are sufficient to manage PE when only psychological factors are operating.

Hence in a nutshell, it can be concluded that *Erandamoola basti* with *Vanari kalpa* can be a drug of choice for PE.

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हिंदी सारांश

शुक्रगत वात की चिकित्सा में एरण्डमूल बस्ति एवं वानरी कल्प का चिकित्सिय अध्ययन

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परिचयः शीघ्र स्खलन, पुरुषों में सबसे ज्वलंत यौन समस्या है। इस व्याधि में अल्प स्खलन समय, स्खलन नियंत्रण में कमी, संभोग में संतुष्टि की कमी के कारण पारस्परिक तनाव के कारण आत्मविश्वास में नकारात्मक प्रभाव एवं जीवन गुणवत्ता में कमी आ जाती है। आयुर्वेद में इस व्याधि को शुक्रगत वात के अंतर्गत सम्मिलित किया गया है. आयुर्वेद अनुसार शुक्र के स्खलन एवं वात परस्पर सम्बंधित हैं। एरण्डमूल को चरक संहिता में श्रेष्ठ वातहर एवं वृष्य कहा गया है एवं वानरी गुटिका भावप्रकाश में शीघ्र स्खलन की चिकित्सा हेतु निर्दिष्ट है।

उद्देश्यः एरण्डमूलबस्ति एवं वानरी कल्प (ग्रेन्युल) का शीघ्र स्खलन के रोगियों में चिकित्स्य प्रभावात्मकता का अध्ययन करना।

सामग्री एवं विधिः शीघ्र स्खलन से ग्रसित ४५ को तीन समूहों में बराबर बाट कर एक समूह में (समूह २) वानरी कल्प दूध के साथ २ माह दिया गया, समूह ३ में एरण्डमूल बस्ति प्रथम १६ दिन तदुपरांत वानरी कल्प दूध के साथ २ माह दिया गया एवं समूह १ में प्लेसिबो के तरह गेहूं के बने ग्रेन्युल दिए गए. सभी समूह में मनोवैज्ञानिक परामर्श दिया गया।

परिणामः चिकित्सोप्रांत एरण्डमूलबस्ति एवं वानरी कल्प समूह में प्लेसिबो समूह के मुकाबले सभी मापदंड यथा इंट्रा एजेक्युलेटरी लेटंसी टाइम, वीर्य स्खलन पर एच्छिक नियंत्रण, रुग्ण एवं सहकारी की तृप्ति आदि में सांख्यकी की दृष्टी में प्रभावशाली सुधार पाया गया।

निष्कर्षः सभी समूहों में से समूह ३ (एरण्डमूलबस्ति एवं वानरी कल्प) में सभी मापदंड़ो में सबसे ज्यादा सुधार पाया गया इसके बाद समूह २ एवं समसे कम समूह १ में सुधार मिला।