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Prevalence and Factors Associated with Premature Ejaculation in Urological Consultation in the City of Douala

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Abstract

Introduction: Premature ejaculation (PE) remains the most common male sexual disorder, yet it is still insufficiently explored in urology services in Cameroon. Through this study conducted in Douala, we aimed to estimate the frequency of this condition in urological consultations, identify associated factors, and assess its psychological impact. **Methods:** Between February 1 and May 16, 2025, a cross-sectional and analytical study was conducted in three urology departments in Douala. All men aged 21 years and above who attended the consultation and provided informed consent were included. PE was defined as an intravaginal ejaculatory latency time (IELT) of ≤3 minutes, according to the criteria of the International Society for Sexual Medicine. A sensitivity analysis using a stricter ≤ 1-minute cutoff was performed to assess robustness. Anxiety, depression, and quality of life were assessed using the STAI-T, BDI, and SF-36 scores, respectively, with validated cutoffs. Statistical analyses were performed to identify factors associated with PE. **Results:** Among the 301 patients included, 70 presented with PE, corresponding to a prevalence of 23.26%. Using a ≤1-minute cutoff, prevalence was 9.63% (n = 29). After adjustment, independently associated factors included a history of sexually transmitted infections (aOR = 3.98), erectile dysfunction (aOR = 3.25), frequent alcohol consumption (≥4 times/week; aOR = 4.86), and heavy smoking

(>15 pack-years; aOR = 2.04). Among patients with PE, the mean STAI-T score was 48.6 ± 8.4, with 75.7% having moderate anxiety; mean BDI score was 16.8 ± 5.2, with 52.9% having at least mild depression. While mean quality of life was preserved (SF-36: 67.3 ± 14.1), 20% reported poor quality of life. **Conclusion:** Premature ejaculation is relatively common in urological consultations in Douala and appears to be associated with several medical and behavioural factors. Signs of anxiety and depression are frequent among affected patients. These findings highlight the importance of a comprehensive approach that includes mental health and lifestyle factors. However, due to the clinic-based, cross-sectional design, results are not generalizable to the general population and do not imply causality.

Keywords

Premature Ejaculation, Urology, Erectile Dysfunction, Sexually Transmitted Infections, Smoking, Alcohol, Anxiety, Depression, Quality of Life

1. Introduction

Premature ejaculation (PE) is the most common male sexual disorder and is frequently observed both in urology consultations and outpatient practice [1] [2]. According to the World Health Organisation, PE is defined as persistent or recurrent ejaculation occurring after minimal sexual stimulation—before, during, or shortly after penetration, and before the individual wishes it, with little or no voluntary control, resulting in personal and/or interpersonal distress [3].

The International Society for Sexual Medicine (ISSM) defines PE as "ejaculation that always or nearly always occurs prior to or within about 1 minute of vaginal penetration (for lifelong PE) or a clinically significant reduction in latency time, often to about 3 minutes or less (for acquired PE)" [1] [4]. The most recent European Association of Urology guidelines [5] reaffirm this distinction, emphasizing the importance of differentiating between lifelong and acquired forms for etiological understanding and treatment planning.

This condition is estimated to affect 20% - 30% of men across all age groups and is associated with significant psychological, relational, and physical consequences [6]. A recent systematic review by Opolony *et al.* [7] analyzing 79 studies with over 319,000 participants reported a pooled prevalence of 14.2%, though this varied significantly by diagnostic criteria used. PE causes individual and couple distress, impairing quality of life, sexual satisfaction, and relationship dynamics [2] [8]. Several studies have also shown that men with PE often exhibit alterations in social cognition and anxious attachment profiles [9].

Commonly reported risk factors include performance anxiety, low self-confidence, depression, history of psychological trauma, erectile dysfunction, prostatitis, hyperthyroidism, stress, change of partner, excessive alcohol consumption, and the use of psychoactive substances, such as opiates, amphetamines, or dopaminergic medications [10].

In Italy, Verze *et al.* reported a prevalence of 18.5% in general consultation, with 12.4% of men presenting an IELT of less than one minute [11]. In Africa, Hanafy *et al.* described a prevalence of 26.7% in Egypt among 750 patients with a mean age of 37.4 years [6]. In Cameroon, available data remain limited. Angwafor *et al.* reported a prevalence of 18.1% among 166 men consulting for sexual dysfunction at the Yaoundé General Hospital [12]. More recently, Mboumwa *et al.* observed a prevalence of 20% in two hospitals in Douala [13], while Tanze *et al.* reported a lower rate (3.1%) at the Buea District Hospital [14].

Given these regional disparities and the scarcity of recent Cameroonian data, it appears necessary to better characterize this disorder in the local context. The present study therefore aimed to determine the prevalence of premature ejaculation in urology consultations in Douala, identify its predictive factors, and assess its impact on psychological status and quality of life.

2. Patients and Methods

2.1. Study Design and Setting

We conducted a cross-sectional and analytical study with prospective data collection in the outpatient urology units of three hospitals in Douala: Laquintinie Hospital of Douala, the Military Hospital of Region No. 2, and the Deido District Hospital. The study period extended from February 1 to May 16, 2025.

2.2. Study Population

The target population consisted of all men attending urology consultation in these facilities during the study period. Inclusion criteria were: age ≥ 21 years, non-castrated status, attendance at outpatient urology consultation, and provision of free, informed, and signed consent. Consecutive and exhaustive sampling was used.

2.3. Ethical Considerations

Ethical approval was obtained from the Institutional Ethics Committee for Human Health Research of the University of Douala, along with administrative authorizations from the respective hospitals. Eligible patients were informed about the objectives and procedures of the study and signed an informed consent form prior to participation.

2.4. Data Collection

Patients completed a self-administered questionnaire in a confidential setting. For participants with limited literacy (17.6% primary education only, 1.7% no formal education), questionnaires were administered by trained research assistants who read each item aloud in the patient's preferred language (French or English), using standardized neutral phrasing to avoid influencing responses.

Collected data included:

- **Sociodemographic characteristics:** age, occupation, education level, marital status, religion.

- **Medical and surgical history:** hypertension, diabetes, prostatitis, Peyronie's disease, sexually transmitted infections, erectile dysfunction, prostatectomy, hernia repair.
- **Lifestyle habits:** alcohol consumption, tobacco use.

2.5. Assessment of Premature Ejaculation

Intravaginal ejaculatory latency time (IELT) was assessed using self-reported estimated average time from vaginal penetration to ejaculation over the past 4 weeks. Patients were instructed to provide an average estimate based on their recent sexual experiences.

Patients with an IELT ≤ 3 minutes were classified as having PE, in accordance with the broadened ISSM definition including acquired forms [1] [4]. We applied a single cutoff of ≤3 minutes to all participants for the following reasons: 1) clinical pragmatism in routine urological consultation; 2) consistency with recent epidemiological literature [6] [11]; and 3) sample size considerations. However, we acknowledge that this does not distinguish between lifelong and acquired PE. To assess the robustness of our findings, we conducted a sensitivity analysis using a stricter definition of PE (IELT ≤ 1 minute), which more closely corresponds to the classic definition of lifelong PE.

2.6. Assessment of Key Predictor Variables

2.6.1. Erectile Dysfunction (ED)

Erectile dysfunction was defined based on clinical evaluation by the consulting urologist, using DSM-5 criteria: persistent or recurrent inability to attain or maintain an erection sufficient for satisfactory sexual performance, present for at least 3 months.

2.6.2. History of Sexually Transmitted Infections (STIs)

History of STIs was obtained through self-report of prior physician diagnosis. Patients were asked: "Have you ever been diagnosed with a sexually transmitted infection by a healthcare professional?" Those answering "yes" were asked to specify the infection(s). Only professionally diagnosed infections were counted. The timeframe was lifetime prevalence, which is acknowledged as a limitation.

2.6.3. Alcohol Consumption

Alcohol consumption was assessed using a standardized frequency questionnaire. Patients were asked: "On average, how often do you consume alcoholic beverages?" Response options included: Never; Once per month; 2 - 4 times per month; 2 - 3 times per week; ≥4 times per week.

Definition of a standard drink: Patients were instructed that one standard drink corresponds to approximately 330 mL of beer (one bottle), 150 mL of wine (one glass), or 40 mL of spirits (one shot).

2.6.4. Smoking Exposure

Smoking history was quantified using the pack-years metric, calculated as:

Pack-years = (Number of cigarettes smoked per day ÷ 20) × Number of years smoked

Patients were categorized as: **Non-smokers:** Never smoked or smoked < 100 cigarettes in lifetime; **<5 pack-years:** Light smoking history**; 5 - 15 pack-years:** Moderate smoking history**; >15 pack-years:** Heavy smoking history.

Former smokers who had quit for ≥12 months were classified according to their cumulative pack-years.

2.6.5. Assessment of Psychological Status and Quality of Life

1) Anxiety Assessment (STAI-T)

Trait anxiety was assessed using the **State-Trait Anxiety Inventory—Trait version (STAI-T)**, a 20-item self-report questionnaire. Each item is scored on a 4-point Likert scale (1 = "almost never" to 4 = "almost always"), with total scores ranging from 20 to 80. Higher scores indicate greater anxiety levels.

Score interpretation followed standard cutoffs: **20 - 37:** Very mild anxiety (no clinically significant anxiety); **38 - 44:** Mild anxiety; **45 - 56:** Moderate anxiety; **57 - 80:** High/severe anxiety.

2) Depression Assessment (BDI)

Depressive symptoms were assessed using the **Beck Depression Inventory (BDI)**, a 21-item self-report questionnaire. Each item is scored from 0 to 3, with total scores ranging from 0 to 63.

Score interpretation followed standard clinical cutoffs: **0 - 13:** Minimal depression; **14 - 19:** Mild depression; **20 - 28:** Moderate depression**; 29 - 63:** Severe depression.

3) Quality of Life Assessment (SF-36)

Health-related quality of life was evaluated using the **Short Form-36 (SF-36)** questionnaire. For this study, we focused on the overall quality of life perception. Scores range from 0 to 100, with higher scores indicating better quality of life. Based on established thresholds [15], quality of life was categorized as good (score ≥50) or poor (score <50).

4) Cultural and Linguistic Validation

The questionnaires were administered in French or English based on patient preference. All three instruments have been previously validated in French and English versions and have been used in sub-Saharan African research settings [10] [13] [14].

2.7. Statistical Analysis

Data were entered into Epidata and analyzed using R (R Commander interface) and SAS software. Sociodemographic characteristics were described using frequencies, proportions, means, and standard deviations. Binary logistic regression was performed (univariate then multivariate), with statistical significance set at $p < 0.05$. Variables with $p < 0.10$ in univariate analysis were included in the multivariate model. Adjusted odds ratios (aOR) with 95% confidence intervals (CI) were calculated.

3. Results

3.1. Participant Characteristics

A total of 311 eligible patients were identified, of whom 10 refused to participate, yielding a participation rate of 96.8%. The analysis included 301 patients seen in urology consultations at the three hospitals.

3.1.1. Sociodemographic Characteristics (Table 1)

The mean age of patients was 49.8 ± 13.9 years (range: 21 - 80 years). The most represented age group was 61 - 70 years (19.9%), followed by 31 - 40 years (17.3%) and 51 - 60 years (16.6%). The majority were employed (66.1%), while 26.6% were retired and 3.3% were unemployed. Regarding educational level, 42.2% had higher education, 38.5% secondary education, 17.6% primary education, and 1.7% no formal education. In terms of marital status, 60.1% were married, 29.6% single, and 5.9% cohabiting. Most patients were Christians (92.0%).

Table 1. Sociodemographic characteristics of participants (N = 301).

Characteristic	Count (n)	Proportion (%)
Age group (years)		
21 - 30	49	16.28
31 - 40	52	17.28
41 - 50	44	14.62
51 - 60	50	16.61
61 - 70	60	19.93
>70	46	15.28
Mean age ± SD	49.8 ± 13.9 years	
Occupation		
Employed	199	66.1
Retired	80	26.6
Unemployed	10	3.3
Student	12	4.0
Education level		
No formal education	5	1.7
Primary	53	17.6
Secondary	116	38.5
Higher	127	42.2
Marital status		
Married	181	60.1
Single	89	29.6

Continued

Cohabiting	18	5.9
Divorced	5	1.7
Widowed	8	2.7
Religion		
Christian	277	92.0
Muslim	14	4.7
Other	10	3.3

3.1.2. Medical and Surgical History (Table 2)

Among participants, 67.8% reported no medical history. The most frequently reported conditions were erectile dysfunction (12.6%) and hypertension (11.3%). Other conditions included diabetes (2.3%), sexually transmitted infections (2.9%), prostatitis (1.7%), and Peyronie's disease (1.3%). Regarding surgical history, 94.7% had none; hernia repair accounted for 3.7% and prostatectomy for 1.7%.

Table 2. Medical and surgical history of participants (N = 301).

Characteristic	Count (n)	Proportion (%)
Medical history		
None	204	67.8
Hypertension	34	11.3
Erectile dysfunction	38	12.6
Diabetes	7	2.3
STIs	9	2.9
Prostatitis	5	1.7
Peyronie's disease	4	1.3
Surgical history		
None	285	94.7
Hernia repair	11	3.7
Prostatectomy	5	1.7

3.1.3. Lifestyle Habits

Concerning alcohol consumption, 43.2% reported drinking 2 - 4 times per month, 33.2% 2 - 3 times per week, and 15.3% at least 4 times per week. Only 1.7% reported never consuming alcohol. Regarding smoking, 40.2% were non-smokers, while 59.8% were current or former smokers. Among smokers, 18.3% had <5 pack-years, 22.6% had 5 - 15 pack-years, and 18.9% had >15 pack-years.

3.2. Prevalence of Premature Ejaculation

Out of 301 participants, 70 met the study definition of premature ejaculation

(IELT ≤ 3 minutes), corresponding to a prevalence of 23.26% (Figure 1).

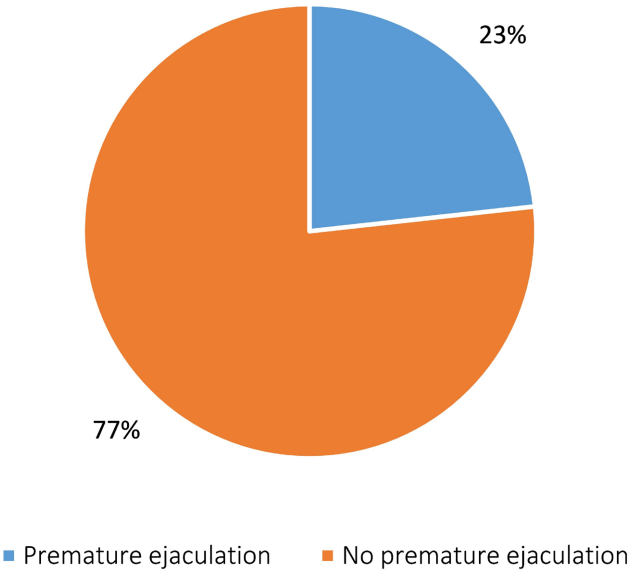

Figure 1. Prevalence of premature ejaculation in urological consultation in Douala (N = 301).

3.3. Sensitivity Analysis Using Stricter Definition

Using a stricter definition of PE (IELT ≤ 1 minute), which more closely approximates lifelong PE:

- **29 patients (9.63%)** reported IELT ≤ 1 minute.
- **41 patients (13.63%)** reported IELT between 1 - 3 minutes (acquired PE range).

3.4. Psychological Impact of Premature Ejaculation

Among the 70 patients with PE, psychological assessments revealed:

Anxiety (STAI-T): Mean score 48.6 ± 8.4 (range: 32 - 68). The majority (75.7%, n = 53) had moderate anxiety, while 10.0% (n = 7) had very mild anxiety, 11.4% (n = 8) mild anxiety, and 2.9% (n = 2) high anxiety.

Depression (BDI): Mean score 16.8 ± 5.2 (range: 6 - 31). Nearly half (47.1%, n = 33) had minimal depression, while 35.7% (n = 25) had mild depression and 17.1% (n = 12) had moderate depression. No patients met criteria for severe depression.

Quality of Life (SF-36): Mean score 67.3 ± 14.1 (range: 38 - 92). Most patients (80.0%, n = 56) reported good quality of life, while 20.0% (n = 14) reported poor quality of life (Table 3).

3.5. Factors Associated with Premature Ejaculation (Univariate Analysis)

Age: Prevalence increased slightly with age but none of the differences were statistically significant ($p > 0.05$) (Table 4).

Table 3. Psychological state and quality of life of patients with premature ejaculation (N = 70).

Evaluation	Count (n)	Proportion (%)	Mean ± SD	Range
Anxiety (STAI-T score)			**48.6 ± 8.4**	**32 - 68**
Very mild anxiety (20 - 37)	7	10.00		
Mild anxiety (38 - 44)	8	11.43		
Moderate anxiety (45 - 56)	53	75.71		
High anxiety (57 - 80)	2	2.86		
Depression (BDI score)			**16.8 ± 5.2**	**6 - 31**
Minimal depression (0 - 13)	33	47.14		
Mild depression (14 - 19)	25	35.71		
Moderate depression (20 - 28)	12	17.14		
Severe depression (29 - 63)	0	0.00		
Quality of Life (SF-36)			**67.3 ± 14.1**	**38 - 92**
Good quality of life (≥50)	56	80.00		
Poor quality of life (<50)	14	20.00		

STAI-T: State-Trait Anxiety Inventory-Trait; BDI: Beck Depression Inventory; SF-36: Short Form-36.

Table 4. Factors associated with premature ejaculation (Univariate Logistic Regression).

Factor	Total (N = 301)	PE n (%)	OR	95% CI	p-value
Age (years)					
21 - 30	49 (16.28)	9 (18.37)	1 (ref.)	—	—
31 - 40	52 (17.28)	10 (19.23)	1.06	0.42 - 2.64	0.90
41 - 50	44 (14.62)	11 (25.00)	1.48	0.59 - 3.71	0.40
51 - 60	50 (16.61)	12 (24.00)	1.39	0.57 - 3.40	0.47
61 - 70	60 (19.93)	15 (25.00)	1.48	0.63 - 3.46	0.38
>70	46 (15.28)	13 (28.26)	1.74	0.71 - 4.29	0.23
Past medical history					
None	204 (67.77)	35 (17.16)	1 (ref.)	—	—
Hypertension	34 (11.30)	10 (29.41)	2.00	0.89 - 4.49	0.09
Diabetes	7 (2.33)	3 (42.86)	3.55	0.78 - 16.17	0.10
Prostatitis	5 (1.66)	2 (40.00)	3.10	0.50 - 19.11	0.20
Peyronie's disease	4 (1.33)	1 (25.00)	1.60	0.16 - 15.75	0.70
STIs	9 (2.99)	5 (55.56)	**6.00**	**1.68 - 21.48**	**0.005**
Erectile dysfunction	38 (12.62)	14 (36.84)	**2.85**	**1.31 - 6.18**	**0.008**
Past surgical history					
None	285 (94.68)	65 (22.81)	1 (ref.)	—	—
Prostatectomy	5 (1.66)	2 (40.00)	2.23	0.38 - 13.09	0.37
Hernia repair	11 (3.65)	3 (27.27)	1.27	0.33 - 4.90	0.73
Alcohol intake					

Continued

Never	5 (1.66)	1 (20.00)	1 (ref.)	—	—
1×/month	20 (6.64)	3 (15.00)	0.70	0.07 - 6.66	0.76
2 - 4×/month	130 (43.19)	20 (15.38)	0.73	0.09 - 6.00	0.76
2 - 3×/week	100 (33.22)	15 (15.00)	0.70	0.08 - 5.90	0.74
≥4×/week	46 (15.28)	31 (67.39)	**9.67**	**1.12 - 83.7**	**0.012**
Tobacco (pack-years)					
Non-smoker	121 (40.20)	20 (16.53)	1 (ref.)	—	—
<5 PY	55 (18.27)	13 (23.64)	1.56	0.71 - 3.43	0.27
5 - 15 PY	68 (22.59)	19 (27.94)	1.96	0.94 - 4.10	0.07
>15 PY	57 (18.94)	18 (31.58)	**2.31**	**1.09 - 4.92**	**0.03**

STIs: *Sexually Transmitted Infections*; *PY*: *pack-years*.

Medical History: Significant associations were found for:

- History of sexually transmitted infections: 55.6% with PE (OR = 6.00; 95% CI 1.68 - 21.48; p = 0.005).
- Erectile dysfunction: 36.8% with PE (OR = 2.85; 95% CI 1.31 - 6.18; p = 0.008)

Surgical History: No significant associations observed (p > 0.05).

Alcohol Consumption: Significant association only for frequent drinking (≥4 times/week): 67.4% with PE (OR = 9.67; 95% CI 1.12 - 83.7; p = 0.012).

Smoking: Significant association only for heavy smoking (>15 pack-years): 31.6% with PE (OR = 2.31; 95% CI 1.09 - 4.92; p = 0.03).

3.6. Factors Independently Associated with PE (Multivariate Analysis)

After adjustment for variables significant in univariate analysis, the factors independently associated with premature ejaculation were Age, hypertension, and diabetes were not significantly associated in the multivariate model (Table 5).

Table 5. Factors independently associated with premature ejaculation (Multivariate Logistic Regression).

Factor	aOR	95% CI	p-value
Age (years)	1.01	0.98 - 1.04	0.42
Hypertension	1.40	0.62 - 3.15	0.41
Diabetes	2.12	0.68 - 6.64	0.19
STIs	**3.98**	**1.18 - 13.36**	**0.026**
Erectile dysfunction	**3.25**	**1.42 - 7.47**	**0.005**
Alcohol ≥ 4 times/week	**4.86**	**1.55 - 15.21**	**0.006**
Tobacco > 15 PY	**2.04**	**1.00 - 4.16**	**0.048**

STIs: *Sexually Transmitted Infections*; *PY*: *pack-years; aOR*: *adjusted odds ratio*.

3.7. Sensitivity Analysis for Risk Factors

When re-analyzing factors associated with PE using the stricter ≤ 1-minute cutoff:

- History of STIs remained significantly associated (OR = 5.82; 95% CI 1.52 - 22.31; p = 0.010).
- Erectile dysfunction showed a stronger association (OR = 4.12; 95% CI 1.89 - 8.98; p = 0.0004).
- Frequent alcohol consumption (≥4×/week) remained significant (OR = 7.23; 95% CI 1.98 - 26.45; p = 0.003).
- Heavy smoking (>15 pack-years) showed a trend but lost statistical significance (OR = 1.89; 95% CI 0.88 - 4.06; p = 0.102), possibly due to reduced sample size.

4. Discussion

4.1. Prevalence of Premature Ejaculation

In this study conducted in three urology departments in Douala, premature ejaculation affected 23.26% of men surveyed using the ≤3-minute cutoff, and 9.63% using the ≤1-minute cutoff. The primary estimate falls within the range reported in several hospital-based studies internationally [5]-[7] [11]. A recent systematic review by Opolony *et al.* [7] reported pooled prevalence of 14.2% across 79 studies, though this varied considerably by diagnostic criteria and population.

In Africa, Hanafy *et al.* [6] reported a prevalence of 26.7% in Egypt, closely matching our findings. In Cameroon, our estimate is higher than the 18.1% reported by Angwafor *et al.* [12] in Yaoundé and the 20% reported by Mboumwa *et al.* [13] in Douala, but substantially higher than the 3.1% reported by Tanze *et al.* [14] in Buea. These variations likely reflect differences in diagnostic criteria, study settings, and population characteristics.

The sensitivity analysis using a ≤1-minute cutoff (9.63%) is remarkably consistent with the 12.4% reported by Verze *et al.* [11] in Italy using the same threshold, suggesting that the prevalence of probable lifelong PE may be relatively consistent across populations.

4.2. Psychological Burden of PE

The high prevalence of anxiety symptoms among our PE patients (75.7% with moderate anxiety; mean STAI-T 48.6) is consistent with findings from Rowland *et al.* [8] and recent meta-analyses. Che *et al.* [16] reported a pooled anxiety prevalence of 42% in PE patients, while Xie *et al.* [17] confirmed strong associations between sexual dysfunction and psychological comorbidity. Our higher rates may reflect clinic-based sampling, where men seeking care may have greater distress.

Regarding depression, 52.9% of our PE patients had at least mild depressive symptoms (BDI ≥14), aligning with Hanafy *et al.* [6], who reported significant depression in 48% of Egyptian men with PE. The absence of severe depression in our sample may reflect cultural factors, coping mechanisms, or the relatively high mean age.

The mean SF-36 score of 67.3 in our PE patients is higher than the 58.4 reported by Verze *et al.* [11] in Italy, suggesting that Cameroonian men with PE may per-

ceive less impact on overall quality of life. This could be due to cultural differences in the centrality of sexual performance to overall well-being. However, the 20% with poor quality of life represents a clinically important subgroup requiring attention.

4.3. Factors Associated with Premature Ejaculation

The independent associations we identified—history of STIs, erectile dysfunction, frequent alcohol consumption, and heavy smoking—are consistent with international literature [1] [4] [5] [11].

History of STIs (aOR = 3.98) may contribute to PE through several mechanisms: chronic prostatic inflammation, psychological distress following diagnosis, or relationship disruption. This finding aligns with Serefoglu and McMahon [3] [4], who documented higher PE frequency among men with urogenital history.

Erectile dysfunction (aOR = 3.25) showed the strongest association in multivariate analysis. The bidirectional relationship between ED and PE is well-established [1] [5]; men may rush to ejaculation for fear of losing erection, or ED may reflect underlying vascular or neurological pathology that also affects ejaculatory control.

Frequent alcohol consumption (≥4 times/week; aOR = 4.86) was strongly associated with PE. This relationship, also observed in studies from Türkiye, Italy, and Egypt [6] [11] [18], may reflect alcohol's disruptive effect on sensory perception and central inhibitory control, although residual confounding (e.g., underlying anxiety) cannot be excluded.

Heavy smoking (>15 pack-years; aOR = 2.04) was associated with PE, consistent with some European studies [11]. The loss of statistical significance in the ≤1-minute sensitivity analysis suggests smoking may be more strongly associated with acquired PE (IELT 1 - 3 minutes) than lifelong PE, a hypothesis warranting further investigation.

4.4. Limitations

Several limitations should be considered when interpreting our findings.

First, **clinic-based sampling** limits generalizability. This study was conducted among men attending urology consultations, who may differ from the general population in health-seeking behavior and symptom severity. Our prevalence estimate reflects urology consulters, not community-based prevalence. Men with mild PE or those not perceiving their symptoms as problematic may be underrepresented.

Second, the **cross-sectional design** precludes determination of causality or directionality. We cannot establish whether factors such as anxiety precede, predict, or result from PE. Longitudinal studies are needed to elucidate temporal relationships.

Third, **reliance on self-reported data** introduces potential information bias. IELT was estimated rather than stopwatch-measured, which may affect accuracy [19]. STI history, alcohol consumption, and smoking were based on recall without

objective verification. Social desirability bias may have led to underreporting of sensitive behaviors.

Fourth, **measurement limitations** affect specific variables. ED was assessed clinically rather than with a validated instrument like the IIEF-5. Alcohol consumption was assessed by frequency only, without quantifying amount per occasion. For smoking, we did not distinguish current from former smokers in the main analysis.

Fifth, the **absence of distinction between lifelong and acquired PE** limits etiological interpretation. Our sensitivity analysis using a ≤1-minute cutoff partially addresses this by approximating lifelong PE, but this remains a limitation.

Sixth, while the STAI-T, BDI, and SF-36 are widely used, their **validation in Cameroonian populations** is limited. Cultural differences in expressing psychological distress may affect accuracy.

Seventh, the **relatively small sample size for subgroup analyses** (70 PE cases) limited statistical power for detecting associations with less common exposures.

Finally, **unmeasured confounding** is possible. We did not assess partner characteristics, relationship quality, frequency of sexual activity, occupational stress, or detailed medication use.

Despite these limitations, this study provides valuable contemporary data on PE in urological consultations in Cameroon, identifies key associated factors, and highlights the psychological burden of this condition.

5. Conclusions

This study demonstrates that premature ejaculation is relatively common among men attending urology consultations in Douala, with a prevalence of 23.26% using a ≤3-minute cutoff and 9.63% using a ≤1-minute cutoff. The condition is independently associated with history of sexually transmitted infections, erectile dysfunction, frequent alcohol consumption (≥4 times/week), and heavy smoking (>15 pack-years).

Future research in Cameroon should employ longitudinal designs to establish temporal relationships between PE and its associated factors, incorporate community-based samples to estimate true population prevalence, utilize culturally validated instruments, and distinguish between lifelong and acquired PE. Until such data are available, our findings provide a useful foundation for evidence-based care of men with premature ejaculation in Cameroon.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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