The Healthy Male

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Newsletter of Andrology Australia – Australian Centre of Excellence in Male Reproductive Health

Contents

An early warning sign of heart disease

The leading cause of death in Australia is cardiovascular disease, which accounted for nearly 40 per cent of all deaths in 2002[1]. Males are two to three times more likely die from cardiovascular disease than females[2]. To identify a symptom that could be used as a predictor of heart disease might then allow early intervention and a possible reduction in the number of deaths due to the disease.

Erectile dysfunction (ED) has been linked with cardiovascular disease as they have similar risk factors. A study was conducted in the USA to determine whether ED can be considered an early warning sign for cardiovascular disease[3].

A group of over 9000 men aged 55 years and older were assessed every three months over a seven year period. Their age, body mass index, blood pressure, cholesterol, diabetes, family history of heart attack, race, smoking history, physical activity and quality of life were examined.

The study found that the number of men who developed erectile dysfunction, and then experienced a cardiovascular event (angina, heart attack or stroke) was significant. One year after initially reporting erectile dysfunction, 2 per cent of men had experienced a cardiovascular event, and five years later it was 11 per cent of men.

The degree of risk for a cardiovascular event after experiencing ED was similar to the risk of being a current smoker or having a family history of heart attack.

Men with erectile dysfunction should see their doctor and be evaluated for cardiovascular risk factors. Positive lifestyle, diet and exercise changes can contribute to protecting the heart and can improve quality of life.

1 The National Heart Foundation of Australia website, Heart disease facts http://www.heartfoundation.com.au/index.cfm?page=47

2 Australian Institute of Health and Welfare 2002. Australia's health 2002. Canberra: AIHW.

3 Thompson IM, Tangen CM, Goodman PJ, Probstfield JL, Moinpour CM, Coltman CA. Erectile dysfunction and subsequent cardiovascular disease. JAMA 2005; 294 (23): 2996-3002

From the Director

As the new Director of Andrology Australia, I'd like to welcome you to my first issue of *the Healthy Male* newsletter. I'm very excited to take on the role of Director, and look forward to continuing David's legacy to raise the awareness of male reproductive health amongst the community and professions in Australia.

As I start this new role, some exciting initiatives are well under way. Many of our readers will now be familiar with the revamped website, which we hope will become a 'one-stop shop' for both the general public and professionals.

Continuing our work with Indigenous and Culturally and Linguistically Diverse (CALD) communities remains a priority for Andrology Australia. We are focusing on helping men and health professionals in these communities gain access to services and information.

And finally, MATeS and other international studies are now beginning to highlight the close association between male reproductive health and general health. While we will not lose sight of our priority areas, we will ensure that these conditions are not dealt with in isolation. A holistic approach to all aspects of health is an imperative if we hope to improve men's health overall.

Professor Rob McLachlan

Improving Indigenous health at a grass roots level

An education module is being developed to equip Aboriginal Health Workers (AHWs), GPs, and nurses with the appropriate knowledge to talk to indigenous males about their sexual and reproductive health.

The need for an education module on male health was established after meetings between Andrology Australia and the Aboriginal and Torres Strait Islander Male Health Reference Group. The module will be designed primarily for health workers employed in either Aboriginal community controlled health services or primary care community health services, as they are often the first point of contact in the medical consultation process.

Broad objectives of the module are to provide basic clinical knowledge on a range of common disorders affecting indigenous males, including reproductive health disorders, and the links between general and reproductive health and lifestyle issues. Many AHWs assume a health promotion role in their communities; therefore the information and the skills necessary to help AHWs effectively engage men to seek medical assistance if and when needed, will also be included.

The module content will also be sensitive to cultural and social issues unique to Aboriginal and Torres Strait Islander communities. The input of indigenous community groups will be sought to ensure it meets the needs of local communities. Similarly, the module will be designed to allow flexible delivery – as a component of existing AHW training or as a stand alone training package that can be delivered as a one day workshop or short course.

Members of the Andrology Australia Aboriginial and Torres Strait Islander Male Health Reference Group will oversee and provide input for module development and delivery. Module development is being undertaken by the Indigenous Health Unit, School of Rural health, Monash University, with financial support from Andrology Australia.

International Men's Health Week 2006

International Men's Health Week 2006 (IMHW) was a great opportunity for the community to think about the health of husbands, fathers, brothers, uncles and sons and the important contribution men make to society.

Men's health encompasses a whole range of issues, and the physical and psychosocial sides often interact with each other. This means that any specific health problems should be considered with regard to overall health and well-being.

Dr Carol Holden, chief executive of Andrology Australia, said that men with reproductive health problems may also suffer from other chronic conditions, such as heart disease, diabetes and depression."With links between general and reproductive health, making lifestyle changes to improve physical health may also benefit quality of life and relationships," said Dr Holden.

"International Men's Health Week is a good reminder that the health of men in our community needs to be a focus not just this week, but throughout the year," she said.

Andrology Australia received a huge influx of orders for resources for this year's IMHW. Over 450 requests for materials were received, and more than double the amount of resources were ordered in comparison with last year.

Over 2000 posters, 20,000 of the 'User's Guides', 17,000 contact lists and 66,000 fact sheets were distributed.

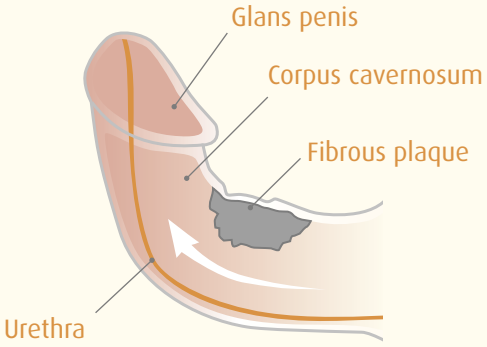
Thank you to all who took part in IMHW by holding a display or running an event. We hope it was a success, and Andrology Australia looks forward to doing it all again next year.

Focus on PEYRONIE'S DISEASE

Author: Dr Peter Sutherland

What is Peyronie's Disease?

Peyronie's disease (named after François de la Peyronie, surgeon to King Louis XV of France) is the hardening of tissue (fibrosis) in the penis. A lump or scar tissue (plaque) forms on the lining of the erectile tissue which holds much of the blood in the penis during erection. The hardened area or plaque prevents normal stretching and can impact on the size and shape of the erect penis.



What are the symptoms?

Peyronie's disease (PD) begins as a small swelling or inflammation which hardens into a lump on the upper or lower side of the penis. It usually develops over time but sometimes appears very quickly. It can be painful, reduce flexibility, and in some cases shorten or create a bend or hour-glass effect in the penis when erect. Some men find it difficult to get or keep erections, or the penis only becomes rigid up to the area of the scar and remains flaccid past that point.

How common is Peyronie's Disease?

About one in every hundred men, develop this disease, although definite numbers are hard to determine as many men do not recognise the problem or seek medical attention as symptoms are mild.

What causes Peyronie's Disease?

It is not clear exactly what causes PD, but it is thought to involve trauma, genetics or auto-immune factors or a combination of these.

When the penis is bent or bumped, the lining to the shaft is damaged. Small blood vessels can rupture or burst and proper blood flow is interrupted. Generally such an injury would only swell, or become inflamed, and would heal within a year. However recovery can take longer and fibrosis (scarring) can happen.

Men with male blood relatives with this problem are more likely to develop PD, which suggests that there are genetic factors involved. It is also thought that a pre-existing problem with the immune system could explain why some men recover from a simple injury to the penis and others develop PD.

Does it always follow an injury or accident?

Sometimes PD follows an obvious injury to the penis, such as a sporting incident, motor vehicle accident or pelvic or urologic surgery. Injury can also be caused, even without realising, during sexual activity, when the penis is pushed or bent against the partner's pelvic bone. However, in many cases no injury can be identified as a trigger.

Also, injection of the penis for treatment of erectile dysfunction can on occasions bring about scarring and the development of PD.

How is Peyronie's Disease diagnosed?

A general practitioner (GP) can generally diagnose PD based on a physical examination. Lumps can usually be seen and felt when the penis is not erect (flaccid). However, to determine the extent of the bend, the penis needs to be erect. To avoid the need to produce an erection in the doctor's surgery, it is sometime suggested that patients take a photo of their erect penis at home. Erectile dysfunction medicine is sometimes given by the doctor in order to check the erect penis.

Why is ultrasound or X-ray sometimes used?

An ultrasound helps identify the exact the location, size and shape of the plaque and determines to what extent blood flow in the penis is affected. An X-ray will show any calcium deposits (calcification). About one in three men with PD develop calcification, which generally indicates the end-stage of the disease. This means the disease has run its full course and the lump or malformation is unlikely to worsen or change. This is useful in planning treatment.

Who is most at risk of developing Peyronie's Disease?

PD usually affects men aged between 45 - 60 years, but can happen at any age. Men with a family history of PD are more likely to develop this problem. It also appears to be more common in white men with Northern European ancestry. It is uncommon in African-American men and rare in Asian men.

How serious is Peyronie's Disease?

PD lumps are benign or non-cancerous. Consequently it is not life-threatening. However, it can prevent sexual intercourse and the pain and impact on sex life, can lead to distress, anxiety and lower self-esteem.

How does Peyronie's Disease affect sexual intercourse?

In mild cases of Peyronie's where there lump does not cause the penis to bend very much, or at all, the effect on intercourse can be minimal. However, moderate or severe disease can prevent intercourse due to erectile dysfunction or the shape making penetration impossible.

Why isn't treatment always suggested?

PD does not follow a set pattern or clearly defined clinical course. Lumps and scar tissue can disappear without any treatment. Doctors often suggest waiting about 12 months before surgery is recommended.

How is it treated?

Most men do not need treatment for PD. The condition does not progress to a degree that treatment is required. However, time and surgery are the only proven cures for the condition. The most common surgical form of treatment is plication of the penis. PD can also be treated through excision of the scar and grafting, and also with implantation of a penile prosthesis.

How are surgical treatments selected?

If the curvature or pain continues after 12 months, surgery is generally recommended, particularly if the ability to have sexual intercourse is affected. There are a number of different procedures. Treatments are generally recommended to suit the following criteria:

- the man's ability to get and keep an erection
- the length of the penis
- the extent of the bend or curvature

What is plication?

Penile or corporal plication involves making a tuck using sutures in the lining of the penis on the side opposite the bend to straighten the penis. Known as the Nesbit procedure, it is a simple operation with minimal side effects, other than a shortening of the penis. It is best suited for men that have good erectile function, only a slight bend, no pain and where penile shortening is not a major concern.

What is incision of the scar and grafting?

Incision of the scar and grafting involves cutting the scar tissue to release the tethered penis, returning the length, and the opened area is then patched. The plaque is divided with a scalpel and the defect created is then covered with skin graft or a piece of vein or other suitable grafting material. Synthetic patches are now available. This procedure successfully can treat pain, curves and other deformities. It can also improve length if shortening of the penis, secondary to the scarring, is significant.

This type of surgery, though, has a greater chance of causing erectile dysfunction than plication because disturbing nerves on the penis is often necessary and a loss of penile sensation may happen in about 10 per cent of patients. The surgery is technically more difficult. Because of these reasons, plication is often offered as a simpler initial therapy with incision and grafting offered to men with severe scarring in whom short penile length is a major problem.

When are penile prostheses used?

Men whose PD has led to severe erectile dysfunction or who are unable to get and keep an erection can also have penile implants inserted to assist them. Sometimes an implant alone will straighten the penis. However a combined procedure is often needed to completely fix the problems. The plaque is excised and grafted before the prosthesis is implanted.

What non-surgical treatments are available?

Over a long period of time, many medical therapies have been tried with some reporting initial success but once they have been tested in a truly controlled sense with placebo, no treatment has been shown to reduce or remove penile scarring.

Non-surgical treatments include:

- vitamin E in tablet or cream form, an inexpensive and simple treatment with minimal side effects;
- potassium aminobenzoate, a chemical that belongs to the Vitamin B group and is used to break down hard, fibrous skin in conditions like scleroderma;
- colchicines, an anti-inflammatory drug generally used to treat gout but often has severe gastrointestinal side-effects;
- tamoxifen, an anti-estrogen drug used to treat breast cancer and other malignant tumours, which can have a range of side-effects;
- extracorporeal shock wave therapy (ESWT), sometimes used to break down kidney stones;
- radiation therapy, high-energy rays targeting the scar tissue can relieve pain, but can also cause several side-effects;
- verapamil, a calcium channel blocker often used in the treatment of high blood pressure, that is injected directly into the plaque;
- interferons, naturally-occurring proteins which are also injected directly into the penis to break down the scar tissue.

Are injectable treatments safe?

Some controversy surrounds the use of injectable treatments for PD. The benefits are still uncertain and some treatments could make the problem worse. Steroid injections, particularly cortisone, are not recommended as they can lead to the death of healthy tissue (atrophy).

Are all lumps in the penis Peyronie's Disease?

Not all lumps in the penis are PD. Hard swellings that suddenly appear on the shaft of the penis near the foreskin after sexual intercourse are usually lymphoceles. These are caused by temporary blockage in lymphatic channels in the penis and will go away on their own without after-effects. Small bumps, cysts and pimples on the outside of penis and scrotum are also quite common and generally harmless. Any persistent or painful cyst with a discharge should be checked by a doctor to rule out the possibility of a sexually transmitted disease.

Could it be penile cancer?

The symptoms for penile cancer are very different from the symptoms of PD. Penile cancer generally starts with a tender spot or wart like bump on the outside of the penis. Bleeding and unusual discharge from the penis are also symptoms associated with penile cancer. This cancer is extremely rare in Western countries, although more common in Africa and Asia.

In summary, Peyronie's disease, it must be emphasised, is an entirely benign condition and only affects a man secondary to its functional effects on the penis. If these are minimal, no treatment should be considered. Treatment should only be reserved for those men in whom anger and frustration, secondary to the loss of function, are real issues. Treatment should always be delayed at least 12 months from the development of the scar as in many patients scarring improves to a degree so that no treatment is required.

Intimacy in the 'Viagra Age'

Recent research has often focused on the effectiveness of oral drugs for erectile dysfunction (ED). However, very little is known about how using these drugs can affect couples' relationships.

Andrology Australia supported a study exploring the experiences of couples who were effectively using oral ED medication, and the changes that it brought about in their relationships. The study looked at couples' decision making, communication, expectations and concerns about this treatment. The study also explored couples' preferences for treatment use, and the welcome and unwelcome impacts that treatment has on relationships.

The study found that men and their partners were often equally satisfied with the treatment.

Many couples also agreed that both partners equally wanted the treatment. However, several couples also described an imbalance in their desire for treatment, typically tending towards men wanting the treatment more than their partner.

Whilst couples discussed ED treatment options together, most men visited their doctor alone to seek treatment. Only a few women said they would have preferred to be more involved in the treatment-seeking process.

Couples' sexual relationships commonly improved after treatment as they felt more relaxed and confident, which in turn led to an increase in sexual activity and intimacy. Several women also highlighted an increase in communication and affection with their partner as a result of the treatment.

Although most couples experienced positive changes in their relationships as a result of their ED treatment, the majority of couples also experienced unwelcome aspects of the treatment. For many couples, the use of treatment was loaded with expectations. There was a common belief that the man would be able to achieve an erection when desired, and that the couple should have sex once the man had taken a tablet. As the treatments can be costly, there was an element of not 'wasting a good erection', and disappointment if the opportunity for sex was not actualised. This created some difficulties, particularly among couples with differing sexual desires.

Treatment for ED was sometimes a problem for couples who wanted a more spontaneous sex life. There were difficulties in deciding whether or not to take a tablet in anticipation of sex, the frustrations of delays in getting an erection, and occasionally inconsistencies in the effectiveness of treatment.

Overall, many couples participating in the study believed that the effective use of ED treatment had a positive impact on their sexual and broader relationship. Many described their relationship as 'much better' or back to 'normal'.

For more information about the study, contact Dr Cath Andrews at the Department of General Practice, Monash University at catherine.andrews@med.monash.edu.au or 03 8575 2223.

Latest news

Klinefelter's Syndrome and the importance of male examination

Klinefelter's Syndrome (KS) is the most common genetic disorder affecting male reproductive health. Although KS has been associated with a number of medical conditions, there is limited information about long-term health outcomes.

A recent study using the Danish Cytogenic Central Register looked at data on hospitalisation of KS patients[1]. Over 800 KS patient records were compared with a randomly selected, age-matched control group of over 4000 men.

The authors found a 69% increased risk in KS men of being hospitalised for a wide variety of disorders, compared to the matched controls. Some of the disorders are likely to be caused by the lack of testosterone (hypogonadism) that is present with KS. Other disorders may be linked to the syndrome itself, such as socioeconomic status related to learning disabilities and psychiatric disturbances.

Klinefelter's Syndrome is under-diagnosed in many countries. An estimated 75 per cent of men with Klinefelter's Syndrome are not being diagnosed, the reasons for which are highlighted in an editorial accompanying this research article. The editorial was written by Professor David Handelsman and Dr Peter Liu from the ANZAC Research Institute and Department of Andrology in Sydney[2].

They note that the failure to diagnose KS through the detection of small testes infers that most men do not, at any time, have a genital examination performed by their doctor. This is an important male reproductive health care issue, as the hormonal deficits associated with KS are readily treatable.

They also comment that such studies of KS, apart from providing useful information for the detection and treatment of KS, may shed light on the long-term consequences of androgen deficiency among older (non-KS) men. This information may help doctors better define which men might benefit from testosterone treatment.

1 Bojesen A, Juul S, Birkebæk N, Gravholt C. Morbidity in Klinefelter's Syndrome: A Danish Register Study Based on Hospital Discharge Diagnoses. Journal of Clinical Endocrinology and Metabolism 2006; 91: 1254-1260

2 Handelsman DJ, Liu P. Editorial: Klinefelter's Syndrome – A Microcosm of Male Reproductive Health. Journal of Clinical Endocrinology and Metabolism 2006; 91: 1220-1222

In brief

Leaders in medical education and research awarded

Professor Leon Piterman, management group member of Andrology Australia and Professor of General Practice at Monash University, received a Member of the Order of Australia in this year's Queen's Birthday Honours List.

Leon received the award for his service to family medicine through distance education for doctors in remote areas, to research and student training, and to international medical education.

Patron of Andrology Australia, Professor David de Kretser, received a Companion in the Order of Australia. David received this award for distinguished contributions to public life as a medical researcher of international reputation in the field of reproductive biology, to the development of the biotechnology industry, and to bioethics.

Congratulations Leon and David!

Annual report available

Andrology Australia's annual report for 2005 is now available. The report has the theme 'Bridging the gaps in men's health' and provides an overview of the highlights and major achievements of the program in 2005.

If you would like a hard copy of the report, please call 1300 303 878. The report is also available to download at www.andrologyaustralia.org.

Long lasting testosterone injection now available on PBS

The new 3 monthly testosterone injection, Reandron® 1000, will be available on the PBS from 1 August 2006. Recently approved in Australia, the injections last up to 14 weeks. The testosterone is released slowly so that men do not experience the peaks and troughs that are common with standard injections.

Reandron® 1000 is available from pharmacies now.

Recent events

Preventive health check to improve quality of life

Funding of a preventive health check for all Australians over the age of 45 years has been included in the Australian Government budget for 2006 – 2007.

Some of the key areas of focus include promoting healthy lifestyles, supporting the early detection of lifestyle risks and chronic disease, and encouraging active patient self-management of chronic disease. People with chronic disease such as diabetes, heart disease, cancer and arthritis, and those at risk for these diseases, will benefit from the new health policy.

Professor Rob McLachlan, Director of Andrology Australia, said that this preventive health check will help men and doctors to engage in discussion about overall health.

"The MATeS study showed that men aged over 45 are visiting doctors, but many are walking away without discussing health issues that can impact on their quality of life," said Prof. McLachlan.

"General health and lifestyle behaviours such as diet, exercise, drinking and smoking, all contribute to overall health and can lead to potential health risks," he said.

"With the association between reproductive health problems, chronic disease and lifestyle behaviours, it's important for a full health check to be carried out," he said.

The Commonwealth government will contribute $250 million over five years to the new health policy, and State and Territory governments will also contribute.

"We hope that the policy will support a greater assessment of men's health, which will improve lifestyle and quality of life," said Prof. McLachlan.

"This preventive health check is a positive step forward for men's health".

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