1st World Congress on Men's Health

November 2–4, 2001
Vienna, Austria

Sex & Gender Matter – From Boys to Men
The Future of Men's Health

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Proceedings
&
Abstracts

Acknowledgements

The Collection of Proceedings & Abstracts is generously supported by:

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The 1st WCMH is planned and organized by

- the Center of Advanced Medical Education and Health Communication, Medical School, University of Vienna
- the Institute of Social Medicine, Medical School, University of Vienna
- the Men's Health Initiative

in cooperation with

- the University of Vienna, Medical Faculty
- the Municipal Health Planning Department, City of Vienna
- the World Health Organization, Vienna

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** the BMJ publishes a theme issue on "Men's Health"*

Contents

All Abstracts are in order of the time schedule of the program of the 1st World Congress on Men's Health.

The Program of the 1st World Congress is subject to CME-Credits through the endorsement of the Family Practice Education Network, coordinated by the Illinois Academy of Family Practice.

Preface

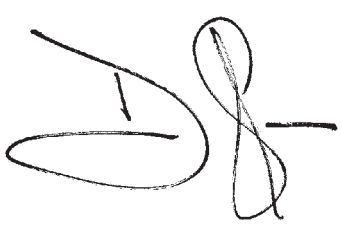
In the light of the enormously growing field of sex and gender related medicine, the First World Congress on Men's Health 2001 represents a unique and absolutely innovative opportunity for global information transfer and experience exchange on the highest level possible. To continue to advance human health and medical practice, research on and knowledge of sex and gender differences in health and illness across the whole life span are essential.

The contributions to these proceedings are based upon invited papers and the abstracts of the invited and free lectures, presented at the First World Congress on Men's Health WCMH 2001, held in Vienna, Nov. 2 – 4, 2001. Due to the tragedy of September 11th, 2001, many invited speakers and participants from all over the world unfortunately could not participate.
Due to the special circumstances the format of the conference differs slightly from usual ones in that there are more formal invited lectures and satellite symposia. The posters are presented in three sessions.

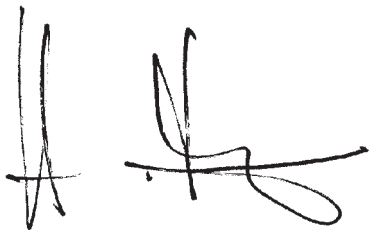
It would not have been possible to organise the WCMH 2001 without the support of the City of Vienna, the Medical School, University of Vienna and the International Society for Men's Health.

We acknowledge and thank the assistance of Christian Pangratz, M.A., Margarete Steiner, M.Sc., Elisabeth Pavlis, Gabriela Winkler and Willy Stöckl.

We thank all the authors for their contributions under very special circumstances.



Siegfried Meryn, M.D.
President of the Congress



Anita Rieder, M.D.
Vice-President of the Congress

Andreas Jungwirth, M.D.
Congress Secretary

The Future of Men

Siegfried Meryn [1], Anita Rieder [2]

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The information society is at present – there was probably no prior warning – faced with processes of decision-making which will have a lasting effect. This concerns not only a completely new quality of the conflict oriented to life and death, which has left all conventional forms of warfare far behind, but also the challenge of a completely new quality of research, which for the first time ever is vehemently intervening in the emergence of life and its lifelong accompaniment. Both developments are international, and even worldwide, and escape all national or globalized control. With these dramatic aspects the 'normal' threat to the world, the risks through technological megalomania, ecological ignorance and the failure of the conventional model of education, is completely forced to one side, although its deficits will have consequences, if not now then at the latest over the next generations, and these will reach far beyond our imagination. For example hardly any social formation has understood the dimension of childhood influence, with its development of natural language learning, the molding of emotional intelligence and thus the optimization of life for 80 % of all human decisions, instead this socialization has been abandoned to quite arbitrary markets, which are above all determined by the media. The one-dimensionality of a capitalistically-oriented world society, which discovers its differences in apparently religious conflicts that in one way or other act as substitutes for winning power, aims, on both sides of those striving for power, at a discouragement of human values, the disavowment of a world view, the loss of poly-culturality, solidarity and "antiquated" notions like compassion, goodness or tolerance. Today, as before, the theory predominates that these social expressions should be addressed as typically male, even though conversely, due to his life expectancy and health profile, the male should rationally be addressed as a disadvantaged.

A medicine with a sense of responsibility cannot follow mainstream economic developments alone, but in the interests of human beings has to counteract whatever ill-considered and probably unforeseen deficits emerge. In contrast to emancipatory ideas that literally everything should be thrown into the breach for the good of women, it will be necessary to develop a kind of therapeutic justice for people, one which attempts to eliminate gender deficits and disadvantages and to alleviate suffering where it arises to a significant degree, independently of the gender group to which people belong.

Even if there is a tendency for cliché of the 'new man' to achieve a great deal of medial presence, it is important not to forget the human dimensions: solidarity and responsibility, tolerance and respect, goodness and humanity, but also the endeavor to love and tenderness. The most important dimension is that of creating a reflection of the human from the cliché of the male. A dimension which, as may be seen from the deficits, also requires medical support. Male health is accordingly not a singular function for a specific gender type, but a singular contribution to the improvement of the human climate in both physical and mental respects. Thus it becomes evident that every deviation from the equally valid, if highly differentiated view of things which the sexes have, can finally produce only one result: A kind of communicating vessel in caring for gender-specific differences, which balance as well as possible the well-being of both sexes on parallel levels.

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Men follow Women

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We hope that the 1st WCMH is inspiring, interesting and enjoyable, and achieves its aim of helping to raise the profile of men's health in the 21st century.

Men's health has, in recent years, become a key concern, not only to healthcare professionals, but also to governments. Statistics reporting the generally shorter life-spans of men compared with women, together with the reluctance amongst men to talk about health matters, are worrying. Differences between men and women with regard to access to health information and willingness to seek medical advice have been reported clearly indicating the importance of addressing health issues from a gender perspective.

The broad spectrum of issues covered at the WCMH has demonstrated that the area of men's health is highly complex, however, the potential for improvement of men's health is great. In particular, through targeted dissemination of information, promotion of preventive measures in health-care, and increased gender-specific research, marked improvements in mortality due to illnesses, such as, CVD, cancer etc. may be expected.

- The "World of Men's Health" presentations provide interesting and thought provoking statistics regarding the state of men's health around the world. Of particular importance is the way in which health report statistics may be used to identify specific areas for attention and thus provide a focus for health care policies. A great deal may also be learned from the strategies adopted by the women's health movement for creating awareness, prevention programs and encouraging more frequent doctor's visits. Finally 'sex matters' – sex based differences can influence the physiological functions of men and women as well as the way in which disease can affect the body.

- Specific problems and illnesses, such as erectile dysfunction, CVD, prostate cancer, hypertension etc. are discussed as part of the clinical pearls symposia. These illnesses are gaining in importance, partly due to increased life expectancy. Of particular concern is prostate cancer for which more research is required in the field of prevention and early detection in young men. Here too, gender specific aspects play a role, for example, the different ways in which men and women experience their cancer.

- "New Frontiers in Men's Health" addresses a wide range of issues not commonly associated with men's health problems. The aim of this section is to raise awareness of problems with which physicians may be confronted in the future due to the increasing life expectancy of men. Gender differences in approach and attitude are arguably most apparent in this area. Osteoporosis, menopause, and depression are conditions more often associated with women, however, in recent years incidence of osteoporosis in men has increased, symptoms of male climacterium have been identified and depression has become more prevalent. A wealth of

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information is available to women concerning these illnesses, however, there is a lack of information targeted at men. The way in which information may be communicated to men is a field of study in itself. It appears that men are less likely to discuss health matters with friends or family and as such, distribution of information via alternative methods, such as the internet, becomes an interesting and viable option.

- Undoubtedly there are many challenges in the field of men's health. Topics regarding HIV and AIDS, health issues for gay men, and psychosocial aspects, such as, male aggression and violence have all been identified as potential future study areas.

- So what does the future hold for men? Although there appear to be many risk factors with regards to men's health, focusing attention on these important issues through events such as the annual World Congress on Men's Health (WCMH) helps to increase awareness amongst those involved in health care. Through continued research and attention to these issues improvements in men's health may be achieved. Ultimately men must also be encouraged to take a proactive role in their own health care.

Men’s Health in Europe

Peter Baker, Ian Banks

Men's Health Forum, United Kingdom

The work to improve men’s health across Europe has begun. A key step will be the launch of the European Men’s Health Forum (EMHF) at the First World Congress on Men’s Health. The EMHF is an independent, non-governmental, non-profit-making organization whose aims include raising the profile of men’s health at a Europe-wide level and within individual states and encouraging Europe-wide, national, regional and local organisations to include men’s issues in their health policies and practices.

There is certainly a big job to be done. Male life expectancy at birth varies widely across Europe with Hungary having one of the lowest levels at 66.1 years. In Latvia, the death rate for coronary heart disease in males aged 35-74 is 800 per 100,000. The incidence of prostate cancer is rising in most countries and there are high levels of suicide, especially among young men. The total potential years of life lost for males under the age of 70 across the European Union is 6,063 per 100,000 population, almost twice the female figure. Despite their health problems, however, men remain under-informed about health issues, take excessive risks with their health and are reluctant to seek help from a health professional.

Fortunately, there are many good examples of men’s health work for the EMHF and others to draw on. In England and Wales, for example, the Men’s Health Forum has helped develop policies to tackle the growing problem of young men and suicide, established research into increasing prostate health awareness among men in the workplace, launched a website for health professionals interested in men’s health and recently begun a dialogue with women’s health organisations about how to create a new ‘gender agenda’ in health policy and practice.

Elsewhere in Europe, the Men’s Health Forum Scotland has established a national Men’s Health Week (held in September) during which local health organisations are encouraged to run men’s health initiatives. The city of Vienna has published a report on men’s health, introduced a cardiovascular disease prevention programme targeting men and women in different ways and organized two Men’s Health Days in 2000 and 2001. The Swiss Foundation for Health Promotion is supporting a wide-ranging men’s health initiative which aims to facilitate the work of professionals and directly assist specific pilot projects.

Activity is accelerating, although only the first tentative steps have so far been taken to put men’s health onto the agendas of both governmental and non-governmental organisations across and within Europe. However, while there is little prospect of ending European men’s health inequalities in the next 10-20 years, it is perhaps now possible to foresee a time when the concept of ‘men’s health’ is no longer a contradiction in terms.

Men’s Health in the USA

Will Courtenay

Sonoma State University, California, USA

Gender-based approaches to health recognize that in addition to having different reproductive health needs, women and men have different risks for specific diseases and disabilities, and that they differ in their health-related beliefs and behaviors. Research conducted in the European Union and the United States indicates, for example, that men are less likely than women to perceive themselves as being at risk for most health problems, even for problems that they are more likely than women to experience.

The concept of gender-specific health is not new. Thirty years ago, feminist theorists and researchers first challenged the medical establishments of Western nations to recognize that being a woman means more than being female; that gender – or womanhood – is relevant to women's health for reasons unrelated to biological sex. Yet even today, researchers in many countries do not take into account male and female sex, let alone gender.

The distinction between the term gender – which refers to the social and cultural meanings assigned to being a woman or a man at a given time in history – and sex – which refers to biological differences between human males and females – is more than semantic. It can be argued that most of what we know about health is about men's health, that most medical research of the last century was conducted on men. But in fact, it was conducted on male bodies.

Gender-specific health approaches go beyond physiology to explore how socio-cultural, psychological, and behavioral factors influence the physical and mental health of men and boys – as well as how these factors interact with and mediate men's biological and genetic risks. In exploring these factors, they attempt to explain exactly why they occur, and to develop appropriate intervention strategies. For example, gender-specific interventions might take into account recent research in the United States that indicates that traditional or dominant societal beliefs about what a man should be – and should not be – can predict high-risk behavior and the likelihood of death among men and boys.

Health care industries, public policies, and health professionals alike increasingly hold individuals accountable for their health-related behaviors. In the United States, an estimated one half of men's deaths each year could be prevented through changes in personal health practices. And in the United States, as in many countries, men and boys are more likely than women and girls to adopt unhealthy beliefs and engage in risk-taking behavior, and are less likely to adopt health-promoting behaviors. We must begin to learn, and to explain, how larger contexts – social systems – either foster or constrain the adoption of particular beliefs and behaviors that influence the health of men and boys.

The health-related beliefs and behaviors that men and boys adopt are influenced and often determined by a wide variety of social structures. Men and boys are always participating in social systems larger than themselves

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– such as families, schools, temples, and workplaces – where their lives are structured by a broad range of material, political, religious, institutional, ideological, and cultural factors. They live in dynamic relationship with these social systems.

Economic structures profoundly influence health and shape men's health and health behavior. The social and institutional structuring of health care also influences men's health. Public health care systems, managed care, investor-owned hospital chains, corporate health care mergers, and government health policies all contribute to the patterning and organization of men's health beliefs and behaviors – as do political systems and policy-making institutions. We must analyze social systems such as these, and the structuring of social inequality, if we are to understand the broader context of men's health and learn how these factors help to shape men's health and risks.

In the United States, death rates for cardiovascular disease – which is the leading cause of death for men – are highest in the South. One possible explanation for this disparity is a high-fat Southern diet, which may of may not be a geo-cultural marker reflecting factors such as climate or agricultural practices unique to the South. Another possible explanation is Southern men's views about manhood. Research indicates that, among men in the United States, Southern men hold the most traditional beliefs about gender – beliefs that have been found to be associated with greater cardiovascular reactivity. But the geography is even more specific: rural Southern men hold the most traditional beliefs, and rural Southern men also have more serious health problems than other U.S. men. We must examine such levels of specificity if we are to better understand regional differences and the complex interactions that mediate them.

In the United States, the difference between the life expectancies of African American men and European American men exceeds the difference between the life expectancies of women and men. Indeed, the deaths of indigenous men and men of color around the world account for much of the reported gender difference in mortality. Economic and ethnic differences among men also contribute to risk associated with specific health behaviors. While one in four U.S. men in general smoke cigarettes, the ratio among Laotian immigrants is nearly three out of four.

Men also have very different experiences within various systems of health care based on their ethnicity and socioeconomic background. In the United States, African American men are less likely to receive surgery for glaucoma, to be prescribed a potentially life-saving drug for ischemic stroke, or to have mental health conditions diagnosed; and they are more likely to be denied insurance authorization for emergency treatment than are European American men. It is perhaps not surprising that African American men report less trust of doctors than other men do and that they rate their doctors and their doctors' decision-making styles as less participatory than do European American men. However, little is known about the causes of these differences, or about the relative health care experiences of men around the world.

New research on men's health must examine questions of this kind. We must also examine similarities and differences among men in physical and mental health; in health care experiences; and in the mechanisms that mediate health status, health care utilization, and health behavior.

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Men's Health in Africa

Gabriel Ogah

Association of General and Private Medical Practitioners of Nigeria, Nigeria

Men's health is an important, but previously unappreciated, issue in Africa. Whereas Africa has one-tenth the world's population she bears one-fourth the health burden. Male Africans between the ages of 15 and 59 years have a 47.7% probability of dying compared to the world average of 22.5. The average male life expectancy in Africa is 49 years (world, 63). Disability life expectancy (DALE) is about 40.

Communicable diseases, represented by TB, HIV/AIDS; malaria and others are responsible for up to two-thirds the deaths in Africa yearly. The prevalence of non-communicable diseases—hypertension, erectile dysfunction, depression, diabetes, prostate and liver cancers, benign prostate enlargement, prostatitis, viropause and others is high but under-reported. Deaths from injuries in Africa occur three times more commonly in men than women. Every year, 5-10 per 100,000 people die from road traffic accidents and an additional three times this number sustaining only injuries. Most of the deaths from conflicts in Africa - - 600,000 per year- - involve men. Social problems in the form of lack of potable water, adequate sanitation, basic infrastructure, basic education; poverty, poor financial services and resources, coupled with low resource allocation to health (3.2% of GDP) and inadequate health education, contribute to my mind, about 50% to men's ill health in Africa.

If we should adopt the WHO definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", then we can see that the male African is quite unhealthy and needs more broad based strategies to improve on his health. From the above, it is clear that the most important strategy to improve male health in Africa is to build a sub-structure composed of good and stable governance that guarantees economic development and social/physical security. African governments should be encouraged to allocate more funds to the provision of health care, especially health education. The international business community that fans the embers of wars in Africa, because it benefits by selling arms and trade in minerals, should be pressurized to desist. A progressive, economically strong and healthy Africa will breed less asylum seekers or refugees and require less palliative donations. A rich Africa will provide a market that bolsters world economy! Everybody will be the gainer.

There should a strong advocacy for men's health in Africa (as in other regions) by all stakeholders, to ensure participatory progress, anchored by the UN, WHO and a coalition of national and international NGOs, like the proposed International Society of Men's Health. All countries or sub-regions should be encouraged to form Men's Health Associations.

Finally, we join all men of goodwill to congratulate the organizers and sponsors of the 1st WCMH 2001, Vienna, while sincerely wishing this conference a resounding success.

We bring you all warm felicitations from Africa.

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Men's Health in Asia

H.M. Tan

Asia Pacific Council for the Study of the Aging Male, Malaysia

Asia, where more than half of the world's population are found is a huge land mass with marked diversity not only in its geography, flora and fauna but also its people who has contrasting cultures, religions, beliefs, standard of living, education and health care. However, like the rest of the world the life expectancy of most Asian countries has increased significantly, even though this can range from the early fifties in countries like Cambodia, Laos and Burma to over eighties in developed nations like Japan, Hong Kong and Singapore. Simultaneously, the overall fertility rate in Asia is declining, and in 2020, majority of the aging population of the world (which comprise of 15% of the world's population) will live in Asia(1). This clearly corresponds to the period of peaked population growth in most Asian countries, which is in the 1950's and 1960's (see table I)(2).

Even though Asian population is living longer, their health expectancy (Disability Adjusted Life Expectancy, DALE), do not improve as well. (See table II)(3). This is particularly true for the poorer developing Asian countries where majority of the population above 60 years suffer at least one major disability.

The major issues that affect men's health in Asian countries differ markedly, from infectious diseases like diarrhoea, pulmonary tuberculosis, whooping cough etc and nutritional deficiency problems which predominate in the poorer developing countries, to those of chronic diseases like cardiovascular diseases, diabetes, strokes and lifestyle problems like obesity and physical inactivity, which predominate in the richer developing or developed countries. However, the most significant health issue that affects the whole region across Asia is the high prevalence of smoking. The WHO Regional report in the year 2000, clearly shows that Asia has the steepest rise in overall consumption of cigarettes in the world, and this include poor countries like Cambodia to developed country like Japan. Over 60% of the men and 8% of the woman in Asia smokes and the trend is still rising.(4)

The estimated percentage of adult male smoking in Asia is about 50% and this figures can go up to as high as 80% in countries like Cambodia and Vietnam. In these two countries, the cigarette industry forms a vital component of the economy, posing a major dilemma to the decision makers.

In most of Asian countries the prevalence of chronic diseases and life style diseases are progressively climbing. Coronary vascular diseases, diabetes mellitus, problems of obesity, hyperhpidaemia and physical inactivity are following closely those of the western countries even though most of the Asian economies are those of developing status. Currently China has the second highest number of obese people in the world, next to the U. S, and its population demography is rapidly aging like those of Western Europe. China will have more than 20% of its population above 60 years of age by the year 2020.(5)

The rapid development of Asia and increasing competition because of globalisation, have also brought about increasing demand for workforce. The result of which has caused straining and even dismantling of traditional

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Asia family structure. In countries like Taiwan, Hong Kong, Singapore and Korea, more than 50% of the women are coaxed into the workforce. This has significant repercussions on the welfare of the family and many studies have shown that working wives are detrimental to men's health. The intense competition and prolong duration of working time resulting from the prevailing free market economy, have also taken a heavy toll on men's health. The percentage of adult male spending time on regular physical exercise is certainly less than 30% overall.(6)

Further, rapid urbanization has made Asian cities the most crowded and the most crammed environment. Asia is already hosting nine out of ten most populated cities in the world by 2020, the population of Asian cities and metropolis will increase from 1.1 to 2.5 billions. Most Asian cities will be struggling with acute increase in air pollution, diminished water resources and shrinking agricultural land.(7)

Another issue peculiar to Asia, which is important to overall men's health is the culturally dominant view on masculinity. With the changing world economy, Asian men are finding it more and more difficult to fill their role successfully. They tend to turn to alternative measures such as violence and lifestyle abuses. Male gender role may also encourage risk taking and discourage men from using health care services of any kind (Rappaport 1984, Moynbian 1998)(8). Certain cultures even glorify sexually transmitted disease that confirms manhood, further endangering the men's life in these days of AIDS. Asian men, obviously contributed greatly to the rising trend of AIDS in the region because of their macho attitude about sexuality and sense of invulnerability.

Other common sexuality issues peculiar to South Asian countries include problems of psychosexual 'weakness', urethral discharge, premature ejaculation and sexual dissatisfaction. In one study done by Raju & Leonard, 2000, as high as 41% of the patients attending special men's clinic seek treatment for these peculiar psychosexual problems.

With accelerated improvement in education and economic status throughout Asia, the overall health status including men's health will invariable improve. As more Asian countries achieved near or full industrialized status, the overall environment will further improve, which has been the experience of Western Europe.(9) Asia is also the birthplace of two well-recognized physical exercise movements viz Yoga and Taichi which were established about 3000 years ago. The promotion of these physical activities in the middle and elderly age male community will certainly improve their health status. Lastly, Asian traditional medicine namely those originated from China and India which have gain world recognition, have great potential to be incorporated into Western medicine. These long standing resources which have stood the test of time will certainly help to improve the overall well being and enhance men's health status.

In conclusion, men's health in Asia is undergoing rapid transformation in tandem with the rapidly changing economic and demographic status of the various countries. Overall, men's health promotion is taking root and the awareness of building positive health is rapidly gaining ground especially in the better developing and well developed countries of Asia. In these more advanced Asian countries, both the male life and health expectancy have already risen to be among the highest in the world.

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Country	Fertility Rate		Life Expectations		% of Aging Population (>60 years)		Period of peaked Population Growth Rate
	2000	2025	2000	2025	2000	2025	1960-1970
Burma	2.4	1.7	54.9	63.4	7.09	12.56	1960-1970
Vietnam	2.5	2.0	69.3	75.8	7.60	13.13	1950-1960
Philippines	3.5	2.4	67.5	74.6	5.65	10.04	1950-1960
Thailand	1.9	1.7	68.6	75.3	9.74	19.94	1970-1980
Indonesia	2.6	2.0	68.0	74.9	7.17	13.8	1960-1970
India	3.1	2.2	62.5	70.9	7.02	11.76	1950-1960
Malaysia	3.3	2.6	70.8	76.9	6.52	12.15	1960-1970
China	1.8	1.8	71.4	77.4	10.20	20.30	1960-1970
Singapore	1.2	1.5	80.1	82.5	9.73	18.4	1950-1960
South Korea	1.7	1.7	74.4	79.2	10.83	23.37	1960-1970
Taiwan	1.8	1.7	76.4	80.4	12.6	24.08	1950-1960
Japan	1.4	1.6	80.7	82.9	23.04	33.75	1950-1960

Table I

US Bureau of the Census, 2000

Country	Life Expectancy	DALE	Disability (yrs)	% Disability of Aging Life
Japan	81	74.5	6.5	40.6
Australia	79.5	73.2	6.3	43.5
Singapore	78	69.3	8.7	66.9
S.Korea	72.8	65	7.8	100
Brunei	77.2	64.4	12.8	74.4
China	69.7	62.3	7.4	84.1
Malaysia	68.8	61.4	7.4	84.1
Philippines	66.7	58.9	7.8	-
India	60.4	53.2	7.2	-
Cambodia	53.8	45.7	8.1	-

Table II

DALE : Disability Adjusted Life Expectancy

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Cambodia	65-80%
China	70%
Hong Kong	25%
Japan	52%
Malaysia	51%
Mongolia	55%
Papua New Guinea	46%
Philippines	43%
Rep. Of Korea	>60%
Singapore	31%
Vietnam	73%
Indonesia	60%

Table III *(Adult Male Smoking in Asia)*

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Men’s Health in Australia

Anthony J. Brown

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Life expectancy for men in Australia is 75, six years less than for women . In brief we know that in Australia:

- Men die at a greater rate in all age groups
- Men have higher levels of morbidity for many common illnesses
- Men are more likely to commit suicide (up to 8 times the rate of women in some age groups)
- Men suffer from a greater level of severe mental illnesses
- Men suffer from a greater rate of all cancers that are not sex related
- Men’s use services (hospital and GPs, as well as other health related providers such as naturopaths and telephone counselling services) at a lower rate than women
- Men use preventive services at a lower rate than women
- Men are the overwhelming majority of those injured or killed in work settings
- Men are almost twice as likely to be the victim of homicides
- Indigenous Australian men (Aboriginal or Torres Strait Islander men) have a life expectancy of 53 years (some 22 years less than non-indigenous men) .

Government response to men’s health

Despite these figures no Australian government (either Commonwealth or state) currently has a men’s health policy.

In 2000 the Australian Commonwealth Government allocated a total of $212,500,000 (Australian dollars) on public health programs specifically for women. This included preventative programs (such as national cervical and breast cancer screening), research (including a National Women’s Longitudinal Study), sexual assault programs, legal services, domestic violence services and the Office for the Status of Women. In the same year the only male specific Commonwealth public health funding was the allocation of $4 million for the establishment of Andrology Australia.

In 1993-94 (the only years for which figures are available) the Australian health system spent a total of $13.4 billion on males (this includes preventative programs as well as acute care). In the same year $18 billion (34% higher) was spent by on females.

Non-Government Response to Men's Health

The most effective response to men's and boys' health needs in Australia has come at a grass roots level. Non-government organisations and consumer groups have worked for many years, primarily on preventative programs, that focus on the causative factors of ill health, in order to improve the health and wellbeing of men and boys in Australia.

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The Program

Friday, November 2, 2001

The World of Men's Health

Room: Festsaal
09:00–09:30 a.m. **OPENING CEREMONY**

CHAIR: A. KALACHE – A. RIEDER

09:30–09:50 **Exploring the Biological Contribution to Human Health: Does Sex matter?**
P. McGUIRE, Europ. Institute of Women Health, Brussels, Belgium

09:50–10:10 **Lessons from the Women's Health Movement**
B. WIMMER-PUCHINGER, City of Vienna, Austria

10:10–10:40 **Men's Health, North-South Prospects**
A. KALACHE, WHO, Geneva, Switzerland

10:40–11:00 **Men's Health in Africa**
G. OGAH, Association of General and Private Medical Practitioners of Nigeria, Lagos, Nigeria

11:00–11:20 **Men's Health in Central and Eastern Europe**
V. SHKOLNIKOV, Max Planck Institute for Demographic Research, Rostock, Germany

11:20–11:35 **The World's First Men's Report**
A. RIEDER, University of Vienna, Austria

11:35–11:50 **The Men's Health Movement around the World**
P. BAKER, Men's Health Forum, London, England

BREAK

CHAIR: B. LUNENFELD – W. PETRITSCH

Room: Festsaal
01:00–01:30 p.m. **Prostate Cancer: Lessons from the Baltimore Longitudinal Aging Study**
L. BRANT, Johns Hopkins University, Baltimore, USA

01:30–02:00 **Prostate Cancer: State of the Art**
M. MARBERGER, University Hospital Vienna, Austria

02:00–02:30 **Sex matters, Gender too: Differences in Psychosocial Aspects of Prostate and Breast Cancer**
A. KISS, Kantonsspital Basel, Switzerland

The Program

Friday, November 2, 2001

Room: Säulenhalle
01:30–02:30 p.m.

SATELLITE-SYMPOSIUM

Aspekte der Männergesundheit
(Aspects of Men's Health)
Sponsor: Pfizer

CHAIR: A. RIEDER

Program: (all lectures in German)
– 3 Jahre in der Behandlung der Erektilen Dysfunktion mit Viagra
(3 Years in the Treatment of Erectile Dysfunction with Viagra)
A. JUNGWIRTH, LKH Salzburg, Austria

– Die Depression des Mannes –
Diagnosestellung, Symptomatik & Behandlung
(Depression in Men – Diagnosis, Symptoms & Treatment)
S. KASPER, University Hospital Vienna, Austria

BREAK

Room: Festsaal
02:45–03:45 p.m.

Clinical Pearls Symposia – It's a Man's World I

CHAIR: L. BRANT – M. MARBERGER

The Prostate – A Clinical Field Trip from BPH to Cancer
– Lower Urinary Tract: Current Approaches, Evaluation and Treatment
N. SCHMELLER, LKH Salzburg, Austria

– BPH: New Treatment Developments – Surgical & Non-Surgical
B. STEIN, Brown University, Providence, USA

BREAK

Room: Festsaal
04:00–05:00 p.m.

CHAIR: B. STEIN – A. JUNGWIRTH

Erectile Dysfunction – Disease or Men's Destiny
– Sexual Dysfunction of the Elderly-Advances in Screening & Diagnosis
W. WEIDNER, University, Giessen, Germany

– Management of ED: From Present to Future
W. STACKL, Rudolfstiftung, Vienna, Austria

CHAIR: I. BANKS – M. KUNZE

05:00–06:00

Sexually Transmitted Diseases – A real Challenge in Men Q&A
Of Microbes and Manhood – a real Challenge in Men
W. GRANNINGER, University Hospital of Vienna, Austria

The Program

Friday, November 2, 2001

Room: Säulenhalle
04:00– 06:00 p.m.

SATELLITE-SYMPOSIUM

Anti-Cancer Screening and Prevention in Men

Sponsor: Aesca, Eli-Lilly, Icos, Glaxo SmithKline, Merck, Olympus Austria, Pharmacia Austria, Roche Austria, Sanoft-Synthelabo

Supporter: Austrian Cancer Society
Felix-Burda-Foundation for Cancer Research

CHAIR: W. SCHEITHAUER – M. KUNZE

Program: (all lecteures in English)

– Cancer Incidence in Males and Prognosis: The Size of the Problem
W. SCHEITHAUER, University of Vienna, Austria

– Preventing Lung Cancer and other Tobacco-Related Malignancies
W. ZATONSKI, Poland

– Current Early-Detection and Screening Trials for Lung Cancer
I. C. HENSCHKE, New York, USA

– Colorectal Cancer Screening Saves Lives
H. J. SCHMOLL Halle/Saale, Deutschland

– Chemoprevention of Colorectal Cancer
K. MUIR, Nottingham, United Kingdom

– Primary and Secondary Prevention in Melanoma
H. PEHAMBERGER, Vienna, Austria

– Conclusions and Future Aspects
M. KUNZE, University of Vienna, Austria

The Program

Friday, November 2, 2001

FREE LECTURES

Room: Säulenhalle
02:45–03:45 p.m.

Lectures 10 Minutes (incl. Discussion)

Men's Health I

CHAIR: H. SCHULTE – P. PIETSCHMANN

The role of decreased sex steroids in male osteoporosis
S. KHOSLA, Mayo Medical School, Minnesota, USA

Osteoporosis as complication of androgen deprivation therapy for carcinoma of the prostate
B. STEIN, S. ASHOK, Brown University, Providence, RI, USA

Bone mineral density (BMD) in men with adenocarcinoma of the prostate and androgen deprevation therapy and aged matched normal controls – do we miss osteoporosis in men by using conventional T and Z scores for post-menopausal women
P. F. ENGELHARDT, P. LANGMANN, E. DAHA, E. PLAS, H. PFLÜGER, Urolog. Abteilung Krankenhaus Lainz, Wien

AMAS-2000: Beneficial effects of mountain holidays in patients with metabolic syndrome
W. SCHOBERSBERGER, D. FRIES, H. C. GUNGA, P. SCHMID, M. LECHLEITNER, E. HUMPELER, Division for General and Surgical Intensive Care Medicine, University Hospital Innsbruck

A global perspective on the field of men's health
COURTNEY W, Mc Lean Hospital, Harvard Medical School, USA

The Program

Saturday, November 3, 2001

New Frontiers in Men's Health

CHAIR: A. KISS – S. KASPER

Room: Festsaal

08:30–08:50 a.m. **Communicating with Male Patients: Improving Men's Health**
I. BANKS, Men's Health Forum, London, UK

08:50–09:10 **e-Health: Promotion of Men's Health in the Age of Internet**
A. JADAD, University of Toronto, Canada

09:10–09:40 **Key Note Lecture: Aids 2001 – Looking to the Future**
R. C. GALLO, Institute of Human Virology, University of Maryland Biotechnology Institute, USA

BREAK

CHAIR: R. D. HESCH – G. FISCHER

Room: Festsaal

09:50–10:20 a.m. **Gender Differences in Addiction: Emerging Evidence**
W. MAIER, Universiy of Bonn, Germany

10:20–10:50 **Unmasking Male Depression: Challenges in Diagnosis and Treatment**
S. KASPER, University Hospital of Vienna, Austria

10:50–11:20 **Male Contraception: State of the Development**
E. NIESCHLAG, M. ZITZMANN, Wilhelms University, Münster, Germany

BREAK

Male Osteoporosis

CHAIR: S. KHOSLA – S. MERYN

Room: Festsaal

11:30–11:50 a.m. **The Unitary Model and the Development of Osteoporosis in Males**
S. KHOSLA, Mayo Clinic, Rochester, USA

11:50–12:10 **Clinical Presentation and Diagnosis of Male Osteoporosis**
E. RESCH, KH Barmherzige Schwestern, Vienna, Austria

12:10–12:30 **Treatment of Osteoporosis in Men**
P. PIETSCHMANN, University Hospital of Vienna, Austria

BREAK

The Program

Saturday, November 3, 2001

SATELLITE-SYMPOSIUM

Room: Säulenhalle
12:15–01:30 p.m.

Von der Gesundheit zur Lebensqualität
(From Health to Quality of Life – From Quality of Life to Health)
Sponsor: Abbott

CHAIR: G. LUNGLMAYR, Austria

Program: (all lectures in German)
– Übergewicht – der verdrängte Risikofaktor
(Obesity – Hidden Risk Factor)
M. KUNZE, University of Vienna, Austria

– Erektile Dysfunktion – vom Tabu zur Therapie
(Erectile Dysfunction – from Taboo to Therapy)
G. LUNGLMAYR, Mistelbach, Austria

CHAIR: I. HUHTANIEMI – J. E. MORLEY

Room: Festsaal
01:30–02:00 p.m.

Andropause: Facts and Fiction
J. E. MORLEY, Saint Louis University, USA

02:00–02:20

Andropause: Lessons from the Turku Male Aging Study
I. HUHTANIEMI, University of Turku, Finland

02:20–02:40

Male Hormone Replacement Therapy: Managing the Pieces of the Puzzle
E. NIESCHLAG, M. ZITZMANN, Wilhelms-University, Münster, Germany

02:40–03:00

The Future of the Aging Male
B. LUNENFELD, ISSAM, Tel Aviv, Israel

Clinical Pearls Symposia – It's a Man's World II

CHAIR: G. FODOR – R.TAN

Physicians Most Wanted: CVD and effective control of male lipid disorder & Hypertension

Room: Festsaal
03:00–03:20 p.m.

The Male Lipid Profile: Highway to CVD
G. FODOR, University of Ottawa, Canada

The Program

Saturday, November 3, 2001

03:20–03:40 p.m. **State of the Art: Treatment of Male Hypertension**
F. HOPPICHLER, KH Barmherzige Brüder, Salzburg, Austria

03:40–04:00 **Stress – Male Status Symbol? Results of Objective Determinations**
S. PORTA, University of Graz, Austria

BREAK

Cardiovascular Prevention Available – but not for men

CHAIR: R. PRAGER – A. RIEDER

Room: Säulenhalle
04:15–04:35 **Is there a Difference in Prevention between Men and Women?**
A. RIEDER, University of Vienna, Austria

04:35–04:55 **State of the Art in Cardiovascular Prevention**
O. TRAINDL, Mistelbach, Austria

04:55–05:15 **What's new in Cardiovascular Prevention?**
T. STEFANELLI, University Hospital of Vienna, Austria

SATELLITE SYMPOSIUM

Room: Säulenhalle
02:00–04:00 **Addiction**

Sponsor: Torrex, Aesca

CHAIR: G. FISCHER – M. IGUCHI

Program: (all lectures in English)

– **Genetic and Environmental Contributions to Gambling Behavior among middle aged American Males**
S. EISEN, Washington University, St. Louis, USA

– **Craving in Alcohol and Cocaine Dependent Men**
R. SINHA, Yale University School of Medicine, New Haven, USA

– **Opioid and Cocaine Addiction – Gender Differences – a Public Health Issue**
M. Y. IGUCHI, Drug Policy Research Center RAND, Santa Monica, USA

– **Retention in Treatment in a double-blind, double-dummy Study with slow release Morphine versus Methadone – who is the strong Gender?**
G. FISCHER, University of Vienna, Austria

The Program

Saturday, November 3, 2001

Clinical Pearls Symposia – It's a Man's World III

CHAIR: J. E. MORLEY – M. CARRUTHERS

HORMONES, HEALTH AND MEN

Room: Festsaal

04:15–04:35 p.m. **Male Hormone Replacement Therapy – The View of the Pharmaceutical Industry**
M. OETTEL, Jena, Germany

04:35–04:55 **Testosterone Deficiency: Its Diagnosis and Therapy under Special Consideration of Prostate Carcinoma**
R.-D. HESCH, University of Constance, Germany

04:55–05:25 **The Andropause and Memory Loss: Is there a Link between Androgen Decline and Dementia in the Aging Male?**
R. TAN, University of Texas, Houston, USA

05:25–05:55 **Testicular Function and Aging**
J. M. KAUFMAN, University of Gent, Belgium

05:55 – 06:25 **Fertility of the Aging Male**
W. B. SCHILL, University of Giessen, Germany

The Program

Saturday, November 3, 2001

FREE LECTURES

Each Lecture 10 Minutes (incl. Discussion)

Men's Health II

CHAIR: G. K. PAPP – A. JUNGWIRTH

Room: Säulenhalle
08:30 – 9:30 a.m.

Men's Health Day 2001 in Vienna: Is there a rationale for free available testing
E. PLAS, R. SIMAK, P. F. ENGELHART, T. ZILS, H. PFLÜGER, Dept. Of Urology and LBI for Urology and Andrology, Lainz Hospital Vienna, Austria

Impact of PSA-Test on prostate cancer incidence and mortality in Austria
T. VUTUC WALDHOER, M. MIKSCHE, G. HAIDINGER, Division of Epidemiology, Institute of Cancer Research, University of Vienna, Austria

Outcomes of treating lowering urinary tract symptoms (LUTS) on quality of life
K. F. QUEK, W.Y. LOW, A. H. RAZACK, C. S. LOH, Health research Development Unit, University Malaya Medical Centre Kuala Lumpur, Malaysia

Transurethral needle ablation of the prostate: an office based approach
B. STEIN, Brown University, Providence, RI, USA

Determinants of hypogonadism in aging males during the andropause
R. TAN, University of Texas, Houston, USA

The conservative treatment of ED
G. K. PAPP, President of the Hungarian Andrology Section, Budapest, Hungary

9:30 – 09:40 **BREAK**

The Program

Saturday, November 3, 2001

FREE LECTURES

Each Lecture 10 Minutes (incl. Discussion)

Men's Health III

Room: Säulenhalle
09:40–10:50

CHAIR: J. M. KAUFMAN – B. WIMMER-PUCHINGER

Best practices in working with men: an evidence-based psychological and behavioral model
W. COURTNEY, Mc Lean Hospital, Harvard Medical School, USA

Detecting depression in men: a matter of guesswork
S. BROWNHILL, K. WILHELM, L. BARCLAY, G. PARKER, School of Psychiatry, University of New South Wales, Sydney, Australia

Men, body image and eating disorders
M. DRUMMOND, University of South Australia, Adelaide, Australia

Gender specific differences in dietary habits and changes in plasma micro-nutrient status following dietary supplementation
I. KIEFER, P. PROCK, C. LAWRENCE, P. BAYER, M. KUNZE, A. RIEDER, University of Vienna, Institute of Social Medicine, Austria

Body Mass Index, physical activity, steroid hormones and erectile dysfunction
C. KRATZIK, N. RIEDL, N. BRANDSTÄTTER, M. METKA, J. C. HUBER, Urologische Universitätsklinik Wien, Androx Vienna Study Group, Austria

Anorexia in the older male
J. E. MORLEY, Health Sciences Centre School of Medicine, St.Louis, USA

The state of men's health in the United Kingdom – an analysis based upon the MHF-database of projects and initiatives
A. K. WHITE, D. CAMIGE, Camige D, School of Health and Community Care, Leeds Metropolitan University, UK

10:50–11:00 **BREAK**

The Program

Saturday, November 3, 2001

FREE LECTURES

Each Lecture 10 Minutes (incl. Discussion)

Men's Health IV

Room: Säulenhalle
11:00–12:15 a.m.

CHAIR: D. McDERMOTT – G. OGAH

Building Spirit, Building Health: Implications of innovations in Australian indigenous health for all men's health.
D. McDERMOTT, J. J. McDONALD, Men's Health Information and Resource Center, University of Western Sydney, Australia

A salutogenic population health approach: a tramework for a global strategy for men's health and wellbeing
J. J. McDONALD, A. J. BROWN, Men's Health Information Centre, Sydney, Australia

A call for change: rethinking HIV prevention education approaches in gay community
A. G. YOUNGMAN, Aids Education Services, Massena, NY, USA

The role of male peer promoters in family planning and the prevention and control of STI/RTI/HVI in rural Bangladesh
K. GAUSIA, Killewo, A. M. MASUDUZZAMAN, S. S. ISLAM, F. AHMED, J. CHAKRABORTY, Centre for Health and Population Research, ICDDRB, Bangladesh, India

Men's Health Matters: Gender in Crisis
R. L. ALT, Dean Medical Center and University of Wisconsin

Square pegs in round holes: The relationship of sense of belonging to men's health.
L. M. HOPES, S. McLAREN, B. A. JUDE, University of Ballarat, Ballarat Australia

Working with Filipino Men Towards the Prevention of domestic Violence: Lessons and Insights
R. B. LEE, De La Salle University, Manila, the Philippines

The Program

Sunday, November 4, 2001

The Future of Men

CHAIR: B. COOLSAET – T. SNITKER

Room: Festsaal

09:00–09:20 a.m. **Understanding Men's Health in Gay Men**
S. WRIGHT, Gaymen, UK

09:20–09:40 **"The Good and the Ugly!" – What Psychoanalysis can tell us about Men and Health Service Compliance**
S. CARROLL, Sydney Psychotherapy Association, Australia

09:40–10:00 **Two Decades of AIDS Starting Point for Men's Health**
G. A. YOUNGMAN, AIDS Education Services, Massena, NY; USA

10:00–10:20 **Addressing the American Crisis in Men's Health through educational and legislative Action**
D. H. GREMILLION, Univ. of North Carolina & Men's Health Network, Washington D. C.

BREAK

CHAIR: I. BANKS – A. BROWN

10:40–11:00 **Prevention in the Male Life Cycle: From Boys to Men**
M. KUNZE, University of Vienna, Austria

11:00–11:20 **Re-modelling of the Male Identity**
B. COOLSAET, Wuustwezel, Belgium

11:20–11:40 **Male Agression and Violence**
R. D. HESCH, University of Constance, Germany

11:40–12:00 **Developing an International Approach in the Field of men's Health**
S. MERYN, University of Vienna, Austria

Discussion, Question & Answer

The Program

Sunday, November 4, 2001

PUBLIC DAY (all lectures in German)

Room: Festsaal

10:00–10:05 a.m. **Welcome Remarks/Begrüßung**
– The Male Patient
Der männliche Patient
A. RIEDER,University of Vienna, Austria,
P. HOPFINGER, Diabetes Forum Austria

10:05–10:20 **Group work between asking man, contemporary therapies and the search for competent physicians**
Gruppenarbeit zwischen fragenden Patienten, modernsten Therapien und der Suche nach kompetenten Ärzten
E. WOLFRUM, Vienna, Austria

10:20–10:35 **Diabetes – what does it mean for physicians**
Diabetes und seine Bedeutung für den behandelnden Arzt
R. PRAGER, MD, Vienna, Austria

10:35–10:50 **“Male fertility and uremia – solution for the taboos”**
Die männliche Zeugungskraft und Uraemie – Lösung der Tabus
E. KAHNERT, Vienna, Austria

10:50–11:10 **Dialysis – beginning of a new life span for men**
Dialyse – Beginn eines neuen Lebensabschnitt für den Mann
H.-H. KOECK, MD, Vienna, Austria

11:10–11:25 **Osteoporosis – the new disease in men**
Osteoporose – Eine neue Männerkrankheit
H. RESCH, MD, Vienna, Austria

11:25–11:35 **The role of patient advocacy groups for apnoe in Austria – content and objectives for work**
Die Bedeutung der Selbsthilfegruppen für Schlafapnoe in Österreich – Inhalt und Ziele der Arbeit
G. STOCKNER, Vienna, Austria

11:35–12:00 **Sleep and its medical significance for men**
Der Schlaf und seine medizinische Bedeutung für den Mann
R. POPOVIC, MD, Vienna, Austria

11:50–12:00 **Introduction of the Austrian Heart Community**
Der Österreichische Herzverband stellt sich vor
H. SCHULTER, Vienna, Austria

The Program

Sunday, November 4, 2001

PUBLIC DAY (all lectures in German)

Room: Festsaal

12:00–12:15 p.m.	**Men's hearts beating differently** Männerherzen schlagen anders F. RAUSCHER, MD, Vienna, Austria (not confirmed)
12:15–01:00	**Break & Exhibition of Patient Advocacy Groups**
01:00–02:00	**Seminar Lecture** Professional media work – the case of diabetes „Medienarbeit am Beispiel Diabetes" A. FEHRINGER, P. HOPFINGER, Vienna; Austria
02:00–02:10	**Prostate cancer: Control mechanisms & treatment – desires and demands from the patient's perspective** Prostatakrebs: Vorsorge und Behandlung – „Wünsche und Forderungen aus der Sicht der Patienten!" E. F. BÜCHLER, Vienna, Austria
02:10–02:25	**The prostate and its meaning to a man** Die Prostata und ihre Bedeutung für den Mann A. JUNGWIRTH, MD, Salzburg, Austria
02:25–02:40	**Colostomia, illeostomia, and urostomia – the problems for men prior to and after surgery from the perspective of the patient advocacy group** „Colostomie, Ileostomie und Urostomie – Probleme des Mannes vor und nach der Operation aus der Sicht der Selbsthilfegruppen." S. UJVARY, Vienna, Austria
02:40–03:00	**New exits for men after bladder and colon cancer** Auswege nach Krebs beim Mann an Blase und Darm F. HERBST, MD, Vienna, Austria
03:00–03:25	**The situation for men with Morbus Bechterew in Austria from the viewpoint of patients** „Situation der Morbus-Bechterew-Erkrankten in Österreich aus der Sicht der Patienten" E. VOSTROVKY, MD, Vienna, Austria
03:25–03:40	**The problems of asthma and COPD patients** Nöte von Patienten mit Asthma und COPD O. SPRANGER, Vienna, Austria
03:40–04:00	**New hope for men with short breath** Neue Hoffnung für Männer mit kurzem Atem H. ZWICK, MD, Vienna, Austria
04:00–04:30	**Question & Answer – Closing Remarks** S. MERYN, MD, Congress President & P. HOPFINGER, Vienna, Austria

ABSTRACTS

ABSTRACTS

(in order of time schedule of congress program)

Friday, November 2, 2001

THE WORLD OF MEN'S HEALTH

Men's Health, North-South Prospects

Kalache A. Co-ordinator, Life Course and Ageing, World Health Organization, Geneva

Within the next few decades a demographic revolution will have taken place affecting all societies, throughout the world. By mid-century, the proportions of older persons in both the developed and the developing world will have grown substantially. The issues for the North will be, by and largely, to ensure that access to good health care will be universal and of highest possible quality. For the South, the challenge will be more substantial. Never before in the history of humankind it had been possible for societies to age in the context of poverty. We will be seen for the next few years an unprecedently rapid population ageing in developing countries that will continue to have the majority of their populations below the poverty line. The emphasis will have to be on promoting health throughout the life course (in order to minimise health problems in later life) and the provision of appropriate levels of affordable care for those who, in older age, will need them. That implies strengthening the capacity of the primary health care sector to deal with ageing-related conditions. In either case, North and South, there are some basic perspectives to be observed. Among them, a focus on gender.

It is impossible to understand ageing and health without a gender perspective. Both from a physiological and from a psychosocial point of view, the determinants of health as we age are intrinsically related to gender. There is increasing recognition that unless research and programs – on both clinical science and public health – acknowledge these -differences, they will not be effective. While women experience greater burdens of morbidity and disability, men die earlier, yet the reasons for such premature mortality are not fully understood. The rapidity with which the worldwide population is ageing will require a sharp focus on gender issues if meaningful policies are to be -developed. Yet so often gender in the health context is taken as being synonymous only with women's issues.
This perception has its roots in the successful campaigns orchestrated by women's groups in the 1970s and 1980s. These campaigns were -imperative. The health status of women had been neglected throughout history, and a sharper focus on it was essential in order to extend services to millions of women throughout the world who were exposed to neglect and an unnecessary burden of diseases. It was therefore largely due to very appropriate advocacy, often led by -non-governmental organizations, that the importance of women's health gradually gained prominence in many, although not yet all, countries. This achievement must not be eroded; on the contrary, it requires consolidation.

By and large, the reasons why such advocacy was successful stemmed from the fact that women were fighting a battle against oppressors – men, who for as far back as history goes had retained power through politics, economics and their prominence in society. The challenge involved in placing the concerns of men firmly on the health agenda is even greater, since it will entail orchestrating a fight in which there is no opponent, no oppressor. The battle will be against complacency, against established attitudes, towards a culture in which men would recognize the importance of looking after themselves, a culture of self-care, as opposed to the current common belief of men who regard themselves as 'indestruct-ible machines'. And this battle could eventually lead the health sector to acknowledge the fact that it should also cater for men's health issues. So often, throughout the world, the message transmitted by health services is 'We are not interested in your health'; many men come into contact with the health sector only when they are children and/or at the end of their lives. Too little, too late. By the time they consult a physician diseases, that could have been prevented or adequately managed if detected earlier, have already progressed to an -irreversible stage, leading to premature death. It follows that a life-course perspective is required on gender and health; our health, at the end of our lives, is the result of past experiences in terms of lifestyle, envi-

ronmental exposures and encounters with the health sector.

Despite the enormous medical progress achieved during the past few decades, the fact remains that the last years of life are still often accompanied by increasing ill health and disability. The key factor in healthy ageing is the ability to maintain independent living for as long as possible. Effective programs promoting healthy ageing and preventing disability in older people will result in more efficient use of health and social services, and will improve the quality of life of older persons by enabling them to remain independent and -productive.

In addition, interventions such as hormone replacement therapy may help to prevent the preventable and delay the inevitable. Evidence is available that such interventions may slow the -progression of disease in women. There is an urgent need to obtain comparable information for men.

In the light of this, public awareness of -established medical knowledge needs to be increased and basic clinical, socio-economic and epidemiological research intensified. This challenge will necessitate a quantum leap in -international research efforts, supported by new partnerships between intergovernmental, governmental, private and voluntary sectors.

A public health agenda for the 21st century will need to incorporate a strong focus on the health of ageing males. In the process, the gains will be shared by society as a whole.

Men's Health in Africa

Ogah G. Association of General and Private Medical Practitioners of Nigeria, Lagos, Nigeria

Men's health is an important, but previously unappreciated, issue in Africa. Whereas Africa has one-tenth the world's population she bears one-fourth the health burden. Male Africans between the ages of 15 and 59 years have a 47.7% probability of dying compared to the world average of 22.5. The average male life expectancy in Africa is 49 years (world, 63). Disability life expectancy (DALE) is about 40.

Communicable diseases, represented by TB, HIV/AIDS; malaria and others are responsible for up to two-thirds the deaths in Africa yearly. The prevalence of non-communicable diseases - hypertension, erectile dysfunction, depression, diabetes, prostate and liver cancers, benign prostate enlargement, prostatitis, viropause and others is high but under-reported. Deaths from injuries in Africa occur three times more commonly in men than women. Every year, 5-10 per 100,000 people die from road traffic accidents and an additional three times this number sustaining only injuries. Most of the deaths from conflicts in Africa - - 600,000 per year - - involve men. Social problems in the form of lack of potable water, adequate sanitation, basic infrastructure, basic education; poverty, poor financial services and resources, coupled with low resource allocation to health (3.2% of GDP) and inadequate health education, contribute to my mind, about 50% to men's ill health in Africa.

If we should adopt the WHO definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", then we can see that the male African is quite unhealthy and needs more broad based strategies to improve on his health. From the above, it is clear that the most important strategy to improve male health in Africa is to build a sub-structure composed of good and stable governance that guarantees economic development and social/physical security. African governments should be encouraged to allocate more funds to the provision of health care, especially health education. The international business community that fans the embers of wars in Africa, because it benefits by selling arms and trade in minerals, should be pressurized to desist. A progressive, economically strong and healthy Africa will breed less asylum seekers or refugees and require less palliative donations. A rich Africa will provide a market that bolsters world economy! Everybody will be the gainer.

There should a strong advocacy for men's health in Africa (as in other regions) by all stakeholders, to ensure participatory progress, anchored by the UN, WHO and a coalition of national and international NGOs, like the proposed International Society of Men's Health. All countries or sub-regions should be encouraged to form Men's Health Associations.

Finally, we join all men of goodwill to congratulate the organizers and sponsors of the 1st WCMH 2001, Vienna, while sincerely wishing this conference a resounding success.

We bring you all warm felicitations from Africa.

Men's health in Central and Eastern Europe as reflected by the toll of premature death

McKee M, Shkolnikov V. Max Planck Institute for Demographic Research, Rostock, Germany

There is a sharp divide in mortality between Western and Eastern Europe, which has largely developed over the past three decades. In 1997 life expectancy at birth was 78 years in the countries of European Union, 72 years in countries of Central and Eastern Europe, and 67 years in the countries of the former Soviet Union. For men the east-west mortality gap is much wider with male life expectancies at birth being 75 in the EU countries, 68 in Central and Eastern Europe, and 62 in the former Soviet Union. In the mid-1990s the probability of death before reaching age 65 for a man aged 20 was about one half in Russia versus about one tenth in the UK.

Analysis of mortality trends in Eastern Europe since the World War II suggests that mortality in this region was rapidly declining between the late 1940s and the mid-1960s due to reduction of mortality from infectious diseases among infants and children. During this period a Soviet-shape medical care system was very successful in granting a universal access to basic medical facilities via territorial networks of polyclinics and hospitals. The progress stopped in the mid-1960s when chronic and man-made diseases began to play a dominant role in the mortality structure. Since then life expectancy of men has been contiguously declining, while life expectancy of women has been stagnating around the same level. By the 1990s an enormous burden of premature death in Eastern Europe has been formed and it has become obvious that the policies pursued by the communist countries have had profound implications for health of their populations. After the fall of communism many countries of the region experienced a short-term increase in mortality among young adults. Since the early 1990s several countries, such as Poland, Czech Republic, Slovakia, Hungary, Slovenia, Slovakia, have seen marked improvements in mortality, while other countries (Bulgaria, Romania) have not. Russia and other countries of the former Soviet Union experienced a dramatic rise in mortality in the early 1990s and its stabilization at a very high level at the end of the decade.

Excess mortality of men in Eastern Europe is concentrated in young and middle adult ages. Its major part consists of premature deaths from coronary heart disease, stroke, lung cancer, external and alcohol-related causes. Analyses show that people with low education and manual workers, those who are unemployed and those who are not married, are exposed to a much higher risk of premature death than others. Individual-level studies suggest that behavioral factors are responsible for a big part of male deaths. High mortality of the working age men is partly a legacy of the communism, but is also linked with new societal challenges. Socio-psychological stress induced by a sudden termination of the state paternalism of the communist era and rapid societal transformation probably plays a significant role.

Extensive studies on the phenomenon of high mortality in Eastern Europe produced suggestive demographic and epidemiological information. Much less is known, however, about physiological mechanisms of premature death in Eastern Europe. This gap in our knowledge calls for research and understanding.

The World´s First Men´s Health Report

Rieder A. University of Vienna, Institute of Social Medicine, Vienna, Austria

Internationally, there are very few reports on men's health. The City of Vienna supported a first Report on Men´s Health (1,2,3), in the framework of sex- and target-group-specific health reporting. The objective of the Men's Health Report is to present the importance and priorities of prevention with regard to men's health. Further it offers a view of male health problems into the next century. The Report was presented to public in Vienna in July 1999.

It is the intent of the Men's Health Report presented to provide the health system a basis to identify focal points of men's health issues. With the help of this Report it is possible to step up promotion of the issue as well as to contribute to the improvement of men's health. The Report builds on demographic conditions and trends and the health status of the male population. This report deals particularly with those health issues that are most essential to the state of health and the life expectancy of the male population. In addition, it deals with the connection between male health and social status.

Literature:

1. Schmeiser-Rieder A, Kiefer I, Panuschka C et al, The Men´s Health Report of Vienna 1999, The Aging Male 1999: 2:166-179
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The Men's Health Movement Around the World

Baker P. Director of The Men's Health Forum, London, UK

Objective: To inform delegates of men's health activities throughout the world
Design and method: The presentation is primarily based on desk research.
Results and conclusions: Men's health is emerging as an important issue in an increasing number of countries around the world, notably the United Kingdom, Austria, Switzerland, Australia and the United States of America. There is also increasing interest in working with men on sexual and reproductive health issues in parts of Central and South America, Africa and A sia. However, progress towards international contact and collaboration between men's health advocates with an interest which extends beyond traditional clinical specialities such as erectile dysfunction or prostate cancer has so far been extremely slow.

But there are now signs that men's health work has reached a sufficient level of maturity in enough countries to create a new interest in developing international links. The most significant event in this process is the First World Congress on Men's Health. The International Society for Men's Health will be established at the World Congress, an organization which is expected to have an advocacy as well as a networking role, as will the European Men's Health Initiative. This seeks to encourage the development of men's health policy and practice at a Europe-wide level as well as within individual countries.

One major benefit of increased international collaboration will be that the proponents of men's health, particularly in those countries where work with men is unusual or where the arguments for improving men's health are not yet been widely accepted, will gain encouragement and confidence from work going on elsewhere. International collaboration will also create important new opportunities for sharing information and examples of good practice. There is now an increasing body of men's health work for health professionals and others to refer to.

The development of international discussion and collaboration on men's health will enable new bodies like The International Society for Men's Health and the European Men's Health Forum to take the important next step of putting men's health on the agenda of key international bodies such as the European Commission and the World Health Organisation.

Prostate Cancer - Lessons from the Baltimore Longitudinal Study of Aging

Brant LJ. National Institute on Aging and Johns Hopkins University Baltimore, Maryland, USA

Objective: To review the findings about prostate disease from 40 + years of the Baltimore Longitudinal Study of Aging (BLSA), including the use of repeated measurements of prostate specific antigen (PSA) as a screening method for the detection of preclinical prostate cancer.

The use of repeated measurement data from the Baltimore Longitudinal Study of Aging (BLSA) has proven useful for understanding human variation and for identifying early stages of disease processes. The BLSA is an ongoing study of community-dwelling volunteers begun in 1958. Participants return to the study center every two years for three days of biomedical and psychological examinations; new participants are continually enrolled into the study to replace those who leave the study or die. At present, over 1500 men with an average of about 9 visits to the study center and 15 years of follow-up and approximately 900 women (women were first studied in 1978) with an average of almost 5 visits and 9 years of follow-up have participated in the study. The BLSA participants are mostly white (95%), well educated (at least 75% have a college degree), and financially comfortable (82%).

One noteworthy area of research dealing with men=s health in the BLSA involves studies of prostate disease. Prostate cancer is one of the common causes of cancer deaths in men; after lung and stomach cancer, it accounts for the largest number of new non-skin cancer cases reported worldwide per year. In the United States, for example, prostate cancer is the most common clinically diagnosed non-skin cancer with about 1 in 10 American men eventually getting a positive diagnosis. Since the chance of a diagnosis of prostate cancer increases with age, the present shift in the age distribution toward larger numbers of older men is expected to result in an even larger increase in the number of men diagnosed with prostate cancer. This increase in the occurrence of prostate disease

makes the early detection of the disease an important issue. Using the molecular biomarker PSA together with a unique longitudinal bank of frozen serum, the BLSA conducted a historic prospective study of changes in PSA levels for decades prior to the diagnosis of prostate disease, which led to the determination that an average PSA velocity of 0.75 ng/ml or more per year is an effective screening criteria for prostate cancer. The longitudinal rates of change in PSA have proven to be a useful indicator of preclinical prostate disease with PSA rates showing an increase from a linear to an exponential pattern on average 5 years before a clinical diagnosis of local cancer and 12 years before a diagnosis of metastatic cancer.

Recently, a new classification procedure using sequentially collected PSA measurements and based on empirical Bayesian posterior probabilities of developing prostate disease has been developed for classifying each male into the diagnostic states of prostate cancer. This procedure resulted in a sensitivity (rate of correctly classifying cancer cases) of 68 % and a specificity (rate of correctly classifying normal men) of 92%. Using this classification method the observed mean lead time is 6.7 (standard deviation 2.9) years prior to the actual diagnosis for local cancer and 7.9 (standard deviation 3.9) years for metastatic cancer. Thus, there would appear to be an important window of opportunity for intervention or secondary prevention in the case of prostate cancer.

Conclusion: The need to study disease processes such as prostate disease using longitudinal data follows the belief that clinically-diagnosed diseases are characterized by biological, behavioral, environmental, and social factors that can act in a complex fashion, but that these factors leave patterns of change over time that can be predictive of the onset of the early stages of disease. By the early identification of preclinical disease states using longitudinally-collected measurements of biological markers of health, the medical practitioner has the best opportunity for intervention and disease prevention, resulting in reduced costs for the individual, health-care system, and society in general.

Prostate Cancer: State of the Art

Marberger M. Professor and Chairman, Department of Urology University of Vienna, Austria

PSA testing has resulted in a dramatic increase in the incidence of prostate cancer, yet mortality is only beginning to drop. Prostate cancer is still the most common killing cancer in men over 50 years of age. The decrease in mortality is usually considered to result from earlier diagnosis and curative treatment. Geographical comparisons of mortality data appear to prove this point, but they are based on small patient numbers and lack statistical power. Proof of the effectiveness of PSA screening can only come from randomized control trials comparing a screened to a non screened population, which are ongoing.

With extensive PSA testing overdiagnosis, i.e. the ratio between prostate cancer incidence and mortality, has muliplied. Clearly, a large fraction of cancers detected today need not be treated, and probably not even diagnosed. New diagnostic algorithms for defining risk groups, biopsy indications and aggressive, but organ confined and hence curable prostate cancers are now becoming available.

Curative therapy of aggressive organ confined cancer has proven effective, but at the expense of considerable morbidity. Both surgery and radiotherapy are at the present time seeing significant technical improvements that reduce morbidity at equal efficacy. Most important however, the best therapy chosen for a specific patient situation can now be defined on pretreatment parameters.

Palliative therapy today centers arround patients failing curative therapy. The rising PSA has become the daily “nightmare” scenario for urologists, as no consensus exists on the optimal management. Should adjuvant/salvage radiotherapy be offered to patients who had radical surgery? What is the role of adjuvant/early endocrine therapy in operated or radiated patients?

The incidence of focal prostate cancer appears to be similar throughout the world, but regional differences in mortality suggest an influence of environmental factors, mainly diet. A low consumption of animal protein and fats and a high intake of isoflavonoids, antioxidants and weak estrogenic hormones seem to deter the oncogenic cascade to clinical progression. Chemoprevention may ultimately prove the road to take prostate cancer its present biting edge.

Sex matters, gender too: differences in psychosocial aspects of prostate and breast cancer

Kiss A. Psychosomatic Division, University Hospital Basel, Switzerland

Men and women not only differ with regard to their reproductive organs and bodies (sex) but also in the way they think, feel and behave (gender). The main issue of this oral presentation is to demonstrate the major impact of gender on psychosocial differences in men and women with prostate and breast cancer, respectively, by reviewing the recent literature. Although prostate and breast cancer share many similarities concerning biology and epidemiology the impact of prostate and breast cancer on patients and their partners varies considerably. Important domains are the impact of cancer treatment, on sexual function, on gender, on quality of life, on psychological distress, on predominant coping, and last but not least, impact on partner. Physicians attitudes and behavior with prostate and breast cancer patients is also substantially different in areas such as shared decision making, detecting and treating psychosocial distress, and giving way to gender-specific support groups.

SATELLITE SYMPOSIUM

Sildenafil – a clinical review of 3 years

Jungwirth A. Head of the Andrological Unit, Department of Urology and Andrology, Salzburg General Hospital, Austria

In the three years since its launch, sildenafil citrate (Viagra), an oral agent for the treatment of erectile dysfunction (ED), has been prescribed to more than 10 million patients worldwide and has been further evaluated in clinical studies in diverse patient populations.

Significant improvements in erectile function have been demonstrated in double-blind, placebo-controlled trials in patients with ED and underlying diabetes, cardiovascular disease, minor depression, spinal cord injury and multiple sclerosis (MS). Promising results have also been reported for patients with treated prostate cancer, end-stage renal failure, Parkinson's disease, and spina bifida and in multiple organ transplant recipients. Accounts of sildenafil use in clinical practice and postmarketing data reflect clinical trial findings of effectiveness in a broad spectrum of ED aetiologies and overall good tolerability. As in the clinical trials, most adverse events associated with sildenafil use have been transient, mild or moderate effects that rarely lead to treatment discontinuation.

The efficacy of Viagra in patients with ischemic heart disease based on a combined, retrospective, subgroup analysis showed promising results: compared with placebo, patients taking Viagra were significantly more likely to report improved erections (16% versus 62%, respectively; P=0.0001). Conti et al have reported on an earlier analysis in ED patients with ischemic heart disease that reported response rates of 70%.

Fowler and coworkers tested the efficacy and tolerability of Viagra in 217 MS patients with ED in a 16-week, double-blind, placebo-controlled, flexible-dose study with a 4-week run-in and a 12-week double-blind period. Patient mean age was 46 years, and all patients had clinically definite MS of 1 or more years duration. Viagra proved to be an effective and well-tolerated treatment for ED in patients with multiple sclerosis. While 24% of patients taking placebo reported improved erections, 89% of the Viagra group experienced improvement (P<0.0001). No patients discontinued Viagra treatment because of an adverse event.

Viagra has also been found to be effective in men with ED secondary to radical prostatectomy. In an analysis of clinical trials, Viagra was found to be effective in 43% of radical prostatectomy patients with ED, compared with 15% of patients taking placebo. Zippe et al performed a study to determine whether the response to Viagra in patients with ED secondary to radical prostatectomy is influenced by the presence or absence of neuro-vascular bundles. They reported higher response rates up to 70% in patients in whom a bilateral nerve sparing approach is used.

Viagra is effective in patients with concomitant conditions (eg, hypertension, depression, diabetes, spinal cord injury). 70% of ED patients with hypertension reported improvement in erections versus 18% in the placebo group (P=0.0001). In addition to being effective in ED patients with hypertension, Viagra is also effective in ED patients with concomitant diabetes. Viagra was significantly better than placebo in the ED patients with diabetes (63% versus 17%, respectively; P=0.0001). The efficacy of Viagra in ED patients with depression is also demonstrated. While 14% of patients on placebo reported improvement in erections, 83% of patients taking Viagra experienced improvement (P=0.0001).
Overall, the evaluation and management of ED shows

significant benefits in terms of
– identifying important co-morbid conditions,
– improving patient compliance with medications and lifestyle advice, and
– elevating the QoL of patients and
– their sense of satisfaction with the healthcare they receive.

CLINICAL PEARLS SYMPOSIA – IT'S A MAN'S WORLD I

The Prostate – A Clinical Field Trip from BHP to Cancer

Lower urinary tract: current approaches, evaluation and treatment

Schmeller NT. St. Johanns-Spital, Salzburg, Austria

Terminology: Because the relationship between the size of the prostate, obstruction and symptoms is complex, we differentiate between the enlargement of the prostate (Benign Prostatic Enlargement=BPE), the obstruction of the bladder outlet by any cause (Bladder Outlet Obstruction=BOO) or by the prostate (Benign Prostatic Obstruction=BPO) and the symptoms of the patient (Lower Urinary Tract Symptoms= LUTS). The etiology of BPH is poorly understood. Two major factors necessary for the onset of BPH are age and normal testicular function. Many potential risk factors for BPH have been investigated but no causal relationships established.

Evaluation: History (including detailed listing of current medication, which may incluence the function of the micturation) and physical examination with digital-rectal examination (DRE). The symtoms must be classified using a scoring system like the International Prostate Symptom Score (IPSS). Laboratory examinations should include creatinine, PSA (in patients older than 45 years, only if there are therapeutic consequences), urine analysis, uroflowmetry and residual urine. Sonography of the kidneys and bladder and determination the the volume of the prostate (best by transrectal sonography) are mandatory. A protocol of micturation may be helpful. Other tests, which may become necessary, include the IVP, urethrogram, cystoscopy and urodynamic evaluation. Conservative therapy (medication) can improve the symtoms, but has no or little influence on bladder outlet obstruction. Morbidity is low. Watchful waiting may be indicated in the case of mild symtoms (IPSS <7). Phytotherapy is used widely, but the evidence of its value is scientifically not sufficiently undermined. Alpha1-receptorblocks are useful for symptomatic therapy of the BPH-syndrome. Evaluation of bladder outlet obstruction is recommended before initiation of this therapy. 5-alpha-reductase-inhibitors may be used for the therapy of the BPH-syndrome if the volume of the prostate is >40 ml.
Surgical treatment: Over half of men over 50 years of age have symptoms caused by BPH and 25 per cent to 30 per cent ultimately may have surgery. Transurethral resection of the prostate (TURP) has been the preferred operative procedure. Recently, however, alternatives to TURP have been developed and are at various stages of development and introduction. The introduction of some of these alternative therapies is likely to add to, rather than replace, existing therapies. This could result in a cascade of treatments, and a potential widening of indications for treatment, with associated cost implications. While the results obtained from a number of the alternative treatments to TURP are promising, they are at an early stage of development and not yet proven. There is very limited data on the cost effectiveness of the new technologies. Because of their early stage of development and the absence of information on failure rates, retreatment rates and the mix of technologies which might prevail, it is difficult to arrive at meaningful data on the range of therapeutic alternatives in the treatment of BPH.

BPH new treatment developments – surgical and non-surgical

Stein B. Brown University, Providence, USA

BPH is a universal problem in the aging male. Due to the ubiquitous nature of this disease, many alternative treatments have been sought. New developments include improvements in both medical and surgical treatments. Medical treatments now include the use of herbal products, new alpha-blocker medications, and newer indications for the use of finasteride. Surgical treatments now include an array of minimally invasive therapies including TUIP, TUMT, TUNA, and a variety of lasers. This talk will review these new developments, and conclude with a perspective of how they all fit into the treatment of the male suffering from BPH.

E*rectile Dysfunction – Disease or Men's Destiny*

Sexual Dysfunction of the Elderly - Advances in Screening & Diagnosis

Weidner W. University of Giessen, Germany

Partial androgen deficiency of the aging male is associated with symptoms collectively accepted as the andropause syndrome. The underlying hormonal changes, the definition of age-dependent cofactors for changing sexuality, and the data on decreasing erectile function are the main topics of this critical analysis. Alterations in libido, ejaculation and sperm quality also have to be considered in order to define a change in male sexuality as part of the natural process of aging.

Management of Erectile Dysfunction: from Present to Future

Stackl W. Department of Urology and Ludwig Boltzmann Institute for Extracorporeal Lithotripsy and Endourology, Rudolfstiftung, Vienna, Austria

The introduction of sildenafil (Viagra) in 1998 marked a revolutionary turning point in the history of the management of erectile dysfunction. The success of sildenafil has resulted in explosive growth in the field of sexual pharmacotherapy. Recently apomorphine SL (Ixense, Uprima) was approved and is available in Austria. Currently vardenafil and Cialis, both selective inhibitors of phosphodiesterase 5, are being examined.

Drugs for intracavernous injection are used since 1983. Only three, used alone or in combination, have become widely clinically accepted and administered on a long term basis, namely papaverine, phentolamine and prostaglandin E1 (Androskat, Caverject).

Further understanding of the physiology and pathophysiology of erection stimulated the research on the central regulation of the erectile process. It involves several transmitters, including dopamine, serotonin, noradrenalin, nitric oxide and peptides. These systems may be targets for future drug designs.

Gene therapy and molecular biology utilizing ex-vivo-transformed endothelial cells injected intracorporally are tested in rats. In the same model inducible nitric oxide syntheses restored the age-related decline in the intracavernous pressure response. Based on the encouraging preclinical data the future of gene therapy in the treatment of human erectile dysfunction seems promising.

ABSTRACTS

(in order of time schedule of congress program)

Saturday, November 3, 2001

NEW FRONTIERS IN MEN'S HEALTH

Reaching Men: Evidence-Based Communication and Marketing Strategies for improving Men's Health

Courtenay W. McLean Hospital, Harvard Medical School, USA

Gender-based medicine and health care is receiving increasing attention among health professionals. Research suggests that the failure to tailor interventions to patients' gender-specific needs is associated with fewer positive outcomes. However, while many mental health counseling interventions and communication techniques with men have been recommended in the past two decades, few interventions have been developed for working with men in health care settings. Given this lack of clinical guidance, it is not surprising that men receive significantly less clinician time in their health care visits than women do, and generally receive fewer services and dispositions than women. Because men utilize relatively few health services, any encounter a clinician does have with a man may be the only opportunity for assessment and intervention that any health professional might have with him for a long time.

This presentation will explain how to maximize this opportunity, and to successfully educate and counsel men. Based on the only evidence-based clinical practice guideline for working with men, it will identify specific, evidence-based communication strategies for improving compliance and fostering behavioral change when providing clinical services to men. The presentation will also explore best practices for successfully increasing men's utilization of health care services. It will identify specific research-based marketing techniques for attracting and retaining male patients, including gender-specific applications of social norms and stage of change approaches.

Communicating with Male Patients: Improving Men's Health

Banks I. Men's Health Forum, London, UK

Colin Francome in his book 'Improving Men's Health' says that, "one problem is that men often do not seek help until a disease has progressed". US research shows that 'Among persons with health problems, men are significantly more likely than women to have had no recent physician contacts regardless of income or ethnicity'. Why?

Myths surround men's health the greatest of which is that men do not care about their health. The fact is that men worry over health concerns but feel unable to talk about them or seek help until it is often too late. This is all confounded by the impact of social class where morbidity and mortality increase in direct proportion to the level of deprivation. Doctors surgeries are not often male friendly and with the present style of medical training the consultation can bring out the worst in male/male interaction. Solutions are not always immediately at hand, men's health as an issue is very young but there is a growing amount of evidence based work which will address areas such as education, health promotion and better use of the health services. The Men's Health Forum seeks a fundamental change in school education placing health on the schools curriculum, greater provision of alternative services such as NHS Direct on-line and walk in centres, improved use of occupational health services for health promotion, multidisciplinary approaches to suicide prevention and an awareness of gender when health bodies structure health policies. Otherwise the health services will effectively remain a no man's land.

e-Health: Promotion of Men's Health in the age of the Internet

Jadad A. Director Program in eHealth Innovation Rose Family Chair in Supportive Care, Professor Departs. of Health Policy, Management and Evaluation, and Anesthesiology, University Health Network and University of Toronto, Canada

Rapid developments in information and communications technologies (ICTs) are promising a radical transformation in the way in which humans communi-

cate and use information. However, despite worldwide efforts to promote and implement them, ICTs appear to have a remarkably small impact on the health system and on men's health.
In this presentation, I will highlight opportunities created by existing and emerging ICTs to help transform the health system into a system that respects and meets men's health needs. I will also identify major initiatives that are promoting evidence-based decision-making around men's health issues, as well as emerging technologies that could have an important effect on men's health promotion and wellbeing. I will also generate discussion around some of the threats that the Internet and other ICTs are presenting to the traditional role of men in society.

Unmasking Male Depression: Challenges in Diagnosis and Treatment

Kasper S. Professor and Chairman, Department of General Psychiatry, University of Vienna, Austria

The prevalence of major depression in men is half that in women. This is due to an interaction of social and biological factors, in which marital and employment status play a major part. Clinical features of depression in men and women are similar, apart from men having fewer sleep changes, psychomotor and anxiety/somatisation. Men also tend to suffer from mild to moderate depression, whereas women have more severe and chronic forms of depression. Depression in men is more difficult to detect since men do not like to admit to such feelings, and so primary care physicians should be on the alert for the risk factors of depression in men, e.g., single marital status, unemployment, low level of education and emotional reliance, severe physical illness. Furthermore, as men are much less willing to discuss their feelings, they tend to adopt alternative mechanisms for coping with their depression. These are frequently expressed as risk-seeking behaviour such as alcohol abuse, domestic violence, law-breaking, social abandonment and suicide. Despite being half as likely to experience major depression as women, men are up to four times more likely to take their own lives. Because they value decisiveness and independence, men avoid receiving help, which they see as a weakness. Women on the other hand readily accept help, which can protect them against successful suicide. Male depression can be treated so it is important that we make the effort to identify sufferers so they can receive effective treatment.

Male contraception: state of development

Zitzmann M, Kamischke A, Nieschlag E. Institute of Reproductive Medicine of the University, Münster, Germany

To date, men using contraceptive methods rely on methods such as vasectomy or condoms. Pharmacological approaches target the testis or post-testicular functions. While research in the latter is still restricted to animal models, hormonal suppression of sperm production is an emerging reality. As the pituitary hormones LH and FSH play a pivotal role in maintenance of spermatogenesis, suppression of gamete production can be achieved by elimination of these gonadotropins. In about two thirds of Caucasian men and to a higher degree in East Asian men, this is feasible to a high degree by administration of testosterone, causing a negative feedback effect. In order to achieve azoospermia, which is the most effective prerequisite for contraception, additional compounds such as gestagens or GnRH-antagonists are needed. As GnRH-antagonists are impractical and expensive, long-acting gestagens represent the most favourable regimen to date. As they lead to a marked depletion of LH and FSH, not only spermatogesis, but also testosterone levels decrease. Thus, the additional administration of a, favourably, long acting testosterone ester to maintain sexual functions, bone density, hematopoesis and cognitive aspects is required. Among the most promising regimens, the high efficacy of a combined, 6 to 8-weekly injection of norethisterone-enanthate and the long-acting testosterone undecanoate has been demonstrated. Although safety aspects should be investigated on a long-term basis, there are no clinical indications for severe disturbances concerning lipid metabolism or hemostasis.

Male Osteoporosis

Male osteoporosis: New insights into pathogenesis and treatment

Khosla S. Professor of Medicine, Mayo Medical School, Minnesota, USA

With the aging of the population, osteoporosis in men is a growing public health problem. Recent estimates are that the lifetime risk of an osteoporotic fracture in

men is approximately 13% with an annual health care cost in the US of almost $3 billion. Unlike the situation in women, the precise bone density diagnostic criteria to define osteoporosis in men are still under debate. Similar to women, however, evidence from estrogen receptor and aromatase deficient males, cross-sectional and longitudinal observational studies, and direct interventional studies indicates an important role for estrogen in bone metabolism in men. This suggests the possibility of using selective estrogen receptor modulators to prevent or treat osteoporosis in men, and preliminary studies indicate that this may be beneficial in a subset of aging men who are truly estrogen deficient due to declining sex steroid levels. The most definitive data on the treatment of osteoporosis in men, however, comes from a trial of alendronate, which appears to be as efficacious in men as it is in women. An early study with intermittent parathyroid hormone also suggests that this agent may have significant utility as a bone-anabolic agent in men. In summary, while osteoporosis in men has been a neglected problem until recently, the past few years have witnessed significant strides in both our understanding of the factors regulating bone metabolism in men, as well as new approaches to prevent and treat osteoporosis in men.

Clinical Presentation and Diagnosis of Male Osteoporosis

Resch H. Medical Department II, KH Barmherzige Schwestern, LBI for Aging research, Vienna, Austria

Osteoporosis in men is a heterogeneous condition, encompassing a wide variety of etiologies and clinical presentations. The average bone loss at the spine in the second half of life is estimated to be 2% per years for males and 1% per year for females. The fracture threshold is higher for males than for females. The vertebral fracture risk in the second half of life is 5% for males and 16% for females in the same age. The incidence of hip fracture rises exponentially in men with aging, but the age at which the increase begins is slightly older than in women. Perhaps as a result of a higher prevalence of concomitant disease the mortality associated with a hip fracture in elderly man is considerably higher than in woman. In clinical practice several potential explanations for bone loss and fractures in a single patient are usually detected. In males, age-related bone loss alone may be able to cause non-traumatic fractures, even when other causes of bone loss are present like a variety of metabolic disorders. Osteoporosis in males has been termed idiopathic if no known cause can be identified on clinical and laboratory grounds. Although metabolic bone disease in men has been traditionally considered to be more commonly related to “secondary” causes, this impression is difficult to substantiate. The 3 major causes of osteoporosis in men are alcohol abuse, glucocorticoid excess and hypogonadism. In many series, these etiologies account for up to 50% of all men for osteoporosis. Other causes are also important to rule out, such as primary hyperparathyroidism, thyroid disorders, multiple myeloma and gastrointestinal disorders. In own investigations in large series of osteoporotic men, many patients were considered to have bone disease of unknown etiology. The diagnosis is typically by bone densitometry in the context of symptoms ors signs. In some men the diagnosis of an osteopenic metabolic bone disease can be made with basic clinical information. There are several clinical situations in which the presence of osteoporosis cannot be confidently determined, but should be considered likely. In these circumstances further diagnostic steps are appropriate. These situations include the presence of suspicious fractures, the radiographic presence of low bone mass, and conditions known to be associated with increased risk of bone loss.

Andropause: Facts and Fiction

Morley J E. Division of Geriatric Medicine, Saint Louis University Health Sciences Center and Geriatric Research, Education and Clinical Center, St. Louis VA Medical Center, USA

The diagnosis of andropause is at times very difficult. The symptom complex is often non-specific and may overlap with the diagnosis of depression. The 10 point Saint Louis University Questionnaire has proved a useful tool to screen for andropause:

1. Do you have a decrease in libido (sex drive)?
2. Do you have a lack of energy?
3. Do you have a decrease in strength and/or endurance?
4. Have you lost height?
5. Have you noticed a decreased “enjoyment of life”?
6. Are you sad and/or grumpy?
7. Are your erections less strong?
8. Have you noted a recent deterioration in your

ability to play sports?

9. Are you falling asleep after dinner?
10. Has there been a recent deterioration in your work performance?

A positive questionnaire is defined as a "yes" answer to questions 1 or 7 or any three other questions.

This questionnaire has a 88% sensitivity and 60% specificity and there is a positive response of symptoms to testosterone treatment. A risk factor questionnaire was developed out of the Massachusetts Male Aging Study. It is less sensitive 71% or specific 53% than the ADAM. However, it highlights the importance of including treated asthmatics and diabetics as risk factors for andropause. The Aging Male Survey developed in Germany and validated in English is another available questionnaire. A Taiwanese questionnaire has given further validation for some of the questions utilized in the ADAM questionnaire. None of the questionnaires is ideal and further work is required in this area.

With aging, SHBG increases. This makes a total testosterone less than an ideal assay in older persons. The recommended assays are a free testosterone by dialysis or ultra centrifugation or a bioavailable (weakly bound) testosterone. Kaufman and Vermeulen have provided a calculated free testosterone, which performs excellently. Recently with Wittert and Hagen, we have developed a calculated BT, which also appears to perform better than the total testosterone and is loosely correlated with measured bioavailable testosterone. The free testosterone analog assay and the free androgen index (testosterone/SHBG) are not recommended.

Utilizing these approaches, the diagnosis of andropause can be made with some certainty. An algorithmic approach to the diagnosis of the andropause will be presented.

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Facts and Fictions of Andropause: Lessons from the Turku Male Ageing Study

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The purpose of this population based study is to assess the frequency of subnormal testosterone (T) production, and its relationship with subjective symptoms, and other hormonal, biochemical and anthropometric parameters in ageing men. Our future goal is to develop an array of biochemical tests that predict genuine andropause and its response to eventual androgen replacement therapy (ART). A questionnaire about andropausal symptoms (Heinemann score > 37) was sent to the whole population of 40-70 year-old men (n = 31000) in the city of Turku, Finland. The reply rate was 55%, and all men reporting high andropausal symptom score (n = 2300), were invited for T and LH measurements. Of these men, 1900 arrived, and of them, 260 displayed low serum total T (< 10 nmol/), and 260 low-normal T and high-normal LH (> 6.0 U/l), considered as compensated or 'subclinical hypogonadism'.

Upon more detailed history taking and clinical examination, about 50 out of the original 520 men had genuine isolated "andropause", i.e. hypotestosteronaemia or subclinical hypogonadism, high andropausal symptom score and absence of underlying systemic disease; the rest of the men had other diseases. In conclusion, high andropausal symptom scores in the random population of 40-70-year old men are relatively common (13.5%). However, only a fraction of such men (27.4%) appear to have concomitant hypotestosteronaemia or 'subliclinical hypogonadism'. When

the latter two groups are studied more rigorously, most of them seem to have underlying systemic diseases (e.g. prostatic hypertrophy, hypercholesterolaemia, sleep apnoea). Finally, only 2.6% on ageing men suffering from andropausal symptoms seem to have 'genuine andropause' without underlying systemic disease. Ill health rather than isolated andropause is the commonest cause of suppressed testicular function in the ageing male population. Whether these men could benefit from ART poses a challenge for future research.

Testosterone Replacement Therapy

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Substitution therapy with androgens is reserved for men with hypogonadism. There is no universally accepted definition of hypogonadism and the extent to which the incidence of hypogonadism increases with advancing age is not well known. Nevertheless, regardless of age we generally consider serum T levels below 12 nmol/l accompanied by symptoms of androgen deficiency such as decrease of libido, bone density, hematopoesis, muscle mass and depressiveness as an indication for testosterone (T) substitution provided a prostate carcinoma has been excluded. Injectable T enanthate or cypionate (200-250 mg) provide serum T levels above the lower limit of normal for 2-3 weeks. Longer acting T esters (such as undecanoate and buciclate), currently under clinical development, allow injection intervals to be spaced between 6 to 12 weeks and provide lower fluctuations of androgen levels. While these substances are most useful for the therapy of younger hypogonadal men or in male contraception, for older patients one would prefer shorter acting preparations which can be easily withdrawn in case unwanted effects (e.g. polycythemia) or interfering diseases (e.g. prostate carcinoma) occur. For these reasons, transdermal preparations such as patches or gels should be preferred. In particular, the transdermal route of application has the advantage of adapting serum T levels to the physiological circadian rhythm. Future studies will reveal whether synthetic androgens with a lower prostatotropic effect, such as 7a-methyl-19-nortestosterone (MENT), are of advantage in substituting aging hypogonadal men.

CLINICAL PEARLS SYMPOSIA – IT'S A MAN'S WORLD II

The Male Lipid Profile: Highway to CVD

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It is well documented that up until the fifth decade of life, the risk of developing coronary artery disease (CAD) in males is six times higher than in females. In the frist 14 years of follow-up in the Framingham Study, approximately every fifth man and every seventeenth woman developed CAD by sixty years of age1. In countries where CAD is common, there is a comparatively greater excess mortality in younger males. The reasons for these mortality differences in younger males are complex. At the age of 45-54 years, the decisive age for intervention, statistically males are at a disadvantage based on their lipid profile. Men are generally characterized by lower HDL, higher total cholesterol/HDL ratio and greater abdominal obesity (visceral adipose tissue) which yields at least a partial explanation for the gender differences seen in CAD morbidity and mortality. According the Canadian Heart Health Surveys about 33% of Canadian males in the 45-54 age category are afflicted with the most severe level of dyslipidemia (TC>6.2mmol/L) vs. only 17% of women. This is coupled with a greater lack of awareness of hypertension (RR=1.58) and higher smoking rates (31% men vs. 26% women) in this age bracket. As therapy with statins is one of the most efficacious measures in primary prevention of cardiovascular diseases in men, development of national lipid strategies could result in significant reduction of male morbidity and mortality

Literature:

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Hypertension and Treatment of Male Hypertension

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Men are at a greater risk for cardiovascular and renal disease than are age-matched, premenopausal

women. Recent studies using the technique of 24-hour ambulatory blood pressure monitoring have shown that blood pressure is higher in men than in women of similar ages. With respect to the pathophysiology of hypertension as well as the treatment procedures the influence of gender was underestimated. Men tend to develop abdominal obesity and the increase in abdominal adipocytes with a high metabolic rate is followed by an increase in insulin resistance and the cascade of symptoms summarized as the metabolic syndrome. Muscle fiber composition and capillarization are also related to insulin sensitivity and to blood pressure. While female sex hormones enhance endothelial function, reduce oxidative stress and protect against atherosclerosis, testosterone worsens endothelial dysfunction associated with hypercholesterolemia. These data indicate that men are more prone to hypertension and male life-style with an increased alcohol intake and smoking further increases this risk. Diagnosis of hypertension is made in men at a younger age than in women, and also therapeutic procedures reveal several differences. ACE-inhibitors are prescribed to a larger extent and a higher dosage than in women. Side-effects, including erectile dysfunction, have to be considered expecially with respect to the patients compliance.

Stress – A Male Status Symbol? New Aspects

Porta S. Head of the Institute of Applied Stress Research, Bad Radkersburg, Austria. Head of the Endocrinological Research Unit Institute of Pathophysiology, University of Graz, Austria

A metamorphosis of the most common types of male stress situations has taken place. Nowadays, a stressor cannot be fled or killed any more but its presence has to be endured, due to the loss of individual mobility in our rather strictly reglemented society. Thus not necessarily the fastest or strongest, but those with stamina are the most successful. This means, in a still male dominated working ambient, an increasing exposure, not to fight or flight reactions, but to chronical stress.

Surprisingly, our endocrine - substrate emergency system is well equipped for that kind of demand. Catecholamine – glycogen and -glucose interactions are much more intimate than we thought. This interrelationship culminates in the fact, that there is no direct feedback of catecholamines without involvement of carbohydrate turnover. This means that on the one hand epinephrine and norepinephrine can be secreted additionally on top of any kind of pre – existent levels (myocardial infarctions), on the other hand carbohydrate turnover controls catecholamine secretion to a large extent which may explain stress related eating bouts.

This linking of the phylogenetically old adrenal medulla with our modern liver created liver bound adaptation systems which e.g. use the very same epinephrine levels – situation dependently – both as a glycogenolytic or gluconeogenetic agent, together with stress induced cortisol and insulin changes (experiments with applications of protracted epinephrine delivery systems). Epinephrine induced glycogen deficiency increase synthetase activities even during still remaining high catecholamine levels. This allows for a kind of uncoupled local, anabolism in the liver during a still overall catabolic situation. A surprising situation, which is nevertheless responsible for continuous fuel allowances during chronical stress.

Abuse of that system especially in approaching exhaustion leads to slightly less increased catecholamine levels than the situation would afford, resulting in a less efficient resource management. In such terms stress induced exhaustion seems to mark not so much absolute lack of resources but the increasing difficulty to get at them, whereby endemical lack of magnesium aggravates the situation (experiment with Austrian officer trainees).

So called “post stress provocation tests” show that amateur sports, still atavistically slightly male dominated, represent one of the most important factors for amelioration of chronical mental stress effects (experiments with female and male high school courses). Dangerous accumulation of serum substrates during pure mental stress, meant for physical muscle involvement in emergency reactions, e.g. blood glucose increase, can best be regulated by simulating atavistic fighting by jogging or sports subsequent to mental stress.

SATELLITE SYMPOSIUM

Addiction

Genetic and Environmental Contributions to Gambling Behavior Among Middle Aged American Males

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Slutske W. University of Missouri, Columbia, MO, USA

Pathological gambling is defined by the Diagnostic and Statistical Manual (DSM-IV) of Psychiatric Disorders as, "persistent and recurrent maladaptive gambling behavior that disrupts personal, family, or vocational pursuits." Individuals who have five of ten gambling symptoms are given the diagnosis of pathological gambling, while those who have fewer symptoms are described as having problem gambling. The lifetime prevalence of problem and pathological gambling (P&PG) in the United States has been estimated to be five percent, although the increasing ease of access to legalized gambling in the last decade will likely increase this figure. To date, there has been little research into the causes of P&PG. The purpose of this presentation will be to highlight data that demonstrates that both genetic and inherited factors contribute to vulnerability a broad range of gambling behavior.

The genetic and environmental contributions to P&PG behavior will be examined using data derived from the Vietnam Era Twin (VET) Registry, a cohort of 4,500 mono and dizygotic male-male twin pairs who served in the armed forces of the United States between 1965 and 1975. The presentation will discuss how data derived from twin pairs can be used to estimate the genetic and environmental contributions to gambling behavior, and will address the following issues: (1) Why do some people get into trouble if given the opportunity to gamble and others never do? (2) Why are some people who get into trouble with P&PG more likely to also have a problem with other psychiatric disorders, in particular, alcohol abuse and dependence? and (3) Are P&PG best understood as extreme degrees of a continuous spectrum of behavior, or distinct patterns of behavior that are fundamentally different from normal? The limitations of the twin methodology and generalizations derived from the VET Registry cohort will also be discussed.

Craving in Alcohol and Cocaine Dependent Men

Sinha R. Associate Professor, Department of Psychiatry, Yale University, School of Medicine, USA

Various environmental stimuli associated with alcohol and drug use are known to elicit drug craving and increase the likelihood of relapse to addictive substances. These stimuli include the drug itself, drug related stimuli such as people, places and objects associated with drug cues, and finally stress and negative affect situations known to increase the risk of relapse in addicted individuals. This presentation will focus on neurobiological changes associated with the drug craving state when alcohol and cocaine dependent individuals are exposed to alcohol cues, stress cues and drug cues. Data on the effects of naltrexone treatment on alcohol craving and related neurobiology in alcoholics will be discussed. Furthermore, potential treatment targets for reducing drug craving and risk of relapse in cocaine dependent men will also be addressed. The main objectives of this presentation are:

1. To discuss the craving and neuro-endocrine response to alcohol cues in alcohol dependent individuals treated with naltrexone/placebo.

2. Potential mechanisms that may underlie naltrexone's efficacy in reducing alcohol craving will be presented.

3. To present data on neurobiological changes associated with stress and drug cue-induced craving in cocaine and alcohol dependent men.

4. To present potential pharmacological targets that may be developed to address drug craving in alcohol and cocaine dependent men.

Opioid and cocaine addiction - gender differences - a public health issue

Iguchi MY. Director Drug Policy Research Center RAND, Santa Monica, USA

Objective: To provide a clinical overview of treatment considerations for cocaine and opiate abusers, with a special emphasis on differential considerations asso-

ciated with gender.

This presentation will provide a clinical overview of pharmacological and behavioral treatment options for opiate and cocaine abusers, with a strong focus on gender differences. Pharmacological interventions to be discussed include methadone, buprenorphine, LAAM, and a few of the pharmacotherapies that have been utilised without much apparent success for cocaine abusers. The discussion of behavioral options will focus on the use of positive incentives to promote a drug free life style. Finally, the presentation will consider the impact of the criminal justice system as it impacts options for treatment and behavior change.

CLINICAL PEARLS SYMPOSIA – IT'S A MAN'S WORLD III

Hormones, Health and Men

Male Hormone Replacement Therapy – The View of the Pharmaceutical Industry

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While hormone replacement therapy has been established in postmenopausal women for decades and is being optimized step by step, our knowledge of endocrine pharmacology of the aging male and with that, male hormone replacement is rather limited at the time being. Data from our own epidemiological studies are shown and the molecular biological, endocrinological and clinical correlate is discussed. Our previous knowledge of steroid biosynthesis in the aging Leydig cell is also presented. A general idea is given of the trends for new androgen preparations and non-feminizing estrogens. Finally, a comparison is drawn between hormone replacement and hormone displacement in aging male.

Testosterone defiency, diagnosis, therapeutic options and prostate cancer risk

Hesch RD. Professor of Medicine and Biology (h.c.), University of Constance, Germany

A few years ago testosterone (T) defiency in man was a rare diagnosis and T substitution performed only in cases with primary testicular failure or pituitary diseases. Today low T-concentrations have become a major concern for men's health and they are observed at all ages as the result of stress induced failure of the pituitary-testicular axis. In a typical case of "Complex Androgen Defiency" T-values at early morning are below 4 ng/ml and the diurnal rhythm is abolished, LH and FSH are below 10 U/L and the LH/FSH ratio is < 1. Symptoms vary considerably and a rating scale is recommended for evaluation. Low T can be associated with increasing risk of PBH and represents an indication to treat on its own.
For prostate health it is mandatory to determine dihydrotestosterone (DHT) under application of T. Increased DHT values are an important risk factor for prostate cancer and may, surprisingly, be observed in two opposite situations, namely low endogenous T and during overdosage of T during substitution. Genetic polymorphisms of 5 a reductase leading to high conversion of T to DHT must be considered.

In summary T defiency and T substitution become a frequent health problem at any age in man.

The Andropause and Memory Loss: Is there a link between Androgen Decline and Dementia in the Aging Male?

Tan RS. Medical Director, Garden Terrace Alzheimer's Center Geriatrician, University of Texas Health Sciences Center, Houston, USA

Studies demonstrate a partial decline in androgens with age and this results in the andropause, alternatively termed A.D.A.M or P.A.D.A.M.. The objective of this presentation is to review the literature on hormonal changes that occur in the aging males and determine if there are associations between decreased androgens and decreased cognitive function. Testosterone is the most potent androgen and will be reviewed in detail. DHEA is widely used by patients and will also be reviewed. Data on weaker androgens such as and-

rostenedione, progesterone etc. is unfortunately lacking. Trials of androgen replacement (testosterone & DHEA) and its impact on cognitive function will also be analyzed. Method of analysis will be by a comparative review of articles on MEDLINE, the Internet and other major abstract databases.

Results of the author's own research in 302 men of the association of memory loss as a symptom in the andropause will be presented. In addition, the author's open trial of testosterone replacement in hypogonadal men with Alzheimer's disease will also be presented. The results of the author's trial will be compared with other investigators.

High endogenous testosterone level predicted better performance on visual spatial tests in several studies, but not in all studies. Likewise, testosterone replacement in hypogonadal patients improved cognitive functions in some but not all studies. Testosterone has also been shown to improve cognitive function in eugonadal men. Several studies have shown that declines in DHEA may contribute to Alzheimer's disease and the results of double blind studies with DHEA replacement and its effect on cognition will also be presented.

In summary, there is still no consensus that androgen replacement is beneficial in cognitive decline but this option may prove promising in some patients. Overall, the evidence is leaning towards testosterone and perhaps DHEA in memory enhancement. Subjective reports from patients do suggest improvement in memory for details after androgen supplementation. There may be long-term benefits of androgen supplementation in hypogonadal aging males that could parallel that of estrogen replacement in women, and can include neuroprotective effects. Until larger clinical trials are designed and undertaken, there is no recommendation for treating cognitive deficits with androgens; but androgens may play a supplemental role along with acetylcholinesterase inhibitors in some cases of Alzheimer's disease.

Testicular function and aging

Kaufman JM. Dept. of Endocrinology, Ghent University, Ghent, Belgium

Ageing in men is accompanied by a progressive decline of gonadal function with, in particular, a decline of total and free testosterone (T) plasma levels resulting in a significant proportion of elderly men over age 60 years presenting with subnormal T levels compared with the levels in young adults. A great interindividual variation in T levels is observed in elderly men, a variability explained in part by physiological variables and differences in life style, while associated acute or chronic diseases may accentuate the age-related decline of T levels. The progressive decrease of plasma T levels has been shown to result from both primary testicular changes and altered neuroendocrine regulation of Leydig cell function. More limited information indicates that global Sertoli cell function and spermatogenesis are relatively well preserved in elderly men, although this appears to require increased FSH drive to compensate for primary testicular changes. Thus, whereas aging is accompanied by testicular changes affecting both Leydig cells and Sertoli cells, there appears to be a dissociation in neuroendocrine response with deficient LH secretion but appropriately increased FSH release. At present, little is known about the clinical relevance of the relative hypoandrogenism of elderly men and there is an urgent need for more longitudinal studies, which may clarify a possible role of decreased T levels in the modulation of the clinical consequences of ageing in men. In view of the lack of relevant controlled clinical trials having careful assessment of the risks and benefits of androgen replacement therapy in elderly men, this treatment should be reserved for selected patients with clinically and biochemically manifest hypogonadism, after careful screening for contraindications.

Reproductive capacity of the aging male

Schill W-B, Jung A, Schuppe H-C. Department of Dermatology and Andrology, Hessian Center of Reproductive Medicine, Justus Liebig University, Giessen, Germany

There is great interest in aging and its effect on the reproductive potential of men, as an increasing number of couples wish to have children in their late reproductive years. In principle, fertility in men persists well into old age, because changes in Leydig cell or seminiferious tubular function do not occur as rapidly as do menopausal alterations. Similarly to other organs, there is a considerable interindividual variation in age-dependent changes of the testes. In general, a gradual decline of fertility is observed with increasing age, although alterations in semen quality may be minimal. Most freqently, a decrease in motility

and the percentage of spermatozoa with normal morphology is demonstrated.

Apart from investigations evaluating the fertilizing capacity of spermatozoa from older compared with younger fathers, a retrospective study covering a period of 3 years was performed in our andrology outpatient clinic. Semen analyses of older men (n=66, > 50 years, median 53) were compared with those of younger patients (n=133, 21-25 years, median 24). Semen quality was investigated with and without adjustment for duration of sexual abstinence. In agreement with other studies, a decrease in progressive motility and ejaculate volume and an increase in the percentage of morphologically abnormal spermatozoa was observed in older men compared with younger patients. Impaired sperm morphology was mainly attributed to abnormal staining of flagella and an increased portion of coiled or bent tails, indicating epididymal dysfunction. In contrast, total sperm count and sperm concentration were unaffected. Moreover, serum testosterone levels were significantly reduced in the group of older men (median 3.0 vs. 3.6 ng/ml, $p < 0.005$).

ABSTRACTS

(in order of time schedule of congress program)

Sunday, November 4, 2001

THE FUTURE OF MEN

"The Good, the Bad and the Ugly" (What Psychoanalysis Can Tell Us About Men and Health Service Compliance)

Carroll S. Representative of The Federation of Men's Health & Well Being Associations of Australia

Men are difficult to engage in health care practices. With higher rates of morbidity in all non-sex specific pathologies this remains a concerning event. Little inroads have been made in this area but those that have, have had excellent results. What is it that characterises these successful interventions? It is the intention of this paper to discuss this phenomenon using the theoretical base of psychoanalysis.

The theories of psychoanalysis, first postulated by Sigmund Freud in 19th century Vienna, are ubiquitous. The nature of the unconscious now pervades all serious academic thought. Until recently the psychoanalytic notion of masculinity has remained unchanged but recent work by European psychoanalysts has brought new insights to this area.

This paper will examine the notion of how men relate to their physical body and what may underlie the apparent "refusal" to engage in health care practices, or engage in them obsessionally. This examination will include the work of Freud, Lacan, Kristeva, Green and original research by the author. A section of the paper will present a method of how to employ this new psychoanalytic understanding to engage men in both physical and psychological health care practices. In this new understanding of "how a man may unconsciously construct himself", engagement will be considered as the province of the practitioner rather than the health consumer. How this is done will conclude this paper.

Addressing the American Crisis in Men's Health through Educational and Legislative Action

Gremillion DH[1,2], Snitker T[2], Henry R[2]. [1].University of North Carolina School of Medicine, Chapel Hill, NC, [2]. Men's Health Network, Washington DC, USA

The growing disparity in male longevity and an increasing recognition of factors associated with the poor health status of men has focused attention on programmatic and legislative responses to this crisis. The Men's Health Network, organized as a non-profit in 1992, has served as an American clearinghouse for public awareness programs, screening programs and legislative promotion. The Network has assembled a broad coalition of clinicians, academicians, politicians and industry sponsorship with a mission of improving the health and well-being of men, boys and families. The process, strategies, and evolution of involvement hold important lessons for others pursuing a similar mission and will be detailed in our presentation.

Responding to a void in advocacy and public awareness MHN in 1991 formed a working group that evolved into the current program. With support from key politicians, including those with personal clinical crises, the Network has become the national focal point for legislative action, education, and public awareness. MHN sponsored legislation that established National Men's Health Week in 1994 with collaboration of Senator Robert Dole and Representative Bill Richardson. MHN advocated for the introduction of H.R. 632 The Men's Health Act of 2001 which when passed will create an Office of Men's Health at the Department of Health and Human Services to serve as a focal point for promotion Men's Health education and public policy within the Federal government.

MHN also addresses men's emotional wellness through promotion of positive fatherhood programs and legislation, and promotes fair information regarding men and violence issues.

The Men's Health Network delegation to the World Congress on Men's Health will present current and past strategies and initiatives that have worked in the complex political and clinical environment of the Uni-

ted States. Current initiatives such as the MHN HealthZone project and legislative goals for 2002 will also be discussed.

Prevention in the Male Life Cycle: From Boys to Men

Kunze M. Institute of Social Medicine, University of Vienna, Austria

There are considerable differences and also many similarities as far as health issues during the life-span of males and females are concerned. Life expactancy is the best indicator for the differences.

There are some fundamental biological reasons for

that difference in life-expactancy and health issues between males and females, but also the influence of society health matters is relevant in the various age categories. The cultural influences become especially visible in childhood and early adulthood of the male population.

As far as preventive strategies are concerned, basic science has to provide more evidence on the mechanisms underlying the aging process. Social sciences should lead to a better understanding of the cultur and political influences which effect health in disease in the various life-periods of men.

From a public health point of view the implementation of already existing scientific results and turning them into preventive action, has top priority. One example is the similarity of preventive approaches in childhood and old age special reference to vaccination programs and accident prevention.

Remodelling Male Identity

Coolsaet B., Belgium

Definition of the problem: The process of evolution is a series of slow and stepwise changes. Mankind is currently engineering an evolutionary leap to which his own model is not yet adapted. Men, in particular, are suffering from chaotic uncertainty. Through information systems he is being misled towards a model of achievement whose main elements are production and consumerism. He questions his identity: who is he and how will he become as a man, a lover, a father, a caregiver and as a pawn in the globalised network of the large group.

Method,theoretical systems approach: In order to gain some insight we shall consider man as a dynamic model. The genome world, and the structures and hormonal set-up that go with it, form the raw material. Linked to this is the brain and consciousness. The brain is profoundly influenced by both the small group (a monogamous family environment in the West) and the large group (the socio-cultural dynamics of society).

The pre-revolution model: Man and his systems remained rather stable for a long time with the previous model. The small group was characterised by his work and her presence. He was the caregiver but lived mainly outside the small group, somewhere in the pyramids of the economic and power systems.

1)The triangle: mother-child-father
The triagular model is the basis of the Western love model. Fusion with the love partner is fundamental. The ideal of fusion stems from the absolute love of the idealised maternal relationship,from wich he must break loose and be released. From these experiences elements develop in his subconscious and conscious brain which will influence subsequent relatonships:
-idealisation of her tenderness,warmth,care
-gratitude
-frustration, anxiety, distrust and aggression because of the teasing he has experienced
-focus on sexuality in relations,because his mother is a woman
-in cases of fixation or regression, an "omphalos-syndrome" might develop, which is
manifested by a whole range of symptoms.
His father is his example, his rival, his authority, elements which contribute to his interpretation of his gender role.

2) The large group
Systems of norms and values, authority and power apply in the circles that surround the triangle: family, neighbours, work circles, power systems. There are influences from religions.

The model during and after the revolution: In a large percentage of cases the triangle is physically or emotionally damaged or broken. The father-child relationship is increasingly fragile or non-existent, the mother-child relationship is weakening. Gender roles

are changing. Supposed favoured male qaulities are no longer gender specific. Women have gained equality and no longer depend on his approval. Love, sexuality and procreation are becoming disconnected. Other social structures are developing in which a man's position is no longer the defining factor. Because of the explosion in communication systems, men end up in ever-increasing, more global circles. Pressure to produce and compulsive consumption deprive him of freedom and time. Immediate unlimited pleasure is advocated. This system leads to discontent and depression.

It would not be natural to attempt to slow down evolutionary leaps. Man's identity will be remodelled into a new, temporary identity through dynamic adaptation processes. The influence of the triangle will lessen. The separation process will become easier, both from oedipal love and oedipal rivalry. As a result he will probably be less sexually focussed and will have broader emotional relationships. It is possible he will be less anxious and frustrated, and have more confidence in both the small and the large circles. The circles will be increasingly global, and perhaps more justly organised. Responsibility for caring will be shared and probably facilitated by a better understanding of consciousness.

Male Aggression and Violence

Hesch R.-D. University of Constance, Germany

Male violence is a fundamental problem in human history, it can be traced until ancient times and is omnipresent in our daily life. Male violence is responsible for all individual or public aggression, for wars and genocide. Democracy yet is the only social condition to alleviate male violence; but the biology responsible for coding of violence in the male brain remains still present although modern social organization does not need male aggression and violence as creative resources any more.

There is evidence that male violence, indeed, is a biological phenomenon resulting from the evolution of the most recent form of the Y-chromosome aged about 25.000 years in contrast to the current X-chromosome whose age is about 110.000 years. The Y-chromosome codes for the particular genetic, anatomical and functional structures of male amygdala and for its hormonal modulation by aminergic systems, testosterone and its metabolites.

Emotions act through this complex system to be transformed into will, physical activity and social interaction.

Future research is needed to understand the organization of male brain and to downregulate its emotional and hormonal activation to release violence. The design of selective androgen receptor ligands and the genetic manipulation of the Y chromosome are mandatory to overcome the evolutionary delay of the Y-chromosome in a modern world.

Men's Health in Asia

Lau E. Chinese University of Hong Kong, Hong Kong

By 2050, there will be 70 billion men who will be 65 years and over, 6% of whom will be living in Asia. There has been much advances in research in women’s health in the last decade, but men’s health clearly suffers from lack of awareness and treatment. Men die younger than women, and the reason for this shorter life span are unknown. As Asia undergo rapid economic developments and social changes, improving men’s health will remain a challenge. Research has to be conducted on the epidemiology of diseases in men, as well as on their prevention and control. Improving men’s health will be key to advancing social-economic developments in Asia in the next decade.

The first World Congress on Men’s Health will bring together scientist, professionals and policy makers to address men’s health issues. This is a key scientific event of the millennium, and I wish the meeting every success.

Developing an International Approach in the Field of Men's Health

Meryn S., Steiner M. Center for Advanced Medical Education and Health Communication, Institute for Medical Education, Medical Faculty, University of Vienna,

Major studies are now generating increasing amounts of evidence on important differences between men and women from the cellular to the societal level. The strong, important and necessary emphasis on women's issues has revealed areas of men's health that require just as much special attention. With the advent of

sperm banks, IVF sex sorting techniques, human cloning and same-sex marriages, it is also reasonable to wonder about the future role of men in society. What will be the implications of the redefinition of men's roles within family, work, and society, on their health? The "Men's Health Report of Vienna 1999" and the WHO report "Men, Aging and Health", published in 2000, provide a good starting point to develop a multidisciplinary and international approach in the field of men's health, and to look at the priorities and specific strategies that will be required to improve and maintain men's health in a rapidly changing world. Men's health has an enormous potential for improvement. The excessively high number of lost years of life can be reduced. The high number of risk factors in men demand appropriate measures for primary and secondary prevention. Support for gender specific research and for translation of the results into practical application in the healthcare system needs to be stepped up. The areas of research range from epidemiology and public health to basic research and clinical medicine.

There are a number of obstacles that hamper the promotion of men's health, for instance lack of participation in preventive activities, gaps in health consciousness, careless attitudes towards health, risk behavior and male roles in society. Furthermore communication studies in primary care have demonstrated that male and female physicians conduct their medical visits differently in some respects. These differences can have important implications for the nature of the therapeutic relationship between male and female physicians and their patients. There are three broad areas of impact: patient-physician partnership, exploration of the patient's psychosocial context, and patient expectations and judgement.

What is new in the concept of men's health promotion is the emphasis on the prerequisites for health. It, therefore, does not primarily address only the single individual. The main effort is to change and to develop the physical and social environment, even though health is partly the responsibility of the individual. Changing to the healthy option means that increasing the sense of responsibility for health within organizations, institutions and communities is the most important task. The prevalence of organizational structures characterizes modern societies. This means, however, that the society cannot handle problems and tasks for which no organization has yet been established. The International Society for Men's Health (ISMH) is, therefore, the first but crucial step and a prerequisite for men's health. Men's health promotion is the "process of enabling men to increase control and to improve their health". Reading the Ottawa Charter for Health Promotion (1986) from the viewpoint of organizational development, health promotion action means: building public health policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services.

All together much work has been done and must continue to be done to motivate and encourage men to take greater responsibility for their health. In addition efforts made in different fields should be combined to promote an approach to health issues from a gender specific viewpoint.

The time is right: International Society for Men's Health.

FREE LECTURES

FREE LECTURES

(in order of time schedule of congress program)

Friday, November 2, 2001

Men's Health I

Osteoporosis as a complication of androgen deprivation therapy for carcinoma of the prostate

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There is a new awareness that osteoporosis can be a late complication of androgen deprivation therapy for prostate cancer. We studied 50 patients undergoing hormone therapy either with leuprolide injections or by orchiectomy. The patients were on therapy for a variable period of time ranging from just initiating to as long as 13 years on therapy. All patients underwent a screening evaluation by AccuDexa scan, and patients with abnormal scans underwent a full table hip and spine scan to confirm the diagnosis.

Our results show that 44% had normal scans, 34% had osteopenia, and 22% had osteoporosis. The two factors which were important in predicting abnormal results were: patients age over 68 at the initiation of therapy, and > 2 years on hormone therapy. Of the patients less than 68 years old, 75% had normal scans vs 29.5% of the patients who started hormone therapy after the age of 68. In fact 14 of the 17 patients with osteopenia (82%) and 10 of the 11 with osteoporosis (91%) were over 68 years of age at the time their treatments were begun. Of the patients on therapy for <2 years 60% had a normal scan, while of the patients on therapy for >2 years, only 33% were normal.

We find a significant incidence of abnormal bone mineral densities in our prostate cancer patients undergoing hormone therapy, with 56% of the entire series having an abnormal BMD. The incidence is related to the age at onset of therapy, and the number of years on treatment. All patients undergoing androgen deprivation therapy should have an evaluation of BMD in order to prevent the complication of osteoporosis.

Bone mineral density (BMD) in men with adenocarcinoma of the prostate and androgen deprivation therapy and aged matched normal controls – do we miss osteoporosis in men by using conventional T and Z scores for postmenopausal women?

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Objective: The importance of senile osteoporosis in men as a public health problem has long been underestimated. In men the relevance of BMD measurement and its evaluation is discussed controversial. Although there are several gender specific differences in BMD, measurements are related to 30 y old women (T-score) and postmenopausal female BMD values (Z-score). In light of these gender dependent variables it would be surprising if the same algorithms could be used to relate absolute BMD in males with female parameters. We investigated bone mineral density in patients under androgen deprivation for prostate cancer and in age matched healthy controls.

Design and Method: We assessed BMD of the spine in 47 male patients. (ave. 73.8 years) using the dual energy X-ray absorptiometry (DXA) and utilised standard T and Z scores for definition of osteoporosis and osteopenia. Two groups were investigated and compared: Group 1 (31 pat., ave. 74.5 years) with hormonal deprived adenocarcinoma of the prostate (ave. 3.6 years of antihormonal treatment), group 2 (16 pat., ave. 73.1 years) age matched healthy controls without any hormonal deprivation (control group).

Results: Using common standards for BMD measurements as supported by the WHO in group 1 61% were osteoporotic, 26% had an osteopenia and 13% were considered as normal. In group 2 (control group) 50% of osteoporosis, 31% of osteopenia and 19% normal results were found. There was no significant difference of the T and Z scores values of group 1 and 2 (p=0.135, p=0.104) respectively. However, determination of absolute BMD (g/cm2) revealed a highly significant difference in BMD (group 1: 69.9g/cm2 and group 2: 97.9g/cm2, p=0.005).

Conclusion: A highly significant difference in absolute BMD in androgen deprivated males as compared to age matched healthy controls was found. Using stan-

dard T and Z scores, which are not gender specific, no significant difference was observed. These results emphasise the importance of gender specific and related T and Z scores for the interpretation of osteoporosis and osteopenia in aging males.

AMAS-2000: Beneficial effects of mountain holidays in patients with metabolic syndrome

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Million people visit moderate altitude regions (1500 – 2500 m above sea level) every year, quite a large number of them with metabolic syndrome (hypertension, obesity, hyperlipidemia, insulin resistance). Data on how such patients tolerate a long-term moderate altitude exposure are very scanty. We investigated the changes in the cardiovascular system, body composition, fluid balance, and metabolism of subjects suffering from the metabolic syndrome during a 3-weeks sojourn at 1700 m in the Austrian Alps.

Methods: 22 male subjects with metabolic syndrome. Baseline investigations: Innsbruck (500 m a.s.l). All participants remained at 1700 m for 3 weeks simulating a holiday with moderate sports activities. Examinations at altitude: Day 1, 4, 9 and day 19. Post-altitude examinations:After 7-10 days and 6-7 weeks, respectively.

Results: The subjects reduced their body mass by 2 %. The lean body mass showed no changes, whereas the body fat decreased significantly. Total body water decreased during the first days of altitude exposure and was above the control level at the end of the study. Heart rate, blood pressure and the rate pressure product dropped. The ECG revealed no ischemic ST-segment changes. The HOMA index (measure of insulin resistance) decreased significantly and glucose concentrations obtained after an oral glucose tolerance test were significantly lower after the stay at altitude compared to the basal values.

Conclusions: After moderate altitude exposure patients with metabolic syndrome 1) tolerated their sojourn without any physical problems, 2) reduced their body mass, mainly due to a reduction in body fat, 3) were able to maintain an adequate water balance, 4) showed short-term favourable effects on the cardiovascular system, and 5) had significant improvements in glycemic parameters which were paralleled by improvements in lipid metabolism.

A Global Perspective on the Field of Men's Health

Courtenay W. McLean Hospital, Harvard Medical School, USA

Gender-specific approaches to health and health care recognize the different experiences of women and men, and of various populations of women or men. As yet, little is known about men's gender-specific health care needs. This presentation outlines precepts for developing new theoretical paradigms and research models and offers direction for social scientists and practitioners in the nascent field of men's health. It advocates interdisciplinary approaches that explore how biological, sociocultural, psychological, and behavioral factors interact to mediate the physical and mental health of men and boys. It recommends that these approaches apply social structural analyses, examine geographic and cultural contexts, integrate recent theory and research on masculinity, and develop relational paradigms that recognize dynamic intersections of various social factors. It suggests that the multinational nature of men's health requires new global community health models for addressing the convergence of micro and macro health determinants at international, national, community, and individual levels.

FREE LECTURES

(in order of time schedule of congress program)

Saturday, November 3, 2001

Men's Health II

Men's Health Day 2001 in Vienna: Is there a rationale for free available PSA testing

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The men's health day in Vienna has been initiated as a free institutional day for the public with the emphasis to increase men's health awareness. It is repeatedly performed on a yearly basis. One of the investigations freely available is PSA testing. Since prostatic cancer is the second major cause of death in men, we investigated the outcome of patients with a pathological PSA determined at the Men's Health Day held in February 2001.

1056 men underwent PSA testing with PSA>4ng/ml found in 102 men (9.8%). An age adjusted interpretation of PSA was not performed. All patients were informed within 4 weeks about their results and those with elevated PSA were strongly advised to consult a urologist within 4 weeks. To investigate the outcome of these patients, the 102 men were questionnaired by mail - whether they visited a urologist as recommended, whether they attended a urologist for the first time, and what further steps were initiated.

From 102 patients with a PSA >4ng/ml, 45.1% replied to the questionnaire including 2 men with no information given (4.3%). The majority of men (77.3%) investigated were between 55 – 75 years. Maximum PSA was 19.5ng/ml. Due to PSA testing 95.5% of men had seen a urologist within the last 7 months since the Men's Health Day 2001, only 4.5% did not consult a urologist as recommended. 42% visited a urologist for the first time. Repeated PSA testing was initiated by all urologists indicating transrectal biopsy in 59%. According to the questionnaire, 41% of men with PSA elevation were considered not suspicious by urologists either by transrectal examination and/or transrectal ultrasound. In cases undergoing prostatic biopsy (59%), prostate cancer was found in 27.3% with subsequent radical prostatectomy in 22.7% and radiotherapy or androgen deprivation in 4.5%.
Our data strongly support the importance for public services to increase men's health awarenss. Although rectal examination and PSA testing has been recommended for men older than 45years, 42% of men above 45years did not consult a urologist prior to Men's Health Day 2001. Due to PSA testing, prostatic carcinoma was found in 27.3% with organ confined disease in 22.7%. Health care systems are advised to support these free available investigations to prospectively improve men's health.

Impact of PSA-test on prostate cancer incidence and mortality in Austria

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Objective:The aim of the study was to assess the impact of prostate-specific antigen testing (PSA) on prostate cancer mortality in Austria.

Method: A joinpoint regression model and permutation tests were used for identifying changes in the slope of age-specific trends respectively calculating the annual percent change (APC).
Results: Age-adjusted incidence increased ($p<0.01$) between 1983 and 1997 by 79% from 52.2 to 93.6 cases per 100 000 men/year. Incidence in localized/regional stage disease increased in all ages by 143% from 25.7 to 62.4 cases per 100 000 men/year. Incidence in distant disease decreased ($p<0.01$) between 1983 and 1997 in all ages by 38% from 9.5 to 5.9 cases per 100 000 men/year. Incidence in unstaged disease increased ($p<0.01$) between 1983 and 1997 in all ages by 300% from 4.5 to 18 cases per 100 000 men/year. Age-adjusted mortality increased ($p<0.05$) by 13% from 26.8 in 1983 to 30.3 deaths per 100 000 men/year in 1999. No significant changes of trends in mortality rates were detected in the age groups 50-59 years. In the age group 70-79 years the trend changed ($p<0.05$) direction in 1991 and in 1994; 1983 through 1991 APC = 3.52 (95% CI 1.37, 5.72), 1991 through 1994 APC = -10.27 (95% CI -26.20, 9.1) and 1994 through 1999 APC = -0.25 (95% CI -4.55, 4.24).

Conclusion: PSA testing increased incidence but no impact on mortality in the target population can be observed so far.

Outcomes of Treating Lower Urinary Tract Symptoms (LUTS) on Quality of Life

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Objectives: The aim of the study is to determine the effects of medical and surgical treatment for lower urinary tract symptoms (LUTS) on quality of life in a Malaysian population.

Patients and Methods: The study group comprises of 111 patients with LUTS (age 69.56 ± 4.94 years) underwent surgical treatment (transurethral resection of the prostate, TURP) and 116 patients with LUTS (age 63.77 ± 8.27 years) who underwent medical treatment (alpha blockers). All patients were evaluated using the International Prostate Symptom Score (I-PSS), the International Index of Erectile Function (IIEF-15), the Health-Related Quality of Life (HRQOL-20), the Spielberger State-Trait Anxiety Inventory (STAI), the Beck Depression Inventory (BDI) and the General Health Questionnaire (GHQ-12). The patients were assessed at baseline, three months, six months and twelve months. Multiple regression analysis using the stepwise regression were performed for the prostatic symptoms, sexual function and health-related quality of life.

Results: Before treatment, patients suffers more severe LUTS, bothersomeness and deterioration in health-related quality of life and subsequently improved following treatment. In the surgical group, all aspect of quality of life improved except sexual function. Psychiatric morbidity, depression and anxiety seems to be the main factors in predicting the improvement in LUTS, bothersomeness, sexual function and health-related quality of life in both medical and surgical group.

Conclusions: The results showed that both medical and surgical treatment significantly improved the overall quality of life of patients with LUTS. Psychological factors such as anxiety, depression and psychiatric morbidity were the factors predictive of the improvement in their overall quality of life.

Transurethral Needle Ablation of the Prostate: an office based approach

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We evaluated the feasibility of using the TUNA precision system for the office based surgical treatment of BPH. All patients for this treatment were determined to have BPH requiring surgical therapy, the overwhelming majority of which have already failed alpha-blocker therapy. TUNA was performed in the office, as an outpatient, under local anesthesia, with IM sedation. To date, 14 patients have been so treated. All patients arrive at our office 40 minutes prior to the planned treatment and are given an IM injection of Demerol (50-75mg) and Visteral 25mg. Thirty minutes pre-treatment, the patients are given 50cc of 2% liquid lidocaine at 4∞C via a urethral catheter, and ten minutes prior to therapy 20cc of 2% lidocaine jelly at 4∞C is instilled. The patient then undergoes TUNA with the Precision system (VidaMed). The average treatment time for these patients was 35.2 minutes. The patients rated the discomfort of the anesthesia and surgical procedure on a scale of 1-10. The average ratings were 4.1 for the anesthesia, and 5.2 for the surgery. The patients also rated their overall satisfaction with this procedure on a scale of 1 (very satisfied) to 4 (not at all satisfied). The overall rating was 1.8, indicating patient satisfaction with the operative experience. The average IPSS pre-treatment was 24.6, with a pre-op maximum flow rate of 7.6. By three months the average IPSS had fallen to an average of 8.6 and the uroflow rate had risen to 12.3.

In summary, we believe that the TUNA is an office based surgical procedure for BPH. This can be comfortably performed in the office, and the symptomatic improvement is comparable to other surgical treatments for BPH.

Determinants of Hypogonadism in Aging Males during the Andropause

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Objective: The Andropause is a transition period for older males in which certain hormones such as testosterone gradually decline. We wanted to determine if there were risk factors for hypogonadism, which is in part responsible for the Andropause.

Design & Method: We performed a cross sectional survey of 71 consecutive males attending a geriatric clinic. The diagnoses of these patients were recorded, along with variables including age, weight, smoking, drinking, BMI, functionality scales (ADL, IADL, Nutrition), and cognitive assessment scales (MMSE, CDT). Each patient had their total and free testosterone, PSA FSH, LH and albumin levels determined. Data was entered into Excel, and descriptive and comparative analyses performed using SPSS.

Results: The average age of the patients was 73 years. The mean total testosterone was 405ng/d (range: 32-877ng/dl). 33% of this group of patients was diabetic, 76% had hypertension and 18% had hyperlipidemia. The average BMI was 26.7. Patients with diabetes were significantly more likely to be hypogonadic (<300ng/dl), p= 0.006.
However, we did not find any significant association of hyperlipidemia or hypertension with hypogonadism (p= 0.558, 0.729 respectively). On the other hand, BMI>27 was significantly related to hypogonadism (p= 0.006).

Conclusion: Diabetes and obesity predisposes to hypogonadism in our study group. Long-term vasculopathy from diabetes could impair production of testosterone from the gonads. Obese patients were more likely to be hypogonadic because of increased aromatization of testosterone to estradiol in peripheral fat tissue. This study suggests that diabetes and weight control may be preventive strategies to delay the Andropause.

Men's Health III

Best Practices in Working With Men: An Evidence-Based Psychosocial and Behavioral Model

Courtenay W. McLean Hospital, Harvard Medical School, USA

Gender-based medicine and health care is receiving increasing attention among health professionals. Besides differing in their reproductive health needs, women and men have different risks for specific diseases and disabilities. They also differ in their perceptions of health. Research consistently indicates, for example, that men are less likely than women to perceive themselves as being at risk for most health problems, including problems they are more likely than women to experience. Furthermore, research suggests that the failure to tailor interventions to patients' gender-specific needs is associated with fewer positive outcomes.

Behavioral and psychosocial factors are critical considerations when working with men, because men's greatest health risks are largely preventable. A growing body of research provides evidence that men's behaviors and health-related beliefs - including beliefs about manhood - significantly increase men's risks.

Because men utilize relatively few health services, any encounter a clinician does have with a man may be the only opportunity for assessment and intervention that any health professional might have with him for a long time. However, few interventions have been outlined for working with men to effectively reduce their risks.

This presentation will identify psychosocial and behavioral factors affecting the onset, progression, and management of men's injuries and diseases. It will outline the 6-Point HEALTH Plan for addressing men's health, which is based on the only evidence-based clinical practice guideline for working with men. The 6-Point Plan integrates behavioral and psychosocial research with recognized medical guidelines, and identifies best practices for working with men.

Detecting depression in men: A matter of guesswork

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Objective of the study: To investigate men's experience of depression, coping styles and help-seeking behaviour.

Design and Method: A non-clinical sample of male teachers and students were recruited from a tertiary education institution, to a series of focus groups. Qualitative data were analysed using a grounded theory approach. Quantitative methods were used to gather sociodemographic and behavioural data, and two standard measures of mood and dispositional optimism. Women were recruited from the same context, as a comparative group.

Results: The findings suggest that men have a tendency to suppress their problems and emotions, which is translated into delayed help-seeking. When men eventually do (or are forced to) seek help for physical symptoms, any depressive symptoms can be overlooked because of men's reticence to disclose, coupled with their view that doctors should be 'smart enough' to read the signs.

Conclusion: The doctor-male patient relationship appears to be a subtle, yet complex, dynamic process. The challenge for doctors is to employ new methods of non-threatening questioning within a safe environment in order to facilitate self-disclosure in men.

Men, Body Image and Eating Disorders

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Health professionals have few resources to help them work with men who suffer from eating disorders (i.e., anorexia nervosa or bulimia nervosa) apart from the literature that focuses on females who suffer with eating disorders. This paper presents an analysis of in-depth interviews with eight men with eating disorders. These men provided rich descriptive information to document their plight with body image concerns and eating disorders.

Further, it draws on their experiences of suffering with a disorder linked primarily to women. The paper emphasizes some critical issues confronting men and boys in relation to body image concerns and eating disorders while providing links with the social construction of masculinity.

Gender specific differences in dietary habits and changes in plasma micronutrient status following dietary supplementation

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Background: Epidemiological studies have shown the importance of a diet rich in fruit and vegetables in the prevention of illnesses, such as, heart disease, cancer, metabolic disorders etc. Low plasma levels of micronutrients with antioxidant properties, often found in fruit and vegetables, are associated with increased risk for these diseases.

Objective: The aim of the study was to assess the common dietary habits of a group of healthy men and women. Further assessment focussed on the effect of supplementation with a natural phytonutrient and antioxidant preparation*, derived from a mixture of fruits and vegetables, on plasma levels of various antioxidant micronutrients.

Study Design: The trial followed a double blind cross over design. A group of 59 healthy adults (26 men and 33 women, age 40–60 yrs) were selected, following a clinical examination to evaluate health status and inclusion criteria for the study. All participants were asked to continue with their usual diets and fill in a food frequency questionnaire at the start of the study, at week 7 and week 14. The subjects were split, randomly, into two groups. Phytonutrient supplement preparations were obtained by creating juice concentrates from a mixture of fresh fruits and vegetables followed by low temperature drying. Supplements and placebos were given for a total trial period of 14 weeks with crossover at week 7. Blood samples were taken from all subjects at the start, at week 7 and week 14 and plasma levels of the micronutrients b-carotene, vitamin C, vitamin E, selenium, and folic acid were measured. Finally participants were also

asked to complete a mood adjective checklist (EWL-K) at the start, week 7 and week 14 of the study.

Results: Dietary analysis showed that, in general, men consumed significantly less fresh fruit and vegetables than women ($p<0.01$). Only 50% of the men consumed fruit at least once per day compared with 83.9% women. Overall, men consumed more meat/meat products ($p<0.05$) and more potatoes than women. Consumption of cereals and grains, or their products, appeared to be low with only 7.4% of men and 11.3% of women consuming these on a daily basis. The majority of both men and women had fish no more than once a week. Plasma levels of all nutrients studied rose significantly during supplementation. Mood characteristics showed a tendency, though not significant, towards increased activity, improved mood, and reduction in disactivity and tiredness in men. Interestingly this tendency was not as clearly defined in the women.

Conclusions: Our data suggests that participants, although generally health conscious, still fell short of the recommended five portions of fruit and vegetables per day. Differences in diet between men and women appeared to be reflected in baseline plasma nutrient levels for example for, b-carotene (lower in men), selenium and vitamin E (lower in women). Supplementation, in general, proved to be effective in raising plasma levels of all the nutrients studied. Ranges measured fell into those associated with a reduced risk for disease for vitamin C and selenium. Data for the men showed a greater dietary shortfall in fruit and vegetables and positive trend in response to supplementation in terms of both nutrient plasma levels and general well being. A well designed supplement derived from natural fresh fruit and vegetable juices may be beneficial in the prevention of disease through increased bioavailability and synergistic effects of the nutrient combination. Ultimately there may be a role for supplementation with a natural phytonutrient antioxidant formula in disease prevention, though not as a replacement for a healthy diet containing plenty of fresh fruit and vegetables.

*Juice Plus+, NSA AG, CH-4015 Basel

Body Mass Index, Physical Activity, Steroid hormones and Erectile Dysfunction

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Objectives: To evaluate the influence of Body Mass Index, physical activity and lifestyle factors on erectile dysfunction.

Design and Methods: 674 healthy blue collar workers aged 45 to 60 years were entered in this study. We evaluated the role of BMI, physical activity, smoking, coffee and alcohol intake as predictors of serum testosterone, bioavailable testosterone, estradiol prolactin, LH and SHBG. All Subjects completed the International Index of Erectile Dysfunction (IIEF-5). Blood Samples were taken between 8.00 and 11.00 am.

Results: The strongest correlations were found found for BMI with each of the IIEF-5 questions as well as with the total score, physical activity, testosterone and SHBG. Alcohol consumption correlated with prolactin and estradiol.

Conclusions: We conclude that BMI was the most important factor, followed by physical activity and dietary factors for erectile dysfunction and explaining steroid hormone variability.

The state of Men's Health in England and Wales – An analysis based upon the Men's Health Forum Database of projects and initiatives

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The Men's Health Forum database of projects and initiatives on men's health in England and Wales originated with a Department of Health grant in the Summer of 2001. Over a three-month period over eighty projects were identified and included on the database. There are now over 100 wide ranging projects offering a unique insight into men's health activity within the United Kingdom.

The main impact of the database, which is now upda-

ted on a monthly basis, is in its use by policy makers, local health authorities, and practitioners to help guide service provision. In addition, through discussions with the practitioners, the database also serves as a medium for networking with others in the field of men's health as many feel isolated in their work.

Methodology – the database was created through a telephone survey based upon snowball sampling. The internal validity of the entry was achieved by sending the completed entry back to the project leader for verification of accuracy. Reliability was addressed through the design of the questionnaire and consistency of data collection methods. Analysis of the database is based on content analysis.

This paper will discuss the findings of the analysis and outline the long-term implications for the database will also be discussed in terms of its ability to map trends in men's health activity.

Men's Health IV

Building Spirit, Building Health: Implications of innovations in Australian indigenous health for all men's health

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In Australia, indigenous males die 16-18 years ahead of non-indigenous males and 10 years ahead of indigenous females. Indigenous male rates of hospitalisation are higher than those for indigenous females. Overall, reported health outcomes are worse than their Canadian or New Zealand counterparts.

Policy and practice in indigenous men's health occurs at the intersection of two population sets, men and indigenous Australians. Recent research describes failure in engaging men, per se, with existing health systems to the same degree as women, as well as in meeting the specific needs of indigenous men.

The failures within Australian indigenous male health have brought about alternative models that hold promise of better health outcomes for all men and boys. The models reject the Deficit Model of male health, one arising from a blaming, inappropriately shaming discourse prevalent in western research and funded programmes around men's health. These alternative approaches insist on cultural and contextual appropriateness - in the indigenous case, the legacy of colonization, dispossession, trans-generational trauma, loss of role, poverty and systemic racism - yet innovatively seek out what is positive, the cultural strengths, as the starting point. They take a salutogenic, as opposed to a pathogenic, view of boys and men.

This paper raises the possibility of western health systems learning from holistic indigenous systems. In particular, it argues for a central role, in health, for spirit. Reports from the recent 2nd National (Australian) Indigenous Male Health Convention, September, 2001, will be drawn on to illustrate building health through building spirit.

A salutogenic population health approach: a framework for a global strategy for men's health and well-being

Macdonald JJ, Brown AJ. Men's Health Information and Resource Centre University of Western Sydney, Australia

Current approaches to men's health have concentrated mainly on both physical and social pathologies and the pathogenic (environments which foster pathologies). Broader causal factors of ill-health are often overlooked. A lack of understanding of these social, political, psychological and cultural factors (often referred to as the "social determinants of health") leads not only to an increase in male heath problems; it also makes effective health promotion and treatment of existing health problems difficult.

This paper will review the current approaches taken in the area of men's health; based on this analysis suggestions will be made which advance the health and wellbeing of men.

The way in which health services and health providers engage men is also a key factor in promoting health and wellbeing. Men are less likely to access health services than women. In developed countries this is due in part to the lack of health services engaging men in a respectful dialogue.

The environments which men in which men find themselves are also important in determining health

and wellbeing. Salutogenic environments nourish the physical, social and spiritual wellbeing of people , in this case men. In addition healthy environments are those which promote positive attitudes to men; such attitudes are as important to male health and well-being as a nutritious diet and absence of carcinogens.

Our conclusion from this analysis is the need to rethink our current attitudes to men's health. This involves a move away from existing models to a population health approach that responds to the needs of specific sup-populations of men.

A Call for Change: Rethinking HIV Prevention Education Approaches in the Gay Community

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It has now been twenty years since HIV prevention education targeted gay and bisexual men. Over the last 20 years, gay and bisexual men have undertaken dramatic behavior changes that have led to a marked decrease in the occurrence of unprotected anal intercourse.

However this is not the case today. Despite these achievements, some gay men are still engaging in unportected anal sex. Surveys have confirmed that men have reported engaging in unprotected anal sex over the last three months. The need for prevention messages has to change and that is what this paper will lay out.

The role of male peer promoters in family planning and in the prevention and control of STI/RTI/HIV in rural Bangladesh

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Introduction: Bangladesh is one of the countries where attempts are being made to explore ways to increase male involvement in reproductive health. To that end, a study was conducted in rural Bangladesh to assess the extent to which male voluntary peer promoters had involved fellow men in reproductive health, particularly family planning and prevention and control of STI/HIV and AIDS.

Methodology: The study established male clinics to provide clinical and counselling services to men in need of diagnostic and treatment services for STIs. A total of 260 local male volunteers were identified and sensitized to basic knowledge about reproductive health physiology, family planning methods and STI/HIV/AIDS which they would use to target their peers in the community about the services of the clinics. After one year the peer promoters were interviewed using a structured questionnaire.

Results: In total, 251 volunteers responded of whom 93% reported having made contacts with at least one peer and 89% with individuals requiring services of the male clinics. Although 26.5% reported having experienced health problems requiring the services of the clinic, 67% of these reported having actually used them. Ninety three percent reported to have talked to their peers about vasectomy, STI/HIV/AIDS and condom use. The routine clinic data indicated that female community health workers (CHWs) on payroll and the volunteers had referred 33% and 25% of the attendances to the male clinics respectively. Moreover, 38% of attendances reported symptoms suggestive of reproductive health problems of which 26% were suggestive of STIs.

Conclusions: Although the volunteers' specific role was peer promotion, their yield in clinic attendance was lower than that of CHWs whose main responsibility was different. Hence, voluntary male peer promoters are a great potential for involving men in STI/HIV prevention and control as well as in family planning activities in places without CHWs.

Men's Health Matters: Gender in Crisis

Alt RL, Dean Medical Center & University of Wisconsin,USA

In the US, Men die on average 6 years younger than women. This death gap is of crisis proportions and is the most serious US health problem today. Male deaths outnumber females in 14 of the top 15 causes of death. These top 15 causes of death are in the domain of primary care. Yet, unlike women, men are not cla-

moring for more health care. In fact, "traditional masculinity" leads men to disregard their health as an actual expression of virility. Nor is medicine reaching out to men to improve their lot. Most US physicians are men and likely suffer from the same sexual stereotypes as society at large. The task of responding to the crisis in men's health is enormous and involves nothing less than redefining masculinity. Individual health care professionals, health care institutions, and the government will have to collaborate to stop the needless wastage of male life.

Square pegs on round holes: The relationship of sense of belonging to men's health

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Preliminary research has suggested that sense of belonging may be an important mental health concept. The present research aimed to assess men's mental and physical health as a function of sense of belonging. One hundred and sixteen Australian men (aged from 18 to 82 years) completed a number of inventories, including sense of belonging, health, depression, stress, and suicidality inventories.

Results showed a significant relationship between sense of belonging and health. Participants who felt a stronger sense of belonging reported significantly fewer somatic concerns, better social functioning, less stress, less suicidality, more reasons to live, and lower levels of anxiety, insomnia, and depression. The results confirm the importance of sense of belonging to both mental and physical health.

Working with Filipino Men Towards the Prevention of Domestic Violence: Lessons and Insights

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The two-year project, funded by the Ford Foundation/Manila, was the first in the Philippines to evolve a male model largely independent of women-centered violence prevention endeavours. It involved two phases: research and intervention. The research component examined men's relationships, knowledge, values and beliefs hastening or hindering their violent behavior towards their partners. The intervention aimed at modifying men's violent behavior by addressing their cognitions and attitudes, and by developing in them personal and interpersonal communication skills; emotional empathy; and awareness and effective management of anger.

Cohorts of men, meeting a set of criteria and from rural and urban centres, were recruited and enlisted. With these men, research activities - involving face-to-face interviews and focus group discussions - were undertaken. With the same groups of men, the intervention - in the form of workshops, and interpersonal counseling - was then conducted. The effects of the intervention were documented through pre and post-tests.

The broad findings, from research, indicate that certain facets of the project participants' knowledge, values and attitudes tended to contribute to their propensity to be violent; but other facets conducive towards violent behavior modification were also documented. Moreover, men were in marital and familial relationships highly favourable to conflicts and violence.

The general intervention results reveal that workshops and counseling were indeed effective in creating the desired outcomes. However, there were variations in effects across groups.

The study also generated lessons and insights regarding the processes of involving men, and how these processes helped shape the quality of men's participation. The study concludes that Filipino men can be effective participants and partners in domestic violence prevention in the country.

POSTERS

POSTERS

(titles in alphabetical order)

Body Weight: The Male and Female Perception

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Aim and Methods: The aim of the present study was to examine gender-specific differences in relationship between actual body weight, characterization of one's weight, and satisfaction with it. 246 students of medicine in the third (clinical) stage of their studies at the University of Vienna responded to a questionnaire asking about their weight and attitudes regarding their personal body weight.

Results: The results indicate that many young women and men are either unable to characterize their weight (as normal, underweight, overweight, or obese) or guess incorrectly. The results point to the fact that a lot of women and men do not estimate their body weight in correspondence to the valid definition of the BMI. Women in particular seem to model themselves more on the current beauty ideal than men. Women seem to be more influenced by the current ideal of slenderness than their male counterparts. Women are more frequently dissatisfied with their weight, and see themselves as considerably heavier than they actually are. Because of this perception, women attempt to reduce weight more often than men.

Discussion: This type of dissatisfaction with one's body weight and excessive attention paid to body image, particularly weight, are considered risk factors for the development of eating disorders. Not surprisingly, women are significantly more prone to these conditions than are men.

Developing more accessible and appropriate health services for men

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Following an Open Space event, held in Glasgow, to mark Men & Health Week 2000, men's access to Primary Care was identified as a key priority in improving the health of Glasgow's men. Greater Glasgow Health Board's Men's Health Team then organised a seminar on the issue, which raised a range of barriers and recommendations from service users and agencies alike. These issues and recommendations have been developed into a research project, commissioned by the team (present - September 2001) which aims to gain men's views (focus groups) on practical improvements to current service delivery, which will then be utilised to illicit practitioners views (individual interviews) on the mechanisms needed to support the development of more accessible and appropriate health services.

Disconnected and depleted: Men's experience of depression

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Objective of the study: To investigate men's experience of depression, coping styles and help-seeking behaviour.
Design and Method: A non-clinical sample of male teachers and students was recruited from a tertiary education institution, to a series of focus groups. Qualitative data were analysed using a grounded theory approach. Quantitative methods were used to gather sociodemographic and behavioural data, and two standard measures of mood and dispositional optimism. The same technique was used to compare the experience of women.

Results: Men report the commonly accepted symptoms of depression. However, a 'big build' or escalation of affect, triggered by external negative events is also common to men's experience. Gender differences are more apparent in coping styles where women actively seek connection with others to 'talk it out', while men tend to disconnect from others to 'work it out alone'. Both coping styles offer 'repleting' and 'depleting' effects.

Conclusion: Men can be 'disconnected but repleted', and 'depleted but connected', but men who are depressed are more likely to be 'disconnected and depleted'.

Gay Men and Domestic Violence

Youngman GA. AIDS Education Services, Massena, NY, USA

Gay men's domestic violence is not a new problem, just a newly recognized problem.It has existed ever since gay men began coupling and living together. What is new is that abused gay men all over are starting to come forward seeking help, as victims of domestic violence. Their lovers are violent me, and the victims are being battered. As battered men emerge from their "inner closets", they face a gay community and a society at large that is unprepared and ill-equipped to help them. It is estimated that as many as 500,000 gay men are victims, and, of course, equal numbers are perpetrators. Thus, only substance abuse and AIDS adverseely affect more gay men, making domestic violence the third largest health problem facing gay men today. The problem is too brutally realistic to ignore any longer.

How health conscious are Austrian men?

Rieder A[1] Meryn S[2], Bayer P[1], Panuschka C[1], Kiefer I[1], Lawrence C[1], Groman E[3], Kunze U[1], Exel W[4], Kunze M[1]. [1]Institute of Social Medicine, University of Vienna. [2]Center for Advanced Education and Health Communication, University of Vienna. [3]Nicotine Institute, Institute of Social Medicine, University of Vienna. [4]Health editorial office, Neue Kronen Zeitung, Austria

Background: In recent years there has been a particular focus on the promotion of good health with regards lifestyle, working environment and of course diet. Although life expectancy is increasing, mortality due to serious illnesses, such as cancer and heart disease, is still a cause for concern. Analysis of statistics regarding life span has identified men to be at higher risk than women.

Objective: The objective of the study was to obtain a picture of the overall health status of Austrians with special focus on Austrian men. The aim was, in particular, to assess the resolve amongst men to achieve optimum health, evaluate the interest men have in health issues, and to identify whether male climacteric symptoms exist.

Study Design: The study was carried out using a questionnaire survey, the questionnaire was distributed with an Austrian daily newspaper *. Survey participants came from all federal states of Austria. Results were compiled from a total of 982 questionnaires, representative for around 60.000 filled in questionnaires being sent back of which 32.2% were men and 67.8% were women. The average age of the men was 50.44yrs and of the women was 48.4yrs.

Results: Our data showed that resolve to improve state of health was greater amongst men (80.3%) than women (75.1%), with more men having already acted on their intentions (70.2% men vs. 66.2% women). Most people surveyed exercised more (67.9%) and ate a healthier diet (53.5%) than before, however, men tended to do more exercise than women, whereas women tended to have a healthier diet than the men. Nearly all those surveyed felt that acting on your own initiative was of prime importance when dealing with health issues. The majority of men (76.9%) knew of the availability of medical checks to identify early symptoms of prostate cancer and 61% had already had this type of examination. 71.8% of men felt that men also experience symptoms of male menopause. Almost half the men (49.8%) felt they were sufficiently informed on health matters. Subjects about which men felt they would like to know more included: impotence (34.5%), prevention of heart disease (43.8%), male menopause (32.6%) and healthy lifestyle (40.3%). Men said they would prefer to seek advise on health issues from doctors and 56.6% of men felt they would like to consult with a doctor specialising in men's health.

Conclusions: The results of the survey, in particular for men, were very encouraging. A wide majority expressed a definite resolve to optimise their health, however, about 20% still expressed little or no intention regarding health matters indicating that there is still potential for raising awareness. It must be noted that far fewer men than women took part in the survey possibly reflecting less interest in health matters amongst men from the outset. Interest in health issues amongst the men surveyed was, however, great. This was reflected, for example, by the numbers already having medical checks for prostate cancer. Only about 50% of men felt they were well informed on health issues. This shows the potential need to present information through sources and in formats more likely to appeal to men. The relatively large proportion of men who still felt they would like more lifestyle related information substantiated this fact. The survey showed that men were less likely than women to talk to friends or relatives about health issues and expressed

a preference for more formal sources, such as, doctors. Finally the survey showed that the male climacterium is an important and current issue and thus efforts should be made to continue research and improve the distribution of information concerning this subject.
* "Neue Kronen Zeitung"

Initiative "Men Against Violence"

Meryn S[1], Kindel G[2], Hesch R.-D[3]., [1]University of Vienna, [2]Initiative Männergesundheit, [3]University of Constance, Germany

Men's increasing aggression and auto-aggression remain as an unsolved health and societal problem. As you read this, over 30 wars and conflicts rage out around the world, mostly created, maintained and aggravated by men.

We are deeply shocked over the horrendous terror attacks on the United States and the tremendous loss of life. These cowardly acts of Violence have sadly changed our world forever. The WCMH 2001 and the Men's World Day 2001 will be a global call for peace and tolerance, allowing all those participating to personally take a firm stance against all forms of violence. War and violence are still the domains of men therefore it is essential to change the attitudes of men.

On November 3rd, on Men's World Day in Vienna, an international initiative "Men against Violence" will be established which will be under the auspices of Men's World Day and the International Society for Men' s Health (ISMH). It intends to provide an international platform for people – regardless of race, creed, color, origin or religion – to work togther in order to propagate freedom and demonstrate resolve against violence and terror in every form.

We hope to motivate many people to join us in this global initiative.

Male Lung Cancer Patients Die Earlier: An Analysis over a 20-Year Observation Period

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Aim and Methods: Approximately 3200 lung cancer patients die each year in Austria, and Austrian males have a four times higher risk dying of lung cancer than females. A statistical analysis (ANOVA) was used to identify significant differences in the mean age at death of lung cancer patients. The annual mean ages at death were divided into three groups: the first group consisted of the annual mean ages at death between 1976 and 1982, the second group between 1983 and 1989, and the third between 1990 and 1996. Males and females were analyzed separately.

Results: While the annual mean age at death of female lung cancer patients did not change significantly ($p = 0.976$) over the 20-year observation period (1976 – 1996), we found that the annual mean age at death of male lung cancer patients decreased significantly over this period ($p < 0.001$). Male lung cancer patients in the 1990s die approximately one year earlier than in the 1970s.

Discussion: Early onset of tobacco smoking could be one explanation, as adolescent smokers in the 1950s and 1960s may have had different smoking patterns than earlier generations of smokers. One can assume that young male smokers in the 1950s and 1960s (the time of emancipation of young people) had a higher nicotine dependence and a higher daily consumption of cigarettes than adolescent male smokers of the 1930s and 1940s, and that many have continued to smoke at a high level. Consequently, they have developed lung cancer at a relatively young age in the 1980s and 1990s, even though general life expectancy is increasing and the mortality and incidence rates of male lung cancer are decreasing.

Prostatic state – as criteria of reproductive health in children

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Objective of the study: Most of the researchers consider that the prostatitis is distinctive for adult men. However, in scientific literature the term "juvenile prostatitis" is sometimes found. This study is devoted to the settlement this problem.

Design and method: 66 patients with age from 12 to 16 years (average 13 ± 1.3 years) with subclinical varico-

cele were examined. 34 healthy adolescents were included into the control group (age from 12 to 15 years, average 13 ± 1.7 years). The examine included individual conversation with every patient, complex research of reproductive system's organs with ultrasonic scanning and microscopic study of flora from urethra by method PCR.

Results and conclusions: The obtained data convincingly testify, that the chronic prostatic infection has a beginning in the age of 14 years. From 67%, whom demonstrated the magnification of a prostatic gland, has recognized careless sexual contact. In difference from the adult patients, acute manifestations prostatitis in a history of the patients was revealed not. However, practically at all patients the manifestations not specific subfebrility took place.

Most frequently in secret analysis were determined ureaplasma urealytyca and chlamidia. With equal probability took place a usual infection (streptococcus, staphylococcus) and association.
Our judgment is unequivocal - rather frequently chronic pathology of a prostatic gland has the radicals in childhood and youth.

Reaching men in rural Bangladesh for vasectomy operation

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Introduction: Family planning is a well-established reproductive health service in Bangladesh which is currently encouraging men to undertake male FP methods such as condom use and vasectomy operation in order to further reduce the country's fertility towards replacement levels. Therefore, a study was conducted to determine the reasons leading vasectomized men to accept the procedure.

Methodology: Within one year of establishing male clinics in a rural area of Bangladesh, a total of 81 non-scalpel vasectomy operations was performed by a trained physician. The vasectomized clients and their wives were then interviewed using a structured questionnaire. Out of 81 couples where the husbands had undergone vasectomy 70 were interviewed.

Results: All except one of the men reported having discussed with their wives before accepting vasectomy. Fifty-six percent of the clients reported that community health workers (CHWs) had persuaded them to undertake vasectomy while 17%, 9% and 7% were persuaded by medical assistants, other vasectomized clients and their wives respectively.

While 71% of the wives were positive about their husband's intention to undergo vasectomy, 8.5% were negative. The main reasons for accepting vasectomy were to stop having more children, to avoid the side-effects of other contraceptives and to have a health family.

Although, the study found a number of misconceptions about vasectomy operations, no significant stigma seemed to be attached with it.

Conclusions: CHWs were found to be important in reaching men for the uptake of vasectomy. Although pre- and post-counselling services are necessary for sustainable vasectomy operations, it is essential to study the root of misconceptions about vasectomy and ways to address them.

Seasonal Variation in Birth Rates

Shaikhani M. Sulaimanyah College of Medicine, South Kurdistan, North Iraq

Objectives: To study the effect of season on contraception rates.

Design: Prospective.

Results and Conclusions: We concluded that the conception rates are highest at spring and autumn when the weather is temporate, probably through an effect on the sperm activity and coupling rates.

High and ultra high male mortality rate in Russia
Akopyan AS, Kharchenko VI, Koryakin MV, Mikhailova P Yu. National Centre for Human Reproduction, Moscow, Russia

The official data review made by the State Committee of the Russian Federation of Statistics (Goscomstat of Russia) showed that in Russia the percent of men who do not live up to 60 pro rata the total number of men deceased (M-60) was 33% in 1958, 33,9% in 1969, 33,8% annual average for 1958-1990, and 43,1% annual average for 1991-1998. The highest rate of M-60 in Russia was reached in 1994 (49,9%), 48,3% in

1993, 47,9% in 1995, 44,2% in 1996, and 42,0% in 1997. In 1998 the death rate coefficient grew over the level of 1990 in the 20-24 age group making +57,7% (still higher than in 1994 (+53,8%). For 25-29 to 40-44 age groups the 1990 level was outstripped by (+30% to +40%), in 45-49 and 55-59 age groups – 15% to 20%, and the death rate coefficient for 75-79 and up was lower than that of 1990, particularly for the age group 85 and up (-14,0%). Since the summer 1998 economic crisis, in 1999-2000 the growth of death rate coefficient also has been registered basically among men.

We call the exceeding factor of death in Russia as compared to the death rates of developed countries in 1958-1990 “the period of high mortality”, and the exceeding death factor in 1993-1997 as compared to the developed countries’ rate “the period of ultra high mortality” among Russian men.

Spontaneous Pneumothorax - our experiences in the treatment

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The appearance of a foreign content in the pleural cavity causes respiration disturbances. Finding of air in the pleural cavity, together with exclusion of trauma as an etiologic cause, is called spontaneous pneumothorax. Over the period from 1994 to 2000, we have treated 60 patients with spontaneous pneumothorax average aged 44±17 years. There were 77% of male and 23% of female patients, with the highest frequency of spontaneous pneumothorax between 20 and 40 years of life. Spontaneous pneumothorax was more frequent on the right side (58%); there were no bilateral findings.

X-ray examinations revealed presence of complete spontaneous pneumothorax in 55% of all patients, partial in 32%, and 13% of the patients had hydropneumothorax. Recurrence of the disease was observed in 8% of the patients, usually with two, rarely three episodes. Idiopathic spontaneous pneumothorax was the most common (73%), while the others suffered from the diseases secondary to other pulmonary conditions (tuberculosis, chronic obstructive pulmonary disease, and broncho-pneumonia). Forty-two patients were treated by thoracal drainage (70%), and 18 patients conservatively (antibiotics + bed rest). Thirteen patients were transferred to the Department of Pulmology because of further treatment of the basic diseases, and eight patients were referred to subsequent subspecialistic treatment because of unsatisfactory reexpansion.

We had no lethal outcomes among the treated patients.

Notes

Notes

The International Society for Men's Health

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"Knowing is not enough; we must try.
Will is not enough; we must do."
Johann Wolfgang von Goethe

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