THE MALE

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HEALTHY MALE

ANDROLOGY AUSTRALIA

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Welcome

Welcome to issue #4 of *The Male*. In this edition, we're talking about all things sex—from contraception to porn addiction to the effects of heart disease.

It concerns me that sex, and therefore sexual health, as a topic, is still taboo. People need to feel comfortable discussing all parts of their body, so if something's not right, they can talk to a friend or doctor. Sexual and reproductive health issues should be treated like any other health condition, because avoiding uncomfortable conversations won't make the problem go away.

Many parents find it difficult to talk about sexual and reproductive health with their kids, but having open conversations delivers long-term benefits. By making words such as penis or testes 'normal', they just become other parts of the body that need attention and care.

It's also good to start conversations at the GP while kids are young. Children are taught about their bodies at school (and it's come a long way from what you were taught), and medical professionals have seen it all before. Sometimes it's only the parents who find it awkward!

Popular culture doesn't help. Kids can watch people getting shot, stabbed and worse on TV, at the cinema and on computer games, but they don't see naked bodies on screen, especially naked male bodies. There's a real imbalance around what's 'okay' for children to view.

I see changes in the way we talk about sexual health, but it's not enough. Mental health is an excellent example of dragging a difficult topic into the spotlight. No one was talking about depression or anxiety in the past, but thanks to better awareness, Australians are overcoming the stigma.

Crucially, we need to stop hiding behind language. We need to discuss sexual and reproductive health issues in ways that people understand. 'Erectile dysfunction' is just about getting or maintaining an erection.

Language also plays a key role when working with gender diverse people. Currently, we're working on a clinical summary guide to help GPs and clinic staff support transgender patients. It's important to have a GP who is the right fit, and that's why we've included an article about finding a doctor you can talk to comfortably.

In this issue, we're also talking about male contraceptives. The science is there, but what are the ramifications? What does it mean for STIs?

There's lots to talk about, so have a read, chat with your partner, kids and friends and get the conversations going. It's good for everyone.

Simon von Saldern
Healthy Male CEO

What impacts your sexual health?

1

Heart health

Struggling to get or maintain an erection may be an early warning sign of cardiovascular disease, often preceding a heart attack or stroke by three to five years.

2

Drugs

Recreational drugs aren't the aphrodisiac many consider them to be, with their use linked to low libido, erectile dysfunction and difficulties reaching orgasm. Your fertility can also take a hit.

3

Stress

Whether it's personal, professional or performance-related, stress can reduce arousal and lead to low libido, erectile dysfunction and difficulties reaching orgasm.

4

Alcohol

Alcohol might decrease inhibition in the short-term, but over time drinking can put a dampener on your sex drive and increase your risk of erectile dysfunction.

5

Mental Health

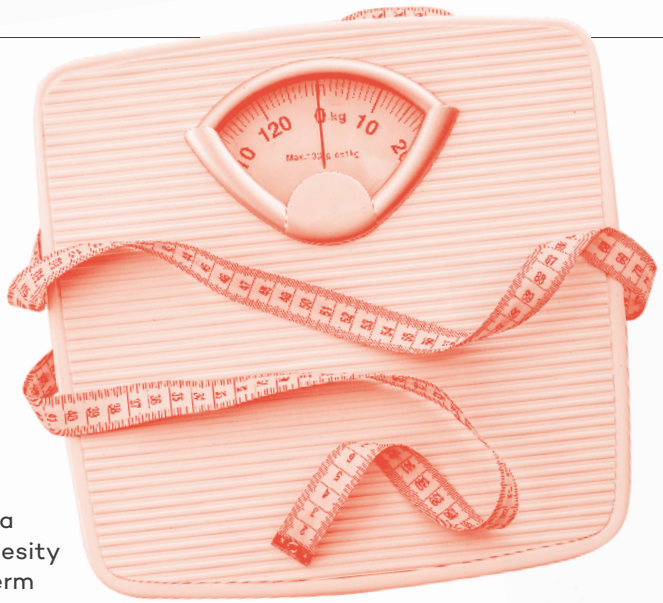
Psychological concerns such as anxiety, depression, and low self-esteem can be common causes of erectile dysfunction, particularly for young men.

6 Relationships

If you're not getting along with your partner as well as you used to, the stress might encourage unhealthy behaviours (like drinking too much or not eating well).

7 Sleep

Sleep quality impacts sexual and reproductive health. Sleep deprivation can affect sperm health as well as contribute to low libido and erectile dysfunction.

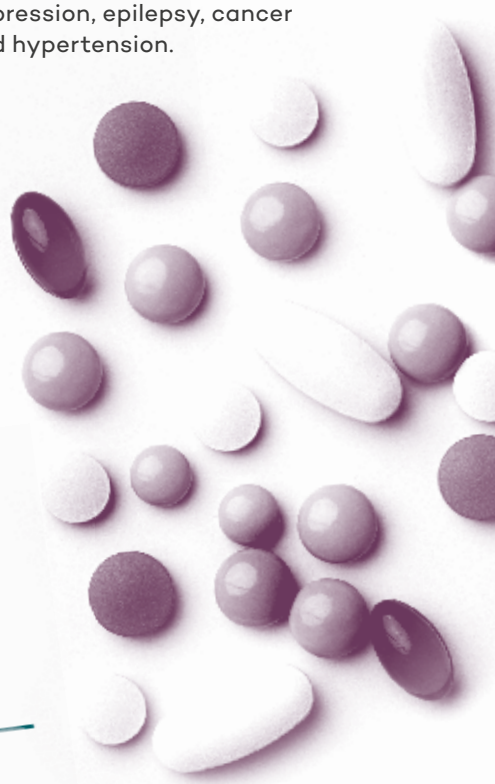


8 Obesity

Men who are overweight or obese are more likely to experience erectile dysfunction than men in a healthy weight range. Obesity is also linked to lower sperm counts and reduced sperm mobility, impacting fertility.

9 Medication

Sexual function (good or bad) can be a side effect of various medications, particularly those used to treat depression, epilepsy, cancer and hypertension.

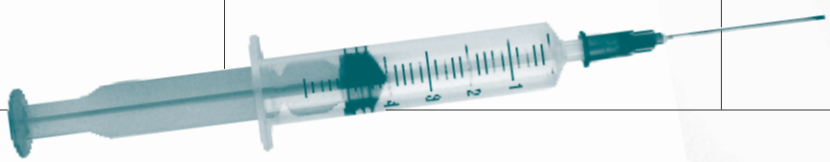


10 Diabetes

Men with diabetes often experience a range of complications that impact sexual function including erectile dysfunction, low testosterone, low sex drive, balanitis and retrograde ejaculation.

11 Steroid misuse

The illegal misuse of anabolic steroids (often in the pursuit of building muscle) switches off the body's production of testosterone, reducing sperm count and shrinking your testes.



Why COVID-19 shines a light on critical men's health issues

Australia's response to the COVID-19 pandemic undoubtedly saved hundreds, if not thousands, of lives. It showed that the coordinated efforts of government, industry, the public service, education providers and health services can respond rapidly and effectively to public health needs. COVID-19 is a reminder that different interventions are required by different groups in our society to achieve the best health outcomes for everyone.

COVID-19 also reminds us of the health disparities between Australian men and women. In Australia and around the world, COVID-19 disproportionately affects the elderly, people with chronic disease, and men. As of 19 January 2021[1], five Australians under 50 years of age have died of COVID-19 — all of them were male. Ten men and five women in their 50s, 23 men and 13 women in their 60s, and 105 men and 56 women in their 70s, have died from the infection. For every age group, the mortality rate is higher for men than women.

Male vs Female COVID-19 Mortality Rate

Age Bracket	Male	Female
20s	1	0
30s	2	0
40s	2	0
50s	10	5
60s	23	13
70s	105	56
80s	183	196
90s	115	189
100s	1	11

What's to blame?

Male susceptibility to COVID-19 is unlikely to be due to things as simple as the genetic or hormonal differences between men and women. Men's general state of health, arising from their behaviour, might be the cause. Men are more likely than women to have poor diets, to drink too much alcohol and smoke, to delay seeking help for health problems, and to behave in ways that puts their health at risk[2]. This all adds up to a situation where Australian men have four-and-a-half fewer years of healthy life than women[3].

The poor health of men doesn't just account for their risk of dying from COVID-19. Men's health and wellbeing is closely associated with sexual function[4] and fertility[5].

The physical factor

Your physical health can play a major role in having a healthy sex life and starting a family.

While the connections between our body's various organs and systems are not always as straightforward or direct as 'the foot bone's connected to the leg bone', the effects of one system on another can be strong.

In some cases, problems with sexual function can be due to the consequences of chronic disease — glucose in the urine of men with diabetes can encourage bacterial growth, leading to foreskin infections and phimosis, for example. In other cases, the underlying issue responsible for health problems may affect the reproductive system as well as other parts of the body — for example, the nerve damage that causes multiple sclerosis can affect the nerves to the penis and cause erectile dysfunction.

The relationship between obesity and fertility in men further demonstrates the complexity of connections that can link different diseases and health conditions[6]. In recent decades, as obesity rates have increased worldwide[7], sperm counts have fallen[8]. While this might just be coincidence, there's good reason to suspect that this global phenomenon is a consequence of men's biology. An analysis of data from other studies of individual men shows that, indeed, as body fat rises, fertility falls[9].

Fat cells (called *adipocytes*) convert testosterone to estradiol (a kind of estrogen hormone), lowering the levels of the hormone that is needed for male sexual function. Fat cells also produce a hormone called leptin, which can reduce testosterone production and sperm development. One of the effects of inflammation associated with obesity is damage to sperm, which might also account for the low sperm counts in obese men.

Mental health matters

This interplay of diseases is not just about physical ailments — it's your mental health too.

Take erectile dysfunction, for example. Getting and maintaining an erection is complicated. It requires arousal from the brain, stimulation of nerves supplying blood vessels, and proper function of these blood vessels, to change blood flow in the penis.

If you're depressed or anxious, getting aroused can be a challenge. If your nerves or blood vessels are affected by diabetes, or your blood vessels' ability to dilate is damaged, the mind might be willing but the body not able. Regardless of the cause of your erectile dysfunction, it has considerable effects on your quality of life and can lead to depression.

Depression might lead to poor diet, lack of exercise, obesity and diabetes.

Managing your health holistically

Although you might go to a specialist to help manage a specific health condition — a urologist for erectile dysfunction, an endocrinologist for diabetes, a cardiologist for heart disease, a psychologist for depression, a physiotherapist for sore joints or muscles — having a general practitioner who knows you well, who can help integrate all the information about your health and wellbeing, is really important.

Managing your health is easier when there's cooperation and coordination between everyone who cares for you, but there needs to be someone in charge. That someone should be you. And your team shouldn't just be your general practitioner and other medical specialists. It should be everyone who cares for you — your physio, acupuncturist, personal trainer, the people who prepare your food, friends and family.

Think of looking after yourself as requiring the same sort of cooperation needed between all the different parts of society required to deal successfully with COVID-19. If we have a clear goal and the help we need, we can do great things.

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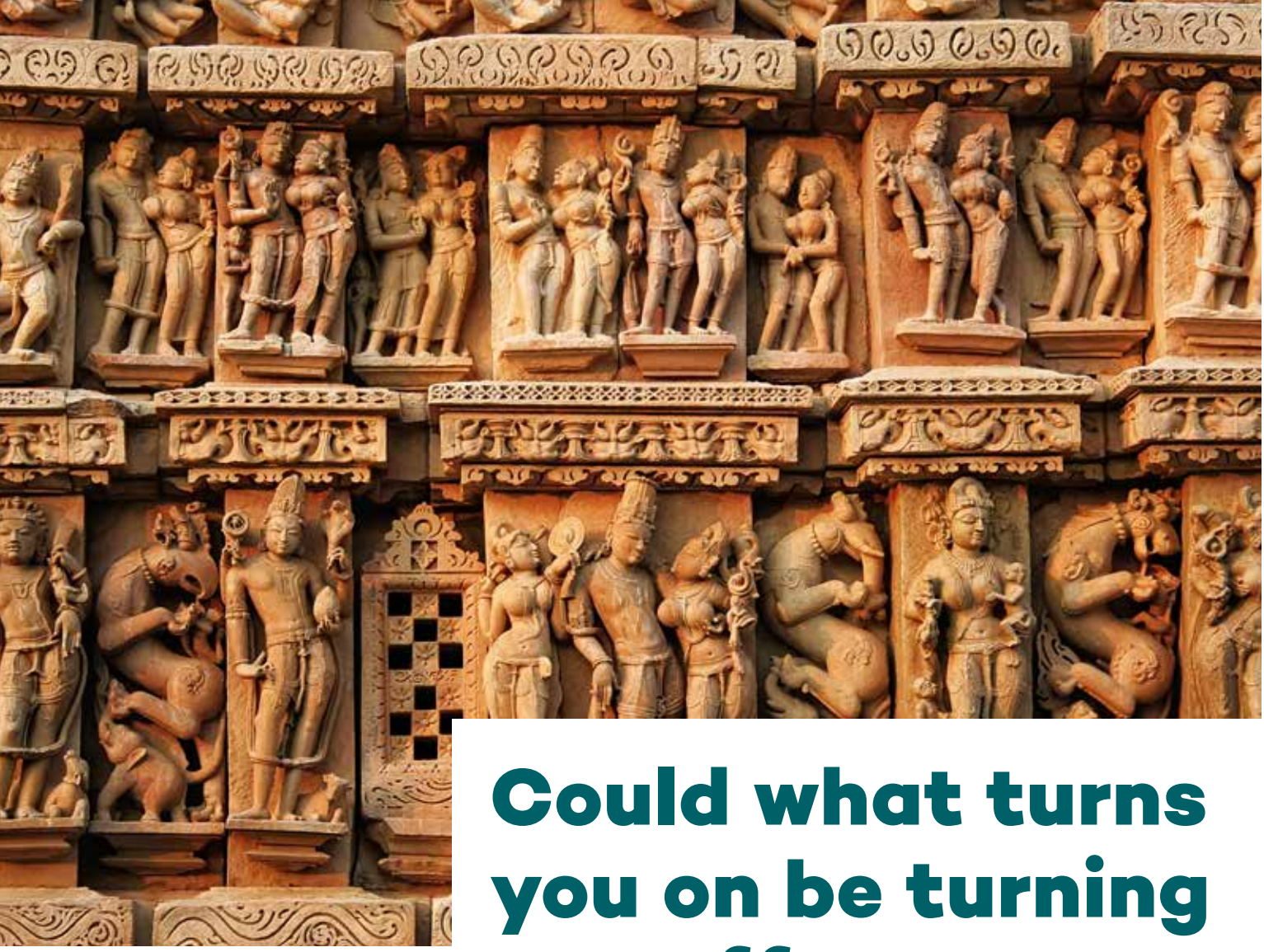

Could what turns you on be turning you off?

While pornography and erotica have been around for tens of thousands of years —originally in the form of pottery figures and cave paintings — its evolution is now having a significant impact on sexual health.

A quick refresher on how we got here — soon after the invention of the printing press, pornographers began publishing images and stories to satisfy an obvious demand. Eight-millimetre film in the 50s, video cassettes in the 80s and DVDs in the 90s allowed production by virtually anyone and distribution to growing audiences. When the internet arrived, pornography rapidly filled its servers and led the way in generating revenue from website traffic[1].

Pornography is now more accessible and affordable than ever before, with a prolific range of free options just a scroll away.

So, what's the problem with porn?

We should think of pornography like we do alcohol. Both have the potential to be harmful but for most people, occasional use isn't a cause for concern. However, just like with alcohol, pornography can be used as a coping mechanism or lead to addiction. Pornography use can also contribute to problems with sexual function, including erectile problems or delayed ejaculation.

When I'm working with men experiencing these concerns, I need to understand their relationship with pornography. I ask all new clients three questions:

1. Do you watch pornography?
2. How often do you watch pornography?
3. How long do you usually watch pornography for?

Identifying why men use pornography is not as straightforward. Is it because they are aroused or simply bored? Is it a form of escape from stress, anxiety or depression? Is it a way to explore aspects of their sexuality without any pressure or stigma? These answers can help determine the best course of action for dealing with the following, most common porn-related problems.

Performance anxiety

'I watch these vids on Pornhub and I know it's not real, but why can't I be like that?'

I hear this a lot, particularly from younger men who feel that they are inadequate compared to the actors in pornographic movies. This can lead to anxiety when they have real-life sexual experiences. Porn is highly scripted, edited, airbrushed and unrealistic, and shouldn't be the basis of sexual education or a point of comparison.

Edging

Edging is the deliberate drawing out of the time before orgasm to relish stimulation. Edging can result in delayed ejaculation, leading to frustration for both the client and their sexual partners.

Needing more

'I can't blow with my partner unless we have porn on.'

Often when men watch pornography, they don't just watch one video. They might jump from one movie to another, or not focus on the video that's on the screen because they're thinking about finding a 'better' one. This can translate into the bedroom, so they aren't stimulated enough by their sexual partner and need extra stimulation. This isn't about attraction or love, but the level of stimulation needed to become aroused and reach orgasm.

Masturbation mismatch

From hundreds of conversations with men about their masturbation style, I've learnt that there are many ways to masturbate. Some techniques can cause problems because they don't simulate a sexual act. Again, the conflict between the fantasy world of pornography and reality causes problems.

Death grip

This is the problem I see most often. If a man watches hours of porn and masturbates frequently, his penis can become less sensitive. Rather than go without, he may start to grip his penis harder to achieve sufficient stimulation. This has the contradictory effect of further reducing sensitivity, making it gradually, ever more difficult to reach orgasm.

How to get help

If porn is impacting your sexual health and wellbeing, there are a range of ways you can get help. Effective treatment for these problems includes using a combination of cognitive and behaviour-based therapies, such as cognitive-, dialectical- and activity-based therapies (CBT, DBT and ABT, respectively). Experiential activities, which may include the use of sex toys such as a masturbation sleeve, are also effective.

Authored by

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  Counsellor and Sex Therapist

MORE INFORMATION

For more information on erectile dysfunction, delayed ejaculation or low sex drive, visit healthymale.org.au

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Not-so-strange bed fellows:
Cardiovascular disease and erectile dysfunction

Cardiovascular disease — a range of conditions affecting the heart and blood vessels — kills one Australian every 13 minutes, the majority of which being men[1]. Some have little awareness of risk factors or early symptoms of these disorders until they have a cardiovascular event such as a heart attack, angina, stroke or heart failure. But for men there's a canary in the coal mine, so to speak, that should make you consider whether there's something amiss with your heart health well before it takes a turn for the worse. It's erectile dysfunction — difficulty getting or maintaining an erection — a treatable condition that can greatly impact the wellbeing of men and their partners and could indicate cardiovascular disease[2,3].

What's love got to do with it?

A quick explainer on erections — in order to achieve one, three things must occur. The nerves to the penis must be functioning properly, there must be stimulus from the brain, and there must be adequate blood flow to the penis. When your artery walls get built up with plaque (a process called atherosclerosis) it can restrict blood flow to the heart, brain and — in the case of erectile dysfunction — the penis. It's the underlying cause of most heart attacks and strokes, beginning years before there are any signs or symptoms. It can also cause vascular erectile dysfunction.

Research published in the journal *Circulation*[4] found that in a study of 1700 men over a four-year period, experiencing erectile dysfunction was linked to a two-fold increase in heart attacks, strokes, and cardiovascular death beyond traditional risk factors.

"Because the penile artery is of a smaller calibre, about 1-2 millimetres, erectile dysfunction will present earlier than cardiovascular disease, a stroke, or peripheral vascular disease," Dr James Navin Richards, GP, says.

In fact, research has found that erectile dysfunction can precede cardiovascular symptoms by two to three years and cardiovascular events, such as a heart attack or stroke, by three to five years[5]. That's a canary that's giving its vocal cords a workout.

Are men missing the connection?

Erectile dysfunction affects one in five men over the age of 40, but Dr Richards says that most men aren't aware of the connection between the condition and heart health.

"It's a common issue but they don't see the connection with heart disease," he says. "They think of it as an erection issue and don't think anything else of it. A lot men just get Viagra or Cialis or over the counter stuff [without looking any further]."

Care is also hindered by men's reluctance to speak to a GP about erectile dysfunction in the first place, meaning many are missing the opportunity to catch cardiovascular disease early. A survey of nearly 6000 Australia men aged 40 or older found that only 30% of men with moderate to severe erectile dysfunction discussed the issue with a health professional[6]. Some doctors are also disinclined to broach the problem with patients due to time constraints and their own discomfort.

Our own research indicates that men who had never been married were the least likely to speak to a health professional about erectile dysfunction, while those living in a rural or regional area, or from a non-English speaking background, were less likely to receive treatment for erectile dysfunction compared to other men. However, the link between erectile dysfunction and cardiovascular disease shows that even if you don't want to have sex, it can still be treated as a barometer of your overall health.

Beating them both

A heart attack shouldn't be the first step in diagnosing cardiovascular disease or treating erectile dysfunction, and neither conditions need to be 'normal' parts of ageing. Your GP can help you explore options for improving sexual function and potentially prevent a life-threatening event like a heart attack.

Understanding your risk factors and managing them with the help of your GP is important for leading a heart (and erection) healthy life.

What you can't change

- Age (getting older)
- Sex (men are generally at greater risk)
- Family history
- Race (Indigenous Australians are more likely to report having heart-related events, stroke and vascular disease)

What you can change

- High blood pressure
- High cholesterol
- Smoking
- Being overweight or obese
- Physical inactivity
- Excessive alcohol consumption
- Poor diet

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Sex ed 2.0

The extent of your sexual education at school (that's if you were given one) likely involved a banana and a condom, focusing on puberty and avoiding pregnancy. While these are undoubtedly important topics for adolescents, it might be time adults got a refresher course.

Unfortunately, there's still a significant amount of stigma associated with sex and sexual health in Australia. Many men don't know what is considered 'normal' to know when something might be wrong.

So, we're taking it back to basics and raising the red flags that deserve a visit to the doc.

ANATOMY

There's a lot more going on below the belt than you might realise, or remember from school, and you aren't alone in not knowing much about it. For example, a survey by Prostate Cancer UK found that more than half of the 2,000 men they queried didn't know where their prostate was and 17% didn't know they had one. Only 8% knew what it did[1].

The male reproductive system is an intricate area with many different organs working together and is responsible for producing semen and sex hormones. Some of the genitals are visible, such as the penis and the scrotum, and some are hidden, such as the testes, epididymis and vas deferens.

Red flags

Genitals come in all colours, shapes and sizes so there's no one set that's 'normal'. However, what's not normal is anything that causes you pain or distress.

Peyronie's disease

It's normal for your penis to curve slightly to the left or right when erect but a significant bend, paired with swelling or pain, could be a sign of Peyronie's disease. It occurs when the tissue in the penis hardens permanently and a lump of scar tissue forms on the lining of the penis. This area stops the penis from stretching normally during an erection. In severe cases it can make sex impossible because of the shape of the penis or problems getting an erection. If you're experiencing this, take a photo to show your doctor and make an appointment to discuss it.

Balanitis

Balanitis is a common and treatable infection that can happen when you don't keep the inside of your foreskin clean, causing pain or tenderness at the head of the penis, redness or swelling on the foreskin, itchiness or a rash, the inability to pull back your foreskin, or discharge. It can also be caused by irritation from chemicals, allergies, viruses and diabetes. If you do have a foreskin, it's important to look after it. This means gently pulling your foreskin back and washing inside and outside with water, daily. Don't overdo it on the soap.

Penis lumps

As everyone's anatomy is slightly different it can sometimes be hard to discern what's part of the scenery and what needs to be seen to. This can often be the case with lumps and bumps down below. There are several different types of penis lumps, most of which are harmless. Common ones include cysts, ulcers, genital warts and penis papules. Very rarely will a penis lump be cancer. Nevertheless, it's best to speak to your GP about any lumps you've noticed.

SEX

Healthy sexual function can be influenced by your biology, mental state and society at large. It can also change naturally as you age. But the bottom line is that it should be pleasurable and pain-free, both physically and emotionally. Unfortunately, there are a number of factors that impact this important part of life for men.

Red flags

When it comes to sexual health there's plenty to compare. From the tape measure to time spent between the sheets, it's unsurprising that men get stressed about what's seen as normal and what's not. If you find your response to sexual stimulation or lack of interest in sexual activity causes you distress, that's a problem.

Premature ejaculation

Ejaculation is the release of semen from the penis at orgasm or sexual climax. Ejaculate, or 'cum', is a mix of sperm and a small amount of fluid, it's normally a whitish-gray colour and the amount can range anywhere from 1.5ml to 5ml. The 'normal' amount of time it takes to ejaculate is subjective and there's no set time that's 'too soon'.

Premature ejaculation is the most common male sexual problem, impacting men of all ages but predominantly younger men. Premature ejaculation is when you have trouble controlling when you orgasm and you ejaculate at a time that you or your partner feel is too fast or early, causing a significant amount of anxiety and distress.

Premature ejaculation can be 'lifelong' — continuing consistently from your first sexual experience — or 'acquired' — when you've had a normal period of control over your orgasm before experiencing premature ejaculation. It's important to speak to your doctor about it as there are treatments available.

Erectile dysfunction

Erectile dysfunction (ED) — the inability to get or maintain an erection — is very common, more so as you get older. At least one in five men over the age of 40 has erectile problems, but there's no age when you're 'too old' to get help with your erection and enjoy healthy sexual function. There might be several contributing issues that cause your ED, usually it's a combination of physical and psychological factors. Given the statistics, you won't be alone in raising erection problems with your doctor and it's important to do so whether you want to have sex or not as ED may be a symptom of underlying conditions such as heart disease or diabetes.

Low libido

Sex drive is another subjective area — a level of desire that's natural for one person isn't necessarily the same for another. Your sex drive can also change over time depending on what's happening in a person's life. However, if you lose interest in sex for no apparent reason, and it worries you, talking to a doctor can help. Low sex drive can be caused by short-term or long-term conditions such as depression or low testosterone.

STIS

Sexually transmitted infections (STIs) are a group of bacteria and viruses that can be transmitted through vaginal, anal or oral sex. They're more common than you probably think, about 16% of Australians report having an STI in their lifetime[2]. While there's no need for shame and stigma around STIs, it's also important to be switched on about prevention and understand the long-term consequences if STIs go untreated. STI symptoms will vary between infections, but they can include unusual discharge from the penis or anus, pain during urination, pain in the scrotum or testicles, and sores, rashes, blisters, warts, lumps or bumps on the genitals. Sometimes there are no signs that you, or your sexual partner, has an STI.

The most effective way to protect yourself is by using condoms and having regular tests. These tests are incredibly simple and nothing to stress about (your doctor has seen and done it all before). Get tested at your GP or a sexual health clinic, every six to 12 months and when you change partners.

Red flags

While there are some major wins in Australia's management of STIs (including significant increases in vaccinations against Human Papillomavirus and the near elimination of previously endemic donovanosis in remote Indigenous communities) some conditions have bucked the downward trend — particularly in high priority populations such as gay men, Aboriginal and Torres Strait Islander people, men who have sex with men (MSM), and young people. Compared to 2008, rates of infections for males in 2017 were four times higher for gonorrhoea, three times higher for syphilis and almost twice as high for chlamydia[3].

So, what gives? There are a range of factors behind each STI's growing prevalence in different populations, some of which researchers and healthcare professionals are across and others aren't as clear. What can be agreed on is timely testing and treatment, which are essential for stopping the spread of STIs. While there has been an increase in screening for many priority populations, further education and encouragement is needed for others. There's also been an increase in testing among gay and bisexual men[4], in part thanks to the uptake of HIV prevention tool, Pre Exposure HIV Prophylaxis (PrEP), which requires a routine STI screening every three months. More advanced and widespread testing has contributed to the statistical jump in Australia's most commonly diagnosed STI, chlamydia[3], however, there's still a concerning gap in screening for younger people. Stats show that while 15 to 29-year-olds accounted for 75% of chlamydia cases in 2016, they only accounted for 15% of Medicare-rebated testing[3]. The lack of access to testing and treatment is an issue particularly facing Aboriginal and Torres Strait Islander people, who are disproportionately impacted by STIs compared to the non-indigenous population[5].

Despite the prevalence of STIs and the relative ease of testing and treatment, there's still a significant amount of shame attached to the conditions[6]. The expression, experience and anticipation of stigma can influence whether someone will get tested, take treatment and notify their sexual partners to prevent further spreading[7]. Overall, there's a critical need to improve the knowledge and awareness of STIs among priority populations, health professionals and the wider community.

MORE INFORMATION

- For more information on the male reproductive system, penis problems and sexual function problems, visit healthymale.org.au
- For more information on STIs, visit healthdirect.gov.au

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Why you should care about male contraceptives

The importance of men's involvement when it comes to pregnancy prevention is widely recognised but not strongly reflected in the contraceptives currently on the market.

Despite the range of options for women (including the contraceptive pill, female condoms, diaphragms, vaginal rings, skin implants, injections and Intra Uterine Devices), the choices for men are limited to two. Condoms, with their high failure rates[1], and vasectomies, which are invasive, expensive and not always reversible.

While pickings are slim, it certainly doesn't mean men are well versed in the pros and cons of each product. So, we're getting a bit more familiar with what's on offer and whether additional options are on the horizon.

Condoms

Most men would be familiar with condoms — a fine sheath of rubber or plastic that covers the erect penis, acting as a physical barrier to stop fluids passing between people during sexual activity. It's the main, male-dependent method of contraception, with the added benefit of reducing your risk of getting or spreading sexually transmitted infections (STIs).

Although they have the advantage of being affordable and accessible, the downsides are that they can only be used once, they're perishable, and their effectiveness relies on perfect use. Something that studies suggest isn't so straightforward[1].

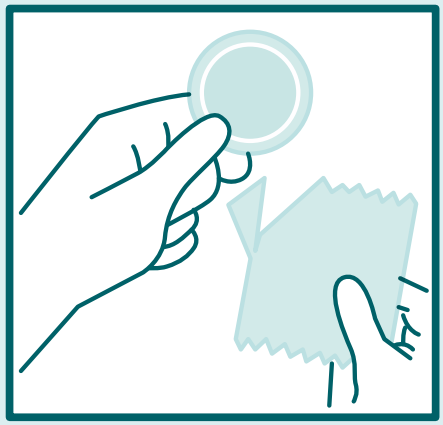
While condoms are 98% effective against pregnancy with perfect use, around 18% of women will still get pregnant using them, generally because they're not used correctly[2]. Issues include breakage, slippage and leakage as well as putting on the condom after genital contact or removing it early.

Research has also found that only a quarter of Australians used a condom the last time they had vaginal intercourse, and one in six of these condoms were put on after genital contact[2]. Not only is that bad news for preventing STIs but it's also possible to fall pregnant with pre-ejaculate (also known as 'pre-cum').

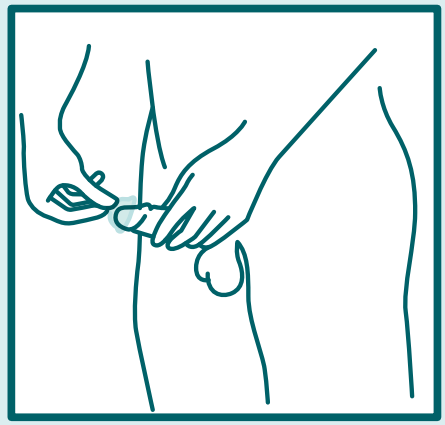
Vasectomy

A vasectomy is a surgery that cuts the vas deferens — the tubes that carry sperm from the testicles to the urethra. It's a safe, effective and permanent method of pregnancy prevention that's used by about one in four men over the age of 40. To get a vasectomy you'll need a referral from your doctor to see a specialist. The procedure will be performed in a hospital or in a doctor's private rooms and take

How to put on and take off a male condom

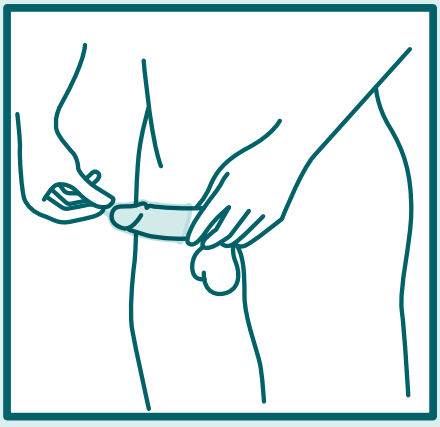


1. Carefully open and remove the condom from the wrapper — don't use your teeth or scissors.



2. Make sure the condom's ready to roll on the right way — the rim should be on the outside.

   Place the condom on the head of your erect (hard) penis — but before your penis touches your partner's mouth or genital area. If uncircumcised, pull back the foreskin first.



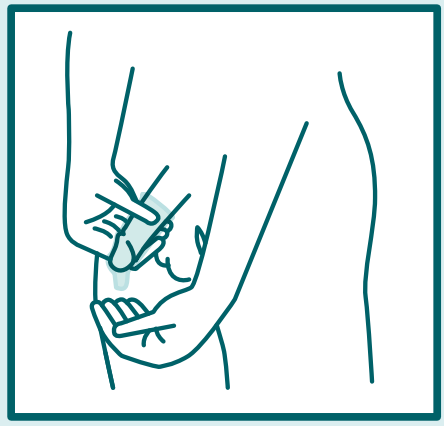
3. Pinch air out of the top of the condom — this leaves space at the top for the semen to collect.

   Roll the condom on when your penis is erect and wear it the whole time you're having sex.

   If you lose your erection, you should remove the condom and put on a new one when your penis becomes erect again.

4. After sex, but before pulling out, hold onto the rim of the condom and pull your penis out of your partner's body.

   Carefully take off the condom away from your partner so you don't accidentally spill semen on them.



5. Carefully remove the condom and place it in the rubbish — don't flush it down the toilet (it can clog pipes).

roughly 15 to 30 minutes, either under general or local anaesthetic.

You'll need to use another method of contraceptive for a few months after your vasectomy, while the sperm clears out of your ducts. After a vasectomy, you'll still ejaculate but it won't contain any sperm. It won't affect your sex drive, sexual function or testosterone levels in any way. But this contraceptive isn't entirely risk free — in about one in 500 men, sperm can reappear months or years down the track. The surgery also carries a small risk of infection or significant bleeding.

One of the most important factors to remember is that vasectomies are intended to be permanent, so you should be certain that you don't want any, or more, children. There's a misconception that they can always be reversed should you change your mind, but that's not always the case.

Hormonal contraception

Despite starting research on long acting, reversible birth control for men in the 1970s, we're yet to see a product hit the market.

There are several reasons why the pace of male contraception development has been slow in comparison to female. One of them being that physiologically, it's much harder to achieve effective pregnancy prevention in men. Women produce one egg a month while men produce millions of sperm constantly, and the former is easier to supress than the latter.

But we came close in the last couple of years.

The most promising option — an injectable combination hormonal contraceptive — entered a Phase II trial across seven countries between 2008 and 2012, with results released in 2016[3]. It saw 320 men receive a contraceptive injection every eight weeks containing testosterone and progesterone, a combination that would shut down the body's testosterone production and supress sperm production.

The injection was effective in preventing pregnancy in nearly 96% of couples but the trial was stopped after an independent review panel determined that the drug had too many side effects. These included injection site pain, mood disorders, acne and increased libido, which caused 22 men to drop out of the trial. This also saw the last pharmaceutical backer pull out.

Professor Robert McLachlan AM, Medical Director of Healthy Male and key researcher in this area, said the news was fairly heartbreaking for those working on it.

"Because here's a product that we know works and is reversible, and we know a lot about its delivery, monitoring, safety and efficacy," Professor McLachlan says. "Australia has punched above its weight in this area and we were really there at the forefront of it. But it's 'run out of legs' since the cancellation of that study and withdrawal of industry from development."

However, more than 75% of the men who didn't drop out of the trial said they would use the injection if it became available and some initiatives are still ongoing — including a trial running in the US using gel patches. Despite the positive results seen previously, we're unlikely to see anything hitting pharmacy shelves any time soon.

"The road to commercialisation is long, people do not understand how much it costs to bring a medication to the marketplace, especially the required large clinical studies involving thousands of couples ," Professor McLachlan says. "One of these days it will come back but not in my professional lifetime I'm afraid."

MORE INFORMATION

For more information on vasectomy and vasectomy reversal, visit healthymale.org.au

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Health information in a language you can understand

Healthy Male offers important evidence-based information on common male reproductive and sexual health conditions for the public and health professionals — from fertility issues to erectile dysfunction, ejaculatory problems to prostate disease.

You can find this information in several locations:

Website	healthymale.org.au
YouTube channel	youtube.com/HealthyMale_AU — Watch over 80 health videos!
Facebook	@healthymaleau
Twitter	@healthymale_au — Follow us for regular health professional updates!
Instagram	@healthymale_au
The Male magazine	healthymale.org.au/subscribe-to-the-magazine — Subscribe here!
Free hard-copy resources	healthymale.org.au/order-resources — Order here!

Our website is home to condition information (like symptoms, causes, diagnosis and treatment), topical articles, real stories, research studies that you can be involved in, and health promotion opportunities.

For health professionals, we also offer online professional education, position statements, research reviews and clinical resources.

Plus Paternal:
A focus on fathers

The Case for Change

Fathers deserve more from our healthcare system. They need better engagement, support and education from preconception through to the early years in their child's life. In 2020, Healthy Male established the Plus Paternal: A focus on fathers project in response to the National Men's Health Strategy 2020-2030.

Through our research, it was recognised that Australian men need more from our health system. It is clear that men are being excluded from the journey to parenthood.

Healthy Male CEO and Director Simon von Saldern notes instead of, "Non-birthing parents, most commonly men, are not systematically engaged or supported from preconception to parenthood. They are often treated as secondary to fertility, birthing and parenting processes — welcome but not active partners."

Where the Plus Paternal project addressed gaps in the health system, the Case for Change is the next step in the journey to engage with fathers. Healthy Male undertook over 300 surveys, two literature reviews of 150 articles and publications, sector engagement and stakeholder consultation to create a new evidence-based advocacy document.

The surveys found that 43% of men thought the healthcare system did not engage with them. "The problem with the 43% result is that you don't know what you don't know. Men don't understand what real engagement could look like. We've got a long way to go. For change to occur, Australia needs to see a cultural, political, and social change," says Simon. "Change needs to occur at a policy level. Inclusion for fathers is something that can also be achieved, it just takes application and thought."

Today, more and more couples are turning to IVF clinics, and again, men aren't engaged. "They are perceived as secondary during this emotional time, and when couples are unsuccessful, there are few mechanisms for support," says Simon. Successful pregnancies also affect men, with 1 in 10 suffering from anxiety or depression after a child's birth.

The Case for Change draws upon the knowledge and experience of fathers, experts and health organisations and seeks to make the healthcare system work better.

The Case for Change outlines:

- How social and gendered norms affect fathers
- Why our health system needs to change, and
- How, by taking a top-down and bottom-up approach, the system can be changed to recognise, value and support the health and wellbeing of men and women from preconception to parenthood.

The Case for Change calls for a fundamental shift in the way society and the health system view and treat fathers. The document also asks organisations, policymakers and the community to work towards seven goals.

1. Society recognises and values both parents equally
2. Health policy addresses the health and wellbeing of both parents
3. The health system supports the proactive engagement of both parents
4. Health professionals are willing and able to support men and women
5. Both parents are prepared for the transition to parenthood
6. Parents who experience loss, distress or are struggling with parenting receive the care they need
7. Practice is evidence-informed and shaped by the lived experiences of both men and women.

Diversity is an essential driver in the Case for Change. The document acknowledges that men's health is influenced by a complex range of cultural and economic factors and that tailored support is vital.

Healthy Male has facilitated the Case for Change and 26 organisations endorse it. Collaboration is critical, and we will only achieve meaningful change through partnerships and shared purpose.

Social, cultural, and systemic change will require many people's collective efforts, but the results will benefit men, their families, and communities across the country for generations to come.

Plus Paternal
A focus on fathers

"Don't just include fathers, treat us as equal partners and parents...Prepare fathers for being a dad and don't just treat us as assistants, carers or servants to our partners. Inform us of the severe emotional and mental changes that we may undergo after the birth."

MORE INFORMATION	Find out more about Plus Paternal: A focus on fathers and join the collective effort by supporting the Case for Change at healthymale.org.au/plus-paternal

Transgender people's sexual and reproductive health

A satisfying and safe sex life is important for many adults' wellbeing, regardless of age, physical ability, sexual preference or gender identity.

Transgender people face several barriers to accessing appropriate healthcare, including overt discrimination and a scarcity of cultural and clinical competence by some service providers.

Sexual and reproductive healthcare is particularly personal and must be tailored to meet the needs of individuals. There are a few fundamental considerations that go a long way to help provide appropriate and informed care to transgender people.

Don't assume

There's no need to make assumptions about a person's gender identity. Forms to collect information from new patients can include an option to select 'other', rather than simply 'male' or 'female', for gender. This provides an opportunity to ask clear and direct questions about a new patient's gender identity and the words they use to refer to themselves and their body parts, which can lead into a conversation about their sexual and non-sexual healthcare needs.

Transgender people have diverse sexual partners and practices. Taking a sexual health history is critical to assess risk and provide appropriate care. Being clear about why you need to ask specific questions may help a patient feel more comfortable with providing information.

Language that focuses on parts (specific anatomical structures) and practices (what goes where during sexual activity) can help avoid assumptions about individuals' gender and sexuality.

Of course, an individual's gender or sexuality is not always relevant when they seek healthcare.

Some transgender people will seek medical assistance to affirm their gender and others will not.

Be informed

Providing healthcare for transgender people does not require special expertise but some healthcare providers lack basic knowledge about transgender people and their healthcare needs. Familiarity with the terminology used by transgender people to refer to themselves helps to make them feel included and considered and is critical for overcoming barriers to communication.

Sexual health education for young people might not adequately address transgender issues, creating a need for education by health practitioners for some patients.

Patients' anatomy dictates the preventive health practices and screening tests required to maintain wellbeing. Some risk of disease may be attributable to a patient's anatomy (i.e. cervical or prostate cancer) so surveillance and disease screening must be appropriately individualised.

Safe sex

As a group, transgender people have a higher risk of sexually transmitted infections and blood-borne viruses than cisgender people. An individual's risk is determined by their own behaviour though, so testing for sexually transmitted infections should be matched to sexual activity.

Transgender men who have sex with men can get pregnant, and some transgender women can get their female partners pregnant.

Transgender patients may require assistance with choosing and accessing an appropriate contraceptive method to avoid pregnancy and minimise risk of sexually transmitted infections. Pre- and post-exposure prophylaxis against HIV infection may be appropriate for some transgender people.

Gender affirmation

Gender affirming treatments can influence sexual function and fertility. Some effects may be welcomed by some people and unwanted by others (i.e. effects on sex drive by masculinising or feminising hormonal therapies). Adjustment of hormonal treatments might be necessary to avoid unwanted effects for some people, or counselling to understand the effects and how to live with them might be suitable for others.

Patients seeking medical or surgical intervention for gender affirmation should be counselled about the impacts of treatment on their fertility. Hormone treatment might not always suppress fertility, and a spontaneous return of fertility upon cessation of gender affirming hormonal therapy is possible. However, gamete cryopreservation is a feasible and desirable option for fertility preservation for some transgender people.

MORE INFORMATION	Download and order the Transgender Health Clinical Summary Guide at healthymale.org.au/clinical-summary-guides

Moving beyond simplistic and stereotypical ideas about men's health

Testosterone has copped a lot of the blame for men's poorer health outcomes compared to women when it comes to COVID-19, so much so that sex chromosome differences have been raised as a potential reason behind increased vulnerability. But such a simple explanation is an example of consistent failure to consider the complex social influences on men's health, and the interactions between these and biology. In the words of the World Health Organisation, "The exact contributions of sex and gender to health disparities are often hard to separate because they do not operate independently."

If looking solely at sex, lifespan is a crude indicator of wellbeing but it's easy to compare between males and females in populations of humans and other animals. In most species of wild mammals that have been studied, lifespan is about 20% longer for females than males. In humans, women live almost 8% longer than men. So, there does seem to be some fundamental sex effect on lifespan, but it looks like there's something we're doing that our non-human mammalian counterparts aren't, which has reduced the gap.

But beyond biology, men's propensity for risk-taking undoubtedly contributes to their higher likelihood of death from interpersonal violence and road injury than women. This same characteristic may also explain men's delay, when compared to women, in seeking healthcare. Although this doesn't mean that men don't go to the doctor — men monitor their own health and seek help when they think they need it, but they tend to take this important step later in the course of disease than women.

The consequences of gender characteristics and men's delayed action in seeking care is exemplified by sex differences in rates and outcomes of thyroid cancer. In Australia, new cases of thyroid cancer in women outnumber those

in men by almost 3-to-1, yet the number of deaths from thyroid cancer is about the same for men and women. This profound difference in outcomes can be attributed, at least in part, to men presenting at a more advanced stage of disease.

We know what some of the things are that prevent men going to the doctor. To start with, men are more likely to seek health information from family members or the internet than a health professional. And when men realise that they need a visit to the doctor, a lack of affordability and availability are two of the most common things that stand in the way[4]. Tired masculine traits like stoicism, independence and self-reliance can also get in the way of men seeking healthcare when they need it. However, a majority of young Australian men reject harmful masculine stereotypes, raising the prospect of new generations of men who may be more willing to seek help early when they need it[4].

Health professionals can play an important role in supporting this encouraging outlook and maximising opportunities to engage men effectively, especially in primary healthcare. Acknowledging the challenges men face in making and waiting for appointments, providing a broad range of services and evening appointments can help deal with issues of availability. Communication style is also an important factor in engaging men in discussions about their health and these strategies can help:

- Stating facts clearly during consultations
- Using terminology that is easily understood
- Providing written information for patients to read after consultations
- Listening to and responding to patient needs to facilitate an empathetic style of communication based on respect and trust
- Aiming to deal with a man's health issues quickly and comprehensively
- Referring patients onto specialists when required, particularly if the problem remains unresolved
- Keeping abreast of the latest developments and conveying these during consultations
- Applying and explaining the role of 'new' knowledge to patients when making diagnoses
- Alleviating the perceived seriousness of health concerns by using humour thoughtfully to facilitate the building of rapport
- Being proactive and sensitive in managing patients' sexual and mental health concerns via:
  - Routine sexual and mental health history taking, within medical histories
  - Asking about sexual and mental health when risk factors are evident.

MORE INFORMATION

For tips and clinical resources to help you engage men in primary healthcare settings, visit healthymale.org.au

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Can testosterone prevent type 2 diabetes in men?

T4DM was a two-year randomised, double blind, placebo controlled clinical trial, conducted across six Australian specialist centres, funded by National Health and Medical Research Council (NHMRC). The aim was to identify whether treatment with testosterone can prevent progression of impaired glucose tolerance to type 2 diabetes (T2D) or reverse newly diagnosed T2D in men.

Background

Serum testosterone concentration is lower than normal in men with obesity, particularly if they have 'abdominal obesity' accompanied by insulin resistance. The low testosterone concentration in this situation is independently associated with an increased risk of developing T2D.

Weight loss, achieved by a healthy diet and exercise, prevents T2D and reverses newly diagnosed T2D. Weight loss and its beneficial metabolic effects also increase serum testosterone, with the magnitude of effect depending on the amount of weight lost.

Testosterone treatment decreases fat mass and increases muscle mass in men. However, it has never been established in a rigorously

conducted and sufficiently powered clinical trial whether testosterone can also prevent T2D, or reverse newly diagnosed T2D.

The T4DM trial

In the trial 1,007 men (aged 50-74 years; waist circumference ≥95 cm; with impaired glucose tolerance or newly diagnosed T2D; and with serum testosterone concentrations ≤14 nmol/l) were enrolled in a lifestyle program provided by WW (formerly Weight Watchers), and randomised to receive three monthly intramuscular injections of either testosterone undecanoate (1000 mg) or placebo. Men with hypogonadism due to pathological abnormality in the pituitary, hypothalamus or testis, with unstable cardiovascular disease or prostate cancer, were excluded.

Primary outcome measures were:

1. The proportion of participants with T2D defined as a two-hour OGTT result of glucose ≥11.1 mmol/l, and
2. The difference between groups in the change in two-hour glucose concentration from baseline at two years, with the study powered to find a difference of at least 0.6 mmol/l between groups.

Results

The relative risk of T2D after two years was 0.59 with testosterone treatment. The decrease in two hour glucose from baseline was 0.75 mmol/l greater in men treated with testosterone than in the placebo group. There was no effect of the testosterone concentration at the time of entry into the study on either of the primary outcomes (i.e. the effect is pharmacological).

There was a greater decrease in fasting glucose (0.17 mmol/l) in testosterone versus placebo treated men but no difference in HBA1c between the groups.

At two years, normal glucose tolerance was observed in 43% and 52% of men, respectively, in the placebo and testosterone groups. Fat mass decreased (-4.6 vs -1.9 kg) and skeletal muscle mass increased (+0.39 vs -1.32 kg), accompanied by increased hand grip strength, as well as small improvements in sexual function in men treated with testosterone, compared to those who received placebo. Lower urinary tract symptoms, adherence with the lifestyle program, and overall change in quality of life and mood, were similar in the two groups of men.

Testosterone did not result in more adverse cardiovascular events or prostate cancer diagnoses compared to placebo. However, a small increase in average haematocrit (0.04) and prostate specific antigen (0.3 ng/ml) during the study occurred in the testosterone group. An increase in haematocrit to 0.54 or higher was observed in 105 men (22%) who received testosterone — 25 ceased treatment early as a result.

What does this mean for practice?

Testosterone treatment for two years, in combination with a diet and lifestyle program, prevented T2D or reverted newly diagnosed T2D in overweight men without pathological hypogonadism.

The magnitude of the effect of testosterone on glucose metabolism is like that of metformin (without diet and exercise intervention) in the Diabetes Prevention Program. Metformin and testosterone have comparable effects when it comes to decreasing fat mass, but metformin does not increase skeletal muscle mass or strength. However, metformin has cardiovascular benefits and may improve erectile function, whereas testosterone suppression of gonadal function is protracted and without benefit.

It is premature to advocate widespread use of testosterone for diabetes prevention or reversal in men without pathological hypogonadism. The minimum effective dose, duration of treatment, durability of effect, and long-term safety, including cardiovascular outcomes, are all unknown.

Writing a prescription might be quicker and easier than providing a comprehensive and holistic approach to care but it represents an abdication from our duty of care to men's health.

Written by

- Prof Gary Wittert MBBch MD, FRACP, FRCP
  T4DM Study Chair

Getting in the best position to find a GP

The relationship between patient and doctor can be a surprisingly complex one, involving professional, personal and transactional aspects. A good relationship builds over time as GPs begin to understand the many factors influencing their patient's health and well-being.

The doctor-patient dynamic has shifted in recent years, thanks to the emergence of quality improvement programs and health consumer movements. Whereas doctors were once seen as all powerful, thanks to their monopoly on medical knowledge, patients can now readily access information online. Self-diagnosis can be a dangerous undertaking, but with doctors called upon to treat patients in ever-tightening appointment slots, there's little time to build rapport or ask questions that unearth the bigger medical picture.

Healthy Male receives 2,000 calls and emails each year from people looking for information that they haven't been able to find elsewhere or wasn't provided in a consultation due to embarrassment or a lack of time.

Brodie, Healthy Male Office Coordinator, regularly chats to people who have called the Healthy Male 1300 number. "While we're happy to share information, it's important that people feel comfortable asking their doctor about their specific health concerns. And if they're not happy with how they're being supported, they should seek a second opinion." Brodie adds. "Callers tell me that they didn't have an opportunity to ask the right questions. They're conscious of the time and forget to ask questions. And then they don't want to take time off work for a second appointment."

Patients also hesitate to move from one doctor to another, even if they feel they aren't receiving the support they want. This can be due to a sense of loyalty or the reluctance to repeat a full or sensitive medical history.

Finding a GP for the long-term begins with taking a proactive approach. For A/Prof Tim Moss, Health and Content Manager at Healthy Male, this means identifying a GP who's a bit like him. He explains, "A doctor the same age and gender as me would have an interest in the types of health problems that afflict people like us and be up to date with relevant knowledge and best practice."

Having found just such a GP, Tim is happy to see his doctor as often as needed and, like 68% of patients polled in a 2005 survey[1], he reports high levels of satisfaction with his GP's care and communication as well as better health outcomes overall.

While time pressures, coyness and life, in general, might make building a rapport with a GP difficult, it is possible to achieve success with some homework and a little persistence.

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HEALTHY MALE

ANDROLOGY AUSTRALIA