

Men's Health Issues

DURING THIS first year of publishing the ARCHIVES, the editors have been careful to avoid issues dedicated to a single theme. However, a first-year retrospective shows several themes that highlight the topics faced by family physicians most often, including acute and chronic diseases, family violence, and issues of women's and men's health. Men find themselves, in the early part of this decade, at the beginning of an interesting era. On the one hand, even the lay literature highlights the rapidly changing roles of the American man (*Time*, June 28, 1993:141); on the other, the medical literature promises, more than ever before, a brighter future for preventing and treating maladies that are uniquely male.

Parallel to the flurry of articles appearing throughout the general and specialty medical literature, this past year the ARCHIVES has published several studies that highlight gains in our understanding and treatment of male disorders. The first of these articles described the natural history and surgical treatment of benign prostatic hyperplasia,¹ the second reviewed the treatment of localized prostate cancer,² and the third described health care-seeking behaviors of men with urinary symptoms.³ This issue includes a report on the efficacy of a nonsurgical option for treatment of the major cause of these symptoms—benign prostatic hyperplasia.⁴

Men make over 7 million visits to urologists in America each year. While there are no differences in visit rates among white, black, and other racial groups, nonwhite men are more likely to experience prostate cancer. Men older than 65 years account for the majority of visits to urologists, and over 1 million visits per year are made to urologists because of prostatic hyperplasia.⁵ At least an additional half million visits are made annually to primary care physicians for the same condition.

In this decade, we have seen significant advances in the treatment of acute and chronic prostatitis with the availability of fluoroquinolone antibiotics. We are learning more about the paradoxical nature of prostate cancer, which although extremely prevalent, fulfills its malignant potential in a relatively small proportion of men.

Recent news about men's health has not been all good,

however. This year, vasectomy, previously one of the fastest growing methods of birth control for American men, was implicated in the development of prostate cancer.⁶ Further evidence is being sought to suggest cause and effect. Preliminary reports from carefully conducted studies such as the one by Giovanucci et al⁶ may persuade as yet unknown, significant numbers of men to discount this popular option of contraception. Sexually transmitted diseases are on the increase.⁷ We are now more aware of the wide racial disparities in occurrence of male urogenital diseases, including those of the prostate, and especially of advanced prostatic cancer.⁸ Increasing evidence shows that annual routine digital rectal examinations are infrequent and not specific enough to reduce mortality from prostate cancer.⁹ Measurements of prostatic serum acid phosphatase are being offered more commonly as a screening examination for prostatic cancer, but there are few data to suggest their effectiveness in reducing rates of mortality among those screened.¹⁰

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Men often delay seeking health care, even when symptomatic. In an earlier issue of the ARCHIVES, Jacobsen et al³ reported that men of lower socioeconomic and educational status were more likely to seek care for urological symptoms, as were men without insurance, those who were not married, older men, and those with severe symptoms. The study concluded that the decision to seek care for urological symptoms—whether frequency of occurrence, perceived discomfort, or interference with daily activities—is a complex one, only partially explained by demographic characteristics or those related to severity of symptoms.

The medical literature is now devoting substantial attention to two drugs, finasteride and terazosin, for treatment of obstructive symptoms of benign prostatic hyperplasia. Finasteride is a 5- α -reductase inhibitor that blocks the conversion of testosterone to dihydrotestosterone, the androgen primarily responsible for growth and enlargement of the prostate gland. Finasteride has been shown to decrease symptoms of urinary obstruction and increase urine flow, although it may cause sexual dysfunction, even at low doses, in nearly 10% of men.¹¹

Terazosin, a long-acting α_1 -blocker, produces smooth-muscle relaxation in the bladder neck and can relieve bladder obstruction in those with benign prostatic hypertrophy. The first large, randomized study using terazosin for the treatment of urinary obstruction showed significant improvement in symptoms and urinary flow in those treated for 12 weeks.¹² These two agents now offer men an alternative to urologic surgical procedures such as transurethral prostatectomies. This is important because although nearly 280 000 transurethral prostatectomies are performed each year solely for benign prostatic hypertrophy, up to 35% of men may have no¹³ (or only temporary) relief of symptoms.¹⁴

In this issue of the ARCHIVES, Brawer et al⁴ report on the safety and efficacy of using terazosin for twice as long as previously reported in men with benign prostatic hyperplasia. Similar to the original report by Lepor et al,¹² men taking terazosin experienced a substantial improvement in obstructive symptoms, an effect sustained throughout the 24-week study. Compared with placebo, irritative symptoms improved significantly after treatment with the drug for 6 weeks. Symptoms that improved most noticeably were hesitancy, intermittency, force of stream, nocturia, and daytime frequency. Both peak and mean urine flow rates significantly improved with treatment.

All of these studies used validated and similar instruments to measure changes in symptoms. But because two thirds of those taking the active agent experienced an improvement in their symptoms in 6 months, as did nearly one third of the placebo group, one wonders if symptom variability simply reflects changes in perception or indicates fluctuations in the natural course of the disorder.

An interesting difference between this study and the previously reported one of shorter duration was that nearly half of the men taking placebo reported worsening of their symptom scores. Unlike the shorter-term study by Lepor et al,¹² in which all men given terazosin had appreciable symptomatic improvement, at the conclusion of the longer trial by Brawer et al, 15% of the participants taking terazosin had worse scores.

Although the proportions of men who dropped out of these new studies were similar with finasteride, terazosin, and placebo, terazosin may offer some patients at least two advantages over finasteride in the treatment of benign prostatic hyperplasia. First, the antihypertensive effects of terazosin caused a significant decrease (mean decrease of 16 mm Hg in diastolic blood pressure) in men with hypertension but little decrease (5 mm Hg) in the blood pressure of normotensive subjects. Second, although 10% of men taking placebo developed urinary tract infections during the trial, only 1% of the men in the treatment group did so, probably because of significantly reduced bladder outlet obstruction with treatment.

Side-effect profiles of the two agents are similar for erectile dysfunction (7% to 10%). However, nearly one fifth of men taking terazosin complained of dizziness compared

with 1% of men taking finasteride, while 5% of those taking finasteride complained of decreased libido. This underscores the fact that while terazosin may have clear advantages in the treatment of urinary obstruction due to prostatic hyperplasia, neither drug is likely to be a panacea.

Since the two classes of agents have very different mechanisms of action achieving the same overall desired effect—a decrease in urinary flow obstruction and symptoms—it would be interesting if future studies tested the efficacy of combined therapy using smaller doses of both a 5- α -reductase inhibitor (finasteride) and an α_1 -blocker (terazosin, prazosin, or doxazosin); the former agent would reduce the size of the prostate gland and its compression on the prostatic urethra, and the latter would relax the bladder neck. Perhaps such combination therapy would lead to greater relief of symptoms and improved urinary flow with fewer adverse side effects due to the lower doses of both agents.

Results of clinical studies similar to those just described have prompted a flurry of continuing education programs teaching primary care physicians more about the rapidly changing options and therapeutic advances relevant to maintaining, if not improving, men's health. Pharmaceutical companies marketing terazosin and finasteride, as well as professional organizations such as the American Academy of Family Physicians, the American Urological Association, and others, have developed extensive campaigns to update clinicians on developments in related areas. Undoubtedly we will be hearing more about pharmaceutical options for treating benign prostatic hypertrophy and about other novel treatments such as transurethral microwave hyperthermia, balloon dilation, and placement of stents.

In addition to the advances reviewed here, a large study begins this month (September) to determine if 5- α -reductase inhibitors, such as finasteride, can prevent the development of clinically significant prostate cancer. The Prostate Cancer Prevention Trial sponsored by the National Cancer Institute and the Southwest Oncology Group will ultimately enroll 18 000 men from more than 100 centers. Subjects receiving finasteride as well as those who do not will undergo annual digital rectal and prostatic serum antigen examinations for at least 5 years. In addition to determining whether the 5- α -reductase inhibitor is efficacious in preventing prostate cancer, follow-up of control subjects may shed more light on the efficacy of digital rectal and prostatic serum antigen examinations.

In summary, the exciting news for men is that significant advancements are being made in our understanding of uniquely male problems. Many promising new therapies appear to be at hand, the majority of which are likely to be available to men through their family physicians.

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