Men's health: what's a GP to do?

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ABSTRACT

- Men are at highest risk of cardiovascular disease, chronic lung disease, some cancers, suicide and transport-related injury.
- An anticipatory approach to men's health in general practice should assess risk for these conditions and offer effective interventions, either to prevent them or manage them early.
- This requires attention to the barriers, not only to men accessing general practice, but also to appropriate assessment and management, especially among disadvantaged groups.

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The health of men has received greater attention in recent years — partly because they have a higher risk of certain health problems and injury, but also because of the way in which men use (or do not use) health services. We present a generalist approach to men's health, focusing on their most important health problems and what general practitioners can do about them. Of course, men are not a homogeneous group, and it is important to consider the influence that other factors, including socioeconomic status, ethnicity and where they live, have on their health risks and health service use.

What are the most important health problems in men?

Men's health is much more than reproductive health. The major burden of disease in Australian men is attributable to cardiovascular disease, cancer and injury, and, for many conditions, men have higher incidences and higher age-standardised death rates than women.[1]

Despite declines in cardiovascular disease mortality, ischaemic heart disease is still common and much more prevalent in men than in women aged 40–74 years, with men being twice as likely to die from it. This is partly because of the greater contribution of smoking, alcohol intake, overweight, elevated cholesterol levels and type 2 diabetes to their cardiovascular risk. Indigenous men are particularly vulnerable, having 2.6 times the risk of dying from cardiovascular diseases than non-Indigenous men.[2] More generally, men with low socioeconomic status are more likely to develop cardiovascular disease. Hypertension and ischaemic heart disease are particularly prevalent in men, increasing dramatically from the age of 45 years (Box 1).[2]

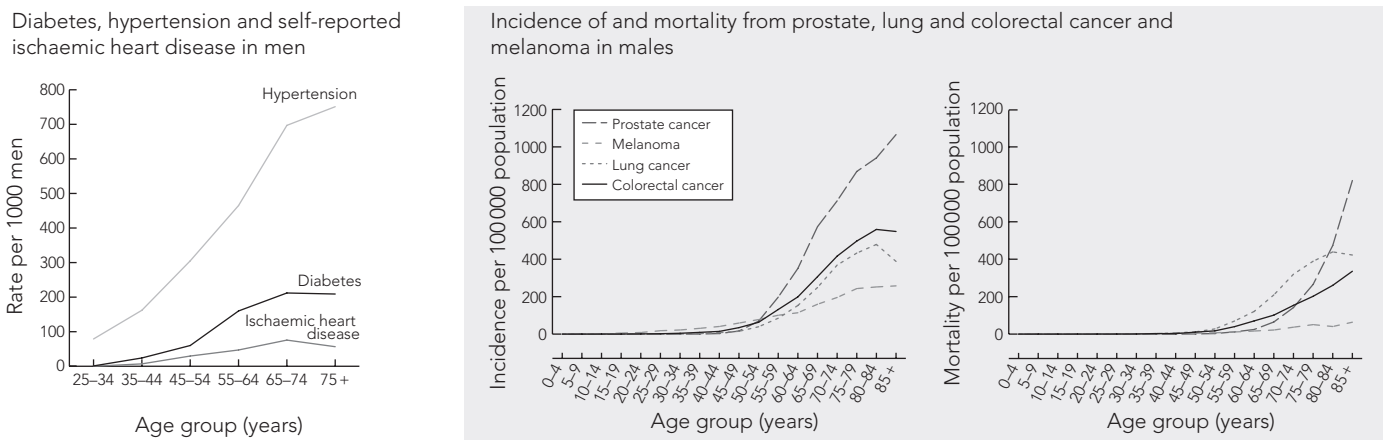
Box 1 shows the incidence of and mortality from major cancers affecting men in 2001.[3] The dramatic increase in both incidence and mortality from around age 50 is notable. The rate of death from lung cancer in men (23% of cancer deaths) was 2.4 times the rate in women. Prostate cancer accounted for 14% of cancer deaths and the death rate from colorectal cancer (12% of cancer deaths) was 1.6 times the female rate. Melanoma was the third most common cancer and the fourth most common cause of cancer death in men (3.5% of cancer deaths).[3] Testicular cancer had a low incidence and mortality rate.

The 2004 age-standardised death rate from accidents and adverse events was 2.5 times higher for males than for females, with a third of injury-related deaths involving men aged 25–44 years. Most of the non-suicide deaths were the result of transport injuries (24.4%) and falls (19.4%).[1] This is partly because of the higher risk involved in male-dominated occupations, especially in the building and transport industries (with almost all the occupational deaths involving males). Mortality among young men from road traffic accidents is associated with higher levels of risk-taking behaviour.[4]

Although the 2004 prevalence of depression was higher in females, the mortality rate from suicide was much higher in males than females in the 15–24-years age group and in the over-65-years age group. It was especially high in rural and remote areas, probably because of the greater availability of more lethal means and higher rates of alcohol misuse.[1] Depression may manifest differently in men, especially through somatic symptoms and anger, or risky or uncontrolled behaviour.[5]

Reproductive and sexual health problems in men are relatively common, especially in those over the age of 40. They include:

1 Prevalence of common diseases[2] and incidence of and mortality from selected cancers affecting men[3]



2 Age-specific priorities for preventive care in men

	Low-risk groups		High-risk groups — additional actions*	
Age group	Priority	Evidence for intervention*	Action	Group
All men 18 + years	SNAP risk factors:		Melanocytic skin cancer screening	Men with multiple atypical or dysplastic naevi with personal or first-degree relative history of melanoma
	Smoking	IA		
	Nutrition and weight	IIB	Depression screening	Men with past history of depression or other psychological conditions; multiple or unexplained somatic complaints; chronic illness/pain; misuse of alcohol or other drugs
	Alcohol	IIB		
	Physical activity	IIIB		
	Blood pressure	IA		
35–44 years	Lipids	IA	Colorectal cancer enquiry	Men with family history of colorectal cancer (see guidelines*)
			Diabetes testing	Men with Aboriginal and Torres Strait Islander and certain ethnic backgrounds
			Non-melanocytic skin cancer check	Men with fair skin; high-level ultraviolet radiation exposure; family history of skin cancer
			Kidney disease testing	Aboriginal or Torres Strait Islander men
45–55 years	Colorectal cancer	IA	Diabetes testing	Men with impaired glucose tolerance or impaired fasting glycaemia; obesity, hypertension; clinical cardiovascular disease
	Diphtheria and tetanus vaccination	IIIA		
			Kidney disease testing	Men with diabetes; multiple risk factors; evidence of kidney disease
			Glaucoma testing	Men with family history of glaucoma; high myopia (> 8 diopters); diabetes; history of long-term steroid use
			Influenza and pneumococcal vaccination	Men with chronic diseases (see guidelines*)
			Osteoporosis assessment	Men with low-trauma fracture
55–64 years	Diabetes	IIIB		
	Stroke	IIIB		
	Kidney disease	IIIB		
	Glaucoma	IIIC		
65–74 years	Influenza and pneumococcal vaccination	IIA		
	Falls	IA		
75 + years	Dementia	IIC		

* Based on Royal Australian College of General Practitioners' *Guidelines for preventive activities in general practice*.[13]
SNAP = smoking, nutrition, alcohol and physical activity. ◆

- Benign prostatic hypertrophy, affecting 20% of men aged 40–49 years and 40%–50% of those aged over 65 years.[6]
- Erectile dysfunction, affecting 20% of 40–64-year-olds, increasing to 43% in those aged 65 years or over.[7] The cause may be organic and/or psychological. Organic causes are more frequent, especially in middle-aged and older men, most frequently penile vascular disorders, often in association with cardiovascular disease or type 2 diabetes.
- Male hormone disorders (including androgen deficiency), which occur in about one in 200 adult men (although undiagnosed cases may make this an underestimate).[8]

How to manage these problems in general practice

Logically, the priorities in men's health should be consistent with the impact of male health problems in the community, provided effective interventions are available. Thus, cardiovascular disease, cancers, injury and depression should receive the most attention, especially among males aged 15–64 years. However, other effective preventive strategies such as immunisation for tetanus (at age 50), influenza (yearly from age 65) and pneumococcal disease (repeated once, 10 years after the first dose) should not be neglected, especially in high-risk patients with chronic illnesses (eg, chronic obstructive pulmonary disease, diabetes, renal disease).[9]

3 Key assessments for men aged 45 years and over in general practice*

SNAP risk factors

Ask:

- How many cigarettes a day do you smoke?
- How many portions of fruit and vegetables do you eat each day?
- How many standard drinks of alcohol do you usually drink per day on weekdays and on weekends, and how many alcohol-free days do you have each week?
- How many times a week do you usually do 30 minutes (all together or in shorter amounts) of brisk walking or moderate physical activity?

Physiological risk

Measure:

- Body mass index (weight in kilograms divided by the square of height in metres) and waist circumference.
- Blood pressure.
- Total cholesterol and glucose levels by fasting blood test.
- Urine protein level and GFR if high risk.

Emotional health

Ask:

- Over the past 2 weeks have you felt
  - down, depressed or hopeless?
  - little interest or pleasure in doing things?

Early disease

Ask about:

- Skin lesions or changes, and examine high-risk men.
- Symptoms of sudden onset of loss of focal neurological function in patients aged over 55 years.
- Shortness of breath and chest pain.
- Change in bowel habits.
- Family history of cardiovascular disease, cancer, diabetes.

Perform:

- Faecal occult blood test for colorectal cancer (from age 50 years) or colonoscopy for high-risk groups.

Reproductive health

Enquire about changes over the past few months in:

- Urination (and its impact on life).
- Sexual function.

* Adapted from Royal Australian College of General Practitioners' *Guidelines for preventive activities in general practice*.[13]
SNAP = smoking, nutrition, alcohol and physical activity. GFR = glomerular filtration rate. ◆

4 Case study of a patient for whom motivational interviewing techniques may be useful

Joseph is a 45-year-old self-employed electrician who is overweight (body mass index, 28 kg/m^2). He does 20 minutes of moderate physical activity once a week. He is married with two grown-up children who do not live at home. He does not smoke, and drinks 2–3 standard drinks of beer per day. Joseph's diet is high in fat. He also drinks 1–2 bottles of soft drink per day. He eats little fruit and 1–2 servings of vegetables per day, and eats a very large meal at night. His father died at the age of 60 from a heart attack. On examination, his blood pressure is 140/90 mmHg. His fasting blood glucose level is 4.8 mmol/L; total cholesterol level, 6.0 mmol/L; high-density lipoprotein cholesterol level, 1.0 mmol/L; low-density lipoprotein cholesterol level, 3.0 mmol/L; triglyceride level, 3.0 mmol/L.

He finds it difficult to eat more healthily because there are no healthy food alternatives available at his workplace. He finds it difficult to find the time for physical activity because of his work. He is concerned about his health, but unsure whether he wants to change his lifestyle. He says: "I'd like to lose weight, but I've tried before and failed." According to the Stages of Change model,[15] he can be classified as "unsure" (contemplation), which places him in the most suitable group for motivational interviewing techniques.

Decision balance is one such technique in which, rather than telling the patient what to do, the doctor helps patients to reflect on their current behaviour and on changing it. For example: "What do you like about your current diet? What are the things you do not like about it? What would be the benefits of change? What would be the risks of change?" Then the doctor summarises what the patient has said, and asks the patient to weigh this up. This gentle approach is likely to result in patients coming up with a realistic plan which they can follow. ◆

The principal tasks for GPs in dealing with men's health problems can be summarised by the 5As approach:[10]

- **A**sk about risk factors or early signs of major health problems;
- **A**ssess the level of risk and diagnose as early as possible;
- **A**dvise and motivate patients to lower their risk;
- **A**ssist patients with pharmacological and non-pharmacological therapies;
- **A**rrange referral and follow-up.

How do we do this in general practice, where men are likely to present with a specific problem that may be unrelated to other potential health problems for which they may have risk factors, or in response to suggestions from their partners? And how do we deal with their reluctance to discuss emotional issues or reproductive health issues?

Incorporating a systematic preventive approach into the consultation involves understanding the whole person in his or her context.[11,12] To achieve this understanding involves assessing five components of the patient's world: (i) present and potential disease; (ii) the patient's experience of health and illness; (iii) the patient's potential for health; (iv) the patient's context; and (v) the patient–doctor relationship. Over time and multiple consultations, the processes of establishing common goals, exploring alternative ways of looking at current practices, and finding and trying new ways of fulfilling personal values, needs, motives and expectations will help men to become more aware of their health, and to be able to play an active role in reducing their risk of disease.

Thus, the first task is to proactively identify and assess health problems and their risk factors in the context of the whole person. The priorities for preventive care will vary across a man's life cycle (see Box 2). Key areas that should be be assessed are described in Box 3.

Assessment should take into account that each area may have different priority for the individual concerned, depending on the presence of other risk factors or disease. For example, the risk of diabetes increases in patients who are obese or have hypertension. More sensitive issues such as alcohol dependence, mental illness or sexual dysfunction may not be revealed until trust has been established with the doctor.

Prostate and testicular cancer are not specifically identified in this list of preventive assessments. This may be surprising given

5 General practitioner strategies for overcoming barriers to men pursuing appropriate care in general practice

Barrier	Strategy
Access	• Arrange special after-hours clinic times that are more accessible to men • Arrange access to other health professionals in the practice[28]
Identifying risk	• Use a preventive care checklist in the patient's records[29] • Have prompts in the waiting room, practice newsletter or local media encouraging men to have a check-up at least every 5 years, starting from age 45 years[30]
Short consultation time	• Arrange longer consultations for men who have not presented recently or for follow-up consultations[31]
Changing behaviour	• Enhance support by partners[26] • Use motivational interviewing techniques[16]
Follow-up	• Make follow-up appointments • Use phone or mail reminders for preventive care[32] ◆

the importance of prostate cancer in terms of its incidence and mortality. However, while screening (with a prostate-specific antigen test) can detect early-stage prostate cancer, there are problems with the accuracy of the test. There is also insufficient evidence that screening can reduce mortality, and screening, investigating and treating early prostate cancer is associated with significant risk of erectile dysfunction and urinary incontinence.[14] Similarly, there is insufficient evidence to support screening for testicular cancer. However, when men present with concerns about prostate or testicular cancer, their concerns should be respected and they should be informed of the potential benefits, risks and uncertainties of screening.[13]

Having assessed some of the more important health problems in men, the task remains of developing with patients an agreed plan with shared goals to help them make changes to decrease their health risks. For GPs, playing a supportive role is part of the process — listening, empathising and validating changed perspectives through rational discussion.[12] Developing a relationship based on trust and shared decision making will help to enhance men's sense of self-efficacy, and is critically important if GPs are to overcome some of the denial or anxiety that some male patients have about their health. Beginning with non-pharmacological interventions that patients can control themselves may be an important first step in reducing feelings of vulnerability or loss of control. Motivational interviewing techniques that challenge the patient's thinking and expectations of the consultation (such as asking them to list the good things about a health risk behaviour as well as the bad) may be especially useful.[15] The effectiveness of this strategy varies according to the problem, but it has produced changes in alcohol and diet behaviour in over 50% of "unsure" patients in trials.[16] An example of how such techniques might be applied is provided in the case study in Box 4.

Of course, if problems are identified, both follow-up and referral may be required. Engaging the patient in planning referral or follow-up visits and discussing the expected outcomes are important to help achieve goals.[17]

Overcoming some of the barriers

Although they suffer higher premature mortality rates than women, males aged 15–64 years are less likely to use GPs' services than women.[18] Almost one in four males hasn't seen a doctor in 12 months (compared with one in 10 females), with much lower rates of consultation in males than females aged between 15 and 44 years.[19] One of the main reasons is a reluctance to seek help until symptoms become undeniable.[20] This militates against a proactive approach to managing risk and early detection, which may be compounded by not having a previous relationship with a GP. Promoting the importance of early detection and help-seeking behaviour through practice newsletters may help. Metaphors such as looking after their bodies in the same way that they look after their motor cars may help some men to see the value in preventive health care interventions.[21,22] They are also very likely to be influenced by partners, both in seeking help and in changing their behaviour as a result.[23]

While there are no differences in rates of prescription per general practice encounter with males or females, females are more likely to have longer consultations.[24] This may be associated with the reluctance of male patients to signal the need for a comprehensive "check-up" and their lack of familiarity with general practice. Information in the waiting room highlighting the importance of a regular health check, encouraging longer appointments for patients who have not had a check-up for a number of years or who have multiple problems, and providing practice newsletters with specific information about men's health may help to encourage men to present more regularly to the GP. The effectiveness of establishing special clinic sessions for men's health check-ups has not been established.[25] It may also be useful to engage men's partners in supporting them to undertake preventive health care.[26]

Of course, we GPs ourselves may be reluctant or embarrassed to raise sensitive, emotional or reproductive health issues, especially if the patient is unfamiliar to us or reluctant to talk about their problems.[27] This may be compounded by concerns about lack of time, or our own adequacy in dealing with the problems uncovered. Obviously this requires reflection and education, but may be aided by prompts such as men's health questionnaires for patients to complete in the waiting room. Box 5 summarises some specific strategies GPs can use to make it easier for men to seek optimal health care.

It is important to realise that, even having overcome the hurdle of coming to the GP, men from low socioeconomic groups tend to experience barriers to preventive care. Men from low socioeconomic groups, including Indigenous patients, are less likely to receive preventive care such as colorectal cancer screening even after they present to general practice.[33] The reasons for this are not clear, but relate in part to the lower supply of GPs and shorter consultations in general practices in low socioeconomic areas.[34] Strategies to overcome this include increasing the supply and use of other health care professionals in general practices in disadvantaged areas, specific incentives to support GPs to provide preventive care in these areas, and population-based measures, such as taking health screening to workplaces.

Conclusion

General practice can play an effective role in identifying, assessing and managing some of the major health problems faced by men. Priorities should be set according to the impact of the conditions being focused on, the availability of effective interventions and the patient's own views. Barriers to effective preventive care for men in general practice include not only barriers to patients attending the practice but also barriers to GPs providing the best care — especially for patients from low socioeconomic backgrounds who have an increased burden of disease. Overcoming these barriers to men's health requires specific attention at both the practice and policy levels. Preventive care will certainly be greatly aided by the introduction of a Medicare item number for a routine comprehensive health assessment at age 45–55 years for all men, as this group is both less likely to present for preventive care and more likely to be at risk of disease.

Competing interests

None identified.

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