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Abbreviations: **CRPC**, castrate-resistant prostate cancer; **ET**, endothelin.

# ONLY CONNECT

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## INTRODUCTION

'Only connect': those two words are used to introduce E.M. Forster's classic novel *Howards End*. In fact, the same maxim could be used to persuade urologists to adopt a more holistic attitude towards the health of their male patients. All too often the primary condition with which a man presents, such as prostate cancer, BPH or erectile dysfunction (ED), is viewed too much in isolation, while other comorbidities and lifestyle issues are overlooked or ignored. Indeed, it is the connections between the wide spectra of disorders to which men are prone, which provide an explanation as to why men so often die earlier than women. Addressing these in a holistic manner might afford some solutions to the problem [1].

As the eminent Professor Anthony Clare, who sadly himself died prematurely not long ago, pointed out, one of the key components that made up the successful man (in addition to those virile attributes of strength, power, authority, decisiveness and rationality) was health. Until relatively recently femininity was associated with notions of frailty, vulnerability, sensitivity and weakness, and therefore masculinity was equated with health. It is therefore arguable that one of the explanations why men are reluctant to seek healthcare and appear to lack awareness of their health needs is that to admit to such needs would weaken their very maleness. Perhaps because of this, men are much less able to mobilize the support and social networks that are available to women in times of stress, and much male behaviour, including the way men negotiate their work/life balance, is a major contributory factor towards the poor prognosis for men's health.

Men not only die younger than women, but when sick, they seek help later, often too late. They show a much greater propensity to kill themselves, either directly by suicide, or indirectly by drinking abusively or taking unwarranted risks. Factors such as smoking, family breakdown, unemployment and the changing role of the sexes all appear to affect male health and life-expectancy. But it is when one looks at the health of men and women in the context of various degrees of socioeconomic disadvantage that the starkest contrast between the sexes is revealed. This is illustrated by the fact that women living in the least favourable circumstances have a substantially better life-expectancy than men living in the most favourable circumstances. To reduce these differences there need to be new health policies directed specifically towards men.

ED provides one of the best illustrations of an important connection between conditions affecting men. ED is often bothersome enough to drive the patient to consult his urologist and can usually be effectively treated by a phosphodiesterase type 5 inhibitor. However, ED can often be the presenting symptom of more widespread endothelial dysfunction; moreover, many afflicted patients are also suffering from many of the features of the metabolic syndrome, as highlighted by Jackson [2,3].

Several other recent reports review the published data on the prevalence of ED and the association of ED with overt and silent coronary artery disease. The mechanisms by which ED is associated with coronary artery disease and potential clinical implications of this association have been analysed extensively. Recently, the role of endothelial dysfunction in the pathophysiology of ED and the potential clinical usefulness of ED as a means of identifying patients with silent coronary artery disease have been emphasized [4].

A prospective study recently evaluated patients with ED in terms of coronary artery calcium (CAC) levels assessed by multidetector CT to investigate if the severity of ED could be used to predict the risk of coronary heart disease [5]. In all, 66 men with ED, with a mean age of 55.7 (range 41–77) years, and 23 men with no ED, aged 53.2 (39–76) years, were included in the study. A Pearson correlation test showed a significant negative correlation between the

International Index of Erectile Function (IIEF) score and CAC score ($r = -497$; $P < 0.001$). CAC scores increased significantly with decreasing IIEF score, such that a mean IIEF score of 1–10 (18 men) was associated with a mean CAC score of 557.7; an IIEF of 11–16 (13 men), with a mean CAC of 541.3; an IIEF of 17–25 (29 men) with a mean CAC of 84.6; and an IIEF of ≥26 (23 men, control group) with a mean CAC of 10.1. The difference between the mean CAC scores of these four groups was statistically significant ($P < 0.001$). When a threshold value for the IIEF score of 26 was used the CAC scores were significantly higher than in the group with an IIEF of <26 (mean 325.5 vs 10.1; $P < 0.001$). There was a positive correlation with ED severity and CAC levels. It was concluded that the detection and quantification of preclinical coronary artery disease by CAC scoring with a noninvasive method might have great potential for early cardiac-preventive measures, and should be considered in men presenting primarily with ED.

Returning to the broader issue of men's health, there is little doubt about the central role of health education. It is little help for a man to wait until he is ill and then stating 'if I had known that I would live this long, I would have taken more care of myself'. Men themselves, as well as the doctors who care for them, must learn to think more in preventative terms and change their lifestyles accordingly. Addressing the intertwined issues of obesity, exercise and diet, as well as hypogonadism and the increasingly frequently encountered metabolic syndrome, provides a very good start, and this is one that urologists should not eschew [6–10]. The premature death of a father and provider often leaves his partner and family in despair and disarray. If, as urologists, we can help to avoid such scenarios, we will have done a great deal of good.

## CONFLICT OF INTEREST

None declared.

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Abbreviations: **ED**, erectile dysfunction; **IIEF**, International Index of Erectile Function; **CAC**, coronary artery calcium.