

PATTERNS OF PRIMARY AND SECONDARY INFERTILITY IN QATARI MALE POPULATION

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Background: Infertility is a common problem in the world. Studies on prevalence of infertility among men are rare, and to our knowledge there are no studies that have reported male infertility in the Qatari population.

Objective: The aim of this study was to assess the prevalence of primary and secondary male infertility and examine its associated factors.

Design: This is a cross-sectional study.

Setting: The survey was conducted at Primary Health Care Centers and outpatient clinics of the Hamad General Hospital during a period from January 2008 to April 2008.

Subjects: The selected subjects for the study were Qatari men aged 20 to 60 years who were married for more than one year. 1050 men were approached and only 756 men gave consent, giving a response rate of 72%.

Methods: Face-to-face interviews were based on a questionnaire that included variables on socio-demographic characteristics, type of infertility in men, life style habits, type of environmental exposures and common diseases found among infertile men. All studied men were recruited using cluster random sampling at 10 randomly selected primary health care centres and outpatient clinics of the Hamad General Hospital in Qatar.

Results: The prevalence of primary infertility in men was (10.2%) with 95% CI (8.0%-12.4%) and secondary infertility (19.6%) with 95% CI (16.7%-22.4%). The primary (35.1%) and secondary infertility (40.5%) was significantly higher in the age group 31 — 40 years ($p < 0.001$). Only 6.5% of primary infertile men had had two or more wives, where as 10.8% of secondary infertile men had more than one wife. 36.4% of Infertility men had problems of obesity and 44.4% of infertile men had overweight. Nearly half of the infertile men were smokers (48.9%).

Conclusion: The study findings revealed that male infertility is high and a significant public health problem in Qatar. Efforts directed towards early diagnosis and health education for modifying lifestyle will clearly be important tasks for the future.

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OSTEOOMA OF THE TESTIS - CASE REPORT AND REVIEW OF THE LITERATURE

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Introduction: The formation of bone in soft tissues is uncommon. Ossification has been reported in benign and malignant tumors metastases. Osteoma has also been reported in the renal pelvis and the urinary bladder with and without the presence of stones.

Osteoma of the testis on the other hand is more of a medical curiosity than a rarity with one case having been reported in the medical literature. In this communication we report a case of osteoma presenting as an incidental testicular mass.

Case Report: A 43 years old gentleman presented in the urology clinic with secondary infertility, gave no history of epididymoorchitis, sexually transmitted disease, mumps, or having had surgery before.

Examination of the testes revealed a small hard painless lump in the right testis about 1 cm in size. The right epididymis and vas deferens were normal and so was the left hemiscrotum. Seminal fluid analysis showed azoospermia.

Ultrasound showed a calcified mass in the right testis in its lower pole around 1 cm in size, possibly a calcified granulomatous infection or a hematoma. The left side was within normal. CT —scan of the abdomen and pelvis was within normal apart from this small lesion in the Rt testis for which he was scheduled for exploration. After surgery, pathologic examination revealed a well demarcated bony lesion that consists of interlacing network of broad bony trabeculae consisting of dense lamellar bone containing few osteocytes. The bone marrow spaces are replaced by loose connective tissue. Surround testicular tissue showed atrophied seminiferous tubules and occasional interstitial cells of Leydig. There is no evidence of inflammation, calcification, granulomas, or germ cell tumor elements in the adjacent tissue and surrounding normal testicular tissue showing spermatogenesis.

Discussion: The controversy on osteoma occurring in the testis is whether this is arising from a monodermal teratoma, a hamartoma or indeed a calcification of an inflammatory granuloma.

In our case, we postulate that this is a case of monodermal teratoma since there is no evidence to attribute it to infection, trauma or otherwise. If so, it would be the first reported case of monodermal teratoma of the testis consisting exclusively of bone tissue.

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SOCIAL PRESSURE, STIGMA AND MARGINALIZATION: EXPERIENCES OF RECENTLY RITUALLY CIRCUMCISED XHOSA MEN IN EAST LONDON, SOUTH AFRICA

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Background: Male circumcision is largely practiced throughout South Africa among the Xhosa people as a rite of passage from boyhood to manhood. The manhood status achieved during this ritual accords initiated men power and authority in the community over women and uncircumcised men. As such, uninitiated men experience pressures to be circumcised in order exercise their masculinity and identify with other men.

Methods: This paper describes the experience of uninitiated Xhosa men in East London, South Africa. Interpretive phenomenology was used as an inquiry of choice. Data were collected through focus group discussions FGD's. Fourteen participants took part in the FGD's.

Findings: Only one theme emerged during the FGD's, marginalization of uninitiated Xhosa males, with two categories, namely: (a) rejection; and (b) lack of respect. The participants revealed that uninitiated men are rejected by the community, their own friends and families, and by women.

Conclusions: The discussion of the paper is framed around the concept of stigma as formulated by Link and Phelan (2001). We believe that by acknowledging that uninitiated males are stigmatized, a move towards the mitigation of such stigma can be made that would decrease the health complications resulting from stigmatization and the circumcision process.

Keywords: Culture; Hermeneutics phenomenology; Marginalised populations; Interpretive methods; Initiation rituals; Men's health; South Africa; Stigma

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IS THERE A NEED FOR DEGARELIX AS LH/RH ANTAGONIST IN TREATMENT OF ADVANCED PCA: COMPARATIVE REVIEW OF LITERATURE

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Introduction: After orchidectomy, patients achieve rapid suppression of serum testosterone levels, followed by decreases in levels of the tumour marker PSA. Testosterone levels of <0.2 ng/mL were achieved at 3–12 h (mean 8.6 h) after orchidectomy. This is accompanied by a remarkable decrease in PSA level by 21 days after orchidectomy. [1] Administration of GnRH agonist, causes serum testosterone levels initially to rise, to a peak 1.5–2 times greater than the initial testosterone levels [2]. Testosterone levels then remain above baseline levels for 7 days and do not reach castrate levels until 3 weeks after administration of the GnRH agonist. This could lead in the majority of the patients to the so called "testosterone flare effect".

Methods: Literature search through Pubmed and medline and comparative review of related articles. Four scientific posters and four papers had been considered in this work.

Results: GnRH agonists stimulate testosterone production before shutting it down. The initial testosterone surge can result in a transient increase (flare). As a result, serum PSA levels are not effectively suppressed until at least 4 weeks after administering the GnRH agonist in prostate cancer growth and in some patients can lead to a worsening of symptoms attributable to rapid cancer growth, such as bone pain and urinary obstruction or Treteric compression, known as the flare phenomenon. For this reason, patients beginning GnRH agonist therapy are generally also treated with short-term (eg three weeks' duration) oral anti-androgen therapy to prevent flare. Indeed, a recent survey found that in five European countries, 75–95% of all patients are given flare protection therapy on starting continuous GnRH agonist therapy. Faced with the shortcomings of current GnRH agonists, there is a need to develop agents that produce rapid, profound and sustained suppression of testosterone without a testosterone flare, similar in its effects to surgical castration which is increasingly unacceptable procedure from most of patients. Morote et al redefined the castration level and found in elegant study that testosterone was less than 20 ng/dl in all determinations in 32 patients (43.6%). Breakthrough increases between 20 and 50 ng/dl were observed in 23 patients (31.5%), and increases greater than 50 ng/dl were observed in the remaining 18 (24.7%). The lowest testosterone level with a significant impact on survival free of androgen independent progression was 32 ng/dl. A promising class of agents that might address these shortcomings is the GnRH blockers. GnRH blockers, like GnRH agonists, bind to the GnRH receptor, but produce immediate LH and testosterone suppression (i.e. with no initial testosterone flare), as has been reported for Degarelix, the most promising agent in this class to date.

Conclusion: Degarelix (regimens of 240/80 and 240/ 160 mg) induced testosterone and PSA suppression significantly faster than leuprolide; PSA suppression was also maintained throughout the study. Degarelix represents an effective therapy for inducing and maintaining androgen deprivation for up to 1 year in patients with prostate cancer, and has a different mechanism of action from traditional GnRH agonists. Its immediate onset of action achieves a more rapid suppression of testosterone and PSA than leuprolide. Furthermore, there is no need for antiandrogen supplements to prevent the possibility of clinical 'flare'.

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