



Stephen A Margolis

Embarrassing problems

Breaking down the barriers to therapy

'Embarrassment isn't a just cause of action.'¹

Jodi Picoult

In this month's issue of *Australian Family Physician* we consider some common, intimate, and potentially embarrassing problems. Perera and Sinclair² discuss excessive sweating and body odour; Bolin³ provides an overview on excessive intestinal gas; Wijesinha and colleagues⁴ provide an assessment of four common male conditions: erectile dysfunction, premature ejaculation, low libido, testicular lumps and prostate problems; and Rane and Read⁵ discuss how to help prevent unnecessary treatment by distinguishing normal penile anatomical variants from pathological conditions. In each of these articles, practical information on diagnosis, management and treatments to help the busy clinician stay abreast of the advances in the evidence base for effective clinical decision-making is discussed.

Despite these potentially embarrassing problems being relatively common, polite society historically delegated problems with wind, sweat, body odour and male genitals to the outer. Although we now live in a seemingly relaxed society where private and intimate medical problems are routinely examined under the microscope on celebrity talk shows and reality TV, many people appear to be reticent to discuss these issues with their healthcare providers. The reasons are complex and include personal privacy concerns, doubt about normal male genital anatomy, uncertainty of whom to consult for help, and misunderstanding of potential therapies. This may be manifested in the clinical consultation when a reluctant patient postpones voicing their true agenda of awkward or embarrassing issues, opting instead to start with the safe haven of 'standard problems'. Delayed introduction of their

embarrassing problem then results in insufficient time to deal with it, especially if it is introduced in a 'by the way' fashion as they are about to leave the consultation.⁶

The media has encouraged patients to directly engage with their healthcare providers in tackling intimate problems. For example, erectile dysfunction has received an intense media campaign, profiling that this is a common condition with simple, safe, effective and affordable treatments. Another new development has been the proliferation of websites focused on 'normalising' those intimate, embarrassing health concerns. They commonly provide reassuring words that these problems are worthy of consideration by their doctor, who will provide a sympathetic hearing and effective treatments. In particular they provide practical tips on how to actually broach the subject in the consultation.

That erectile dysfunction remains one of the most common untreated conditions in Australia⁴ suggests that these programs have had somewhat limited success to help patients introduce intimate topics while seeing their doctor.

Another approach is to move embarrassing problems that have lived in the shadow of standard clinical medicine towards the mainstream and 'normalise' their place in the consultation. A range of potential barriers for clinicians in raising these issues within the standard history, rather than leaving it to the patient to introduce them, include time constraints, language and ethnicity concerns, presence of the patient's other family members in the consultation, first contact with a patient, fear of embarrassing the patient, and lack of knowledge about the topic.⁷

This is an increasingly prudent course of action for erectile dysfunction, as this has now been demonstrated to be a reliable independent marker of silent vascular disease.⁸ Perhaps the same considerations should apply to other embarrassing problems where the potential consequences

of a missed diagnosis range from psychological distress for misinterpreting penile anatomical variation, diminished self-esteem and disrupted personal relationships for untreated excessive bowel gas or premature ejaculation, through to delayed diagnosis of testicular cancer.

Patients' reluctance to introduce their embarrassing conditions to their doctors may lead to significant morbidity. Although changes in public attitudes appear the best mode to address this, the addition of routine questions in the clinical history to inquire about these problems, may hasten the normalisation of managing these concerns in everyday clinical practice.

Author

Stephen A Margolis MBBS, MFM, MD, GEM, DRANZCOG, FRACGP, FACRRM, is Medical Editor, *Australian Family Physician*; Professor, School of Medicine, Griffith University, Queensland and a medical officer, the Royal Flying Doctor Service.

References

1. Picoult J. Handle with care. USA: Atria, 2009.
2. Perera E, Sinclair R. Hyperhidrosis and bromhidrosis: a guide to assessment and management. *Aust Fam Physician* 2013;42:266–9.
3. Bolin T. Wind: problems with intestinal gas. *Aust Fam Physician* 2013;42:280–3.
4. Wijesinha S, Piterman L, Kirby C. The male reproductive system: an overview of common problems. *Aust Fam Physician* 2013;42:276–8.
5. Rane V, Read T. Penile appearance, lumps and bumps. *Aust Fam Physician* 2013;42:270–4.
6. Hamilton W, Britten N. Patient agendas in primary care. *BMJ* 2006;332:1225–6.
7. Verhoeven V, Bovijn K, Helder A, et al. Discussing STIs: doctors are from Mars, patients from Venus. *Family Practice* 2003;20:11–15.
8. Jackson G. Erectile dysfunction: a marker of silent coronary artery disease. *Eur Heart J* 2006;27:2613–4.

correspondence afp@racgp.org.au