Obesity, especially male-pattern abdominal obesity, is strongly correlated with hypertension, diabetes, dyslipidaemia and consequent cardiovascular risk. It is also linked with erectile dysfunction (ED) and increased risk of benign prostatic hyperplasia (BPH), as well as greater morbidity after treatment for prostate cancer. Although diets low in carbohydrates and energy-rich fats are often successful in achieving weight reduction, their impact is often disappointingly short-lived, so that their long-term efficacy is limited. A urologist is frequently the first clinician that a patient, especially a middle-aged male patient, comes into contact with. Urological specialists are therefore in a unique position, not only to assess the presenting urological problem, often BPH and/or ED, but also to draw the patient’s attention to his abdominal obesity and inspire him to make the sustainable lifestyle modifications that can help to achieve, and maintain, significant weight reduction.

We advise our patients to ‘get to a better PLACE’ and achieve the balance between energy intake and calorie use that provides the key to weight reduction. A mnemonic of five simple rules acts as an aide mémoire for both clinician and patient (Figure 1):

**Portion control.** Generally speaking, the portions of energy-rich foods, eaten both at and away from home, are much larger than actually required. The overweight individual should be encouraged to eat smaller portions, without necessarily clearing his plate, and to resist the temptation to indulge in a second helping. This can help to reduce energy consumption.

Getting to a better ‘PLACE’: helping patients counter obesity by achieving enduring lifestyle change

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In the domain of public health, common sense is not always common practice. How best then to enable patients to act on the advice that they have constantly heard, but find hard to actually carry out?
Lose the booze. Cutting back, without necessarily cutting out altogether, regular alcohol in the evenings is another excellent way of reducing energy intake. Alcohol not only provides calories in its own right (around 100 calories per glass of wine, for example), but also encourages the recipient to consume extra food by, for example, finishing up the bottle of claret with a generous helping of cheese and biscuits. While moderate alcohol intake, especially red wine, may be mildly beneficial, consuming larger quantities on a regular basis not only encourages abdominal weight gain, but also disturbs sleep patterns and may jeopardise liver function.

Ax the snacks. Eating in between meals, especially foods high in energy but low in micronutrients, is associated with overweight and obesity. It has become customary these days to eat fast foods while walking around shopping, and the scent of, for example, doughnuts baking makes them difficult to resist. There is evidence that limiting consumption of sugar-sweetened beverages and snack foods (defined as high-fat, energy-dense foods) may be associated with a reduction in the risk of obesity.

Cut the carbs. Consumption of sugar-sweetened beverages, particularly carbonated soft drinks, may be a key contributor to the epidemic of overweight and obesity, by virtue of their high added sugar content and low satiety value. Processed white bread in the form of sandwiches with high-fat fillings should also be avoided. Fast foods, such as hamburgers and accompanying fries, are packed with starch, fat and salt, and sweet chocolate snacks produce rapid insulin release. These result in the laying down of body fat and the stimulation of the appetite centre, with consequent craving for another high-calorie, sugary or starchy, fatty fix.

Exercise every day. Emerging literature highlights the need to incorporate physical activity into every strategy intended to prevent weight gain as well as to maintain weight loss over time. Furthermore, physical activity needs to be part of any plan to lose weight. The stimulus of exercise provides valuable metabolic adaptations that improve energy and macronutrient balance regulation. A tight coupling between energy intake and energy expenditure has been documented at high levels of physical exercise, suggesting that exercise may improve appetite control. Regular physical activity also reduces the risk of stress-induced weight gain and improves health-related quality of life. The ideal time to do exercise is first thing in the morning when insulin and glucagon levels are low: this encourages fat burn and increases metabolic rate for up to 18 hours afterwards, promoting weight reduction.

One additional strategy to recommend is to Sleep more (in order to get to better PLACES), since chronic lack of sleep has also been shown to be associated with problems of overweight and obesity. Patients should also be advised to eat and drink less alcohol in the evening, and get to bed earlier. A memorable maxim is to practise 7/7/11: that is, exercise before 7am, eat in the evening before 7pm and get to bed before 11pm.

With modern environments promoting overeating and sedentary behaviour, a chronic minor imbalance between energy intake and energy expenditure inevitably leads to progressive obesity. Eventually a balance is reached and weight stabilises, because the adipose tissue mass is ‘sensed’, moderating energy intake. The cloning of the ob gene and the identification of its encoded protein, leptin, has elucidated the system signalling the amount of adipose energy stores to the brain. Leptin, a hormone secreted by fat cells, acts via hypothalamic receptors to inhibit feeding and increase thermogenesis. A feedback regulatory loop with three distinct steps has been identified:

1. a sensor (leptin production by adipose cells) monitors the size of the adipose tissue mass
2. hypothalamic centres receive and integrate the intensity of the leptin signal through leptin receptors
3. effector systems, including the sympathetic nervous system, control the two main determinants of energy balance, namely energy intake and energy expenditure.

Although some urologists may feel reluctant to venture outside the comfort zone of their urological expertise, the wellbeing of the patient as a whole, and not simply his prostate, is surely their clinical responsibility. Moreover, there is now evidence that reduction in abdominal girth not only reduces cardiovascular risk, but can also improve ED, a condition that drives many men to seek urological help. Although, of course, we should still retain Hippocrates’ imperative to ‘first do no harm’, perhaps a maxim for the 21st century should instead be ‘first do some good’. Encouraging our patients to adopt a healthier lifestyle in order to reduce their waistline measurements would be a very good start. However, before we offer advice to our patients to get to a better PLACE, we had better make a start by making sure we get there ourselves!

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Continued on page 43
anaesthetic (n=110). Using a rigid metric ruler, three penile measurements were taken: flaccid pendulous penile length, flaccid penopubic penile length (to the pubic arch) and stretched flaccid penopubic length. In addition, testicular size was measured using an orchidometer. The patient’s age and the reason for referral were recorded. Statistical analysis was carried out using Pearson correlation analysis.

Measurements from 610 patients aged 16–90 years were available for analysis. The mean penile lengths were: pendulous length 8.7cm (SD 1.6cm), penopubic length 10.2cm (SD 1.4cm) and stretched length 14.3cm (SD 1.7cm). The mean testicular volume was 19.8ml (SD 5.4ml) for both left and right testicles. Men with penile disease (including phimosis and Peyronie’s disease) had slightly reduced penile length (pendulous −3.3mm, p=0.014; penopubic −2.3mm, p=0.029; stretched −5.1mm, p<0.001) compared with other referral groups (erectile dysfunction, testicular disease, prostate and bladder disease). There was no significant correlation between penile length and age or testicular size.

These data establish a reference range for adult male genital size in the UK, which should be helpful for urologists when counselling patients.


MESSAGE FOR THE CLINIC

There is a wide range of size and appearance of the penis. The growth of the penis with age has been documented and a centile chart is available, published by Schonfeld in 1943. The normal adult appearance has not been as effectively documented. Most teenagers exploring their sexuality have anxieties, and concern about penile size is common. Unsolicited emails offering penile enlargement procedures often exacerbate the problem. Exposure to pornographic material can further add to the problem by providing unrealistic expectations. There is limited research into the relationship between penile size and sexual satisfaction, particularly from the partner’s point of view. In primary care, it is often reassurance that is necessary, combined with sex education.

This study establishes a reference range for adult Caucasian male genital size in the UK using penile length measurements. The data demonstrate an average flaccid pendulous length of 8.7cm and a stretched flaccid length of 14.3cm. The authors advise use of the stretched flaccid length because pendulous length may be confounded by prominent prepubic fat pad, and stretched length may better correlate with erected length. Pendulous flaccid length is from the tip of the penis to the base of the penis and stretched flaccid length is from the pubic bone to the tip of the penis, under gentle painless extension.

The threshold for a micropenis in UK men is 4.7cm pendulous length and 6.7cm penopubic length. The authors suggest that anything less than 10cm erect length can cause functional problems. Identification of micropenis in paediatric practice is important and treatment of hormonal deficiencies is effective at increasing penile size. Treatment of the adult micropenis is more controversial and both urological and psychological expertise should be sought.

Continued from page 40

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