



## Male gender role and its implications for family medicine

Rohan Maharaj, MB BS Yves Talbot, MD

**M**en experience more life-threatening and serious illness and die younger than women.<sup>1</sup> Across cultures and countries there is an average 7-year difference in longevity between men and women.<sup>1,3</sup> Social and cultural barriers<sup>4</sup> to seeking health care have been used to explain this difference; however, a large part of this mortality can be explained by male gender\* behaviour.<sup>1</sup>

Male gender behaviour can be defined as behaviour regarded by a particular culture to be acceptable for men.<sup>5</sup> Male gender behaviour in Western societies has been thought to consist of four roles<sup>6</sup> that lead to risky health behaviours, such as drinking and not wearing seat belts or protective equipment while playing sports. The following paragraphs describe these four roles and some of the evidence for their existence.

### No sissy stuff

In this role men deny their emotions and hide their tears and vulnerability. It has been shown that men are less emotionally expressive than women. This behaviour has been implicated as the reason men do not ask for emotional support or express distress so that others can respond to their needs. The more traditional men's views of masculinity are, the less likely they are to seek psychological help.<sup>7,9</sup> This image is sometimes nurtured by the popular media, which often portrays and maintains the stereotype of men as cold and emotionless.<sup>10</sup> Admittedly this stereotype is not as widespread as before in North America.

### The "big wheel"

The big wheel role encourages success, status, and power. Evidence suggests that there is a benefit to being in control<sup>11</sup>; however, type A behaviour, often a feature of the big wheel, has been found to be associated with increased morbidity. Several investigators have found a positive correlation

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\*Gender role or behaviour used throughout this article refers to patterns of culturally approved behaviours that are regarded as more desirable for either women or men.

between type A behaviour and the male sex role.<sup>12,13</sup> Extreme aggressiveness, easily aroused hostility, a sense of time urgency, and striving for achievement (the features of type A behaviour), have been associated with an increased risk of mortality from coronary heart disease.<sup>14,15</sup> The construct of social dominance, which can be measured by verbal behaviours such as quick responses or interrupting another's speech, have been found to be positively correlated to mortality.<sup>16</sup>

### The sturdy oak

In this role men maintain an air of toughness, confidence, and self-reliance and might deny pain, eg, angina. Denial of pain can translate into delayed intervention for myocardial infarctions and increased risk of death. The sturdy oak also denies the psychological pain, loneliness, and despair of depression, which might ultimately lead to suicide. In 1991, 80% of all suicides in Canada involved men.<sup>17</sup>

### Give them hell

This role asks men to take risks and be aggressive and might manifest by the use of guns or by working in physically hazardous environments. These factors are thought to account for 5% to 10% of gender difference in mortality.<sup>1</sup>

Pleck and Sonnenstein<sup>18</sup> interviewed 15- to 19-year-old male subjects on two occasions in 1980 and 1988. Results of their analyses showed that traditional male role attitudes had a significant, independent association with problems, such as being suspended from school, drinking and using street drugs, and frequently being picked up by police. The traditional male role extended into sexual behaviour; these men were sexually active, had a large number of heterosexual partners in the last year, and had tricked or forced someone to have sex.

### Role of family physicians

Men are often victims of their own constricting role expectations. How can family physicians use this knowledge to assist men to overcome these

stereotypes? The four principles of family medicine help explore this issue.<sup>19</sup>

Evidence shows that organizational and environmental support can assist in changing health behaviour (personal communication from Skinner H, Botelho R. 1999). Because men do not readily present to doctors' offices, much of what doctors can do for men is often at a social and organizational level.

### **Physician-patient relationship is crucial**

The quality of the physician-patient relationship will often determine the success of attempted health intervention.<sup>20</sup> As male physicians we need to recognize our blind spots when dealing with male patients. We are vulnerable to the same roles. Do we feel uncomfortable talking about sexual preferences and practices with our male patients because of our own homophobia or prudishness? Do we assume that our male patients are healthy and reinforce the male sex role of invincibility? Men often attend our clinics at the bidding of their wives,<sup>21</sup> families, or employers; we need to acknowledge this before we can foster the relationship.

Finally, family physicians need to remember that the gender role often teaches men that revealing their feelings or emotions is "sissyish." For the relationship to flourish, men must feel that their physicians are accepting and nonjudgmental.

### **Family medicine is community-based**

As first contact, family physicians must recognize that, with male patients, their presentation could be ambiguous. It is important to look beyond their work stress and family issues. Further, as community-based physicians we must be aware of the appropriate male-friendly organizations available, whether men's groups, physical education, or andrology clinics, and be prepared to refer when necessary.

### **Family physicians as resources**

First, as a resource we need to be aware of the special risk factors facing our male population. These risk factors are likely to be different in industrial settings, gay communities, and retirement communities.

Next, physicians should be involved in data collection and analysis of their practice patterns and be prepared to evaluate new information pertaining to their male patients, as it becomes available. Our waiting room reading material should reflect our interest in the health of men.

Also, by understanding how social and financial inequality, sex roles, power, and race affect the

determinants of health, family physicians will help patients gain insight into the struggles of modern living. Family physicians should always remember that those at the bottom of the class hierarchy have greater risk of morbidity and mortality.<sup>16</sup>

We need to structure our clinic hours so working men have access to us, and we need to promote an environment in our clinic where men receive information on their health and feel that male issues will be addressed.

### **Family physicians are skilled clinicians**

As skilled clinicians, we must use our knowledge of male gender roles to understand the illness experience of men. For men, the illness might diminish their feelings of manliness. Skilled clinicians should expect this and are prepared to explore and validate men's illness experience. We must be prepared to use open-ended questions, counseling skills, and a patient-centred approach to allow men space to bring up troublesome issues. We should always remember to search for the hidden agenda.

Skilled clinicians use evidence-based information in counseling male patients. For example, there is fair evidence for routine detection and counseling of men about alcohol and wearing seat belts in automobiles. Evidence also shows the benefits of physician education programs on suicide prevention in high-risk groups and support to stop smoking.<sup>17</sup>

### **Conclusion**

When we address societal expectations and gender and power influences, we help both our male and female patients understand how these forces shape our lives and how they can, in turn, cause substantial morbidity and mortality.

Family physicians need to understand how the male role contributes to risky behaviour. Evidence is accumulating that our subconscious concepts of masculinity are dangerous to men's health. We need to use this knowledge first in our medical practices and second in designing programs, organizations, and environments that reflect these understandings and bring awareness to our male patients. ♦

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### References

1. Waldron I. Contributions of changing gender differences in behavior and social roles to changing gender differences in mortality. In: Sabo D, Gordon DF, editors. *Men's health and illness: gender, power and the body*. Thousand Oaks, Calif: Sage Publications; 1995. p. 22-45.
2. Harrison J, Chin J, Ficarroto T. Warning: masculinity may be dangerous to your health. In: Kimmel MS, Messner MA, editors. *Men's lives*. 2nd ed. New York, NY: McMillan Publishing Co; 1992. p. 271-85.
3. Stillion J. Premature death among males. Extending the bottom line on men's health. In: Sabo D, Gordon DF, editors. *Men's health and illness: gender, power and the body*. Thousand Oaks, Calif: Sage Publications; 1995. p. 46-67.
4. Umberson D. Gender, marital status and the social control of health behavior. *Soc Sci Med* 1992;34(8):907-17.
5. Sabo D, Gordon DF. Rethinking men's health and illness. In: Sabo D, Gordon DF, editors. *Men's health and illness: gender, power and the body*. Thousand Oaks, Calif: Sage Publications; 1995. p. 1-21.
6. Brannon R. The male sex role: our culture's blueprint for manhood, and what it's done for us lately. In: David D, Brannon R, editors. *The 49% majority*. Reading, Mass: Addison-Wesley; 1976. p. 1-45.
7. Ganong LH, Coleman M. Sex, sex roles and emotional expressiveness. *J Genet Psychol* 1984;146(3):405-11.
8. Saurer MK, Eisler RM. The role of masculine gender role stress in expressivity and social support network factors. *Sex Roles* 1990;23(5):261-71.
9. Good GE, Dell DM, Mintz LB. Male role and gender role conflict: relations to help seeking in men. *J Counseling Psychol* 1989;36(3):295-300.
10. *Stale roles and tight buns: images of men in advertising* [videorecording]. Brighton, Mass: O.A.S.I.S.; 1989.
11. Wilkinson RG. Socioeconomic determinants of health: health inequalities: relative or absolute material standards. *BMJ* 1997;314:591-5.
12. Zeldow P, Clark D, Daugherty S. Masculinity, femininity, type A behavior and psychosocial adjustment in medical students. *J Pers Soc Psychol* 1985;45:481-92.
13. Stevens M, Pfost K, Ackerman M. The relationship between sex role orientation and the type A behavior pattern: a test of the main role hypothesis. *J Clin Psychol* 1984;40:1338-41.
14. Siegel JM. Type A behavior. Epidemiological foundations and public health implications. *Annu Rev Public Health* 1984;5:343-67.
15. Hegelson VS. The role of masculinity in a prognostic predictor of heart attack severity. *Sex Roles* 1990;22(11):755-74.
16. Houston BK, Babyak MA, Chesney MA, Black G, Ragland DR. Social dominance and all-cause mortality in men. *Psychosom Med* 1997;59:5-12.
17. Canadian Task Force on the Periodic Health Examination. *The Canadian guide to clinical preventive health care*. Ottawa, Ont: Canada Communication Group Publishing; 1994.
18. Pleck JH, Sonnenstein FL. Problem behaviors and masculinity ideology in adolescent males. In: Ketterlinus RD, Lamb ME, editors. *Adolescent problem behaviors*. Hillsdale, NJ: Lawrence Erlbaum; 1991.
19. *The four principles of family medicine* [monograph online]. Mississauga, Ont: College of Family Physicians of Canada; 1997 [updated 1997 Nov]. Available from URL <http://www.cfpc.ca/four.htm>. Accessed 1998 Oct 24.
20. Stewart MA. Effective physician-patient communication and health outcomes: a review. *Can Med Assoc J* 1995;152(9):1423-33.
21. Norcross WA, Ramirez C, Palkinas LA. The influence of women on the health care-seeking behavior of men. *J Fam Pract* 1996;43(5):475-80.

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## Le rôle masculin et ses ramifications en médecine familiale

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Les hommes sont aux prises avec un plus grand nombre de maladies sérieuses, susceptibles d'être mortelles, et meurent plus jeunes que les femmes<sup>1</sup>. Dans toutes les cultures et tous les pays, la différence dans l'espérance de vie entre les hommes et les femmes est d'environ sept ans<sup>1-3</sup>. Des obstacles d'ordre social et culturel<sup>4</sup> qui empêcheraient de recourir aux soins de la santé en seraient à l'origine selon certains; par ailleurs, cette mortalité s'explique en grande partie par des comportements typiquement masculins\*<sup>1</sup>.

Le comportement masculin peut être défini comme celui considéré acceptable chez les hommes dans une culture donnée<sup>5</sup>. Dans les sociétés occidentales, le comportement masculin comporterait quatre rôles<sup>6</sup> qui engendrent des façons d'agir posant des risques pour la santé, comme la consommation d'alcool, ou le fait de ne pas porter de ceinture de sécurité ou d'équipement de protection dans la pratique d'un sport. Les paragraphes suivants décrivent ces quatre rôles et présentent certaines données en démontrant l'existence.

### À bas les efféminés

Dans ce rôle, les hommes renient leurs émotions et cachent leurs larmes et leur vulnérabilité. Il a été démontré que les hommes expriment moins leurs émotions que les femmes. Ce comportement a été associé au motif pour lequel les hommes ne demandent pas d'appui émotionnel, ni n'expriment leur détresse de manière à ce que les autres puissent répondre à leurs besoins. Plus l'homme a une vision traditionnelle de la masculinité, moins il est susceptible de demander de l'aide psychologique<sup>7-9</sup>. Cette image est parfois alimentée par les médias populaires, qui dépeignent et font persister le stéréotype de l'homme comme étant froid et insensible<sup>10</sup>. Il faut quand même admettre

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\* Le rôle ou le comportement masculin ou féminin, selon le cas, est utilisé dans le présent article pour désigner les modes de comportement culturellement acceptés et jugés plus souhaitables respectivement chez l'homme ou chez la femme.

que ce stéréotype n'est plus aussi répandu qu'autrefois en Amérique du Nord.

### « L'engrenage de la réussite »

Le rôle associé à l'engrenage de la réussite préconise le succès, le statut social et le pouvoir. Des données probantes font valoir qu'il y a des avantages à maîtriser la situation<sup>11</sup>; par ailleurs, le comportement du type A, souvent caractéristique de l'engrenage de la réussite, a été relié à une hausse de la morbidité. Plusieurs analystes ont découvert une corrélation positive entre le comportement de type A et le rôle masculin<sup>12,13</sup>. Une agressivité extrême, une hostilité facilement déclenchée, un sens de l'urgence et l'aspiration à la réussite (les caractéristiques du comportement de type A) ont été associés à un risque accru de mortalité pour cause de coronaropathie<sup>14,15</sup>. Il a été reconnu que le construct de la dominance sociale, pouvant être mesuré par des comportements verbaux comme des réponses rapides ou l'interruption de la parole d'autrui, est définitivement relié à la mortalité<sup>16</sup>.

### Le roc de Gibraltar

Dans ce rôle, les hommes tiennent à donner l'impression de rudesse, de confiance et d'autosuffisance, allant jusqu'à ignorer la douleur, comme l'angine. Le fait de passer outre la douleur peut se traduire par une intervention tardive dans un cas d'infarctus du myocarde, d'où un risque accru de décès. Le roc de Gibraltar désavoue aussi sa souffrance psychologique, sa solitude et le désespoir de la dépression, ce qui peut mener en fin de compte au suicide. En 1991, de tous les suicides au Canada, 80% avaient été commis par des hommes<sup>17</sup>.

### Pas froid aux yeux

Ce rôle impose aux hommes de prendre des risques et d'être agressifs. Il peut se manifester par l'usage d'armes à feu ou par un travail dans des environnements physiquement dangereux.

On croit que ces facteurs seraient à l'origine de 5 à 10% de la différence dans les taux de mortalité<sup>1</sup>.

Pleck et Sonnenstein<sup>18</sup> ont interviewé des sujets masculins de 15 à 19 ans à deux reprises, en 1980 et en 1988. Les résultats de leur analyse ont fait valoir que les attitudes liées au rôle traditionnellement masculin ont un rapport considérable et direct avec des problèmes comme le fait d'être suspendu de l'école, de consommer de l'alcool et des drogues illicites, et d'être fréquemment conduit au poste de police. Le rôle traditionnel masculin se retrouve aussi dans le comportement sexuel; ces hommes étaient sexuellement actifs, avaient eu un grand nombre de partenaires hétérosexuels au cours de la dernière année et avaient usé de force ou de ruse pour avoir une relation sexuelle.

### **Le rôle des médecins de famille**

Les hommes sont souvent victimes de leurs propres attentes contraignantes entourant leur rôle. Comment les médecins de famille peuvent-ils utiliser leur savoir pour aider les hommes à se défaire de ces stéréotypes? Les quatre principes de la médecine familiale contribuent à explorer plus profondément cet enjeu<sup>19</sup>.

Des données probantes font ressortir que le soutien organisationnel et environnemental peut contribuer à changer le comportement en matière de santé (communication personnelle de Skinner H, Botelho R., 1999). Puisque les hommes ne se présentent pas spontanément au cabinet d'un médecin, la majorité de ce que les médecins peuvent accomplir se situe sur le plan social ou organisationnel.

### **La relation médecin-patient est d'une importance capitale**

La réussite d'une tentative d'intervention en matière de santé est souvent tributaire de la qualité de la relation médecin-patient<sup>20</sup>. En tant que médecins de sexe masculin, nous devons reconnaître nos faux-fuyants dans nos rapports avec des patients de même sexe. Nous sommes vulnérables aux mêmes rôles. Sommes-nous mal à l'aise de parler avec nos patients masculins de préférences et de pratiques sexuelles en raison de notre propre homophobie ou pudeur excessive? Présomons-nous que nos patients mâles sont en santé et renforcent le rôle masculin de l'invincibilité? Les hommes se présentent souvent à la clinique à la demande de leurs épouses<sup>21</sup>, de leur famille ou de leurs employeurs; il nous faut reconnaître ce fait avant de pouvoir favoriser la relation.

Enfin, les médecins de famille doivent se rappeler que le rôle masculin enseigne souvent aux hommes que l'aveu de leurs sentiments ou de leurs émotions est un acte efféminé. Pour que la relation soit fructueuse, il faut que les hommes sentent que leur médecin fait preuve de réceptivité et ne porte pas de jugement.

### **La médecine familiale est centrée sur la communauté**

En qualité de premier contact, les médecins de famille doivent reconnaître qu'avec leurs patients masculins, leur présentation pourrait être ambiguë. Il importe de regarder au-delà de leur stress professionnel et des problèmes familiaux. De plus, à titre de médecins centrés sur la communauté, nous devons être au fait de l'accessibilité d'organismes propices aux relations d'amitié entre hommes, qu'il s'agisse de groupes d'hommes, d'éducation physique ou de cliniques d'andrologie. Il faut également être disposés à aiguiller les patients, au besoin, vers de tels services.

### **Les médecins de famille en tant que ressources**

D'abord, en qualité de ressource, nous devons être sensibilisés aux facteurs de risque particuliers à la population masculine. Ces facteurs de risque différeront probablement s'il s'agit d'un milieu industriel, d'une communauté homosexuelle ou d'une collectivité de retraités.

Ensuite, les médecins devraient participer à la collecte et à l'analyse de données sur leurs modes de pratique, et être disposés à évaluer de nouveaux renseignements concernant leurs patients masculins, au fur et à mesure qu'ils sont disponibles. Les publications dans notre salle d'attente devraient refléter notre intérêt à l'endroit de la santé des hommes.

De plus, en comprenant comment les inégalités sur le plan social et financier, les rôles types masculins et féminins, le pouvoir et la race peuvent influencer les déterminants de la santé, les médecins de famille aideront les patients à avoir un meilleur aperçu des luttes de la vie moderne. Les médecins de famille ne devraient jamais oublier que ceux au bas de l'échelle hiérarchique dans la société présentent des risques plus élevés de morbidité et de mortalité<sup>16</sup>.

Il nous faut structurer nos heures de clinique de manière à ce que les hommes qui travaillent aient accès à nous. Nous devons également favoriser dans nos cliniques un environnement où les hommes reçoivent de l'information sur leur

santé et sentent que les questions masculines seront prises en compte.

### Les médecins de famille sont des cliniciens compétents

En tant que cliniciens compétents, nous devons nous servir de notre savoir sur les rôles masculins pour comprendre l'expérience de la maladie qu'éprouvent les hommes. La maladie peut diminuer chez l'homme son sentiment de masculinité. Les cliniciens compétents s'y attendent et sont préparés à explorer et à valider l'expérience de la maladie chez les hommes. Nous devons être disposés à recourir à des questions ouvertes, aux habiletés de counseling et à une approche centrée sur le patient pour donner aux hommes la possibilité voulue de soulever les questions qui les troublent. Nous devrions toujours nous rappeler d'être toujours en quête des intentions cachées.

Les cliniciens compétents se servent de renseignements fondés sur des données probantes quand ils prodiguent des conseils aux hommes sur la consommation d'alcool et le port de la ceinture de sécurité en voiture. Les données probantes font également valoir les bénéfices des programmes d'éducation des médecins sur la prévention du suicide dans les groupes à risque élevé et elles appuient la cessation du tabagisme<sup>17</sup>.

### Conclusion

Lorsque nous tenons compte des attentes sociétales et des influences du sexe et du pouvoir, nous aidons à la fois nos patients et nos patientes à comprendre comment ces forces façonnent nos vies et comment elles peuvent, en retour, être à la source d'une morbidité et d'une mortalité considérables.

Les médecins de famille doivent comprendre comment le rôle masculin contribue à un comportement à risque. Les données probantes se multiplient à l'effet que nos concepts subconscients de la masculinité sont dangereux pour la santé des hommes. Nous devons nous servir de ce savoir, d'abord dans notre pratique médicale et, en deuxième lieu, dans la conception de programmes, d'organisations et d'environnements qui manifestent cette compréhension et consciencient nos patients masculins. ♦

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### Références

1. Waldron I. Contributions of changing gender differences in behavior and social roles to changing gender differences in mortality. Dans: Sabo D, Gordon DF, éditeurs. *Men's health and illness: gender, power and the body*. Thousand Oaks, Calif: Sage Publications; 1995. p. 22-45.
2. Harrison J, Chin J, Ficarrotto T. Warning: masculinity may be dangerous to your health. In: Kimmel MS, Messner MA, editors. *Men's lives*. 2<sup>e</sup> éd. New York, NY: McMillan Publishing Co; 1992. p. 271-85.
3. Stillion J. Premature death among males. Extending the bottom line on men's health. In: Sabo D, Gordon DF, éditeurs. *Men's health and illness: gender, power and the body*. Thousand Oaks, Calif: Sage Publications; 1995. p. 46-67.
4. Umberson D. Gender, marital status and the social control of health behavior. *Soc Sci Med* 1992;34(8):907-17.
5. Sabo D, Gordon DF. Rethinking men's health and illness. Dans: Sabo D, Gordon DF, editors. *Men's health and illness: gender, power and the body*. Thousand Oaks, Calif: Sage Publications; 1995. p. 1-21.
6. Brannon R. The male sex role: our culture's blueprint for manhood, and what it's done for us lately. Dans: David D, Brannon R, editors. *The 49% majority*. Reading, Mass: Addison-Wesley; 1976. p. 1-45.
7. Ganong LH, Coleman M. Sex, sex roles and emotional expressiveness. *J Genet Psychol* 1984;146(3):405-11.
8. Saurer MK, Eisler RM. The role of masculine gender role stress in expressivity and social support network factors. *Sex Roles* 1990;23(5):261-71.
9. Good GE, Dell DM, Mintz LB. Male role and gender role conflict: relations to help seeking in men. *J Counseling Psychol* 1989;36(3):295-300.
10. *Stale roles and tight buns: images of men in advertising* [enregistrement vidéo]. Brighton, Mass: O.A.S.I.S.; 1989.
11. Wilkinson RG. Socioeconomic determinants of health: health inequalities: relative or absolute material standards. *BMJ* 1997;314:591-5.
12. Zeldow P, Clark D, Daugherty S. Masculinity, femininity, type A behavior and psychosocial adjustment in medical students. *J Pers Soc Psychol* 1985;45:481-92.
13. Stevens M, Pfost K, Ackerman M. The relationship between sex role orientation and the type A behavior pattern: a test of the main role hypothesis. *J Clin Psychol* 1984;40:1338-41.

14. Siegel JM. Type A behavior. Epidemiological foundations and public health implications. *Annu Rev Public Health* 1984;5:343-67.

15. Hegelson VS. The role of masculinity in a prognostic predictor of heart attack severity. *Sex Roles* 1990;22(11):755-74.

16. Houston BK, Babyak MA, Chesney MA, Black G, Ragland DR. Social dominance and all-cause mortality in men. *Psychosom Med* 1997;59:5-12.

17. Groupe d'étude canadien sur l'examen

médical périodique. *Guide canadien de médecine clinique préventive*. Ottawa, Ont: Éditions du Groupe Communication Canada; 1994.

18. Pleck JH, Sonnenstein FL. Problem behaviors and masculinity ideology in adolescent males. Dans: Ketterlinus RD, Lamb ME, éditeurs. *Adolescent problem behaviors*. Hillsdale, NJ: Lawrence Erlbaum; 1991.

19. *Les quatre principes de la médecine familiale* [monographie en direct]. Mississauga, Ont: Collège des médecins de famille du Canada;

1997 [mis à jour en nov. 1997]. Accessible à l'adresse URL <http://www.cfpc.ca/four.htm>. Accédé le 24 oct. 1998.

20. Stewart MA. Effective physician-patient communication and health outcomes: a review. *Can Med Assoc J* 1995;152(9):1423-33.

21. Norcross WA, Ramirez C, Palkinas LA. The influence of women on the health care-seeking behavior of men. *J Fam Pract* 1996;43(5):475-80.

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NASACORT™ AQ (triamcinolone acetonide aqueous nasal spray) is indicated for the topical treatment of the symptoms of perennial and seasonal allergic rhinitis unresponsive to conventional treatment. Regular use is essential since maximum relief may not be obtained until after 2 to 3 days of treatment.

**CONTRAINDICATIONS:**

Hypersensitivity to any of the ingredients of NASACORT™ AQ (triamcinolone acetonide aqueous nasal spray), and in patients with active or quiescent tuberculosis, or untreated fungal, bacterial and viral infection.

**WARNINGS:**

In patients previously on prolonged periods or high doses of systemic steroids, the replacement with a topical corticosteroid can be accompanied by symptoms of withdrawal, e.g. joint and/or muscular pain, lassitude, and depression; in severe cases, adrenal insufficiency may occur, necessitating the temporary resumption of systemic steroid therapy. These patients should be carefully monitored for acute adrenal insufficiency in response to stress. Careful attention must be given to patients with asthma or other clinical conditions in whom a rapid decrease in systemic steroids may cause a severe exacerbation of their symptoms. The use of NASACORT™ AQ (triamcinolone acetonide aqueous nasal spray) with alternate day systemic prednisone could increase the likelihood of hypothalamic-pituitary-adrenal (HPA) suppression compared to a therapeutic dose of either one alone. Therefore, NASACORT™ AQ should be used with caution in patients already receiving alternate-day prednisone treatment for any disease. Patients who are on immunosuppressant drugs are more susceptible to infections than healthy individuals. Chickenpox and measles, for example, can have a more serious or even fatal course in children or adults on immunosuppressant doses of corticosteroids. In such children, or in adults who have not had these diseases, particular care should be taken to avoid exposure. If exposed, therapy with varicella zoster immune globulin (VZIG) or pooled intravenous immunoglobulin (IVIG), as appropriate, may be indicated. If chickenpox develops, treatment with antiviral agents may be considered. Pregnancy: See Precautions

**PRECAUTIONS**

1) The replacement of a systemic steroid with NASACORT™ AQ (triamcinolone acetonide aqueous nasal spray) has to be gradual and carefully supervised by the physician. The guidelines under "Administration" should be followed in all such cases. 2) During long-term therapy pituitary-adrenal function and hematological status should be assessed. 3) Patients should be informed that the full effect of NASACORT™ AQ therapy is not achieved until 2 to 3 days of treatment have been completed. Treatment of seasonal rhinitis should, if possible, start before the exposure to allergens. 4) Treatment with NASACORT™ AQ should not be stopped abruptly but tapered off gradually. 5) Corticosteroids may mask some signs of infection and new infections may appear. A decreased resistance to localized infections has been observed during corticosteroid therapy; this may require treatment with appropriate therapy or stopping the administration of NASACORT™ AQ. 6) Glaucoma and osteoporosis are possible adverse effects associated with a long-term use of large doses of corticosteroids. The possibility of atrophic rhinitis and/or pharyngeal candidiasis should be kept in mind. 7) There is an enhanced effect of corticosteroids on patients with hypothyroidism and in those with cirrhosis. Acetylsalicylic acid should be used cautiously in conjunction with corticosteroids in hypothyroidism. 8) Because of the inhibitory effect of corticosteroids on wound healing, in patients who have had recent nasal surgery or trauma, a nasal corticosteroid should be used with caution until healing has occurred. As with other nasally inhaled corticosteroids, nasal septal perforations have been reported in rare instances. 9) Patients should be advised to inform subsequent physicians of prior use of corticosteroids. 10) Until greater clinical experience has been gained, the continuous, long-term treatment of children under age 4 is not recommended. 11) **Pregnancy:** The safety of NASACORT™ AQ in pregnancy has not been established. If used, the expected benefits should be weighed against the potential hazard to the fetus, particularly during the first trimester of pregnancy. Like other glucocorticosteroids, triamcinolone acetonide is teratogenic to rodents and non-human primates. The relevance of these findings to humans has not yet been established. Infants born of mothers who have received substantial doses of glucocorticosteroids during pregnancy should be carefully observed for hypoadrenalism. 12) **Lactation:** Glucocorticosteroids are excreted in human milk. It is not known whether triamcinolone acetonide would be secreted in human milk, but it is suspected to be likely. The use of NASACORT™ AQ in nursing mothers, requires that the possible benefits of the drug be weighed against the potential hazards to the infant. 13) **Children:** NASACORT™ AQ is not presently recommended for children younger than 4 years of age due to limited clinical data in this age group. Oral corticosteroids have been shown to cause growth suppression in children and teenagers, particularly with higher doses over extended periods. If a child or teenager on any corticosteroids appears to have growth suppression, the possibility that they are particularly sensitive to this effect of steroids should be considered. 14) To ensure the proper dosage and administration of the drug, the patient should be instructed by a physician or other health professional in the use of NASACORT™ AQ (see Patient Instructions).

**ADVERSE REACTIONS:**

In placebo-controlled, double-blind and open-label clinical studies, 1483 adults and children 12 years and older received treatment with NASACORT™ AQ Nasal Spray. These patients were treated for an average duration of 50.7 days. In the controlled, seasonal trials (2-5 weeks duration) from which the following adverse reaction data is derived,

1394 patients were treated with NASACORT™ AQ Nasal Spray for an average of 18.7 days. In the long-term, open-label study, the 172 patients enrolled received treatment for an average of 286 days duration. The most commonly reported adverse reactions included those involving mucous membranes of the nose and throat. The three most prevalent adverse reactions considered to be at least possibly drug-related in adults and children 12 years and older were rhinitis (1.5%), headache (0.7%), and pharyngitis (0.3%), and in children 4 to 12 years were epistaxis (3.1%), rhinitis (1.4%) and headache (1.2%). Children 4 to 12 years of age (n=622) were studied in 3 controlled clinical trials. Of these, 179 received 110 mcg/day and 215 received 220 mcg/day of Nasacort AQ Nasal Spray in two, six, or twelve week trials. The longest average duration of treatment for patients receiving 110 mcg/day was 76.3 days and 79.6 days for those receiving 220 mcg/day. The incidence of specific nasopharyngeal-related adverse reactions considered drug related is summarized as follows:

	Placebo (N=178)	Nasacort AQ 110 mcg (N=178)	Nasacort AQ 220 mcg (N=187)	Placebo (N=626)	Nasacort AQ 27.5-440 mcg (N=1068)
Nasal AEs (overall)	15 (8.5%)	8 (4.5%)	12 (6.4%)	20 (3.2%)	31 (2.9%)
Dry mucous membranes	0	0	0	2 (0.3%)	3 (0.3%)
Epistaxis	9 (5.1%)	6 (3.4%)	6 (3.2%)	3 (0.5%)	17 (1.6%)
Nasal irritation	5 (2.8%)	0	2 (1.1%)	3 (0.5%)	9 (0.8%)
Naso-sinus congestion	0	1 (0.6%)	1 (0.5%)	1 (0.2%)	2 (0.2%)
Sneezing	1 (0.6%)	0	2 (1.1%)	6 (1.0%)	2 (0.2%)
Throat discomfort	1 (0.6%)	1 (0.6%)	1 (0.5%)	6 (1.0%)	3 (0.3%)

These adverse reactions, with the exception of epistaxis (in adults), and the exception of nasal congestion and sneezing (in children) were reported at approximately the same or lower incidence as placebo treated patients. Only 1% of the patients in the controlled trials discontinued treatment (e.g. pharyngitis, headache). In children, no patient receiving 110 mcg/day discontinued due to a serious adverse event and one patient receiving 220 mcg/day discontinued due to a serious event that was considered not drug related. Overall, these studies found the adverse experience profile for NASACORT™ AQ to be similar to placebo. The following table summarizes the adverse events (% of patients) present in at least 5% of patients in the double-blind and open label phase studies in adults and in controlled studies in children 4 to 12 years of age.

VARIABLES	STUDIES IN ADULTS		
	Double-Blind Placebo N=90	Nasacort, AQ 220 mcg N=88	Open Label Nasacort, AQ 220/110 mcg N=172
Flu Syndrome	5 (5.6%)	5 (5.7%)	17 (9.9%)
Headache	12 (13.3%)	6 (6.8%)	38 (22.1%)
Epistaxis	1 (1.1%)	6 (6.8%)	31 (18.0%)
Pharyngitis	5 (5.6%)	13 (14.8%)	55 (32.0%)
Rhinitis	5 (5.6%)	6 (6.8%)	49 (28.5%)
Injury/Accident	—	—	20 (11.6%)
Back Pain	—	—	13 (7.6%)
Cough Increased	—	—	14 (8.1%)
Sinusitis	—	—	27 (15.7%)
Pain	—	—	10 (5.8%)
Diarrhea	—	—	10 (5.8%)

  

VARIABLES	Placebo N=202	Nasacort AQ 110 mcg N=179	Nasacort AQ 220 mcg N=215	Nasacort AQ 440 mcg N=26
	Fever	11 (5.4%)	8 (4.5%)	12 (5.6%)
Flu syndrome	15 (7.4%)	16 (8.9%)	4 (1.9%)	0
Headache	22 (10.9%)	18 (10.1%)	16 (7.4%)	4 (15.4%)
Infection	15 (7.4%)	13 (7.3%)	16 (7.4%)	0
Injury accidental	3 (1.5%)	3 (1.7%)	4 (1.9%)	2 (7.7%)
Cough increased	13 (6.4%)	15 (8.4%)	15 (7.0%)	0
Epistaxis	14 (6.9%)	8 (4.5%)	10 (4.7%)	1 (3.8%)
Pharyngitis	13 (6.4%)	14 (7.8%)	16 (7.4%)	2 (7.7%)
Rhinitis	18 (8.9%)	18 (10.1%)	18 (8.4%)	0
Sinusitis	16 (6.4%)	7 (3.9%)	7 (3.3%)	0

In the event of accidental overdose, an increased potential for these adverse experiences may be expected, but systemic adverse experiences are unlikely. Hypersensitivity reactions including skin rash and edema of the face or tongue have been reported with other intranasal corticosteroids. When patients are transferred to Nasacort™ AQ from a systemic steroid, allergic conditions such as asthma or eczema may be unmasked (see Warnings).

**DOSAGE AND ADMINISTRATION:**

See Warnings. NASACORT™ AQ (triamcinolone acetonide aqueous nasal spray) is not recommended for children under 4 years of age. Careful attention must be given to patients previously treated for prolonged periods with systemic corticosteroids when transferred to NASACORT™ AQ. Initially, NASACORT™ AQ and the systemic corticosteroid must be given concomitantly, while the dose of the latter is gradually decreased. The usual rate of withdrawal of the systemic steroid is the equivalent of 2.5 mg of prednisone every four days if the patient is under close supervision. If continuous supervision is not feasible, the withdrawal of the systemic steroid should be slower, approximately 2.5 mg of prednisone (or equivalent) every ten days. If withdrawal symptoms appear, the previous dose of the systemic steroid should be resumed for a week before further decrease is attempted. The therapeutic effects of corticosteroids, unlike those of decongestants, are not immediate. Since the effect of NASACORT™ AQ depends on its regular use, patients must be instructed to take the nasal inhalations at regular intervals and not as with other nasal sprays, as they feel necessary. In the presence of excessive nasal mucus secretion or edema of the nasal mucosa, the drug may fail to reach the site of action. In such cases it is advisable to use a nasal vasoconstrictor for two to three days prior to NASACORT™ AQ therapy. Patients should be instructed on the correct method of use, which is to blow the nose, then insert the nozzle firmly into the nostril, compress the opposite nostril and actuate the spray while inspiring through the nose, with the mouth closed. An improvement of symptoms usually becomes apparent within a few days after the start of therapy. However symptomatic relief may not occur in some patients for as long as two weeks. NASACORT™ AQ should not be continued beyond three weeks in the absence of significant symptomatic improvement.

**Adults and children 12 years of age and older:**

The recommended starting dose of NASACORT™ AQ (triamcinolone acetonide aqueous nasal spray) is 220 mcg as two sprays in each nostril once daily. It is always desirable to titrate an individual patient to the minimum effective dose to reduce the possibility of side effects. Therefore, when the maximum benefit has been achieved and symptoms have been controlled, reducing the dose to 110 mcg (one spray in each nostril once per day) has been shown to be effective in maintaining control of the allergic rhinitis symptoms in patients who were initially controlled at 220 mcg/day. (see PRECAUTIONS, WARNINGS, INFORMATION FOR PATIENTS, and ADVERSE REACTIONS sections).

**Children 4 to 12 years of age:**

The recommended starting dose is 110 mcg per day given as one spray in each nostril once a day. Patients who do not achieve maximum symptom control may benefit from a dose of 220 mcg given as 2 sprays in each nostril once a day. Once symptoms are controlled, patients can be maintained on 110 mcg (1 spray in each nostril) once daily.

**AVAILABILITY:**

NASACORT™ AQ (triamcinolone acetonide aqueous nasal spray) is supplied as a non-chlorofluorocarbon (CFC) containing-metered dose pump spray which will provide 120 actuations. It is supplied with a nasal adapter and patient instructions. Each bottle contains 9.075 mg triamcinolone acetonide. Each actuation releases approximately 55 mcg triamcinolone acetonide from the nasal actuator to the patient (estimated from *in vitro* testing). There are at least 120 actuations in one NASACORT™ AQ bottle. After 120 actuations, the amount delivered per actuation may not be consistent and the unit should be discarded. In the information for Patients, patients are provided with a check-off form to track usage.

**References:**

1. Nasacort AQ (Triamcinolone Acetonide Aqueous Nasal Spray): Product Monograph.

2. Settipane G, Korenblat PE, Winder J, et al. Triamcinolone acetonide aqueous-nasal spray in patients with seasonal ragweed allergic rhinitis: A placebo-controlled, double-blind study. *Clin Ther* 1995;17:252-263.

3. Kobayashi RH, Beaucher WN, Koepke JW, et al. Triamcinolone acetonide aqueous nasal spray for the treatment of patients with perennial allergic rhinitis: A multicenter, randomized, double-blind, placebo-controlled study. *Clin Ther* 1995;17:503-513.

4. Smith JA, Kobayashi RH, Beaucher WN, et al. Triamcinolone acetonide aqueous nasal spray for the long-term treatment of perennial allergic rhinitis. *Ann Allergy Asthma Immunol* 1996;76(1):96.

5. Goldberg P, Simpson B, et al. Safety and efficacy of triamcinolone acetonide aqueous spray in pediatric patients with perennial allergic rhinitis. *J Allergy Clin Immunol* 1997 Abstract (in press).

6. Howland WC, Dockhorn R, Gillman S, et al. A comparison of effects of triamcinolone acetonide aqueous nasal spray, oral prednisone, and placebo on adrenocortical function in male patients with allergic rhinitis. *J Allergy Clin Immunol* 1996;98(1):32-38.

7. Schenkel EJ, Ellis MH, Gross G, et al. Triamcinolone Acetonide Aqueous Nasal Spray Does Not Alter Adrenocortical Function in Children With Allergic Rhinitis. *J Allergy Clin Immunol* 1996;97(1pt3):198. Abstract.

Complete Product Monograph available upon request to health professionals.



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