The aging process in men is accompanied by a progressive decline in serum testosterone (T) levels. The magnitude of such decline and the prevalence of older men with a clinically relevant reduction of T levels remains controversial despite a relatively large number of studies. The extent to which androgen decline leads to health problems that might affect or alter the quality of life is under debate. The validity of common methods used for assessment of testosterone levels has been recently questioned. In addition, total testosterone levels may be misleading because of an increase in sex hormone-binding globulin levels. In addition to chronological aging, the various illnesses occurring in mid- to late-adult life and the medications used to treat them further contribute to lowering circulating testosterone levels. Testosterone replacement therapy has been advocated for ameliorating sexual dysfunction and resistance to pro-erectile drugs in men with reduced testosterone levels. Independent meta-analyses showed that the effects of T on erectile function and libido, are inversely related to the mean baseline T concentration. These reviews show that T treatment might be useful for improving erectile dysfunction in selected subjects with low or low-normal T levels. The evidence for a beneficial effect of T treatment on erectile function should be tempered with the caveats that the effect tends to decline over time, is progressively smaller with increasing baseline T levels, and long-term safety data are not available. Recent studies have also demonstrated that testosterone replacement in hypogonadal men improves bone density, angina and possibly the metabolic syndrome. Nevertheless, these fascinating data still need large-scale, long-term, randomized controlled trials to formally confirm the efficacy of T replacement in symptomatic middle-aged and elderly men with reduced T levels.

Sex research tradition in Finland 1971-2007: main trends and analysis on representativeness

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Sex surveys based on random samples from national population registers have been conducted in Finland in 1971, 1992, 1999, and 2007. They are representative of the total population within the age range of 18-54 years in 1971 and 18-74 years in 1992, 1999, and 2007. Sex survey in 1971 was only the second sexuality study in the world ever that was based on a representative national population sample.

Studies were conducted in 1971 and 1992 by individual face-to-face interview visits during which each interviewee also completed a self-administered questionnaire. Due to this technique response rates were very high: in 1971 93% and in 1992 76%. In 1999 and 2007 a mail survey was conducted. The implication of this renewed method was lower response rate, in 1999 46% and in 2007 43%.

By analyzing the distributions in parallel generations of several identical retrospective questions measuring sexual issues in these four surveys it was possible to show that the lower response rate in 1999 and 2007 (due to renewed data collection technique) did not have a major impact on the results from the sexual histories of women and of those men who were less than 55 years of age. In the 55-74 years old age group, the male respondents were more monogamous than the corresponding birth cohorts interviewed in 1971 and 1992.

The main trends in sexual patterns and sexual attitudes from 1971 to 2007 will be presented.

Nordic sex education: a case of Finland

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Nordic sex education has been estimated by the International Planned Parenthood Federation (IPPF) to represent an advanced model of a comprehensive sex education in Europe. Finland is the only Nordic country where this education has been followed up by two national surveys directed to biology and health education teachers in 1996 and 2006 and by measuring adolescents’ sexual knowledge in national sexual health knowledge quizzes in 2000 and 2006.

Sex education survey to teachers covered 421 schools in 1996 and 518 schools in 2006. Sexual health knowledge quiz was participated in 2000 by 401 schools and 30241 students and in 2006 by 462 schools and 33819 students. In 2006 responses from teachers and students could be combined in 339 schools.

The most important educational objectives of sex education were, based on teachers’ responses, to educate students to responsibility and to provide them correct facts. Among boys sex education had much more important role in relation to their knowledge than among girls. Among girls the success in school was more important predictor of the higher level sexual knowledge than hours allocated to sex education in school.

The level of students’ sexual knowledge was promoted positively by teachers who: wanted to teach natural attitudes and tolerance toward sexuality, who found sexual issues easy to talk, who told students of her/his personal life, and who applied drama and role play methods and students’ talks and lectures in the classroom.

The Role of Surgery in Sexual Medicine

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Introduction: From the realms of quackery, to Viagra®, inflatable penile prostheses, and stem cell research, our understanding of sexual medicine has come a long way over the years. The current status of surgical intervention in sexual medicine is presented in this lecture.

Body: Broadly, surgery in sexual medicine may be classified as under: (I) Surgery for male sexual dysfunction (II) Surgery for female sexual dysfunction (III) Gender reassignment surgery (IV) Others. Surgery for male sexual dysfunction includes vascular surgery for erectile dysfunction, penile prosthetic implantation surgery, surgery for penile curvature, Peyronie’s disease, priapism, ejaculatory disorders, etc. Surgery for female sexual dysfunction includes surgery for vulvar vestibulitis, Bartholin’s gland cysts, clitoral phimosis, hyper-

Speakers