Male Genital Exam

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Penis
- Shaft
- Corpus cavernosa
- Corpus spongiosum
- Dorsal vein
- Glans
- Corona and coronal sulcus
- Prepuce (foreskin)
- Frenulum
- Urethral meatus
- Penoscrotal junction
- Median raphe

Penis Anatomy

Scrotum and Testes
- Scrotal sac
- Tunica vaginalis
- Cremasteric muscle
- Testes
  - Production of sperm and testosterone
  - Ovoid - 4 x 3 x 2 cm
  - Smooth and rubbery in texture “hard boiled egg”

Scrotum and Testes
- Epididymis
  - Posterolateral to the testes
  - Provides storage, maturation and transit of sperm
- Vas Deferens
  - Connects the epididymis and the ejaculatory duct
  - Part of the spermatic cord
Scrotum and Testes

Normal Male Genitalia

**Inguinal Canal**

- **Inguinal Canal Components**
  - Internal inguinal ring
  - Landmark: middle of inguinal ligament
  - Canal
    - Canal traversed by the spermatic cord
  - External inguinal ring
    - Located at the pubic tubercle
    - Medial and inferior to the internal inguinal ring

- **Prostate Gland**
  - Surrounds the urethra at the bladder neck
  - Resembles a large chestnut
  - Approximately same size as a testes
  - Produces the major volume of ejaculatory fluid
  - Milky, acidic fluid

**Taking a Sexual History**

- Privacy
- Take history while patient is dressed
- Clarify need to ask intrusive questions
- Provide opportunities to ask and answer questions
- Prioritize goals-address concerns and educate

**Addressing Sexual Matters**

- Take the initiative
- Use language that is simple and direct
- Maintain privacy and confidentiality
Addressing Sexual Matters
- Keep your attitude nonjudgmental, caring and respectful
- Provide explanations and allow for questions
- Acknowledge and explore responses

Common Concerns
- Symptoms of STD’s
- Premature Ejaculation
- Erectile Dysfunction
- Prostate Problems
- Infertility Problems

Predictors of Sexual Dysfunction
- Daily alcohol consumption
- Past or current STD’s
- UTI symptoms
- Emotional problems or stress

Predictors of Sexual Dysfunction
- ↓ economic status
- Negative sexual experiences
- Low physical or emotional satisfaction

Risk Factor for STD/HIV
- Multiple sex partners
- New partner(s) in last 3 months
- Alcohol/drug use
- Inconsistent condom use

Risk Factor for STD/HIV
- Past history of STD’s
- Same sex partners
- Exchanging money/drugs for sex

Risk Factor for STD/HIV
- Partner with HIV/AIDS
- Sharing needles
- Body piercing or tattoos

Risk Factor for STD/HIV
- Contact with blood
- Young age at first sexual activity
- History of sexual assault

Points to Remember
- Explain exam procedure before patient undresses
- Start exam from less invasive to most invasive
- Examine painful areas last
**Points to Remember**
- Talk to the patient during the exam, tailor language to meet need of patient
- Encourage open discussion and elicit questions throughout the exam
- Watch patient face for signs of discomfort
- Take light off of genital area as soon as exam completed

**Other Considerations**
- Before genital exam:
  - Inspect mouth (gums, tongue, tonsils, throat, soft and hard palate)
  - Palpate lymph nodes (cervical, axillary, etc)
  - Inspect skin (face, trunk, hands/palms, soles of feet)

**Preparation For Genital Exam**
- Prepare supplies need for exam
- Label all specimens and slides
- Wash and warm hands
- Put on gloves

**Preparation For Genital Exam**
- Explain what you are doing and why
- Have client stand at end of exam table with feet about shoulder width apart
  - Supine position if unsteady or unable to stand
- Examiner: sit on low rolling stool in front of client

**Beginning of Exam**
- **General Inspection**
  - **Sexual Maturity**
    - Hair patterns of mons pubis
    - Look for lice, nits, folliculitis, molluscum, scabies
  - **Note size and shape of penis and testes**

**Beginning of Exam**
- **General Inspection**
  - Note color and texture of scrotum
  - Scars or bulging in inguinal area
  - Penile or scrotal abnormalities
Examination of the Scrotum

- Inspect skin
  - Assess for warts, cysts, nodules
- Lift scrotum to assess posterior aspect

Common alterations

- Vitiligo
- Sebaceous Cyst
- Hemangiomas Scrotum
- Epidermoid Cyst
- Angiokeratoma
- Molluscum Contagiosum
**Palpation**
- Start from least invasive area to most invasive
- Let patient know that you will be touching him
- Start by checking for any inguinal lymphadenopathy

**Palpation**
- If erection occurs, assure patient that this is natural and common reaction and continue the exam
- Have patient inform examiner of any discomfort during the exam

**Examination of the Scrotum**
- Palpate scrotal content
  - Gently compress each testes and epididyma between your thumb and first two fingers
- Palpate spermatic cord and vas deferens
  - Note swelling, tenderness
  - Assess for varicocele

**Scrotal Lesions**
- Varicocele
- Spermatocele
- Orchitis
- Transillumination
Inguinal Canal Exam
Checking for inguinal hernia
- With the patient standing, ask him to bear down as if having a bowel movement
  - Inspect area for any bulging; then have patient relax
  - If bulges present—note size, shape and location

Gently insert finger into the lower part of the scrotum and carry it upward along the spermatic cord
- Ask patient to bear down then turn his head and cough once

Inguinal Hernia

Examination of Penis
- Inspect skin
  - Look for warts, ulcers, vesicles, chancre
  - Retract foreskin or have patient retract
  - Assess ease of retraction and release

Rt. Inguinal Hernia
Inguinal scrotal hernia hydrocele
Inguinal hernia
Examination of Penis

- Inspect Glans
  - Look for:
    - warts
    - ulceration
    - balanitis

Examination of Penis

- Inspect Glans
  - Locate urethral meatus
  - Assess for hypospadias or epispadias
  - Gently compress the glans between your thumb and index finger to open the urethral meatus

Examination of Penis

- Inspect Glans
  - Locate urethral meatus
  - Check for discharge, warts, ulcers, vesicles
  - If no discharge—either milk or have patient milk the shaft

Examination of Penis

- Gently grasp the lateral aspect of the penis and lift to inspect all sides
- Palpate along the shaft
  - Assess for any firm areas or irregularities
  - Assess for any unusual curves
- Exam at the base of the shaft
  - Look for warts, vesicle, or sores

Examination of Penis

- Examine the urethral meatus
  - Note position and size of opening
  - Gently compress the glans between the index finger and thumb
Examination of Penis

- Examine the urethral meatus
  - Inspect inside the opening – discharge, inflammation, lesions
  - Milk for discharge
  - If discharge is present assess for consistency and color of fluid

- Collect specimens as needed
  - Gram stain usually done if discharge present
  - Gonorrhea culture and/or swab
  - Chlamydia swab
  - Herpes culture
  - Darkfield slide if indicated
  - Urine testing for GC, Chlamydia

If gloves become contaminated with body fluids, change gloves before any further examination

Non-infectious Alterations

- Trauma
- Testicular Torsion
- Inguinal Hernia
- Penile shaft fracture
- Hydrocele, spermatocle, varicocele

- Phimosis
- Paraphimosis
- Priapism
- Neoplasm
  - Lymphoma
  - Testicular
  - Squamous cell

Paraphimosis

Sexually Transmitted Infections

- Urethritis
  - Gonococcal
  - NGU-(C. trachomatis, mycoplasma, trichomoniasis, or other

- Epididymitis
Sexually Transmitted Infections

- Ulcers
  - Primary syphilis
  - HSV
  - Chancroid
  - LGV

Herpes

Chancroid

LGV primary lesion

Molluscum Contagiosum

- Central umbilication
- Can be burned off
- Spread by skin to skin contact
- DNA pox virus

Lichen Planus

- Itchy
- Thickened
Psoriatic plaques

Pearly Penile papules
- Normal
- Occur on corona
- Should not change over time but often have not been noticed previously

Behcet's

Pruritic Burrows

Skin scraping

Reiter's syndrome
- Urethritis
- Arthritis
- Dry eyes
- Associated with Chlamydia infection

Tinea cruris
- Scrapings with fungal elements
- Responds to antifungals

Varicella Zoster

Gonococcal Phimosis

GC urethritis with penile edema
Examination of the Anus and Perineum

- Ask patient to stand and bend forward with hands positioned in the back to spread buttock apart.
- May be performed in the knee-chest position.
- Examine the external areas for lesions, warts, rashes, sores, fissures, discharge.
- Collect specimens as indicated by exam.
  - GC, herpes, darkfield (syphilis).
- Common finding include hemorrhoids and anal tags.

Rectal Exam

- Done as patient history indicates.
- Done as last part of genital exam.
- Change gloves if contaminated.
- Position patient.
  - Prone position.
  - Sims position.
**Inspection and Insertion**
- Lubricate index finger
- Separate buttocks
- Have patient bear down or take a deep breath and inform of insertion
- Insert index finger as they bear down or on inspiration
- Allow a few seconds for relaxation of muscles

- Rotate finger 360°
- Evaluate rectal walls
- Evaluate the prostate
  - 2-4 cm long
  - Triangular in shape
  - Two lobes with central groove
- Guiac for occult blood

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**End of Exam**
- Take off gloves and dispose
- Offer box of tissues to remove lubricant if used during the exam
- Allow privacy to dress
- Either take him to your office or sit down to discuss results of exam or questions the patient may have
- Allow time for education

**Case #1:**
23 y.o. patient presents with discharge and dysuria

**Differential Diagnosis of Urethritis**
- Infectious
  - Neisseria gonorrhoeae
  - Chlamydia trachomatis
  - Mycoplasma genitalium
  - Trichomonas vaginalis
  - Herpes simplex virus 1 and 2, adenovirus
  - Enteric – enterobacteriac

- Non-infectious
  - Trauma – physical, chemical (drugs), catheterization, sex-play related
  - Adenovirus – Reiter’s syndrome, Behcets

**Neisseria gonorrhoeae**
- Gram-negative intracellular diplococci
- Syndromes
  - Urethritis, pharyngitis, cervicitis, proctitis, neonatal ophthalmia
  - Asymptomatic in 80% of women and at least 10% of men; >95% of oral infections ax
  - Increases HIV transmission
  - Complications include pelvic inflammatory disease, ectopic pregnancy, infertility, chronic pelvic pain

**Gonorrhea treatment**
- Ceftriaxone 250 mg
  - Plus treatment for Chlamydia
- Azithromycin 1 gm po once
- Doxycycline 100mg po BID x 7 days
Partner Management
- Maintain abstinence for 7 days while completing treatment regimen and until all partners are treated
- All sexual contacts within past 60 days should be evaluated and treated
- Expedited Partner Therapy (e.g., Field delivered Therapy, Patient Delivered Partner Therapy) should be offered if legal

Non-gonococcal Urethritis
- Mucopurulent or purulent discharge
- Gram stain of urethral secretions ≥ 5 WBC per oil immersion field
- Positive leukocyte esterase on first void urine or ≥10 WBC per high power field

Case 2: Non-Gonococcal Urethritis
- Mucopurulent or purulent discharge
- Gram stain of urethral secretions ≥ 5 WBC per oil immersion field
- Positive leukocyte esterase on first void urine or ≥10 WBC per high power field

Non-gonococcal Urethritis
- Azithromycin 1 gm in a single dose or Doxycycline 100 mg bid x 7 days

Nongonococcal Urethritis Alternative regimens
- Erythromycin base 500 mg qid for 7 days or Erythromycin ethylsuccinate 800 mg qid for 7 days or Ofloxacin 300 mg twice daily for 7 days or Levofloxacin 500 mg daily for 7 days

NGU
- Case scenario:
  - 33 yo heterosexual male presents to clinic with dysuria - NGU by gram stain. Treated with doxy 100 BID. Returns in 2 wks and states no relief

NGU persistent

NGU
- Mycoplasma genitalium getting some attention
- Occurs about 10% of NGU but much higher in pts with “persistent NGU” as relatively resistant to Doxycycline
- Pearl: responds best to Azithromycin or Moxifloxacin but not Cipro or Levo

Case #3: 36 y.o. patient presents with genital ulcer

Recommended Regimens
- Metrodolone 2 g orally in a single dose
- OR Tinidazole 2 g orally in a single dose
- PLUS Azithromycin 1 g orally in a single dose (if not used for initial episode)
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