

NURSE PRACTITIONER CLINICAL GUIDELINES
MALE SERVICES

COMMUNITY HEALTH SERVICES
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DISTRIBUTION:

Copies of Nurse Practitioner Clinical Guidelines for Male Services were supplied to:

Community Health Services Administrative Office
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Nurse Practitioners
Coordinator of Clinical Staff Development
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MALE SERVICES

Community Action provides limited male services that include initial diagnostic history and physical, diagnostic tests as necessary, and non-surgical management or referral for the conditions/findings listed below. These services are available to all men seeking the health care services outlined in this section.

- (1) Contraceptive options and Counseling
- (2) Screening and Treatment for Sexually Transmitted Infections (STIs)
- (3) Screening for:
 - Hydrocele
 - Spermatocele
 - Varicocele
- (4) Diagnosis and management of:
 - Balanitis
 - Epididymitis
 - Penile Skin Lesions (HPV, Molluscum, HSV)
 - Tinea corporis
 - Tinea cruris
 - Urethritis
 - UTI

Emergency Care:

Clients suspected to have the following conditions must be referred to an emergency department immediately:

- Orchitis
- Non-reducible inguinal hernia
- Testicular torsion

Referrals:

Clients with the following conditions must be referred for evaluation and management. The specialty is suggested below

- Erectile dysfunction to Primary Care (PCP) or Urology
- Premature ejaculation to PCP or Urology
- Benign prostatic hypertrophy to PCP or Urology
- Signs of chronic prostatitis to Urology
- Testicular masses to Urology
- Large varicocele to Urology
- Reducible inguinal hernia to General Surgeon
- Renal stones to PCP or Urology
- Abnormal thyroid, cholesterol, or DM labs on screening based on guidelines in Health Care Policy and Procedure Manual (HCPPM) to PCP

Medical Emergencies - see Emergency Procedures in HCPPM

Medical Screening and Evaluation

- A targeted history must be completed. If applying for Title XX, history components required by DSHS are completed at initial visit and reviewed annually
- Physical examination – a targeted exam based on the chief complaint should be performed. Components of the physical exam may include:
 - Vital signs, height and weight
 - HEENT including thyroid
 - Heart/lungs
 - Abdomen, inguinal nodes
 - Extremities
 - Prostate/rectal if indicated
 - External/internal genitalia
 - Penis
 - Scrotum – spermatic cord, testes, vas deferens, epididymis, inguinal canal
- Laboratory tests as indicated including but not limited to STI screening, thyroid testing, liver function testing, cholesterol screening and diabetes screening

MANAGEMENT AND TREATMENT OF SPECIFIC CLINICAL FINDINGS

BALANITIS

- An inflammation of the glans penis
- Most commonly seen in uncircumcised men with poor personal hygiene
- Also associated with diabetes, morbid obesity, chemical irritants and drug allergies
- Patients usually present with some or all of the following complaints:
 - Penile discharge
 - Tenderness of the glans penis
 - Itching
 - Inability to retract foreskin (phimosis)
 - Impotence
 - Difficulty urinating or controlling urine stream (in severe cases)

Testing - Do random blood sugar in clinic. Above 200 is diagnostic for diabetes and needs referral. May include fasting blood sugar (as part of diabetic screening), HIV/RPR, wet mount with KOH for candida, culture of discharge

Treatment –

- Topical clotrimazole applied TID for suspected candidal balanitis
- Bacitracin applied sparingly TID for patients with bacterial balanitis
- Instruct patient to retract the foreskin and soak the penis and foreskin in warm water daily until symptoms are resolved. Be sure to dry penis completely after bathing
- In recurrent cases, do diabetic work up and HIV testing, then consider referral

Follow-Up - Refer to PCP for recurrent cases and to urologist for severe cases or severe phimosis

EPIDIDYMITIS

- Inflammation of the epididymis, most commonly caused by infection
- Can be acute (<6 weeks) or chronic
- Common complaint is acute scrotal pain and must be differentiated from testicular torsion
- Gradual increase in pain over 24 hours – may start in the abdomen or flank and then localizes in the scrotum
- In sexually active men <35 years old, Chlamydia and gonorrhea are the most common pathogens causing this infection. It can also be caused by UTI bacteria (e. coli)
- Can lead to an epididymal abscess and testicular involvement
- Nausea, fever/chills, urinary frequency and dysuria may be present

Testing –

- Testing may include: UA, genprobe, HIV, RPR, CBC.
- If testicular torsion is a possibility, patient must be referred for immediate evaluation in an emergency setting which will include ultrasound

Treatment -

- Sexually active men will be treated empirically for gonorrhea and Chlamydia with ceftriaxone plus azithromycin or doxycycline. Counsel on analgesics for pain control, scrotal elevation and support and ice packs

Follow-Up -

- Patients must follow-up with PCP or urologist in 3-7 days, or go to emergency room if no improvement within 72 hours

HYDROCELE

- A collection of serous fluid in the scrotum related to a defect or irritation of the anatomy
- Usually appear in men >40 years, often associated with hernia
- Usual presentation is a painless enlarged scrotum
- May report a feeling of fullness, heaviness or dragging. Occasional discomfort radiating to the back
- Pain may be sign of underlying epididymitis. Systemic symptoms are usually absent in uncomplicated hydrocele

Testing -

- Diagnosed largely by exam – lump is located superior and anterior to the testis
- A light source will shine brightly through a hydrocele with transillumination
- Ultrasound can be used for diagnosis to rule out other causes

Treatment -

- May need surgical management if especially large or uncomfortable
- Refer for evaluation and management

INGUINAL HERNIA

- Occurs when soft tissue in the abdomen protrudes through a tear in lower abdominal wall, resulting in a bulge in the groin or scrotal sac
- 25% of men will have one during their lifetime

- More common on the right side
- Hernias that are not reducible can cause complications including bowel necrosis from limited blood supply
- Most common presenting complaint is a bulge when the client sits, stands, or strains. Pain may or may not be associated with the bulge

Testing –

- Physical exam including abdomen, cremasteric reflex, inguinal lymph nodes and external genitalia
- Transillumination can differentiate between hernia and hydrocele
- Clinician must search for a bulge in the groin or scrotum and make sure the bulge is easily reducible. Bowel sounds may be heard over the bulge
- No laboratory tests are needed. Refer general surgeon for evaluation.

Treatment and Referral –

- Refer non-reducible hernias to the emergency department
- Refer reducible or questionable hernias to surgeon for evaluation, observation, and treatment options. Many clients will opt for observation alone for some time, but the client must make that decision with the surgeon

ORCHITIS

- Acute inflammatory reaction of the testis, secondary to infection
- Usually associated with viral mumps infection, but can be caused by other viruses and bacteria. Bacterial orchitis is rare and usually associated with concurrent epididymitis or prostatitis.
- Orchitis complicated by reactive hydrocele may need surgical drainage
- Signs and Symptoms
 - Acute testicular pain and swelling
 - Chills, fatigue, fever, headache, malaise, myalgia, and nausea are frequent
 - Mumps symptoms precede orchitis when it is related to the virus
 - Testicles are usually enlarged, indurated, and tender with an erythematous and edematous scrotal skin

Testing –

- Vital signs including temperature
- Physical exam including abdomen, cremasteric reflex, inguinal lymph nodes, external genitalia, prostate

Treatment – Must refer to emergency department immediately.

PENILE SKIN LESIONS

- Penile cancer is very rare in the U. S. It is more common in uncircumcised men. Seen mostly in men who are 60 – 80 years old.
- May first appear as subtle lesions on the lateral surface of the penis, penile cancer must be included in the differential of penile lesions. Most penile skin lesions, however, will be benign in origin.

- HPV, lichen sclerosis, molluscum contagiosum, pearly penile papules, and STI-related lesions can all be confirmed by biopsy if diagnosis is uncertain. Kaposi's sarcoma must also be considered in an HIV-positive client.
- Clients may present with a new mole, papule, skin change, ulcer on the penis, or wart. Lesions may or may not be painful.

Testing –

- Exam includes examination of genital skin, inguinal lymph nodes, and testicular exam
- Genital warts, molluscum contagiosum, and pearly penile papules may be diagnosed by exam and application of white vinegar. Referral for a skin biopsy may be offered to the client to confirm diagnosis of these conditions but is usually not necessary
- HSV culture or blood testing or HIV/RPR testing may be done based on clinical findings

Treatment

- Based on specific diagnosis.
 - See Genital Warts and Molluscum sections of NPCG for treatment of these lesions
 - Pearly penile papules need no treatment except education and observation STI related lesions should be treated based on STI protocols (see Genital Warts and Molluscum section of guidelines). Any lichen sclerosis and other suspicious or persistent lesions unresponsive to treatment are referred to a specialist

Pearly Penile Papules

Pearly penile papules are benign lesions that are usually seen in a circumscribed area around the penis corona or sulcus. They are flesh colored, not STI-related, and usually present in men age 20 – 30. They are usually asymptomatic. Often the client presents with concerns about STIs or cancer when the lesions are new. Pearly penile papules may persist through life and require no treatment. They only require reassurance and observation.

ACUTE PROSTATITIS

- Occurs mostly in young and middle-aged men
- Usually caused by the same organisms that cause urethritis and UTIs. There may be concomitant epididymitis and/or UTI. Since UTI is rare in men younger than age 70 without chronic illness, most men with UTI symptoms have prostatitis.
- Symptoms may include, but are not limited to, back pain, blood in semen, cloudy urine, dysuria, fever, myalgia, and pelvic pain.

Testing –

- Vital signs including temperature
- Examination of abdomen, genitals, and prostate
 - A boggy, tender prostate helps to make the diagnosis
 - Never massage prostate for secretions in men with acute prostatitis. This can worsen bacteremia.
- Do GC/CT testing, Urine culture, and CBC, prior to initiating treatment.

Treatment

- Began treatment pending lab results with Azithromycin 1 gram plus Cipro 500 mg bid for 14 days.
- If there is any suspicion the client is septic (febrile, tachycardia, low BP, cannot urinate) refer to ER immediately.
- Instruct client who is treated in clinic that if he develops fever, vomiting, increase in pain, cannot urinate or is worse in any way to go to ER immediately.
- Return to clinic for follow-up in 2-3 days. If doing well, continue medications. If not, refer to PCP or ER

CHRONIC PROSTATIS – (more than 3 months of symptoms or recurrent acute prostatitis) – must refer to urologist.

SPERMATOCELE (Epididymal Cyst)

- a benign cystic accumulation of sperm that arises from the head of the epididymis, usually <1 cm, etiology is usually unclear
- generally smooth, soft, and well-circumscribed – may be on the testicle itself or along the course of the vas deferens
- will not enlarge with increased intraabdominal pressure (varicoceles and hernias may)

Testing –

- referred evaluation technique is ultrasound. UA may be warranted to rule out epididymitis if patient complains of scrotal pain
- surgical intervention may be warranted in some cases. Refer to urologist for evaluation and management

TESTICULAR TORSION

- a true urologic emergency that must be differentiated from other complaints of testicular pain because a delay in diagnosis and management can lead to loss of the testicle
- can occur at any age but is most common in teens or men younger than 30
- history involves sudden onset of severe unilateral scrotal pain, may also involve abdominal pain, fever, urinary frequency and nausea/vomiting. Usually clients are in such severe pain with vomiting that they rarely present to a clinic.
- On exam, the involved testicle will be painful and often elevated in position compared to the other side
- Edema and erythema of the testicle and scrotum may be present
- Cremasteric reflex is almost always absent on the same side as the affected testicle
- Generally no relief of pain with elevation of scrotum
- REFER IMMEDIATELY TO EMERGENCY DEPARTMENT

TESTICULAR TUMOR

- True testicular solid masses are most often testicular cancer. Testicular cancer represents 1% of all cancers in men. Testicular cancer is most commonly found in the 15 – 39 year-

old age group. Undescended testes are 2 – 20 times more likely to become testicular cancer (even if surgically brought down).

- Masses arising from the testis are most often malignant, and masses arising from the spermatic cord are most often benign.
- The most frequent complaint with testicular cancer is a painless, firm, irregular mass. Most often the client finds this himself. There may also be
 - Complaint of a heaviness in the testis
 - Unexplained fatigue
 - Occasional gynecomastia
 - Sudden collection of fluid in the scrotum

Testing –

- Examination of abdomen and external genitals should be performed
- Check cremasteric reflex
- Transillumination of the scrotum
- If a suspected testicular tumor is palpated, must refer to urologist for immediate ultrasound of testis and scrotum

Treatment – Refer to urologist immediately

TINEA CORPORIS – see Tinea Corporis on page 44 of NP Clinical Guidelines

TINEA CRURIS

- Superficial, pruritic fungal infection of the groin
- Risk factors include wearing tight-fitting or wet clothing or undergarments, can also be transmitted by contaminated towels or sheets
- Large erythematous patches with central clearing, edges may be scaly. Chronic infections may be dry, while acute infections may be moist and exudative
- Microscopic examination with KOH slide can be used for diagnosis, but a negative result does not completely rule out infection
- Treat with topical antifungal agents of the azole or allylamine family such as: Clotrimazole (Lotrimin, Mycelex), Terbinafine (Lamisil), etc. Patients should apply cream to affected area daily for 1-4 weeks
- Do random or fasting blood sugar to rule out diabetes
- Patients with resistant, recurrent, or extensive infections may need systemic antifungal therapy. Refer to PCP for management
- Prevent reinfection by recommending treatment of tinea pedis simultaneously if present, putting on socks before underwear, and drying the groin completely using different towels from the rest of the body

URETHRITIS

- Infection induced inflammation of the urethra – usually caused by an STI, may be called gonococcal (GU) or non-gonococcal (NGU)
- May also be associated with other processes like epididymitis, prostatitis, orchitis or UTI
- Exam should include checking for skin lesions, urethral discharge, testicular pain or lumps, lymphadenopathy, and checking the prostate

- Urethritis can be diagnosed based on the presence of one or more of the following
 - (1) a mucopurulent or purulent urethral discharge
 - (2) urethral smear that demonstrates at least 5 leukocytes per field on microscopy
 - (3) first-voided urine specimen that demonstrates leukocyte esterase on dipstick test or at least 10 white blood cells (WBCs) per high-power field on microscopy.
- Test all patients for gonorrhea and Chlamydia. HIV and blood sugar tests are recommended.
- Treat patients and partners empirically – Azithromycin 1 gram PO treats both GU and NGU.
 - Ceftriaxone, Cefixime, Doxycycline, and Ciprofloxacin can also be considered
- Recurrent urethritis is most often a reinfection and should be treated with:
 - a single dose of metronidazole 2 grams PO
 - AND a 7 day course of erythromycin base 500 mg qid PO
 - Refer to CDC STI treatment guidelines for alternative treatment regimens
 - Refer to PCP if patient does not respond or has recurrent infections
- Educate patients on the importance of partner treatment and safer sex to prevent infection

UTI

- Rare in healthy men. Usually urethritis or prostate disease is the cause of urinary complaints.

Signs and Symptoms – may include abdominal pain, back pain, dysuria, fever, general malaise, hematuria, hesitancy, increased urinary frequency, nausea, and vomiting.

Testing –

- Vital signs including temperature
- Physical exam including abdomen, costovertebral angle, and genitals
- If the client is ≥ 30 years old or has participated in receptive anal intercourse, the clinician must also consider a prostate exam.
- Labs including; urine culture, UA (ask lab to look for trichomonas), GenProbe, consider a DM workup based on history
- A urine culture for men is considered to be positive if there are more than 1,000 colony-forming units/ml

Treatment – in men, treatment for true UTI is based on urine culture. Treatment should be started before culture results and then modified, based on results.

- Initial treatment should be
 - Septra DS BID for 10 days or Ciprofloxacin 500 mg po BID for 10 days or Levoquin 500 mg po QD for 10 days
 - Plus or minus Pyridium 200 mg po TID prn (or AzoStandard)
- If UA is positive, but prostatitis is possibility, treat per Prostatitis Guideline
- If UA is positive, but GC or CT is a possibility, follow GC/CT guideline for treatment as well as starting on an antibiotic for UTI

Follow-up – must be done within 24 – 48 hours to evaluate symptoms and follow up lab results.

- If lab results show new treatment is needed, then treatment regimen should be changed and repeat follow up must occur in 24 – 72 hours.

- If there is no clinical improvement, the client must be referred to emergency department or specialist, immediately.
- For men with positive UTI, a 2-week follow-up urine culture must be done to test for cure. If the second culture is positive, treat with Metronizazole 2 grams plus a different antibiotic of those listed above and reculture in 2 weeks.
- If the 3rd culture is positive, recommend evaluation by a urologist to consider anatomical defects, which may have led to the UTI. This is especially important if the client has had more than one UTI.

VARICOCELE

- A varicosity in the veins of the spermatic cord
- Patients may complain of scrotal pain or heaviness or may be asymptomatic
- 40% of infertile men have a varicocele
- An obvious variococele is described as feeling like a “bag of worms” on exam
- May also be diagnosed with ultrasound and surgical correction may be necessary in some cases. Refer to urologist for evaluation and management if symptomatic or large varicocele is suspected