Making Scrotal Pain Less Painful for Patients AND Providers:

Algorithm + tips/tricks

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Doesn't need to be painful for BOTH parties

Objectives

- Deciphering the underlying issue(s)
- Developing a standardized approach to evaluation
- Highlighting key components of communication
- Tips on avoiding pitfalls
- Establish a headache-free algorithm for management

Perception is Reality

- Several patient and provider profiles surrounding CC of genital pain
- Assumptions are to be avoided
  - Preconceived notions of narcotic-seeking or psychological primary
  - Providers get anxiety, try to placate quickly, and fail to listen
  - Patients feel dismissed
- “Same way every time” is a key to provider well-being

Patient Assessment

- Structured questionnaire helps contain the longwinded patient
- Control conversation with balance of open/closed questions
- *“Mr. Smith, I’m Dr. Terlecki and I’m glad to meet you today. I see you’ve been struggling with scrotal pain since a prior hernia repair. I’m hopeful that I can help you with this. I see you’ve tried several treatments without success and based on the symptoms you’ve checked off, there are some possibilities I’d like to discuss. Does this sound reasonable to you?”*

Intake Questionnaire for MGP

- Timeline, perceived cause(s), nature of pain (dull/sharp, constant/intermittent), aggravators (e.g., lifting/walking/sex)
- Bowel and urinary function questions (constipation, obstructive LUTS)
- Orthopedic/Neurologic history (think spine/hip pathology-referred pain)
- Associations with ejaculation? Relieved in sleep?
- Hormonal deficiencies? Use of narcotics? Poorly controlled DM?

Intake Questionnaire for MGP

Dr. Terlecki's Questionnaire for Male Genital Pain

1. When did this pain **BEGIN**? (CIRCLE)

Within the past month 1-3 months ago 3-6 months ago >6 months ago

2. Choose the **LOCATION(S)** that best describes the area associated with pain. (CIRCLE ALL that apply)

Right groin Left groin Right testicle Left testicle Entire scrotum Lower pelvis Penis

3. Did the pain begin after a specific **EVENT** (e.g., trauma, surgery, etc)? Yes No

If yes, describe: _____

4. Choose the terms that best describe your pain. (CIRCLE ALL that apply)

NATURE: Intermittent Continuous Sharp Dull Burning

WORSE WITH: Activity Sex/ejaculation Urination Erection

BETTER WITH: Activity Sex/ejaculation Urination Rest/sleep

5. Choose the appropriate answers relative to sexual activity and function. (CIRCLE)

Sexually active: Yes No

If yes, partner(s) is/are: Female Male Both

Libido: Strong Moderate Weak/Poor

Erections: Normal Weak Absent

Use of medication for erectile function: Current Present Never

Ejaculation: Normal Weak Absent Painful

6. Choose the term(s) that best describes the quality of your **URINE FLOW**. (CIRCLE ALL that apply)

Strong Moderate Weak Dribbles Painful Start/stop pattern

7. Choose the term the best describes your **BOWEL FUNCTION**. (CIRCLE)

Regular (daily/normal consistency) Irregular/Constipation (less frequent, harder stool)

8. Do you have or have you ever had **ANY** of the following? (CIRCLE ALL that apply)

Diabetes Chronic pain Arthritis IBS Anxiety

Stroke Autoimmune disorder Neuropathy or Neurologic condition

Enlarged prostate Urethral stricture Kidney Stones

Urinary tract infection Prostatitis Blood in urine Chlamydia/Gonorrhea

Cancer Radiation therapy Chemotherapy Low testosterone

9. Have you ever had **SURGERY** involving any of the following? (CIRCLE ALL that apply)

Hernia repair Hip Back Prostate Bladder Scrotum

Vasectomy Varicocele Cystoscopy Urethral procedure(s)

Abdomen Pelvis

10. Do you take medication(s) for pain? Yes No

If yes, describe: _____

11. Choose the terms that best describe your level and type(s) of **EXERCISE**. (CIRCLE ALL that apply)

Regular cardiovascular exercise No regular exercise Disabled

Weightlifting Cycling

Prolonged periods of sitting Long-distance driving

Other: _____

12. Have you been evaluated/treated for this condition before? (CIRCLE) Yes No

If yes, describe (including name/type of physician, lab testing, imaging, and therapies tried):

_____

Set Expectations Immediately

- I am a surgeon who does NOT manage chronic pain
- I will rule in/out surgical pathology, but I will do my due diligence before considering a referral for long-term pain management
- State that you use a structured program for assessment and management, but personalize for all patients (show them the algorithm)

Set Expectations Immediately

Dr. Terlecki's Approach to Male Genital Pain

Pain involving the male pelvis or genital area can be due to a variety of causes. Urologists are surgeons of the urinary and genital tracts. Our goal is to try and determine the underlying cause(s) of pain to direct appropriate treatment. We do not manage chronic pain medication.

Our approach to evaluation and management involves the following:

1. A discussion of your history and a physical exam.
2. Consideration of the following:
    a. Laboratory studies (e.g., hormonal panels, vitamin levels, urinalysis)
    b. Urine flow studies
    c. Imaging (e.g., scrotal ultrasound, CT of abdomen and/or pelvis, MRI of hip and/or back)
    d. Cystoscopy (endoscopic assessment of bladder)

If a urologic source is found, this will be addressed in Urology. These may include:

1. Infections and/or inflammatory conditions of the bladder, prostate, testicle, or epididymis
2. Stones
3. Testicular tumors
4. Urinary tract obstruction (e.g., urethral stricture, enlarged prostate)
5. Hormonal deficiencies (e.g., low testosterone)
6. Peyronie's disease

Based on the results of the initial workup, we can also decide if your condition warrants referral to any of the following:

1. Pelvic floor physical therapy (e.g., pelvic floor dysfunction)
2. Orthopedic surgery (e.g., labral tear(s) involving hip joint)
3. Neurology/Neurosurgery (e.g., spinal pathology)
4. General surgery (e.g., hernia)

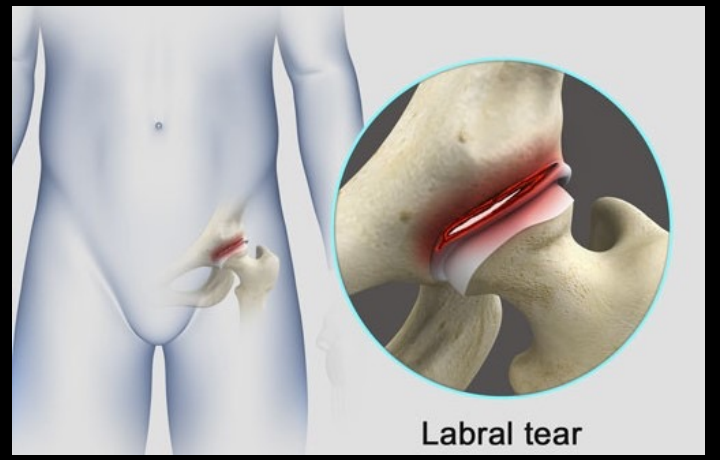
IF investigational studies do **NOT** identify any treatable pathology, we would advise your primary care provider (**PCP**) to consider a referral to pain management.

In select cases of chronic testicular pain in the absence of obvious cause or refractory to other therapies, some men may be considered for a procedure known as **denervation** that involves dividing the nerve fibers going to and from the affected testicle(s). This is **ONLY** done if patients have completed a full workup without identifiable cause or without improvement to targeted therapy **AND** show significant improvement with injection of local anesthesia.

Rarely the Cause

- Prostatitis
  - My personal opinion, largely overused diagnosis when provider is w/o answers
  - Fluoroquinolones for multiple weeks carries tendon risk, and a patient improving is NOT evidence of a correct diagnosis (rule of thirds, anti-inflammatory properties)
- Varicocele
- Incidental scrotal u/s findings
  - “trace hydrocele”
  - Epididymal cyst
  - Fat-containing inguinal hernia

Often Overlooked Causes



- Pelvic floor dysfunction (PFD)
- Urethral stricture
- Labral tear of ipsilateral hip
- Spinal pathology
- Pudendal neuralgia (on spectrum with PFD)

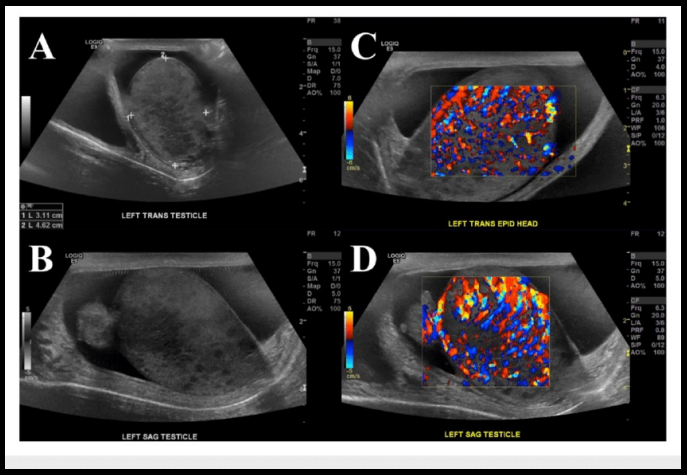
In-Office (Initial Visit)

- H/P (look for the obvious on scrotal exam)
- Uroflow/PVR (Super-voider? Stacatto? Plateau tracing?)
- U/A, Labs (T panel, B12, Vit D, +/- PSA based on age, CMP, CBC; I avoid nonspecific labs like ESR and CRP)

Treat the Obvious

- Supplement deficiencies found on labs
  - B12 protocol for those with levels below 400
  - For low T, w/u appropriately; consider clomiphene as initial mgmt
- Alpha blockers in some patients, but rarely a cure-all
- Bowel regimen when needed

Assessments to consider

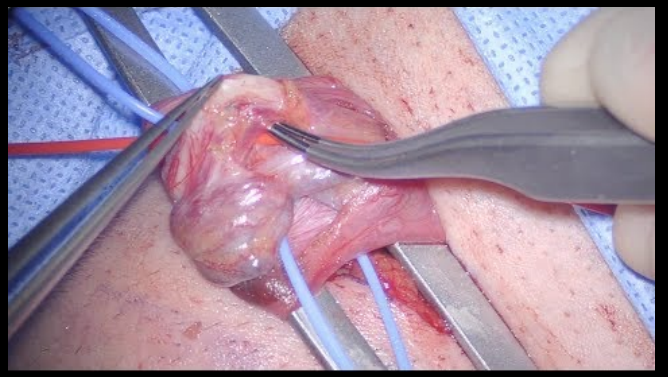


- Imaging
  - Scrotal u/s (in nearly everyone; unless done already)
  - MRI arthrogram of ipsilateral hip (may need xray for insurance, which can sometimes note occult constipation)
  - Possible MRI of lumbosacral spine
- Evaluation by pelvic floor PT (helpful in many patients)
- Alternative medicine based on patient profile (e.g., acupuncture)

Medical therapies

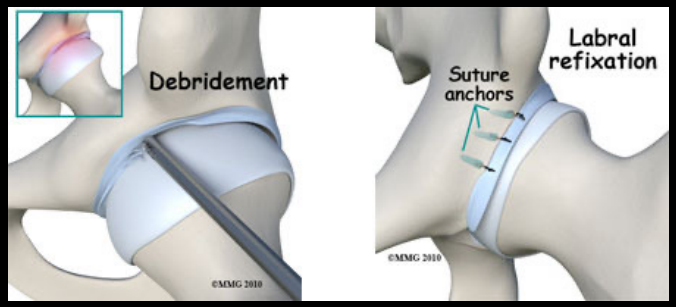
- Valium suppositories in some PFD patients
- Oral baclofen (start with 10 mg in late afternoon or evening)
- Not a big believer in gabapentin or amitriptyline
- Spermatic cord block (multipurpose)
- Pudendal nerve block (by provider or by IR)? Botox? Steroids?

Surgical options (urologic)



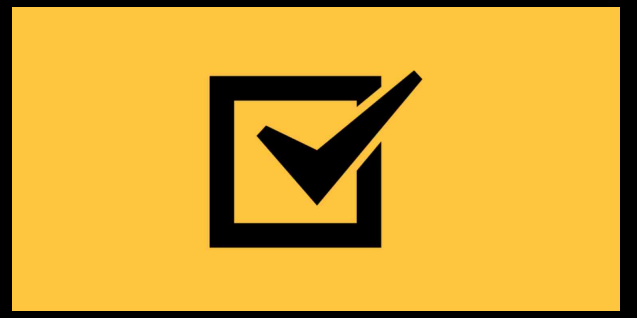
- Data is mixed on varicocelectomy or vasectomy reversal
- Cord denervation if criteria met and expectations set
- Orchiopexy if truly suspect intermittent torsion (rare in adults with inciting event such as trauma, prior surgery, etc)
- I suggest avoiding orchiectomy (rarely improves pain in my anecdotal experience)

Surgical options (other disciplines)



- Address the hip pathology (injections, surgery)
- Address the spinal pathology (injections, RFA, surgery)
- Address the pudendal canal (decompression)
- Address the recurrent hernia (mesh entanglement may or may not be a correctable problem)

Conclusions



- Male genital pain doesn’t have to cause providers pain as well
- A structured intake and management algorithm are both valuable
- It is essential to set the tone and expectations up front
- This protocol is well-suited for both urologists and APPs
- Multidisciplinary management makes matters easier