2 Sexual and Reproductive Health Assessment

A health assessment is an essential part of men’s reproductive health care. It consists of obtaining the client’s sexual and reproductive health history, which includes prior illnesses, surgeries, and inherited traits, and performing a routine genital examination. The information obtained during the assessment is the foundation for providing effective, efficient reproductive health care. This information, along with the findings from the physical examination, will enable you to determine how to help the client. Because men visit health care facilities infrequently, service providers often take the opportunity to screen for men’s sexual and reproductive health conditions when they come in with other concerns. This chapter discusses sexual and reproductive health history taking; performing a genital examination is discussed in Chapter 3.

Importance of Taking a Sexual and Reproductive Health History

Taking a sexual and reproductive health history is a critical component of providing sexual and reproductive health care for men. Inaccurate or incomplete histories can result in inadequate screening or in the inadequate treatment of potentially life-threatening conditions. As a service provider, you must be prepared to hear a wide range of sexual and reproductive health concerns. A kind and straightforward assessment is not only essential and professional, but also compassionate.

Goals, Timing, and Scope

The objectives of taking a sexual and reproductive health history are:
- To identify symptoms of genital, sexual, and reproductive disorders
- To obtain information about sexual abuse, traumas, and injuries
- To identify risk factors for sexually transmitted infections (STIs)
- To elicit psychological concerns relating to the genitals, body image, sexuality, sexual orientation, and sexual dysfunction
- To determine whether the client needs additional information or education about sexual and reproductive health matters, such as contraceptive options

The timing and scope of taking a sexual and reproductive health history may be determined by a specific situation or may be part of a routine medical history. When a client does not have any specific sexual or reproductive health concerns, the questions you ask can be open-ended questions to screen for possible problems, and then narrowed for in-depth questioning whenever the client’s answer raises additional issues. On the other hand, when a client has a specific, acute problem, a narrowly focused history may be required. Giving a client an opportunity to discuss sexual and reproductive health does not mean
that the client’s entire history and the whole subject have to be discussed during the initial visit to the facility. A subsequent visit (or referral) can be scheduled in order to explore a subject in more depth once it has been raised.

**An Effective Step-by-Step Approach**

It is essential to provide an atmosphere of acceptance for the client so that he feels comfortable discussing his history, fears, concerns, current symptoms, and future expectations. In an environment in which a useful sexual and reproductive health history is obtained, respect the client’s right to his own values, attitudes, and behavior, even if you do not agree with them. Also explain to the client that the information he provides is strictly confidential and that only critical details are recorded on his chart. Only other service providers who treat the client will have access to his chart.

Being patient while taking a client’s sexual and reproductive health history is also essential. Because of the sensitive and personal nature of the information, the question-and-answer pace of the discussion may be slow. Be prepared to wait longer than the usual amount of time for the client to decide what to say and how to answer each of your questions. If you hurry on to the next question too quickly, you will most likely fail to obtain important information.

It is also essential that you observe the client’s nonverbal cues (e.g., facial expressions, appearing nervous or worried, looking downward, or crying). These cues may indicate that the client is experiencing strong emotions or failing to disclose significant information. If you notice any nonverbal cues, be sure to ask the client more questions in an attempt to find out what he is feeling or thinking.

Remember that because sexual and reproductive health information is private, personal, and even secret, the client may not initially articulate his primary concern. Sexual concerns may be the reason why the client is vague or unclear when describing his symptoms or when you suspect a functional overlay (e.g., headache, anxiety, or fatigue); this is particularly true in primary health care settings. Careful and compassionate listening can make all the difference.

To effectively obtain a sexual and reproductive health history, follow these four steps:

1. Make the client feel comfortable.
2. Ask direct questions about the client’s sexual and reproductive health.
3. Address the client’s questions and concerns.
4. Ask follow-up questions specifically related to the client’s questions and concerns.

**Make the Client Feel Comfortable**

- Provide a quiet, private room that is free of interruptions.
- Have the client remain fully dressed and seated at eye level.
- Greet the client, and introduce yourself; wear a name tag so that he knows who you are.
• If an interpreter is necessary, use one who has experience in interpreting sexual and reproductive health concerns and understands the importance of confidentiality. If possible, assess the appropriateness of using interpreters of the opposite sex from the client. This depends on the client, the culture, and the individual circumstances. Avoid having the client’s family members or friends interpret unless an emergency exists. Sometimes, family members or friends make assumptions, provide only medical information and not mention other related issues, or provide all the information and not let the client respond.

**Ask Direct Questions about the Client’s Sexual and Reproductive Health**

• Explain to the client that you will be asking him several questions about sensitive health concerns.

• If the client has been accompanied by family members or friends, offer him the chance to reassess whether he wants them to remain in the room with him during the sexual and reproductive health history taking.

• Ask clear, direct, and unambiguous questions regardless of your own discomfort or fear of embarrassing the client. He has a right to be heard in a nonjudgmental way, even if your values differ from his.

• Ask open-ended questions to identify any areas of concern.

**Address the Client’s Questions and Concerns**

• Reassure the client that other men ask similar questions and have similar concerns.

• Do not become anxious about periods of silence. They enable the client to be more frank about his concerns. The client may need time to sort out how much he wants to reveal.

• Encourage the client to discuss his concerns in his own words.

• Listen attentively as he presents his reason(s) for seeing a service provider.

**Ask Follow-Up Questions Specifically Related to the Client’s Questions and Concerns**

• Narrow your follow-up questions about the client’s questions and concerns to elicit additional information when necessary. Begin an organized approach to your follow-up questions so that you can understand the condition’s onset, location, duration, character, and extent, as well as any associated factors and prior diagnoses and treatments.

• Give the client an opportunity at the end of the history taking to raise issues he did not mention earlier.

• Pay close attention to the client’s last question or concern as the history taking is about to end or as he leaves the room. Because men are often uncomfortable discussing sexual and reproductive health issues openly, a client may disguise his real concern by making a joke or a seemingly casual remark. He might say, “Well, I guess that will satisfy my wife.” Frequently, this is the first indication that the client has a sexual concern. Take such jokes and remarks seriously, and follow up, at least briefly, on them with appro-
appropriate questions. Respond to these comments as if the client really wants information or an opportunity to talk—he probably does. But you also need to recognize that because of time and/or schedule constraints, you may have to ask the client to return for another visit to discuss any significant issues that were identified toward the end of the initial visit.

**Major Components of Sexual and Reproductive Health History Taking**

There are seven major components of taking a sexual and reproductive health history. For each component, the reasons for needing the information are provided, along with some sample questions that will enable you to explore the subject if the client’s initial answers indicate that you will need additional information before making a diagnosis or risk assessment.

1. **Number and Type of Sexual Partners**

   **Why This Information Is Needed**
   - To determine the client’s level of risk for contracting an STI
   - To obtain information without using terms that can be interpreted inaccurately or as value-laden (e.g., homosexual, bisexual, heterosexual)

   **Sample Questions**
   - Do you have sex with women, men, or both women and men?
   - How many partners have you had in the last year?
   - Have you had any new partners in the past few months?
   - Have you ever had any casual or one-time partners?
   - Have you ever had any partners you would consider risky in terms of HIV/AIDS or other infections? What makes these partners risky?
   - Have you ever been infected by any partners? [If the client answers yes, ask:] How were you and your partners treated? How are you and your partners now?

2. **Sexual Activities**

   **Why This Information Is Needed**
   - To determine the client’s level of risk for contracting an STI
   - To determine the focus of the genital examination and the need for throat, rectal, and urethral (in the client’s partner) cultures to test for STIs

   **Sample Questions**
   - What kind of sexual activities do you engage in? (Modify these questions according to the client’s prior answers to the questions about the number and type of partners he has had and other information he has provided.)
– Penis in vagina (penile-vaginal sex)?
– Penis in mouth (fellatio)?
– Mouth on vulva (cunnilingus)?
– Your penis in your partner’s anus (anal sex)?
– Your partner’s penis in your anus?
– Any other sexual activities? [This question is particularly important when the client’s prior answers or other information he has provided indicate, possible trauma or infection transmission through such activities as oral-anal contact or the use or sharing of sexual devices.]

3. Risk for Contracting STIs

Why This Information Is Needed

• To identify whether the client needs information about risks and/or protective measures for STIs, including gonorrhea, hepatitis, HIV/AIDS, syphilis, and other STIs that you are likely to see in your clients
• To encourage the client to evaluate his own risks and sexual behaviors so that he can determine whether he is adequately protecting himself

Sample Questions

• In what ways, if any, are you protecting yourself from HIV/AIDS and other STIs?
• Are you:
  – Having sex with someone who has sex with others?
  – Having sex with someone who is HIV-positive?
  – Having sex with someone who uses intravenous (IV) drugs, injection drugs, or vitamins?
  – Having sex with someone whose sexual history and HIV status you do not know? [If the client answers yes, ask:] How do you know this person is not HIV-positive?
  – Having unsafe sex?
• Do you protect yourself with all of your partners or only some of your partners?
• Do you protect yourself consistently (every time) you have sex, or do you sometimes have unsafe sex?
• Do you drink alcohol or use drugs? [If the client answers yes, ask:] Does this affect whether you protect yourself when you have sex?
• Have you taken an HIV test? [If the client answers yes, ask:] When did you take the HIV test? [If the client answers no, ask:] Are you willing to consider taking an HIV test? [If the client answers yes, suggest that he make another appointment. If the client answers no, explain the importance of taking an HIV test. If the test reveals that he is HIV-positive, he can be treated for the infection and receive follow-up care. If the test reveals he is HIV-negative, he can receive counseling to prevent him from becoming infected with HIV.]
4. Symptoms of Infections, Injuries, and Disorders

Why This Information Is Needed

- To determine if the client has an STI or an injury to or a disorder of his sexual and reproductive organs, such as an infection or enlargement of the prostate gland
- To inform the client of signs and symptoms that require medical care when they appear

Sample Questions

- Do you have any problems with your genitals, such as burning or pain during urination, discharge from your penis, bumps or sores on your genitals, or pain or lumps in your genital area? (Follow up on any specific signs and symptoms that the client mentions.) [If the client answers yes, ask:] What color is the discharge? Is the sore painful? When did you notice the discharge [or sore]? Did you notice a change in the discharge? Did the sore become more painful?
- Do you have any pain, lumps, or heaviness in your testes?
- Do you have any other problems with urination, such as having difficulty emptying your bladder, urinating frequently, having to get up during the night to urinate, or dribbling?
- Do you have any lower abdominal pain?
- Do you have dark urine or any yellowing of your skin or eyes?
- Have you ever had any history of genital injuries or surgery?
- Do you want to be checked for STIs today?
- Do you routinely examine your testes and other genitals?
- Do you have any questions about STIs or other men’s sexual and reproductive health problems?

5. Sexual Satisfaction

Why This Information Is Needed

- To assess the client’s sexual concerns
- To evaluate the client’s possible sexual dysfunction
- To educate the client about sexual satisfaction issues
- To reassure the client that his sexual concerns will be addressed, that his concerns are normal, and that other clients have sexual concerns also

Sample Questions

- How satisfied are you with your sex life at this time?
- Do you have any doubts, problems, or concerns about how you function sexually?
- Do you have any problems achieving or maintaining an erection or reaching orgasm?
- Have you had any change in how often you have sex or how interested you are in sex?
- Have you noticed any change in your sexual functioning? (This question is particularly important if the client has any chronic diseases [e.g., heart disease], has a history of
relevant diseases or surgeries [e.g., coronary bypass surgery], or takes medications that may affect his sexual functioning [e.g., antidepressants or antihypertensives].

- Have you had any change in your alcohol, drug, or tobacco use? (Ask this question only if the client’s prior answers or other information he has provided indicate alcohol, drug, or tobacco use, which may be related to sexual dysfunction. [If the client answers yes, ask:] Has this change affected your sexual functioning?
- Have you ever been forced to have sex or had abusive sexual contact?
- Do you have any sexual problems with your current partner?
- Have you or your partner had any problems or illnesses that have affected your sex life?
- Do you have any problems with controlling your anger or feeling depressed (lethargic, unable to sleep)?
- Has anything affected the way you feel about yourself as a man (e.g., unemployment, mental health problems)?
- Do you have any sexual problems or concerns that you want to talk about today?

### Overview: Using Sexual Slang

When you take a client’s sexual and reproductive history, the client may use common, slang, or colloquial terms to describe his body, sexual behaviors, and sexual function. It is important for you to understand the medical and common or slang terms used in your local area and to be comfortable hearing (and perhaps using) common or slang terms in order to communicate effectively with the client.

You have several ways to help the client learn and use the medical terms. For example, you might say to a client, “You have a sore on your dick? Oh, another word for dick is *penis*. I will probably call it a penis more often, but it means the same thing.” In this way, the client learns the correct term without feeling criticized or unknowledgeable for having used the slang term.

Medical terms that may be used when providing men’s sexual and reproductive health services include:

- **Body parts**: penis, scrotum, testes/testicles/male gonads, clitoris, vagina, vulva, breasts, anus
- **Sexual behaviors and related terms**: erection, masturbation, sexual intercourse, penile-vaginal sex, coitus interruptus, oral sex (*fellatio* when performed on a man; *cunnilingus* when performed on a woman), anal probing, anal receptive intercourse, anal sex, withdrawal, ejaculation, orgasm, condom, impregnate, erection, erectile dysfunction, gonorrhea, syphilis, infertility, pre-ejaculate, semen, vasectomy
6. Contraception

**Why This Information Is Needed**
- To assess whether the client and his partner need contraception
- To determine whether the contraceptive method that the client and his partner are using is satisfactory for both partners, and whether they are using it correctly
- To encourage the client to evaluate his role in preventing pregnancy in their relationship

**Sample Questions**
- How important is it to you and your partner to prevent pregnancy at this time? [If the client answers that preventing pregnancy is *not* important to him and his partner, continue with the next component. If the client answers that preventing pregnancy *is* important to him and his partner, continue with the rest of the questions in this component.]
- Do you and your partner agree on whether you want to prevent pregnancy now?
- Which contraceptive method(s) are you and your partner using to prevent pregnancy? [If the client and his partner use a female-directed method, ask him:] Are there ways in which you help your partner use this contraceptive method?
- How satisfied are you and your partner with your current contraceptive method(s)?
- What would you or your partner change about your current contraceptive method(s)?
- Have you or your partner had any illnesses or problems that interfere with your current contraceptive method(s)?
- Do you understand how emergency contraception works?
- Can you talk with your partner about contraception and sexuality?
- Do you have any questions about preventing pregnancy?

7. Infertility and Pregnancy

**Why This Information Is Needed**
- To elicit the client’s reproductive health history
- To assess the client’s desire and/or ability to have (more) children

**Sample Questions**
- Have you ever made a woman pregnant?
- Do you have any children? [If the client answers yes, ask:] How many children do you have? How old are they/is he or she?
- Do you want any (more) children? [If the client answers yes, ask:] When? How many? With your current partner?
- Do you have any concerns about your ability to make someone pregnant? [If the client answers yes, follow up with additional appropriate questions or refer the client to the appropriate specialist.]
• Are you and your partner trying to conceive? [If the client answers yes, ask:] How long have you been trying to conceive?

• Has your partner had any children?

• Have you or your partner seen a service provider, been tested, or been treated previously for infertility? [If the client answers yes, ask:] Can you give me details about these tests and treatments?

• Have you had a semen analysis?

• Does your partner have irregular menstrual cycles? (If the client’s partner has irregular menstrual cycles, this could indicate anovulation, which is a lack of ovulation.)

• Does your partner have pain while she is menstruating (has her period), especially progressive pain while she is menstruating? (If the client’s partner has pain [not just menstrual cramps] while she is menstruating, this could indicate endometriosis, which can cause infertility.)

• Has your partner ever had, or has she had any signs and symptoms that indicate, uterine leiomyomata, menometrorrhagia, pain while she is menstruating, deep pelvic pain with sexual intercourse, or pelvic pressure?

Global Screening Recommendations
Several national and international medical organizations have made official recommendations regarding when and which types of physical and laboratory screening tests should be performed on men. The following are global screening recommendations for various sexual and reproductive health conditions.

Note: It is likely that you will not be able to perform all of the screening tests described below at your health care facility. So it is important to begin to develop a list of local laboratories and other organizations to which you can refer clients when such screening tests are necessary. Do not screen for any condition that you cannot treat or for any condition for which the client will not have access to treatment (if the screening test is positive).

Review the screening tests that follow, and identify the ones that you can perform at your facility and the ones for which you will need to refer clients to other facilities.

HIV (Voluntary Screening)
Assess the client’s risk for HIV by carefully taking his sexual and reproductive health history and inquiring about injection drug use. Periodic screening is recommended for any client at increased risk for HIV (U.S. Preventive Services Task Force, 1996). Testing for HIV is suggested in facilities in the developing world in which such testing is available.

Prostate Cancer
Two screening tests are used to detect prostate cancer: the digital rectal examination (DRE) and the prostate-specific antigen (PSA) test. The DRE has been used for many years as a screening test, but its ability to detect prostate cancer is limited, as some tumors form in areas
of the prostate gland that the DRE cannot reach. These areas are in the center of the prostate gland, where the DRE cannot feel the tumor, and directly on top of the prostate gland, where the DRE cannot reach the tumor because it is too high. Sometimes, service providers also have difficulty distinguishing between benign abnormalities and prostate cancer.

The PSA test measures an enzyme in the blood that can rise naturally as men age and when men have prostate gland abnormalities. However, it cannot distinguish between prostate cancer and benign growths or other conditions, such as prostatitis. The PSA test also fails to detect some prostate cancers.

There is some controversy over the early detection and treatment of prostate cancer. Although screening detects some prostate cancers early in their growth, it is not yet known whether screening saves lives or whether treatment reduces disability and death from disease. For some men, screening and treatment may be more harmful than helpful because current screening tests do not indicate which prostate cancers will grow slowly. Slow-growing prostate cancers may not require surgery or radiation, which can cause impotence and incontinence. Therefore, the harm associated with prostate cancer treatment can outweigh the benefits. Additionally, it is not clear how well treatment works for fast-growing prostate cancers.

The U.S. Centers for Disease Control and Prevention (CDC) does not recommend prostate cancer screening, but it does recommend that clients be provided with up-to-date information about screening, including its potential harm and benefits (CDC Web Site).

**Testicular Cancer**

Most testicular cancers are first detected by the client, either unintentionally or through genital self-examination; some are discovered during routine genital self-examinations. However, no studies have been conducted to determine the effectiveness of genital self-examination or genital examination performed by service providers in reducing the mortality rate from testicular cancer.

The early detection of testicular cancer may have little to no effect on mortality, since it is so high. However, it may have a practical effect on therapy. The more advanced is the testicular cancer, the higher are both the number of courses of chemotherapy and the extent of surgery required for treatment. Clients diagnosed with localized testicular cancer require less treatment and have lower morbidity than those with more advanced disease.

**Sexual and Reproductive Health History Taking Case Studies**

The following case studies illustrate the common men’s sexual and reproductive health signs, symptoms, and concerns that service providers must consider when taking a sexual and reproductive health history. By asking the suggested questions and performing a genital examination, you will obtain enough information to make a differential diagnosis and plan a course of treatment.
Case Study 1: Testicular Torsion

Signs, Symptoms, and Concerns
You are Mohammed, a 24-year-old Egyptian graduate student. You come to the health care facility with scrotal pain and swelling. The problem started about two hours ago, and you thought it would get better on its own because it did when it happened before. You would prefer to talk to a male service provider, but you will talk to a female provider if necessary because you are very worried that you may have cancer. The pain is getting worse, and you have nausea and low-grade fever and are vomiting. You worry that if you have cancer, the treatment will involve castration, you will never have children, you will not carry on your family name, and you will cease to be “a man.”

Suggested Questions
• How often has this happened? (A client with a history of testicular torsion may mention prior episodes of acute pain that resolved themselves.)
• What were you doing when this happened? (Was the client straining? Was he lifting? Was he having sex?)
• Do you have a fever?
• Does it hurt to urinate?
• Does your urine have blood in it?
• Have you ever been diagnosed with an STI?

Physical Examination Findings
The client’s testicle is high in the scrotal sac and has a horizontal orientation.

Differential Diagnosis
A client with sudden-onset scrotal pain and swelling should be considered to have testicular torsion until proven otherwise. The condition is a medical emergency and requires prompt treatment and referral. Misdiagnosing the condition can lead to testicular loss and infertility.

Other possible causes for the client’s condition are:
• Epididymitis and orchitis. The client may have a more gradual onset of pain, urethral discharge, a history of urinary tract infection, and a work or exercise history consistent with lifting and straining. Epididymitis and orchitis are the disorders most commonly misdiagnosed as testicular torsion. These conditions are rare before adolescence.
• Hydrocele. The client may have painless scrotal swelling. During transillumination, the scrotal contents are visible.
• Idiopathic scrotal edema. The client may have thickened, edematous, and often inflamed scrotal skin, but the testicle is nontender and is normal size.
• Incarcerated scrotal hernia. The client may have signs and symptoms that are similar to those of testicular torsion, but he may also have abdominal pain and pain in the geni-
tal area. You may be able to diagnose the condition by carefully examining the inguinal canal.

- **Testicular torsion or torsion of epididymal appendage.** The client usually has localized tenderness in the upper pole of the testicle. Occasionally, light-skinned boys may have a **blue dot sign**. Systemic symptoms are rare. The condition usually occurs in young boys.

- **Testicular tumor.** The client may have a more gradual onset of pain, although pain is not generally a primary symptom. **Infarction** of the tumor can complicate the diagnosis.

**Management**

Depending on the resources available at your health care facility, the outcome of the condition can be very different. Performing an ultrasound (if it is available at your health care facility) may help you diagnose the condition. With a prompt diagnosis (within six hours of onset) you can attempt manual detorsion, which may be successful. If manual detorsion is not successful, refer the client to a surgeon for testicular rescue.

**Case Study 2: STI**

**Signs, Symptoms, and Concerns**

You are Effesone, an 18-year-old man who lives in a rural village 22 miles from Addis Ababa, Ethiopia. Two days ago, you noticed a blister on your penis, and the blister has gotten larger. You were not too worried originally because it was not that painful, but now you are worried because you have pain and swelling in the genital area. You also have a low-grade fever. This is the first time you have had something like this. You are also uncomfortable talking about sexual activity.

**Suggested Questions**

- How many blisters did you notice initially?
- Do you have any discharge from your penis?
- Are you sexually active?
- Do you have sex with other men?
- Do you practice safer sex?

**Physical Examination Findings**

The client has a sharply circumscribed ulcer with some yellow exudate, as well as inguinal lymph node enlargement.

**Differential Diagnosis**

Genital ulcers are most likely caused in young men by an STI. Although genital ulcers are also most frequently caused by an STI in older men, genital ulcers in older men have other causes, such as malignancies and systemic diseases. Infectious causes of the condition include chancroid, HIV infection, herpes simplex, lymphogranuloma venereum (LGV),
and syphilis. Noninfectious causes of the condition include cancer, reactions to medications, and trauma.

Possible causes of the client’s condition are:

- **Chancroid.** The client has a painful ulcer that may be sharply marked (has a clearly defined margin or edge) and is associated with inguinal lymph node swelling. The lymph nodes can rupture. The condition is caused by *Haemophilus ducreyi*.

- **Herpes simplex.** The client has multiple vesicles in clusters that can open, forming a shallow, painful ulcer. The condition is caused by the herpes simplex virus.

- **HIV infection.** The client has different types of lesions depending on the particular opportunistic infections he has. These lesions include the white plaques of *Candida* infection and the painful *dermatomes* of herpes zoster.

- **Lymphogranuloma venereum (LGV).** The client has a small, painless ulcer that may not be observed because it heals quickly. He may also have large, painful inguinal lymph nodes. The condition is caused by *Chlamydia trachomatis*.

- **Syphilis.** The client has a painless, swollen ulcer with smooth, firm borders. It is usually singular and can heal spontaneously. The condition is caused by *Treponema pallidum*.

**Management**

Accurate diagnosis is particularly important with STIs. If adequate screening tests are not available at your facility, treat the client presumptively with appropriate medications. The client’s partner(s) should also be treated. This is an opportunity to educate the client about sexual behaviors that can put him at risk for HIV infection and other STIs. Several studies indicate that the presence of genital ulcers is an important risk factor for the sexual transmission of HIV infection.

**Case Study 3: Erectile Dysfunction**

**Signs, Symptoms, and Concerns**

John is a 65-year-old man who lives in the Ukraine and comes to your health care facility with “sexual problems.” He is slightly embarrassed and has difficulty responding to questions. Upon further questioning, he admits that he has had trouble maintaining an erection. The problem has been gradually getting worse for the past four years, and he now has trouble achieving an erection. John says that he never told his regular service provider about this problem because he was embarrassed. However, he is not satisfied with his sex life and wants help. He thinks that this problem is affecting his marriage. John also says that he has had hypertension for 10 years, and that recently his service provider told him that his cholesterol level is high. He has a family history of coronary artery disease, hypertension, and hypercholesterolemia.

John tells you that he takes two hypertension medications. He had smoked one pack of cigarettes a day for 30 years, but he quit smoking two years ago. He also drinks three beers each night.
He describes his work situation and home life as stressful. He is worried about losing his job, and his son has been arrested.

**Suggested Questions**

- What aspects of your sex life are you unsatisfied with at this time?
- Can you maintain an erection until your partner reaches orgasm?
- Do you ejaculate?
- Have you had any prior surgeries? *(Note: Some surgeries interfere with blood or nerve supply, or require follow-up medication(s) that interfere with erection.)*
- What other medications do you take, including any nonprescription and natural medications?
- How much caffeine do you drink each day?
- What is it about your home life and your work that makes you feel stressed?
- Do you have any problems with your moods, such as feeling angry and not being able to control your anger, or feeling depressed (lethargic, unable to sleep)?
- Have you ever had this sexual problem before?

**Physical Examination Findings**

The client has a blood pressure reading of 160/90 mm Hg. Otherwise, his findings are normal.

**Differential Diagnosis**

Erectile dysfunction usually has many causes: organic, physiologic, endocrine, and psychogenic. Generally, erectile dysfunction is divided into organic and psychogenic impotence, but most men with organic causes usually have a psychological component. Almost any disease may affect erectile function by altering the nervous, vascular, or hormonal systems. Various diseases may produce changes in the smooth muscle tissue of the corpora cavernosa or influence the client’s mood and behavior.

Possible causes for the client’s condition are:

- **Coronary artery disease.** The client has coronary artery disease. This is a risk factor for erectile dysfunction, and recent studies indicate that merely having a history of hypercholesterolemia points to an underlying vascular cause.
- **Excessive alcohol intake.** The client has a problem with excessive alcohol intake, which is directly toxic to the testes and can result in decreased testosterone production. Excessive alcohol intake is also directly toxic to the liver. The resulting liver dysfunction can cause an imbalance in testosterone and estradiol metabolism, which is often associated with gynecomastia.
- **Hypertension.** The client has long-standing hypertension. His elevated blood pressure indicates that the hypertension is not well controlled.
- **Medication side effects.** The client has been taking two medications that have been associated with erectile dysfunction.
• Smoking. The client had a long-standing smoking habit. Smoking increases the risk for vascular disease.
• Stress. The client has many sources of stress, which can also contribute to erectile dysfunction.

Management
In the absence of an organic cause, or together with treatment for erectile dysfunction, psychological support and reassurance are important to the management of this disorder.

Case Study 4: Paraphimosis

Signs, Symptoms, and Concerns
Usha, who lives in India, brings her 5-year-old son, Dinesh, to your health care facility. She says that he has been complaining of pain in his genital area since that morning. He has been cranky and crying intermittently. He told her that he could not urinate. Usha also says that Dinesh has no health problems.

Suggested Questions
• Has this ever happened before?
• Does Dinesh have a fever?
• Did Dinesh have any trauma in the genital area?
• Does Dinesh clean the genital area daily?
• Is Dinesh circumcised?

Physical Examination Findings
The client has penile skin edema. The genital area is painful to touch. The foreskin is retracted and cannot be returned to its normal anatomic position. Another possible finding is that the client appears to have been circumcised and the skin behind the foreskin may look asymmetrically red and swollen (this is the constricting retracted foreskin).

Differential Diagnosis
The foreskin usually provides a cover for the glans, and retracting the foreskin is usually easy. However, in some young boys, retracting the foreskin is difficult, which may lead to infection, inflammation, edema, fibrosis, and scarring. Obstruction to urination also may occur, and urinary infection can result. Additionally, such chronic inflammation may lead to penile cancer.

Note: This condition is usually discovered in newborn infants.

Possible causes for the client’s condition are:
• Balanoposthitis. The client has an inflammation of the superficial area of the foreskin, involving the distal foreskin. The condition can look like paraphimosis because of the red, swollen glans. Balanoposthitis can occur in boys, people with diabetes, and men
with poor hygiene. The condition can be caused by an irritation resulting from contact with external products or by infections, such as Candida.

- **Paraphimosis.** The client has a retracted foreskin that cannot be returned to its normal anatomic position. Paraphimosis is the most serious diagnosis for the client. This condition is a medical emergency and requires prompt treatment and referral. Paraphimosis leads to a tight ring of skin around the glans. Eventually, edema develops and leads to decreased blood flow to the penis and then to necrosis. Boys, and even men, can get penile constriction from other objects that can wrap around the penis, such as hair.

Three types of clients can develop paraphimosis:
- Young boys who have a retracted foreskin and swelling
- Men with chronic penile infections who develop contracture of the foreskin
- Men with catheters who do not have their foreskin returned to its normal anatomic position after catheter insertion

- **Phimosis.** The client has stenosis of the foreskin, which prevents foreskin retraction. The condition is not usually an emergency. Phimosis often occurs in young boys, and by adolescence, almost all boys can retract their foreskin. The only reason to address this condition is urinary retention.

**Management**

The client most likely has paraphimosis. Manual reduction can be attempted. Refer the client to a surgeon immediately if the foreskin cannot be returned to its normal anatomic position. Elective circumcision should be performed as soon as the foreskin is healthy.

**Case Study 5: Urinary Retention**

**Signs, Symptoms, and Concerns**

Louis is a 66-year-old man who lives in Tunis. He comes to your health care facility in the late afternoon, accompanied by his son. Louis’s main complaint is that he has not been able to urinate since yesterday, and now his abdomen feels full and painful. He says that he has been healthy all of his life and has never been to a service provider. Louis admits that for the past few months, he has had trouble emptying his bladder. He has difficulty initiating a urinary stream. When the urine does come out, the stream is less forceful than usual. Louis also says that he feels like his bladder does not empty completely. He is uncomfortable.

**Suggested Questions**

- Have you had any weight loss?
- Do you have back pain?
- Do you have a fever or chills?
- Have you had any urinary tract (or bladder or penile) infections?
- Have you had any traumas?
- Has anyone in your family had cancer?
- Do you have diabetes?
• Do you use any medication(s)? [If the client answers yes, ask:] What medication(s) do you use?
• Do you have difficulty walking?
• Does your urine have blood in it?

**Physical Examination Findings**
The client has pain during palpation in the suprapubic region. A full bladder can be palpated. The client’s genitals are normal. During a rectal examination, the findings indicate that the client has a smooth, symmetric, enlarged prostate gland. His neurological examination findings are normal.

**Differential Diagnosis**
Urinary retention refers to the function or structural changes in the urinary tract that impede the normal flow of urine in a variety of settings and is a fairly common cause of **obstructive uropathy**. It is relatively common in all age groups—e.g., urethral valves in infants, urinary tract stones in young adults, and benign prostatic hyperplasia (BPH) in elderly men. The obstruction can occur at any level of the urinary tract, from as high as the renal tubules to as low as the urethral meatus. The clinical manifestation depends on the location and degree of the obstruction, and whether it is acute or chronic.

The client may be in pain and may present with a renal change in urine output or frequency, hematuria, palpable masses, hypertension, and recurrent urinary tract infections.

Possible causes for the client’s condition are:

- **Benign prostatic hyperplasia (BPH).** The client usually has a nonnodular, symmetric enlargement of the prostate gland. He may also have progressive symptoms, including urinary hesitation, urinary frequency, decreased force of urinary stream, and straining during urination. BPH is the most common cause of urinary retention.
- **Bladder neoplasm.** The client has painless hematuria. The tumor can bleed and cause a clot to form, which leads to obstruction of urine flow from the bladder through the urethra.
- **Medication side effects.** The client takes medications that can lead to urinary retention. The list of possible medications is extensive and includes anticholinergics, antidepressants, hypertension medications, hormones, and spinal anesthesia.
- **Metastatic disease.** The client has metastatic disease, which is a primary malignancy of the bladder, prostate gland, or gastrointestinal tract. The condition may cause urinary retention, usually by pressure effects. Metastatic disease may also cause neurological impairment of spinal cord function. The condition should be considered in any client with no obvious obstructive etiology.
- **Multiple sclerosis.** The client has multiple sclerosis. Symptoms usually occur between ages 20 and 50 and occur more frequently in women than in men. The condition produces many varied neurological signs and symptoms, depending on which body parts are
involved. The client may have some combination of progressive spastic leg weakness, instability, and impairment of bladder function. Bladder dysfunction includes urinary urgency with incontinence or hesitancy and incomplete emptying of the bladder. However, multiple sclerosis does not usually cause urinary retention. The signs and symptoms of multiple sclerosis lessen over time, but as the condition progresses, new signs and symptoms often appear, old signs and symptoms recur, and residual symptoms increase.

- **Paraphimosis.** The client has a retracted foreskin for a prolonged period of time, which leads to swelling and constriction. *This condition is a medical emergency and requires prompt treatment and referral* (see page 1.12).
- **Phimosis.** The client has a narrowing of the opening of the foreskin that prevents the foreskin from being retracted. The opening may be dilated with a hemostat to relieve the obstruction.
- **Prostate cancer.** The client may have symptoms of a malignancy, such as weight loss, fatigue, and pain. During a rectal examination, the findings indicate that the client has a nodular or hard prostate. Prostate cancer does not often cause a voiding obstruction, but it should be considered as a possible differential diagnosis.
- **Prostatitis.** The client may have a fever, pain during urination, and low back pain. The client’s urine is cloudy. During a rectal examination, the findings indicate a warm, tender prostate gland. Prostatitis is an infection of the prostate gland. The condition can be diagnosed by carefully taking the client’s history, performing a rectal examination, and urinalysis. Prostate massage should be avoided to prevent further spread of the bacteria.
- **Spinal cord trauma.** The client has additional motor symptoms and a history of severe trauma to the back or backbone. Spinal cord tumors do not usually cause urinary retention.
- **Urethral strictures.** The client has scar tissue that can surround the urethra. Urethral strictures are usually caused by trauma, such as catheter placement, radiation therapy, or prior infections.

**Management**

Performing a urinalysis will help you diagnose the condition. Carefully inserting a catheter relieves the obstruction. If the client has a urethral stricture, a special catheter may be required. Refer the client to a specialist for further testing. If the client has a history that is consistent with BPH, doing a PSA test may be helpful when a differential diagnosis of prostate cancer is being considered.