Performing a Genital Examination

This chapter provides the information that service providers need to correctly perform a genital examination on a male client. It explores what providers must do before performing a genital examination, including setting up the examination area and preparing the client psychologically and physically. The chapter also identifies and describes the parts of a genital examination, with step-by-step directions; discusses gentle, respectful verbal and physical techniques for performing a testicular and prostate examination; and explains the techniques for obtaining urine and rectal specimens and prostate secretions. A strategy for incorporating client education during a genital examination is also discussed.

Before the Genital Examination

Before the genital examination can begin, the service provider must take several steps to ensure that the examination area and the client are fully prepared. This section discusses the preparation of the examination area that a provider must do beforehand, as well as the psychological and the physical preparation that a client must undergo before a genital examination.

Preparing the Examination Area

The first step is to gather and arrange all the supplies that you will need to perform the genital examination, including any tests, cultures, and client-education materials.

You will need a chair and examination table, pens to write the examination findings on the client's chart, and a bright light source. A good light source is essential; without one, you will not be able to accurately observe during the examination. You will also need a drape, examination cover, or gown to offer the client to ensure his comfort and to protect his modesty; during the examination, you will uncover only the area being examined at the time. Have extra charts, referral forms, and referral sources available. Be sure that all the required supplies are conveniently located in the examination area.

The following is a checklist of supplies needed for the genital examination:

- Drapes, examination covers, or gowns
- Latex or vinyl gloves
- A light source and magnifying glass for assessing skin lesions
- Vinegar (dilute acetic acid solution) for assessing possible genital warts
- Urethral swabs for collecting cultures
- Glass slides for specimens
- Specimen cups for collecting urine
- Test kits and reagent for collecting stool for occult blood testing
• Supplies for drawing blood (tourniquet, blood tubes, labels, needles, syringes, small bandages, and sharps container [disposal container for used needles])
• Lubricant for performing rectal examinations
• Viscous lidocaine for topical application and/or injectable local anesthetic
• Items for client comfort (table paper, a pillow, tissues, cloth covers for foot stirrups if the lithotomy position will be used)
• Free condoms
• Client-education materials that are culturally and age-appropriate and are written out at the appropriate literacy level, such as a diagram of the male anatomy, an anatomical-development chart, information about condoms and sexually transmitted infections (STIs), and other community resources for services
• Extra charts, referral forms, and referral sources

At referral sites, having the following supplies available will be helpful for higher-level assessment:
• For diagnostics: anoscopes, orchidometer, and a Wood’s light (Note: An anoscope is inserted into a client’s anus, so it is important to have several anoscopes available to prevent transferring microorganisms from one client to another.)
• For diagnostics, depending on the arrangements with a local laboratory (some laboratories perform only certain tests, so depending on which tests your facility performs routinely, you will need specific items): cover slips, Gram stain supplies, a microscope, paper reagent strips (“dipsticks”), saline solution, specimen collection tubes for special tests

Other supplies will be needed depending on the level of care and the specific procedures to be performed during the genital examination. The decision to provide advanced care depends on other community resources, budget, adequate staff training, and a local laboratory to provide a histologic examination of biopsy specimens.

Preparing the Client
It is helpful to view the genital examination as a process you do with the client, not to the client. Generally, men are somewhat anxious and ambivalent when they go to health care facilities. They may be afraid that they have a serious physical problem, or that the examination or procedures will be painful or embarrassing. They also may be afraid that they will have to share detailed information about their private life or their sexual behaviors. Therefore, before the examination begins, make every effort to prepare the client both psychologically and physically and to ensure that he is as comfortable as possible. This includes:
• Establishing a rapport with the client
• Explaining to the client what the examination consists of
• Preparing the client for any painful or potentially embarrassing procedures
• Educating the client about his genital health
Making the client feel comfortable requires treating him in a nonjudgmental and unbiased manner. Never assume that because a client is older, he is not concerned about sexual function, or that because he is not married or does not have a female partner, he is not sexually active. Finally, do not assume that the client’s partner is female.

Preparing the client for a genital examination includes providing him with adequate information, preparation, and instructions. Always explain to the client what you plan to do during the examination (the sequence of steps and the steps themselves) or for treatment, and why you are doing it. The client has the right to know about all of the parts of the examination and treatment, as well as the right to refuse them. The client also has the right to make an informed choice, which is a voluntary, thoughtfully considered decision based on a clear understanding of the information and options presented to him.

If the client tells you before the genital examination that he thinks that he will not be able to tolerate it because of discomfort or pain, consider using an analgesic or anesthesia before beginning. For example, a client with an infected testicle expresses concern about being in pain during the examination. Since the examination can cause pain, nausea, vomiting, and syncope, reassure the client that adequate anesthesia will be used, and that if he feels discomfort or pain, more anesthesia will be delivered.

Another way to prepare the client for the genital examination is to explain to him beforehand that he can “assist.” Often, this minimizes the client’s anxiety. For example, asking the client to help insert a urethral swab can lessen his fear because he can maintain control (see “Overview: Pain and Anxiety” on page 3.4).

Preparing the client also means informing him about the possible effect of medication (oral medication or anesthetic gel) used during the examination on his sexual function (erection, ejaculation, and orgasmic sensations) and reproductive ability. Understandably, the client may be anxious about the impact of the genital examination on his penile sensation, libido, sexual function, and fertility. Do not wait for the client to ask about these effects; raise these concerns in a straightforward manner. Explain to the client that he is in charge and has the right to tell you to stop the examination or any treatment that takes place during the examination at any time, as well as the right to seek care elsewhere. Always remind the client that he has the right to make an informed choice. If the client has an opportunity to go to another facility and get a second opinion, encourage him to do so.

**During the Genital Examination**

When you perform a genital examination, it is important to keep in mind the following steps and strategies in order to make the client feel comfortable:

**Supporting the Client Verbally**

Wearing examination gloves during the genital examination will protect you from possible STI infection. Gloves also establish a sense of propriety and formality that may help to reduce the client’s anxiety about having his genitals touched.
As you go through each step of the examination, briefly explain to the client what you are about to do and why. Always tell the client to inform you immediately if he feels pain or excessive pressure; let the client know that you will stop if he finds any part of the examination to be painful, and will consider further measures to assist him in dealing with the pain. Let the client know immediately when a painful procedure is over. Never proceed with an examination if the client asks you to stop.

As you confirm normal examination findings, comment on them. This is particularly important for adolescents and young men. Many adult men seldom, if ever, have physical and/or genital examinations, yet they may have questions about whether they are “normal.” Clients find it reassuring when the service provider who is performing a close inspection says that their body is normal. For example, you might say, “I’m checking your genital area now, feeling for any lumps or swellings that shouldn’t be here. Everything feels fine so far. Your penis is a normal size and shape, and I don’t see anything abnormal here…”

The following statements are examples of what you might say during the genital examination to support the client:

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**Overview: Pain and Anxiety**

Two issues are essential to pay attention to when providing services to men with genital disorders: pain and anxiety.

Men from various cultural backgrounds may respond differently to illness, concerns about their genitals, and pain. In many cultures, men are expected to be stoic; coping with anxiety and pain may be viewed as a sign of male strength. These cultural expectations of bearing fear and pain in silence can lead to a delay in the diagnosis and treatment of serious illnesses or injuries. Men may wait until an illness becomes very severe before seeking health care. As a service provider, you must understand the cultural traditions that shape the behaviors of your male clients and provide care accordingly.

In some religious traditions, for example, men may perceive an illness or injury to be an atonement for negative behaviors in previous lives, and they may not express their pain or accept medication to relieve their suffering. For this reason, when listening to a client, remember that a seemingly minor complaint may indicate a significant problem.

In other settings, men may be expected to be in control of themselves and their situation at all times. A lack of control is implicit in exposing one’s body for examination, in asking for information, and in expressing doubt, uncertainty, or vulnerability. Being unwilling to seem, to be, or to feel out of control prevents men from seeking health care promptly and makes them reluctant to ask for information. The experience of the actual genital examination, which involves a passive yielding of control and body penetration during the digital rectal part of the examination, may also cause anxiety.
• Explain to the client what the genital examination involves and why you will be examining him. You might say, “The examination will include checking your penis, scrotum, testes, and anus. I’ll explain each step of the examination as we go along. If you have any questions during the examination, please ask me.”

• Reassure the client that you will make the examination as comfortable and painless as possible. This is especially important if he has been sexually traumatized or is young because he may be very apprehensive, as well as very sensitive to even minor discomforts and a lack of consideration. You might say, “I don’t want the examination to be painful for you” or “I’ll do everything I can to make you as comfortable as possible during the examination.” Another option is to say, “I’ll tell you everything I’m going to do. You must tell me immediately if at any time you feel pain or feel anxious. I’ll stop and help you become more comfortable.” If the client has been sexually traumatized or is young, you might say, “I understand that this examination may be uncomfortable for you and may cause you some concern. I’m going to be as gentle as I can and will try not to hurt you. Please tell me immediately if at any time you feel any pain or discomfort, or feel anxious. I’ll stop and help you become more comfortable.” Avoid directions like “Don’t move” and “Hold still.” Offer the client a choice of positions (e.g., standing up or lying on his side), and provide him with a drape, examination cover, or gown for when he is undressed.

• Explain to the client why you will check his rectum during the genital examination. You might say, “A rectal examination may be necessary depending on what I find (or “given the history of the symptoms you’ve shared with me”). The rectal examination will involve feeling pressure and will feel somewhat like a bowel movement. I’ll use a lubricant to make the examination easier. I’ll slowly insert my finger in your anus to check for tumors, enlargement, or infection of your prostate gland. You must tell me immediately if at any time you feel pain or feel anxious. I’ll stop and help you become more comfortable.”

• Explain to the client that he may feel like he has to urinate during the genital examination. You might say, “You might feel like you have to urinate or defecate during the examination. Usually this urge passes quickly, but if the urge is strong, I’ll stop.”

• If the client is anxious during the genital examination, ask him to guide you. You might say, “Let me know when it’s all right to check your right testicle” or “May I go ahead and check your left testicle now?” By having the client guide the examination, you put him in a position of control.

• Relaxation techniques (e.g., focusing on something pleasant, rhythmic breathing) can be very useful with an anxious client. You might say, “Two ways to relax is to imagine a place or situation in which you are relaxed and happy or to breathe deeply.”

• Explain to the client that he may develop an erection during the examination. It is important to remember that erections can result not only from sexual arousal, but from anxiety and temperature changes and as a reflex response to touch. If you are learning the skills needed to perform a male genital examination, you should consider the most sensitive and culturally appropriate manner in which to respond to a client who has an erection during the examination. Most experts feel that a service provider should tell the
client that having an erection is a very normal reaction to being examined and that he
should not be concerned about his erection. You might say, “It’s normal to have an erec-
tion during this examination. You don’t need to be concerned or worried about it.”

• Often, the client realizes that the genital examination was easier than he had imagined
it would be. Reviewing the experience with the client can help him revise his expecta-
tions about future examinations. You might say, “You were very anxious when you first
came to see me today, but you were able to calm yourself for the genital examination
and you learned a great deal about your body. I hope you’ll feel more comfortable the
next time you come to see me.”

Note: You may also feel some discomfort or embarrassment when performing a genital
examination, especially if you are a woman. The best approach to avoiding personal dis-
comfort or embarrassment is to be straightforward and kind to the client. A very helpful
strategy is to explain, step by step, to the client exactly what you are checking for during
the examination and to teach the client about his body as the examination progresses. By
continually explaining the steps of the examination, you have little time to focus on your
discomfort or embarrassment—and the client receives an excellent education at the same
time.

Positions for the Genital Examination

Any of the following three positions may be used during the genital examination:

• The client stands, and the service provider sits facing him.
• The client sits on a stool or on the end of the examination table, and the provider stands
  facing him.
• The client lies on his back in the supine position on the examination table or in the lith-
tomy position.

Before performing the genital examination, ask the client which position he will find most
comfortable. Balance the client’s preference with your view of which position will be the
most effective for the genital examination. Additionally, explain the various steps of the
genital examination to the client (see below) and reassure him that if he feels uncomfort-
able at any time, he should tell you.

The Genital Examination, Step by Step

A general physical assessment is often part of a genital examination, and an examination
of both the breasts and the lower abdomen is usually performed at the beginning of the
genital examination.

General Physical Assessment

The first part of the genital examination is a general physical assessment. This preliminary
assessment should include an examination of the client from head to toe, to identify condi-
tions that may be relevant to sexual and reproductive functioning, as well as to identify
possible endocrine, neurological, vascular, or other health problems. It involves checking the client’s height, weight, blood pressure, and appropriate vital signs (pulse, blood pressure, respiration rate, and temperature). For this part of the genital examination, the client may be sitting or lying on the examination table or standing up. He may need or want to vary his position.

During the general physical assessment, pay particular attention to the following:

- **Body habitus and proportions** (obesity/thinness, muscle development, female or male body proportions), to check for deformities, developmental anomalies, and gynecomastia
- **Eye sclerae**, to check for jaundice (which may indicate liver disease)
- **Skin**, to check for temperature, color, moistness, rash, and lesions (a generalized rash may indicate secondary syphilis or early HIV infection; lesions around the mouth and lips may indicate STIs; purplish lesions may indicate Kaposi’s sarcoma; and dry skin may indicate hypothyroidism)
- **Hair pattern and amount** (a beard, chest hair, other body hair, and **male-pattern baldness** all indicate the presence of androgens; cool skin and the absence of hair on the legs in an older man may indicate impaired circulation to the lower limbs; and the absence of the outer third of the eyebrows may indicate hypothyroidism)
- **Voice pitch** (a high voice may indicate primary low levels of androgens that prevent a male type of larynx and vocal cords to develop sufficiently, so even if androgen levels drop after reaching normal levels, the voice will not become much higher)
- **Posture, expression, and mannerisms**, to check for evidence of depression, mania, alcohol or substance abuse, and psychological inappropriateness
- **Femoral and pedal pulses**, to check for evidence of blood flow to the legs in a man with erectile dysfunction (check the femoral pulse by palpating the femoral artery, which is located at the upper third of the inner thigh; check the pedal pulse by palpating the dorsalis pedis artery, which is located on the top of the foot, in front of the ankle)

**Lower Abdomen Examination**

The client should stand during this part of the genital examination. The lower abdomen examination should include an examination of the lower abdomen for masses or tenderness and for direct or umbilical hernias (see page 3.8). It should also include an examination of the groin area for inguinal swelling or enlarged lymph nodes.

**Lymph nodes** can be soft or firm, tender or nontender, and movable or fixed. Lymph nodes associated with penile infections tend to be slightly tender and enlarged. They may return to their normal size if an STI is the cause of the penile infection, and is associated with an ulcer and the ulcer has healed. Enlarged inguinal lymph nodes may also be caused by disorders of the legs and feet (e.g., infection, injury, and malignancy) and systemic lymphadenopathy (e.g., lymphoma, HIV infection). If the client has erectile dysfunction, also check the femoral pulses; an interference in the blood flow in the pelvic area can result in erectile dysfunction.
Next, check for direct hernias (see Photograph 18 in Appendix H on page H.9). Ask the client to bear down as if he was lifting a heavy object. This is the Valsalva maneuver. As the client bears down, look for lower abdominal bulging from a direct hernia. While the client continues to bear down, place the palm of your hand against the client’s lower abdomen just lateral to (to the side of) the bladder area and palpate for any bulging. If there is no bulging between the abdominal muscles, the client does not have a direct hernia. An umbilical hernia may also be checked through inspection and palpation. When the client bears down, part of the intestine protrudes through the umbilicus.

**Basic Components of the Genital Examination**

Remember, the client can be in any of the following three positions during the genital examination:

- Standing, with the service provider sitting facing him
- Sitting on a stool or on the end of the examination table, with the provider standing facing him
- Lying on his back in the supine position on the examination table or in the lithotomy position

The basic components of the genital examination are:

1. Checking the cremaster reflex
2. Inspecting the pubis
3. Inspecting the penis
4. Inspecting the scrotum
5. Palpating the scrotal contents
6. Palpating for an inguinal hernia
7. Inspecting the perineum and anal orifice
8. Examining the prostate gland

**Checking the Cremaster Reflex**

The cremaster muscles in the scrotum act to pull the testes closer to the body. An intact cremaster reflex indicates the integrity (wholeness) of the sensory and motor nerves. To elicit and check the client’s cremaster reflex:

1. Lightly stroke the upper third of the inner thigh on each leg.
2. Observe whether the testicle on the same side pulls upward slightly toward the groin.

*Note:* Check the cremaster reflex before performing other parts of the genital examination, because exposure of the testes and inner thighs to cool air and tactile stimulation will diminish the reflex as the examination progresses.

**Inspecting the Pubis**

1. Look at the client’s pubis. The hair may be more or less abundant. Slight differences in genes among races cause variations in hair distribution, type, and thickness. Pubic
hair typically extends onto the inner sides of the thighs, over the scrotal skin, and often in a central line up toward the umbilicus, forming a diamond-shaped pattern (which is sometimes called the male escutcheon). A triangular-shaped pattern without any vertical extension, which is more typical in women, may indicate a hormonal disorder when present in men.

2. Next, check the client’s pubic hair and skin for lice, folliculitis, lesions, rash, and signs of scratching. Note the client’s skin color. It may indicate a disorder. For example, jaundice turns the skin yellow, respiratory problems and heart failure turn it blue, and blood disorders turn the skin purple.

Note: Most of these problems will already have been discovered during the general physical assessment.

**Inspecting the Penis**

1. Look at the client’s penis, noting its size, color, symmetry, and hair distribution, as well as any penile deviation.

2. Next, hold the shaft of the penis gently and examine it for skin lesions, excoriations, abrasions, and tumors.

3. Carefully check the veins on the penis for signs of phlebitis; this condition is indicated by veins that are tender and inflamed or nodular.

4. If the client reports penile curvature during erection, which indicates Peyronie’s disease, or if the penis appears to bend or deviate to one side, palpate the corpora cavernosa for fibrotic plaques. To do this, either hold the penile shaft between your thumb (which is below the penis) and your first two fingers (which are on top of the penis), or support the penis with one hand while palpating with the fingers of the other hand.

5. Next, retract the foreskin (or ask the client to retract it), and observe whether it retracts easily.

6. Look for lesions, chancres, and eruptions on the glans, which is exposed; note any signs of infection (opportunistic) or lesions (Kaposi’s sarcoma) that indicate HIV infection.

7. Check whether the glans is clean when the foreskin is retracted; if the glans is not clean, discuss penile hygiene with the client.

8. The next step is to check the penile shaft and glans for lesions, sores, abrasions, and tumors. Genital warts in men may be difficult to recognize. Sometimes they look like smooth, dull, or slightly shiny macules and differ very little in appearance from the surrounding skin. More typically, on moist skin, as on the female genitals, genital warts have a papillomatous, ragged, or bumpy appearance. If necessary, use a magnifying lens during the inspection. Around the corona, it is normal to find very small (1- to 2-mm) papules that are flesh-colored, soft, and nontender (called pearly penile papules). If these are present, explain to the client that they are a normal finding.

9. If you notice an ulcer while inspecting the penis (which indicates balanitis, chancroid, granuloma inguinale, herpes genitalis, penile carcinoma, or primary syphilis), palpate
the ulcer to check for tenderness and the consistency and texture of its border. Use the tips of one or two fingers when palpating the ulcer.

10. Next, check the urethral meatus (see Photograph 19 in Appendix H on page H.9). Apply gentle pressure on the top and bottom of the glans to open the meatus, then look for discharge, erythema, vesicles, pustules, plaques, and intraurethral warts. If the client’s history indicates urethritis but no discharge is visible, ask him to milk the shaft of the penis to express discharge. To do this, ask the client to encircle his penis at the base, next to the scrotum, by making a ring with his index finger and thumb. Tell him to tighten the “ring” moderately as he slides it down his penis to the glans. This expresses any discharge in the urethra.

11. After explaining to the client what you are about to do, take a urethral smear with a urethral swab. To obtain the smear, gently insert a urethral swab only 1 to 2 cm into the client’s urethra.

*Note:* A urethral smear should be obtained only from a client who has not urinated for at least two hours. If the client has urinated within the last two hours, obtain a specimen; some discharge may have accumulated. If the smear is negative, you may want to direct the client not to urinate for two hours, and then take another specimen at that time.

12. If the client reports symptoms of chronic urethritis or urethral blockage (dribbling, incontinence, urinary hesitancy), which indicates urethral stricture or urethral carcinoma, palpate the urethra for masses, firmness, swelling, and tenderness. Hold the penile shaft between your thumb (which is below the penis) and your first two fingers (which are on top of the penis).

### Overview: Tips for Inspecting the Penis

When you inspect the penis, note the following serious situations:

- A syphilitic ulcer or carcinoma has a smooth, firm border and is nontender. The carcinoma is a visible, nodular mass.
- Tender, indurated (slightly swollen, firm) areas along the urethra indicate periurethritis resulting from urethral blockage or chronic infection of the periurethral glands.

### Inspecting the Scrotum

1. Look at the client’s genital (also called genitocrural) folds and scrotal skin. The scrotal skin is more darkly pigmented than the skin on the torso and thighs. In young men, the scrotal skin is usually wrinkled and firmly hugs the testes; in elderly men, it is usually flaccid. Visible, tiny, and numerous dilations of veins in the scrotal skin are a normal finding. Epidermoid cysts—pale, smooth, shiny, firm, and nontender nodules containing skin secretions—are also a normal finding on the scrotum and do not require treatment. Explain the findings to the client, in the proper context.

2. Check for bacterial or fungal infections and skin lesions, separating any skin folds with your fingers to ensure that you do not overlook anything.
3. Next, check the size and configuration of the scrotum. Look at the anterior scrotal wall. The scrotum is divided into two compartments containing a testicle, epididymis, and vas deferens. Note whether the size of the scrotum is normal and whether it is fairly symmetrical in shape. One testicle may hang lower than the other, so that one side of the scrotum is typically lower. If the client has a hernia, you may notice a swollen area because the peritoneum or a portion of the bowel protrudes into the inguinal canal or into the scrotum, causing asymmetry. Asymmetrical fullness may also indicate a varicocele, hydrocele, or testicular tumor.

4. Look at the posterior scrotal wall. Ask the client (who is wearing a drape) to assume the lateral recumbent position: to lie on his side on the examination table, facing away from you, with both knees flexed, with the upper knee flexed more than the lower knee. Alternatively, ask the client to bend forward, place his elbows on the examination table, and place his feet comfortably apart (you will sit behind him). Then check the posterior scrotal wall in the same manner as you did the anterior scrotal wall; the normal features are the same.

5. To check for a varicocele, ask the client to do the Valsalva maneuver (see page 3.8) while you inspect the scrotum. When the client is in this position, the dilated veins of the varicocele are more prominent and look like a “bag of worms.”

   Note: Varicoceles are more common on the left side of the scrotum.

6. The final step of the scrotal inspection is to transilluminate the scrotum, which is helpful in checking for hernias, hydroceles, testicular tumors, and varicoceles. Darken the room, and place a high-intensity flashlight against the posterior scrotal wall, with the beam pointing forward so that the light shines through the scrotum toward your eyes. Then gently stretch the scrotal skin across the swelling or mass, and view the scrotum from the front. Relatively clear fluids in the scrotum, such as those in hydroceles, transilluminate; solid masses, such as testicular tumors, do not transilluminate.

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**Overview: Inspecting the Scrotum**

Remember the following important points when inspecting the scrotum:

- When inspection shows an asymmetric scrotum or palpation reveals a swollen or abnormal mass in the scrotum, transilluminate the scrotum.
- The scrotal wall transmits light, causing solid tissues inside the scrotal sac to appear as opaque shadows and most fluids to appear translucent, with a red glow, during transillumination.
- Hydroceles also appear translucent during transillumination.
- Normal scrotal contents, swollen areas other than hydroceles, and abnormal masses (including inguinal hernias in the scrotal sac and testicular cancers) appear opaque during transillumination.


**Palpating the Scrotal Contents**

1. Gently hold the scrotal sac, and separate the testes (see Photograph 21 in Appendix H on page H.10). Since the scrotal contents are usually paired structures, you should be able to feel similar structures in each half of the scrotum.

2. Next, check each half of the scrotum for a testicle (which feels like a large ovoid mass), epididymis (which feels like a ridge of tissue lying vertically on the posterolateral surface of the ovoid mass), and spermatic cord (which feels like a firm, nontender column of blood vessels and tissue ascending through and leaving the scrotal sac near the groin).

   *Note:* If the scrotal sac is empty on one or both sides, this indicates cryptorchidism or temporary migration of the testicle, which is caused by the cremaster muscles drawing the testicle up toward the inguinal canal. Palpate for the testicle along the inguinal canal.

3. Next, use both hands to examine each testicle and epididymis for normal size (2.5 to 5 cm), contour, consistency, and tenderness. Place one hand behind the scrotum to stabilize the testicle. Use your other hand to capture the testicle, and gently palpate it to check its width and length. Compare one side of the scrotum to the other.

   *Note:* The testes are usually sensitive but not tender. Testes feel slightly rubbery, but not hard, with a smooth surface. A very firm, nodular, or tender testicle indicates cancer (see Appendix C). If testicular cancer is indicated, refer the client to a urologist or surgeon immediately. A small or abnormally soft testicle may indicate an endocrine disorder or testicular atrophy.

   The epididymis is usually insensitive to pressure. Any mass, localized pain, or swelling of the epididymis is abnormal. In acute epididymitis, the epididymis is enlarged and tender compared to the other side. In severe epididymo-orchitis, the testes and epididymis may not be distinguishable from each other through palpation. They are extremely tender, and the scrotum is usually inflamed. Chronic, painless induration of the epididymis indicates tuberculosis, *schistosomiasis* (also called *bilharzia*), or nonspecific chronic epididymitis. Cystic masses near the upper pole of the testicle that are separate from the testicle and epididymis are usually spermatoceles, which contain thin, milky fluid and sperm; spermatoceles usually are not clinically significant.

4. The next step is to check the spermatic cord. The cord, which consists of blood vessels, tissue, and the vas deferens, is palpable between the upper border of the testicle and the external inguinal ring. When palpating the spermatic cord, you can identify the vas deferens by feeling for a firm tube approximately 3 mm in diameter in a *posterior-medial* location within the spermatic cord. A swollen area in the spermatic cord may be cystic (indicating, for example, a hydrocele or hernia) or solid (indicating, for example, a lipoma or rare connective tissue tumor). Diffuse swelling and induration of the spermatic cord are present with filariasis. If the client does the Valsalva maneuver, palpating the spermatic cord may reveal a varicocele. Palpating the spermatic cord may also reveal bead-like enlargements of the vas deferens, which indicates tuberculosis, or the absence of the vas deferens, which, if bilateral, causes infertility.
Overview: Teaching the Client How to Perform a Genital Self-Examination

Regular genital self-examinations are an important way to detect problems. During the genital examination, teach the client how to perform a genital self-examination (see Appendix F). This self-examination helps the client identify physical abnormalities, such as testicular cancer, epididymal cysts, STIs, and skin disorders (see Photograph 22 in Appendix H on page H.10). The genital self-examination also helps the client become more aware of his body’s functions and promotes responsible health behaviors. Self-examination of the testes is particularly important for men between 15 and 40 years old, and those with a history of undescended testicle.

Palpating for an Inguinal Hernia

1. When palpating for an inguinal hernia, use only your smallest finger or index finger. Gently insert the examining finger into the scrotal wall just above and lateral to the testicle.  
   
   Note: A fold of the scrotal skin covers your finger as you push it into the scrotal wall.

2. Feel for the vas deferens, and follow the vas upward and laterally to the inguinal ring (which feels like a sphincter) or inguinal canal. Never force your finger through the inguinal ring. Instead, gently hold your finger against the inguinal ring, and ask the client to do the Valsalva maneuver. Usually, you feel nothing against your finger. But if the client has an inguinal hernia, you feel pressure from a soft mass pushing through the inguinal canal onto the tip of your finger; this may be abdominal tissue or the bowel. When abdominal tissue penetrates the inguinal canal through the internal inguinal ring, the client has an indirect hernia. You can also palpate some direct hernias using this technique. If abdominal tissue penetrates the inguinal canal through an abnormal opening in the abdominal wall, you feel a direct hernia pressing against the more proximal portion of your examining finger, away from the tip.

3. When palpating for an inguinal hernia, also palpate the inguinal lymph nodes for swelling and tenderness. Infection and cancers of the penis and scrotal wall, as well as those of the legs, can spread to the inguinal and subinguinal nodes. When assessing a client with these conditions, remember to check for inguinal node enlargement and tenderness.

Overview: Palpating for an Inguinal Hernia

When you palpate for an inguinal hernia, keep in mind the following important points:

- Palpating for an inguinal hernia may routinely be performed as part of an abdominal or genital examination.

- When you palpate for an inguinal hernia, it is normal to find a soft inguinal lymph node, up to 1 cm in diameter, in the inguinal fold lateral to the femoral artery.
**Inspecting the Perineum and Anal Orifice**

When inspecting the perineum and anal orifice, you are performing the rectal examination part of the genital examination (see Photograph 20 in Appendix H on page H.9). This involves the following steps:

1. Ask the client (who is wearing a drape) to assume the lateral recumbent position, with both knees flexed, with the upper knee flexed more than the lower knee; or ask the client to bend forward, place his elbows on the examination table, and place his feet comfortably apart (you will sit behind him).

2. Next, look at the **perineum**, which should be smooth and unbroken, and should have a regular contour with no significant discoloration or bulges.

3. Then check the anal orifice, which should be brown or pinkish-brown and should not have any visible protruding masses. The anal orifice and **perianal tissue** are covered by smooth, unbroken skin. Some hair growth around the orifice is normal.

4. The next step is to look for hemorrhoids, scars from trauma, warts, lesions (e.g., *Condylomata acuminata*, herpes, and chancres), anal bleeding, and mucous discharge. Purulent discharge from the anus may indicate rectal gonorrhea. If the client has anal discharge or has risk factors for rectal infections or STIs (which you learned while taking his history), obtain a rectal specimen *before* placing a lubricant gel in his anus (see below).

5. After explaining to the client what you are about to do, obtain the rectal specimen. For a gonorrhea culture, ask the client to bear down gently. Then slowly and gently insert a cotton swab into his anus, and gently rotate the swab to capture the purulent discharge on the swab. Immediately place the specimen on the gonorrhea culture and label the plate.

6. Before you continue the rectal examination, check for rectal fissures (deep cracks), hemorrhoids, and anal herpes. If the client has any of these conditions, use an anesthetic gel to lessen his pain before proceeding with the rectal examination. Wait at least five minutes after applying the gel to ensure that the anesthetic has time to work. If the client has a history of pain or bleeding with defecation, carefully examine the anus for rectal fissures, which may be hidden between the skin folds.

7. If the client has a history of erectile dysfunction (particularly if he also has a history of possible neurological disease, injury, pelvic surgery, or diabetes), check for the **bulbocavernosus reflex** *before* touching the anal area. To elicit this reflex, ask the client to squeeze the head of his penis. Observe the resulting reflex anal contraction. A normal bulbocavernosus reflex indicates an intact **spinal reflex arc**.

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**Overview: Obtaining a Rectal Specimen**

When you obtain a rectal specimen, keep in mind the following information:

- Lubricant gels contain **phenols** to keep them free of bacteria, and the phenols can inhibit accurate results from collected rectal specimens. To prevent false negatives even when an infection is present, use lubricants that do not contain phenols.

- Bearing down gently helps to relax and open the rectal sphincter.
Examining the Prostate Gland

When examining the prostate gland, check the prostate gland itself and other internal structures. The prostate examination consists of the following steps:

1. Inspecting the prostate gland
2. Palpating the prostate gland
3. Palpating the seminal vesicles
4. Checking the rectal walls
5. Checking the urethral meatus (if prostatitis is indicated)

*Note:* Before you begin the prostate examination, tell the client that he does not have to change position. Then explain the importance of the prostate examination. Tell the client that it enables you to inspect the prostate gland and to check for tumors and other possible disorders. Remind the client that he may feel the urge to defecate or urinate, that this is normal, and that he will not lose bowel or bladder control.

1. Before inspecting the prostate gland, place your nonexamining hand on the client’s hip or against his buttock to stabilize him and to enable him to prepare himself psychologically for the examination. Place the ball (the soft, fleshy part of the tip) of your well-lubricated, gloved finger flat against the anus. Ask the client to do the Valsalva maneuver as you slowly insert your finger into the anus.

   *Note:* Rarely, a client may have a spasm of the rectal sphincter, which can be very painful. If this occurs during the prostate examination, hold your finger still and wait for the spasm to subside. This usually takes at least one minute but may last several minutes, especially if the examination is not gentle or unhurried or if the client is anxious. Explain to the client what is happening.

2. Next, with your finger pressing against the anterior wall of the rectum, feel for the prostate gland. The prostate gland is a roughly heart-shaped, symmetric organ, with two halves (lobes) that may be separated by an indentation through the rectal canal. The base of the prostate gland is wider than its apex and will be farther away from the examining finger than from the apex. The prostate gland usually feels rubbery and smooth; it should not feel hard, nodular, irregular, enlarged, or tender.

   *Note:* Most clients feel a mild-to-severe burning sensation in the penis when the examining finger pushes on the prostate gland. You can massage the prostate gland if necessary.

3. The next step is to assess the size of the client’s prostate gland. To do this, you must know the length and width of your examining finger in centimeters. Typically, a prostate gland is palpable 2 to 5 cm inside the anal sphincter through the anterior rectal wall. With your examining finger, find the median sulcus, move your finger from the sulcus to the lateral borders of the right and left lobes, and assess the size of each lobe. A shallow lateral sulcus is palpable lateral to each lobe. Typically, a prostate gland is approximately 3 cm wide and 4 cm long, and its two lobes are symmetrical in size and shape.

   *Note:* The size of the prostate gland increases with age.

4. If you have long fingers, try to palpate for the seminal vesicles, which are superior and lateral to the prostate gland, for palpability and tenderness. Typically, they are not palpable and are nontender.
5. During the prostate examination, feel the rectal walls to check for polyps, fissures, internal hemorrhoids, and tumors. The rectal walls should feel very soft. If you feel a mass, determine if it is stool. Stool can be indented, but a mass cannot be.

6. If, given the client’s history and the examination findings, you think that the client may have prostatitis, check the urethral meatus during the prostate examination for any discharge that might indicate this condition. The discharge is usually clear and does not have a smell.

7. When you have finished the genital examination, explain to the client that you are about to withdraw your finger. Remove it smoothly and slowly to prevent any client discomfort.

8. After the rectal examination, take a sample of stool from your glove to test for occult blood. This is particularly important in men who are over 40 years old. Explain to the client that he should have an annual rectal examination for occult blood and prostate disorders.

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**Overview: Inspecting the Prostate Gland**

When you inspect the prostate gland, keep in mind the following points:

- Poor sphincter tone (a very relaxed sphincter) indicates that the client has a history of either anal penetration (which is common among male homosexuals) or possible neurological deficit. In neurological disorders with widespread nerve involvement, both sensory and motor nerves may be affected. The effect on sensory nerves may lead to decreased sensation in the client’s perianal area.

- The normal consistency of the prostate gland is like that of the contracted thenar eminence. A prostate gland also may have a somewhat soft, boggy consistency if ejaculation is infrequent or if chronic infection impairs the drainage of prostatic fluid.

- An enlarged prostate gland may have a firmer, boggy consistency with obliteration of the median sulcus.

- Prostate tenderness indicates acute or chronic prostatitis.

- Chronic infection can also lead to induration or nodularity of the prostate gland, especially with tuberculosis.

- Carcinoma of the prostate gland or a prostatic stone can be suspected if one or both lobes of the prostate gland has a very hard nodule or mass. Generally, prostate gland nodules are caused by nodular BPH or cancer.

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**After the Genital Examination**

When the genital examination is complete:

1. Give the client tissues to wipe away excess lubricant used during the examination.
2. Explain to the client that the examination is over and that he may get dressed.
3. Leave the examination room to give the client privacy to get dressed.
4. Once the client has dressed, meet with him to review the examination findings, answer any questions that he may have, discuss treatment and management plans and referrals, and provide client education. Ask the client to return to the facility if necessary. If you will need to take a urethral smear during the second visit, explain to the client that he cannot urinate for two hours beforehand, to prevent washing away any urethral secretions.

5. Write the examination findings on the client’s chart as soon as possible after the examination to avoid omitting any important details. Draw diagrams as needed to record any abnormal findings, including their locations and dimensions.

Interpreting Laboratory Test Results

Part of the male genital examination involves laboratory test results that help the service provider make a differential diagnosis and determine the appropriate treatment. To effectively diagnose and treat men’s reproductive health disorders, the provider should be able to interpret the results of two commonly used laboratory tests: the urine test and prostate secretions tests.

Urine Test

A urine sample is easy to obtain and can provide important information. Urine can indicate the condition of the kidneys, as well as infections of the genitourinary tract. A urine sample also can provide information about systemic conditions, including diabetes and hypertension. Urine is usually checked for blood, protein, glucose, ketones, nitrites, and leukocyte esterase. When present in urine:

- Ketones indicate an insulin deficiency, which is significant in diabetes
- Nitrites indicate a bacterial infection in the urinary tract, kidneys, or bladder
- Leukocyte esterase indicates white blood cells (WBCs; also called leukocytes) and probable bacterial infection in the genitourinary system

In addition, the sample can be studied under a microscope to quantify the number of WBCs and red blood cells (RBCs), and describe the types of cells. Some WBCs and RBCs are mature, and some are not. When stained in the laboratory, some WBCs contain granules, and some do not. RBCs have different shapes and sizes.

A midstream urine sample prevents the contamination of the sample with skin and urethral organisms. To provide a midstream sample, an uncircumcised client retracts the foreskin, cleans the glans penis with antiseptic solution, and then urinates into a wide-mouth sterile container placed over the toilet, under his penis. He continues to retract the foreskin as he urinates. A circumcised client provides a midstream urine sample by urinating a small amount into the toilet, stopping, then urinating another small amount into a wide-mouth sterile container placed over the toilet, under his penis. Because circumcised clients do not have a foreskin to retract, there is less risk for contamination with skin and urethral organisms.
An infertile client should provide a postcoital urine sample. This sample may reveal sperm if the client has retrograde ejaculation. With retrograde ejaculation, semen is forced backward into the bladder, nor forward through the urethra and out the penis.

**Prostate Secretions Tests**

Normally, few WBCs are present in prostatic secretions; the presence of many WBCs indicates prostatitis. Acute and chronic prostatitis and epididymitis can be identified through the interpretation of the results of testing the secretions. Prostate fluid usually does not stain well for bacteria because of the makeup of their cell walls, but it can be stained to check for **acid-fast** organisms, which have slightly different cell walls. Prostate secretions collected during a genital examination must be collected in a sterile container to prevent contaminating the secretions with organisms already in the container, which would confuse test results.