Penile pain-
“What’s wrong, doc?”

Lincoln Tan
Registrar
“The Good”
- Penile pain associated with symptoms or signs consistent with common causes e.g. STDs, UTIs

“The Bad”
- Chronic penile pain without other features pointing to an obvious cause e.g. pelvic pain syndromes
- Often difficult to treat

“The Ugly”
- Penile emergencies where diagnosis may be obvious but urgent management if required

Approach
- History
  - Acute vs chronic
  - Dysuria vs pain independent of voiding
  - During erection? During ejaculation?
  - Unprotected sex/ CSW
  - Previous surgery/ urethral instrumentation
  - Associated symptoms
    - Urethral discharge
    - Scrotal or perineal pain/ numbness
    - Previous loin/groin pain/haematuria
**Approach**

- Physical examination
  - Penile mass
  - Penile plaque
  - Penile sores/ulcerations/ inflammation
  - Urethral meatus
  - Inguinal nodes
  - Abdominal, scrotal, prostate examination

**Investigations**

- UFEME/urine culture
- Urethral swabs
- Kiv flexible cystoscopy
The ugly!

Penile emergencies
Penile fracture

- During sexual intercourse
- “Crack”
- “Egg plant” deformity
- Surgical management

Paraphimosis

- Inability to reduce the foreskin
- Most common after catheterisation
- Adequate analgesia
  - Consider penile block
- Lubrication
- Manual reduction
- Dorsal slit
- Elective circumcision
Priapism

- Erection > 4 hours not a/w sexual stimulation

- Causes
  - ED therapy
  - Antipsychotics, illicit drugs, antidepressants, anticoagulants
  - Sickle cell anemia, hematological malignancies
  - Perineal/pelvic trauma
  
- Analgesia

- Refer to ED for management
Penile cancer

- Often clinically obvious
- Beware “chronic balanitis”; lesion under phimotic penis
- Refer to dermatology for biopsy of suspicious lesions that are chronic and do not respond to treatment
- Refer to Urology for definitive treatment

The good
Infections

- UTIs
- STDs
- Balanitis +/- posthitis

Male UTI

- Less common in men <50 compared to females
- Dysuria, frequency, urgency
- Look for alarm symptoms – haematuria
- Urine dipstick/urine culture
- Antibiotics x minimal 1 week
- If a/w fever, commonly involve prostate → 2/52 antibiotics and refer to urologist for review
STDs

- Usually associated with urethritis (dysuria) +/- urethral discharge
- Gonorrhea
- Chlamydia
- Syphilis

Urethral swabs for GC and Chlamydia
- Notify, refer to DSC
- Exclude HIV
- Contact tracing + mx of sex partners
- Gonorrhea
  - I/M Ceftriaxone 250mg single dose + Rx for Chlamydia
- Chlamydia
  - Azithromycin 1g single dose OR doxycycline 100mg bd x 1/52
Balanoposthitis

- Usu in uncircumcised men
- DM risk factor
- Fungal or bacterial
- Antibiotics/antifungals
- Hygiene advice
- Circumcision in recurrent cases
- **Beware of persistent balanitis → may be penile CIS in disguise!**

Painful penile dermatoses

- Chemical dermatitis
- Candida balanitis
- Fixed drug eruption
  - pruritic or burning,
  - appears within days to weeks of initiating culprit drug and resolves after withdrawal of the medication
  - Often recur at the same sites within hours of drug rechallenge and heal with residual hyperpigmentation
  - most common causative agents are antibiotics
  - Drug rechallenge
  - Patch testing and intradermal skin testing are other options
Pain during intercourse

- Tight foreskin
  - Circumcision

- Short frenulum
  - Frenuloplasty or circumcision

Peyronies disease

- Curvature only apparent on erection
- Ask specifically for it
- Refer to urologist
- Acute painful phase
  - Pain during erection/ flaccid/ palpation
  - Pentoxifylline
- Chronic painless phase
  - Surgical correction
Urethral pathology

- Urethritis
- Strictures
- Stone
  - Urethral pain a/w difficulty voiding or retention
  - Stone may be palpable along shaft of penis
  - Referral to urologist for cystoscopy and removal

Urethral pain syndrome

- Dysuria (with or without frequency, nocturia, urgency and urge incontinence) in the absence of evidence of urinary infection
- Exclude UTI/STDs
- Flexible urethrocystoscopy
- No consensus on treatment
  - Trial of alpha-blockers; NSAIDS; acupuncture
  - Pain team referral if above fails
Referred pain

- Keep in mind, especially in the absence of physical findings
- Stone in the distal ureter or bladder

Neuropathies

- Pudendal nerve compressions
  - Preceded by genital numbness
  - May be a/w sexual dysfunction such as ED, altered sensation of ejaculation/ orgasm
  - Compression in Alcock canal or just outside pelvis during cycling
- Ilioinguinal nerve
  - Pain, parasthesia/numbness over base of penis and scrotum and upper medial thigh
  - Injury after lower abdominal incisions, e.g. appendectomy, inguinal herniorrhaphy, inguinal lymph node dissection
Management of Neuropathies

- If related to cycling
  - changing the riding style and schedules as well as modifying the design of the saddle and its positioning
- Gabapentin/ amitriptylline
- Trial of local anaesthesia
- Physical therapy
- Surgical excision

The bad
Painful ejaculation

- Prostatitis
- Urethral pathology
- Ejaculatory duct obstruction
  - May be a/w decreased semen volume/subfertility
- Psychogenic
- Pain on orgasm usu a/w spinal or pelvic injury

Prostate pain syndrome

- Previously known as prostatitis
- Penile pain (usu after ejaculation)
- May be a/w perineal/scrotal/rectal pain
- Prostate may or may not be tender
- Urine dipstick may be normal
- Raised white cells or positive culture from expressed prostatic secretions or post prostatic massage urine
Diagnosis of bacterial prostatitis

- 4 glass test
- Semen culture

Bacterial prostatitis

- Acute bacterial prostatitis
  - Acutely ill, febrile, tender prostate
  - Admission for IV antibiotics, rule out abscess
  - At least 2/52 of antibiotics to prevent progression to chronic prostatitis

- Chronic bacterial prostatitis
  - Cipro/bactrim x 2/52 – if symptoms relieved, complete 6 weeks
  - NSAIDS, alpha-blockers, Sitz baths
Chronic pelvic pain syndrome (CPPS)

- Culture negative, WBC in semen/EPS/VB3
- Difficult to treat
- Counsel patient symptoms may be prolonged, will wax and wane, treatment largely empirical
- Single trial of empiric antibiotics x 4-6/52
- Analgesia – NSAIDS, opiates
- 5α-reductase inhibitors/phytotherapy
- Pelvic relaxation exercises; acupuncture

Pelvic floor dysfunction

- Overactive pelvic floor
  - Muscular ache
  - Compression of nerves/vessels to penis
- Myofascial trigger points
- Physiotherapy
- Amitriptylline/gabapentin
- Injection with LA
Conclusion

- Common causes of penile pain can be diagnosed with careful history and physical exam
- Exclude UTI/STDs/local skin conditions
- The “bad” and “ugly” of penile pain should be referred to urologists