Article Summary: Phenotyping in Male Chronic Pelvic Pain (CPP)

Basics

- Historically, patients have been approached as having an infection and treated with antibiotics or prostate-specific medications
- Patients with CPP have varying etiologies, progressions of their conditions, and responses to intervention
- Traditional approaches to managing CPP have not been successful

Recommended Evaluation

- Pre-and post-massage two glass test for culture
- Outcomes tool such as NIH-CPSI
- Urine flow rate and residual urine determination
- Screen for depression, maladaptive social and/or coping behavior
- Ask about associated conditions (IBS, etc)

Optional Evaluation

- Urine cytology
- Semen analysis and culture
- Urethral swab for culture
- Pressure flow studies
- Videourodynamics
- Cystoscopy
- Transurethral US
- Pelvic imaging (US, CT, MRI)
- Prostate specific antigen (PSA)

UPOINT Domains

- **Urinary**: CPSI urinary score > 4, complaints of urinary urgency, frequency, or nocturia, flow rate, 15mL/s and/or obstructed pattern
- **Psychosocial**: Clinical depression, poor coping or maladaptive behavior such as catastrophizing, poor social interaction
- **Organ specific**: specific prostate tenderness, leukocytosis in prostatic fluid, haematospermia, extensive prostate calcification
- **Infection**: exclude patients with evidence of infection
- **Neurological/systemic conditions**: pain beyond abdomen and pelvis, IBS, fibromyalgia, CFS
- **Tenderness of skeletal muscles**: palpable tenderness and/or painful muscle spasm or trigger points in perineum or pelvic muscles

Reference

Article Summaries: Peyronie’s

Basics

- Peyronie's disease was first described in the medical literature by de La Peyronie in 1743
- Can also be called “plastic induration of the penis”
- It is usually associated with an inflammatory reaction and fibrotic plaque within the tunica albuginea of one or both corpora cavernosa
- The indurated area may be painful, and if the deformity is severe, the disease may interfere with sexual function, the plaques may calcify
- Estimated prevalence is 3-6% with suspected under-reporting

Medical Management

- There is no consensus currently regarding etiology, prevalence, treatment, or definition of the condition
- There is a lack of large scale, multicenter controlled clinical trials
- There is lack of a validated questionnaire and there is a spontaneous improvement of 5-12% reported in the literature
- Non-surgical options include oral, topical, intralesional, external energy and combination therapies
- Ask about associated conditions (IBS, etc)

Rehabilitation

- US with hydrocortisone has been suggested as having benefit (Miller & Ardizzone, 1983)
- Successful use of iontophoresis use has been reported on as a case in the literature (Kahn, 1982)
- Penile traction therapy with FastSize medical extender has been utilized and found to produce increased length, decreased curvature, and increased girth in area of induration (Levine et al., 2008)

References


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Article Summary: Testicular Cancer

General
- Testicular cancer is rare, with slow advances in diagnosis and treatment
- Occurs in the skin or tissues of the penis and usually begins in the glans penis
- Can be physically and psychologically devastating for the patient
- In US, 1570 new cases are estimated to be diagnosed in 2013, about 310 men will die of penile cancer (less than 1%)
- In some parts of Asia, Africa, and South America, up to 10% of male cancer is of the penis
- In the UK, up to 20% of cases have occurred in men under 40 years of age
- Patients often delay reporting of lesion, possibly due to embarrassment

Risk Factors
- Phimosis
- Poor hygiene
- Human papillomavirus (HPV)
- PUVA light therapy (psoriasis)
- Having many sexual partners
- Age 60 or older
- Chronic inflammation (e.g., lichens)
- Smoking
- AIDS diagnosis
- Priapism
- Family history

Signs
- Redness, irritation, or sore on the penis
- Swelling at tip of penis
- Swollen groin lymph nodes
- A lump on the penis

Medical Examination
- Physical examination and history, biopsy
- If cancer detected, CT scan, MRI, US, Chest X-ray, or lymph node biopsy may be completed

Medical Intervention
- Microsurgery
- Medications
- Chemotherapy
- Laser therapy
- Radiation

Factors affecting prognosis and treatment
- Stage of cancer, location and size of tumor, initial diagnosis or recurrence

References
Article Summary: Varicocelectomy for Testicular Pain

General

- Varicoceles are common in adolescent boys and men, incidence is approximately 15%
- Recognized as a significant cause of male infertility, with varicocele present in up to 1/3 of infertile men

Pain

- Varicoceles are painful in up to 10% of men
- Symptoms often described as dull, aching, throbbing, worsened with activity or physical exertion
- Conservative measures for pain may be helped by scrotal support, limiting physical activity, and anti-inflammatory medications

Physical Exam

- Should be performed in a warm room in supine and standing positions
- In supine the varicocele should decompress
- Varicocele feels like a "bag of worms" that is compressible cranial to or surrounding the testicle
- Grading system is as follows: Grade I is palpable only with Valsalva, Grade II is palpable without Valsalva, and Grade III is visible without palpation
- Differential diagnosis includes testicular torsion, epididymitis, inguinal hernia, testicular tumor, trauma, hydrocele, epididymal cyst, or idiopathic orchialgia, post-surgical complications include post-inguinal hernia repair nerve entrapment or postvasectomy orchialgia, or sperm granuloma

Surgery

- Various approaches have been used including retroperitoneal, inguinal, subinguinal, scrotal, laparoscopic, and microsurgical
- Microsurgical ligation has been shown to be effective for pain with minimal complications
- Classic symptoms of a dull, dragging ache and pain duration greater than 3 months is associated with more positive surgical outcomes
- Nonclassic symptoms, a small varicocele, pain of short duration may have pain following a repair and should have all other possible sources of pain ruled out prior to surgery
- Only varicoceles detected on physical exam should be treated according to several urological guidelines
- This article describes various surgical approaches and reported results

Reference

The Section on Women's Health is proud to announce the course schedule for 2014. We hope you will be able to take advantage of the variety of course options and locations throughout the country.

Registration for 2014 educational courses and the 2014 Fall Conference is now open on our website. www.womenshealthapta.org/education/regional_courses/index.cfm

For updates on courses and registration openings, please follow the Section's Twitter and Facebook pages.

**2014 CONTINUING EDUCATION COURSES**

### Pelvic Physical Therapy 1
**January 17-18, 2014**
Speakers: Lori Mizue, PT, DPT, WCS
Carina Sircassa Majzen, PT, DPT
Greenville, SC

**March 21-23, 2014**
Speaker: Lori Mizue, PT, DPT, WCS
Houston, TX

**June 20-22, 2014**
Speaker: Lori Mizue, PT, DPT, WCS
MJ Strauhal, PT, BCB-PMD
Baton Rouge, LA

**July 11-13, 2014**
Speaker: Lori Mizue, PT, DPT, WCS
Des Moines, IA

**October 10-12, 2014**
Speaker: Carina Sircassa Majzen, PT, DPT
East Lansing, MI

**November 14-16, 2014**
Speaker: Barb Settles Hugle, PT
Boca Raton, FL

### Pelvic Physical Therapy 2
**February 26-March 2, 2014**
Speaker: MJ Strauhal, PT, BCB-PMD
Portland, OR

**April 25-27, 2014**
Speaker: Barb Settles Hugle, PT
Madison, WI

**August 1-3, 2014**
Speaker: Carina Sircassa Majzen, PT, DPT
Towson, MD

### Pelvic Physical Therapy 3
**June 27-29, 2014**
Speaker: MJ Strauhal, PT, BCB-PMD
Rochester, NY

**September 12-14, 2014**
Speaker: MJ Strauhal, PT, BCB-PMD
Portland, OR

**November 7-9, 2014**
Speaker: MJ Strauhal, PT, BCB-PMD
Madison, WI

### Gynecologic Visceral Manipulation
**LEVEL 1-2**
**October 2-5, 2014**
Speaker: Gail Wetzler, PT
Bethlehem, PA

### Fundamental Topics in Pregnancy and Postpartum Physical Therapy
**March 28-30, 2014**
Speakers: Suzanne Badillo, PT, WCS
Susan Giglio, PT, RYT
Baton Rouge, LA

**May 16-18, 2014**
Speakers: Karen Litkos, PT, MPT
Valerie Boilo, PT, MPT, WCS, ATC
East Lansing, MI

**July 25-27, 2014**
Speaker: Suzanne Badillo, PT, WCS
Edina, MN

**August 22-24, 2014**
Speakers: Susan Giglio, PT, RYT
Karen Litkos, PT, MPT
Longmont, CO

### Advanced Topics in Pregnancy and Postpartum Physical Therapy
**February 21-23, 2014**
Speaker: Susan Giglio, PT, RYT
St. Louis, MO

**May 4-6, 2014**
Speaker: Susan Giglio, PT, RYT
Baltimore, MD

### The Physical Therapist in Labor & Delivery: Advanced Techniques in Labor Support
**October 24-26, 2014**
Speaker: Susan Steffen, PT (CDOWN)
Austin, TX

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Check website for new courses throughout the year!

This course is part of the Section on Women's Health Certificate of Achievement in Pelvic Physical Therapy (CAP-Pelvic) Program.

For more details on CAP® go to http://www.womenshealthapta.org/cap.cfm

For more information on Section on Women's Health sponsored courses go to http://www.womenshealthapta.org/education/education.cfm or contact the SOWH at sowh@apta.org, or 703-610-0224.

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Article Summary: Managing Epididymo-orchitis in General Practice

General

- Epididymitis and orchitis commonly occur together, and if isolated in presentation, epididymitis is more common (25/1000,000 in the UK in 2004/2005)
- Most common cause in young men: sexually transmitted infection (STI), in older men: urinary tract infection (UTI)
- In older men, risk factors include having a functionally abnormal urinary tract or having recently been treated with instrumentation
- In younger men, any suspicion of testicular torsion warrants immediate referral

Causes of epididymitis-orchitis

- Urinary tract infection
- Sexually transmitted disease such as gonorrhea or chlamydia
- Other bacterial, fungal, viral, inflammatory, or other infections

History and examination

- In order to rule out testicular torsion, the following are to be noted: a sudden onset of unilateral and severe testicular pain and scrotal swelling, vomiting, absent cremasteric reflex, and an abnormally lying and severely tender testis on examination
- Ask about urinary symptoms and about sexual health history, as men who have penetrative anal intercourse are more likely to have enteric organism infection and sexually transmitted disease
- The testicle is likely to be swollen and tender, the spermatic cord thickened, scrotal erythema, a reactive hydrocele and penile discharge indicative of an infection
- Abdomen should be palpated to rule out a distended bladder, digital rectal exam completed to assess for benign prostatic hyperplasia, prostate cancer, constipation, or prostatitis
- Urine dip and culture, urethral swab, mid-stream urine sample should be completed
- Hospital admission should be made for patients suffering from severe pain, fever, tachypnea, tachycardia or hypotension

Treatment

- Paracetamol and NSAIDS should be started for analgesia
- Ice packs and scrotal elevation or supports may be helpful
- Antibiotics should be started prior to confirmation of the pathogen

Outcomes

- Potential diagnosis or complications of unresolved symptoms can include neoplasm, testicular infarction, abscess formation, testicular atrophy, and chronic induration of the testicle with potential for infertility

Reference

Article Summary: Pain Following Hernia Repair

General

- Often categorized into neuropathic (inguinal nerves) or non-neuropathic (mesh-related or postoperative fibrosis)
- Inguinal nerves include ilioinguinal, iliohypogastric, genital branch of the genitofemoral, and rarely, the lateral femoral cutaneous nerve
- Nerves can be damaged by partial or complete transection, stretching, contusion, crushing, electrical damage, by getting caught in the sutures or tacks used in the repair, or by secondary effects of inflammatory or scarring process
- Clinical differentiation between inguinal nerves is difficult due to overlapping sensory distribution, peripheral communication among nerve branches, and common origins

Diagnosing Chronic Groin Pain

- Requires a comprehensive patient history and knowledge of inguinal nerves
- Screen for risk factors: age below median, female gender, postoperative complications, recurrent hernia repair, open techniques, history of preoperative repair, less than 3 years from surgery
- Tinel’s test medial to ASIS
- Nerve blocks may be useful in diagnosing condition, but there is no consensus on procedures or interpretation of results

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- Physical Therapist Management of Patients with Chronic Pelvic Pain
- Medical Management and Physical Therapy Management of High-Risk Pregnancy
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- Anatomy and Physiology of Intra-abdominal Pressure

For more information, go to the Section on Women’s Health website at www.womenshealthapta.org or call 703-610-0224.

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Medical Intervention

- Neurectomies
- Previously, a sedentary lifestyle was recommended, and this is no longer the case
- Medications: NSAIDs, opioids, muscle relaxants, antiepileptics, antidepressants
- Physical therapies: massage, PT, acupuncture, capsaicin cream
- Nerve blocks as diagnostic and therapeutic intervention
- Surgery to remove mesh, scar tissue, or to resect nerves
- Referenced article lists studies and outcomes of varying surgical approaches

Reference

Genital Pain and Referral from Muscles

General

- Muscle dysfunction in posterior pelvic floor muscles cause poorly localized pain into the back, tailbone, or hip pain
- Muscles in anterior half of pelvic floor tend to refer pain to genital structures
- Examination should include the lower abdomen, thigh, and intrapelvic muscles

Scrotal Pain

- Iliopsoas

Perineal Pain

- Bulbospongiosus, ischiovavernosus

Pelvic Floor Pain

- Posterior: sphincter ani

Anococcygeal Pain

- Obturator internus

Sacroccocygeal Pain

- Levator ani, coccygeus

Anterior Thigh Pain

- Iliopsoas

Posterior Thigh Pain

- Obturator internus, piriformis

Vaginal Pain

- Levator ani, obturator internus, ischiocavernosus, bulbospongiosus

Penile Pain

- Bulbospongiosus, ischiovavernosus

Reference

Article Summary: Male Genital Pain and Psychotherapy

General

- Management of chronic male genital pain is generally unsatisfactory
- Patients are often treated with attempt to control the symptoms, with multiple courses of antibiotics (in absence of identified organisms), anti-inflammatory drugs (in absence of evidence of inflammation), narcotics to control pain, and even orchiectomy
- Deep seated emotions may be considered an underlying cause for male genital pain
- Medical causes should be first ruled out and treated as appropriate

Select Case Descriptions

- 55 year-old man presented with chronic rectal and scrotal pain that started after a TURP at age 30. Patient described feeling unwanted and rejected and that he was given away for adoption at 10 days old. This patient typically did not show emotion and would escape into his mind to avoid feelings. He did not show improvement at 1 month post-therapy.
- 34 year-old man with 9-year history of testicular pain described a tour in Iraq with a supervisor whose attitude and behavior left the patient feeling “impotent.” One week after therapy the pain was resolved.
- 35 year-old male had complaints of left testicular pain that was not resolved by hydrocelectomy. He described fears of “always being alone.” One week after the session, symptoms were 50% improved.
- A male in his 50’s reported a one-year history of right testicular and groin pain. He described feelings of helplessness, hopelessness, impotent, and “unable to fix a loved one’s cancer.” Within 2 weeks of the session, pain was 80% improved, at 4 years follow-up, pain only occurred during high stress.

Intervention

- 11 men with refractory genital pain were counseled with one session of “Journey process” that lasted 2-3 hours
- The therapy is emotion-based rather than cognitive, and follow-up occurred for up to 4 years in some cases
- Relaxation and guided imagery are used to go into the body and uncover “old hurts”
- The patient then speaks the words they wanted to say at the time of the hurt

Outcomes

- 4 had significant pain relief, 4 had partial relief, and 3 did not benefit or were lost to follow-up

Reference

References


review. *Current Opinion in Urology, 22*(6), 499-506.


