When should I perform an examination?

1. As part of a standard health check-up with new or existing patients
2. 45–49 year old health assessment (MBS) (Note, Aboriginal and Torres Strait Islander men are eligible at younger ages)
3. Prior to initiation of drug treatment (e.g. testosterone, PDE5 inhibitors) or investigation of conditions such as infertility or prostate disease
4. On presentation of relevant disorders and symptoms (below):

<table>
<thead>
<tr>
<th>Disorders</th>
<th>Risk factor for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Undescended testes as an infant</td>
<td>Testicular cancer</td>
</tr>
<tr>
<td>• Past history of delayed puberty</td>
<td>Androgen deficiency</td>
</tr>
<tr>
<td>• Gynaecomastia</td>
<td>Androgen deficiency, Klinefelter’s syndrome</td>
</tr>
<tr>
<td>• Infertility</td>
<td>Androgen deficiency, testicular cancer</td>
</tr>
<tr>
<td>• Erectile dysfunction (ED)</td>
<td>Co-morbidities</td>
</tr>
<tr>
<td>• Past history of testicular cancer</td>
<td>Testicular cancer</td>
</tr>
<tr>
<td>• Pituitary disorders</td>
<td>Androgen deficiency, male infertility</td>
</tr>
<tr>
<td>• Osteoporosis and atraumatic fractures</td>
<td>Androgen deficiency</td>
</tr>
<tr>
<td>• Haemochromatosis</td>
<td>Androgen deficiency, male infertility</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Symptoms</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Testicular pain or lumps</td>
<td>Tumour or cyst</td>
</tr>
<tr>
<td>• Reduced libido, hot flushes, fatigue,</td>
<td>Androgen deficiency,</td>
</tr>
<tr>
<td>gynaecomastia, ED, mood changes, reduced</td>
<td>male infertility</td>
</tr>
<tr>
<td>beard or body hair, poor or reduced muscle development</td>
<td></td>
</tr>
</tbody>
</table>

How do I best approach an examination with my patient?

- Posters or pamphlets in your clinic can raise awareness about men’s health examinations and convey that patients can discuss reproductive health concerns with you
- Explain why you need to perform the examination and ask for permission to proceed
- Allow the patient to ask questions and express any discomfort before/during the examination
- Ask specific questions during history-taking, to assist those patients reluctant to raise sensitive problems

Presentation with acute testicular pain

- Testicular torsion
  - This is a medical emergency
  - Refer immediately for evaluation for surgery
  - (e.g. epididymo–orchitis)

History

- Fertility in current and past relationships
- Testicular trauma, cancer, STI
- Inguinal-scrotal surgery (undescended testes, childhood hernia)
- Symptoms of androgen deficiency
- Systemic treatment for malignancy, immunosuppression, organ transplant (for possible testicular damage)
- Gynaecomastia
- Occupational or toxin exposure

Testicular examination

- Testicular volume
  - Normal range of adult testicular volume: 15–35 mL
  - Small firm testes <4 mL: suggests Klinefelter’s syndrome
- Scrotal and testicular contents
  - Abnormalities in the texture or hard lumps: suggests tumour or cyst
  - Enlargement, hardening or cysts of the epididymides
  - Varicocele
  - Nodules or absence of vas deferens

Penile examination

- Hypospadias
- Peyronie’s disease
- Micropenis
- Urethral stricture
- Evidence of infection (STI) or inflammation
- Foreskin: balanitis, phimosis

Secondary sexual characteristics of androgen deficiency

- Reduced facial, body and pubic hair
- Gynaecomastia
- Reduced or poor muscle development

Prostate and other examinations

- Digital rectal examination in older men suspected of prostatic disease, or androgen deficiency
- If the prostate is enlarged or nodular, refer to urologist
- General medical review of erectile dysfunction. Focus on cardiovascular risk (BP, pulses) & diabetes (including neuropathy)

Refer to Clinical Summary Guide 9
Androgen deficiency (AD)

**Presentation**
- Symptoms of AD, including AD in ageing men
- Following testis surgery, torsion, trauma, cancer treatment
- Incidental findings of small testes
- In association with infertility

**Primary investigations**
- Total testosterone level (two morning samples) and LH/FSH level

**Investigations if low total testosterone with normal or low LH/FSH**
- Serum prolactin (prolactinoma)
- MRI pituitary (various lesions)
- Olfactory testing (Kallmann’s syndrome)
- Iron studies (haemochromatosis)
- Also commonly seen with co-morbidities (obesity, depression, chronic illness): focus on underlying condition

**Other investigations**
- SHBG/calculated free total testosterone (selected cases, e.g., obesity, liver disease)
- Bone density study (osteoporosis)
- Semen analysis (if fertility is an issue)
- Karyotype (if suspicion of 47XXY)

**Treatment and specialist referral**
- Testosterone Replacement Therapy (TRT)
  - Contraindicated in prostate and breast cancer
  - Withdraw treatment until investigation complete
- In general, TRT is not justified in older men with borderline low testosterone levels and without underlying pituitary or testicular disease
- Low-normal total testosterone is common in obesity or other illness and may not reflect AD. Address underlying disorders first.
- Consult a specialist to plan long term management:
  - Refer to endocrinologist
  - Refer to fertility specialist as needed

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Gynecomastia

**Presentation in adulthood (common)**
- Excessive and/or persistent breast development
- Androgen deficiency
- Chronic liver disease
- Hyperprolactinaemia
- Adrenal or testicular tumours
- Drugs (e.g., spironolactone), marijuana, steroids
- Distinguish from ‘pseudogynaecomastia’ of obesity

**Primary investigations**
- Total testosterone level, estradiol, FSH/LH
- LFTs, iron studies (haemochromatosis)
- Serum prolactin (pituitary tumour)
- Karyotype (if suspicion of 47XXY)
- βhCG, αFP, ultrasound (testicular cancer)

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Male infertility

**Presentation**
- Failure to conceive after 12 months of regular (at least twice weekly) unprotected intercourse
- Consider early evaluation if patient is concerned and/or advancing female age an issue

**Other features:**
- Testis atrophy (androgen deficiency)
- Past history uncircumcised testes (cancer risk)
- Psychosexual issues (primary/secondary)
- Past history STI (obstructive azoospermia)

**Primary investigations**
- Semen analysis: twice at 6-week intervals. Analysis at specialised reproductive laboratory if abnormalities
- FSH: increased level in spermatogenic failure
- Testicular ultrasound (abnormal physical examination, past history of undescended testes)
- Total testosterone and LH (small testes <12 mL or features of androgen level)

**Treatment and specialist referral**
- Refer to endocrinologist as necessary
- Refer to a fertility specialist (ART widely applicable)

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Penile abnormality

**Presentation**
- Hypospadias
- Micro prepuce
- Phimosis
- Peyronie’s disease
- Urethral stricture

**Treatment and specialist referral**
- Refer to urologist for investigation and treatment plan

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Testicular mass

**Presentation**
- Painless lump
- Self report, incidental
- Past history undescended testes (cancer risk)
- Confirm lump is in testis rather than epididymal cyst

**Primary investigations**
- Testicular ultrasound

**Treatment and specialist referral**
- Refer to uro–oncologist
- Offer pre-treatment sperm cryostorage

**Refer to Clinical Summary Guide 6**