Madigan Army Medical Center
Referral Guidelines

Chronic Orchalgia

Diagnosis/Definition

- This guideline is intended for chronic scrotal pain.
    - Acute scrotal pain may be caused by infection, trauma, or torsion of the spermatic cord, testicle or its appendices. Acute scrotal pain mandates a prompt evaluation by the Primary Care Provider (PCM) because testicular torsion requires immediate referral to an urologist for emergent surgery.
- Chronic scrotal pain is a common reason for referral to the Urology Service. Although it is not life threatening, it may affect the patient's quality of life
- Chronic scrotal pain is defined as pain that has lasted for a minimum of six months. It can be unilateral or bilateral, and continuous or intermittent. It is not uncommon for examination to localize the site, and distinguish between testicular and epididymal pain.
- The differential diagnosis is vast and includes the following:
    - Inguinal and/or femoral hernia
    - Testicular tumor (rarely painful)
    - Hydrocele
    - Spermatocele
    - Varicocele
    - Cysts within the epididymis, tunica albuginea or spermatic cord.
- The etiology of benign chronic orchalgia may be from any of the following:
    - Prior vasectomy (post-vasectomy pain syndrome)
    - Extragenital lesions including vertebral disease
    - Ureteral stones
    - Aortic or iliac aneurysm
    - Hypermobility of the testis
    - Entrapment of the pudendal/inguinal nerve (such as seen after hernia surgery), and
    - Chronic pelvic pain of unknown cause

Ongoing Primary Care Management and Objectives

- All patients should have a basic genitourinary exam by a primary care provider in an attempt to localize the source of pain, determine if there are any associated masses/findings, and rule out an inguinal hernia.
- All patients should have genitourinary lab work to rule out an infectious source including UA & Urine culture and GC/Chlamydia.
- All patients should have a scrotal ultrasound to rule out non-palpable or intratesticular pathology.

- Initial treatment for all patients with chronic scrotal pain without a testicular mass or other urgent finding consists of 90 days of conservative management. Conservative management includes, but is not limited to, a protective profile, scrotal support, scheduled non-steroidal anti-inflamatories, and antibiotics if infection is suspected.
    - The protective profile should include provisions prohibiting or severely limiting running, jumping, ruck marching, lifting greater than 15 pounds, and any other strenuous activities that aggravate the scrotal pain (e.g. sit ups, flutter kicks).
    - All patients should be treated with a scheduled non-steroidal anti-inflammatory medication for no less than 30 days and considered for an empiric course of antibiotics for two weeks (a flouroquinolone is preferable).

Indications for Specialty Care Referral

- Patients with intrascrotal lesions (not involving the testicle itself) can be sent for routine specialty urologic referral for surgical consideration (i.e. – symptomatic hydroceles, varicoceles, or spermatoceles/epididymal head cysts).

- Patients with identified extragenital disease (spinal disorders, nerve entrapment) should be treated according to the cause.

- Patients with hernias, or findings suspicious thereof, should be referred to General Surgery.

- Patients with an identified testicular mass on ultrasound should be sent for urgent/immediate urologic evaluation (not to be confused with epididymal or spermatic cord masses/cysts = not urgent)

- Patients with continued duty or lifestyle limiting pain despite 90 days of conservative management (see above) can be referred to Urology. If after specialty evaluation no surgically correctable condition is identified, patients will return to primary care for chronic pain management and disposition

- Primary care evaluation demonstrates an abnormal scrotal finding such as such as a large hydrocele, large spermatocele, or palpable varicocele.

- Elevated PSA (greater than 4.0), abnormal repeat urinalyses, and males with urinary tract infections.

Criteria for Return to Primary Care

Patients will be referred back to primary care after full evaluation shows no demonstrable surgical defects or when the treatment results in the desired resolution of pain.

References for Chronic Orchalgia Guidelines:

Keoghane SR, Sullivan ME: Investigating and managing chronic scrotal pain. BMJ. 2010; 341:c6716.

Davis BE, Noble MJ, Weigel JW, Foret JD and Mebust WK: Analysis and management of chronic testicular pain. J Urol1990; 143: 936.

Bolay H and Moskowitz MA: Mechanisms of pain in chronic syndromes. Neurology 2002; 59: S2.

Yamamoto M, Katsuno S, and Miyake K: Management of chronic orchialgia of unknown etiology. Int J Urol 1995; 2: 47.

Sinclair AM, Miller B and Lee LK: Chronic orchialgia: consider gabapentin or nortryptyline before considering surgery. Int J Urol 2007; 14: 622.

Last Review for this Guideline: **February 2012**
Referral Guidelines require review every three years.

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