The man pictured in this photos has.....

1. Paraphimosis
2. Phimosis
3. Balanitis
4. Posthitis
5. Priapism
6. Hair tourniquet
7. A zipper injury
Disorders of the glans/foreskin

• Phimosis:
  – foreskin cannot be retracted, causing urinary retention
  – Chronic condition
  – Tx: steroids/circumcision

• Paraphimosis:
  – Inability to reduce foreskin over glans
  – TRUE emergency
  – Tx: reduction/incision of dorsal foreskin
Disorders of the glans/foreskin

• Balanitis
  – Inflammation of the glans
  – Commonly associated with DM
  – Usual organisms: Candida, Gardnerella, anaerobes
  – Tx: cleanse w/ mild soap, topical antifungals

• Posthitis
  – Inflammation of the foreskin—often associated with balanitis and similar cause/tx
Priapism is most likely due to...

1. Sickle cell disease
2. Spinal cord injury
3. Drug use
4. Erectile dysfunction medication
5. Idiopathic
6. Acute neoplastic crisis
Disorders of the penile shaft

• Hi-flow priapism (non-ischemic)
  – Inflow=outflow
  – Due to spinal cord or pelvic injury
  – Not painful
  – Not a true emergency
  – Tx: observation/arterial embolization

• Low-flow priapism (ischemic)
  – Inflow>>outflow
  – Most common (80%)
  – Painful
  – TRUE EMERGENCY
  – Tx: Treat underlying condition, penile block, aspiration (10 or 2 o’clock), injection with phenylephrine (1 mL of 100-200mcg/mL q 5 minutes)
Disorders of the penile shaft

• Fracture
  – tear of the tunica albuginea
  – Perform a RUG and urology consultation

• Amputation
  – 90% self-inflicted by mentally-ill
  – 10% caused by nihilists
24 yo male presents with complaint of “bump.” On exam, you find this painful lesion. It is most likely...

1. HSV
2. Syphilis
3. Chanchroid
4. Lymphogranuloma venereum
5. Behcet’s Disease
HSV

- MOST COMMON CAUSE of genital ulcers
- Painful ulcerations/vesicles on an erythematous base sometimes with associated inguinal lymphadenopathy
- Dx: clinical or Tzanck Smear finding multinucleated giant cells
HSV: Treatment

• **Tx:**
  – Primary infections: Acyclovir 200mg PO 5x/day x 7-10 days
  – Recurrent: may benefit if initiated within 24 hours of lesion appearance
  – Daily suppressive therapy: use in patients with >6 recurrences/year—400mg PO bid
Syphilis

• Primary:
  - painless, indurated ulcer ("chancre")
  - VDRL/RPR can be negative
  - Inguinal LAD may be present

• Secondary
  - Constitutional symptoms + rash
  - Rash—macules+papules+plaques (condyloma lata) and involves palms/soles

• Tertiary
  - Thoracic aneurysm, tabes dorsalis, dementia

• TX: PCN G 2.4 mill U IM
Chanchroid

- **Etiology**: Haemophilus ducreyi
- **Painful papules** $$\Rightarrow$$ **pustules** $$\Rightarrow$$ **ulcers**
- **Painful inguinal lymphadenopathy** (buboes) with rupture of lymph nodes
- **Tissue destruction**
- **Dx**: Gram stain/PCR—usually clinical
- **Tx**: Azithromycin 1 g po x 1 or ceftriaxone or cipro
Lymphogranuloma Venereum

- **Etiology:** Chlamydia trachomatis, serovars L1-L3
- **Sx:**
  - Initial — small, shallow, painless vesicle
  - Secondary — tender inguinal LAD that ulcerates above and below inguinal ligament
- **Tx:** Doxycycline
Granuloma Inguinale

- **Etiology:** Calymmatobacterium granulomatis
- **Sx:**
  - Primary: painless papule
  - Secondary: “beefy red velvety” ulcers with rolled borders and inguinal LAD
- **Dx:** Biopsy—Donovan bodies
- **Tx:** Bactrim or Doxy
Behcet’s

• Etiology: likely auto-immune
• Sx:
  – Recurrent oral apthous ulcers
  – Uveitis
  – Painful genital ulcerations
Urethritis

- Gonorrhea (most common cause)
- Chlamydia (serovars D-K)
- Ureaplasma urealyticum
- Trichomonas—2-5%
Epididymitis

- Sx: tender epididymis, hydrocoele, indolent onset, fever
- Prehn’s Sign: NON-diagnostic
- Etiology:
  - Heterosexual <35yo: Chlamydia>>Gonorrhea
  - Heterosexual >35yo: E.Coli, Pseudomonas
  - Insertive anal intercourse all ages: E. Coli
- Tx:
  - Heterosexual <35yo: Ceftriaxone 250mg IM +Doxy 100mg bid x 10 days
  - Increased risk for enteric infection: Bactrim DS
The most reliable physical exam finding to rule OUT testicular torsion is:

1. Negative Prehn’s sign
2. Absence of swelling
3. Presence of Cremasteric reflex
4. Normal positioning of testicle
The Acute Scrotum

• Differential
  – Non-emergent
    • Hydrocoele
    • Varicocele
    • Spermatocoele
    • Epididymal Cysts
  – Urgent
    • Epididymitis
    • Testicular/epididymal appendage torsion
    • Orchitis
  – Emergent
    • Fractured Testicle
    • Testicular torsion
  – Don’t Forget
    • AAA, appendicitis, renal colic, hernia, pyelonephritis
Testicular Torsion

• “Castration by procrastination”
• Peak ages—1 and 14; most commonly in males <30yo
• 6 hour salvage=90%
• 24 hour salvage=0-20%
• Management: reduction/emergency urology consultation
• DO NOT WAIT FOR IMAGING
Prostatitis

- **Sx:** dysuria, frequency, urgency, retention and pain
- **Etiology:** 80% E.Coli
- **Dx:**
  - Exam: tender, swollen prostate
  - NO prostatic massage in acute cases
- **Tx:** Ofloxacin/levofloxacin x 30 days + stool softeners; unless young SA male—ceftriaxone/doxy
Renal Stones

• Etiology:
  – 75% are calcium-based
  – Struvite stones (Magnesium-ammonium-phosphate) caused by chronic UTI with proteus
  – Uric acid stones—radiolucent stones found in patient with gout, high protein diets, myeloproliferative diseases

• Dx:
  – 20% have no hematuria
  – CT is imaging of choice
  – U/S is less sensitive for smaller, more distal stones

• Most common sites of impaction
  – UPJ, pelvic brim, UVJ
Renal Stones

• Stone passage
  – <4mm: 90%
  – 4-6mm:50%
  – >6mm:10%
Acute Urinary Retention

- Obstructive
  - BPH**, stricture etc.

- Neurogenic
  - UMN Lesions—MS, stroke, spinal cord trauma
  - LMN—cauda equina
  - Bladder afferent/efferent dysfunction—diabetes

- Pharmacologic—anticholinergics, antihistamines, narcotics, TCAs, antispasmodics, antipsychotics, sympathomimetics, amphetamines
Postobstructive Diuresis

- Inappropriate excretion of salt/water after AUR
- More common in patients with chronic retention or kidney disease
- Recommendation to observe those with non-acute onset obstruction for 4-6 hours