



TOOLBOX

How to do a sexual physical exam

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Introduction

Examining a patient or couple with sexual problems involves standard procedures. It can sometimes, however, be fraught with difficulties, often related to psychological and social factors not generally experienced in other situations.

Patients may anticipate the examination with dread and profound embarrassment or, conversely, may see it as a potential source of reassurance and relief. Doctors must be aware of the many popular myths about sex and that their patients may often hold quite idiosyncratic beliefs and fears, which also will need to be addressed.

It is important to explain to patients at the outset how the examination, which is essential in all patients with a suspected physical problem, might help them and to tell them precisely what it entails. An unusual history, odd behavior by either partner during assessment, inconsistent findings on examination, or unexplained bruising or trauma may alert you to an abusive relationship. Any suspicions should not be ignored, but great care and sensitivity are needed to address this issue.

Patient's preferences

Many patients will find examination of the genitalia deeply embarrassing. Success will depend on the cooperation and confidence of your patient, and it is best to defer examination if the patient is uncomfortable and unable to relax.

It is good practice to offer the presence of a chaperone to male and female patients. A substantial minority of patients, both men and women, prefer to be examined by a doctor of their own sex. Remember that patients have made complaints of indecent assault even when their examining doctor was of the same sex.

Cultural differences must also be considered. Many Muslim, Hindu, and Sikh

women practice a strict sexual morality. Girls are brought up to be shy and modest, and submitting to a vaginal examination may be abhorred. Remember that our sexual mores are not universally accepted. It is both wise and necessary to explore these issues with the patient before proceeding with an examination.

It is important not to neglect evidence of concomitant disease that may be a contributory factor to the sexual problem. Cardiovascular, respiratory, or neurological diseases may, directly or indirectly, cause sexual problems. Musculoskeletal disorders may lead to sexual problems through chronic pain or immobility. Observe a patient's general mobility, spinal mobility, and movement of the hips and knees. A patient's affect may suggest depression, anxiety, or other mental health problems.

The examination of both men and women should include dipstick analysis of the urine for the presence of glucose. Diabetes is a common cause of erectile dysfunction in men and may also cause autonomic neuropathy affecting sexual response. A measurement of fasting blood sugar concentration would be a more reliable option for detecting diabetes if blood has to be taken for other reasons.



It is important to explain at the outset precisely what an examination entails. (Mercury treatment for venereal disease, circa 1500)

Suggestions for examination

- Remember privacy, warmth, and an unhurried approach are essential
- Consider that one-third of women and one-fifth of men prefer to be examined by a doctor of their own sex
- Carefully consider cultural mores
- Offer patients a chaperone, both for reassurance and for medicolegal reasons
- Assess patients without excluding the possibility that other diseases such as diabetes, hypertension, and depression may have a bearing on their sexual problem

General examination

- Look for evidence of endocrine disease
- Measure blood pressure and perform urinalysis to exclude diabetes
- Check the cardiovascular and central nervous systems
- Examine the abdomen
- Check the external genitalia and, in men, the anus and prostate

Examination of male patients

General

Appearance. Observation of general appearance is important and may reveal signs of androgen deficiency or other endocrine abnormalities. The distribution of facial and body hair and the presence of gynecomastia should be noted. Check blood pressure and radial pulse and palpate the peripheral pulses in men with erectile dysfunction. Evidence of arterial disease, such as the absence of the foot pulses, suggests that an erection problem might be due to arterial insufficiency.

Nervous system. Assess the lumbosacral nervous system if there are indications to do so. There is a dual innervation of the male reproductive system from the sacral roots

(S2-4) through the pudendal and pelvic nerves with predominantly somatic and parasympathetic fibers, and from the thoracolumbar roots (T11-L2) through the hypogastric, sympathetic, and pelvic nerves. Tactile (dorsal column) and pinprick (spinothalamic tract) sensation in the perineal and lower limb dermatomes should be assessed. The condition of the perineal reflexes may provide evidence of spinal cord dysfunction.

Abdomen. Check for abdominal surgery or intra-abdominal pathology such as a palpable bladder or kidneys. Hernias may also cause pain and sexual problems.

Investigations for male sexual dysfunction

In erectile dysfunction

- Urine analysis for glucose or a blood sugar test to exclude diabetes

In loss of sex drive

- Testosterone (9:00 AM sample)
- Sex hormone binding globulin (SHBG)
- Free androgens (calculated from the above)
- Luteinizing hormone (LH)
- Prolactin
- Luteinizing hormone and testosterone have a negative feedback relation similar to that of thyroid-stimulating hormone and thyroxine. This can be useful in distinguishing hypogonadism and pituitary disorders as causes of testosterone deficiency.
- Prostate-specific antigen and other investigations are necessary only when coexisting disease is suspected



Presence of gynecomastia should be noted. This usually settles spontaneously but, rarely, may be severe enough to warrant breast reduction

Rectal examination

- Look for anal warts, hemorrhoids, sinus, or fissure

The prostate

- Should be smooth and symmetrical with the firmness of a tensed thenar eminence
- May be tender but should not be painful
- Hardness, irregularity, or asymmetry suggests malignancy and needs urgent referral

Genital

The appearance of the external genitalia and any apparent developmental anomalies should be noted.

Penis. The size of the flaccid penis is variable, but is usually 5-10 cm in length. It may seem smaller in obese men, being buried in the pubic fat. The presence of any firm plaques of Peyronie's disease should be assessed. The foreskin, if present, should be retracted, and any pain, restriction, or scarring noted. The position of the urethral orifice should be confirmed, and the presence of genital warts or other infective problems noted.

Testes. The testes should feel smooth and symmetrical. The epididymes can be palpated and, again, should be symmetrical and uniform. The vasa should be palpable as firm cords without swellings. A varicocele can sometimes be felt as a swelling above the testicle, more commonly on the left side, and is often seen better in the standing position. They are often cited as a cause of fertility problems or pain, but the evidence is inconclusive.

Prostate gland. A rectal examination should be performed (and any perianal problems noted) to assess the size and shape of the prostate. The size of the gland can vary, but it should be firm, smooth, and symmetrical with a uniform consistency (the same firmness as the thenar eminence when the tips of the thumb and forefinger are pressed together), and the median groove should be palpable. It should not be tender to gentle pressure. If it feels hard, irregular, or asymmetrical, this suggests prostatic malignancy. Tenderness often indi-

cates prostatitis, which can be a cause of perineal pain or pain on ejaculation. In either case, further investigation is warranted, and referral to a urological or genitourinary medicine specialist should be considered.

Testing of reflexes

Perianal reflexes

The muscular contractions provoked in these reflexes can usually be seen or palpated

Bulbocavernosus reflex (S2 and S3)

Firmly squeezing the glans penis provokes a contraction of the bulbocavernosus muscle located between the scrotum and anal sphincter

Bulbo-anal reflex (S3 and S4)

Firmly squeezing the glans penis provokes a contraction of the anal sphincter

Anal reflex (S4 and S5)

Stroking or scratching the skin adjacent to the anus provokes a contraction of the anal sphincter

Examination of female patients

General

As in the male patient, observation of general appearance is important. Assess the development of secondary sex characteristics and exclude hirsutism and other signs of virilization. Check the blood pressure, radial pulse, and urine. Examine the abdomen and the reflexes including a check of the anal reflex if a neurological problem is suspected.

Examining a female patient

- Examination is necessary only when a physical problem is suspected
- Note the general appearance
- Check secondary sexual characteristics as well as pulse, blood pressure, and urine
- Examine cardiovascular system, central nervous system, abdomen, and external genitalia
- To assess stress incontinence, examine the patient with a full bladder and ask her to cough
- Digital and speculum examination of the vagina should be carefully made
- Rectal examination is rarely necessary

Investigations for female sexual dysfunction

- Endocrine investigation has limited role but is necessary in women with menstrual irregularity or other symptoms of estrogen deficiency
- Follicular-stimulating hormone and luteinizing hormone
- Estradiol
- Prolactin to exclude a pituitary prolactinoma
- Thyroxine, as in men; hyperthyroidism and hypothyroidism can cause dysfunction in sexual drive and arousal
- Other investigations only when coexisting disease is suspected

Genital

Inspect the external genitalia for any apparent developmental anomalies. Note the condition of the labia minora, clitoris, urethral orifice, vagina, and anus and whether there is evidence of warts or other infections. Is the vulval skin healthy or is there evidence of atrophy and estrogen deficiency? Are hymenal remnants or adhesions present? Note evidence of previous childbirth and scarring from perinatal tears or an episiotomy.

Urinary incontinence can cause a problem with sexual activity, so it is important to examine the patient with a full bladder. Both stress incontinence and detrusor instability may be the culprit; the latter sometimes is associated with voiding at orgasm. With the patient in the left lateral position, ask her to cough vig-

orously while you observe the urethral orifice: a jet of urine suggests stress incontinence. If incontinence is a substantial problem, referral for urodynamic assessment by a urologist or gynecologist is prudent.

Speculum examination should be performed, and any pain or vaginal discharge during the procedure should be noted. The appearance of the vagina and cervix should be assessed, and, if appropriate, bacterial and chlamydial swabs may be taken from the vagina and endocervical canal. Excluding chlamydia is especially important in women with dyspareunia.

Gentle digital examination of the vagina helps in identifying tenderness and muscle spasm. If tolerated, a bimanual examination should be performed to assess the condition of the cervix, uterus, and adnexa. Particularly

note any tenderness, thickening, or swellings, which often require referral for further assessment by a gynecologist. The position of the uterus, either anteverted or retroverted, can be noted, but this is rarely a cause of sexual problems. Beware of commenting on the position of the uterus to your patient unless you are prepared to address the matter fully.

Rectal examination in a woman is rarely necessary unless an anal or rectal problem is suspected. However, do look at the perianal skin for evidence of scarring, warts, or infection.

Conclusion

When the examination of the patient has been concluded, it is important to give him or her as clear an explanation of the findings as is possible. The findings are often entirely normal, and this reassurance can be very important as a first step in a patient's recovery of his or her sexual well-being.

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