"Stop this burning sensation!"

David Yue, MD

Dan, 52, presents with a four-day history of severe, burning pain at the tip of the penis and radiating to the scrotum.

He denies any dysuria and frequency. There is no abdominal pain or erectile dysfunction.

He restarted himself on ciprofloxacin, 500 mg twice daily (which was prescribed for chronic prostatitis a year ago by a urologist).

The night before, he was seen at the emergency department, but after a normal genital exam and urinalysis, was sent home with only local, topical anesthetics. An acetaminophen/oxycodone combintaion, which had been prescribed earlier by another physician, provides moderate relief.

He denies any history of hematuria, urolithiasis or sexually transmitted disease. There is no recollection of genital herpes infection either. He had a cystoscopy 15 years ago with no abnormality detected.

One year ago, Dan was diagnosed with chronic prostatis; however, he stopped taking tamsulosin after three days due to retrograde ejaculation, but was able to complete his course of ciprofloxacin, 500 mg twice daily for four weeks.

Past medical history is unremarkable, except for a lumbar disc herniation, which did not require surgical intervention.

Dan's exam results

- In moderate distress
- Abdominal palpation and percussion do not reveal any tenderness or organomegaly
- No hernia detected
- He is circumcised
- No urethral discharge
- No skin lesions
- Testicular exam: Slight tenderness in the left epididymitis
- Rectal exam: Normal nontender prostate
- Gait: Normal
- Range of motion of the lumbar spine: Within normal limits
- Urinalysis and micro: Normal

What's your diagnosis?

a) Interstitial cystitis
b) Urethritis
c) Neuropathic pain
d) Epididymitis

Answer:
Neuropathic pain

Dan is treated empirically with doxycycline, 100 mg twice daily for 10 days, and ibuprofen, 600 mg three times daily, as needed, for epididymitis. He is also told to use acetaminophen/oxycodone, one to two tablets three times daily, as needed, for severe pain. Urine culture is negative. Urethral culture is negative for gonorrhea and chlamydia.

Dan returns 10 days later with continual, severe pain at the penile tip, which requires daily acetaminophen/oxycodone for symptomatic relief. The on-call urologist recommends Dan:

- restart tamsulosin,
- stop ciprofloxacin,
- increase fluid intake to 2 L/day,
- decrease acetaminophen/oxycodone as tolerated,
- switch to a different anti-inflammatory for pain,
- avoid stress and
- await cystoscopy.

Dan declines to have cystoscopy performed to rule out any occult causes of his penile pain. Also, he is determined to only take acetaminophen/oxycodone for his symptoms while awaiting a second opinion.

To rule out any other occult causes of Dan's symptoms, ultrasound of the abdomen and scrotum are ordered before his consultation with the second urologist. They are normal.

Based on the normal genital exam performed and all the negative urine culture, urethral culture and normal ultrasounds, the second urologist diagnoses neuropathic pain as the cause of Dan's agony.

A computed tomography (CT) scan of the lumbar spine is recommended to rule out any disc protrusion, which might have been the cause of the pain. The CT scan shows disc bulge and small central protrusions at L4-5 and L5-S1. No significant central spinal, lateral recess or neural foramina stenosis is seen. The sacral foramina and nerve roots are unremarkable.

Dan's symptoms finally subside after a few months and he has stopped taking all his analgesics. Dx

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