THE UNIVERSITY OF BRITISH COLUMBIA
Continuing Professional Development
Faculty of Medicine

SENSITIVE EXAMS REFRESHER – CANDIDATE GUIDE

PRA-BC CENTRALIZED ORIENTATION FALL 2026

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INTRODUCTION

This guide is intended to support the Sensitive Exam Refresher session for the participants in the Practice Ready Assessment (PRA-BC) Centralized Orientation. Physical examination of the genitals is an essential skill for primary care providers but can place the patient in a vulnerable state. Sensitive exams include exams of the breast, chest, vagina, vulva, uterus, ovaries, penis, scrotum, prostate, anus and rectum. It is critical to perform any physical exam in a systematic, respectful, and professional manner.

Health care providers are responsible for creating and maintaining a clinical environment which supports and respects all patients. 'Patient-centred care' in medicine has been a focus for many years. More recently, the concept of cultural humility in medicine has been introduced. Cultural humility involves understanding the complexity of identities and encourages genuine curiosity about the patient experience, their backgrounds, and how that background affects power differentials in clinical encounters.

In addition, following the principles of 'trauma informed care' in all clinical situations with all patients will enhance the patient/healthcare provider relationship and improve care. The principles of Trauma Informed Care are: safety, choice, collaboration, trustworthiness, and empowerment. Adherence to these principles is especially important when patients undergo breast/chest and pelvic/genitourinary (GU) exams. Physicians should treat all patients as though they have a history of trauma to prevent re-traumatisation. Specifically, it is important to recognize the Indigenous Peoples of Canada have endured centuries of trauma from colonisation, including within the healthcare system; therefore, physicians have a vital role to engage in the ongoing reconciliation effort and the sensitive exam refresher provides this opportunity for new-to-BC family physicians.

PREPARING FOR THE SENSITIVE EXAM REFRESHER

Prior to attending the Sensitive Exam Refresher, you are expected to have completed the Sensitive Exams PRA-BC pre-work modules, which included a review of the components of these exams, effective communication, as well as indications for cervical, breast, and prostate cancer screening.

The Sensitive Exam Refresher session will include a short didactic session followed by in-person examinations with a focus on communication and physical exam skills.

Candidate examinations will include instructions from Clinical Teaching Associates (CTAs) and physician instructors. CTAs are professionally trained people, many of whom are healthcare professionals themselves. They are committed to helping to educate other health care providers, such as medical, midwifery and nursing students. They play an integral role in providing a supportive and safe learning environment, which includes acting as both the "patient" and the "tutor" and providing guidance and feedback from a patient's perspective. This session is deliberate in involving the CTA to teach and guide the participants.

Like all other sessions in the PRA-BC Centralized Orientation, it is important for participants to remember that this session is not designed to teach a novice, such as a medical student, on performing sensitive examinations for the first time, but to offer experienced family physicians an opportunity to practice sensitive examinations within the BC/Canadian context in a non-evaluative environment. Therefore, PRA-BC candidates should attend the session fully prepared in order to maximize the benefits from the interactions with CTAs and physician instructors.

OBJECTIVES

In this session, candidates will:

- Demonstrate a trauma-informed approach sensitive examinations.
- Understand the indications for breast/chest and genitourinary (GU) exams.
- Demonstrate appropriate breast examination techniques on the CTA and/or prosthetic model.
- Demonstrate appropriate pelvic examination techniques on the CTA and/or prosthetic model.
- Review cervix screening (provider-collected) CTA and/or prosthetic model.
- Demonstrate appropriate examination techniques of the penis, scrotum, testes, spermatic cord, inguinal canal, rectal and prostate exam (i.e. digital rectal exam, or DRE) on the CTA and/or prosthetic model.

Recommended Viewing (as seen in pre-work)

- CPSBC Standard on Physical Examinations and Procedures (https://youtu.be/CxfZ0OLf5oE)
    - This practice standard outlines the College of Physicians and Surgeons of BC's expectations of physicians when conducting physical exams on patients

- PHSA Female Pelvic Exam review (https://mediasite.phsa.ca/Mediasite/Play/c1f0994f0ff645558d2284ead3aa55891d?catalog=c38b0f078cff4eb2b8f390f440eb5caa21)
- Stanford Breast Exam video demonstration (https://www.youtube.com/watch?v=pJ55UtP0_nA)
- American Urological Association Male GU Exam (https://www.auanet.org/meetings-and-education/for-medical-students/gu-exams/male-gu-exam)

Recommending Readings

- BC Cancer Screening Guidelines (https://www.bccancer.bc.ca/screening/Documents/Screening-Guidelines.pdf)
- Canadian Preventive Health Task Force - Cancer screening guidelines (see Prostate, Breast, and Cervical Cancer) (https://canadiantaskforce.ca/guidelines/published-guidelines/prostate-cancer/)

ASSESSMENT & EVALUATION

Participants will NOT be formally assessed during this Sensitive Exam session. These exams will be assessed during your Clinical Field Assessment.

I. FEMALE GENITOURINARY EXAM

Technique

Obtain a complete history. This is not reviewed here.

Overview of the Exam

The pelvic examination has 5 components:

1. Abdominal examination
2. Inspection of the external genitalia
3. Speculum examination
4. Bimanual examination
5. Rectovaginal examination

It is important for physicians to be comfortable with all five components of the pelvic exam; however, it is equally important to understand the indications for performing each part of the pelvic exam. This

means that while there are five elements of the pelvic exam, **not all of these components need to be performed on all patients**.

- The components of the pelvic exam should be tailored to each individual patient, based on their clinical presentation and past medical history.

- Patients who present with symptoms of pelvic pathology (pain, abnormal bleeding, abnormal discharge, etc) should be offered a complete pelvic exam.

There are five main reasons pelvic exams are performed:

1. Part of the work-up in a patient presenting with gynecological symptoms (e.g., post-menopausal bleeding, pelvic pain, dyspareunia)

2. Pregnancy or any pregnancy-related concerns

3. Procedures including IUD insertion, endometrial biopsy, colposcopy, etc.

4. Follow-up for certain operative procedures (i.e., hysterectomy) or medical history (e.g., cervical cancer)

5. Cervix screening for an asymptomatic patient that requires a provider-collected sample

Preparation

1. Prepare the equipment in advance of the visit (light, drape, speculum, gloves, carbomer-free lubricant, cervix screening equipment, etc.)

2. The patient should be fully clothed during the initial part of the visit, history, and explanation of the exam or procedure. Review the steps of the exam and ask if they have any questions. The patient should be given the opportunity to consent to the examination at this point. Remind the patient they have the right to rescind consent, stop, or pause the procedure at any time.

3. Offer choices to make the experience more collaborative, such as:

    a. Offer a chaperone (and document the presence or absence of a chaperone) **Refer to the CPSBC guidelines in pre-work

    b. Patients may wear socks and/or shoes if they prefer

    c. Ask them if they would like to observe their exam using a hand mirror

    d. Ask them if they would like to empty their bladder before the physical examination

4. Advise them where and how to sit on the exam table. Patients should be given privacy to undress. This means stepping out of the room or standing outside of a curtained area, whichever is the patient's preference.

Draping

The drape should cover any exposed areas, generally extending from the waist to over the patient's knees, providing coverage of the perineum until the examination begins. Always re-drape the patient as soon as the examination is complete.

Abdominal Examination

The abdominal examination should be done with the patient supine and comfortable. The specifics of the abdominal examination are out of the scope of this guideline. However, remember that examination of the abdomen, including the inguinal lymph nodes, is part of the pelvic exam **if the patient is symptomatic**. The abdominal examination is usually performed before the pelvic examination.

Inspection of External Genitalia

1. For the pelvic examination, the patient lies supine on the examination table with the gluteal region close to the end of the examination table. The head of the examination table can be slightly elevated. Patients should be given the option of declining to use foot rests. Proceed with a clean technique; clean your hands before and after the examination, and avoid touching equipment such as lights once gloves are on. Ensure draping is appropriate and only move the drape when necessary and with consent.

2. Inspection of the external genitalia needs a systematic approach, such as perianal skin to the mons pubis, or the other way around. Inspection of the labia needs gentle lateral traction. To adequately visualize the vestibule, again use gentle lateral traction of labia minora. Ask the patient if they would prefer to provide traction themselves.

Speculum Examination

1. Before introducing the speculum, ask for consent. At all times during the examination, tell your patient what to expect next, and ask if they consent to proceed. This will give the patient the option to discontinue the examination. Ask the patient to let their knees fall to the sides. **NEVER** push a patient's legs apart.

2. Ensure that there is lubrication on the speculum, and that the upper bill of the speculum is secured, otherwise it can hurt the patient by causing pain to the anterior structures of the vestibule. A way of doing this is to have the index finger secured over the top bill until the speculum is approximately 3 to 4 cm within the vaginal canal. The speculum bills can be horizontal on entry as long as the labia are not caught in the bills. If the speculum is turned as it enters the vagina, it may 'catch' on hair or skin.

3. When the speculum is in the vaginal canal, open the bills slightly to visualize the cervix. The cervix may not be immediately visible, and careful movement of the speculum may be needed to visualize the cervix. The cervix should be visualized within the bills of the speculum. If

provider-collected cervix screening is required, please refer to the appendix for links to collection techniques.

4. Before the speculum is removed, carefully open the bills slightly so that the speculum can be brought out without pulling on the cervix. Once the bills are clear of the cervix, they should be closed completely while still well within the vaginal canal. Then the speculum can be removed carefully. Inspection of the vaginal canal, if not already completed, can also be done as the speculum is removed.

Bimanual Examination

1. An additional component of the gynecological assessment is the bimanual examination, if indicated. The CTAs prefer that this examination be performed from the foot of the examination table; in clinical practice it may also be performed from the patient's side. Again, always be sure about a clean approach, and if the gloves have touched anything outside the clean space they must be changed. Let the patient know what to expect, and ask for consent to continue.

2. With water-soluble lubricant, one or two fingers (index and long finger) are introduced gently into the vagina. The thumb should be abducted, and the ring and little fingers flexed into the palm. It is important to be mindful of the position of the thumb on the examining hand. The thumb should not touch the patient's clitoris. It can be helpful to initially apply gentle pressure on the posterior fourchette to help relax the pelvic floor muscles.

3. It is important to have a systematic approach.

    a. **Anterior vaginal wall**: One can gently palpate the anterior vaginal wall to rule out any abnormal lesions.

    b. **Cervix**: Palpate the cervix and assess for general consistency and contour. Check for cervical motion tenderness.

    c. **Uterus**: The second and middle fingers of the dominant hand are placed just below the cervix and the other hand palpates just above the pubic symphysis. With an anteverted uterus, the body of the uterus can be predominately felt with the abdominal hand. Assess for size, contour, consistency and the presence of any tenderness. With a retroverted uterus, the bulk of the posterior wall of the uterus will be felt with the pelvic fingers.

    d. **Right adnexa**: The right adnexal area can be assessed by applying upward pressure within the right vaginal fornix, and downward pressure with the other hand in the right abdomen. Check for any unusual masses or irregularities in the pelvic structures in the right adnexal area – other investigations (i.e., ultrasound) may be necessary. If an ovary is felt in a postmenopausal person, it needs further investigation.

    e. **Left adnexa**: The same procedure is applied to the left adnexal area.

f. **Posterior vaginal wall**: Palpation of the posterior vaginal wall will allow assessment of the rectovaginal septum.

Closing the Exam

The clinician should offer to help their patient back into a comfortable sitting position. Provide the patient with tissue to remove lubrication. Provide privacy for the patient to get dressed.

A sensitive, professional approach to the pelvic examination will decrease the risk of harm and re-traumatization.

Cervical Cancer Screening in BC

Human Papillomavirus (HPV) testing and cytology are both currently used in BC as primary screening tests. HPV testing does not require a sample of cells from the squamous columnar junction of the cervix. HPV-based screening can be performed by a provider (vaginal or cervical (LBC) collection) or by the screening participants themselves (vaginal collection self-screening).

1. https://www.bccancer.bc.ca/screening/health-professionals/cervix
2. https://www.bccancer.bc.ca/lab-services-site/Documents/LBC%20Collection%20Method%20Quick%20Reference%20Guide_Sep2022%20v1.pdf
3. https://www.bccancer.bc.ca/screening/Documents/Cervix-Self-Screening-Clinic-Instructions.pdf
4. https://www.bccancer.bc.ca/screening/Documents/Screening-Guidelines.pdf
5. https://www.bccancer.bc.ca/screening/Documents/Cervix-Program-Overview.pdf

II. BREAST / CHEST EXAM

Examination of the Breast – General Considerations

The Canadian Task Force on Breast Cancer screening **no longer recommends routine clinical breast exam in asymptomatic patients**. The BC Cancer Agency states: "There is insufficient evidence to either support or refute routine clinical breast exams (in the absence of symptoms) alone or in conjunction with mammography. The patient and health care provider should discuss the benefits and limitations of the routine clinical breast exam, to determine what is best for the patient. This recommendation **excludes** people with prior breast cancer history". Students may encounter physicians who still perform routine clinical breast exams on asymptomatic patients. They may also encounter patients who expect that those examinations will be performed.

The same task force also **does not recommend that women routinely perform Breast Self-Examinations**. However, patients may recognize when something has changed or is abnormal in their own bodies and should be examined and investigated thoroughly.

- It is not appropriate to examine a patient's breasts through clothing – a breast/chest exam should be done only with thorough explanations, patient's ongoing consent, and proper draping.
- Breast disease may present in people of any gender. A thorough history and physical examination must be done for everyone presenting with breast/chest concerns.
- Explain the components of the exam before the exam, ask if the patient has any questions or concerns they wish to address, and ask for permission to begin the exam. As the exam progresses, ask for permission to continue, indicating they can stop the exam at any time.
- Consider using gender neutral language such as "chest exam" or enquiring about body part name preferences when examining a transgender patient.
- Clinicians and students must never use language which could offend or be misinterpreted by a patient – this is a time for professional, inclusive language and never for attempts at humour.
- Use professional terminology when describing the anatomy of the breast but avoid jargon. Make sure patients understand the terms that are being used.
- For sensitive examinations, or when disrobing is required, inquire whether the patient wishes to have another person of their choice present during the physical examination or procedure. Document the name of the chaperone.
- Patients' breasts may change with hormonal influence, including with the menstrual cycle. Ensure that abnormalities are confirmed at the time of the month when there is the least hormonal influence (about a week after the first day of the period in menstruating people or, if the patient is on oral contraceptives, the first day they take a pill in their monthly cycle.)

Careful documentation of any abnormalities is essential. Be as accurate as possible regarding location, size and character of any abnormal findings.

1. location: left or right; detail location using quadrant, clock face or distance from the nipple, size and depth
2. tenderness
3. mobility or fixation to either deep structures or skin and subcutaneous tissue
4. contours: smooth or irregular
5. texture: soft, rubbery, or hard
6. any overlying skin changes (redness, ulceration, etc.)

Draping

The patient should wear a gown opening at the front. (Some clinicians may prefer to have the gown open at the back.) Ask the patient to lower their gown to the waist while sitting on the side of the examination table. When the patient is supine, the gown should allow exposure of each breast individually as it is being examined. The breast not being examined should be covered by the gown.

Technique

Begin the examination with thorough hand washing. Ensure that fingernails are trimmed short to avoid discomfort during axillary examination. Explain the parts of the physical exam to obtain informed consent. When the patient reports a mass or other abnormality, have them identify the abnormality before beginning the examination. Examine all other areas of the breast before assessing the area of concern.

With the patient sitting at the edge of the examining table:

1. Inspect the arms and hands for edema.

2. Examine the neck and clavicular nodes, first looking at the front for any swelling. Palpate anterior and posterior cervical chains, followed by supra- and infra-clavicular chains.

3. Ask the patient to lower the gown to the waist. Tell the patient that the breasts are observed for symmetry. If there is any significant asymmetry, ask the patient if that is normal for them. It is important to mention to the patient that that no person has breasts that are identical. Look for masses underlying the skin or any indrawing of skin (which might mean fixation of a mass to skin). Look for any skin abnormality such as erythema, ulceration, or an abnormal vascular pattern. As well, check for any patch of localized edema of skin accompanied by apparent exaggeration of the cutaneous openings of sweat glands and sebaceous glands (called ‘peau d'orange’). If the nipples are inverted, ask if this is a change or normal for the patient. Look for dermatitis (particularly a ‘moist’ dermatitis), edema or ulceration involving the areola and/or the nipple; that might represent Paget's disease of the breast tissue or lymphatic obstruction of the skin of the breast.

4. Ask the patient to abduct the arms until the hands meet above the head. Again, always tell the patient what you are doing, and why. During this movement look for any asymmetry, skin indrawing or potential subcutaneous mass. In patients with large pendulous breasts, the skin overlying the lower half of the breast may be seen better in this position than when the arms are down, or sometimes with the patient bent over about 45°, allowing the breasts to hang away from the body.

5. Next, have the patient put their arms down and, with hands pressing on their iliac crests, look again for any skin indrawing or abnormal skin outline. This is important if a mass is present since it may indicate fixation of the mass to pectoralis major muscle.

6. Examine both axillae. Ask the patient to sit facing you with hands on hips. This means the patient is putting the weight of their own arms on their hips to allow for the axilla to be examined thoroughly. Using the left hand, palpate the medial wall of the right axilla with the palmar aspect of the 2nd, 3rd and 4th distal phalanges, beginning as superiorly as possible (without causing discomfort, aiming for the clavicle) and palpating inferiorly along the chest wall and "trapping" any lymph nodes between the fingers and the rib cage. Do this gradually so no area is missed. Continue the examination down to the axillary tail. Repeat the process on the anterior wall, using the opposite hand as counter pressure along the pectoralis muscle. Likewise, examine the posterior and lateral walls of the axilla in the same manner. The bulk of abnormalities will be felt medially. Then examine the left axilla with an identical approach. If there are any masses, assess the location, number, size and mobility while trying to determine if any nodes are matted together.

Ask the patient to lie supine on the examination table. Check if they consent to continue the exam, and ask if there are any questions or concerns. It is useful to place a corner of the pillow under the ipsilateral shoulder, spreading the breast tissue over the chest more thinly. This maneuver is helpful when examining any patient with large pendulous breasts. During this part of the assessment, the physician stands on the patient's right side. The patient may be more comfortable if only one breast/side of the chest is exposed at a time; use the gown to cover the other side not being examined.

1. Ask the patient to place the hand of the side being examined under their head. This pulls the breast tissue up on the chest wall as far as it will go, helping to spread the breast tissue as thinly as possible.

2. The breast/chest wall is examined with the palmar aspect of the distal phalanges of the 2nd, 3rd and 4th fingers and should be thorough, covering from the clavicle to the infra-mammary fold and the mid sternum to the mid-axillary line.

3. Clinicians may use the 'grid' pattern or the 'spokes on a wheel' pattern when performing the breast/chest exam. Bates' and the resource video recommend the 'grid' pattern. Both techniques are acceptable.

4. Whichever pattern used, the examiner should explain what they are going to do, and why. Palpate in a circular manner with varying depths of pressure towards the chest wall until the whole area has been covered. Each circle will usually cover an area of 2 or 3 cm in diameter and each site should be assessed using three different pressures. Repeat this pattern until the entire breast/chest wall is assessed. The circles should overlap slightly to ensure that no area of breast tissue is missed.

5. Repeat the examination on the contralateral breast/side of chest.

6. It is not routine to assess for nipple discharge, but bloody discharge should be considered abnormal. If a patient is presenting with concerns about nipple discharge, the patient can demonstrate the nipple discharge themselves, if necessary.

Breast Cancer Screening in BC

Breast Cancer BC Cancer Screening Guidelines (May 2026)

This BC Cancer document provides evidence-informed breast screening recommendations for trans, gender diverse and non-binary people in British Columbia: http://www.bccancer.bc.ca/screening/Documents/Breast-Screening-Transgender-Patients-Provider-Guide.pdf

The Screening Mammography Program (SMP) for Cis-Women in British Columbia (as of 2020): http://www.bccancer.bc.ca/screening/health-professionals/breast/

III. MALE GENITOURINARY EXAM

Considerations

1. A professional, calm, and courteous approach is necessary.

2. Ask the patient whether they would like to have another person present for any part of the examination.

3. The patient may be concerned about having an erection during the examination. If this does happen, provide the patient with an opportunity for privacy and ask them if they wish to continue with the examination. If the situation recurs, the examination should proceed in a calm and unhurried fashion if the patient is comfortable to continue. The patient should be reassured that this is a normal reaction, if they seem to be flustered by it. If the clinician does not seem embarrassed, it will lessen the patient's discomfort.

4. Avoid joking or inappropriate remarks during the genitourinary examination. Always use medical terminology when describing anatomy; make sure the patient understands what body part is being referred to.

Preparation

Equipment should be ready before the examination, including:

- Disposable latex/non-latex gloves – inquire about latex allergy.
- Water-soluble lubrication
- Tissues
- A penlight or point source light, for trans-illumination of scrotal masses

NOTE: An abdominal exam is part of the complete genitourinary exam, including inguinal lymph nodes assessment. The abdominal exam is covered in previous clinical skills sessions and will not be performed during these sessions.

Draping

If only a local genital examination is being done, the patient should be draped in the supine position and asked to lower their clothing to the level of the mid-thigh. When the patient stands for examination, the drape can be placed on the table.

Technique

General appearance:

The adult penis usually hangs slightly longer than the bottom of the scrotum. This can be variable. Note if the penis is circumcised or not circumcised. Note any rashes, lesions, or discoloration of the penile skin.

1. The Prepuce and Glans:

- Inspect the skin of the prepuce and glans for lesions, colour changes, swelling, erythema, or discharge. If the patient is circumcised, the skin of the glans will be dry, but supple.
- If the foreskin is uncircumcised, the skin of the glans may be moist. Ask the patient to retract the foreskin, or ask if the patient prefers the examiner to retract the foreskin for examination. On retracting the foreskin, white secretions (smegma) may be noted under the foreskin. This is a normal secretion from the glands under the coronal sulcus.
- The foreskin should not be retracted in children younger than six years old, as the normal adhesions between the foreskin and glans penis have not fully separated until this age. Forcible retraction can cause inflammation of the penis, or scarring of the foreskin to the glans penis.
- **Phimosis** is the inability to retract the foreskin in an adult and is usually due to scar tissue or inflammation of the foreskin.
- **Paraphimosis** is the inability for the foreskin to return from its retracted position. This can result in swelling and complications and requires treatment.
- After examination of the glans, the patient may choose if they would prefer to reduce the foreskin or if they would prefer the examiner to reduce it.
- Examine the urethral meatus for stenosis, erythema, or discharge. The meatus should be a slit-like opening, and should not have any associated scarring.
- Gently apply pressure to the ventral and dorsal surface of the glans with the thumb and index finger to open the urethral meatus. Stenosis is a common finding in circumcised boys.

2. The Penile Shaft:

Explain to the patient that after the tissue on the outside of the penis has been examined, the tissue on the inside of the penis is assessed by palpation. Describe clearly what you will be doing and why.

- The shaft of the penis should be examined by inspection and palpation. (Palpation may be omitted in a younger, asymptomatic patient.)

- If there is any complaint of urethral discharge which is not seen on direct examination, the shaft of the penis can be palpated distally from the base to the glans. The characteristics of any urethral discharge obtained as the result of this manoeuvre should be noted, and the discharge should be cultured.

- Palpation of the shaft of the penis is done by gently squeezing the shaft of the penis between the thumb and the first two fingers. Any induration along the shaft of the penis should be noted.

The commonest cause for a mass in the penis is Peyronie's Disease. This usually causes a discrete fibrous lump, most often on the dorsal aspect of the penis.

3. The Scrotum:

- Inspection: Inspect the scrotum for signs of edema, erythema, or lesions.

    - Small sebaceous cysts (Fordyce Spots) are often seen on the scrotal skin. These are small, painless masses inside the scrotal skin itself.

    - The scrotum often appears asymmetric, as the left spermatic cord is longer than the right. The left testis is generally 1-2 cm lower than the right.

    - The scrotal skin may be either contracted, or loose, depending on that ambient temperature.

- Palpation:

    - **The testes**: Palpate each testis between the thumb and index finger from superior to inferior. Palpation should be gentle, as squeezing the testes causes a deep visceral pain. The testicle should be vertical in its long axis. A painful testicle which appears angled on its long axis may represent torsion.

        - The testes feel smooth and rubbery, and slide between the fingers on palpation. They should be free of nodules. Note any irregularity in texture or size.

    - **The epididymis**: This organ is located on the posterolateral and superior surface of the testis about 90% of the time. About 10% of the time it is actually on the anterior aspect of the testis. The epididymis is most easily palpable on the cephalad aspect of the testis. This represents the head of the epididymis. The body and tail of the epididymis are not so easily palpable.

        - Squeezing the epididymis can also cause severe pain.

        - Cysts and epididymal infection, are the commonest lesions noted on palpation of the epididymis.

- **The vas deferens and spermatic cord**: These structures are palpable from the testis up to the external inguinal ring. The vas should feel like a smooth hard cord within the spermatic cord itself. If it is nodular, it may represent chronic inflammation. Indistinct thickening of the spermatic cord, particularly on the left side, may represent a varicocele or hydrocele.
    - Hydrocele: accumulation of fluid around the testicle or spermatic cord.
    - Varicocele: enlargement of the veins of testis/spermatic cord. Varicoceles become more prominent when upright versus supine.

Transillumination:

- Scrotal masses may be trans-illuminated with a pen light in a darkened room. A fluid cystic mass may glow red. A solid mass will not.
- Scrotal masses which trans-illuminate are spermatoceles and hydroceles. Masses which do not trans-illuminate are varicoceles, epididymal inflammations, testicular tumours, and hernias.

Cremasteric reflex:

- The cremasteric reflex is a neurologic reflex caused by contraction of the cremaster muscles. It can be elicited by stroking the inner thigh with a blunt probe or finger. When the inner thigh is stroked, the ipsilateral testis will rise cephalad in the scrotum. The cremasteric reflex may be absent in the setting of testicular torsion or neurological injury. If you check this reflex, ensure the patient understands what you will be doing and why.

4. Examination for Hernia:

Examination can be completed supine or standing or both. Standing is more sensitive due to the added effects of gravity on intra-abdominal contents.

- The patient should be standing facing the examiner who should be seated on a stool. Ask the patient to lift the gown/drape to examine the inguinal region.
- Inspect left and right inguinal regions for the appearance of a mass or bulge. The inguinal ligament runs on a line between the ASIS the pubic tubercle.
    - The external ring represents the inferior-medial aspect of the inguinal canal.
    - The internal ring is the superior-lateral opening of the inguinal canal.
- With the index and long finger, palpate lateral and superior to the pubic tubercle at the external ring. Palpate for bulge or mass. Ask the patient to cough or bear down and feel for a bulge or mass. Repeat the exam on the patients left and right.
- Inform the patient you will next be palpating through the scrotum to the inguinal area as this can be uncomfortable.

- With the right index finger, invaginate 3cm of scrotal skin distally from the external ring and move your finger superiorly and laterally to the external ring.

- Palpate for a mass. Ask the patient to cough. A hernia may descend to touch the finger if present. Repeat the exam on the patient's left side with the left index finger.

The Digital Rectal Examination (DRE)

Preparation

The patient will likely have some anxiety, and concerns about the rectal examination. The examiner should describe the examination, and why it is done. Ask the patient if they are ok to continue, emphasizing again that they may decline at any time. A gentle touch is most important. The examiner must wear examination gloves.

A slow and deliberate pace, with a professional demeanour, is necessary. A hurried, or rough examination, can cause pain due to external sphincter spasm, and possible traumatization/re-traumatization. Reassure the patient that during the exam they may feel the need to void or move their bowels and that this is normal.

Positioning

A rectal examination can be performed in a lateral decubitus position, the lithotomy position, or with the patient standing and the hips flexed. The most commonly used is the lateral decubitus position. Any exposed areas of the body should be covered with clothing or drapes. Undrape the patient’s mid-section/buttocks to begin the examination.

Examination of the perianal areas

Direct examination of the anal area should be done with good illumination. The gluteal region may need to be parted to facilitate inspection – ask the patient if they wish to part the gluteal region or if they would prefer the examiner to do so. Inspect for lumps, rashes, inflammation, scars, and evidence of pilonidal sinus infection. Check for skin lesions, skin tags, warts, external hemorrhoids, anal fissures or fistulas. The perianal tissue should be gently palpated for tenderness. Do not proceed with the DRE if there is rectal tenderness, such as from open anal fissures or inflamed hemorrhoids.

Examination of the anal sphincter

Apply lubrication to the index finger and press the pad of the finger against the anus. Ask the patient to bear down slightly, as this will relax the external sphincter. The tip of the index finger is gently inserted into the anal canal. By progressing slowly, the patient will experience less discomfort. Once the finger is completely inserted, note the tone of the anal sphincter during this part of the examination. Ask the patient to tighten the sphincter around the finger and note the increase in pressure on the finger. Note any unusual amount of pain on doing this part of the examination. Rotate the finger to examine the muscular anal ring. It should feel smooth and exert an even pressure on the finger. Note any nodules or irregularities at the anal verge.

Rectal walls

Note any irregularities in the rectal walls. They should feel smooth and regular. You may be able to palpate the lowest rectal valve. Note any mass on palpation.

Anterior rectal wall and prostate

To palpate the anterior rectal wall, the index finger must be rotated so the pulp is directed anteriorly. With the patient in the lateral position, this may require bending down and rotating the arm, to rotate the finger. The prostate should be palpated, and the consistency, contour, size, and mobility of the prostate should be noted. The consistency of the normal prostate is about the same as the tip of your nose.

The prostate is convex and divided into two halves by a median sulcus. The lateral sulci, which define the lateral aspects of the prostate, should be palpable on each side of the gland. The seminal vesicles lie above the prostate gland and are not normally palpable.

The median sulcus may be obliterated by an enlarged prostate gland. The lateral sulci should be palpable, unless it is obliterated by a carcinoma extending outside of the prostate. The lobes of the prostate should be symmetrical. The size of prostate may be quite variable depending on the amount of benign prostatic hyperplasia that is present. This tends to become greater, as a man becomes older. A person in their 30s or 40s usually has a gland that measures about 4 cm across by 3 cm high.

Tenderness on palpation of the prostate is common. Severe tenderness may represent prostatitis, which is acute inflammation of the prostate gland. Some prostatic secretions may be forced out of the urethral meatus by prostatic examination. These secretions can be swabbed and cultured.

Examination of the stool

On removing the finger from the anus, examine it for fecal material. The characteristics and colour of the stool or presence of blood should be noted. The screening for colon cancer in BC is called the fecal immunochemical test (FIT). For more information, please see https://www.bccancer.bc.ca/screening/colon/how-it-works/what-is-the-fit.

Provide the patient with tissue to clean the peri-anal area. Give the patient privacy to dress. Once the patient has done this, you may re-enter the room to share your findings, and discuss the plan.

Prostate Cancer Screening in BC

The Canadian Task Force on Preventive Health Care **recommends against screening** for prostate cancer using Prostate Specific Antigen (PSA), and thusly, clinicians should not routinely discuss prostate cancer screening. For men under 55 years and 70 years and older, there is no evidence that screening with the PSA test reduces mortality, whereas there is evidence of harms. For men aged 55 to 69 years, there is inconsistent evidence of a small potential benefit of screening, and evidence of harms.

This recommendation places a relatively low value on a small potential absolute decrease in prostate cancer mortality, and reflects concerns with false positive results, unnecessary biopsies, overdiagnosis of prostate cancer, and harms associated with unnecessary treatment.

Please visit https://canadiantaskforce.ca/prostate-cancer-clinician-summary/ for more details.