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Best practice recommendations for male sexual and reproductive healthcare

By Wendy D. Grube, PhD, CRNP

Healthcare providers (HCPs) working in the field of women's sexual and reproductive healthcare (SRH) are accustomed to having a large body of clinical guidelines that establish the standard of care for women. With the advent of a national agenda to improve male SRH, it became critical to identify which services should be provided to which males and when—based on the best evidence available. A new publication from the Male Training Center (MTC) provides evidence-based and expert-informed recommendations for core clinical preventive care services for men of reproductive age.

Preventive Male Sexual and Reproductive Health Care: Recommendations for Clinical Practice[A], a recent groundbreaking publication by the MTC, presents an expansive rubric under which male SRH services are defined and recommendations for best practice are offered.[1] After conducting systematic reviews of the literature and examining current practice guidelines from professional organizations, the MTC developed these recommendations in response to the lack of systematized standards for SRH services for men. The complete recommendations and detailed supporting discussions can be found on the **MTC website**[B]. This article is a brief summary of the recommended male SRH core services.

Health history

In addition to a customary health history, a comprehensive SRH history includes not only the five P's (partners, practices, protection from sexually transmitted infections [STIs], past history of STIs, and prevention of pregnancy) but also the development of a reproductive life plan, which helps direct pregnancy preparation and/or identify male fertility concerns. Assessment for gonadal toxins and excessive heat exposure is recommended. Exploration of factors that may compromise sexual function or responsible sexual decision making (e.g., depression; alcohol, drug, or tobacco use) should occur. Probes for difficulty with sexual function (e.g., premature ejaculation, erectile dysfunction [ED]) and intimate partner/sexual violence are suggested as standard practice. Determination of immunization needs is based on risk: HPV vaccination for all males aged 11-26 years; hepatitis B vaccination for males younger than 19 and those with a risk for acquiring the disease from intravenous (IV) drug use or sexual exposure; and hepatitis A vaccination for males with exposure risks.

Physical examination

Core components of the physical exam include height, weight, body mass index, and blood pressure (BP). An external genital exam is recommended to determine that normal adolescent development has occurred, to identify genital problems such as hydrocele and varicocele, to detect signs of an STI, and to serve as part of a male infertility evaluation. During the exam, hair distribution and skin qualities are assessed, and inguinal nodes, the penis, and the scrotal con-

tents are palpated both to confirm presence of the vas deferens and epididymis and to identify common structural anomalies or signs of infection. In males who engage in receptive anal sex, evaluation of the perianal area is recommended. In asymptomatic males, routine screening for testicular cancer and the teaching of testicular self-exam are not recommended. No evidence suggests that these practices result in improved health outcomes; in fact, they are considered potentially harmful. In addition, hernia screening is no longer recommended as part of the routine physical exam unless a clinical indication exists.

Laboratory screening/testing

Chlamydia

At-risk males younger than age 25 should be screened using urine-based nucleic-acid amplification tests (NAATs). Individuals at risk include men who have sex with men (MSM) and those who reside in a community with a high prevalence of chlamydia (e.g., correctional institution, military barracks). All men diagnosed with chlamydia are advised to be re-screened 3 months after treatment to assess for re-infection. Men who have had anal-receptive sex should be screened for rectal infection using an NAAT rectal swab. Screening for pharyngeal infection is not recommended.

Gonorrhea

Routine screening for gonorrhea is not recommended unless men are at risk for this infection by virtue of their being MSM, having multiple sex partners, or having sex associated with illicit drug use. MSM should be screened annually for urethral, anal, and/or pharyngeal infection depending on sites of exposure. MSM with multiple or anonymous partners should be screened every 3-6 months. Men diagnosed with gonorrhea should be re-screened 3 months after treatment to assess for re-infection.

Syphilis

Routine syphilis screening is recommended only among high-risk populations such as MSM, commercial sex workers, males exchanging sex for drugs, and individuals residing in correctional facilities or high-prevalence communities. Screening schedules are based on the degree of risky sexual behavior and may be as frequent as every 3-6 months.

HIV/AIDS

All males aged 13-64 years should be screened for HIV/AIDS, and those considered to be at high risk should be screened at least annually. In addition to engaging in the high-risk sexual behaviors discussed earlier, having sex partners with HIV/AIDS or who use IV drugs greatly increases men's risk for acquiring HIV/AIDS. The MTC guidelines support the CDC recommendation that HIV/AIDS testing be on an "Opt Out" basis.[2]

Hepatitis C

One-time testing for hepatitis C is recommended for persons born between 1945 and 1965 because of the high disease prevalence among this population. Men considered at increased risk for hepatitis C because of sexual practices, known exposure, or IV drug use should undergo routine testing based on risk exposure.

Hepatitis B, herpes simplex

Routine screening for hepatitis B and herpes simplex among asymptomatic males is not recommended.

Other tests

In addition to screening for infections, the MTC guidelines recommend screening for diabetes in adult males with sustained BPs >135/80 mm/Hg. The MTC follows the recommendation from the U.S. Preventive Services Task Force to not screen routinely for prostate cancer using a prostate-specific antigen (PSA) test, but it acknowledges the alternative recommendations from the American Urological Association, American Cancer Society, and American College of Preventive Medicine, all of which advise various screening schedules using PSA tests and digital rectal exams based on age or risk factors. Other tests to be excluded from routine screening—based on recommendations from healthcare organizations serving males—include urinalysis and hemoglobin/hematocrit. Insufficient evidence exists to support routine screening of males for trichomonas or HPV or to support anal cytologic screening.

Sexual and reproductive healthcare counseling

A substantial portion of the MTC recommendations focuses on core elements of SRH counseling. One of the most important core elements entails education about condom use. In particular, the counseling guidelines detail how to teach men to put on and remove condoms, choose the right type of condom, and avoid substances that might destroy the integrity of the latex and result in an increased risk for STI transmission. In addition, recommendations are made for behavioral counseling (through a series of visits) designed to reduce high-risk sex practices. HIV pre-exposure and post-exposure prophylaxis may be considered for individuals at high risk.

Counseling and support strategies for males struggling with sexuality concerns are outlined in the MTC guidelines, and include a sexuality assessment tool and a sample assessment approach. Elements of respect, safety, support, individuality, equity, acceptance, honesty/trust, and communication are explored in this framework. In addition, indications and warning signs of an unhealthy relationship are offered to assist men in identifying and addressing relationship problems.

Counseling regarding pregnancy planning or prevention is another core element of male SRH. A review of all contraceptive methods, for males and for females, should be provided, with attention to safety, efficacy, and correct and consistent use in a patient-centered reproductive life plan. Included in the discussion of contraceptive methods is prevention of STIs and pregnancy. Men who are planning a pregnancy with a partner should undergo pre-conception counseling. This counseling should include discussions about optimizing their partnership (to ensure that all pregnancies are desired) and about enhancing parenting practices (to ensure best outcomes for their children). Strategies to help men achieve optimal fertility should be offered as well.

For men seeking an infertility evaluation, the assessment/counseling process includes a problem-specific history and a physical exam if a pregnancy does not occur within a year of unprotected sexual intercourse—or sooner if the man is known to have bilateral cryptorchidism or suspected infertility potential or if his partner has infertility risks. However, any man, regardless of his present partner, should be able to seek information about his fertility status. Counseling and referral should be available for semen analysis or for medical evaluation if a possible endocrine or urinary disorder is suspected.

Acknowledging that male sexual dysfunction encompasses a common group of disorders that require multidisciplinary care, the MTC recommends specific resources that provide evaluation and treatment guidelines for ED, Peyronie's disease, priapism, and problems related to libido, orgasm, and ejaculation. Of note, ED can be a sign of early cardiovascular disease (CVD); recommendations for assessment of cardiovascular status are provided along with suggestions for healthy lifestyle interventions that can favorably affect ED as well as CVD.

Conclusion

The MTC's new document provides a comprehensive resource useful to HCPs who want to provide SRH for men that is evidence based and expert informed. This document provides a foundational framework upon which HCPs can build research to close knowledge gaps and move closer to reproductive healthcare equity for all. ●

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References

1. Marcell AV and the Male Training Center for Family Planning and Reproductive Health. *Preventive Male Sexual and Reproductive Health Care: Recommendations for Clinical Practice*. Philadelphia, PA: Male Training Center for Family Planning and Reproductive Health and Rockville, MD: Office of Population Affairs; 2014.

2. Centers for Disease Control and Prevention. 2010 STD Treatment Guidelines. Clinical Prevention Guidance. Updated January 28, 2011. www.cdc.gov/std/treatment/2010/clinical.htm

Web resources

A. http://www.maletrainingcenter.org/wp-content/uploads/2014/09/MTC_White_Paper_2014_V2.pdf

B. www.maletrainingcenter.org