JUSTIN HOUMAN MD
MEN'S HEALTH
TOWER UROLOGY

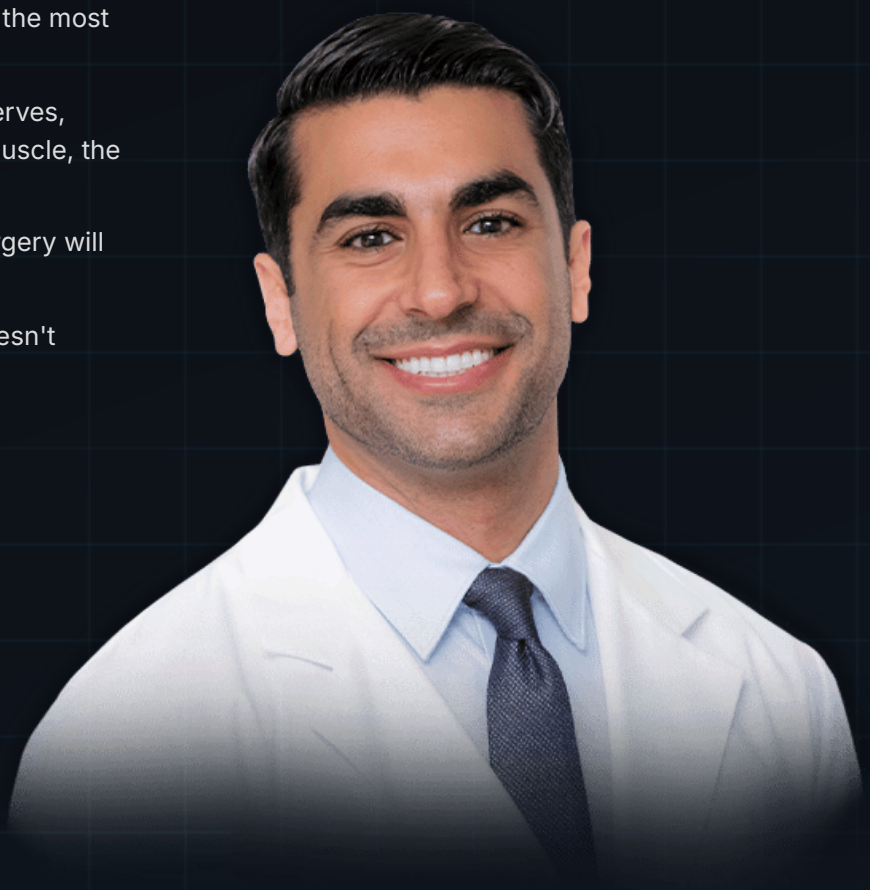
FREE GUIDE

CHRONIC TESTICULAR PAIN

Testicular pain is real.

A normal ultrasound does not mean that everything is alright. It just means that we haven't looked at the right thing quite yet.

- Why a normal ultrasound doesn't rule out the most common cause
- The causes a standard workup misses: nerves, vasectomy, hernia mesh, the cremaster muscle, the pelvic floor
- The in-office test that tells us whether surgery will work
- What changes after surgery, and what doesn't
- Three questions to ask any surgeon



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01 START HERE

A normal ultrasound doesn't mean nothing is wrong.

If you've been experiencing testicular pain for months, even years, I want to tell you that the pain is real. You're not crazy, and you're not imagining things.

Most men with chronic testicular pain have seen about 3 to 4 doctors by the time they see me, and all of them have been told the same thing: everything is fine. Usually that's because the ultrasound came back normal.

Ultrasounds are great. They help us find tumors, twisted testicles, fluid collections, even large varicoceles. So the ultrasound definitely does play a role. But for a lot of men with testicular pain, the problem is not going to show up on the ultrasound, because it's the nerves that run through the spermatic cord that are causing the pain. There's no ultrasound, there's no imaging that we could do, to identify these nerves.

WHAT AN ULTRASOUND CAN FIND

Structural problems

Tumors, a mass or lump, twisted testicles, fluid collections, even large varicoceles.

WHAT IT CAN'T FIND

Nerve pain

Nerve pain or nerve irritation, a very, very common cause of chronic testicular pain. The ultrasound does not show those nerves.

THE SHORT VERSION

A normal ultrasound is incredibly common in men with chronic testicular pain. It doesn't mean that there's nothing wrong. It just means that what is wrong cannot be found on the ultrasound.

02 THE RUNAROUND

Antibiotics, anti-inflammatories, then "it's in your head."

Guys will typically get a number of rounds of antibiotics, because the doctor thinks it's epididymitis or an infection. They get two to three rounds, no help. Then they get an anti-inflammatory medication. Again, no help. At that point, they're told it's just in their head, because all the imaging is normal.

But there's more to it than the ultrasound. You need a physical exam to reproduce the pain and find exactly where it is, and then a diagnostic nerve block. Having a normal ultrasound with testicular pain does not mean it's all in your head. There are solutions for this.

03 WHAT IT IS

Chronic testicular pain, defined.

We define chronic testicular pain as pain lasting at least about three months. It could be a dull, achy pain. It could be a sharp pain. It could be in the testicle or in the spermatic cord. It could even radiate up to the lower abdomen and sometimes into the penis itself.

It affects about 100,000 men every year. Most of them have seen numerous doctors, primary care doctors, even some urologists, and have had urine tests, ultrasounds, even CT scans and MRIs. And they've all been told a lot of the same thing.

04 WHERE THE PAIN COMES FROM

The key is finding the source.

Once we identify the source of the pain, we know how to treat each one. These are the common ones:

NERVES
Nerve irritation
A very, very common cause, and the one an ultrasound cannot show.

VASECTOMY
Post-vasectomy pain
Pain that lasts months after a vasectomy. It's real, and it has a name.

PRIOR SURGERY
Hernia repair
The mesh, or scar tissue, can irritate the nerves around the spermatic cord.

MUSCLE
The pelvic floor
Tight pelvic floor muscles can refer pain into the testicle and groin.

VEINS
Varicocele
Dilated veins in the scrotum. Unlike nerve pain, this one shows up on ultrasound.

OTHER
Infection or the spine
Epididymitis, an old injury, or pain referred from the spine.

The next pages go through the ones that most often get missed.

WATCH ME EXPLAIN IT
Testicular pain: the causes, and the one most doctors miss
Scan with your phone camera, or **tap here** to watch on YouTube.

05 AFTER A VASECTOMY

Still in pain months after your vasectomy?

A vasectomy is an invasive procedure, and you're going to experience some pain afterwards, sometimes for days, sometimes for weeks. But if it persists for months, usually at least three, it qualifies as post-vasectomy pain syndrome. It's a real diagnosis, and it's something we treat quite regularly. There are three common causes:

1. **Back pressure in the testicle.**
   The testicles keep making sperm. When you cut off that outflow, it builds up congestion, and you can get pain as a result.
2. **Irritated nerves.**
   During the vasectomy, nerves within the spermatic cord can get irritated or tied off, and they can start to fire off pain signals.
3. **A sperm granuloma.**
   A small lump that forms next to the vasectomy site and causes irritation and inflammation.

First we try anti-inflammatory medications. Then a spermatic cord block, which numbs those nerves and helps us determine whether this is congestion-type pain or nerve irritation. That tells us whether you're a candidate for a vasectomy reversal to address the pain, or a microsurgical spermatic cord denervation for the nerve pain. A granuloma can also be removed. You don't have to live with this for years and years.

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06 AFTER A HERNIA REPAIR

Your hernia is fixed, so why does your testicle hurt even worse?

Many patients who have had inguinal hernias fixed, with mesh and sometimes without, experience worsening pain in the groin or testicle that won't go away, months after surgery. When the mesh sits around the spermatic cord, it can irritate the nerves there, the genitofemoral nerve for example, which travels down to the scrotum and the testicle. If that nerve gets irritated or trapped in scar tissue, you really feel it in the testicle, even a perfectly healthy one.

We use nerve medication, sometimes targeted nerve blocks, and in the right patient, a microsurgical denervation of the spermatic cord. A lot of times I work alongside the hernia surgeons.

07 A TESTICLE THAT PULLS UP

Does your testicle keep pulling up, and it hurts?

This is called a hyperactive cremaster muscle. The cremaster muscle wraps around the spermatic cord, and its job is to raise and lower the testicle to keep it at the right temperature. For some men, that muscle is overly active. The testicle shoots up towards the groin when you're exercising, when it's cold, when you're sitting, even sometimes with light touch, and it causes a cramping, achy pain that comes and goes.

It's often missed. Even urologists will miss this. The ultrasound and the exam come back normal. Sometimes doctors will even do a surgery to pull the testicle down and attach it to the scrotum when it isn't needed. The options are pelvic floor physical therapy, medications, and sometimes a cremaster muscle release.

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08 THE PELVIC FLOOR

Men have a pelvic floor too.

The male pelvic floor is a thick layer of muscle between your hips, involved in urination, defecation and ejaculation. When it's tight, the pain can radiate into the groin, the scrotum, the lower abdomen, even down into the legs, and sometimes to the tip of the penis. Because the pain is so different for each guy, it can be elusive to diagnose, and a lot of patients get the runaround.

Once it's diagnosed, the treatment is relatively straightforward: anti-inflammatory medications, warm baths, things that help relax that muscle. Even muscle relaxers can help.

> **One thing you don't want to do is Kegel exercises. Kegels can definitely worsen pelvic floor dysfunction.**

WHEN TO GO TO THE ER

Sudden, severe testicle pain is an emergency. If the pain starts suddenly, especially with nausea, vomiting or swelling, go to the emergency room. Testicular torsion, a twisted testicle, needs treatment within hours. This guide is about pain that has lasted for months.

09 HOW I EVALUATE IT

What happens when you come see me.

1. **A good history.**
Where is the pain located? Is it sharp? Is it dull? Is it achy? Where does it radiate to? What makes it better? What makes it worse? Anything in the past that may have caused it? All of this builds a picture of what's going on.

2. **A physical exam.**
We see where the pain is located: the spermatic cord itself, maybe higher up into the lower abdomen, sometimes the testicle. Sometimes there's a hernia causing the pain. The goal is to find where the pain is localized and where it radiates.

3. **An ultrasound, if you've never had one.**
To see what's going on structurally in the testicle and rule out masses, lumps, infection or a varicocele.

10 BEFORE SURGERY

We don't jump straight to surgery.

We do everything before we get to surgery. What does that mean?

STEP 1
Anti-inflammatories, for weeks
Not for three days, not for five days. Anywhere from three to four weeks, to reduce that inflammation and see if it helps.

STEP 2
Nerve medication
Neuromodulation therapy, drugs like gabapentin, which can help address the nerve pain. A great place to start.

STEP 3
The pelvic floor
Pelvic floor dysfunction can cause testicular pain, so we address it to see if that helps as well.

Once patients have tried these things and there's still no benefit, we do something called a spermatic cord block in the office.

11 THE TEST THAT DECIDES

The spermatic cord block.

Before I ever recommend surgery for chronic testicular pain, I do one injection in the office. It tells us whether surgery will work for you.

I numb the skin and inject a numbing agent like lidocaine, plus a steroid, directly around the spermatic cord, where those painful nerve fibers are. It takes anywhere from three to five seconds.

Once the injection is in, the main question is: did the pain go away? Most guys will have an answer within five minutes.

IF THE PAIN GOES AWAY

Those nerves are the cause.

You're a great candidate for a microsurgical spermatic cord denervation, because the surgery targets the same nerves we just numbed.

IF IT DOESN'T

The nerves aren't the cause.

That helps us avoid an unnecessary surgery, and we keep working to find what is causing your pain.

WHY IT MATTERS

The spermatic cord block is the single biggest predictor of whether or not a microsurgical spermatic cord denervation will work. I do this for all my patients before the surgery.

12 ONE PATIENT'S STORY

Four doctors. Three to four years.

I had a patient in his early twenties with testicular pain on his left side for about three to four years. He'd seen about four doctors, his primary care doctor and some urologists. He'd done numerous rounds of antibiotics and numerous ultrasounds. Everything came back negative, and they basically told him to live with it. In his early twenties, which is crazy.

When he came to me, I did an exam and was able to reproduce the pain right at the spermatic cord. Then I did a spermatic cord block. The numbing lasted about two hours, which told us he was a great candidate for surgery. He had the microsurgical spermatic cord denervation, and within about two to three weeks he was basically pain-free. His pain went from about seven to eight out of ten to about zero to one.

One patient's experience. Results vary from patient to patient.

13 THE SURGERY

Microsurgical spermatic cord denervation.

The spermatic cord is a bundle. On the outside are the cremaster muscle and some of the nerves that carry the pain fibers. Inside the cord are the structures we protect:

1. **The testicular artery.**
   It carries blood flow to the testicle and keeps it healthy.
2. **The lymphatics.**
   They drain fluid from the testicle.
3. **The veins.**
   The ones that can get dilated when you have a varicocele.
4. **The vas deferens.**
   The tube that carries sperm from the testicle to the outside world.

The whole point is the word microsurgical. Under the microscope we can see every single part of the spermatic cord, isolate those four structures, and separate and cauterize the painful nerve fibers, so the pain signal stops traveling from the testicle back to your brain.

> **Using a microscope for this surgery is not optional. It's the reason why the surgery works and it's the reason why the testicle survives.**

TIME
45 minutes to an hour per side
An hour and a half to two hours if we do both sides.

SETTING
Outpatient
You go home the same day.

PAIN CONTROL
Tylenol and Advil
Sometimes I add gabapentin for the nerve pain.

WATCH THE FULL WALKTHROUGH
Chronic testicular pain and microsurgical denervation, start to finish
About 12 minutes. Scan, or **tap here** to watch on YouTube.

14 THE MOST COMMON QUESTION

What changes, and what doesn't.

WHAT DOESN'T CHANGE

Your erections don't change. Your testosterone levels don't change. Your fertility doesn't change. Your sensation doesn't change.

It's in close proximity to your penis, but it doesn't touch your erections, penile sensation, orgasms, testosterone levels or fertility.

Patients also ask: is my testicle just going to be numb? The answer is no. You still have sensation in the testicle. We're cutting the nerve fibers that transmit pain, not the ones involved in sensation itself.

15 RECOVERY

- **Keep the scrotum supported** for at least one week, sometimes two. The more the testicles hang after surgery, the more they hurt. I provide scrotal support for those first couple of weeks.
- **No sex and no exercise for at least one to two weeks.** When you start again, start slow and listen to your body.
- **The pain doesn't always go away immediately.** Some of those fibers can keep transmitting for a while, so it can take two to four weeks for the pain to slowly resolve.

16 OUTCOMES

My goal is to get you as close to pain-free as possible. No matter where you were on a zero to 10 scale before surgery, I try to get you to zero to one on a daily basis. What I tell patients: **about 80 to 90% of the time, we're able to get you to pain-free.** For the other 10 to 20%, we get a significant improvement, to where it doesn't impact your quality of life.

The outcomes are good because of careful patient selection. If the cord block does not work for you, you are not a candidate for denervation. You need an alternative.

The risks, like any surgery, are bleeding, infection and damage to nearby structures (the artery, vas deferens, veins and lymphatics). The microscope keeps the bleeding risk low and lets us see and protect those structures, and we give antibiotics before surgery to minimize infection.

17 PUTTING IT TOGETHER

The path, from first visit to pain-free.

STEP 1
Visit, in person or by video
History, plus any labs and imaging you've already had.

STEP 2
Exam
Reproduce the pain and find where it lives. Ultrasound if you've never had one.

STEP 3
Treat it first
Anti-inflammatories for 3 to 4 weeks, nerve medication, the pelvic floor.

STEP 4
Cord block
Did the pain go away? Most guys know within five minutes.

STEP 5
Denervation
Only if the block worked. Outpatient, same day home.

18 CHOOSING A SURGEON

Three questions to ask any surgeon.

Like anything else in surgery, you want to go to a surgeon who does this a lot.

1. **How many of these do you do?**
   The more they do, the more experienced they are. I do a couple of these every month. I think that's a good place to start.

2. **Are you fellowship-trained in male fertility?**
   I did an additional year of training after my urology residency, where we learned the intricacies of this surgery.

3. **Do you do a diagnostic spermatic cord block before surgery?**
   It separates the patients who are good candidates from the ones who aren't. If they're not doing the cord block, you may or may not have a good outcome.

ABOUT WHO WROTE THIS

I'm Dr. Justin Houman.

I'm a board-certified men's health urologist and assistant professor of urology at Cedars-Sinai Medical Center in Los Angeles. I practice at Tower Urology.

When I was in residency, very few urologists specialized in men's health. Men's health is really three buckets: sexual health, fertility health and hormonal health. These are the things that bring men to the doctor for the first time. Men won't tell you when they have high blood pressure, but they'll tell you when they can't get an erection.

A typical urology visit is no more than ten minutes. Patients are meant to be pushed through, not dug into to figure out what is actually going on. My practice is different. I like to figure out what the cause is, so it has better long-term outcomes. Being at Tower Urology at Cedars-Sinai, I have the background of an academic medical center, but with my own practice inside it I'm not on a corporate clock.

TRAINING

Fellowship-trained microsurgeon

Board-certified urologist with fellowship training in male reproductive medicine and microsurgery.

VOLUME

1,000+ varicocelectomies, 800+ implants

Microsurgery for fertility, pain and sexual health is a big part of my practice.

RECOGNITION

Super Doctors® Rising Stars℠

Selected for inclusion in 2027 Southern California Super Doctors® Rising Stars℠, Urology.

DESIGNATIONS

Centers of Excellence

Endo Xiaflex Center of Excellence (Peyronie's) and Boston Scientific AMS 700 Center of Excellence (penile implants).

VISITS IN PERSON OR BY VIDEO

You don't have to live in Los Angeles.

Telehealth is how a lot of my patients actually start. The first visit for a lot of patients, especially patients who are outside of Los Angeles, is a video call from home. We go through your symptoms, your history, and any labs or imaging you've had. Sometimes patients send those in beforehand. A lot of patients come to me for second opinions on results from other urologists, and we figure out what's missing, what hasn't been done. Many times an exam needs to be done in person before figuring out the next steps.

YOUR NEXT STEP

You don't have to live with this.

If you're experiencing chronic testicular pain, seeing somebody who knows how to address it and how to treat it appropriately will help, because we do have good options for it. I have patients from the city, the state, the nation, even sometimes internationally.

REQUEST A VISIT

Book online

Scan, or tap here.
houmanmd.com/contact

CALL MY OFFICE

310-854-7822

Monday to Friday, 8:30am to 5pm
Tower Urology at Cedars-Sinai

Not in Los Angeles? If distance is what's stopping you from coming to see me, a video visit is a great alternative.

BEFORE YOU BOOK

I see patients Wednesday through Friday, and new-patient openings are limited each week.

One practical note so there are no surprises: I'm in-network with Medicare. Other insurance is out-of-network, and my office provides a superbill you can submit to your plan for reimbursement. My team will walk you through costs before you book anything.

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This guide is for education only and is not medical advice. Reading it does not create a doctor-patient relationship. Every patient is different; talk with a qualified physician before making medical decisions.