

EDITORIAL COMMENT

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The authors have provided an excellent review on “Should we investigate every patient with haematospermia”. Haematospermia has been recognized for centuries [1]. It is an anxiety-provoking but almost always is an otherwise self-limited condition that is rarely associated with significant underlying pathology. With the advent of newer imaging modalities, physicians are able to reassure patients who are concerned about a malignancy which may be the cause of the haematospermia [2, 3]. The real question is which patients should have any further testing like imaging to determine if there is an underlying etiology for the blood in the ejaculate. Most men with haematospermia are young (<40 years of age), and the blood is self-limited and requires no further evaluation or treatment other than reassurance. However, occasionally haematospermia can be due to an inflammatory or infectious process. Workup in these patients may include a urinalysis and testing for sexually transmitted infection, with antibiotics as

indicated [4, 5] In men 40 years and older, screening for prostate carcinoma might be considered although the chance that the blood is related to prostate cancer is quite low. A review of 11 published series by Ahmad et al. [6] showed that 33 (3.5%) genitourinary tumors were identified out of 935 cases of men investigated specifically for haematospermia. Prostate cancer accounted for 25 (2.6%) cases. All of these men were older than 40 and presented with either continuous or recurrent haematospermia.

Urology referral should be considered for patients with recurrent haematospermia or troublesome associated symptoms or findings. TRUS is a safe and effective first-line investigation that can be used to visualize the seminal vesicles, ejaculatory ducts, vas deferens and prostate [7]. Nevertheless MRI is superior to TRUS for detecting blood within the seminal vesicles and prostate [8]. Cystourethroscopy is recommended in patients with concurrent haematuria.

References

1. Marshall VF, Fuller NL. Hemospermia. *J Urol.* 1983; 129: 377–378.
2. Papp GK, Kopa Z, Szabó F, Erdei E. Aetiology of hemospermia. *Andrologia.* 2003; 35: 317–320.
3. Torigian D, Ramchandani P. Hemospermia: imaging findings. *Abdom Imaging.* 2007; 32: 29–49.
4. Mulhall JP, Albertsen PC. Hemospermia: diagnosis and management. *Urology.* 1995; 46: 463–467.
5. Han M, Brannigan RE, Antenor JA, Roehl KA, Catalona, WJ. Association of hemospermia with prostate cancer. *J Urol.* 2004; 172: 2189–2192.
6. Ahmad I, Krishna NS. Hemospermia. *J Urol.* 2007; 177: 1613–1618.
7. Yagci C, Kupeli S, Tok C, Fitoz S, Baltaci S, Gogus O. Efficacy of transrectal ultrasonography in the evaluation of hemospermia. *Clin Imaging.* 2004; 28: 286–290.
8. Cho IR, Lee MS, Rha KH, Hong SJ, Park SS, Kim MJ. Magnetic resonance imaging in hemospermia. *J Urol.* 1997; 157: 258–262. ■

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