Promoting the Testicular Self-Exam as a Preventative Health Care Strategy: Do Diagrams Make a Difference?

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Even though the threat exists for developing testicular cancer, most men remain completely unaware of the risk and are not performing the testicular self-examination procedure on a regular basis. The current study attempts to test the effectiveness of educational and instructional materials developed for the purpose of teaching men how to perform the TSE. A central question that arises when such an educational project of this nature is undertaken concerns the nature of the depiction of the TSE in diagrams. After exposure to diagrams varying in their degree of detail, men’s reactions concerning TSE attitudes and intentions were assessed. Results indicate that the “no-diagram” condition was found to produce the most favorable reaction to the messages. Implications for the findings are also discussed.

Key Words: testicular cancer, testicular self-examination, men’s health, masculinity, message design, diagrams

Testicular cancer is the most common malignancy afflicting American white males ages 20-34. Furthermore, it is the second most common malignancy for American men ages 15-19 and 35-39 (Brown, 1996). In 1999 alone, the American Cancer Society estimated that approximately 8,000 cases of testicular cancer were diagnosed in this country. Worldwide, Scandinavian countries have the highest rates, in some cases 45 times greater than for white males in the USA. The lowest rates are

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found in men living in African nations (Bosl & Motzer, 1997; Bosl, Bajorin, & Sheinfeld, 1997; Parkin, Muir, & Whelan, 1992). In fact, the rates of testicular cancer in American white men is six times that for African-American men (Ries, Miller, & Hankey, 1994). Even more alarming is that incidence rates have doubled over the past two decades, rising 51% from 1973 to 1995 (Pharris-Ciurej, Cook, & Weiss, 1999). Overall, testicular tumors have a 96% malignancy rate (Sandella, 1983) leading to the deaths of approximately 400 American men each year (Testicular Cancer, 1990). Among men 18-35, testicular cancer leads to more cancer related deaths than any other non-AIDS related cancer, accounting for 19% of all cancer deaths in this age group (Dachs, Garb, White, & Berman, 1989). The good news is that from 1983 to 1990, testicular cancer survival rates increased to 94% (Brown, 1996), but the bad news is that half of all men diagnosed with this form of cancer seek medical attention after the cancer has spread to other areas of the body, dramatically complicating the chances for survival (Cummings, Lampone, Mettlin, & Pontes, 1983). However, one important key to limiting the serious consequences of this form of cancer is the early detection of the cancerous testicular tumors before metastasis has occurred.

Even though adolescent and young adult men face a risk for developing testicular cancer, most men remain uninformed about this disease and fail to engage in regular testicular self-examination (TSE) practices. A series of studies has repeatedly found that less than 10% of all American men perform the TSE on a regular basis, a performance rate similar to men in other countries (Blesch, 1986; Katz, Meyers & Walls, 1995; Morman, 2000). However, ironically, men themselves discover most testicular tumors, either by accident or by performing the self-examination procedure. One study found that only 4% of testicular tumors are detected by physicians, and usually when performing an exam for other reasons such as a work-up for infertility (Sandella, 1983). For a variety of reasons, young men do not appear to recognize the life-threatening nature of this cancer or the utility of performing the TSE. Ganong and Markovitz (1987) suggested adolescent males believe in a false sense of immunity to disease, do not avail themselves to persons who could educate them about this type of cancer or performing the TSE, and may believe that touching their own genitals is “unmanly” or confuse it with homosexuality. They also suggest a lack of awareness about testicular cancer among health care providers could explain why there is a knowledge deficit about testicular cancer among many men (see Stanford, 1987). Men offer a litany of reasons for failure to perform the TSE ranging from a lack of knowledge about testicular cancer and TSE performance to forgetfulness, laziness, and harboring the belief that testicular cancer is not particularly threatening to their health (Blesch, 1986; Katz, et al., 1995; Ostwald & Rothenberger, 1985).

TSE MESSAGES

In comparison to breast cancer research, relatively little research has been done to discover ways in which to inform men about this threat and motivate them to begin regular performance of the TSE. The research to date has focused on ways to educate and motivate men to learn more about testicular cancer and then put this knowledge into action by beginning regular TSE performance. For example, studies have
found that men exposed to lectures and educational training sessions concerning testicular cancer and the TSE begin performance of the procedure at higher levels than men not exposed to such materials (Craun & Deffenbacher, 1981; Ganong & Markovitz, 1987; Steffen, 1990). The efficacy of written materials and instructional videos has also been compared, with most men preferring written messages to video instruction (Finney, Weist, & Friman, 1995). The source credibility of the message sender has been assessed as well, with messages from actual survivors of testicular cancer being evaluated as more believable and motivational than messages from doctors or anonymous sources (Marty & McDermott, 1985; 1986). When men have had the chance to practice the TSE procedure on lifelike models, their compliance rate with the TSE was found to be higher than for men who only received a lecture about TSE performance (Steffen, Sternberg, & Teegarden, 1994). The positive or negative framing of TSE messages has also been assessed (Steffen, 1990), as well as fear-based, fact-based, or narrative-type messages (Morman, 2000), and messages designed with either an altruistic or egoistic motivational orientation (Morman, 1998). However, to date, no research has been conducted on how detailed visual depictions of the TSE can or should be (i.e., the appropriateness of actually depicting the TSE procedure in diagrams to accompany written messages describing how to perform the TSE). While Friman and his colleagues (1986) found that men prefer a brief, yet specific checklist of how to perform the TSE procedure over more detailed instructions, no study has attempted to assess the impact of using visual diagrams designed to accompany written messages concerning TSE performance.

**Using Diagrams**

The literature on the usefulness and efficacy of picture or diagram usage in educational and/or instructional messages is very well developed (see Kobayashi, 1985, for a bibliography of 703 studies from 1973 through mid-1984 alone). The use of diagrams has been found to be more effective for student learning and retention than the use of text alone (Holliday, 1976). Further, a series of studies have found that using diagrams along with a text message improves recall and analogical reasoning (Beveridge & Parkings, 1987), task completion and analytical processing (Winn, 1988), problem solving (Ferguson & Hegarty, 1995), and the understanding of sequential (Guri-Rozenblit, 1988), spatial (Winn, Li, & Schill, 1991), and causal/dynamic relationships (Gobert & Clement, 1999). The persuasive usage of diagrams as visual evidence in courtroom proceedings has also received attention. For example, the use of photographic evidence has been associated with the rewarding of higher monetary damage awards in personal injury lawsuit cases (Whalen & Blanchard, 1982). Several investigations have been conducted which suggest that responses to such visual cues may indeed affect the judgements of both jurors (DeJong & Hogue, 1978) and witnesses (Buckout, 1974; Buckhout, Figueroa, & Hoff, 1975; Johnson, 1978). Furthermore, still other evidence finds that visual aids designed to supplement and clarify a persuasive message can affect credibility and attitude change (Seiler, 1971).

These message design issues raise important questions concerning the content and presentation of messages promoting the TSE with men, issues that must be
addressed in order to discover which message types are best received by the men who encounter them. Therefore, the current study proposes an investigation of messages and diagrams designed to promote TSE education and performance. In light of the nature of this form of cancer and its location within the male genitals, the basic question becomes how much diagram detail is enough to properly educate men on how to actually perform the TSE. The goal of the current study is to determine the effect of altering the degree of detail of diagrams concerning TSE promotion and education with a male audience. Therefore, the first two research questions addressed by this study will be:

RQ1: Will men react differently to drawings varying in the detail of their presentation of the TSE procedure?

RQ2: What effect, if any, will varying the detail of depictions of the TSE have on men’s attitudes and intentions concerning performing the self-exam?

MASCULINITY

In light of the highly sensitive and personal nature of this form of cancer and the effects of traditionally held views of masculinity on men’s overall health beliefs and behaviors, messages promoting the TSE face additional challenges to their ability to educate and motivate men to begin its performance. For most men, issues of masculinity, homophobia, and self-concept become important if for no other reason than because they may threaten the willingness of many men to pay attention to, much less process, messages promoting male sex organ health. The traditional masculine gender role is often characterized by restrictive emotionality, a preoccupation with success, the inhibited expression of affection, a need for control and power, a competitive orientation to life, homophobia, and a fear of appearing feminine (Doyle, 1995; Herek, 1987; O’Neil, 1981; Pleck, 1987). Skord and Schumacher (1982) called masculinity a “handicapping condition” when it comes to seeking medical or psychological help, and Harrison (1978) warned the male gender role is “dangerous to your health.” A well-established body of literature has found that, compared to women, men report not needing a general physician or specialist and do not have as much faith as women in the value of preventative medical care (Cleary, Mechanic, & Greely, 1982). Even when childbirth visits are not counted, men still do not use medical services as much as women do (Green & Pope, 1999). Furthermore, men spend less time in hospitals and are admitted to them at lower rates than women (Boehm, Selves, & Raleigh, 1993). Men report that they can and do ignore pain and do not “give in” to illness (Verbrugge, 1980, 1982), all in an apparent attempt to maintain the perceived expectancies of the male gender role.

Traditionally held views of masculinity have been linked to a number of startling health related statistics. For example, men’s life expectancy is seven years less than women’s, men have greater mortality from heart disease, men have higher rates of injury from accidents, higher suicide rates, and higher rates of alcohol abuse (Courtenay, 2000; Mathers, 1995). The masculine stereotype portrays men as strong
and independent, characteristics that many argue are playing a role in male socialization to conceal vulnerability and consider themselves invulnerable to health concerns and injuries (Davies et al., 2000). Studies have found that men tend to underestimate the risks associated with a variety of health-related issues, including exposure to the sun, reckless driving, physically dangerous activities, and sexually transmitted diseases (Mermalstein & Riesenberg, 1992; Weissfeld, Kirscht, & Brock, 1990; Zuckerman, 1994). Other studies on risk perception have argued that many young men deny the effects of their behavior on their current and future health (Blesch, 1986; Flynn, Slovic, & Mertz, 1994). Thus, the outcome appears to be that men have less knowledge of basic health information and, when compared to women, are less likely to engage in health-promoting behaviors. Furthermore, this perceived invulnerability is associated with men’s failure to adopt positive health behaviors, such as performing the TSE on a regular basis. In light of the focus of the current study, men are less likely to perform the TSE than women are to perform breast self-examinations (Katz, Meyers, & Walls, 1995). Additionally, traditional beliefs about masculinity were found to be negatively correlated with men’s positive attitudes and intentions toward TSE performance, such that the more a man held firm to the beliefs that he must be tough and avoid the appearance of femininity, the less likely he was to perform the TSE (Morman, 2000).

Clearly, the construct of masculinity is multi-faceted and complex, and over the last few decades views on traditional masculinity have been challenged and criticized as being too narrow or constricting in their approach. And while certainly perceptions of masculinity have been changing in our culture, it still appears, based on the research noted above and in other sources, that it is the traditional view of masculinity that is most related to the negative associations found between men and health-related/promoting behaviors. Therefore, in light of the overall negative impact of traditional masculinity on men’s overall health beliefs and attitudes, the following hypothesis is offered: Regardless of the level of diagram detail, masculinity will be negatively correlated with attitudes and intentions concerning TSE performance.

METHOD

PARTICIPANTS

Male undergraduate students were recruited from communication courses at a private university in the southwest. A total of 75 men participated in this study. The men ranged in age from 20 to 24 (M = 21.71, SD = 1.03). Nearly all the participants were Caucasian (96%), 2% were African-American, and 2% were Hispanic. All participants held at least a high school degree and had completed some college coursework. Finally, none of the respondents had been diagnosed with testicular cancer. Consistent with extant findings from previous studies, many of the men in this study had heard about the TSE (70%), but only 7.7% reported performing the TSE on a monthly basis. While 82.7% of these men correctly responded that the TSE should be performed once a month, 55.8% reported they never performed the TSE.
PROCEDURE

Participants were told they were going to be evaluating messages promoting testicular cancer and TSE education and awareness that are being developed for use on college campuses. Each man was randomly assigned to one of three message conditions and asked to read his particular message carefully, underlining any passages he believed to be particularly important or relevant. After reading the message, each participant was asked to respond to a series of questions that probed his personal reaction to what he had just read. To ensure the student’s privacy while he examined and responded to these materials, each questionnaire was distributed to participants in large, unsealed envelopes. The participant was asked to take the survey home, fill it out, place it back in the envelope, seal it, and then return it. Because of the sensitive nature of some of the questions, anonymity was guaranteed. Research participation credit was offered for the student participants who returned their completed surveys.

MESSAGE DESIGN

Three messages were developed for the purpose of this study. Message one contained only written information about testicular cancer and TSE performance (i.e., Message-Only Group). Message two contained exactly the same information of message one but was accompanied by rather vague, black-and-white line drawings depicting TSE performance (i.e., Moderate Diagram Group). Finally, message three contained the same information as the other two messages; however, the black and white diagrams depicting TSE performance that accompanied this message were much more detailed than those presented in message two and were similar to drawings found in a human anatomy textbook (i.e., Detailed Diagram Group). Each message contained accurate and truthful information about testicular cancer and the TSE using information supplied by the American Cancer Society. The messages contained brief, bulleted statements about testicular cancer, its symptoms, who is susceptible to this form of cancer, and how to perform the TSE. The text was presented in a column on the left side of the page with the diagrams placed on the right side of the page (see Appendices A, B, and C for each of the three messages).

DEPENDENT MEASURES

After exposure to their message, participants were asked a series of questions designed to evaluate their responses to what they had just read. In all cases, seven-point Likert-type response formats were used to assess participant’s reactions. Three dependent variables were assessed in this study. First, respondent reactions to the diagram drawings were measured by having participants rate the following mood adjectives (“not at all” to “extremely”): uncomfortable, uneasy, embarrassed, disgusted, and unpleasant. These five items were averaged together to get an overall respondent reaction index (alpha = .87). Second, attitudes toward actual performance of the TSE were sought with four semantic differential scales (e.g., “bad/good,” “undesirable/desirable,” “unfavorable/favorable,” and “not important/important”). The overall alpha for the averaged scale was .82. Third, intention to
perform the TSE in the next 4-6 weeks was measured with three questions, e.g., “I plan to perform the testicular self-exam during the next month” (“strongly disagree” to “strongly agree”). The overall alpha for the averaged scale was .91.

A few other related items were also assessed. The components of susceptibility and severity were measured with several items each. Three items measured perceived susceptibility to testicular cancer, with questions such as, “When I think about contracting testicular cancer, I feel:” (“completely immune” to “highly susceptible”). The three items were averaged together to create an overall susceptibility index (alpha = .85). Four items measured the perceived severity of testicular cancer with questions such as, “How likely is it for a man to die if he develops testicular cancer?” (“completely impossible” to “highly likely”). These four questions were averaged together to create an overall severity index (alpha = .60).

The perceived efficacy of the TSE was measured with five items. Efficacy was assessed with questions such as, “This message leads me to believe the testicular self-exam will detect testicular tumors:” (“strongly agree” to “strongly disagree”). The five efficacy items were averaged together to create an overall efficacy index (alpha = .63). Also, a three-item learning scale was created to assess whether respondents thought they had learned a lot from reading their message about testicular cancer. The three items were averaged together to create an overall learning scale (alpha = .80).

Finally, the Richmond and McCroskey (1990) Assertiveness/Responsiveness Scale was used to assess gender role orientation. This instrument consists of a list of 10 characteristics typically associated with masculinity (e.g., independent, forceful, dominate) (alpha = .91) and 10 items typically associated with femininity (e.g., helpful, gentle, warm) (alpha = .89). Respondents rated each item to the extent that it was “not at all like me” to “very much like me.” Overall alpha for the combined gender scale was .90.

RESULTS

The first research question asked if the men in this study would react differently to drawings varying in their detail of presentation of the TSE procedure. A univariate analysis of variance test of between-subjects effects for reactions to the diagrams found that there were significant differences between the three message groups of the study, \( F(1, 74) = 7.39, p = .002, \) eta squared = .23. Student-Newman-Keuls (SNK) post hoc follow-up testing revealed that significant differences were found between all combinations of the groups. The message-only group (\( M = 1.22, SD = .44 \)) was found to be significantly different from both the moderate-diagram group (\( M = 1.59, SD = .69 \)) and the detailed diagram group (\( M = 2.27, SD = 1.19 \)). (Note: with this dependent variable, the lower the mean, the more favorable the response.) Additionally, the moderate diagram group was found to be significantly different from the detailed-diagram group. Taken together, the men in this study were found to have the most favorable reaction to the message with no diagrams included and rated the message with a high degree of diagram detail the least favorable of the three types.

The second research question asked what effect, if any, will varying the detail
of diagram depictions of the TSE have on men’s attitudes and intentions concerning performing the self-exam. A univariate analysis of variance test of between-subjects effects found that for attitudes toward TSE performance, there were significant differences between the three groups, $F(1, 74) = 3.42, p = .04$, eta squared = .12. SNK post hoc follow-up testing revealed that significant differences were found between the message-only group ($M = 6.10, SD = .93$) and the detailed diagram group ($M = 5.25, SD = 1.27$). Further, significant differences were also found between the moderate-diagram group ($M = 6.03, SD = .95$) and the detailed-diagram group. Thus, these results reveal that for attitudes toward actual TSE performance, the message with no diagrams generated the most favorable attitude rating, while the message with detailed diagrams received the least favorable attitude rating.

For intentions to perform the TSE, another univariate analysis of variance test of between-subjects effects was conducted. Results indicated that there were significant differences between the three groups, $F(1, 74) = 4.35, p = .05$, eta squared = .49. SNK post hoc follow-up testing revealed that significant differences existed between the message-only group ($M = 5.31, SD = .95$) and the moderate diagram group ($M = 5.09, SD = 1.02$). Further, differences were discovered between the message-only group and the detailed-diagram group ($M = 4.63, SD = 1.13$). Finally, differences were also found between the moderate-diagram group and the detailed-diagram group. Taken together, these results indicate that for intention to perform the TSE, the message with no diagrams generated the most favorable intentions, while the message with detailed diagrams received the least favorable intention rating.

Finally, hypothesis one predicted that regardless of the level of diagram detail, masculinity would be negatively correlated with attitudes and intentions concerning TSE performance. First, an overall correlation matrix was created with all three-message groups collapsed together. In this condition, masculinity was not significantly correlated with any of the three main dependent variables of the study. The only variables masculinity was significantly correlated with were perceived efficacy of the TSE, $r(75) = .293, p < .05$, and severity of testicular cancer, $r(75) = .295, p < .05$. Thus, the more masculine respondents rated themselves, the more severe they found testicular cancer to be and the more efficacious they believed the TSE to be in detecting testicular tumors. Hypothesis one is not supported.

In order to further probe the effects of masculinity on the three main variables of the study, separate correlations were conducted for each individual message group. For the detailed-diagram group only, masculinity was positively correlated with attitudes toward the TSE, $r(25) = .451, p < .05$. Masculinity was also significantly correlated with the perceived efficacy of the TSE, $r(25) = .492, p < .05$. However, in the message-only group and in the moderate-diagram group, masculinity was not found to be significantly correlated with any of the variables of interest.

**DISCUSSION**

The primary goal of the current study was to assess the impact of altering the degree of detail of diagrams depicting the TSE procedure in messages promoting the regular performance of the self-exam for men. Three message conditions were created for the purposes of the study, and results clearly indicate the male participants who
encountered them preferred the no-diagram condition over the other two message conditions that included diagram depictions of the TSE. Not only did the no-diagram condition receive the most favorable overall reaction of the three conditions, it also generated the most favorable attitudes toward TSE performance and the most favorable intentions to actually perform the self-exam.

On all accounts, it appears that the men in this study felt the text-only description of how to perform the TSE was adequate enough and the addition of visual diagrams included to supplement and further reinforce learning the TSE procedure are not as needed. The implications of this finding may, in fact, actually be good news for those involved in the tricky business of trying to explain how to perform a self-exam on the male genitals without being offensive or even borderline pornographic. While our culture has become accustomed to public discussions and even demonstrations of breast-self-examination for women, the same cannot be said for testicular cancer and the TSE. The findings of the current study imply visual diagrams may not be needed to teach men how to perform the self-exam and actually may hinder the message’s effectiveness in terms of attitudes about and intentions to perform the TSE. Men’s discomfort at seeing the male genitals displayed in the TSE instructional diagrams perhaps is reducing the amount of time the messages are being processed, thus reducing the chances of forming more favorable attitudes and intentions about the self-exam. Uneasiness or maybe even embarrassment about the location and nature of this form of cancer perhaps is disconcerting to the men who encounter these types of messages. Thus, it may be that messages promoting the TSE can now find a broader and more public platform because the display of male genitalia in the messages does not appear to be necessary.

The finding that masculinity was not negatively correlated with attitudes and intentions concerning TSE performance is intriguing. As noted above, the negative effects of traditional views of masculinity on men’s health behaviors are well documented. While the findings from this study do not appear to support the extant research position on traditional masculinity’s negative influence on male health, a few supplemental findings appear to indicate the opposite effect. Both perceived efficacy of the TSE and severity of testicular cancer correlated positively with masculinity. Both of these findings make inherent sense when analyzed together. Because testicular cancer strikes at the core of what many men believe to be the center of their masculinity, i.e., their genitals, clearly any threat to this part of their body would also be seen as a significant threat to their masculinity, or perhaps to their ability to maintain the masculine role in a way deemed appropriate or necessary. Once threatened, men will look for a way to reduce the threat, and thus the efficacy of the TSE becomes part of the threat-reducing process (see Witte, 1992, 1994). In this way, traditional beliefs about masculinity, or better, threats to such masculine beliefs, actually serve as positive cues to action, i.e., to protect one’s masculinity. As Courtenay & Keeling (2000) note, reliance on traditional masculine characteristics, such as acting independently and being assertive and decisive, has been linked to the ability of men to cope with cancer (Gordon, 1995) and chronic illness (Charmaz, 1995). So, perhaps not all aspects of traditional masculinity are necessarily negatively related to male health behaviors, and some may actually help men take steps to protect their own bodies from the impact of diseases like testicular cancer.
CONCLUSION

In the age of managed care, messages of prevention and patients’ responsibility for their own health are central to the overall goals of health maintenance organizations. Additionally, because doctors are under increased pressure to save money, cut costs, and see more patients in less time, their ability to spend time educating patients about such behaviors as the TSE is severely constrained. Therefore, health-related written materials will become increasingly important as patients attempt to educate themselves about risks such as testicular cancer. Clearly, any message that is attempted faces important questions concerning design and presentation in order to meet the needs of both time-pressed physicians and uninformed male patients who must live within the current health-care environment in this country. Hopefully, the findings from this study will help to advance the cause of educating men about the risk they face for contracting testicular cancer and what they can do about such a threat.

REFERENCES

PROMOTING THE TESTICULAR SELF-EXAM


APPENDIX A: THE TESTICULAR CANCER SELF EXAMINATION (MESSAGE-ONLY GROUP)

The Testicular Cancer Self Examination

Who Gets Testicular Cancer?
Men who are more likely to get testicular cancer:
• Are white and young (15-35 years old)
• Have a father or brother who had testicular cancer
• Have a testicle that did not come down into the scrotum, even if surgery was done to remove the testicle or bring it down
• Have small testicles or testicles that are not shaped right

What are the signs of testicular cancer?
• A hard, painless lump in the testicle (the most common sign)
• Pain or a dull ache in the scrotum
• A scrotum that feels heavy or swollen

How do I perform the testicular self exam?

a. Check your testicles one at a time.
b. Cup your scrotum with one hand to see if you feel pain or tenderness.
c. Place your index and middle fingers under a testicle with your thumb on top.
d. Gently roll the testicle between your thumb and fingers.
e. Feel for any lumps in or on the side of the testicle. Repeat with the other testicle.
f. Feel along the epididymis for swelling.

It is normal for one testicle to be a little bit bigger than the other. The testicles should be smooth and firm.

The best time to do the exam is during or right after a warm shower or bath. The warm water relaxes the skin on your scrotum and makes the exam easier to perform.

Remember, if you feel any bumps or lumps, visit your doctor as soon as possible. Testicular cancer has a 94% survival rate if the cancer is caught early.
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