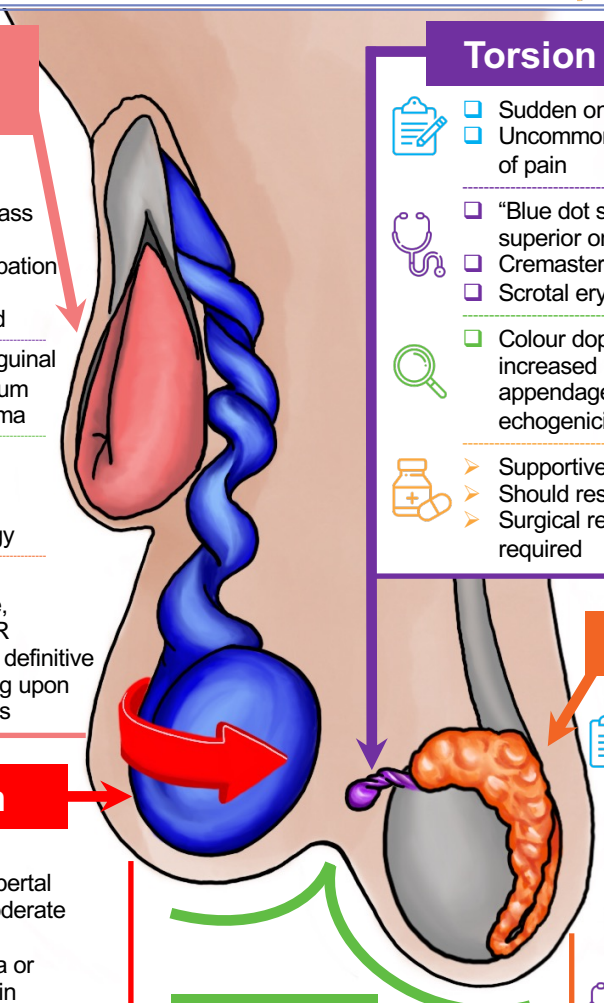
Scrotal Pain

History | Physical Exam | Investigations | Management



Incarcerated Inguinal Hernia

History
- Infants: irritable, crying, poor feeding
- ?Previously reducible mass
- Vomiting, abdominal distension and/or constipation /obstipation if intestinal obstruction has occurred

Physical Exam
- Firm, discrete, tender inguinal mass extending to scrotum
- Scrotal erythema & edema

Investigations
- Labs and imaging of limited use
- Ultrasound occasionally helpful to confirm etiology

Management
- Emergent reduction
- Most manually reducible, to OR if impossible in ER
- Once reduced, timing of definitive surgical repair depending upon age and degree of illness

Torsion of Appendix Testis

History
- Sudden onset mild-severe pain
- Uncommon to have N/V or previous episodes of pain

Physical Exam
- "Blue dot sign": palpable tender nodule at superior or inferior pole
- Cremasteric reflex present
- Scrotal erythema, edema, nontender testicle

Investigations
- Colour doppler ultrasound: normal or increased blood flow to testis, torsed appendage shown as lesion of low echogenicity

Management
- Supportive: analgesics, rest, scrotal support
- Should resolve in 5-10 days
- Surgical removal of appendix testis rarely required

Testicular Torsion

CANNOT MISS!

History
- Peak incidence: peri pubertal
- Pain: Sudden onset, moderate to severe, unilateral
- Occasional Hx of trauma or previous episodes of pain
- N/V common
- TWIST score

Physical Exam
- High-riding testicle, horizontal lie
- Cremasteric reflex absent
- Scrotal erythema, edema, testicular tenderness
- May have reactive hydrocele

Investigations
- Colour doppler ultrasound if low risk (low TWIST score) & Dx in question
  - Contraindicated if high likelihood and results in delay
- U/A generally not indicated and not needed for diagnosis

Management
- High likelihood (high TWIST score) → immediate surgical exploration
  - Surgical detorsion and orchiopexy if viable
  - 97% salvage if **<6h** from sx onset
- Orchiopexy of contralateral testis

Orchitis

History
- Occasionally bilateral testicular pain
- May show systemic manifestations of underlying infection

Physical Exam
- Scrotal erythema, edema, tenderness, shininess of overlying skin

Investigations
- Viral: mumps, rubella, coxsackie, and parovirus common
- Bacterial: brucellosis

Management
- Supportive: rest, NSAIDs, ice packs

Epididymitis

History
- Bimodal incidence:
  - Childhood & sexually active
- Gradual onset pain
- Unlikely: Dysuria, frequency, discharge
- N/V more common with torsion
- No definitive discrimination with torsion

Physical Exam
- Cremasteric reflex present
- Scrotal erythema, edema, epididymis tenderness

Investigations
- Urinalysis: may be normal
- STI testing:
  - Urine NAAT for chlamydia and gonorrhea
  - Most common in pre-pubertal: coliforms and P. aeruginosa
- Colour doppler ultrasound: normal or ↑ blood flow

Management
- No pyuria → no abx, supportive care
- Suspected STI cause: ceftriaxone IM x1 dose + doxycycline PO x10-14 days
- Suspected enteric cause: levofloxacin PO x10 days

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