Introduction

Acute epididymo-orchitis[1] perceived as a clinical syndrome[2], is a set of medical symptoms and signs that are correlated with each other, and often with a specific disease, characterized by pain, swelling and inflammation of the epididymis, with/without inflammation of the testes[3]. Local urethral extension is the most common route of infection, which may primarily be due to Gono-or non-gono-coccal infection spreading from the urethra and/or from the bladder[4]. Although orchitis, an infection limited only to the testis is infrequent, may be an associated feature. There seemed to have been a steady decline in the prevalence of the condition in the recent past[5]. It is, therefore, considered, worthwhile to re-visit the entity to create an-awareness amongst the practitioners, about the condition the acute scrotum[6].

Case Report

A 47-years-married man with single partner was admitted in the ‘indoors’ with spontaneous onset of severe pain and swelling confined to the left side of the scrotum. It was attended by sero-purulent, yellow-green discharge from the penis, burning, pain, urinary frequency and urgency (dysuria) and itching since March 3, 2015. He also had low grade fever. Ever-since the symptoms were on the increase without any perceptible relief. There was neither any history of extra-marital sex nor instrumentation/catheterization.

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than 1 in 100 men with NGU. Nevertheless, acute scrotum is one of the dreaded emergencies in practice [4]. The case under review documents its presenting clinical features, which are required to be addressed expeditiously to alleviate patient’s suffering. Furthermore, emergency evaluation of the patient presenting with acute scrotum using bedside Ultrasonography is imperative. Torsion of testis, hernia, hydrocele, varicocele and genital elephantiasis[8] should be considered and excluded accordingly. It is, therefore, relevant to recall anatomy of the male genitals including the scrotum at this point in time through sketch (Figure 3) which should prove informative to comprehend the entity, complications and its ultimate management.

**Investigations**

Gram-stained smear prepared from urethral discharge from urethra was negative for gram-negative intra-and extra cellular diplococci, the Neisseria gonorrhoeae. Venereal disease research laboratory (VDRL) test was non-reactive. Human immunodeficiency virus (HIV) was negative.

**Culture and Sensitivity**

*Escherichia Coli (E.Coli)* was recovered from the urethral discharge / urine examination on culture on LB broth (Sigma-Aldrich). It was found to be sensitive to Co-trimoxazole, chloramphenicol, tetracycline, nitrofurantoin, Levofloxacin, azithromycin, amikacin, cefitoxime, piperclillin/tazobactum and imipenem. Culture for Chlamydia trachomatis did not yield any growth on transport media.

**Ultrasonography**[7]

High resolution ultrasonography of the testis was performed to evaluate its status, using high frequency 11Mhz (MegaHertz) linear probe; the left testis was normal in size, shape and echo-pattern. Loculated fluid was seen in tunica vaginalis with multiple thin septations. Left spermatic cord was thickened and heterogeneous. Increased vascularity was conspicuous (funiculi) - multiple thin septations. Left spermatic cord was thickened and heterogeneous. Increased vascularity was conspicuous (funiculi). Left epididymis size was enlarged, hypo-echoic with heterogeneous. Increased vascularity was conspicuous (funiculi). Left epididymis size was enlarged, hypo-echoic with increased vascularity. No evidence of dilated veins was seen. Right testis was normal.

**Treatment**

Levofloxacin (Levotas) 0.5 % W/v in 500 mg/100 ml infusion by slow intravenous (I.V) infusion, BDS, twice daily for ten injections spread over period of 5 days. This treatment was supplemented by oral administration of uriliser (Citric acid/ sodium citrate and potassium citrate) 5 ml twice a day, and urispas (Flavoxate HCI) in dosage of 200 mg twice a day for 5 days. The response to the treatment was evident by slow regression of symptoms and signs during the follow-up period.

**Discussion**

Epididymo-orchitis is a well-recognized complication of NGU in men[1-3]. It is a combination of epididymitis and orchitis. The former is an inflammation of the epididymis, along coiled tube in the testicles that helps store, and transport sperms, whereas the latter is an inflammation of the testis. It affects fewer than 1 in 100 men with NGU. Nevertheless, acute scrotum is one of the dreaded emergencies in practice[4]. The case under review documents its presenting clinical features, which are required to be addressed expeditiously to alleviate patient’s suffering. Furthermore, emergency evaluation of the patient presenting with acute scrotum using bedside Ultrasonography is imperative. Torsion of testis, hernia, hydrocele, varicocele and genital elephantiasis[8] should be considered and excluded accordingly. It is, therefore, relevant to recall anatomy of the male genitals including the scrotum at this point in time through sketch (Figure 3) which should prove informative to comprehend the entity, complications and its ultimate management.

**References**


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**Figure 2:** Acute Scrotum displaying erythema, edema and swelling of the scrotum skin confined to left side.

**Figure 3:** Anatomy of male genitals.