

American College of Radiology ACR Appropriateness Criteria®

Clinical Condition: Acute Onset of Scrotal Pain—without Trauma, without Antecedent Mass

Variant 1: Without trauma, without antecedent mass.

| Radiologic Procedure | Rating | Comments | RRL* |
|--|--------|--|----------------------------------|
| US scrotum with Doppler | 9 | Excellent study that is generally available and has high sensitivity and specificity. Operator and equipment dependent. Requires small parts transducer with slow-flow-enhancing techniques. Must be performed in a timely manner. In equivocal situations, power Doppler evaluation of the spermatic cord may be helpful. | None |
| NUC Tc-99m scan scrotum | 7 | Well-established study. Interpretative experience and careful technique required. Must be performed in a timely manner. | Med |
| MRI pelvis (scrotum) without and with contrast | 3 | May be helpful if other tests inconclusive, but must be performed in short time frame. | None |
| US scrotum | 1 | Relatively insensitive to earliest changes secondary to decreased or absent perfusion. | None |
| NUC Ga-67 or In-111 WBC labeling scrotum | 1 | Infection diagnosis not obtainable in appropriate time frame. Isolated case reports as incidental finding. | High |
| Rating Scale: 1=Least appropriate, 9=Most appropriate | | | *Relative Radiation Level |

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ACUTE ONSET OF SCROTAL PAIN— WITHOUT TRAUMA, WITHOUT ANTECEDENT MASS

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Summary of Literature Review

The ability to confidently establish a surgical versus a nonsurgical diagnosis for acute scrotal pain is important. The benefits of early surgery for testicular salvage in ischemic disease, primarily torsion of the spermatic cord, are well known [1,2] but must be balanced against the costs of operating on the much larger number of patients with nonsurgical disease, primarily acute epididymitis [2-5]. Although the acute scrotum is defined as acute unilateral scrotal swelling, with or without pain, most patients present with pain as their primary or at least major concurrent complaint. The differential diagnosis of the acute scrotum includes: 1) torsion of the testis, 2) torsion of the testicular appendages, 3) acute epididymitis or epididymo-orchitis, 4) mumps orchitis, 5) strangulated hernia, 6) inflammatory type of testicular tumor, 7) acute hydrocele, and 8) traumatic hemorrhage. This diagnostic appropriateness discussion, however, will be limited to patients with acute pain who have no history of trauma and no history of a mass before the onset of pain. A minor traumatic episode may call attention to a scrotal process; and in the adolescent, just becoming aware of his sexuality may be an enabling event for him to voice his symptoms.

Torsion is decidedly rare in patients older than 35 years [1,3,6]. Acute epididymitis is commonly the cause of acute pain in patients younger than age 18, very common in patients age 19 to 25, and overwhelmingly the etiology in patients older than age 25. There are enough exceptions to these demographics, particularly in patients younger than age 30 years, such that these statistics must be used with caution. In this group there is also significant overlap in the presence of clinical factors that may favor torsion (abrupt onset, normal urinalysis) or epididymitis (more

gradual onset, abnormal urinalysis). Acute scrotal pain in prepubertal boys occurs most commonly from torsion of the testicular appendages, but may clinically mimic testicular torsion or epididymo-orchitis [7]. A pathognomonic physical examination finding (“blue dot sign”) is infrequently encountered.

Radionuclide scrotal imaging (RNSI) is an accurate examination in the differential diagnosis of ischemia versus infection [8]. The specificity in the diagnosis of ischemia versus other photon-deficient lesions is slightly lower [8]. Photon-deficient areas secondary to hydrocele, spermatocele, uncommonly edematous appendix testis, and rarely an inguinal hernia can be mistaken for an avascular testis [8]. One study found that 20 of 27 photopenic scrotal lesions were false positives (not torsion) and the ultrasound (US) examination prevented unnecessary surgery in 16 (59%) of these cases [9]. There have been many large series reported [1,3,10-14]. The examination and the technique are well established [1,3,8] and reproducible, and most imaging specialists and nuclear medicine technologists have been trained in the performance and interpretation of these examinations. With scintigraphy, some problems arise in infants and very small children whose genitalia are small and therefore difficult to image. Because this examination is performed relatively infrequently in many departments, the experience of individual practitioners may be limited. With increasing use of sonography, experience with RNSI, especially for more recently trained physicians, is decreasing. Availability and time of examination can also be limiting factors [15].

The imaging of infected scrotal contents, testis, or epididymitis with the radionuclide infection imaging agents Ga-67 or In-111 WBC has been noted in isolated case reports [16,17]. There is, however, no routine indication for their use.

Color Doppler ultrasound (CDU) is also a valuable exam for evaluating testicular perfusion [4,12,18-27]. Studies in the early 1990s showed a reasonable sensitivity and specificity for diagnosis of torsion [21,27] comparable to RNSI [24,28]. The CDU equipment has improved, and experience has increased, with resultant sensitivity and specificity now ranging from approximately 89%-100% [29-33]. Experience with CDU in evaluating the acute scrotum has increased, both for practicing physicians and for those in training. It is readily available at most, if not all, institutions and can be done quickly without any specific preparations. Power Doppler (US) can be used in place of, or as an adjunct to, CDU [34]. Power Doppler has been shown to demonstrate flow where CDU does not and, in general, to demonstrate slower flow than CDU

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[15,35,36]. Power Doppler US is especially useful to demonstrate intratesticular flow in prepubertal testes [37,38].

Doppler US is not without drawbacks, and one area of concern has been its application in the young child and particularly the prepubertal child [39]. Studies in children have shown a sensitivity of 89% and specificity of 100%, but there were technically unsuccessful studies which emphasize the need for experience and proper equipment settings when examining the young child [40]. Settings optimized to detect slow flow include a small color-sampling box, lowest pulse repetition frequency, and lowest possible threshold setting [27]. Blood flow can occasionally be preserved in patients with torsion [41,42]. Attention to spectral Doppler waveforms patterns (high-resistance arterial waveform, monophasic waveform) [42] and spermatic cord morphology (thick spermatic cord) [41,43-45] may help diminish false negative examinations. A multicenter study of 919 patients aged 1-18 years studied for an acute scrotum found false negative CDU studies in 50 of 208 patients with torsion (sensitivity 76%) [44]. An abnormal spermatic cord “twist” was identified, however, in 199 of 208 patients (sensitivity 96%). Further, a normal linear cord (705/711, 99% specificity) was found in patients without torsion.

In a comparison of 294 patients with primary scrotal exploration and 332 with US first and exploration if US was positive or there was a high clinical suspicion of torsion [5], one study found that US could obviate the need for exploration in many patients, and thus minimized and shortened hospital stays.

Gray-scale US alone is capable of evaluating the cystic or solid nature of scrotal masses and often the signs of an inflamed epididymitis and a necrotic testicle, but it is much less sensitive to the earliest changes resulting from decreased or absent testicular perfusion. In the setting of torsion, a normal homogenous echo pattern is, however, likely to indicate a viable testis, whereas a hypoechoic or inhomogeneous testis is likely to be nonviable [46].

The most common cause of acute scrotal pain in adolescent boys and adults is epididymo-orchitis. Gray-scale US combined with color Doppler imaging is the prime imaging means to make this diagnosis. The epididymis is enlarged and may be increased or decreased in echogenicity. Scrotal wall thickening and hydrocele are common. The testis is involved in 20%-40% of cases (epididymo-orchitis). Increased color Doppler flow in the epididymis and, if involved, the testis, is characteristic. The most common cause of acute scrotal pain in the child is torsion of a testicular appendage (appendix epididymis or appendix testis). Reactive changes (hydrocele, epididymal head enlargement, increased color Doppler flow) from torsion of a testicular appendage may mimic epididymitis [7]. The torsed testicular appendage can be

difficult to identify with US. It was seen in only 9 of 29 patients (31%) in one study [7], but it is usually larger, rounder, and has more surrounding flow than normal appendages [47]. Size alone may discriminate torsed from normal testicular appendages with low sensitivity (67%) but high specificity (100%), obviating surgery in some cases [48].

Magnetic resonance imaging (MRI) techniques has been rarely used in diagnosing the acute scrotum, although reports of its use in scrotal disease are increasing [49-51]. In one report, 11 patients with subacute signs and symptoms were evaluated, and a differential diagnosis between ischemia in six patients and infection in five patients could be made [6]. In a second study of 39 patients with an acute scrotum and an inconclusive US and physical exam, MRI had a sensitivity of 93% and a specificity of 100% for torsion [51]. Experimental studies also suggest potential use of MRI in acute torsion [52]. Another study [53] suggests that MRI may be useful to identify patients with segmental testicular infarction when US is not conclusive.

Summary

Both CDU and RSNI are valuable techniques for determining the etiology of acute scrotal pain. Although some authors still suggest immediate surgical exploration in patients with a strong clinical impression of testicular ischemia [2,46,54,55], if either CDU or RNSI is readily available and can be performed within 30-60 minutes of the request to simultaneously prepare an operating room, there is ample evidence that fewer patients with infection will be operated on, and also that patients with an ischemic testis will not be treated with antibiotics for infection. The choice of CDU or RNSI should be based on availability and operator experience. In most institutions, availability and experience will favor CDU. If one performs CDU and there remains a question about a diagnosis, US evaluation of the spermatic cord, MRI, or RNSI may be of value.

Relative Radiation Level Information

Potential adverse health effects associated with radiation exposure are an important factor to consider when selecting the appropriate imaging procedure. Because there is a wide range of radiation exposures associated with different diagnostic procedures, a relative radiation level (RRL) indication has been included for each imaging examination. The RRLs are based on effective dose, which is a radiation dose quantity that is used to estimate population total radiation risk associated with an imaging procedure. Additional information regarding radiation dose assessment for imaging examinations can be found in the ACR Appropriateness Criteria® [Radiation Dose Assessment Introduction](#) document.

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| Relative Radiation Level Designations | |
|---------------------------------------|-------------------------------|
| Relative Radiation Level | Effective Dose Estimate Range |
| None | 0 |
| Minimal | < 0.1 mSv |
| Low | 0.1-1 mSv |
| Medium | 1-10 mSv |
| High | 10-100 mSv |

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