Kedaruratan Non Trauma Urogenital

NON TRAUMATIC ACUTE SCROTAL SWELLING

Torsiotestis.epididimitisakut.

Table 1. Differential diagnosis of scrotal pathology

Painless scrotal masses
Inguinal hernia (nonstrangulated, nonincacerated)
Testicular tumors (these may also be painful)
Hydrocele
Spermatocele
Varicocele
Paratesticular tumors/masses
Scrotal edema
Epididymal caput distension from bilateral congenital absence of the vas
Painful scrotal masses
Inguinal hernia (incarcated or strangulated)
Testicular tumors
Testicular torsion
Appendicial torsion (of testicular appendages)
Epididymitis
Epididymo-orchitis
Trauma
Dermatological lesions
Inflammatory vasculitis
Hematocele
Miscellaneous
Empty scrotum (cryptorchidism)

Table 2. Findings on evaluation for common scrotal emergencies

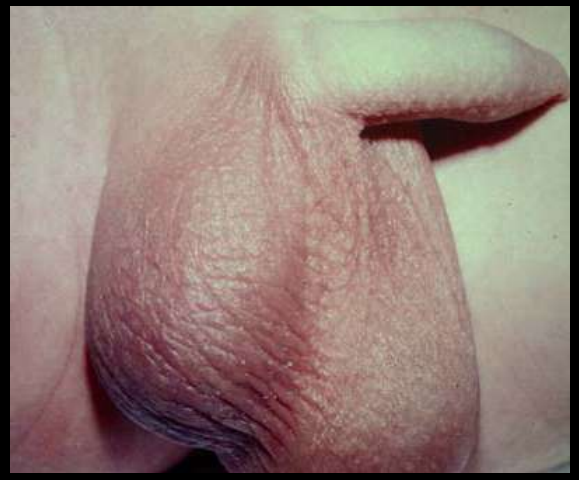
Pathology	Pain	Illumination	Urinalysis	Ultrasound	Doppler
Epididymitis	Yes	No	Abnormal	Heterogenous testis echotexture	Increased flow
Inguinal hernia	Maybe	Maybe	Normal	Hernia sac	Normal
Hydrocele	No	Yes	Normal	Fluid without echos	Normal
Spermatocele	No	Maybe	Normal	Fluid usually with echos	Normal
Testicular rupture	Yes	No	Normal	Heterogenous testicle Possible incomplete tunica	Usually abnormal
Testicular tumor	Maybe	No	Normal	Heterogenous echotexture	Normal
Testicular torsion	No	No	Yes	Normal	Decreased Flow

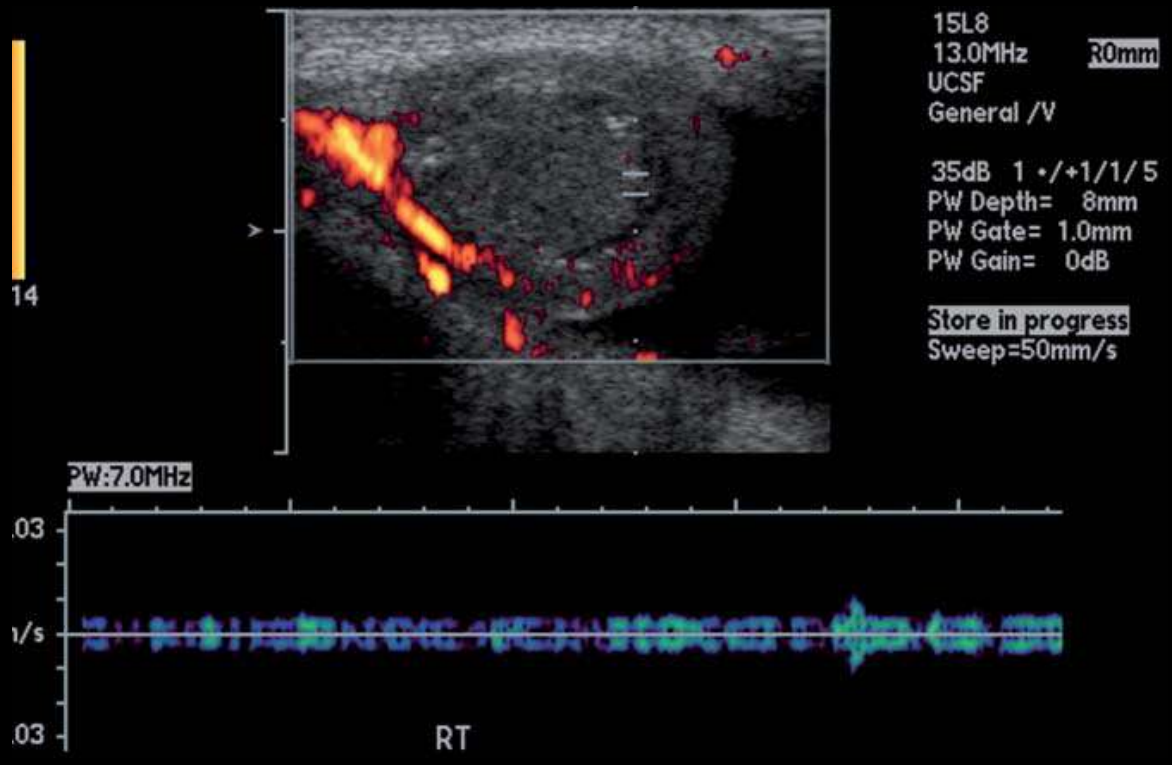
Torsi Testis

Torsio Testis

- Insiden puncak : tahun pertama dan pubertas
- Etiologi :
  - Sistem penggantung normal :
    - Desensus tetis membawa prosesus vaginalis-obliterasi bagian proksimal
    - Epididimis melekat di dinding posterolateral skrotum
    - Funikulus spermatikus tidak dibungkus tunika vaginalis
  - Sistem penggantung tidak normal : epididimis tdk melekat dinding skrotum + funikulus terbungkus tunika → puntiran
- Torsio Intravaginal (bell clapper : pubertas)
  - Testis terpuntir di dalam tunika vaginalis parietalis
- Torsio Ekstravaginal (neonatus)
  - Testis bersama tunika vaginalis parietalis terpuntir bersama

- Gejala Klinis :
  - Nyeri testis hebat mendadak → menjalar sepanjang funikulus
  - Testis bengkak, letak tinggi + horisontal
  - Mual/muntah, demam
- Laboratorium
  - Kadang Lekosistosis (58 % pasien)
- USG dopler
  - Sesitivitas 79 %

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- Terapi :
  - Detorsi eksternal manual : anticlockwise direction
  - Orchidopexy (+ kontralateral) → 4 – 6 jam pasca torsio : prognosis bagus
  - Follow up : atropi testis / oligospermia

Epididimitis Akut

- Radang, nyeri, bengkak epididimis< 6 minggu
- Insiden puncak 20 – 30 th
- Etiologi :
  - Sexual Transmitted Dissease :
    C. trachomatis, N.gonorrhoeae
  - Non STD : enterobacter, pseudomonas
- Patologi
  - dari vas deferen → kauda epiddimis → kaput : cairan serous tunika vaginalis akan pururlen → funikulus menebal → testis bengkak

- Klinis
  - Nyeri hebat menjalar ke skrotum + sepanjang funikulus
  - Bengkak agresif (3 -4 jam : ukuran epididimis bisa mjd 2 x lipat)
  - Fuikulus sulit menebal karena hidrokel sekunder : e.c produksi serosa >> akibat radang
  - Orchitis (58 %), eritema kulit skrotum (62 %)
  - Demam (75 %), disuria
- Laborat
  - Lekositosis + shift to the left
  - Kultur urin biasanya : pseudomonas, N.go, clamidia

Epididimitis akut dd torsio testis

	Torsio testis	Epididimitis akut
Umur	< 30	Semua umur
Onset	Mendadak	➢Pelan
Nyeri	+	+
Benkak	+	+
Letak	➢Tinggi	Normal
Posisi testis	Horisontal	Vertika
Letak epididimis	Tak tentu	Posterolateral
Demam	+/-	+/-
Lekositosis	+/-	+/-
Lekosituria	-	+

- Pengelolaan

➢ Sebab Bakteriuria
  - ➢ Kultur urine + sensitifitas
  - ➢ Antibiotik spektrum luas
  - ➢ Tirah baring dg scotal support k/p MRS
  - ➢ Evaluasi penyebab – ISK

➢ Sebab STD
  - ➢ Pengecatan gram discharge uretra
  - ➢ Antibiotik : doxixiclin / cipro / tetra : 3 -4 mg
  - ➢ Tirah baring dg scrotal support
  - ➢ Pemeriksaan + terapi terhadap pasangan