

Intratesticular and scrotal wall air: Emphysematous epididymo-orchitis or Fournier's gangrene: A dilemma

Dear Sir,

We read with a great deal of interest the manuscript titled "Imaging in emphysematous epididymo-orchitis: A rare cause of acute scrotum" by Mandava *et al.*^[1] in the July-September 2014 issue of *Indian Journal of Radiology and Imaging*, Volume 24, Issue 3. The manuscript is intelligently written with beautiful depiction of pathology with self-explanatory images, leaving little room for criticism. However, we would like to make a few pertinent observations.

In their 51-year-old male patient, the authors made an imaging diagnosis of emphysematous epididymo-orchitis based on the findings of USG, plain radiograph, CT, and MRI scrotum.^[1] We wish to point out that another differential diagnosis of Fournier's gangrene with testicular involvement should be considered on the basis of described imaging findings. Testicular involvement in Fournier's gangrene, though rare, has been previously reported.^[2,3] Rarity of testicular involvement is explained by the difference in blood supply of testes, i.e. from aorta, whereas the scrotal wall and perineal skin receive blood supply from the pudendal branches of the external iliac artery.^[4] The authors state that infection in emphysematous epididymo-orchitis may extend to the skin and superficial layers of the scrotum leading to cellulitis (Fournier's gangrene) for which no reference has been provided. However, the reverse is more likely based on the prevailing body of evidence in the literature. In our opinion, clinical history would be of prime importance in differentiating the two pathologies. Also, air in scrotal wall favors Fournier's gangrene with testicular involvement.

The authors state, "The precise etiology and pathogenesis of this entity is unclear and the incidence reported for this entity in literature consists of only two case reports." However, we believe this is an oversight because the etiology and pathology of this rare entity is not completely unknown. Indeed, there has been description in the literature of a coexistent source of infection in retroperitoneum with resultant hematogenous spread to the epididymis and testis,^[5] and secondary to seminal vesicle involvement by diverticulitis of the colon.^[6]

The authors have not provided the abdominal sections of the MDCT study. It is important to review the abdominal CT sections as there is a high likelihood of coexistent retroperitoneal source of infection. We also find that the use of MRI in this case was non-contributory as the diagnosis could be made with certainty on MDCT study itself. Though MRI may be useful in certain cases, we would like to exercise caution in the use of MRI as it may cause an unnecessary delay in the emergent management in such cases.

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