Partial Testicular Torsion
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History
6 year old male with intermittent scrotal pain for 1 week.

Diagnosis
Partial Testicular Torsion

Discussion
Patients with acute torsion present after a sudden onset of pain followed by nausea, vomiting, and a low-grade fever. Physical examination reveals a swollen, tender, and inflamed hemiscrotum. The cremasteric reflex is usually absent and the pain cannot be relieved by elevating the scrotum. There are two types of torsion, extravaginal and intravaginal. Extravaginal testicular torsion occurs exclusively in newborns. Intravaginal torsion occurs within the tunica vaginalis. The predisposing factors for intravaginal torsion include a long and narrow mesentery in which the tunica vaginalis completely encircles the epididymis, distal spermatic cord, and testis rather than the posterolateral aspect of the testis.

Torsion is not an all-or-none phenomenon but may be complete, incomplete, or transient. Gray-scale images are nonspecific for testicular torsion and often appear normal if the torsion has just occurred. Testicular swelling and decreased echogenicity are the most commonly encountered findings 4–6 hours after the onset of torsion. At 24 hours after onset, the testis has a heterogeneous echotexture secondary to vascular congestion, hemorrhage, and infarction. The whirlpool sign is related to twisting of the blood supply around a pedicle; in addition to the testicle, the whirlpool sign can be seen in the mesenteric root and ovary.

Findings
US-Enlarged spermatic cord with swirling of the vascular pedicle.

Reference
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