

Emphysematous epididymo-orchitis

Sir,

We read with a great deal of interest the article by Mandava *et al.* describing the imaging features of emphysematous epididymo-orchitis^[1] and found it to be informative and excellently written. However, we would like to make a few contributions.

In the manuscript, the authors describe “emphysematous epididymo-orchitis” to have been reported in only two cases prior to the present case. A search on Pubmed, however, reveals a total of five cases including the present one.^[2,3] Yet another case was published by Gretchen.^[4]

Secondly, we would like to understand the indication of MRI in the present case. Since the diagnosis was fairly established on USG and further confirmed on CT, the need to perform a battery of investigations needs to be better explained. Besides, the patient presented with acute scrotal pain and MRI, being a lengthy procedure, is typically not preferred (ACR Appropriateness Criteria® acute onset of scrotal pain - without trauma, without antecedent mass).

Finally, the differential diagnosis should be case-relevant. Torsion of testis is extremely rare in old age. The reported case here is a 51-year-old male, torsion of testis in whom is highly unlikely.

We conclude by once again commending the authors for an excellent article. However, it would be of enormous help if the authors could clarify certain doubts we had.

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Author's reply

We have considered and ruled out the diagnosis of Fournier's gangrene (FG) in this case.

FG is defined as a life-threatening necrotizing fasciitis of the perineal, genital, and perianal regions, which leads to thrombosis of the small subcutaneous vessels and results in the development of gangrene of the overlying skin.^[1,2] The basic pathological process in FG is necrotizing fasciitis, and infection in FG tends to spread along the fascial planes (Colles fascia, Scarpa fascia, Dartos fascia, and Buck fascia).^[3,4] In 90% of cases of FG, the source of infection may be colorectal, urologic, or cutaneous.^[2,5] The infection commonly starts as a cellulitis adjacent to the portal of entry, depending on the source of infection, commonly in the perineum or perianal region.^[4] Infection arising from the

anal triangle can spread along the Colles fascia (superficial perineal fascia) and progress anteriorly along the Dartos fascia to involve the scrotum and penis.^[4,6] The testes and epididymides are normal in FG as a result of deriving their blood supply from the testicular arteries, which originate directly from the aorta.^[4,7] Involvement of the testis suggests retroperitoneal origin or spread of infection.^[4] Testicular necrosis in FG is an indicator of severe disease, as this points to retroperitoneal sepsis which causes thrombosis of the testicular blood vessels.^[8] Systemic findings in FG include leukocytosis, dehydration, tachycardia, thrombocytopenia, anemia, hypocalcemia, and hyperglycemia, and the patient also has pronounced systemic signs, usually out of proportion to the local extent of the disease.^[4,6] FG tends to be polymicrobial in nature with an average of more than