Andres Hernandez

H&P #3 – Emergency Medicine

Chief Complaint: "Groin pain" x 2 days

HPI:
A 72-year-old male with a past medical history of atrial fibrillation and type 2 diabetes presents to the ED with groin pain for two days. On the day of onset, the patient experienced sudden general groin pain, which he reports is not unfamiliar and typically resolves spontaneously. However, this time the pain persisted, and he noticed testicular swelling, causing the scrotal region to appear twice its normal size. The pain was non-radiating, and the groin area was extremely tender, with slight touch to the scrotum producing a burning sensation rated 10/10 in severity. That night, he took Motrin (ibuprofen), and his girlfriend gave him sleeping medication (name unknown), allowing him to sleep through the night after finding a comfortable position while sitting on the couch. The following day, the patient reported that the pain became more tolerable, but the swelling persisted. He continued taking Motrin and sleeping medication. This morning, severe pain returned, now localized entirely to the left testicle. The patient denies any trauma to the area or pain onset following physical activity. He also denies dysuria, hematuria, or changes in urgency, frequency, or issues with urine outflow. Additionally, he denies any history of STDs or recent penile discharge. The patient reports no abdominal pain, nausea, vomiting, or diarrhea. He also denies any general symptoms such as fever, chills, cough, shortness of breath, or recent weight loss.

Past Medical History:
Atrial Fibrillation, unmanaged, no medication taken
Type 2 Diabetes would take metformin, but discontinued after doctor told him he was controlled

Past Surgical History:
Had 45 stiches to head and arms, after glass window fell on head, approximately 40 years ago

Medications:
Ibuprofen (Motrin), prn
Sleep medication (unknown), prn

Allergies:
NKDA
No food allergies
No environmental allergies

Family History:
Mother, deceased in 2008, unknown cause
Father, deceased in 1994 from lung cancer, emphysema
2 Sisters, alive, both have diabetes type 2
2 Brothers, alive, both have diabetes type 2
2 Daughter, alive, both have diabetes type 2
1 son, deceased, drug overdose

Social History:
Substances: Denies a history of substance abuse. Former cigarette smoker 15 years. Denies vaping. Drink coffee daily. Has a glass of wine every other day, and scotch drinker on the weekends.
Travel: Denies recent travel
Diet: Not on any specific diet/regimen
Sleep: Averages 5-6 hours per night
Exercise: Admits to formal exercise, admits working around the yard
Sexual History: Heterosexual. Has one partner, girlfriend of 30 years, sexually active. Denies history of STDs.

ROS:
General – Denies fever, headache, weakness or recent weight loss.

Skin, hair, nails –No changes in texture, excessive dryness or sweating, discolorations, pigmentations, lacerations, moles/rashes, pruritus, or changes in hair distribution.

Eyes –Denies visual disturbance, photophobia, lacrimation or pruritus. Last eye exam is unknown.

Ears – Denies ear pain, muffled sound, deafness, discharge, or sensation of fullness.

Nose/sinuses – Denies discharge, obstruction or epistaxis.

Mouth/throat – Denies sore throat, bleeding gums, mouth ulcers, voice changes.

Neck - Denies localized swelling/lumps or stiffness/decreased range of motion.

Pulmonary System – Denies shortness of breath, dyspnea on exertion, cough, wheezing, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea.

Cardiovascular System – Denies chest pain, HTN, irregular heartbeat, edema/swelling of ankles or feet, syncope, or known heart murmur.

Gastrointestinal System – Denies nausea, vomiting, diarrhea, abdominal pain, or jaundice

Genitourinary System – Denies urinary frequency, nocturia, urgency, oliguria, polyuria, dysuria, incontinence, awakening at night to urinate, or flank pain. Urine is yellow/clear. Last prostate exam/PSA screening unspecified.

Endocrine System – Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, goiter, excessive sweating.

Psychiatric – Denies depression, feelings of helplessness or hopelessness, lack of interest in usual activities, anxiety, or suicidal ideations.

Physical Exam:

Vital Signs:
BP: 143/77 mmHg, right arm sitting

P: 83 beats/min, regular
RR: 16 breaths/min, unlabored
T: 99.0 degrees F (oral)
O2 Sat: 99% room air
Weight: 270 lbs
Height: 6’4”
BMI: 32.9

General: Well-nourished, well-groomed 72 y/o male who appears his stated age. He is awake, alert, and oriented x3. Comfortably laying down on bed upon entry and is in no acute distress. Patient is very cooperative during history taking and the physical exam. The patient can ambulate without assistance.

Nose: Symmetrical. No masses, deformities, or discharge. No lesions, masses, or trauma. Nares patent bilaterally. Nasal mucosa pink and well hydrated. No discharge noted on anterior rhinoscopy. No epistaxis.

Eyes: Symmetrical OU. No strabisumus, exopthalmos or ptosis. Sclera white, cornea clear, conjunctiva pink.

Ears: Ears symmetrical. No lesions, masses, or trauma.

Sinuses: Non tender to palpation and percussion over bilateral frontal, ethmoid, and maxillary sinuses

Mouth: No cyanosis of lips, white teeth, with no loose, or broken teeth. Gums pink in color, no swelling, bleeding, or pain. Oral mucosa pink. No discoloration, lesions, nodules, swelling. Tonsils visible but not enlarged.

Skin: Warm, moist, with good turgor. No lacerations, masses, no bruising, or petechiae.

Cardiac: Regular rate and rhythm (RRR). S1 and S2 are distinct with no murmurs, gallops, or rubs. Chest is symmetrical, no derformities, no trauma. Lat to AP diameter 2:1. Nontender to palpation.

Pulmonary: No wheezing, rales, rhonchi, crackles, heard. Respirations unlabored / no paradoxical respirations or use of accessory muscles noted. No clubbing noted.

Abdomen: Abdomen flat and symmetric with no scars, striae, or pulsations noted. Nontender to palpation and tympanic throughout, no guarding or rebound noted. No evidence of hernias.

Male Genitalia: **Uncircumcised male. No penile discharge or lesions. Significant scrotal swelling and erythema particularly to the left side. Marked left sided/epididymal tenderness. Testes descended bilaterally. No inguinal or femoral hernias noted. No palpable masses. No crepitus or necrosis to the overlying soft tissues noted.**
Not assessed: Prehn's sign and the cremasteric reflex. A digital rectal exam reveals a smooth, non-tender prostate of normal size with no nodules, effectively ruling out prostatitis.

Differential Diagnoses:

Epididymitis – This is one of the most common causes of scrotal pain, typically presenting unilaterally with scrotal swelling and tenderness. More than half of patients with infectious epididymitis also develop epididymo-orchitis, an inflammation of the testicle. In younger, sexually active males without risk factors for urinary tract infections, epididymitis is often caused by sexually transmitted pathogens. In contrast, non-sexually transmitted epididymitis is usually secondary to a urinary tract infection, with risk factors including benign prostatic hyperplasia (BPH) or other urinary bladder conditions. Scrotal erythema and hydrocele may also be present. A positive Prehn's sign, where manual elevation of the scrotum relieves pain, can be a helpful diagnostic clue.

Mumps Orchitis – This is a self-limiting viral infection, typically associated with bilateral parotid swelling. Epididymo-orchitis is the most common complication of mumps, though most patients present with fever and parotitis before any testicular involvement. The diagnosis is usually clinical, but it can be confirmed with serologic testing.

Inguinal Hernia – The inguinal area should be inspected for any bulges or scrotal masses, and having the patient cough may help reveal a hernia. If bowel sounds are auscultated in the scrotum, this strongly suggests the presence of an inguinal hernia. Pain associated with hernias is generally localized to the groin or abdomen rather than the scrotum.

Testicular Cancer – Testicular cancer can cause testicular swelling, although it typically presents as a painless nodule. In some cases, scrotal pain can occur. A mass may be palpable on the testicle, and scrotal ultrasound can be used to assess for the presence of a tumor.

Testicular Torsion / Torsion of the Testicular Appendages – Testicular torsion often presents with erythema of the scrotal wall and testicular swelling, accompanied by severe, acute-onset pain, frequently following physical activity or trauma. Associated symptoms may include nausea, vomiting, and abdominal pain. The affected testicle may be elevated due to shortening of the spermatic cord. The cremasteric reflex is helpful in ruling out testicular torsion, as a positive reflex makes torsion unlikely. However, the cremasteric reflex is typically only reliable in males up to the age of 12, making it a less reliable test in older males. Torsion of the appendix testis is not a surgical emergency and usually presents with a more gradual onset of pain compared to testicular torsion. Both conditions can occur at any age, though they are less common in adults.

Labs and Imagining:

CBC, CMP, Urinalysis with Reflex Culture, Scrotal Ultrasound

Significant Results:

CBC	Urine	Ultrasound
WBC: 20.68 Kcells/µL ↑ Neutrophil: 18.13 Kcells/µL ↑ Lymphocyte: 1.15 Kcells/µL ↓ Monocyces: 1.10 Kcells/µL ↑	Trace Leukocytes Esterase Negative Nitrates Moderate Bacteria	Increased vascular flow to the epididymis Asymmetrical enlargement of the left epididymis up to 1.7 cm, left hydrocele Significant hyper-vascular appearance to the left

		spermatic cord with mass-like echogenic process up to 3.6 cm.

Assessment:
This is a 72-year-old male presenting with two days of severe left-sided scrotal pain and swelling. The physical exam reveals significant left-sided scrotal erythema, swelling, and marked tenderness over the left epididymis. Ultrasound findings show increased vascular flow to the left epididymis, asymmetrical enlargement, a left hydrocele, and hyper-vascularization of the left spermatic cord with a mass-like process. Laboratory results indicate leukocytosis (WBC 20.68 Kcells/μL), neutrophilia, and moderate bacteria on urinalysis. These findings are consistent with acute epididymo-orchitis.

Plan
#Epididymo-orchitis
Pain: Ketoralac 1 dose, NSAID and ice application prn, Scrotal support
Antibiotics: ceftriaxone (500 mg IM, 1 dose) and levofloxacin (500 mg daily for 10 days) for coverage of N. gonorrhoeae, C. trachomatis, and gram-negative bacteria E.coli.

Discharge and follow up with Urology for further assessment of 3.6 cm mass in spermatic cord

#History of Atrial Fibrillation
ASA, 325 mg