

Clinical Image

An Unrecognized Trauma as a Cause of Recurrent Fever

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CLINICAL IMAGE

A 16-year-old boy presented with a 1-week history of fever and scrotal pain, which had recently occurred twice previously. He denied any history of trauma, urethral discharge, or sexual intercourse. He had chronic renal failure secondary to vesicoureteral reflux, and was continuing with hemodialysis and

using immunosuppressant drugs. Diffuse edema and tenderness in the scrotum were observed at physical examination (Figure 1A). Elevated acute phase reactants were determined. Scrotal ultrasound revealed bilateral dense, septated fluid collections, located near normal appearing testes. Empirical piperacillin-tazobactam plus vancomycin were started. He was then operated. Bilateral proximal inguinal hernia sacs were ligated, and two masses were resected (Figure 1B,1C). Histopathological examination revealed two unilocular cystic structures, with abscess foci, calcification areas, and a fibrovascular wall, but no epithelial wall (Figure 1D). Blood culture was negative. Methicillin-sensitive *Staphylococcus aureus* grew in cyst material culture. His symptoms resolved after surgery.

Benign intrascrotal lesions, which mostly occur in para testicular tissue and are cystic in nature, are common in male patients [1]. Definitive diagnosis usually requires surgical procedures to discard malignancy. In this case, histological findings suggested infection of a benign chronic lesion and absence of a 'real' cyst, indicating an unrecognized traumatic injury experienced years previously. Although immune compromised patients usually experience recurrent fever or fever of unknown origin, infection of a pseudo cyst caused by an unrecognized trauma is not a frequent reason. Unsurprisingly, cyst material grew *S. aureus*, the predominant micro-organism in genitourinary skin and soft tissue infections requiring incision and drainage [2]. As the patient was a child and the lesion was benign, a testis sparing procedure was performed in addition to antibiotic therapy. Resection of the foci helped to prevent subsequent infections.

Informed consent was taken from both the patient and his legal guardian.

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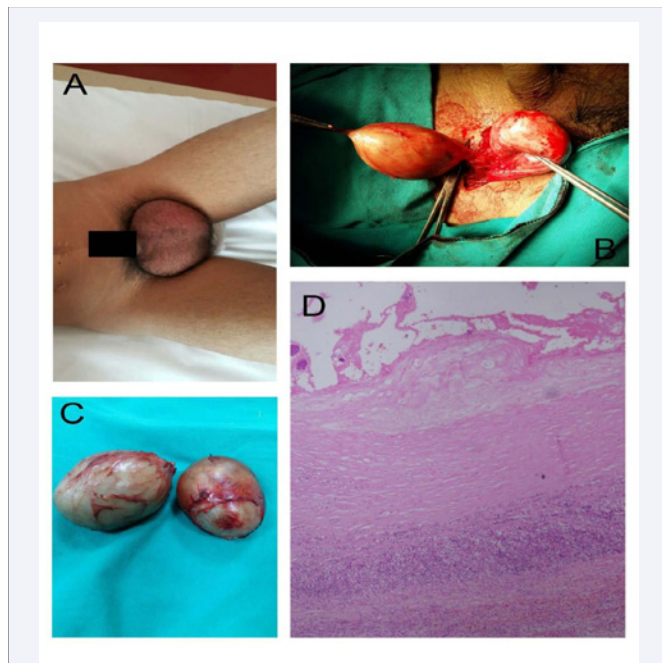


Figure 1 A: The scrotum was slightly hyperemic, edematous, and tender at palpation

Figure 1B, 1C: The resected masses were 6.5x5.4x4 cm and 5x3.5x3 cm in size and resembled testes, with separate capsules inside the scrotum, which were easily detached from scrotal structures

Figure 1D: Histopathological sections stained with H&E (x10) demonstrated absence of surface epithelium on the cyst wall, which was confirmed with calretinin and pan-cytokeratin dyes. Focal abscess foci containing predominantly polymorph nuclear leukocytes, calcification areas, and a fibro vascular wall were present.

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