Successful outcome in perinatal intravaginal torsion of testis in neonate: Long-term outcome

Kashif Chauhan*, Gemma Bown, Brian Davies, Shailinder Singh

Nottingham University Hospital, Nottingham, UK

Introduction: Perinatal testicular torsion can be intravaginal or extravaginal. Extravaginal torsion can be managed in an elective manner. Intravaginal torsion needs an urgent operation to maximize the viability of the testis. The history is vital to distinguish between the two diagnoses. We report a case in which a perinatal intravaginal torted testicle was successfully salvaged due to a timely exploration. This was a retrospective review of a case and literature review of perinatal testicular torsion.

Case description: A term baby was transferred to a tertiary pediatric surgical unit in the for surgical management of exomphalos minor. The child was noted to have normal testes. On the seventh day of life, he was noted to have a firm swelling in his right scrotum with purple discoloration. He was promptly reviewed by the surgical team. A perinatal torsion of intravaginal type was suspected and he was booked for emergency exploration. The surgical findings were 1) significant edema of the right scrotal wall, 2) a thickened tunica vaginalis and small volume of hemolyzed fluid, and 3) a bluish and congested torted testicle in intravaginal plane. Testis was de-rotated and color returned within 5 minutes. A three-point testicular fixation was performed bilaterally. He was reviewed in clinic for the following 2 years and found to have equal growth of the testicles, both of which were appropriately positioned within the scrotum.

Results and conclusions: This case highlights the importance of being aware that perinatal torsion can be extravaginal or intravaginal. The patient history is important to distinguish between the two diagnoses as proven by the above case. A positive outcome can be achieved with judicious assessment and emergent management of perinatal intravaginal torsions.

Take-home message: Clinicians should maintain a high level of suspicion of intravaginal torsion in all cases of perinatal testicular torsion.

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Same old peristomal dermatitis, but what’s causing it?

Mousumi Dasgupta Zaman*, Chathurariya Siriwardena, Robert Graham

James Paget University Hospital, Great Yarmouth, UK

Introduction: Prevalence of peristomal dermatatoses ranges between 6-80%1 and more commonly affects patients with urostomies and ileostomies, than with colostomies. Most common causes include irritant contact dermatitis from urine/faeces, mechanical dermatitis, chronic papillomatous dermatitis, seborrhic dermatitis and allergic contact dermatitis. We report an unusual case of allergic contact dermatitis to printing ink on stoma bag which has not knowingly been reported before.

Case description: A 66-year-old male, presented with a pruritic rash under colostomy bag, not responding to topical emollients and steroids. Examination findings were of an eczematous rash with no obvious leak at stoma site or from bag. He was not on any medication such as Nicorandil which might be contributing to peristomal dermatitis/ulceration. Provisonal diagnoses were allergic contact dermatitis and irritant contact dermatitis. First patch test for standard european battery was negative. Histopathology had shown eczematoid spongiform dermatitis, consistent with allergic/irritant contact dermatitis. He was treated with several emolllients, topical Trimovate®, Betnovate® and topical 0.1%Tacrolimus; however, it had made no significant difference even by occlusion with hydrocolloid dressing.

Subsequently he was patch tested with colostomy bag tied on to forearm for a week. It was divided in five patches:

1. Inner sticky pad
2. Outer sticky pad
3. Bag
4. Printed area of bag and
5. Joined area of bag.

Surprisingly he had shown strongly positive reaction only to number 4 but not to any other part of the bag. It was thought that he was allergic to that particular ink and not to bag itself as he did not show any reaction to un-branded part of the bag.

He was advised to cover the printed under surface of the colostomy bag with Micropore® and to continue Hydromol® as barrier emollient and Mometasone furoate ointment for flare ups. His problem completely resolved with covering inked part of colostomy bag with Micropore® and he was discharged back to GP. Enquiry had been made to manufacturer regarding materials used in ink, as patch test for standard European battery were negative, however manufacturer of the colostomy bag had passed it on to the manufacturer of the ink and no further information had been received to this date.

Conclusion: Allergic contact dermatitis had been reported secondary to ostomy bag/pouch, sealing rings, strapings, deodorizers, adhesives, skin cleansers and topical emollients and ointments. Patch testing had always been the key investigation in these cases. Most reported cases had shown sensitivity to ‘epoxy resin’ which is a component of stoma bag itself.

Allergic contact dermatitis had also been reported to karaya gum seal ring2, colophony & benzyl peroxide3, tinuvin P® / 2-benzotriazol4, di-aminodiphenylmethane and rubber seal surrounding the bag5. Other cases had shown sensitivity to adhesive tapes, polyisobutylene (adhesive ring of ostomy bag), adhesive remover wipes, stomahesive paste®, dansac® soft paste, gantrex ES® balsam of Peru, cinnamic aldehyde, geraniol, benzyl alcohol, isoeugenol, propylene glycol and DOR ostomy deodorant®. However, so far we had not noted any case report showing sensitivity to printing ink on colostomy bag. It is unfortunate that we are still unable to get the information on components of ink however, in suspected cases it would be worth covering the printed under surface of colostomy bag to overcome possible allergic contact dermatitis. Recommending manufacturers of stoma care products to

Prostatic abscess: An unusual presentation

Latifa Al Mutairi*, Abdullatif Al Terki, Tariq Al Shajji*

Amiri Hospital, Kuwait City, Kuwait

Introduction: Prostatic abscess is an uncommon complication of acute prostatitis. While these two conditions may have the same symptoms, prostatic abscess diagnosis relay largely on suspicious examination and imaging. In this study, we describe a case of uncommon presentation of prostatic abscess.

Case description: A 45-year-old diabetic male presented with history of fever for two months and denied any lower urinary symptoms (LUTS). Digital rectal examination was unremarkable with a normal sized, non tender prostate. Urine analysis results showed leukocytes in excess but no red blood cells. After initiating a fever of unknown origin (FUO) workup, a prostatic abscess was discovered on abdominal ultrasound and confirmed with contrast enhanced CT scan. Once the diagnosis was achieved, intravenous antibiotics were started. The patient underwent a minimal transurethral resection of the prostate (TURP) and derooing of the abscess with an uneventful recovery period.

Conclusion: It is important to consider prostatic abscess in the differential diagnosis of fever of unknown origin since it may be present in an atypical clinical picture.

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