# Management of Suspected Epididymo-Orchitis (EO)

- In this guideline the term EO covers orchitis, epididymitis and epididymo-orchitis
- Always consider STI but especially if under 35 years (*Chlamydia trachomatis* and *Neisseria gonorrhoeae*)
- Usually due to gram negative enteric bacteria if over 35 years with low risk of STI (*complete sexual history taking is essential). Increased risk with recent instrumentation (e.g. prostatic biopsy and vasectomy), catheterisation or urinary tract abnormalities.
- Consider differential diagnosis of testicular torsion. Also, mumps (especially in those unvaccinated/incomplete vaccination). Parotitis is absent in 30-40% of cases.
- Consider rarer causes including reactive arthritis/Behçet's disease, TB, tumour or side effects of amiodarone
- Left untreated, EO can result in continued pain/swelling, hydrocele, abscess formation, very rarely infertility

*Taking a sexual history should include whether sexually active, recent change of partner, past history of STI and presence of urethral discharge.

Presentation with symptoms of EO which **may** include scrotal pain (usually unilateral), swelling and erythema, +/- symptoms of UTI (fever, dysuria, urgency, frequency) or urethritis (dysuria, urethral discharge, penile irritation)
**Send 2 samples of urine**
- First pass urine (or in bladder > 2 hours) for chlamydia/gonococcal PCR (yellow top container)
- MSSU for urinalysis AND culture and sensitivity (red top boricon container)

**Other investigations** – FBC, CRP, urethral swab for gonorrhoea culture

**Is there urethral discharge?**

YES

**Higher risk of STI**
**Take sexual history***

NO

**Take sexual history***

New sexual partner(s) in last 3/12 **or** <35 years old

YES

NO

Any fever or back pain or signs of sepsis?

YES

Consider UUTI and treat as per hospital guidance OR primary care guidance

NO

**Ofloxacin 200mg bd 14 days
**OR**
**Ofloxacin 400mg od 14 days
**OR**
**Ciprofloxacin 500mg bd 10 days
(if quinolones contra-indicated: co-trimoxazole 960mg bd or co-amoxiclav 625mg tds for 10 days)

If EO was accompanied by lower urinary tract symptoms consider referral to urology for follow up and investigation.

*Gonorrhoea likely and/or not tested:*
IM Ceftriaxone 1g single dose +
Doxycycline 100mg bd for 14 days

*Gonorrhoea unlikely and test sent OR tested and negative:*
Doxycycline 100mg bd for 14 days

*History of condomless insertive anal sex:*
replace doxycycline with **ofloxacin 200mg bd (or levofloxacin 500mg od 10 days if ofloxacin shortage)

- Discuss need for partner notification if urine culture negative (everyone they have had sex with since 4 weeks before symptoms started, or 2 weeks if gonorrhoea positive)
- Full STI screen (chlamydia, gonorrhoea, HIV and syphilis) and MSSU
- Advise sexual abstinence until treatment for patient and their partner/s completed
- Provide condoms and safer sex advice
- Follow up at 2 weeks recommended to assess adherence and resolution of symptoms, and arrange any further follow up necessary

Refer to Sexual Health (07976942499/01382 425542) if:
- Tests positive for gonorrhoea
- Has had a positive test elsewhere for (or is a contact of) Mycoplasma genitalium
- Inpatient
- Fails to respond/intolerant to treatment

1st line treatment if gonorrhoea positive and not already had ceftriaxone: give ceftriaxone 1g IM stat

**Advice for all patients:**
- Rest
- Adequate analgesia
- Supportive underwear
- Review in 3 days if no improvement (swelling can persist even after adequate antibiotic treatment but should be completely resolved in >80% of men by 3 months) otherwise review at 2 weeks
- Provide written advice here or for Sexual Health patients here

**Refer to quinolone warnings


**References:**
BASHH 2020 CKS 2022 CDC 2021
NICE/PHE 2017 IUSTI 2016 EUA 2023



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