

This department of AJDC is reserved for comment, criticism, observation, and discussion of "issues of current concern and importance for children's health." The Editor encourages our readers to express themselves on a variety of topics and issues. Further, we encourage the submission of unique and brief clinical and scientific observations that do not fulfill the criteria for original articles.

Torsion of Testicular Appendixes as the Most Frequent Cause of Acute Scrotal Inflammation in Infancy

Sir.—One cause of scrotal edema and hyperemia in children is torsion of the hydatid of Morgagni.¹ It usually manifests itself with pain that is sharp in the beginning, continuous or intermittent, frequently of moderate intensity, and located in the superior focus of the testicle, although on occasion it is felt in the groin or iliac fossa of the affected side. It progresses in an irregular manner in the following hours or days. The patient usually does not present with vomiting, fever, or urinary symptoms. Sometimes there is a history of previous episodes of recurrent testicular pain.² Surgical exploration and treatment usually is performed because the clinical picture is similar to that of torsion of the spermatic cord.

Patient Reports.—We studied 28 patients diagnosed as having torsion of the testicular appendix, whose ages varied from 3 years 4 months to 14 years, from 1981 to 1987, which accounted for 67% of all causes of acute scrotal inflammation. In all of the patients, an exploratory scrototomy was performed. In 26 patients the torsion affected the hydatid of Morgagni, in one patient the epididymal appendix was affected, and in only one case were both appendixes affected. The average annual incidence was four cases a year, with a seasonal predominance in the fall and winter months in 71% of the cases. The average interval that elapsed from onset of symptoms until the patient was seen for the first time in the hospital was 36 hours, with a range varying from two hours to seven days. In half of the cases, the diagnosis before surgery was torsion of the testicular appendix, while in the other half it was torsion of the spermatic cord. The number of processes located in the right and left testicle was 11 and 17, respectively. The most frequently observed symptoms and signs were diffuse pain, hypersensitivity, edema, and erythema of the affected scrotum.

Exploratory surgery allowed us to see the torsion of the appendix, but the rest of the testicle was unaffected. Treatment consisted of resection of the twisted appendix and securing the testicle. The anatomopathological study of the hydatid showed a hemorrhagic infarct in 22 cases and edema in six. The postsurgical course was good in all of the patients, and the average hospital stay was four days.

Comment.—In our patients, torsion of the testicular appendixes was the most frequent cause of acute scrotal inflammation in infancy and the hydatid of Morgagni was the most affected (96.4%). We did not observe any case of torsion of Giralde's or Haller organs or bilateral torsion. The maximum age of the patient at incidence was 11 years. These results are similar to others already reported.^{1,3} There was no previous traumatism in any case. Given that in our case study there was a prevalence of cases in the fall and winter months, there could be speculation on the influence of the environmental temperature as a pathogenic factor.⁴

In many children affected by acute scrotal inflammation, the diagnosis of torsion of the spermatic cord can be made after physical exploration. Although testicular scanning helps in the diagnosis, its availability and precision are limited.⁵ In our case study, there was a 50% error in presurgical diagnosis.

There is controversy as to whether the majority of children with torsion of the testicular appendixes develop sufficiently grave symptoms to justify the expense of a surgical excision of the appendix. For this reason, once a diagnosis of torsion of the spermatic cord is ruled out, some investigators prefer conservative treatment.³ However, there are studies that compare the results obtained from groups with and without surgical treatment, showing more optimistic results with surgery.¹ We are in favor of surgical treat-

ment, perhaps because in our experience all of the patients presented with sufficiently intense symptoms to warrant surgery. Furthermore, we observed a disappearance of symptoms 24 hours after minor surgery.

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Asthma Scoring Systems

Sir.—In the February 1988 issue of *AJDC*, Baker¹ reported that the asthma scoring system of Wood et al² failed to relate to outcomes of episodes of childhood asthma treated in the emergency room. As he emphasized, the system was originally devised to select children with respiratory failure, so its poor showing in the emergency room context was not surprising. What is sadly remarkable is how widely this scoring system has been adopted, uncritically, for the assessment of childhood asthma in various clinical settings.

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