

Brucellosis Presenting as Treatment-resistant Epididymo-orchitis in an Adolescent: A Case Report and Literature Review

Tedaviye Dirençli Epididimo-orşit ile Başvuran Adölesan Bir Bruselloz Olgusu: Olgu Sunumu ve Literatür Derlemesi

İD Bekir Erdeve¹, İD Halis Can Demirtürk², İD Zeynep Savaş Şen³, İD Ali Ummahan¹, İD İbrahim Karaman⁴

¹Ministry of Health, Ankara Etlik City Hospital, Department of Pediatric Surgery, Ankara, Türkiye

²Ministry of Health, Ankara Etlik City Hospital, Department of Pediatric Urology, Ankara, Türkiye

³Ministry of Health, Ankara Etlik City Hospital, Department of Pediatric Infectious Diseases, Ankara, Türkiye

⁴University of Health Sciences Türkiye, Ankara Etlik City Hospital, Department of Pediatric Surgery, Ankara, Türkiye

ABSTRACT

Brucellar epididymo-orchitis (BEO) is a rare manifestation of brucellosis in pediatric patients and may clinically resemble acute scrotal emergencies such as testicular torsion. A 17-year-old male presented with persistent left testicular pain and fever despite empirical antibiotic treatment. Physical examination revealed tenderness and swelling of the left testis. Laboratory evaluation demonstrated elevated inflammatory markers, while urinalysis and urine culture were unremarkable. Scrotal Doppler ultrasonography demonstrated epididymal enlargement, heterogeneous testicular parenchyma, and increased vascularity. Due to worsening symptoms and inability to exclude testicular torsion, surgical exploration was performed; however, no torsion was identified intraoperatively. Persistent fever despite broad-spectrum antibiotics prompted further investigation. *Brucella* Coombs agglutination testing was positive at a titer of 1/1280, supporting the diagnosis of brucellosis in the clinical context. Previous antibiotic therapy was discontinued, and targeted treatment with doxycycline and rifampicin was initiated. The patient showed rapid clinical improvement and achieved complete recovery after six weeks of therapy. A narrative literature review was conducted to evaluate previously reported pediatric BEO cases regarding clinical presentation, diagnostic findings, and treatment strategies. Brucellosis should be considered in adolescents presenting with treatment-resistant epididymo-orchitis, particularly in endemic regions. Early serological testing may prevent unnecessary surgical exploration and facilitate timely targeted therapy.

Keywords: Brucellosis, epididymo-orchitis, acute scrotum, testicular torsion, pediatric urology

ÖZ

Brusellar epididimo-orşit (BEO), çocukluk çağında brusellozun nadir görülen bir klinik bulgusu olup, testis torsiyonu gibi akut skrotum tablolarını klinik olarak taklit edebilir. On yedi yaşında erkek hasta, ampirik antibiyotik tedavisine rağmen devam eden sol testis ağrısı ve ateş yakınmaları ile başvurdu. Fizik muayenede sol testiste hassasiyet ve şişlik mevcuttu. Laboratuvar incelemelerinde enflamatuvar belirteçlerde yükseklik saptanırken, tam idrar tetkiki ve idrar kültürü normal olarak değerlendirildi. Skrotal Doppler ultrasonografide sol epididimde büyüme, testis parankiminde heterojen görünüm ve artmış vaskülarite izlendi. Klinik bulguların kötüleşmesi ve testis torsiyonunun dışlanamaması nedeniyle skrotal eksplorasyon yapıldı; ancak intraoperatif olarak torsiyon saptanmadı. Geniş spektrumlu antibiyotik tedavisine rağmen ateşin devam etmesi üzerine ileri inceleme yapıldı. *Brucella* Coombs aglütinasyon testi 1/1280 titrede pozitif bulunarak bruselloz tanısı desteklendi. Önceki antibiyotik tedavisi kesilerek doksisisiklin ve rifampisin tedavisi başlandı. Hasta kısa sürede klinik düzelme gösterdi ve altı haftalık tedavi sonunda tamamen iyileşti. Daha önce bildirilen pediatrik BEO olgularının klinik özelliklerini, tanısal bulgularını ve tedavi yaklaşımlarını değerlendirmek amacıyla bir literatür derlemesi gerçekleştirildi. Özellikle brusellozun endemik olduğu bölgelerde, tedaviye dirençli epididimo-orşit ile başvuran adölesan hastalarda bruselloz ayırıcı tanıda mutlaka düşünülmelidir. Erken dönemde serolojik testlerin yapılması gereksiz cerrahi eksplorasyonların önlenmesine ve uygun hedefe yönelik tedavinin zamanında başlanmasına katkı sağlayabilir.

Anahtar kelimeler: Bruselloz, epididimo-orşit, akut skrotum, testis torsiyonu, çocuk ürolojisi

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Corresponding Author

Bekir Erdeve,

Ministry of Health, Ankara Etlik City Hospital, Department of Pediatric Surgery, Ankara, Türkiye

E-mail: bekirerdeve@gmail.com

ORCID: 0000-0002-6340-0664

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INTRODUCTION

Epididymitis is a common urogenital infection in adolescents and young males and usually responds well to antibiotic therapy⁽¹⁾. However, in treatment-resistant cases, underlying systemic infections should be considered⁽²⁾.

Brucellosis is a zoonotic infectious disease caused by Gram-negative *coccobacilli* of the genus *Brucella*, most commonly *Brucella melitensis* and *Brucella abortus*. It is transmitted through the consumption of unpasteurized milk and dairy products, undercooked meat, or direct contact with infected animals such as cattle, sheep, goats, and pigs, including exposure to their urine, body fluids, and contaminated reproductive materials⁽³⁻⁵⁾.

Brucellar epididymo-orchitis (BEO) is a rare but significant complication in children, especially in regions where brucellosis is endemic^(2,3,6). Although epididymo-orchitis is the most frequent genitourinary complication, affecting 2-20% of males with brucellosis, its occurrence in children is often underrecognized^(2,3,6).

Early recognition is crucial to prevent complications such as abscess formation, infertility, or unnecessary surgical intervention⁽⁶⁾. This study presents a case of treatment-resistant epididymo-orchitis initially managed as non-specific epididymitis but later diagnosed as brucellosis.

CASE REPORT

A 17-year-old male presented to our emergency department with persistent left testicular pain lasting six days. He had previously been evaluated twice at another center and treated with oral antibiotics and anti-inflammatory drugs without improvement.

On admission, the patient was febrile with a temperature of 38.5 °C, heart rate of 110 beats/min, and blood pressure of 100/70 mmHg. Physical examination revealed tenderness and swelling of the left testicle. Laboratory findings showed a white blood cell count of 9,510/ μ L (4,000-10,000/ μ L), C-reactive protein level of 51.35 mg/L (0-5 mg/L), aspartate aminotransferase of 49 U/L (0-29 U/L), and alanine aminotransferase of 22 U/L (0-31 U/L). Urinalysis was unremarkable, and urine culture showed no bacterial growth.

Scrotal color Doppler ultrasonography demonstrated enlargement of the left epididymis and a heterogeneous appearance of both the testicular and epididymal parenchyma. The patient, who was a culinary student, reported no clear history of livestock exposure or

consumption of unpasteurized dairy products; however, indirect exposure through handling raw animal products during culinary training was considered a possible risk factor.

Due to persistent symptoms, he was hospitalized and started on intravenous ampicillin-sulbactam and amikacin, along with oral ibuprofen. On the third day of hospitalization, persistent fever prompted consultation with the infectious diseases department, and antibiotic therapy was modified. Blood and urine cultures, *Brucella* serology, and *Brucella* Coombs agglutination testing were obtained.

On the same day, worsening scrotal pain and swelling led to repeat Doppler ultrasonography, which showed increased vascularity and persistent heterogeneity. Given the discrepancy between clinical findings and imaging, and the inability to exclude testicular torsion, surgical exploration was performed. Intraoperatively, marked edema and enlargement of the testis were observed; however, no torsion was detected (Figure 1).

Despite broad-spectrum antibiotic therapy, fever persisted. On the fifth day, the *Brucella* Coombs agglutination test returned positive at a titer of 1/1280, while all cultures remained negative. Based on the clinical presentation, epidemiological context, and positive serological findings, brucellosis was considered the most likely diagnosis. Previous antibiotic therapy was discontinued, and the patient was started on doxycycline and rifampicin.

By the eighth day of targeted therapy, the patient's symptoms had improved significantly. He was discharged with a plan to complete six weeks of treatment, after which full clinical resolution was achieved.

Literature Review

A literature review was conducted to identify previously reported cases of BEO, using PubMed/MEDLINE, Web of Science, Scopus, and TR Dizin databases using combinations of the following keywords: "*brucellosis*", "*epididymitis*", "*epididymorchitis*", and "*children*". Two authors independently screened titles/abstracts and full texts; disagreements were resolved by consensus. The search included articles published in English and Turkish up to January 2026. Additional relevant studies were identified through manual screening of reference lists of selected publications. Eligible studies were case reports and case series describing pediatric patients with BEO. In some studies, although pediatric cases were included, patient-specific details could not be extracted as these



Figure 1. Intraoperative appearance of the testis showing marked edema and enlargement without evidence of torsion

cases were analyzed together with adult cohorts^(2,6-14). Data regarding clinical presentation, laboratory abnormalities, therapeutic strategies, and clinical outcomes were extracted. Given the descriptive nature of this review and the heterogeneity of available reports, no formal systematic selection process or quantitative synthesis was performed. Therefore, the review should be interpreted as a narrative overview of reported pediatric cases.

DISCUSSION

Brucellosis is a zoonotic disease that is endemic in developing countries and is still seen in rural areas of developed countries as well⁽⁸⁾. It is highly endemic in Türkiye and more often seen in the Eastern and Southeastern Anatolia Regions, where farming is more pervasive^(4,13,15). A history of consuming unpasteurized dairy products or contact with livestock is a key risk factor^(13,15-17). BEO is thought to occur primarily through hematogenous spread of the organism⁽⁴⁾. Patients may

present with a variety of clinical symptoms, with fever and arthralgia being the most common, alongside non-specific findings such as weight loss, night sweats, and abdominal pain^(2,17,18). Although epididymo-orchitis is the most common genitourinary involvement of brucellosis—affecting 2-20% of all cases^(2,3,13)—it is rarely the presenting finding⁽³⁾.

Testicular swelling, scrotal erythema, and fever are the leading features of almost every classical epididymo-orchitis case⁽¹³⁾. While adult cases are typically unilateral, bilateral testicular involvement can also be observed in pediatric patients, particularly in younger children^(13,15). Notably, unlike non-specific bacterial epididymitis, lower urinary tract symptoms are usually absent, and urinalysis is frequently normal in BEO^(8,13). Similarly, our patient had a normal urinalysis and sterile urine culture despite significant scrotal inflammation. Furthermore, pediatric BEO can occasionally present alongside unusual complications, such as neurobrucellosis⁽¹⁹⁾, terminal ileitis⁽¹⁾, or pancytopenia⁽²⁰⁾. Because testicular swelling and fever are non-specific findings in epididymo-orchitis, persistent fever despite broad-spectrum antibiotic therapy, together with the endemicity of brucellosis in our region and the patient's possible exposure to raw animal products during culinary training, prompted consideration of brucellosis.

The differential diagnosis of acute scrotal swelling in children should include tumor, trauma, hematoma, cyst, torsion, and other acute or chronic infections (e.g., abscess, gonorrhea, tuberculosis, mumps, syphilis, or chlamydia)^(2,3,15,16,20). Besides clinical findings and physical examination, scrotal Doppler ultrasonography, testicular scintigraphy, and magnetic resonance imaging can be used in differential diagnosis^(2,3). Ultrasonography findings of BEO typically include testicular and epididymal enlargement, heterogeneous echotexture, and hypervascularity^(3,13). A key challenge in the present case was the differentiation from testicular torsion. Although Doppler ultrasonography demonstrated increased vascularity—favoring an inflammatory process—the progression of symptoms and inconclusive clinical findings necessitated surgical exploration. However, no evidence of torsion was detected intraoperatively. Subsequent serological evaluation supported the diagnosis of brucellosis in the appropriate clinical and epidemiological context, and targeted therapy was initiated. This highlights a critical dilemma in pediatric urology: Balancing the risk of missing torsion against the possibility of unnecessary surgery.

BEO is much less common in children than in adults^(8,18). In their cohort, Çıraklı et al.⁽⁴⁾ reported that 1.9% of their patients had epididymo-orchitis, and Karaman et al.⁽¹⁷⁾ similarly reported a rate of 1.3%. However, a meta-analysis by Zheng et al.⁽⁵⁾ demonstrated that children remain at a notable risk, with the incidence of BEO being 9% in pediatric male patients. The literature indicates that pediatric BEO is predominantly seen in adolescents, such as a 16-year-old male patient reported by Tanıdır et al.⁽³⁾ who presented to the hospital with left testicular swelling and high fever, or an 18-year-old patient described by Günel et al.⁽¹⁶⁾ with pain and swelling in the left testicle. Nevertheless, it can occasionally affect younger children and toddlers, with reports of BEO in children aged 55 months, 110 months, and 9 years^(13,15), as well as an 8-year-old immunosuppressed patient with *Brucella abortus* infection⁽²¹⁾. This review of the literature indicates that most pediatric BEO cases present with unilateral involvement and respond well to medical

therapy. Surgical intervention is rarely required when the diagnosis is established early (Table 1).

Early diagnosis and treatment are critical to avoid complications such as testicular abscess, necrotizing orchitis, oligospermia, and azoospermia^(4,16). The optimal treatment regimen for pediatric brucellosis has not been clearly established and should be individualized according to patient age, disease severity, organ involvement, and drug safety profiles. In children aged 8 years and older, doxycycline combined with rifampicin is commonly recommended, whereas trimethoprim-sulfamethoxazole-based regimens are generally preferred in younger children. The addition of an aminoglycoside, such as streptomycin or gentamicin, may be considered in selected severe or complicated cases but is not routinely required for all patients with BEO^(13,15,22).

Table 1. Review of pediatric BEO cases in the literature

Study	Age (years)	Laterality	Clinical features & complications	Coombs agglutination positivity	Management
Gayretli Aydın et al. ⁽²³⁾	16	Left	Scrotal pain and swelling, high fever	1/160	Doxycycline+rifampicin for 6 weeks
Çıraklı et al. ⁽⁴⁾	14	NR	Scrotal pain and swelling	1/1280	Not specified
Guler et al. ⁽²⁰⁾	15	Left	Scrotal swelling, pancytopenia	1/640	Doxycycline + streptomycin
Günel et al. ⁽¹⁶⁾	18	Left	Scrotal pain and swelling	1/160	Streptomycin + rifampicin → rifampicin + tetracycline 45 days total
Kanık-Yüksek et al. ⁽¹⁹⁾	15	Left	Scrotal pain, neurobrucellosis	1/320	Doxycycline+rifampicin for 6 months with ceftriaxone for 3 weeks
Karli et al. ⁽¹⁸⁾	14	Right	Scrotal swelling and pain	1/1280	Doxycycline for 6 weeks + streptomycin for 2 weeks
Kasap and Küpeli ⁽²¹⁾	8	Bilateral	Febrile neutropenia, immunosuppression	NR	Doxycycline+rifampicin for 6 weeks
Oguz and Oztek-Celebi ⁽¹¹⁾	17	Right	Scrotal pain, terminal ileitis	1/640	Doxycycline+rifampicin for 6 weeks
Savasci et al. ⁽¹³⁾	9	Bilateral	Scrotal swelling	Not specified	Not specified
Tanıdır et al. ⁽³⁾	16	Left	Testicular swelling, high fever	1/160	Rifampicin + tetracycline for 6 weeks
Teke et al. ⁽²⁴⁾	13	Right	Scrotal swelling	1/1280	Doxycycline+rifampicin for 6 weeks
Uygun and Turgut ⁽¹⁵⁾	4.5*	Bilateral	Scrotal pain	1/640	TMP-SMX + rifampicin for 6 weeks + gentamicin for 5 days
Uygun and Turgut ⁽¹⁵⁾	9.1*	Bilateral	Scrotal pain	1/640	Doxycycline + rifampicin for 6 weeks + gentamicin for 5 days
Uygun and Turgut ⁽¹⁵⁾	15.8*	Bilateral	Scrotal pain	1/1280	Doxycycline + rifampicin for 6 weeks + gentamicin for 5 days
Current case	17	Left	Scrotal pain and swelling, persistent fever, suspected torsion	1/1280	Doxycycline + rifampicin for 6 weeks

BEO: Brucellar epididymo-orchitis, NR: Not reported, TMP-SMX: Trimethoprim-sulfamethoxazole, *: Converted from months to years

Most pediatric cases respond well to medical therapy, with surgical intervention (such as orchiectomy) rarely needed if diagnosed early^(6,8,13,15,18). Delayed or inappropriate treatment, however, can lead to irreversible damage or infertility^(9,15,16,18). Our patient received doxycycline and rifampicin for six weeks, and his symptoms resolved. In endemic regions, early serological testing for *Brucella* species should be considered in adolescents with epididymo-orchitis who fail to respond to empirical antibiotic therapy.

BEO should be considered in adolescents presenting with treatment-resistant epididymitis, especially in endemic regions. Early serological evaluation may prevent unnecessary surgical exploration and enable timely initiation of targeted therapy, thereby reducing the risk of complications.

Ethics

Informed Consent: Written informed consent was obtained from the patient's legal guardian.

Declaration of AI Use: During the preparation of this manuscript, ChatGPT (OpenAI, San Francisco, CA, USA) was used for English-language editing and improvement of clarity. The authors reviewed and edited all AI-assisted content and take full responsibility for the integrity and content of the manuscript.

Footnotes

This case was presented as an oral case presentation at the 15th National Congress of Pediatric Urology, Kyrenia, Turkish Republic of Northern Cyprus, 2025.

Author Contributions

Surgical and Medical Practices: B.E., H.C.D., Z.S.Ş., A.U., İ.K., Concept: B.E., H.C.D., Design: Z.S.Ş., İ.K., Data Collection or Processing: H.C.D., Z.S.Ş., Analysis or Interpretation: B.E., H.C.D., Z.S.Ş., A.U., Literature Search: B.E., A.U., Writing: B.E., H.C.D.

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