OKLAHOMA DEPARTMENT OF CORRECTIONS
NURSING PRACTICE PROTOCOLS

MSRM 140117.01.7.6
(R-2/20)

Torsion/Epididymitis

Subjective Data: **Allergies:** _____

Chief complaint: _____

Onset:_____ ❑ New ❑ Sudden ❑ Chronic ❑ Recurrence

History:

Previous testicular torsion: ❑ Yes ❑ No	History of enlarged prostate gland: ❑ Yes ❑ No
Family history of testicular torsion: ❑ Yes ❑ No	Recent injury or trauma to groin area: ❑ Yes ❑ No
An uncircumcised penis: ❑ Yes ❑ No	Strenuous physical activity: ❑ Yes ❑ No
Recent urinary tract infection: ❑ Yes ❑ No	History of insertion of a urinary catheter or scope into the penis. ❑ Yes ❑ No

Associated Symptoms:

❑ **Sudden**, severe pain in the scrotum	❑ Mild irritation	❑ Abdominal pain	❑ Nausea/vomiting
❑ Blood in the semen	❑ Blood in the urine	❑ Discharge from penis	❑ Painful urination
❑ Urine urgency/frequency	❑ Fever	❑ Light-headedness	

What, if anything, seems to improve or worsen your symptoms? _____

Objective Data: (clinically indicated VS)
BP _____Pulse _____ Resp. _____ Temp. _____ Wt._____O_2 sats._____ FSBS: _____

Scrotum	❑ Swelling of the scrotum
	❑ A testicle positioned higher than normal or at an unusual angle
	❑ Supported testes provides no relief (suspect torsion)
	❑ Supported testes provides relief (suspect epididymitis)

CRITICAL: TESTICULAR TORSION REQUIRES IMMEDIATE MEDICAL ATTENTION. A DELAY IN DIAGNOSIS AND MANAGEMENT CAN LEAD TO LOSS OF THE TESTICLE. *Health care provider must be called if not on site or if after clinic hours.*

Emergency Room Notified: Time: _____ Emergency transport: Time: _____ Transported by: _____

REFER TO HEALTH CARE PROVIDER IF: *If during clinic hours the health care provider is to be called if not on site. If after clinic hours the health care provider is to be called the next working day.*

❑ Fever
❑ Antibiotics treatment required

Health Care Provider: _____ Time Notified: _____ Orders Received for Treatment: ❑ Yes ❑ No

If physical exam is negative for any of the above s/s and/or there is no need for additional medication/treatment, proceed with nursing interventions.

Plan: Interventions: (check all that apply)

❑ Check in assessment only for health care providers visit.
❑ Chief complaint resolved prior to appointment. Instructed inmate to follow-up sick call for signs/symptoms warranting further evaluation. Assessment completed.
❑ UA Dipstick.
❑ Prepare for urethral culture if discharge present. **(This will require an order from the health care provider)**
❑ Apply cold packs to your scrotum as tolerated.
❑ Scrotum support.
❑ Avoid lifting heavy objects.
❑ Acetaminophen 325 mg - 2 tablets p.o. three times a day for 4 days PRN
OR
❑ Ibuprofen 200 mg – 2 tablets p.o. three times a day for 4 days PRN
❑ Medical lay-in.
❑ Education/Intervention: Instructed to protect scrotal or groin area, avoid strenuous physical activity, medication use, follow-up sick call if no improvement. Inmate verbalizes understanding of instructions.

Progress Note: _____

Health Care Provider Signature/Credentials: _____ **Date:** _____ **Time:** _____

RN/LPN Signature/Credentials: _____ **Date:** _____ **Time:** _____

Inmate Name (Last, First) DOC #