

CASE REPORTING ON TESTICULAR TORSION IN UNDESCENDED TESTIS

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ABSTRACT

Each year testicular torsion affects 1 in 4000 young males less than 25 years of age. Early diagnosis and definitive management is the key to avoid testicular loss. Undescended testis, or cryptorchidism, which occurs in 2 to 5% of boys born at term, is one of the most common congenital abnormalities. (1) We present case of 26 year male with testicular torsion in undescended testis.

Key words:

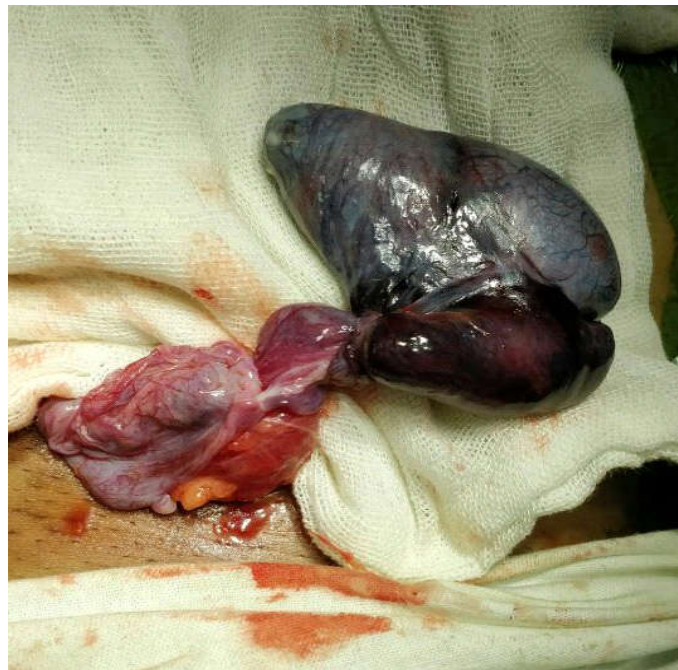
Testicular torsion, undescended testis, cryptorchidism, congenital.

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INTRODUCTION

Case report

26 year male came with 4 days history of pain and swelling in right inguinal region with history of absence of right testis in right scrotal sac.



On examination there was tenderness in right inguinal region, no cough impulse and absence of right testis. Immediately inguino scrotal Doppler was done which was suggestive of torsion of right testis which was in inguinal region with no blood flow in right testis. Right inguinal exploration was done and there was gangrenous right testis in inguinal region with 360 degree torsion. Testis was derotated, but since it was totally gangrenous, orchidectomy was done. Post operative course was uneventful.

DISCUSSION

The annual incidence of testicular torsion is one in 4,000 males younger than 25 years.(2) Intravaginal torsion, caused by a congenital malformation of the processus vaginalis, accounts for 90 percent of cases.(3) In this malformation, the tunica vaginalis covers not only the testicle and the epididymis but also the spermatic cord. This creates a “bell-clapper deformity” that allows the testis to rotate freely within the tunica vaginalis. Torsion usually occurs in the absence of any precipitating event (4); only 4 to 8 percent of cases are a result of trauma. (5) Other factors predisposing patients to testicular torsion include an increase in testicular volume (often associated with puberty), testicular tumor, testicles with horizontal lie, a history of cryptorchidism, and a spermatic cord with a long intrascrotal portion. (6) Torsion initially obstructs venous return. Subsequent equalization of venous and arterial pressures compromises arterial flow, resulting in testicular ischemia. The degree of ischemia depends on the duration of torsion and the degree of rotation of the spermatic cord. Ischemia can occur as soon as four hours after torsion and is almost certain after 24 hours. Testicular torsion must be diagnosed quickly and accurately. Delay in diagnosis (and subsequent delay in surgery) risks testicular viability, whereas

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over diagnosis subjects patients to unnecessary surgery. Studies have shown that between 16 and 42 percent of boys with acute scrotal pain have testicular torsion. (7-9). The differential diagnosis of the acutely painful scrotum includes testicular torsion, trauma, epididymitis/orchitis, incarcerated hernia, varicocele, idiopathic scrotal edema, and torsion of the appendix testis. The most sensitive physical finding in testicular torsion is the absence of the cremasteric reflex. This reflex is elicited by stroking or pinching the medial thigh, causing contraction of the cremaster muscle, which elevates the testis. Intratesticular blood flow can be visualized with Doppler ultrasonography. In patients with testicular torsion, the blood flow in the symptomatic testis is decreased or absent compared with the asymptomatic testis. Surgical treatment involves derotation of the torsion testis and to look for viability of testis, if no signs of viability then orchidectomy is done with opposite side orchidopexy.

CONCLUSION

This case report emphasis on possibility of torsion of undescended testis and importance of thorough clinical examination to reach diagnosis of undescended testicular torsion.

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