

ACUTE SCROTAL DISORDERS

Testicular torsion

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Intravaginal (bell clapper) testicular torsion is well recognised in adolescents but may occur at any age. Abnormal posterior anchoring of the testis allows torsion within the tunica vaginalis. Torsion compromises blood flow, causing acute scrotal or abdominal/groin pain, nausea and vomiting. Tenderness, an absent cremasteric reflex and a high testis may be found on examination; oedema and erythema appear later. Sometimes there have been transient episodes (intermittent torsion). Doppler ultrasound may help (Figure 17.5). Exploration within 6–8 hours of the onset of symptoms improves the chances of testicular salvage. At operation, testicular viability is assessed after derotation (Figure 17.6). Only gangrenous testes should be excised since some severely compromised testes survive, and those that then atrophy are not harmful. If salvageable, three-point fixation of both testes with non-absorbable sutures is performed or a dartos pouch is fashioned. Extravaginal torsion is seen in newborns, with 70% occurring prenatally and 30% postnatally; emergency neonatal exploration remains controversial since salvage rates are low. ACUTE SCROTAL DISORDERS Testicular torsion

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