Treatment

Treatment

Varicocele repair can be e ff ective in men with a low sperm count, a clinical varicocele and otherwise unexplained infer tility . However, treatment of varicocele in adolescents poses a risk of overtreatment: most boys with a varicocele will have no fertility problems later in life. When the discomfort is significant, then percutane ous embolisation of the gonadal veins is the usual first-line Summary box 86.4 Varicocele /uni25CF /uni25CF /uni25CF Antonio Maria Valsalva , 1666–1723, Italian physician and anatomist. (as it does in around 20% after embolisation), surgical ligation of the testicular veins is the appropriate treatment, although recurrence can occur even after such surgery . Current evi - dence indicates that microsurgical varicocelectomy is the most e ff ective method among the di ff erent surgical varicocelectomy techniques, with fewer complications and lower recurrence rates. -

Varicocele is a common condition and 90% are left sided The presence of varicocele in some men is associated with progressive testicular damage from adolescence onwards and a consequent reduction in fertility Varicocele repair can be effective in men with a low sperm count, a clinical varicocele and otherwise unexplained infertility

Treatment

Congenital hydroceles are treated by ligation of the patent processus vaginalis (herniotomy) if they do not resolve spon - taneously . - Small hydroceles do not need treatment. If they are size - able and bothersome for the patient, then surgical treatment is indicated. Established acquired hydroceles often have thick walls. Ther e are three main surgical techniques for hydroceles: 1 Plication . Lord’s operation is suitable when the sac is reasonably thin walled (Figure 86.10). There is minimal dissection and the risk of haematoma is reduced. 2 Eversion . The sac is opened and everted behind the tes - tis, with placement of the testis in a pouch prepared by en. dissection in the fascial planes of the scrotum (Jaboulay’s - procedure) (Figure 86.10).

(courtesy of Dr Davide Prezzi).

3 Aspiration of the hydrocele fluid is simple, but the fluid always reaccumulates within a week or so. It may be suitable for men who are unfit for scrotal surgery , although hydro cele surgery can be undertaken under local anaesthetic. Aspiration can result in bleeding into the hydrocele sac and haematocele formation. Injection of a sclerosant, such as tetracycline, can be e ff ective but painful. Summary box 86.5 Hydrocele /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF

Figure 86.10 Lord’s operation (a) . A series of interrupted absorbable sutures is used to plicate the redundant tunica vaginalis. When these are tied, the tunica bunches at its attachment to the testis. Jabou lay’s procedure (b) . The hydrocele sac is everted and anchored with sutures. Unless great care is taken to stop bleeding after excision of the wall, haemorrhage from the cut edge is liable to

cause a large scr otal haematoma. Overrunning stitches at the cut edge can be used to reduce this risk. A hydrocele is a collection of /f_l uid within the tunica vaginalis Hydroceles surround the testis and transilluminate brightly Ultrasound examination is valuable, especially when the testis and epididymis are impalpable Hydroceles can be treated conservatively unless they are large and symptomatic Surgery is the mainstay of treatment Testicular malignancy is an uncommon cause of hydrocele that can be excluded by ultrasound examination

Treatment

Treatment of a case of Fournier’s gangrene is a surgical emer - gency . Initial management involves intravenous fluid resuscita - tion and broad-spectrum intravenous antibiotics. Urgent wide - surgical excision of the dead and infected tissue is essential and the extent of the internal necrosis is typically much greater than the external appearances suggest, with extensiv e debride - ment often necessary . Urinary and faecal diversion may be necessary . Supportive care is essential because patients often become severely septic. Early review of the wounds is helpful to confirm that all ved; when the infection has been dead tissue has been remo controlled, vacuum-assisted dressing is helpful, if it is available. If the patient survives the acute episode, skin g rafting is often necessary . Despite best therapy , mortality rates as high as 50% are often reported. Summary box 86.10 Fournier’s gangrene /uni25CF /uni25CF

Fournier’s gangrene requires early and aggressive treatment if the patient is to survive Treatment involves urgent surgical debridement of necrotic tissue in combination with early use of intravenous broad- spectrum antibiotics

Figure 86.20 Scrotal cancer.

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