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Medical Memorandum

Three Cases of Torsion of the Testis

Torsion of the testis is uncommon, and when it has a gradual onset it can easily be mistaken for acute epididymitis. Three new cases are recorded which emphasize the difficulties in early diagnosis described in full by Kennedy (1948) and Walton (1952).

CASE 1

A private soldier aged 19 woke with pain and swelling in the left testicle. Four and a half hours later he was referred for admission as a case of acute epididymitis. On examination he was afebrile and not in severe pain. The left side of the scrotum was swollen, red, oedematous, tender, and faintly ecchymosed round its neck. The skin was not adherent to the testis. Lifting the scrotum made no difference to the pain. Through a shallow hydrocele the epididymis could just be made out, lying anterior to the testis. The cord and opposite testis were normal. Examination per rectum and of the urine showed nothing abnormal.

Operation.—The testicle was delivered through a left inguinal incision. The hydrocele contained blood-stained serous fluid. The testis and epididymis were congested, with petechiae and subserous haemorrhages, and were rotated on a narrow pedicle through 180 degrees. After untwisting the testis the colour gradually returned. The surplus tunica vaginalis was resected, and after the testis was replaced the wound was closed without drainage.

Post-operative prophylactic streptomycin was given for 48 hours. Recovery was uneventful. Six weeks later the testis and epididymis were found to be normal in size, position, and consistence.

CASE 2

A lance-corporal aged 20 had intermittent sharp pain in the left loin whilst lifting heavy crates. Two days later the left testicle began to ache, and the next day it became swollen, and a diagnosis of acute epididymitis was made elsewhere. He was admitted on the following day. On admission he remembered three identical attacks in the last four years, during the first of which his appendix was removed. On examination he was afebrile. There was a red tender oedematous swelling of the left scrotum, the skin of which was not bruised or adherent to the testis. Elevation made the pain worse. The testis was indistinguishable from the epididymis; a tense hydrocele was present, and the cord was swollen and tender. Examination per rectum and of the urine showed nothing abnormal.

Operation.—Through a left inguinal incision an elongated tense purple hydrocele containing serofibrinous fluid was delivered. The testis and epididymis were attached at their upper pole by a rounded pedicle which had been twisted through almost one complete turn. The testis was pale, cyanosed, and black at its inferior pole, and the epididymis was congested and haemorrhagic. The vas deferens made a long loop in the parietal layer of the tunica vaginalis, which therefore could not be resected. When the colour was restored the testis was replaced in the scrotum and sutured to the dartos, and the skin closed without drain-

age. Prophylactic streptomycin was given for two days. Recovery was uneventful. One month later the testicle was normal in size and sensation.

CASE 3

A private soldier aged 21 was admitted complaining of lower abdominal pain and nausea for four days and swelling and pain in the right testicle for two days. Acute epididymitis had been diagnosed and sulphonamides had been given for two days before admission. On admission he was afebrile, and the only abnormal finding elsewhere was a scar, from tuberculous glands in the right side of his neck when he was 8. The left testis was normal. The right side of the scrotum was swollen, oedematous, red, and tender, and the testis and epididymis were indistinguishable in a tense hydrocele which adhered to the skin. Elevation made the pain worse. Examination per rectum and of the urine revealed nothing abnormal.

Operation.—Through a right inguinal incision a black hydrocele containing a haemorrhagic effusion was delivered. The testis had rotated anticlockwise through one and a half turns and was cyanosed and soft, while the epididymis resembled a clot of blood. Twenty minutes after untwisting the testis its colour had scarcely improved, but it was returned to the scrotum, and after dusting with penicillin-sulphathiazole powder the skin was closed without drainage.

Prophylactic streptomycin was given for five days afterwards, and recovery was uneventful. One month later, at a second operation through a small scrotal incision, the left testis was sutured to the areolar tissue of the scrotum. Eight weeks later both testicles were found to be normal in size, consistence, and sensation, and the patient was enjoying normal intercourse with his wife.

COMMENT

In adolescent boys "epididymitis" must be regarded as torsion of the testis or its appendix until proved otherwise (Dix, 1931). It is no less important to find good reason for a diagnosis of epididymitis in older patients, for many cases of torsion give a misleading history, lacking the story of trauma, abdominal pain, and vomiting of classical description (Kennedy, 1948). In early cases the local signs are ambiguous, swelling, redness, oedema, and hydrocele being common to both conditions, and unless seen very early the abnormal relations of the parts are obscured by swelling and pain. Dillon's sign (tethering of the skin in torsion) can occur in either condition, and elevation of the scrotum is of doubtful value, being painful whenever the scrotum is tender. Torsion is equally common on either side (Kennedy, 1948), and fever may occur with either condition.

The only reliable guide is the presence or absence of urinary infection, so a careful examination of the urethra, prostate, vesicles, and urine must be done in each case. If there is still any doubt then one should explore, rather than wait until gangrene of the testis makes itself plain. The different estimates of the survival time of the organ (Walton, 1952; Bailey, 1953) can only be a rough guide, because the tightness of the twist may vary from case to case. It is never safe to wait.

If operation is done in time the testis can be untwisted. A frankly gangrenous testicle is usually removed, but a doubtfully viable organ should, I feel, be restored, for it may recover against every expectation, as did Case 3.

If the underlying anomaly—abnormal mobility of the testis within the tunica vaginalis—is bilateral, the other testicle will be apt to twist. If one is already damaged, or absent, this risk should be explained to the patient and the remaining testicle made secure at a later operation, if he wishes.

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