

Perinatal Testicular Torsion; Understand the Urgency and Tactis

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Testicular torsion in the newborn was first time reported by Taylor in 1897. But it took a long time for it to be known as a vascular emergency that needs immediate diagnosis and urgent surgery. Neonatal testicular torsion also known as perinatal testicular torsion (PTT) has significant controversies regarding its etiology, presentation, surgical management and outcome.

Recently it has been subcategorized as either occurring prenatally in utero or postnatally in the first month of life. PTT is always extravaginal which means the testis, epididymis, and tunica vaginalis twist on the spermatic cord. Intravaginal torsion often occurs in older children and is associated with a bell-clapper deformity. According to literature review PTT includes neonates with 5 definite clinical scenarios: 1) If torsion occurs in intrauterine period months before birth, the newborn will have an absent (vanishing testis) or a nubbin testis. In case of (vanishing testis), the patient should be managed as cryptorchid between 6 and 12 months of age. In the second case nubbin can be removed as a result of a long standing intrauterine testicular torsion. 2) If torsion occurs a few weeks before birth, the child will present at birth with a firm and painless scrotal swelling, a little higher in the scrotum and a bit smaller than the opposite normal testis. It will not show acute inflammatory signs. 3) If torsion occurs in the prenatal period a few days before birth, the newborn will present with a firm, and painless scrotal mass, bigger in size than the opposite normal testis, without acute inflammatory features. 4) If torsion occurs a few days or several hours before birth, the newborn will be born with a painful, slightly enlarged hemiscrotum, with reddish or bluish discoloration. Testis will be higher and usually horizontal in position. Area of spermatic cord will also be tender to touch. 5) If torsion occurs in first month of life, the neonate will be born without any

scrotal signs at birth and the signs of acute inflammation will at the time of torsion.

Regarding management, most of the literature is in favour of immediate surgical exploration because surgery is the only way to confirm testicular ischemia and small risk of asynchronous torsion in the perinatal period which can be dealt by early contralateral orchiopexy. Color Doppler and radionuclear scans may help in diagnosis but are not 100% reliable.

Some investigators are of the opinion that since predisposing factors are not evident in extravaginal torsion, there is no need for contralateral orchidopexy. On the other hand most of the literature with bilateral intrauterine torsion supports a predisposing factor. Asynchronous bilateral torsion is uncommon but it may occur at any time and has been reported within 48 hours after torsion on the other side. So, most of the authors agree on exploring the contralateral side in the same operation or soon after that, depending on stability of the patient.

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