Downloaded from www.medrech.com
"Isolated tubercular testicular abscess with pyocele: An extremely rare presentation"

Medico Research Chronicles

ISSN No. 2394-3971

Case Report

ISOLATED TUBERCULAR TESTICULAR ABSCESS WITH PYOCELE: AN EXTREMELY RARE PRESENTATION

Digvijoy Sharma[1], Rajesh Nair*, Vijay Koduru[2], Vinay K[4], Binita Dipak Vadhar[3]

[1]Asst Prof., Dept of General Surgery, Kasturba Medical College, Manipal University
[2]Senior Resident, Dept of General Surgery, Kasturba Medical College, Manipal University
[3]Intern, Department of General Surgery, Kasturba Medical College, Manipal University
[4]Junior Resident, Department of General Surgery, Kasturba Medical College, Manipal University, Manipal, India

Submitted on: April 2015
Accepted on: April 2015
For Correspondence
Email ID:
neurodoc39@gmail.com

Abstract
Despite the genitourinary tract being one of the most common sites affected by extrapulmonary TB, isolated testicular TB is very rare and presentation as acute abscess formation with pyocele is hardly mentioned in literature.

Key words: Tuberculosis, testicular abscess, pyocele.

Case Report

A 25 year old male presented to our hospital with right hemiscrotal pain and swelling associated with fever with chills and rigor of 7 days duration. He was given a trial of antibiotics at a different hospital and did not respond to it and hence was referred to our centre. He had no other co-morbidities. He had no urinary symptoms.

On examination he was febrile and the right hemiscrotum was swollen (Figure 1), erythematous and tender. The right testis was enlarged and tender. The left hemiscrotal examination was unremarkable.

Blood investigations revealed leucocytosis and rest of the parameters were within normal limits. Ultrasound of the scrotum showed multiple intratesticular collections suggestive of abscesses and pyocele.

The patient was taken up for scrotal exploration under spinal anesthesia. Intraoperatively, the right testis had multiple abscesses (Figure 1), some of which has ruptured spontaneously and there was destruction of the parenchyma, hence an orchidectomy was performed along with drainage of pyocele.

Post operative period was uneventful. The final histopathology (Figure 2) report of the orchidectomy specimen revealed tuberculosis which was a histological surprise. He was given ATT for 6 months and tolerated the regimen well and is asymptomatic at present.

Discussion

Genitourinary TB is the second most common site of involvement among extra-pulmonary TB [1]. Isolated genital

Downloaded from www.medrech.com

involvement is seen in about 28% of these patients. [2]. The most common site is the epididymis, and isolated testicular tuberculosis is rare [3, 4]. Epididymal involvement occurs either haematogenously or by a retrograde pathway from an infected prostate. From the epididymis it might spread to the testis. The most probable etiology of isolated tubercular orchitis is spread by hematogenous route rather than the usual direct extension from the epididymis which is the likely etiology in our case.

Diagnosis of isolated tubercular orchitis may be impossible in the absence of a histologic finding and a high index of suspicion is required in cases like ours where it closely mimics acute bacterial orchitis.

Once diagnosed, the treatment consists of Antitubercular Therapy (ATT) for 6 months which is effective in most of the patients [5]. In a scenario like our case in which the testicular parenchyma is destroyed by multiple abscesses, an orchidectomy is warranted.

A literature search yields very few reports of isolated tubercular orchitis with extratesticular spread,[6,7,8] and to the best of our knowledge , this is the first reported case of genitourinary tuberculosis presenting with acute isolated orchitis with multiple parenchymal abscesses and pyocele.

References

1. Wise GJ, Marella VK. Genitourinary manifestation of tuberculosis. *Urol Clin North Am.*2003; 30:111–21.
2. Wolf JS, McAninch JW. Tubercular epididymo-orchitis: Diagnosis by fine needle aspiration. *J Urol.* 1991; 145:836–38.
3. Wise GJ, Shteynshlyuger A. An update on lower urinary tract tuberculosis. *Curr Urol Rep.* 2008; 9:305-13.
4. Viswaroop BS, Kekre N, Gopalakrishnan G. Isolated tuberculous epididymitis: A review of forty cases. *J Postgrad Med.* 2005; 51:109-11.
5. Cek M, Lenk S, Naber KG, Bishop MC, Johansen TE, Botto H, et al. EAU Guidelines for the Management of Genitourinary Tuberculosis. *European Urology.* 2005;48;353–62.
6. Garbyal RS, Sunil K. Diagnosis of isolated tuberculous orchitis by fine-needle aspiration cytology. *Diagn Cytopathol*. 2006; 34:698–700.
7. Shah H, Shah K, Dixit R et al (2004) Isolated tuberculous epididymo-orchitis. Indian J Tuberc 51:159–162
8. Biswas M, Rahi R, Tiwary SK et al (2006) Isolated tuberculosisof testis. Kathmandu Univ Med J 13:98–9

Downloaded from www.medrech.com

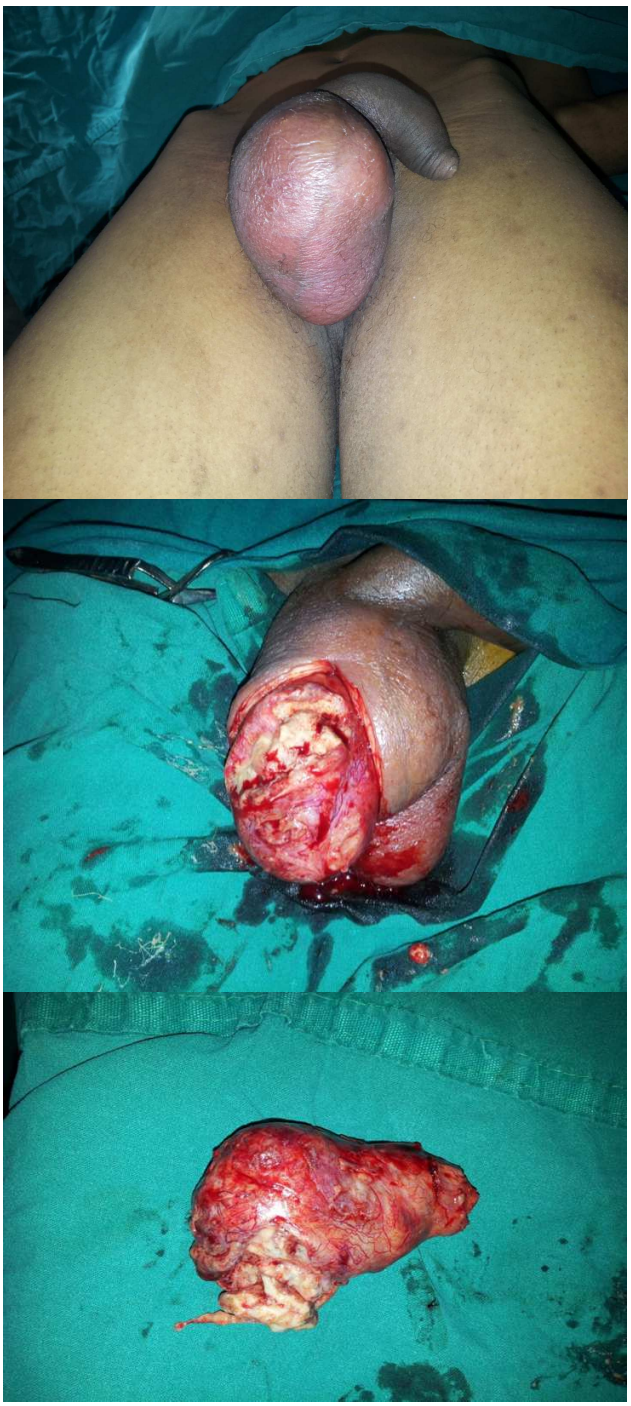

Figure 1: Swollen, erythematous right hemiscrotum, below are the intraoperative images demonstrating the abscess with parenchymal destrcution.

Downloaded from www.medrech.com

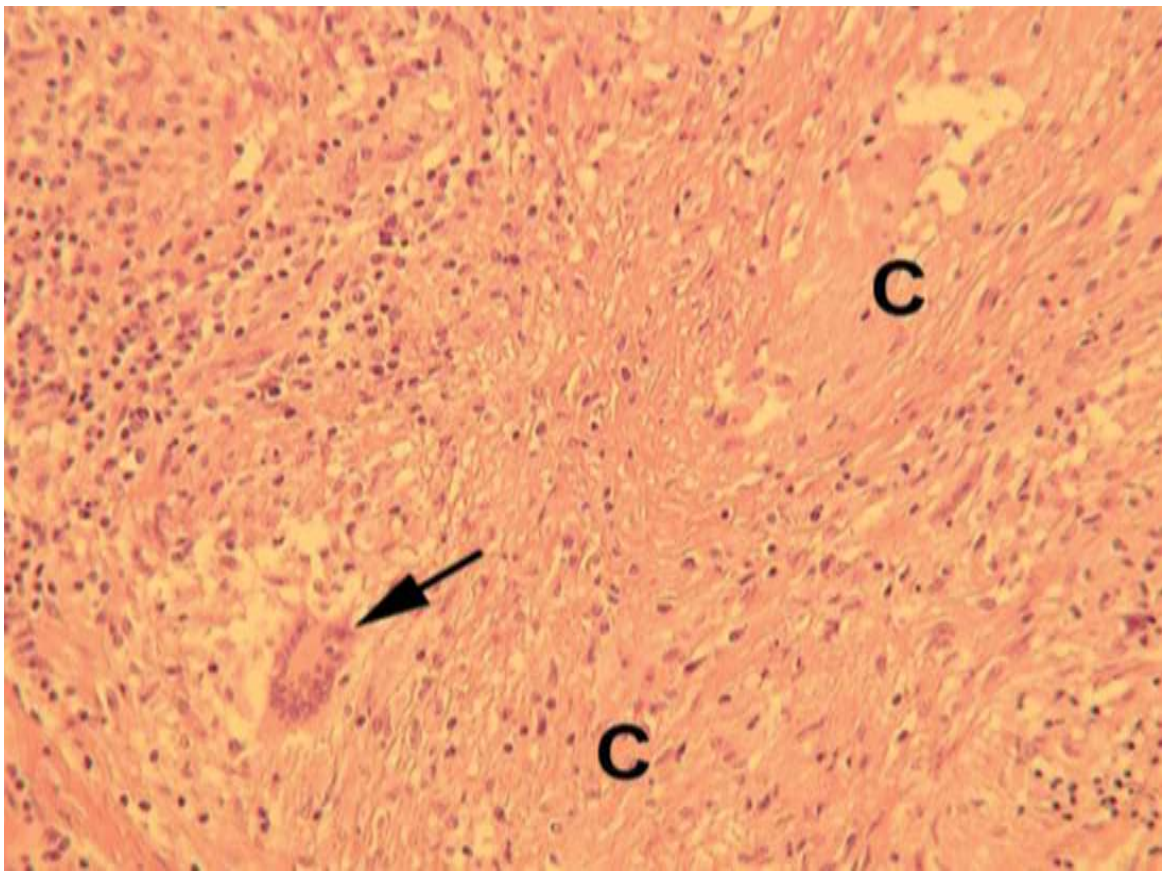

Figure 2: Hematoxylin-Eosin staining, showing caseating necrosis (C), multiple epithelioid cells and a multinucleated giant cell (arrow).