

INTRAABDOMINAL TESTIS CAUSING BOWEL OBSTRUCTION IN ADULT AGE GROUP

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INTRODUCTION

Small bowel obstruction is a common entity with multiple possible causes. Rarely, congenital intraabdominal testes may present as bowel obstruction in adults.

CASE REPORT

A 60 year old male presented with 1 day of central abdominal pain with nausea. He had bowel function on the day of admission. Vital signs were normal and abdominal examination revealed epigastric tenderness and a reducible nontender ventral hernia. He had had no prior surgeries or similar episodes. Laboratory testing revealed leukocytosis of 12.8 and lactic acid of 1.0 (normal). CT scan revealed dilated small bowel with possible transition point between dilated and compressed bowel loops. He was admitted for observation and bowel rest. Over the next 2 days, he reported worsening abdominal pain and distension. He received a nasogastric tube which drained 1 liter over 24 hours. Repeat CT scan showed worsening bowel dilation and copious intraperitoneal free fluid. He continued to pass flatus and leukocyte count was normal. In view of his worsening symptoms and CT findings, he underwent exploratory laparotomy. Operative findings showed dilated but viable bowel, and copious clear fluid. Fibrous bands were seen between the omentum, abdominal wall and the antimesenteric bowel wall. The bands arose from a mass in the left abdomen that appeared gonadal. The bowel had volvulised around the bands. The left testicle was not palpable. The mass was excised, the bands lysed and the procedure concluded in standard fashion. Pathology revealed the mass to be a testis. The patient recovered well and was discharged on postoperative day 4.

Figure 1 CT scan with IV contrast on admission showing intra abdominal testis, Figure 2 CT scan with IV contrast on admission showing intraabdominal testis, Figure 3 Worsening of CT scan 1 day after admission, Figure 4 Xray done 2 days after admission showing distended bowel, Figure 5 Mass excised at exploratory laparotomy

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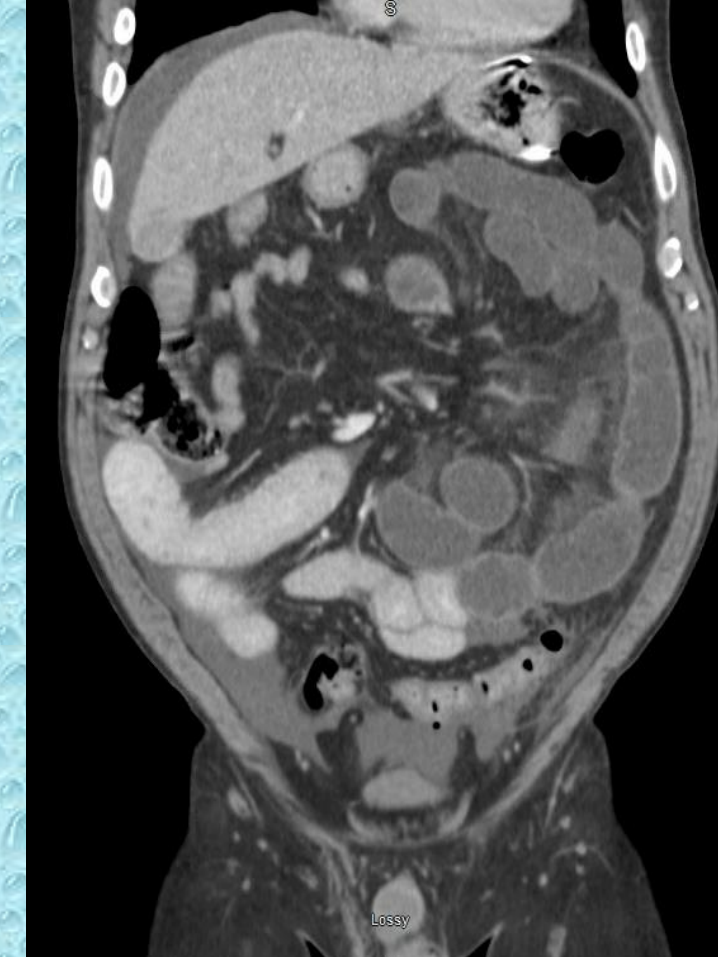
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DISCUSSION

Congenital undescended testes occur in 3% of fullterm and 30% of preterm male neonates. Spontaneous descent occurs by 1 year in 60%. The risk of seminoma in cryptorchid testes is 10 to 40 times that of normal testes⁽¹⁾. Surgical exploration and excision is recommended within 6 months^(2,3). 12 to 24% of undescended testes are not palpable⁽⁴⁾. 12 to 30% of nonpalpable testes are palpable under anesthesia⁽⁵⁾. Ultrasound to locate non palpable testes has a sensitivity of 45% and specificity of 78%⁽⁵⁾. It is useful in obese children⁽⁶⁾. Surgical exploration may adopt either an inguinal or laparoscopic approach^(4,5). The testis is intraabdominal in 6% of cases and the testis is absent in 56%. For high intraabdominal testes, the procedure of choice is the 2 staged laparoscopic Fowler Stephens orchiopexy⁽⁷⁾. All nonpalpable testes should be worked up and excised in a timely manner to prevent malignancy⁽¹⁾. Undescended testis should be considered in the diagnosis of intraabdominal pathology such as bowel obstruction in adults.

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