The Nigerian Journal of GENERAL PRACTICE

Case Report

Management of Primary Vaginal Hydrocele in an Elderly Man: Application of Common Ground Approach to Decision Making

[1]Ajuonuma Onyekachi Fidelis, [2]Butawa Nuhu Natie, [3]Moroof Suleman Omobayowa

[1]Department of Family Medicine 44 Nigerian Army Reference Hospital Kaduna. Kaduna State, Nigeria.
[2]Department of Prevention, Treatment and Care. Kaduna State AIDS Control Agency, Kaduna State, Nigeria.
[3] Department of Obstetrics and Gynaecology. General Hospital Sabon-Tasha, Kaduna State Ministry of Health, Kaduna State, Nigeria.

Abstract

Refusal of consent for a medical procedure can lead to delayed intervention and poor health outcomes. Understanding the patients' perspective on their care is crucial and requires exploration to reach a common ground. This report discusses a 72-year-old man with a primary vaginal hydrocele of 30 years' duration who consecutively refused hydrocelectomy due to his fears. A common ground was achieved by offering aspiration with sclerotherapy, a cost-effective and safe alternative. The patient was satisfied with the care, demonstrating the importance of incorporating patients' perspectives into care decision-making.

Key Words: Hydrocele, Elderly, Common ground, Aspiration with sclerotherapy.

Address for correspondence author: Department of Family Medicine 44 Nigerian Army Reference Hospital Kaduna. Kaduna State, Nigeria. +2347037787042 fkatchydr@yahoo.com
ORCID NO- 0000-0002-0793-2244

How to cite: Ajuonuma OF, Butawa NN, Moroof SO. Management of primary vaginal hydrocele in an elderly man: Application of common ground approach to decision making. NGJP. 2023;21(1):44-47.

DOI: https://doi.org/10.60787/njgp.v21i1.178

Quick Response Code:

Introduction:

Patient-centered care is fast becoming the norm in clinical practice and respecting patients' autonomy is essential. Refusal to consent for a procedure can lead to ethical dilemma that needs to be resolved. The aim of this case report is to demonstrate the application of common ground approach to decision making in care plan.

Case Report:

A 72 year old man was brought to the hospital by his son with right scrotal swelling of 30 years duration. The swelling grew gradually and never went down or disappeared. He had no other swelling on his body. There was no associated scrotal pain, fever, penile discharge or difficulty in urination. There was no history of trauma to the scrotum. He did not have any prior history of body itching with associated leg swelling. There was no history of right groin surgery. Due to the increased size, he felt heaviness with dragging sensation. He could no longer wear simple trousers without the swelling showing. It made walking properly uncomfortable. However, there was no associated weight loss, bone pains, cough or difficulty in breathing. He consulted his doctor on many occasions and was told he would require surgery. He was very afraid of open surgery because a close friend died from scrotal surgery. He was not offered any other treatment modality hence he left it till this presentation.

His desire was to be treated if there was another treatment modality. His co-morbidities included hypertension, diabetes and benign prostatic hyperplasia which were all well controlled. He took tablets Amlodipine 5mg daily, tamsulosin 0.4mg daily and metformin 500mg twice daily. He had no known history of allergy. He was a widower with four children and grandchildren. He retired as an Engineer with a construction company and had no history of tobacco use or alcohol ingestion.

On general physical examination he was stable, he weighed 62kg with height of 1.7m, BMI = 21.8kgm^2 . He had an adult male external genitalia with well circumcised phallus. There was a swelling of the right hemi-scrotum extending down to the level of mid-thigh. It was non tender with no differential warmth. It had a widest circumference of 25cm. The examining fingers got above it. It was cystic and the right testicle was not palpable. Trans-illumination and fluctuancy tests were positive. The left hemi-scrotum was normal. His other systems were essentially normal. The provisional diagnosis of right vaginal hydrocele in an elderly man with fear of surgery was made to rule out right testicular tumour. His scrotal ultrasound scan finding was consistent with right vaginal hydrocele with normal right testicle and cord. Pack cell volume was 39%, fasting blood glucose was 5.2mmol/L with normal urinalysis.

The provisional diagnosis of right vaginal hydrocele was discussed with him. He was told that hydroceles develop from accumulation of body water in-between the coverings of the testis and apart from the open surgical procedure, hydroceles could be treated with aspiration only or aspiration with sclerotherapy. He was educated on the benefits, risks and the alternatives to these procedures for him to make informed choice. He was told that both were office procedures done under local anaesthesia. He opted for aspiration with sclerotherapy after a careful thought. The procedure was explained to him and his concerns were addressed. The cost implication of the procedure, including cytology of the aspirate was acceptable to him. Having reached a common ground the consent form for the procedure was signed. He was happy and expressed satisfaction with the encounter.

In the supine position, routine skin preparation was done covering the external genitalia down to mid thighs. Draping was done exposing the scrotum. 1ml of 2% lidocaine was infiltrated into the skin of the most dependent part of the right hemi-scrotum. With the achievement of anaesthesia, a size 20G IV cannula was inserted into the right scrotum. The stylet was removed as fluid started to come out while the

plastic catheter was advanced properly into the vaginal space. A 20ml syringe was attached to the cannula and the hydrocele was aspirated in 20ml aliquots. A total aspirate of 200ml caused complete collapse of the hydrocele. Another 10ml syringe containing 10ml of the sclerosant solution (1g of tetracycline hydrochloride capsule powder in 10ml of 1% lidocaine injection) was attached to the cannula and same injected into the vaginal space. The cannula was removed and injection site was cleaned with methylated spirit. He received intravenous 200mls of normal saline intra procedure. His immediate post-operative vital signs were satisfactory (Temp. 36.6^{0}C, PR- 68b/m, BP- $\frac{129}{75}$mmHg, and RR-14c/m). The aspirate was sent for cytology. He was placed on Tablet Ibuprofen 400mg bd for 5 days, Tab. Vitamin C 200mg (white) tds for 5 days. He was stable after one hour on observation. He expressed gratitude for the procedure. He was scheduled to return on the third day post operation for review and complete geriatric assessment.

At the first review his general condition was satisfactory with normal scrotal examination. He had a normative ageing from his comprehensive geriatric assessment. He was generally educated on elderly self-care to prevent advancement to frailty and loss of independence as he aged. His fear for surgery was allayed as it could lead to delayed presentation and poor health seeking behaviour. He had poor vision due to age and immature cataracts. He was given a referral to the eye clinic. He was equally referred to the public health unit for covid-19, pneumococcal, and flu vaccination. He was to do a faecal occult blood test (FOBT) and return in two weeks' time. At the second follow-up he was normal, FOBT was negative and the cytology report ruled out malignancy. There was no recurrence at the sixth month follow-up

Discussion:

Primary/Idiopathic hydrocele is defined as an abnormal collection of serous fluid in tunica vaginalis whose cause is not known as it is neither associated with the disease of testis nor epididymis.[1] According to the aetiology and pathophysiology of the disease, it can be classified into primary and secondary.[2] Primary vaginal hydrocele has an idiopathic cause speculated to result from an imbalance of secretion and absorption of fluid inside the tunica vaginalis or the abdomen while secondary hydrocele has a cause like surgical trauma (varicocelectomy), inflammatory diseases (as epididymitis), intrascrotaltumours, systemic hyponatremia, testicular torsion and parasitic infections.[2] He had primary vaginal hydrocele because none of these secondary causes was found.

Vaginal hydrocele is the most common primary hydrocele globally. It usually appears in middle aged or elderly men and mostly on the right hemi-scrotum.[3] This is consistent with our patient who noticed the scrotal swelling 30 years ago while in his middle ages and also it was on the right hemi-scrotum. Clinically most hydroceles are asymptomatic, presenting as painless scrotal swellings which most times will reach a critical size to cause a dragging sensation, heaviness and make walking awkward.[4]He did not feel any pains hence he was able to carry the swelling for 30 years. Clinically, hydroceles are differentiated from other scrotal swellings by its cystic nature, fluctuance, brilliant trans-illumination, and absence of a cough impulse.[4] The gold standard for diagnosis is scrotal ultrasound.[4,5] The diagnosis was made clinically and was confirmed by the scrotal ultrasound scan which also ruled out the differential diagnosis of testicular tumour.

The majority of hydroceles that require treatment are treated with surgery. Two main surgical techniques are used, the Lords plication and the Jaboulay repair.[6] Aspiration and sclerotherapy are only usually considered if the patient is not fit for surgical repair or unwilling to undergo scrotal surgery.[6,7]He was unwilling to undergo scrotal surgery due to his fear. He readily accepted aspiration and sclerotherapy which has been adjudged safe, efficient, cost effective and satisfactory in most outcome parameters.[8]

Sclerosants like phenol, tetracycline, doxycycline or sodium tetradecylsulfate have all been used with comparable result.[4] Tetracycline was used here because dosage of 1g in 10ml of 1% lidocaine at 5ml per 100ml of aspirate has been found effective, cheaper and readily available.[4] Generational care in the elderly requires that opportunity must be seized to offer them comprehensive geriatric assessment for a healthier aging.[9,10] This was done in this episode of care successfully.

Conclusion:

Patient satisfaction with care is paramount in any doctor-patient relationship and this can be achieved by paying attention to patients' perspective and reaching a common ground. This case has demonstrated a clear example.

Declaration of patient consent:

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient has given his consent for his clinical information to be reported in the journal. The patient understands that name and initials will not be published and due efforts will be made to conceal identity, but anonymity cannot be guaranteed

Conflict of Interest: None declared.

Acknowledgement: None available

Funding: No external funding

References:

1. Jayakarthik Y, Patil MB. Comparative study of efficacy of injection sclerotherapy versus surgery as primary modality therapy in primary vaginal hydrocoele: a randomised control study. J Evol Med Dent Sci. 2015;4(9):1405–13.
2. Salem BW, Khalid MA, Alhadi YM, Albarman D, Almunaikh MJ, Mahammed AA, et al. Prognosis and Management of Communicating and Non-communicating Hydrocele. J Pharm Res Int. 2021;33(43B):347–53.
3. Jat N, Bano F, Memon IA, Memon MS. Primary vaginal hydrocele; different surgical procedures: a comparative study. Prof Med J. 2014;21(5):879–82.
4. Kelly Parks LL. Recurrent Hydrocoele. J Fam Med Prim Care. 2013;2(1):109–10.
5. D'Andrea A, Coppolino F, Cesarano E, Russo A, Cappabianca S, Genovese EA, et al. US in the assessment of acute scrotum. Crit Ultrasound J. 2013;5(SUPPL.1):1–7.
6. Taylor WSJ, Cobley J, Mahmalji W. Is aspiration and sclerotherapy treatment for hydroceles in the aging male an evidence-based treatment? Aging Male. 2019;22(3):163-8.
7. Saber A. Minimally access versus conventional hydrocelectomy: A randomized trial. Int Braz J Urol. 2015;41(4):750–6.
8. Francis JJ, Levine LA. Aspiration and sclerotherapy: a nonsurgical treatment option for hydroceles. J Urol. 2013 May;189(5):1725–9.
9. Ajayi SA, Adebusoye LA, Ogunbode AM, Akinyemi JO, Adebayo AM. Profile and correlates of functional status in elderly patients presenting at a primary care clinic in Nigeria. African J Prim Heal Care Fam Med. 2015;7(1):1–7.
10. Ogun O, Adebusoye L, Olowookere O, Majekodunmi O. Visual Morbidities among Patients at a Geriatric Centre in Southwest Nigeria and the Merits of Designated Geriatric Health Care Centres Incorporating Eye Care Services. Niger J Clin Pract. 2021;24(8):1117–25.