SURGICAL TREATMENT OF A VARICOCELE IN A 21 YEAR OLD COLLEGIATE WRESTLER

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Background: A 21 year old collegiate wrestler reported to the athletic training room after a pinning practice, consisting of long isometric contractions. The athlete reported an acute onset of 4/10 pain to the distal abdomen, distal pelvis, and testicular region. The patient also noted diffuse lower abdominal pain lasting 14 days and progressing in severity. During evaluation, athlete could not recall any specific mechanism of injury and reported not having any previous history of injury to the region. Patient reported no point tenderness or edema. Throughout the evaluation vital signs were WNL and stable. At this point symptoms began decreasing in severity so the athlete was instructed to monitor symptoms overnight and report back to the Athletic Training room the following day. The following day the patient reported that pain had increased and became more localized to the lower pelvis and testicular region as well as feeling a lump at the superior testicle. Differential Diagnosis: Epididymitis, Testicular Tumor, Testicular Torsion, Varicocele, Contusion. Treatment: The athlete did not practice and was referred to a general practitioner for further evaluation. The athlete was then referred to a Urologist who conducted blood work and a duplex ultrasound to confirm it was a Varicocele, as well as rule out any infection. At first, the Urologist attempted a conservative treatment for two weeks where the athlete did not practice and was instructed to wear tighter compression shorts to increase support. After two weeks, the patient followed up with the Urologist and reported having little to no change in symptoms. At this point the Urologist recommended the patient receive surgery to relieve symptoms as well as prevent the possibility of infertility if left untreated. Out of the three options given, the surgeon decided on microsurgical subinguinal varicocelectomy because of its short healing time as well as having the least post-operative discomfort. These two factors were important in his decision making because of his anticipated return to play. The other options offered were laproscopic surgery, which was not chosen due to its high failure rate, and varicocele embolization which was not chosen due to a high 5-11% chance of reoccurrence. Surgery was successful and patient was held from all physical activity for 3 weeks. At the beginning of the 4th week athlete reported to the clinic to do aerobic exercises, minor core stabilization such as pelvic tilts, and was instructed proper breathing techniques by the Athletic Trainer. After 3 weeks of rehabilitation the patient was allowed to begin weight lifting gradually with the instruction of the Athletic Trainer. The athlete was cleared for full return to wrestling approximately 10 weeks post-surgery, but never returned to competition during the season. Uniqueness: Typically Varicoceles are asymptomatic and can only be diagnosed due to physical abnormalities. Varicoceles tend to present themselves gradually and in this case it seemed to be caused by a set of long isometric contractions in a specific wrestling practice. These are rarely seen in wrestlers but can be caused by weight lifting, which did not seem to be the cause in this case. Also surgical intervention is typically not performed as quickly as two weeks, but because patients possible return to play the Urologist relied on surgical intervention earlier in the treatment plan. Conclusion: Patient reported no further problems after surgical intervention and rehabilitation program. Although patient did not return to competition, patient continued to lift weights and returned to practice proving that return to play after Varicocele surgery is possible. Athletic Trainers should be aware that this condition can occur and should be aware of the signs and symptoms in order to treat appropriately to prevent the possibility of infertility.