

Successful testicular sperm extraction in an infertile man with non-obstructive azoospermia and hypergonadotropic hypogonadism presenting with bilateral atrophic testis: a case report

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Annotation: *About 50% of men with NOA have minimal sperm production in their dysfunctional testes. Study shows no correlation between testicular size and sperm retrieval rate in a 29-year-old man with NOA and bilateral testicular atrophy. A 29-year-old man with bilateral testicular atrophy had successful sperm retrieval using TESE from a 2.3 cc left testicle. Low testicular volume significantly reduces the sperm retrieval rate with TESE. However, we described a successful*

TESE in atrophic testis. Therefore, low testicular volume does not affect the success rate of TESE and it should not be contraindication for surgery.

Key words: *NOA, TESE, mTESE.*

INTRODUCTION

Azoospermia is identified in approximately 1% of all men and in 15% of infertile males.¹ It is divided into obstructive and non-obstructive azoospermia (NOA). NOA is a challenging condition to diagnose and manage. Microdissection testicular sperm extraction (mTESE) and TESE has become a recognized and effective procedure to isolate sperm for intracytoplasmic sperm injection (ICSI), with reported of 20%- 60% successful rate.² mTESE was first described by Schlegel in 1999 as an advanced microsurgical treatment to retrieve sperm from men with NOA.² Several factors have been evaluated and reported for predicting sperm retrieval (SR) rates, including FSH and testicular volume. Men with NOA usually have smaller testicles. Studies to date have only shown poor correlations between testicular size and SR rates.² Letterie M et al. reported a failed testicular sperm extraction in 2 cc testes.⁴ Here we present a case of 29 years old male infertility who had NOA with bilateral atrophic testes, whose sperm were successfully extracted using TESE method.

Case presentation.



A 29 years old man presented to our outpatient clinic with inability to impregnate his 27 years old healthy wife. They have been married for 3 years, copulate regularly without using any protection. No prior history of trauma, drugs, or delayed onset of puberty. On further anamnesis, patient had history of mumps when he was a child. No remarkable findings were seen on general physical examination, the patient has a normal stature with no signs of gynecomastia and

anosmia. Upon testicular palpation, we found small bilateral testicular volume. No tenderness on palpation, and no mass were found on both testicles. Testicular ultrasound indicated small bilateral testicular volume, with dimensions of $2.6 \times 1.2 \times 1.3$ cm (2,38 cc) of right testicle,

and $2.4 \times 1.3 \times 1.4$ (2.30 cc) of left testicle. The clinical, routine blood and urine examinations were within normal limits. Laboratory evaluation from his previous check up indicated an elevated FSH (25.6 mIU/ml), normal LH (19.70 mIU/ml), and testosterone level (6.29 ng/ml). He did not accept a Gonadotropin hormone injection before surgery. He wanted TESE directly. Sperm analysis indicated azoospermia. We then diagnosed this patient with NOA, and planned for TESE procedure. The surgery was done under general anesthesia, and sperm retrieval

was successfully done using TESE method from left testicle. The sperm was extracted and prepped for ICSI. No serious problems occurred during the post-operative period, the patient was discharged the day after the operation. At follow-up over a week period, the patient's course was uneventful.

Discussion.

Schoor et al. study concluded men with FSH 7.6 mIU/ml. or greater, or testicular long axis 4.6 cm. or less may be considered to have NOA. mTESE and TESE are considered to be the gold standard surgical procedure for sperm retrieval in azoospermic patients.³ Studies documented that mTESE is 1.5-fold more effective than random multiple-biopsy TESE, which is 2-fold more effective than testicular aspiration. There are some indicators that might be predictive for successful SR, one of them is testicular size. Testicular volume is an indirect measure of spermatogenic activity; however, according to the 2019 guidelines of European Association of Urology no testicular volume cut-off value has been estimated for successful sperm harvesting.⁵ Older man also have lower SR rate, it is possible that as they age, men with NOA lose some focal areas of spermatogenesis and may have less spermatozoa maturation, decreasing the chance of finding sperm. Sperm were retrieved successfully in 81.8% of those younger than 30 years and only 33.3% of those older than 30 years.² In a previous study, spermatozoa were obtained in 44% of patients with normal testicular volumes and 25% patients with small testicular volumes. In another study, SR rate was found to be 20.8% for testicular volumes under 5 ml and 58.2% for testicular volumes higher than 16 ml.⁵ Kizilkan et al. study showed higher testicular volumes were found to increase sperm retrieval in mTESE and TESE, and volumes above 11 ml were significantly associated with successful results.³ Marconi et al. reported that men with a testicular volume of less than 8 ml and FSH greater than 12.4 IU had an approximately 30% chance of testicular SR by mTESE. In a study of 106 men. Similarly, in a study of 85 men with NOA, Ziaee et al. observed that those with successful SR had testes that were larger than those of men with unsuccessful retrieval (average 17.5 vs 5.7 ml). These studies provide evidence that smaller testicle size is associated with a decreased chance of SR.²

Conclusion.

It was previously assumed that patients with significantly reduced testicular size would have a decreased chance of SR with TESE. In our case, we described a successful TESE of a 29 years old man with a testicular volume of 2.3 ml. Therefore, small testicular volume does not affect the successful rate



of TESE and severe testicular atrophy should not be a contraindication to TESE. Further studies are needed to determine the inclusion criteria for successful TESE.

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