

Obstructive Azoospermia Secondary to Obstructed Ejaculatory Ducts Treated with Resection of the Verumontanum

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A 25-year old male presented with primary infertility. He and his partner had been trying to conceive for over 12 months despite normal gynecological investigations. There was no history of chronic respiratory disease, infections, sexual dysfunction, genetic abnormalities, trauma or illicit substance use. Secondary sexual characteristics were normal. Physical examination including digital rectal examination was unremarkable. Scrotal ultrasound demonstrated a grade 0 varicocele. Karyotype and hormonal profile were normal. Semen analysis was consistent with obstructive azoospermia, with absent sperm, low pH and reduced volume. Magnetic resonance imaging of his pelvis revealed an 8 mm midline cyst and dilated seminal vesicles (**Figures 1A and 1B**). Subsequent cystoscopy demonstrated an edematous verumontanum which, when resected, immediately released retained semen (**Figures 2A and 2B**). A clinical diagnosis of obstructed ejaculatory ducts was suspected. Ejaculatory duct obstruction causes disruption of spermatozoa transport from the vas deferens to the prostatic urethra via the ejaculatory ducts. Clinical findings such as azoospermia, low volume acidic ejaculate with normal sexual development and dilated seminal vesicles with a midline cyst are highly suggestive.⁽¹⁾ Transurethral resection of the ejaculatory ducts (TURED) and verumontanum has been shown to increase semen volume in patients and successful pregnancies have been reported.^(2,3)

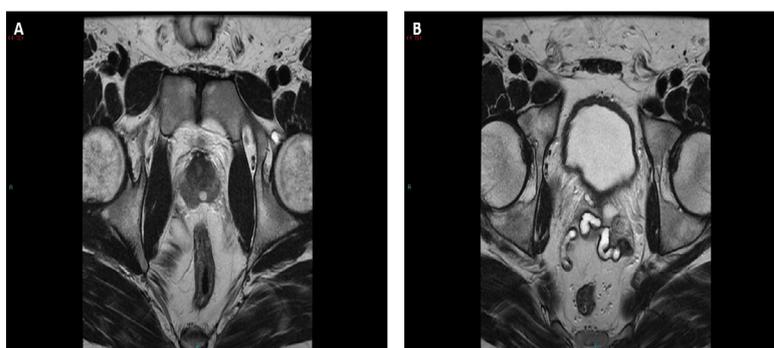


Figure 1. Magnetic resonance imaging of pelvis demonstrates an 8 mm midline cyst (**A**) and dilated seminal vesicles (**B**).

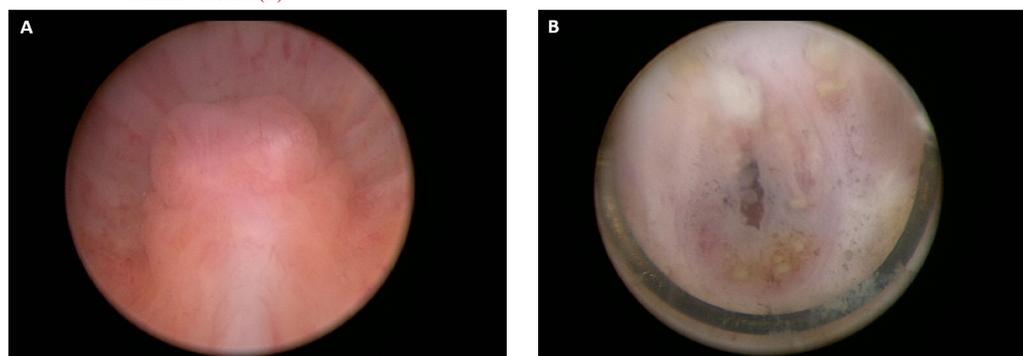


Figure 2. Cystoscopy demonstrates an edematous verumontanum (**A**) which, when resected, immediately released retained semen (**B**).

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