

CASE REPORT

Unique Infective Complication after Routine Vasectomy: A Case Report

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ABSTRACT

Introduction. We present a case of a 51-year-old gentleman who, after undergoing routine vasectomy, presented with an infected wound 7 days after the procedure—one day after receiving oral sex from his wife.

Aim. We hope to present a unique case of an infected wound after oral sex. Group A *Streptococcus* (GAS) was cultured from the patient's wound and the asymptomatic wife's pharyngeal mucosa.

Main Outcome Measures. To educate and expose a rare but potentially devastating postvasectomy complication that, without prompt and aggressive treatment, can lead to significant morbidity.

Methods. The patient was promptly treated and after hydration, broad spectrum antibiotics, and supportive care, patient showed excellent recovery. The wife was also treated with oral antibiotics.

Results. Infective complications are relatively uncommon after routine vasectomy. When present, the vast majority of the infections are treated with a simple course of oral antibiotics. There is strong evidence that establishes oral contact as a vector for transmission of virulent pathogens. Some have linked orogenital transmission of GAS since the 1970s.

Conclusion. To our knowledge, this is the first reported case of oropharyngeal transmission of GAS that led to rapidly progressive infection of the scrotum following vasectomy. Care should be taken to minimize exposure during postoperative healing. **Ramaswamy K and Kaminetsky J. Unique infective complication after routine vasectomy: A case report. J Sex Med 2011;8:2655–2658.**

Key Words. Vasectomy; Complications; Infection; Oral Sex; Streptococcus

Introduction

We present a unique case of infection after routine vasectomy. This is a healthy 51-year-old male with no past medical history underwent routine, uncomplicated, no-scalpel vasectomy in an office setting. After an initial, uncomplicated postoperative course, he presented to the emergency department (ED) 1 week after the procedure with sudden onset of fever, chills, pain, swelling, and drainage from the incision site. In the ED, patient was rigorous, febrile to 102°F, with white blood count (WBC) of 17,000. Patient's physical examination was pertinent for a diffusely tender, swollen, and erythematous scrotum and penis. There was sero-purulent drainage from the incision site with no evidence of an intra-scrotal fluid collection. Patient had

blanching erythema extending into the lower abdomen above the symphysis pubis, laterally into the superior thigh and posteriorly into the flank. The image is shown in Figure 1. Furthermore, there was no crepitus or obvious fluctuance. There was no evidence of necrotizing infection. Patient was started on aggressive intravenous (IV) hydration, broad spectrum IV antibiotics (vancomycin and piperacillin/tazobactam) and was pan cultured, including a sample of the incisional drainage. A computed tomography of the pelvis was negative for air and/or gas in the subcutaneous or intra-fascial planes. There was marked soft tissue swelling of the genitals and the surrounding tissue. There was no fluid collection or abscess. A scrotal ultrasound only showed marked soft tissue swelling, without evidence of an intra-scrotal collection. The patient was admitted for non-surgical



Figure 1 Scrotum at presentation—extent of erythema marked by black lines. Drainage from wound not shown.

management given the low likelihood of a necrotizing infection.

Patient showed swift and substantial improvement with conservative treatment. Blood and urine cultures were negative, but culture of the wound drainage grew Group A beta hemolytic bacteria—*Streptococcus pyogenes* (GAS). All additional studies revealed normal results, including Tzanck test, herpes simplex 1 and 2, cultures for fungi, human immunodeficiency virus, syphilis, gonorrhea, and chlamydia. Upon further questioning, it was determined that the patient's wife had performed fellatio the night prior to presentation. At that time the patient's children were being treated with antibiotics for acute pharyngitis. The patient's wife was asymptomatic; therefore, not being concomitantly treated for the infection. An oral swab culture of the wife was positive for the same bacterial isolate. The partner was asymptomatic at that time, and physical examination did not reveal an erythematous pharyngeal mucosa or lymphadenopathy.

The patient was then transitioned to oral ampicillin 500 mg, observed for 24 more hours, and discharged home on a two-week course of antibi-

otics. Although the wife was asymptomatic, she was also given oral antibiotics for a 7-day course to prevent future complications.

Discussion

In this day and age, wound infection after routine vasectomy is a relatively uncommon phenomenon. A recent review by Adams and Wald reported postoperative infection rates ranging from 1.3% to 5% [1]. Surprisingly, a historical study by Randall et al. found an incredible 25% postoperative infection rate after routine vasectomy. They also found that a preoperative Hibiscrub™ (Mölnlycke Health Care, Göteborg, Sweden) shower did not affect the infection rate, even though it was responsible for a significant reduction in skin flora. They concluded that source of inoculum following vasectomy was likely secondary and not occurring at the time of surgery [2]. Other randomized control studies have shown rates as low as 0.2% [3]. Generally, most infections tend to be limited and may be treated with a simple course of oral antibiotics. Systemic infection following vasectomy is rare, but cases have been reported of Fournier's gangrene following this simple procedure [1–3].

A recent study by Schick et al. found that older adults remain rampantly sexually active, and a careful history is vital to identify patients at risk for infection [4]. Not surprisingly, oral sex is extremely commonplace in the United States today. A recent nationwide probability sample by Herbenick et al. found that more than half of women and men ages 18–49 engaged in oral sex in the past 12 months [5]. Not surprisingly, oral transmission of bacterial infection has been a proposed as a vector for decades. Oro-genital sex has been systematically implicated as a route of transmission for gonorrhea, syphilis, chlamydia trachomatis, chancroid, and others by many studies [4,6–8]. Furthermore, Drusin et al. linked oro-genital transmission as a proven vector for GAS infection as early as 1976 [9]. Still, the potential magnitude of genital infections, especially GAS, from oral contact is largely unknown. Streptococci infections have not been known to directly penetrate intact skin. Because our patient did not have any traumatic exposure beside fellatio the night prior to presentation, it is reasonable to conclude that the wound was contaminated and seeded by the GAS from direct contact with infected oral secretions.

We believe that the origin of our offending organism, the GAS, was postoperative. It is rea-

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