

### SUMMARY

Azoospermia is an important cause of male infertility in which the ejaculated semen is devoid of any spermatozoa. Templeton (1983) found that azoospermia account for 9.2% of new couples attending the infertility clinic. In U.S.A. approximately 15 out of every 100 marriages are barren and do not produce progeny. Defects in the husband's reproductive system are responsible for somewhat over 50% of the cases (Wong et al., 1973).

According to Wong et al., (1978), azoospermia is classified into testicular, pre-testicular and post-testicular. Testicular azoospermia is subdivided into absent testis, small sized testis and normal sized testis. Pretesticular azoospermia may be due to hypogonadotropism, oestrogen excess or androgen excess. Post-testicular or obstructive azoospermia may be at the level of pre-epididymal, epididymal, vasal or ejaculatory duct.

In order to evaluate a case of azoospermia, careful history must be taken and physical examination have to be done. At least two or three specimens of

semen should be examined before a diagnosis of azoospermia is made (Salama, 1982c).

The level of gonadotrophins (F.S.H. and L.H.) in serum must be done. High F.S.H. levels when associated with small testes indicates severe testicular damage (Hargreave and Jequier, 1978).

Testicular biopsy is indicated for azoospermic patients in whom the testicles are essentially normal on physical examination and whose serum F.S.H. levels are normal or only mildly elevated, biopsy provides critical information. In this patient group, scrotal exploration and testicular biopsy allow the clinician to distinguish between ductal obstruction and ablative testicular pathology (Coburn et al., 1987).

Other investigations as Karyotyping, X-ray skull, vasography and chemical analysis of semen are to be done in order to detect the aetiology.

Congenital and acquired hypogonadotropic hypogonadism can be successfully treated with gonadotropins (Vermeulen, 1982). The generally recommended treatment is a combination of H.C.G. (human chorionic gonadotropin) and H.M.G (human menopausal

gonadtropin) when spermatogenesis is desired (Rostom, 1983c).

Epididymal obstruction is conventionally treated by means of the operation vaso-epididymostomy. The basis for this operation is the formation of a fistula between the efferent ductal or the epididymal duct and vas deferens. Vaso-vasostomy operation is designed to that vasal strictures and is fundamentally the same as that used in a reversal of vasectomy. The results of the surgery used to correct obstructive azoospermia are in general poor. (Jequier, 1986a).