INTRODUCTION
Scrotal hydrocele is a common problem affecting all age groups. In tropical countries scrotal hydrocele is of more frequent occurrence than in temperate climates. Such hydroceles are often very large, sometimes bilateral as noted by Burkitt (1951), Burkitt and Willmore (1964) and Davey (1968).

The condition is not life-threatening, the symptoms are usually those of inconvenience or embarrassment. Recent textbooks recommend either repeated aspiration or surgery as the only two acceptable methods of treatment (Fender, 1973), Khitaker (1976), Rains and Ritchie (1977). Aspiration alone is not curative and will need to be repeated at least every three months. The latter method has a high incidence of complications (Moloney, 1973). These, however, can be minimised by careful surgery (Lord, 1964, 1978). Surgery is generally thought to be the most effective treatment of hydroceles (Landes and Leonhardt, 1967). Various surgical procedures have been discovered for treating hydroceles, based on their nature e.g.

- Eversion of sac (Jaboulay's operation).
- Excision of sac (Lord's operation).
- Excision of sac.
- Sharma and Jhawer's minimal dissection.
- Technique.
- Wilkinson's operation.
- Extrusion operations without sac excision or complication (Solomons, 1955).
- Suturing the sac to the epididymis (Gower & Howley, 1962).
- Andrew's bottle operation etc.

Most surgeons are confident that their method of surgical treatment is without mortality or morbidity but a critical review of the post-operative course usually reveals an unacceptably high incidence of the notorious swelling and induration, haematoma and infection. As a result the average hospital stay gets prolonged and leads to a loss of many man-hours of work.

Injection treatment or sclerotherapy in various forms has been used since the thirteenth century (Landa and Leonhardt, 1967). Wilkinson of Saliceto was reported to have inserted sugar and ginger into the hydrocele sac after allowing the fluid to escape through a cannula. Since then a number of other agents have been used including:

Sublimate of mercury.
Port.
Brandy.
Tincture of iodine.
Phenol
Quinine and urethane
Tetracycline
Sodium tetradecyl sulphate (Safrodecol).

But this form of therapy was largely abandoned, probably on poor evidence (B.M.J., 1973).

The reason for the fall from grace of sclerotherapy in the earlier part of this century is unclear. There are no reports listing horrific complications or even reports showing poor results. The evidence appears to be anecdotal as so clearly demonstrated in the answer to an "Any Questions" which appeared in the British Medical Journal in 1973. In responding to a question about the type and amount of fluid recommended for injection of hydroceles it was stated that a "Canvas of opinion amongst urologists elicited only derision and a series of unpublishable anecdotes". Over the last eight years partly in response to this rather unsatisfactory answer many scientists have undertaken clinical studies on the efficacy of phenol sclerotherapy (Nash, JR, 1980).

Holmes' recent report demonstrated that sclerotherapy could be an effective form of treatment for hydrocele.

The role of tetracycline (Achromycin) as an sclerosant for treating hydrocele without any complication
and recurrence after one year follow up has been described by Robert Kay (1982). The similar agent has been used by Dr. Richard Baasmer in many patients with very satisfactory results.

Recent reports of good results with sclerotherapy (Gupta RC, Kala PC, I.J.S., 1983) have prompted us to conduct a study on the role of sclerotherapy in the cure of primary hydrocele.