Surgical emergencies in stallions are not common but obviously require immediate attention and have the added obligation of discussion and determination of likely potential to continue a breeding career. Castration and potential failure of penile erectile function can result from the original incident, or subsequent to surgical treatment and, therefore, client understanding for appropriate decision making is important.

Inguinal-scrotal hernia is an important consideration when acute onset of colic is noted in an intact male horse. Herniation of small intestine into or through the inguinal canal is most common after breeding or other strenuous exercise. Physical and ultrasound examination of the scrotal region, as well as palpation per rectum, can be helpful to diagnosis. Most of these cases require surgical treatment as variable volumes of intestine can be involved and vascular strangulation is common to both bowel and testicular tissues. Surgical approaches can include ventral midline, scrotal, parainguinal or combinations of incisions such that the herniated bowel can be reduced and the affected testicle evaluated. Small intestine is typically found within the vaginal tunic of the scrotum and often resection/anastomosis is required. Jejunojejunostomy, jejunooileostomy or jejunoocecostomy are performed dependent on the segment of bowel involved. Unilateral castration is also commonly required as vascular disruption is typical to the affected testes. Return to normal activity, including breeding can be achieved with one surviving testes and complete recovery from the resection/anastomosis of the affected bowel. Post-operative ileus of the small intestine is common and can protract recovery.

Testicular/spermatic cord torsion is also not common but can be confused with inguinal/scrotal hernia when the torsion is 360° or greater. Emergency castration of the affected testes is usually required.

Penile and scrotal/testicular trauma occasionally will require surgical treatment. Lacerations ideally will be identified and treated early after wounding. Delay and contamination complicate management and outcome. Thorough cleansing and identification of all injured tissues is important to surgical decisions. Most commonly only skin is lacerated and direct suture closure is successful and can often be completed with sedation and local anesthesia. More involved trauma may require general anesthesia, complete exploration and repair of injured tissues. Appropriate sexual rest and ancillary treatment are required in the post-repair period. Penile hematoma rarely occurs in stallions, usually after kick trauma. Surgical treatment is not often required but ligation of ruptured vessels or corpus cavernosum closure may be needed for correction of large volume hemorrhage.

Acute onset of paraphimosis or priapism may require surgical therapy if emergency medical management fails. Paraphimosis can be addressed with a preputial purse string closure which is done in the standing horse. Permanent placement of a paralyzed penis in the prepuce can be obtained with the Boltz phallopexy, however, breeding expectations are lost with this procedure. Priapism can be surgically addressed with cavernosal shunting from the corpus cavernosum penis to the corpus spongiosum. This procedure can result in reduction of the erectile emergency but also has been noted to allow an affected stallion to return to normal erectile and ejaculatory function after the emergency has been resolved.