

UNDESCENDED TESTIS

An empty scrotum may be due to the testis being undescended, ectopic, retractile or absent. Familial predisposition present in 15%. 10 - 25% are bilateral.

Incidence

- at birth: Full term infant 3.4%
Premature infant 30.3%
- at 1 year: Full term infant 0.8 %
Premature 0.8%
- adult 0.7-1%

Spontaneous descent may occur within the 1st year of life. after which descent is rare.

Complications

- trauma (especially if in inguinal canal).
- torsion extravaginal type
- decreased spermatogenesis. Damage occurs in the first 6-12 months of life. 90% of patients with orchidopexy before 2 years have satisfactory spermatogenesis. If done after >15 years old, fertility is 15%.
- testicular tumour: Risk is 22 times higher than the normal population (Intra-abdominal 6 times more than inguinal). It makes the testis more accessible to palpation and thus early diagnosis.
- associated with hernias (up to 65%), urinary tract anomaly (3%, e.g. duplex and horseshoe), anomalies of epididymis or vas deferens and problems of intersex.
- psychological problems

Management

1. Ask mother whether she has ever felt the testis in the scrotum, more easily felt during a warm bath.
2. Examine patient (older children can be asked to squat). A normal sized scrotum suggests retractile testis. The scrotum tends to be hypoplastic in undescended testis.
3. If bilateral need to rule out dysmorphic syndromes, hypopituitarism, and chromosomal abnormalities (e.g. Klinefelter). Exclude virilized female (Congenital Adrenal Hyperplasia).
4. Observe the child for the 1st year of life. If the testis remains undescended after 1 year of life surgery is indicated. Surgery should be done between 6-18 months of age.
5. For bilateral impalpable testis: Management of choice is Laparoscopy ± open surgery. Ultrasound, CT scan or MRI to locate the testes have not been shown to be useful. Check chromosomes and 17 OH progesterone levels if genitalia are ambiguous.