

Undescended Testis (aka Cryptorchidism)



FAST FACTS

3%

of boys will present with a UDT

Diagnostic Imaging

not beneficial for locating the testis

2–3%

lifetime risk (4x average risk) of testicular cancer if the testis remains in the abdomen

12 months

age before which surgical intervention is recommended to help prevent infertility

4 months

age after which observation is no longer beneficial, because UDT is unlikely to descend further

Educate your teenage male patients on the following:

- Testicular pain is never normal. Intense pain, especially with vomiting, should be sent to CCE to rule out torsion. There is only a 6-hour window to ensure survival of the testis.
- Wear a hard scrotal protector (cup) during all contact sports.
- Teach all boys 14+ to self-examine their testicles 1x/month, bringing any mass/lump to your attention.

If you have clinical questions about patients with UDT, email PedsUrology@cchmc.org OR PediatricSurgery@cchmc.org.

Undescended testis (UDT), also known as cryptorchidism, is a congenital condition in which the testicle fails to descend into a location in the lower half of the respective hemiscrotum. One of the most common developmental anomalies, with 30% incidence in preemie infants, 3% full-term infants, and 1% in toddlers. UDT may present as:

- **Undescended/cryptorchid**—testis is not in scrotum and cannot be manipulated into the scrotum
- **Ectopic**—testis is not in scrotum and is not along path of normal descent (may be in thigh or perineum)
- **Retractile**—testis is not in scrotum, but can be manipulated into the hemiscrotum where it remains once traction on the testis is released
- **Ascended**—testis was previously documented as located in the hemiscrotum and is now out of the scrotum

ASSESSMENT

Obtain a detailed history, focusing on gestational age, maternal medication use during pregnancy, and family history of undescended testes or chromosomal abnormalities. Perform complete physical exam focused on the abdomen and genitalia, with child in frog leg position. During exam, prevent stimulation of the cremasteric reflex and close the ipsilateral inguinal ring to prevent the testis from retracting into the inguinal canal. Enhance exam results by ensuring room is warm and comfortable, and use liquid soap on your hands to examine. There is no need for medical imaging.

HPE (HISTORY AND PHYSICAL EXAM) RED FLAGS

Situational history

- Premature infant
- Age <3 months or over 14 years
- Presence of inguinal hernia or patent processus vaginalis
- Presence of abdominal wall defects
- Congenital syndromes; i.e. CHARGE syndrome
- Previous history of inguinal surgery

Family history

- Maternal medication use during pregnancy (i.e., hormonal replacement)
- Maternal diabetes
- Family history of UDT
- Family history of disorders of sex development

WHEN TO REFER

Refer all children >4 months but <9 months, in whom both testes are not in the dependent position of the hemiscrotii, to Cincinnati Children's Urology or Pediatric Surgery to enable correction. No further investigations or imaging studies are necessary prior to referral.

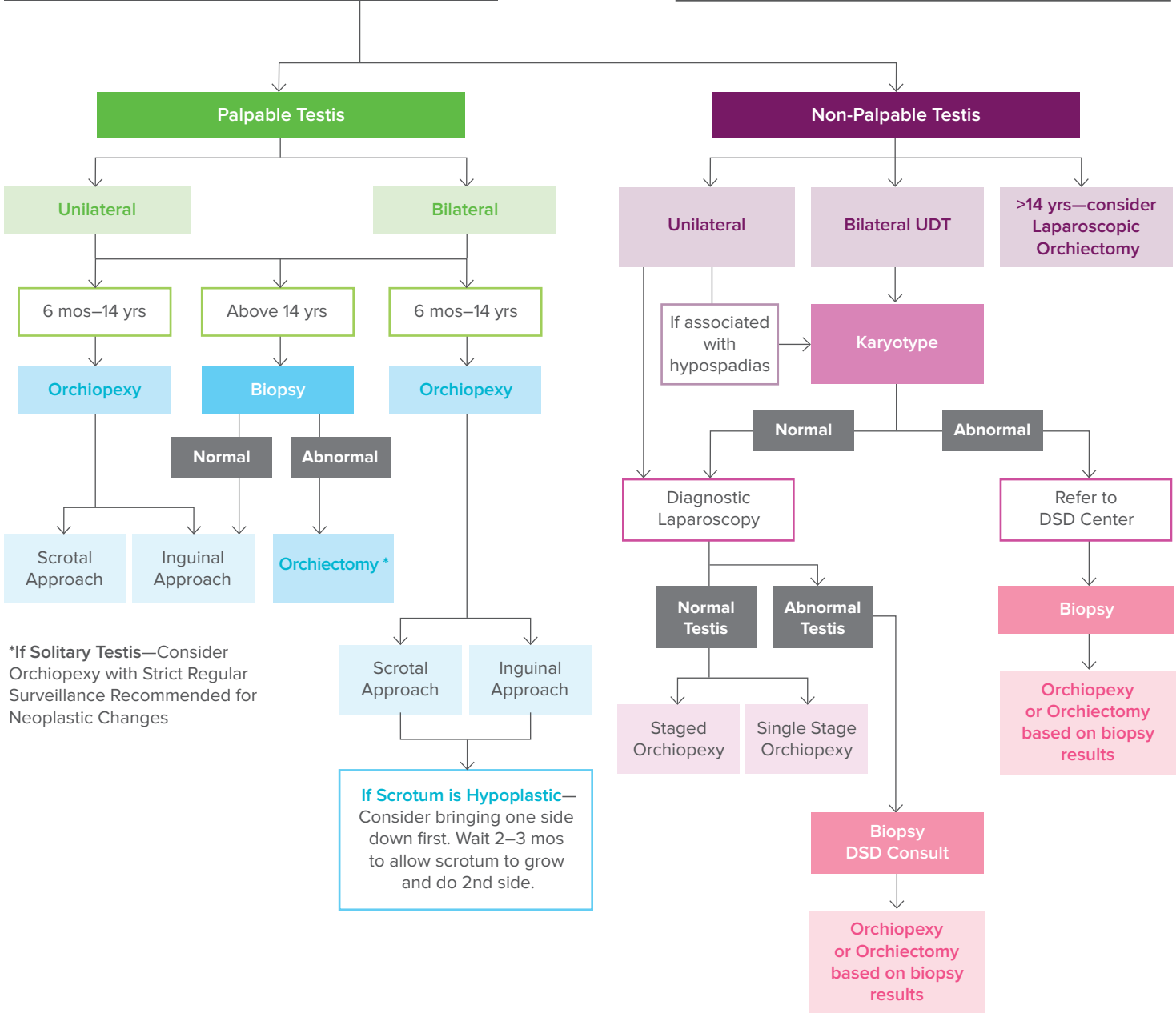
Refer patients aged 4+ months with any UDT for assessment. Reassure family when retractile testis is present, and reassess at later appointments. Recommend scrotal orchiopexy when retractile testis persist beyond age 5 years. Recommend surgical orchiopexy (palpable) or laparoscopic orchiopexy (non-palpable) if true UDT is present.

If you would like additional copies of this tool, or would like more information, please contact the Physician Outreach and Engagement team at Cincinnati Children's.

Undescended Testis

Undescended Testis
Child > 4 months—Refer for assessment to Pediatric Urology or Pediatric Surgery

Retractile Testis
Refer for initial evaluation/assessment by age 4–5 years



*If Solitary Testis—Consider Orchiopexy with Strict Regular Surveillance Recommended for Neoplastic Changes

If Scrotum is Hypoplastic—Consider bringing one side down first. Wait 2–3 mos to allow scrotum to grow and do 2nd side.