**Undescended testes or cryptorchidism is defined as the incomplete descent of one or both testes and absence from the scrotum**

Prevalence

- 3.7% at birth and 1.0% at 3 months of age
- Most will have descended by 3 months if they are going to descend spontaneously

Classification

- **True undescended testes —** testes lie along the normal path of descent in the abdomen or inguinal region
- **Ectopic testes —** testes lie outside of the normal path of descent (e.g. femoral region, perineum, or penile shaft)
- **Ascending testes —** testes previously present in the scrotum and now not

Causes

- Most have no identifiable cause
- Rarely:
  - Congenital hypogonadism
  - Androgen insensitivity
  - Ascending testes - significant proportion of late diagnoses

Complications

- **Impaired fertility**
- Increased risk of **testicular cancer** and **testicular torsion** if uncorrected

Examination:

- **If testis absent from the scrotum:** sweep the groin region along the inguinal canal from lateral to medial. May be felt as a 'pop' under the examiner's fingers.
- **If the testis is not present in the scrotum or inguinal region:** check for an ectopic testis in the femoral, penile, and perineal regions.
- **Check for ambiguity of the external genitalia,** and for other genital abnormalities such as hypospadias
- **Are there any syndromic features?:** assoc syndromes e.g. Prader-Willi, Kallmann, or Laurence-Moon-Biedl

Management:

Surgeons now prefer to undertake surgery earlier – preferably before 1 year

- If **bilateral undescended testes** and/ or any signs of **possible disorder of sexual development** (e.g. ambiguous genitalia, or other assoc genital abnormalities e.g. hypospadias) needs **early senior review** as may require urgent genetic/ endocrine investigations-see below
- Unilateral:
  - Term – refer for surgical outpatient appointment
  - Preterm – there is a higher rate of spontaneous descent therefore refer if remain undescended at approx. 1 month post EDD. If discharged please highlight this for review at the first neonatal review clinic or GP 6 week check if no neonatal review planned in the discharge letter.

**Bilateral Undescended tests**

**Record**

- length of phallus (cm) - should be at least 2.5cm
- position of uretheral opening
- appearance and position of scrotum, and whether bifid
- any other midline opening

**Presence or absence of**

- pigmentation
- other congenital abnormalities/dysmorphic features
- parental consanguinity

Birth weight centile
Any antenatal investigations e.g. amniocentecis

If any of above abnormal contact Paediatric Endocrine consultant
If external genitalia otherwise COMPLETELY NORMAL:

Request pelvic USS for within a week: to view gonads and presence of any internal structures (uterus).

**Baby to reviewed on Day 4 weighed and re-examined** (by middle-grade doctor or more senior).
If either testis palpable - no investigations
If no testes palable: ACTH (on ICE), T, A4, 17OHP to screen for CAH; discuss karyotype for further information if testes do not descend spontaneously (not as a screen for CAH).

**The person sending the ACTH is responsible for mechanism to review result (which should be within 1-2 days). If HIGH i.e. above normal range - urgent recall.**

If ACTH within normal range (and weight loss also within the normal range) can await USS result. **If abnormal i.e. uterus present, requires urgent action/recall.**

**Follow up plan needed for all:**
Results of investigations will usually take 2-4 weeks (longer if karyotype).
Review of ACTH 1-2 days
Review of USS 1 week
Review of T, A4, DHEAS, 17OHP 2 weeks
Review of karyotype 6 weeks
OPD for final results