

birth it should be in its scrotal sac. The gubernaculum testis plays a major part, with double hormonal control by antimullerian and androgenic hormones. The acquired histological changes in undescended testes start appearing during the second year of life. Infertility and cancer of testis are the major risks in these testes. The risks of cancer is estimated to be more than 5 times as high as for healthy men.

Optimal treatment of undescended testis has been considered orchidopexy at the second year of life. Gofrit and Pode describe their 10 years experience on 40 patients with a cryptorchid testis in an age group of 11-63 years (mean 25), who presented with an undescended testis at or after puberty. Orchiectomy was performed in all, and spermatogenesis was present in only 2 of the 40. Testis was atrophic in 38 patients. Malignant tumours were found in 6 patients (15%) at operation. It was concluded from this study, that a patient with a cryptorchid testis who presents at or after puberty should undergo orchidectomy as soon as possible. The prospect for such a testis to contribute to fertility is negligible, whereas the risk of developing malignancy is high.³

Undescended testis is quite easy to diagnose when it is situated in the superficial subinguinal pouch. However it may pose a problem if it is situated high up at the deep inguinal ring or at the posterior abdominal wall. The ectopic testis is defined by a migration differing from the normal descent into the scrotum. This error is due to an anomaly of fixation of the distal extremity of the gubernaculum, resulting in an abnormal position of the testis. The major sites are femoral canal, suprapubic region, contralateral scrotum and perineal region.⁴

Impalpable testis may be located with ultrasonography or laparoscopy.

Extended inguinal exploration may be needed in some cases.⁵ Lala et al in a study in 238 boys with cryptorchidism, between the ages of 4 and 48 months, administered luteinizing hormone releasing hormone (LHRH) as nasal spray 1.2mg/

day for 4 weeks. The non-responders received human chorionic gonadotropin (HCG) 500 I.U. i.m.3 times a week for 3 weeks. With the combined treatment 37.8% of testes descended into the scrotum. Testicular descent occurred more often in patients whose testes were located in a lower position. Early administered combined treatment with LHRH and HCG can be considered as a substitution of the gonadotropins insufficiency manifested by most cryptorchid infants in the first months of life.⁶

The aetiology of testicular tumours is not known but they are known to be more common in men with testicular maldescent. The risk relates to the degree of maldescent and is very much higher in an abdominal testis.

It has been suggested that early orchidopexy may protect against malignancy.

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MALIGNANT TUMOUR ARISING FROM AN UNDESCENDED TESTIS

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Abstract

An unusual case of malignant neoplasm, arising from undescended testis, is reported.

Key Words: Teratoma testis, undescended testis.

Introduction

The increased incidence of testicular cancer occurring in the undescended testis is well documented¹. Undescended testis is a frequent abnormality and presents with acquired histological lesions that start developing during the second year of Life.²

Early orchidopexy, if the testis is situated in the superficial subinguinal pouch or orchidectomy if the testis is quite high and atrophic may reduce the risk of malignancy but this is rather uncertain.

The following case highlights the fact that undescended testis definitely carries a risk of malignancy.

Case Report

A 20 years old man presented with a large mass in the lower abdomen for three months which initially was small but progressively increased to a huge size. There was dull lower abdominal pain and he had lost considerable weight. He was also complaining of passing small amounts of urine, and there was no pain in the flanks. His bowels opened regularly. He was also complaining of generalised weakness.

On examination he looked ill and seemed to be malnourished and cachectic. There was no peripheral oedema and there was no cervical or inguinal lymphadenopathy. Abdominal examination showed a large suprapubic mass extending upto the umbilicus. It was hard and fixed. The mass was also palpable on digital rectal examination. The examination of the genitalia revealed absent left testis. The contralateral testis was normal.

The patient admitted that his left testis was absent ever since his birth.

Hb was 8g%. Urea was 180mg% and creatinine was 8mg%. There was gross electrolyte imbalance. Chest x-ray was normal. The ultrasound revealed renal cortical atrophy and a large para-aortic mass. Biopsy was taken from the mass under local anaesthetic, and histology revealed it to be teratoma undifferentiated. The testicular tumour markers were about 20 times the normal. The patient's lesion was obviously inoperable and therefore the decision was made to treat his renal failure and institute chemotherapy but unfortunately his condition deteriorated rapidly and he expired.

Discussion

Because of lack of awareness of the risks of unilateral or bilateral undescended testes, patients do not seek medical advice in the early age in the country or by the time these patients seek advice, the testis may have undergone irreversible histological changes ranging from carcinoma-in-situ to frank malignancy.

Undescended testes are a frequent abnormality, which has a controversial pathogenesis. In foetal life the testis arises from the germinal ridge in the posterior abdominal wall and descends down; by

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