



ORCHIDOPEXY FOR AN UNDESCENDED TESTIS

Information about your procedure from
The British Association of Urological Surgeons (BAUS)

This leaflet contains evidence-based information about your proposed urological procedure. We have consulted specialist surgeons during its preparation, so that it represents best practice in UK urology. You should use it in addition to any advice already given to you.

To view the online version of this leaflet, type the text below into your web browser:

[http://www.baus.org.uk/_userfiles/pages/files/Patients/Leaflets/Orchidopexy for UDT.pdf](http://www.baus.org.uk/_userfiles/pages/files/Patients/Leaflets/Orchidopexy%20for%20UDT.pdf)

Key Points

- A testicle which has not descended into the scrotum has an increased risk of developing cancer in the future
- Bringing the testicle into the correct position does not eliminate the cancer risk but it does allow the testicle to be surveyed more easily
- Undescended testicles lose the ability to produce sperm the longer they remain in the wrong position
- The procedure performed differs, depending on where the testicle lies; if the testicle lies in your groin, it may be brought down with one operation from your groin; if it is higher up, it may need two operations and, if it lies inside your abdomen (tummy), it may need keyhole surgery
- If your testicle is very small or cannot be brought into the scrotum, it may be more appropriate to remove it completely

What does this procedure involve?

Making incisions in the groin and scrotum to bring one (or both) testicle(s) down into the correct position.

An undescended testicle has an increased risk of developing cancer. Bringing the testicle into the scrotum does not decrease the risk of cancer, but it does allow the testicle to be monitored more easily. If a testicle is brought down in the first years of life, its sperm-producing capacity may be preserved. The longer an undescended testicle remains out of position, the more its sperm-producing ability reduces.

If, on examination, your testicle is not in your groin, it may lie inside your abdomen (tummy). An MRI scan is then used to locate it. If it cannot be found on MRI, [laparoscopic \(“keyhole”\) surgery](#), using a special telescope passed through a small incision (cut) just below your umbilicus (belly button), may be used to find it.

A testicle found in the abdomen may need a two-stage (Fowler-Stephens) procedure to bring it down. This is not possible in all patients and may not be appropriate for very small or damaged testicles, especially those discovered in adult life.

What are the alternatives?

- **Observation without treatment** – this is the only alternative to orchidopexy, but it is associated with:
 - a higher risk of testicular cancer appearing later in life;
 - a risk of the testicle twisting in your groin;
 - psychological problems (especially in children);
 - an increased risk of testicular injury; and
 - possible cosmetic embarrassment.
- [Simple orchidectomy](#) – in adults with a life-long undescended testicle, simple removal is often the most appropriate option, especially if the testicle lies in your abdomen, because it is highly unlikely to recover any useful function

What happens on the day of the procedure?

Your urologist (or a member of their team) will briefly review your history and medications, and will discuss the surgery again with you to confirm your consent.

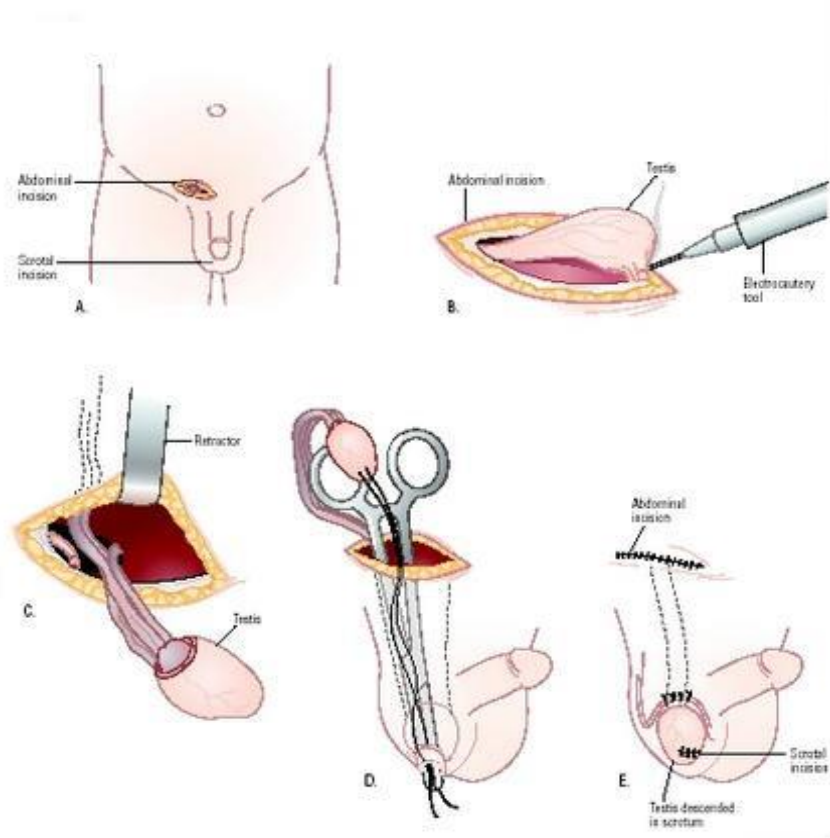
An anaesthetist will see you to discuss the options of a general anaesthetic or spinal anaesthetic. The anaesthetist will also discuss pain relief after the procedure with you.

We may provide you with a pair of TED stockings to wear. These help to prevent blood clots from developing and passing into your lungs. Your medical team will decide whether you need to continue these after you go home.

Details of the procedure

- we normally use a general anaesthetic with local anaesthetic injections to relieve any post-operative discomfort











- we may give you an injection of antibiotics before the procedure, after you have been checked carefully for any allergies



- if your testicle is in the groin area (where most are found), we make a small incision in the groin to free its attachments and bring it down into the scrotum where it is fixed in a pouch under the skin (pictured)
- some undescended testicles are associated with a small hernia which we tie off, at the same time as we free all the attachments to the testicle
- if your testicle is poorly developed or abnormal, we usually remove it to prevent problems in later life
- we close the wounds with absorbable stitches which normally disappear within two or three weeks

Are there any after-effects?

The possible after-effects and your risk of getting them are shown below. Some are self-limiting or reversible, but others are not. We have not listed very rare after-effects (occurring in less than 1 in 250 patients) individually. The impact of these after-effects can vary a lot from patient to patient; you should ask your surgeon's advice about the risks and their impact on you as an individual:

After-effect	Risk
Swelling of the groin and scrotum lasting several days	 Between 1 in 2 & 1 in 10 patients
Infection of the testicle or incision requiring further treatment	 Between 1 in 10 & 1 in 50 patients
If it is not possible to bring the testicle down, it may need to be removed	 Between 1 in 10 & 1 in 50 patients
The testicle may still lie high in the scrotum	 Between 1 in 10 & 1 in 50 patients
Bleeding needing further treatment	 Between 1 in 50 & 1 in 250 patients
Your future fertility cannot be guaranteed and may be reduced even after surgery	 Between 1 in 50 & 1 in 250 patients
Need to repeat the procedure if the operation is not completely successful	 Between 1 in 50 & 1 in 250 patients
Chronic pain in your testicle or scrotum	 Between 1 in 50 & 1 in 250 patients
Your testis may shrink due to poor blood supply after the operation	 Between 1 in 50 & 1 in 250 patients
Anaesthetic or cardiovascular problems possibly requiring intensive care (including chest infection, pulmonary embolus, stroke, deep vein thrombosis, heart attack and death)	 Less than 1 in 250 patients (your anaesthetist can estimate your individual risk)

What is my risk of a hospital-acquired infection?

Your risk of getting an infection in hospital is between 4 & 6%; this includes getting *MRSA* or a *Clostridium difficile* bowel infection. This figure is higher if you are in a “high-risk” group of patients such as patients who have had:

- long-term drainage tubes (e.g. catheters);
- long hospital stays; or
- multiple hospital admissions.

What can I expect when I get home?

- you will get some swelling and bruising of the groin and scrotum which may last several days
- simple painkillers such as paracetamol usually help to settle any discomfort
- you will be given advice about your recovery at home
- you will be given a copy of your discharge summary and a copy will also be sent to your GP
- any antibiotics or other tablets you may need will be arranged & dispensed from the hospital pharmacy
- all the stitches are dissolvable and will usually disappear after two to three weeks
- try to keep the operation site clean and dry for two to three days, and do not soak it in the bath or shower
- you should not ride a bicycle (children should not ride sit-on toys) for four weeks after the procedure
- children undergoing the procedure should be able to go back to school within a few days
- you should refrain from any heavy lifting or strenuous exercise (including all sport) for the first six weeks after surgery
- a follow-up appointment will be made for you

General information about surgical procedures

Before your procedure

Please tell a member of the medical team if you have:

- an implanted foreign body (stent, joint replacement, pacemaker, heart valve, blood vessel graft);
- a regular prescription for a blood thinning agent (e.g. warfarin, aspirin, clopidogrel, rivaroxaban, dabigatran);
- a present or previous MRSA infection; or
- a high risk of variant-CJD (e.g. if you have had a corneal transplant, a neurosurgical dural transplant or human growth hormone treatment).

Questions you may wish to ask

If you wish to learn more about what will happen, you can find a list of suggested questions called "[Having An Operation](#)" on the website of the Royal College of Surgeons of England. You may also wish to ask your surgeon for his/her personal results and experience with this procedure.

Before you go home

We will tell you how the procedure went and you should:

- make sure you understand what has been done;
- ask the surgeon if everything went as planned;
- let the staff know if you have any discomfort;
- ask what you can (and cannot) do at home;
- make sure you know what happens next; and
- ask when you can return to normal activities.

We will give you advice about what to look out for when you get home. Your surgeon or nurse will also give you details of who to contact, and how to contact them, in the event of problems.

Smoking and surgery

Ideally, we would prefer you to stop smoking before any procedure. Smoking can worsen some urological conditions and makes complications more likely after surgery. For advice on stopping, you can:

- contact your GP;
- access your local [NHS Smoking Help Online](#); or
- ring the free NHS Smoking Helpline on **0300 123 1044**.

Driving after surgery

It is your responsibility to make sure you are fit to drive after any surgical procedure. You only need to [contact the DVLA](#) if your ability to drive is likely to be affected for more than three months. If it is, you should check with your insurance company before driving again.

What should I do with this information?

Thank you for taking the trouble to read this information. Please let your urologist (or specialist nurse) know if you would like to have a copy for your own records. If you wish, the medical or nursing staff can also arrange to file a copy in your hospital notes.

What sources have we used to prepare this leaflet?

This leaflet uses information from consensus panels and other evidence-based sources including:

- the [Department of Health \(England\)](#);
- the [Cochrane Collaboration](#);
- the [National Institute for Health and Care Excellence \(NICE\)](#); and
- the [Urology Care Foundation](#).

It also follows style guidelines from:

- the [Royal National Institute for Blind People \(RNIB\)](#);
- the [Information Standard](#);
- the [Patient Information Forum](#); and
- the [Plain English Campaign](#).

Disclaimer

We have made every effort to give accurate information but there may still be errors or omissions in this leaflet. BAUS cannot accept responsibility for any loss from action taken (or not taken) as a result of this information.

PLEASE NOTE

The staff at BAUS are not medically trained, and are unable to answer questions about the information provided in this leaflet. If you do have any questions, you should contact your urologist, specialist nurse or GP.