

# Novità in tema di CRIPTORCHIDISMO

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*Novità e prospettive  
nell'attività professionale  
del pediatra*

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AGADIR (Marocco)

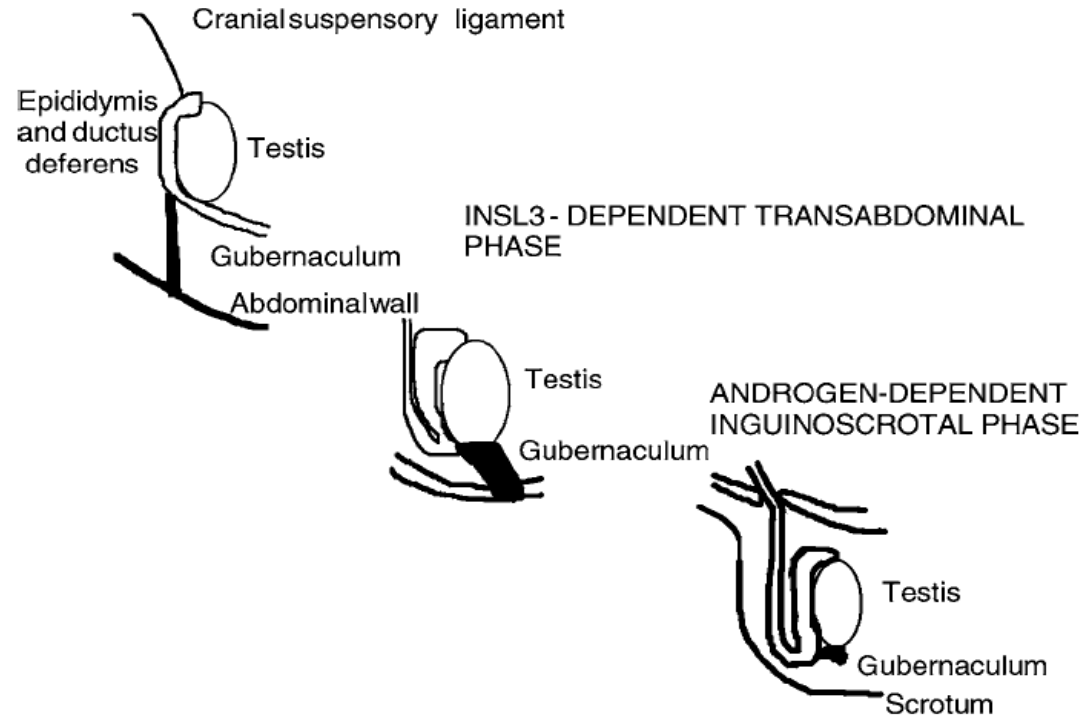
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# 1) ETIOPATOGENESI

# Development and descent of the testis in relation to cryptorchidism

Helena E Virtanen<sup>1</sup>, Dina Cortes<sup>2,3</sup>, Ewa Rajpert-De Meyts<sup>6</sup>, E Martin Ritzén<sup>4</sup>, Agneta Nordenskjöld<sup>5</sup>, Niels E Skakkebaek<sup>6</sup>, Jorma Toppari (jorma.toppari@utu.fi)<sup>1</sup>



**Figure 1** Schematic figure of the phases of testicular descent [reproduced with permission from Elsevier Toppari et al. (60)].

## 2) PREVALENZA

# Birth prevalence of cryptorchidism and hypospadias in northern England, 1993–2000

N A Abdullah, M S Pearce, L Parker, J R Wilkinson, B Jaffray, R J Q McNally

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*Arch Dis Child* 2007;92:576–579. doi: 10.1136/adc.2006.102913

Cryptorchidism and hypospadias in northern England

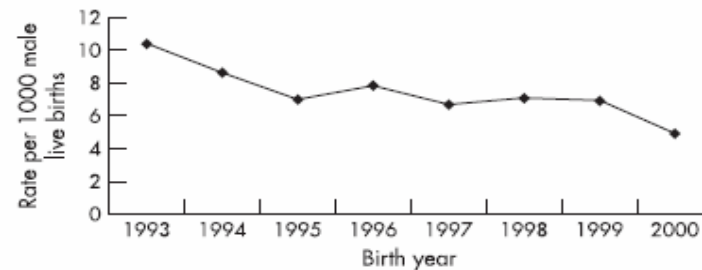


Figure 1 The birth prevalence of cryptorchidism, northern region of England, 1993–2000.

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## What is already known on this topic

- There is controversy as to whether there is an increasing birth prevalence of cryptorchidism and hypospadias.
- Complete datasets of these anomalies are rare because their construction is difficult, with reported trends often hard to interpret due to incomplete ascertainment and varying inclusion criteria.
- Comparison of rates between studies is made difficult by inconsistent choice of denominators.

## What this study adds

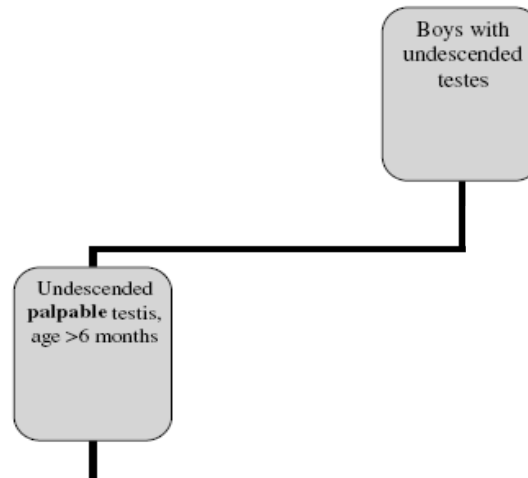
- There was an apparent decline in prevalence of cryptorchidism which may be real or may be due to a decrease in interventions.



# 3) FLOW CHART

# Nordic consensus on treatment of undescended testes

E. Martin Ritzén (Martin.Ritzen@ki.se)<sup>1</sup>, A Bergh<sup>2</sup>, R Bjerknes<sup>3</sup>, P Christiansen<sup>4</sup>, D Cortes<sup>4,5</sup>, SE Haugen<sup>6</sup>, N Jörgensen<sup>7</sup>, C Kollin<sup>1</sup>, S Lindahl<sup>8</sup>, G Läckgren<sup>9</sup>, KM Main<sup>7</sup>, A N

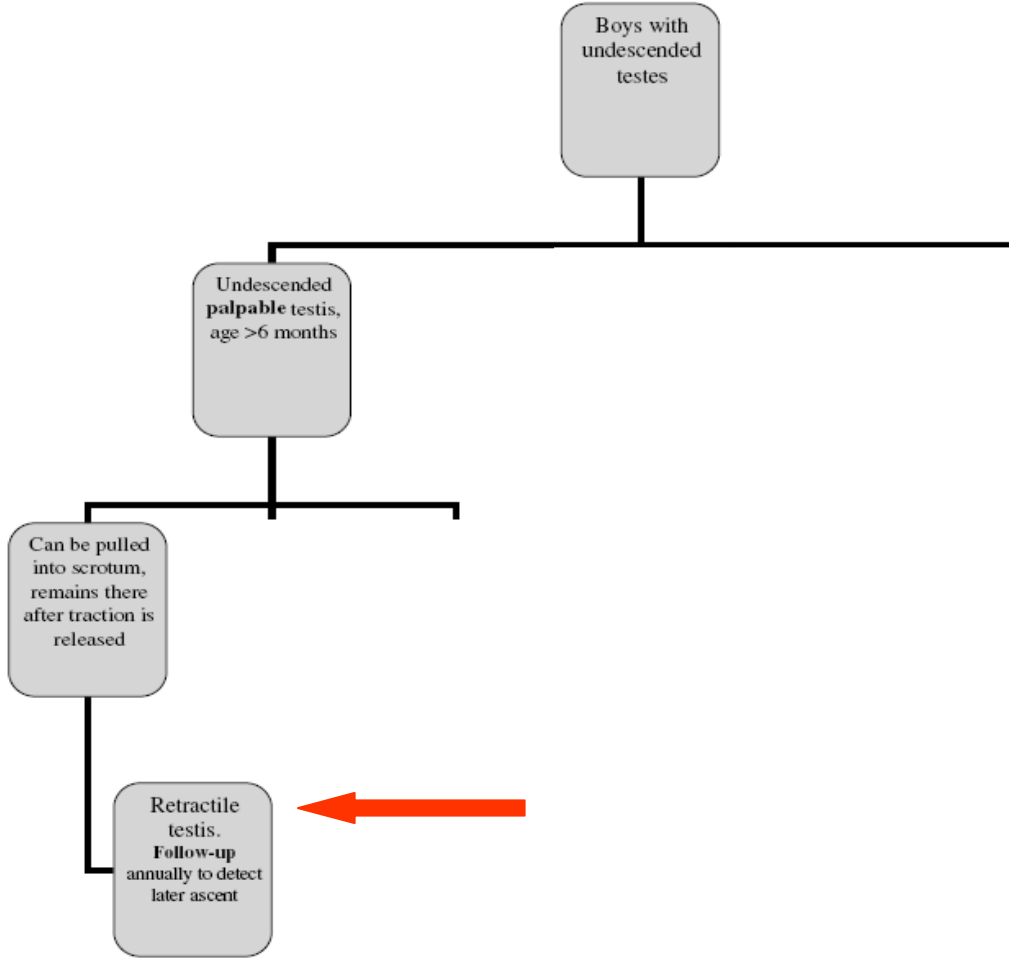


**Figure 1** Schematic representation of a decision tree that can be used for management of boys with undescended testes. See also text, for a more detailed discussion.



# Nordic consensus on treatment of undescended testes

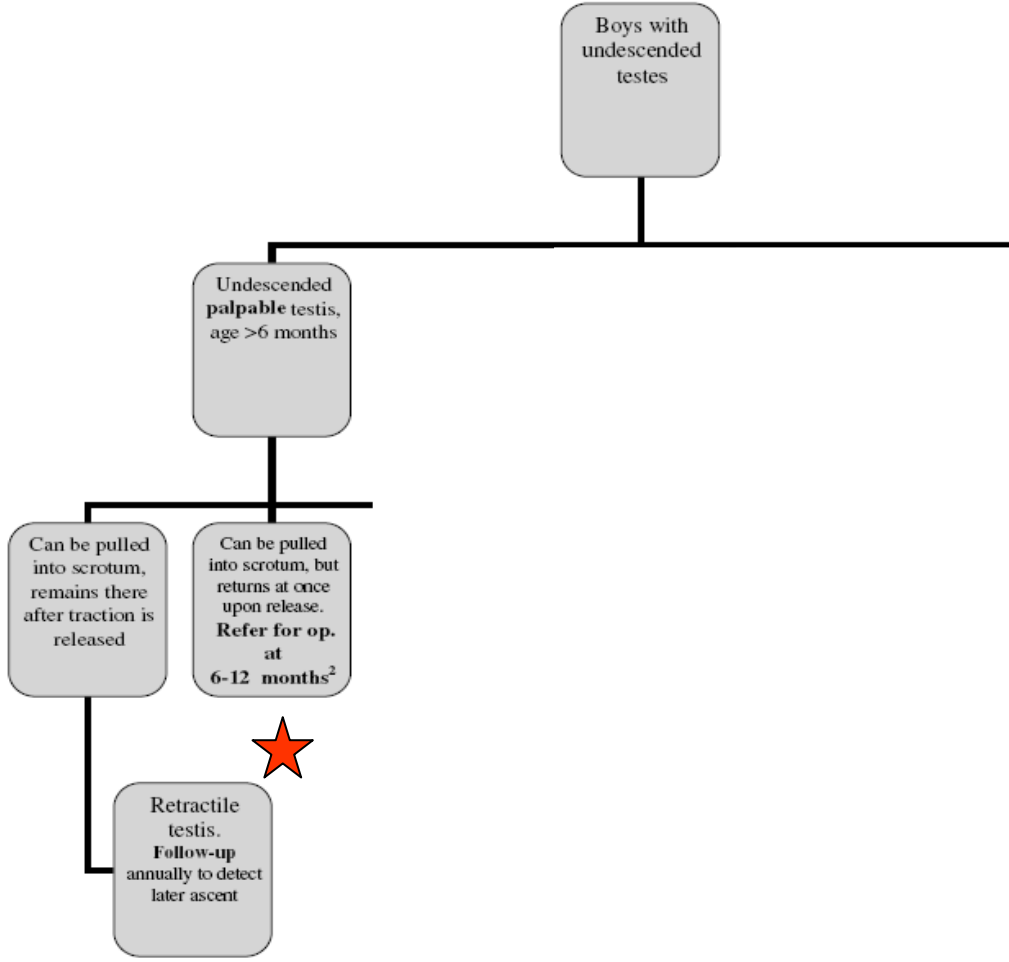
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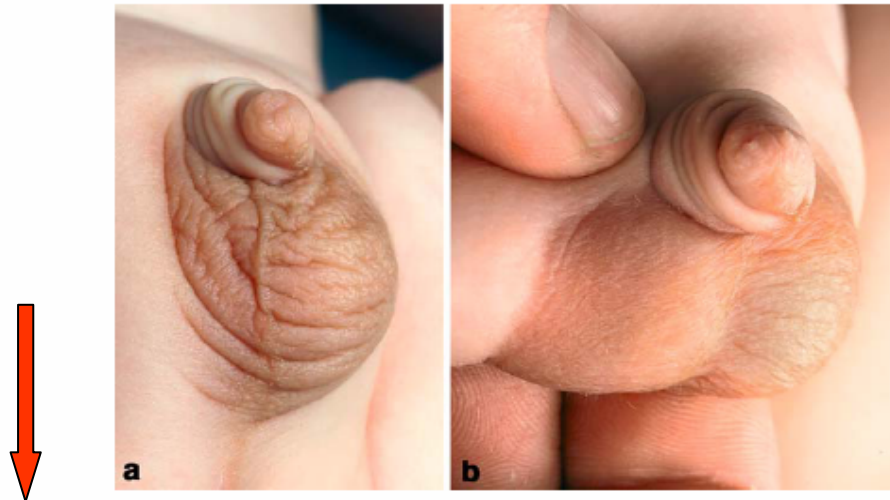
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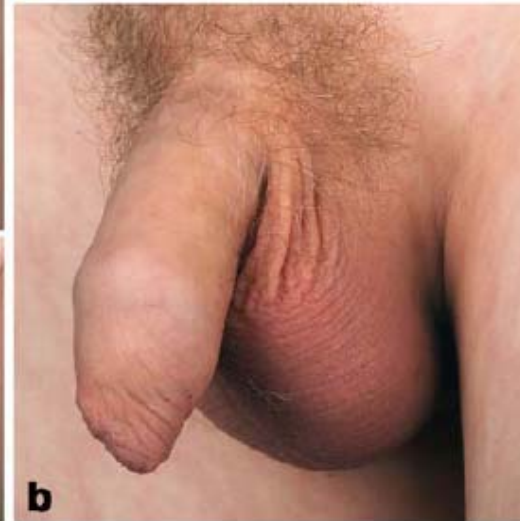
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**Figure 1** Schematic representation of a decision tree that can be used for management of boys with undescended testes. See also text, for a more detailed discussion.



**Fig. 2** a Congenital high scrotal testis in a 6 month old boy. b In squatting position on the mother's lap the right testis can be brought into a high unstable scrotal position. Further traction on cord structures elicited discomfort. After release the testis immediately retracts to the groin region

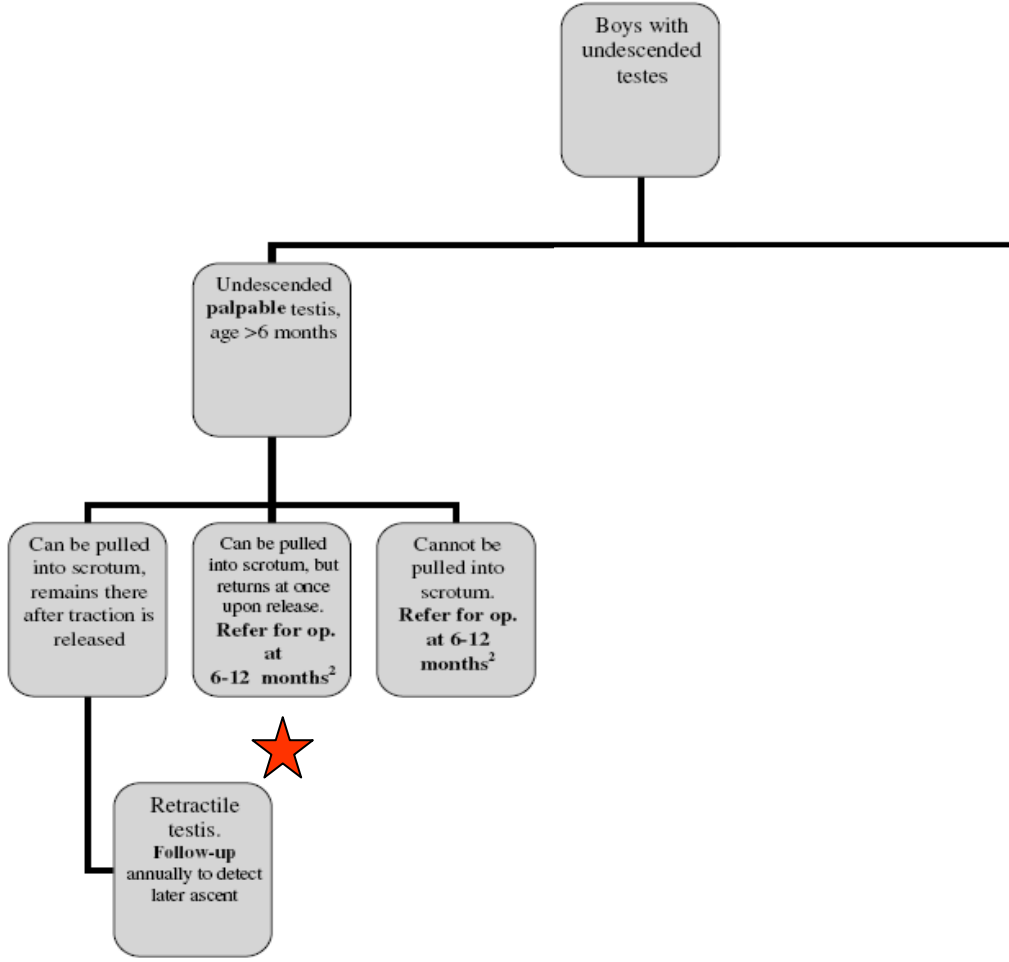


**Fig. 3 a** Acquired high scrotal testis in a 10 year old boy. At squatting the left testis can be brought into a high unstable scrotal position. Active treatment was withheld and puberty was awaited. **b** At age 14

the testis had meanwhile descended spontaneously with a testicular volume appropriate for age (15 ml versus 15 ml of the contralateral gonad)

# Nordic consensus on treatment of undescended testes

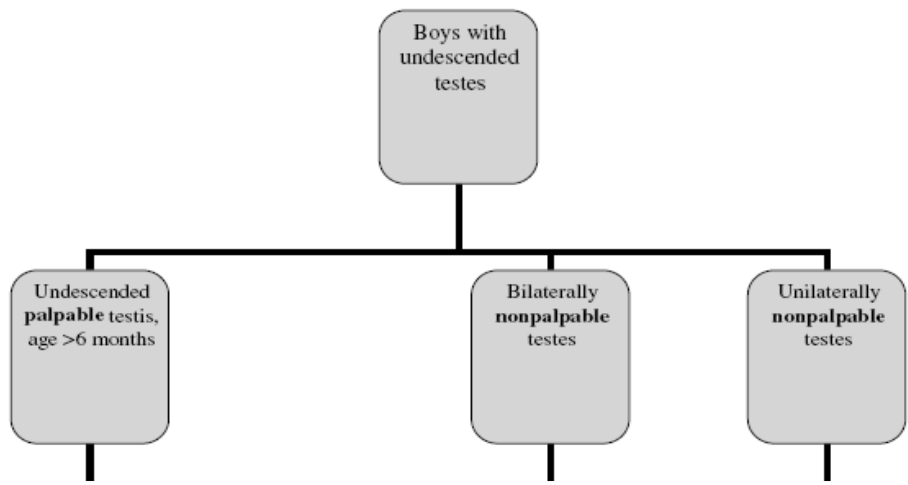
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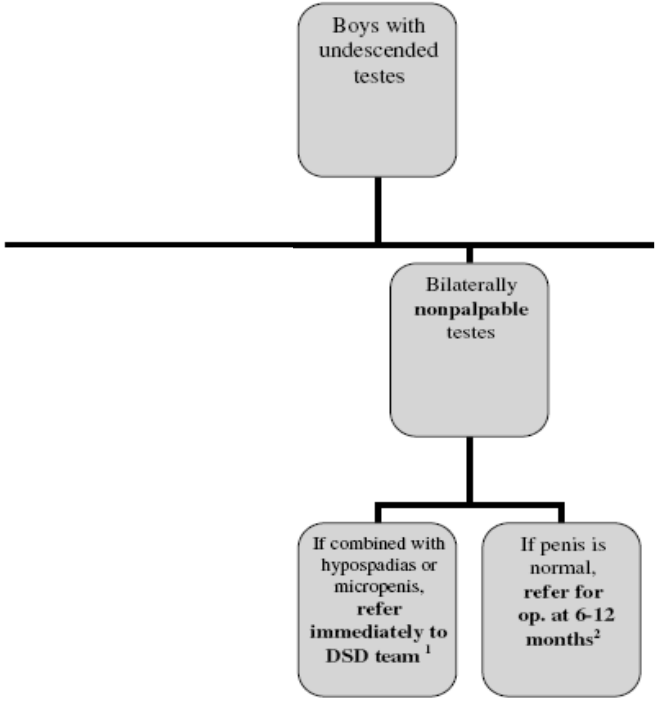
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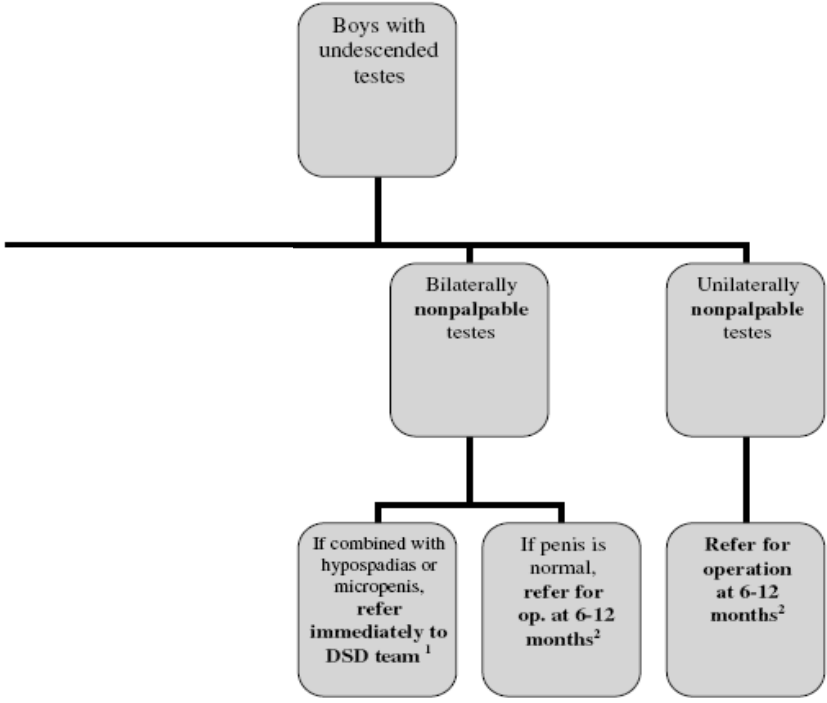
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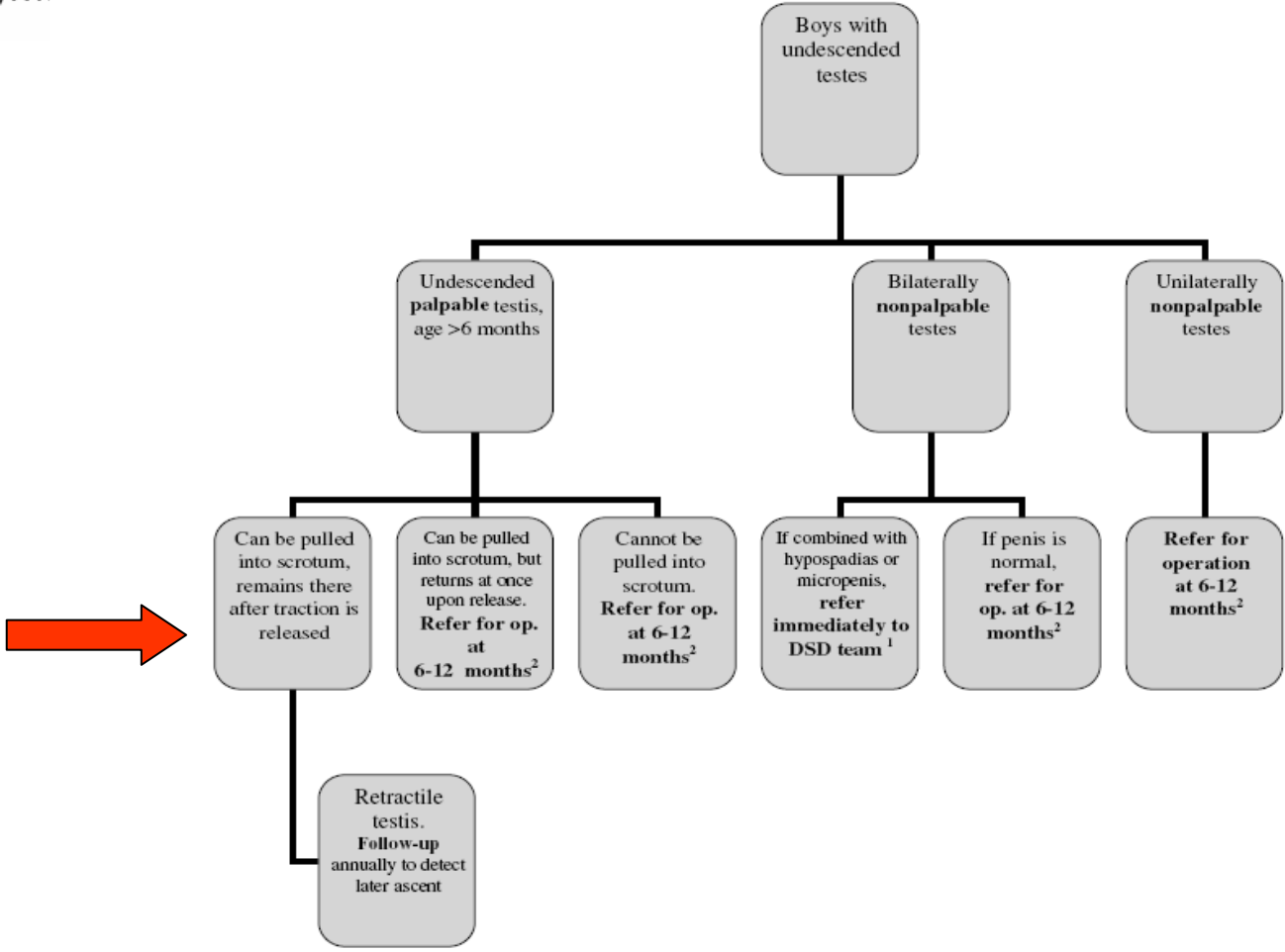
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**Qual è l'aspetto che vi ha  
maggiormente colpito ?**

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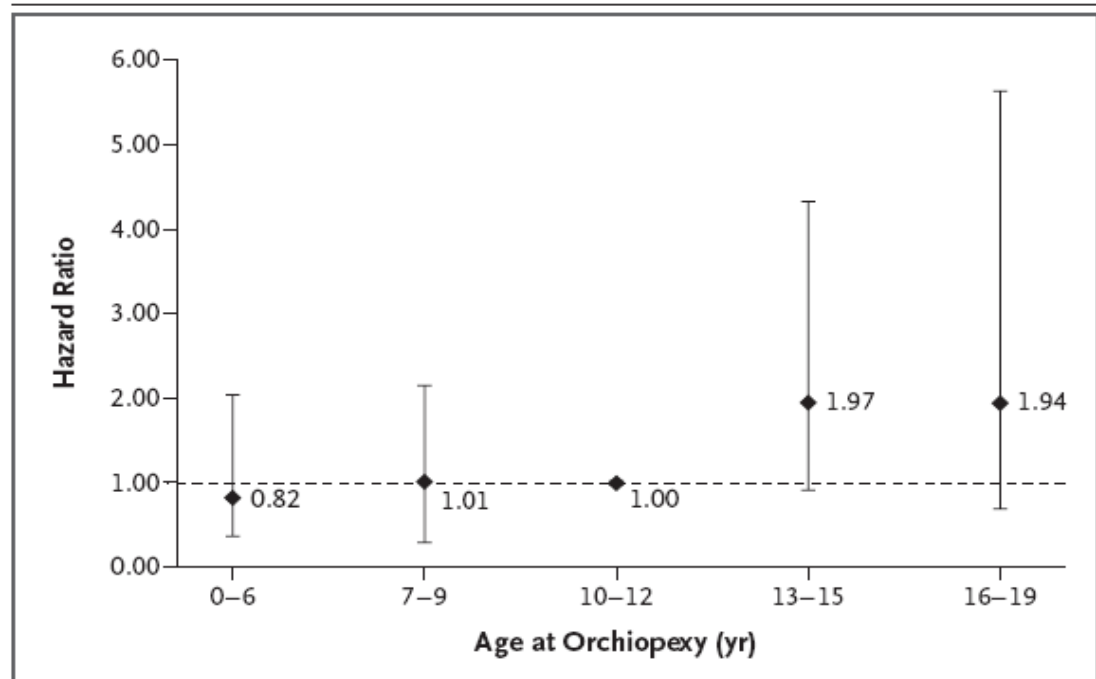
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# Age at Surgery for Undescended Testis and Risk of Testicular Cancer

Andreas Pettersson, M.D., Lorenzo Richiardi, M.D., Ph.D.,  
Agneta Nordenskjold, M.D., Ph.D., Magnus Kaijser, M.D., Ph.D.,  
and Olof Akre, M.D., Ph.D.



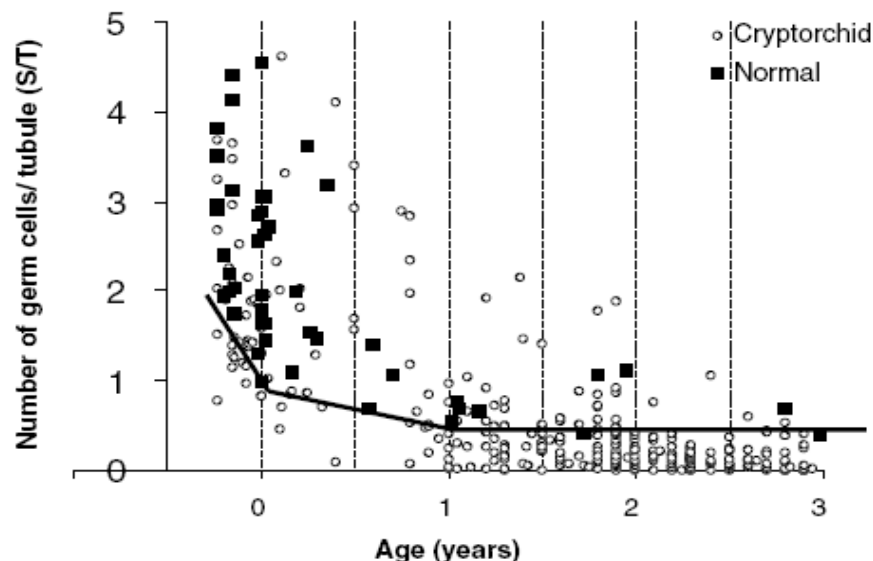
**Figure 2.** Hazard Ratio for Testicular Cancer According to Age at Orchiopexy.

A within-cohort comparison was used. I bars denote the upper and lower limits of the 95% confidence intervals.

N Engl J Med  
2007;356:1835-41.

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**Figure 2** The number of spermatogonia and gonocytes per tubular cross-section (S/T) in 35 human cryptorchid and 22 healthy fetuses, 261 boys who underwent orchidopexy <3 years of age and 22 normal boys who died of other causes <3 years of age. Solid line: lowest normal value [reprinted with permission from Cortes et al. (51)].

**Perché non si ricorre alla terapia  
ormonale?**

# HORMONAL TREATMENT MAY HARM THE GERM CELLS IN 1 TO 3-YEAR-OLD BOYS WITH CRYPTORCHIDISM

DINA CORTES, JØRGEN THORUP AND JAKOB VISFELDT

*From the Departments of Pediatric Surgery and Pathology, Rigshospitalet, Copenhagen, Denmark*

## *Patient characteristics*

	Gonadotropin Releasing Hormone	HCG	Surgery Only
No. pts.	19	8	45
Median spermatogonia/tubule (range)*	0.07 (0–0.31)	0.06 (0.0025–0.21)	0.14 (0–0.86)
No. normal spermatogonia/tubule	0	0	7
No. biopsy without germ cells or with less than 1% normal value for age	3	1	4
Median age at orchiopexy (range)	2.9 (1.9–3.9)	3.2 (2.7–3.8)	2.6 (1.9–3.9)
No. intra-abdominal testis	0	2	5
No. bilat. surgery	3	2	5

\* Hormonal treatment versus surgery only  $p < 0.05$ .

# NEOADJUVANT GONADOTROPIN-RELEASING HORMONE THERAPY BEFORE SURGERY MAY IMPROVE THE FERTILITY INDEX IN UNDESCENDED TESTES: A PROSPECTIVE RANDOMIZED TRIAL

CHRISTIAN SCHWENTNER, JOSEF OSWALD, ALFONS KRECZY, ANDREAS LUNACEK, GEORG BARTSCH, MARTINA DEIBL AND CHRISTIAN RADMAYR\*

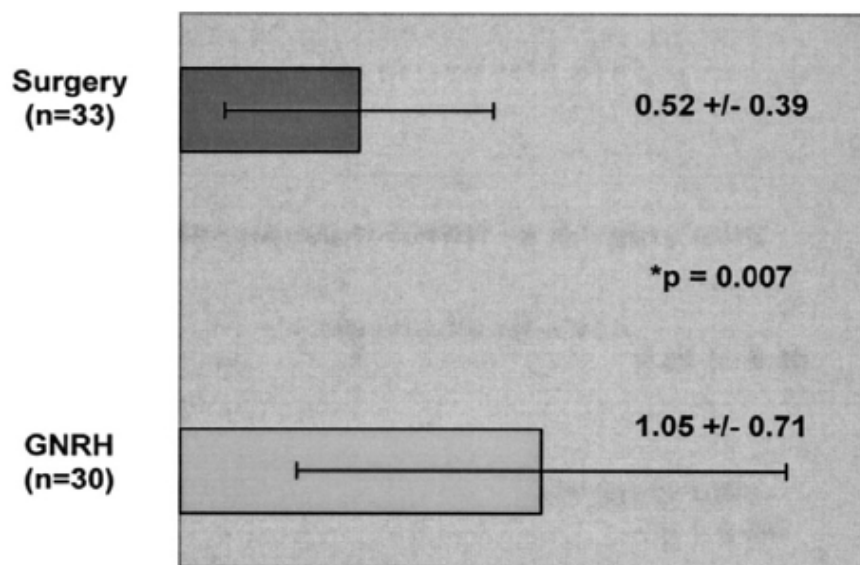


FIG. 1. Average amount of spermatogonia per tubule plus or minus SD with and without GNRH treatment in all investigated age groups. *n*, number of testes. Asterisk indicates statistical significance.

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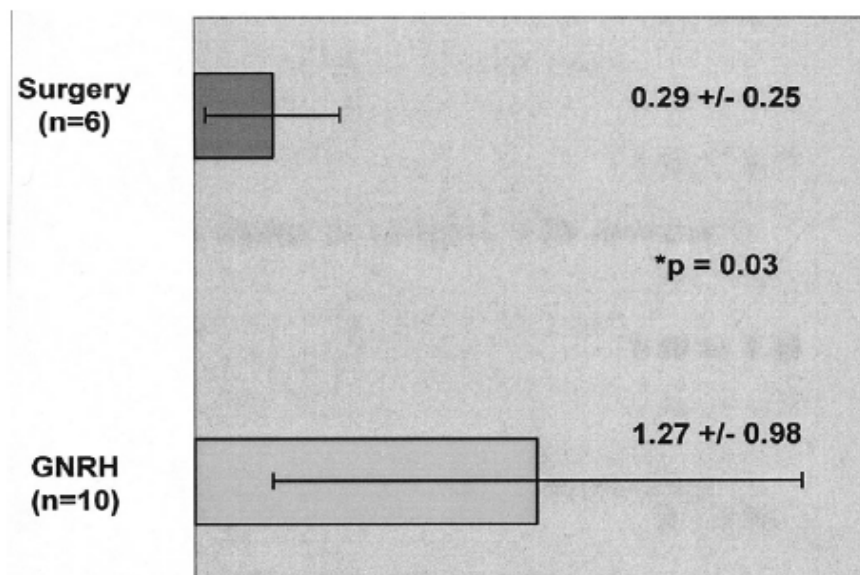


FIG. 2. Statistical analysis demonstrates average spermatogonia per tubule ratio plus or minus SD in both groups younger than 24 months. *n*, number of testes. Asterisk indicates statistical significance.



# Grazie per l'attenzione

