LAPAROSCOPY FOR UNDESCENDED TESTIS

The spectrum of undescended testis includes all cases where the testis is not found in the scrotum in the normal position.
Where it is not possible to feel the testis, ¼ will be absent altogether, ¼ will lie high in the abdomen and ½ will be in the groin area.

Problems associated with undescended testis include:
1. risk of cancer
2. reduced fertility
3. cosmetic appearance
4. risk of torsion and injury
5. groin hernia

Fertility from the undescended testis is not recoverable after infancy but overall is likely to be normal with a normal opposite testis.
The risk of cancer is some 1% and this may not be altered by repositioning of the testis in the scrotum. Repositioning does however permit ready examination of the testis and earlier cancer detection. The risk of cancer declines with age.
In general, surgery to achieve testicular descent, or orchidectomy, may be considered in younger (<35 years) patients as the benefits are more apparent than in older patients (>40 years).
Laparoscopy (key-hole surgery) is accepted as the most accurate method of localising the undescended, impalpable testis. It is associated with less pain, fewer complications and superior recovery, compared to open surgery. In common with all laparoscopic surgery, hospital stay is short and recovery is quicker than the open procedure with few or no wound-related problems.
The procedure is performed under general anaesthetic and surgery performed using a camera and telescope system through the ports (keyholes). If the tissue/specimen to be removed is large, this will usually require an additional wound just above the pubic symphysis (bikini-line).

The aims of laparoscopy are to:
1. establish the presence and position of the testis
2. remove those testes that cannot be brought down into the scrotum
3. position the testis in the scrotum to allow examination and for cosmetic reasons
4. treat associated hernia
5. preserve fertility

WHAT TO DO BEFORE YOUR PROCEDURE:
- ensure laboratory tests are done > 48 hours prior to surgery, unless advised otherwise
- discontinue aspirin and other anticoagulants 1 week prior, other medications may also need to be stopped
- nothing to eat or drink from 6 hours prior to procedure - see Admission Booklet regarding diet restrictions
- you will be admitted to hospital on the day of surgery.
- you do not need to shave prior to surgery

WHAT HAPPENS IN HOSPITAL AFTER YOUR PROCEDURE:
- your surgery is performed on a day-stay basis

WHAT HAPPENS AFTER YOU LEAVE HOSPITAL:

- recovery is reasonably quick, with return to normal activities including driving after 10 days.
- withhold aspirin and other anticoagulants for 1 week but reinstate other usual medications.
- the Steristrip (tape) dressings should be left on the wounds for 4 weeks. If the Steristrips come off, the wounds should be left exposed without further dressings applied
- post-operative constipation may be minimised with good fluid intake, dietary fibre and laxatives.
- you may not drive for 24 hours post procedure and see Admission Booklet regarding further restrictions following general anaesthetic
- avoid heavy lifting for 2 weeks; thereafter resume normal activity including sexual intercourse

WHAT CAN GO WRONG:

Although most cases proceed without particular difficulty and have excellent outcomes, surgical complications occur overall in 5% of patients. The list below details complications recognised as common or serious, but this does not include the rare and extraordinary. Risk of death is approximately 0.03% in generally healthy patients.

AT THE TIME OF AND EARLY AFTER SURGERY:

- Failed procedure and conversion to open procedure <1%
- Bleeding requiring blood transfusion in < 1%
- Infection may require antibiotic treatment <3%
- Temporary shoulder pain is common after laparoscopy
- Damage to other organs, including bowels, spleen, liver and gall bladder, nerves and lymphatics, and CO2 gas embolism
- Numbness or tingling in legs, genitalia and perineum is usually temporary
- Clots (DVT, PE), gas embolism
- Risk of death may be estimated using the nzRISK https://nzrisk.com on-line pre-operative calculator. It has been developed and validated for patients in New Zealand over the age of 18, to help patients and doctors balance benefits and risks of treatment.

LATER POTENTIAL COMPLICATIONS :

- Port site hernia
- Adhesions
- Testicular atrophy despite technically successful relocation of the testis into the scrotum occurs in 30% of patients