Luteinising hormone-releasing hormone nasal spray as therapy for undescended testicle


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SUMMARY Twenty-two prepubertal children with unilateral cryptorchidism were treated. None had undergone previous medical or surgical treatment to modify the abnormal position of the testes, all of which were located in the inguinal canal. Treatment was with luteinising hormone-releasing hormone (LH-RH) nasal spray given for 7 days. 9 boys insufflated 100 μg LH-RH in each nostril 6 times per 24 hours (1200 μg/24 h); the remaining 13 boys insufflated 500 μg 12-hourly (1000 μg/24 h). An LH-RH test (50 μg IV) was carried out before and after therapy. Full descent of the testis into the scrotum was obtained in 7 out of the 22 cases; in a further 6 cases the testis moved down the inguinal canal.

Basal values of luteinising hormone and follicle-stimulating hormone and those for pituitary reserve remained unchanged before and after therapy, and were similar to the values of a control group. No correlation was found between response to therapy and bone age, testosterone level in serum, basal values or pituitary reserve of luteinising hormone or follicle-stimulating hormone.

Luteinising hormone-releasing hormone (LH-RH) therapy in the adult male affected by secondary hypogonadism is known to be effective (Isidori et al., 1974; Mortimer et al., 1974a, b). This releasing hormone, given by nasal spray, was also successfully used in the treatment of adult hypogonadotrophic hypogonadism (Isidori et al., 1974) and cryptorchidism in prepubertal boys (Happ et al., 1975). Since cryptorchidism is sometimes associated with gonadotrophin deficiency (Job et al., 1974; Koch and Rahlf, 1975; Hadziselimovic et al., 1976), we have studied the therapeutic effectiveness of LH-RH in relation to the pituitary reserve of gonadotrophins.

MATERIALS AND METHODS

Twenty-two boys with unilateral undescended testicle, aged from 5 to 11½ years, were treated. Bone age ranged from 4 years 10 months to 11 years 4 months and the difference between chronological and bone age never exceeded 6 months. All fell into the prepubertal stage of sexual development, the first stage of Tanner’s (1962) classification. None had received previous medical or surgical treatment for testicular maldescent. In all cases the undescended testes were located in the inguinal canal, apparently along the normal descent way; none had retractile testes.

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Table  Peak, maximum increase, and area of the LH and FSH curves (mean ± SEM) in the LH-RH test in 22 unilateral cryptorchid oys before and after LH-RH nasal spray therapy given in two dosage schemes (see text)

<table>
<thead>
<tr>
<th></th>
<th>LH (mIU/ml)</th>
<th>FSH (mIU/ml)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Basal value</td>
<td>Peak</td>
</tr>
<tr>
<td></td>
<td>Before</td>
<td>After</td>
</tr>
<tr>
<td>Normal boys (n = 29)</td>
<td>1.81 ± 0.15</td>
<td>4.37 ± 0.52</td>
</tr>
<tr>
<td>Cryptorchid boys (n = 22)</td>
<td>1.98 ± 0.39</td>
<td>4.97 ± 0.71</td>
</tr>
<tr>
<td>LH-RH dosage A (n = 9)</td>
<td>1.43 ± 0.38</td>
<td>5.20 ± 0.65</td>
</tr>
<tr>
<td>LH-RH dosage B (n = 13)</td>
<td>2.32 ± 0.52</td>
<td>4.83 ± 0.64</td>
</tr>
</tbody>
</table>

LH = luteinising hormone; FSH = follicle-stimulating hormone.
Cryptorchidism from retractile or ectopic testis. We think that we can exclude those cases where the testes were retractile, since the testis could not be brought down into the scrotum despite repeated examinations. On the other hand, we cannot be certain that there was no case of ectopic testis as it is well known how difficult it is to differentiate this.

Our results suggest that the hormone need be administered in only two injections per 24 hours, and that the effectiveness of therapy is independent of age. We found no correlation between response to therapy and bone age or basal testosterone level.

The rationale for treating cryptorchidism with LH-RH nasal spray was the efficacy of such treatment for secondary hypogonadism in the adult (Isidori et al., 1974), and the finding of an LH deficit in a certain number of cryptorchid patients (Koch and Rahlf, 1975; Hadziseelimovic et al., 1976; Werder et al., 1976). We therefore expected to find that the response to this form of therapy would correlate with gonadotrophin basal levels and/or gonadotrophin pituitary reserve; and further that this therapy would result in an increase in pituitary reserve and tonic secretion of LH and FSH. However, the response to therapy in our cases did not correlate with the gonadotrophin status either before or after therapy, while the hormone studies carried out before and after the course of therapy failed to show any modification in gonadotrophin secretion as a result of the therapy. We conclude therefore that the efficacy of releasing hormone treatment does not depend on the correction of gross abnormalities of gonadotrophin secretion. It is sufficient to induce repeated small and diminishing stimuli to obtain good therapeutic results in cryptorchidism. The best results were obtained in cases where the undescended testicle was located near the external inguinal ring. No side effects were observed during or after LH-RH nasal spray treatment.

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References


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