



Ref: PQ 34918/25

21<sup>st</sup> July 2025

**Deputy Catherine Connolly**  
**Dáil Eireann**  
**Dublin 2**

Dear Deputy Connolly

I refer to your parliamentary question below which has been forwarded to me for attention. Firstly, please accept my apologies for the delay in issuing a response.

**PQ 34918/25 – To ask the Minister for Health the number of children who have potentially been left infertile or at risk of cancer due to not receiving surgery for undescended testicles in a timely manner; the number of guardians and parents of potentially impacted children contacted to be made aware of these concerns; and if she will make a statement on the matter.**

**Children's Health Ireland (CHI) Response:**

As fertility is a complicated and multifactorial phenomenon, it is more practical to refer to paternity rates when discussing undescended testes (UDT), i.e. the probability that somebody will father a child. Children's Health Ireland (CHI) can advise that children born with undescended testes (UDT) on one side only can expect to have similar paternity rates to the general population irrespective of the timing of surgery (majority of cases of UDT). Those born with UDT on both sides have an approximately 60% paternity rate of the general population as a whole. We are not aware of data regarding paternity rates for children in Ireland who have undergone orchidopexy in childhood, not least because of the challenge presented by the 2-3 decade interval between surgery and paternity for most patients.

Undergoing orchidopexy, regardless of timing, does not per se reduce the risk of testicular cancer, which remains higher than the general population after surgery. The goal of orchidopexy is to move the testes into the correct position to allow early detection of testicular cancer in adulthood and therefore maximize the chances of a good outcome.

As the paternity potential of children with UDT depends heavily on whether the problem affects one or both sides, the location of the UDT (sperm production in intra-abdominal testes is often markedly poorer) and the age at which the condition is recognized, the interval between assessment with a Paediatric Surgeon/Urologist and having an orchidopexy is generally a minor contributor to the overall paternity outcome. Nonetheless, as sperm production is thought to reduce gradually over time in UDT, we triage referrals of suspected

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UDT (around 70-80% of whom do not turn out to have UDT) as semi-urgent and list patients needing orchidopexy with a semi-urgent priority.

In infants that are assessed as having UDT, the decision to proceed with surgery prior to 12 months must be balanced against the risk of anaesthesia at a young age, and in most quality international studies, children under 12 months constitute a small minority (<15%) of those undergoing orchidopexy.

Given that diminished paternity rates are primarily a function of factors other than just the interval between referral and surgery for UDT while also considering that parents and guardians are already counselled regarding expected paternity rates during the clinical journey, we have not retrospectively contacted parents/guardians to rediscuss their children's fertility prospects as they relate to the timing of their surgery.

Yours sincerely

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