

TESTICULAR NEOPLASM WITH INGUINAL LYMPHNODE METASTASIS - AN UNUSUAL PRESENTATION

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Abstracts

Testicular neoplasm and infertility are two common complications of cryptorchidism. Early surgical treatment of undescended testis i.e. between 3 to 12 months of age appears to lower the risk of complications. If done later, the risk of testicular cancer cannot be eliminated. Another important thing is that for diagnosing testicular neoplasm open biopsy or core biopsy is usually not done before operation. If essential, it is done through inguinal route during surgery (frozen section biopsy), and is never through scrotal route until and otherwise it has already invaded the scrotal skin causing ulceration. In that case there may be chance of spreading malignancy into inguinal lymph nodes.

Key words: Testicular neoplasm, Inguinal lymphnode, Metastasis

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Introduction:

Testicular cancer is a relatively rare tumor type accounting for approximately 1% of all male cancers globally.[1] However, this disease has a very distinctive age distribution and in many developed countries it is the most commonly diagnosed malignancy among men aged between 15–40 years.[2] One of the main risk factors for testicular cancer is undescended testis.[3]

Testicular cancer usually presents with painless lump, feeling of heaviness, dragging or dull ache in the lower abdomen or scrotum, para-aortic lymphadenopathy, Virchow's gland and infertility. An ultrasound is often done as the first test for diagnosis and which is supported by some tumor markers such as alpha-fetoprotein (AFP) and human chorionic gonadotropin (HCG). A testicular tumor might also increase the levels of *lactate dehydrogenase* (LDH). Biopsy is rarely done because it might risk spreading the cancer.[4]

Case report

A 34-year-old gentleman presented with a painless swelling of left testis, which was gradually increasing in size. He had history of bilateral incompletely descended testis. He underwent surgery thrice in his boyhood. In first two attempts surgeons failed to bring both testes in position. In the last attempt he lost his right testis for

unknown reason but the left one was successfully positioned into the scrotum. He got married and the couple tried to have a baby but failed. He was diagnosed as a case of obstructed azoospermia and accordingly, for in vitro fertilization his sperm was collected from the testis through scrotal route by means of testicular sperm extraction (TESE). Before TESE he was prescribed clomiphene citrate for spermatogenesis. Subsequently, he felt heaviness in the left testis and noticed gradual increase in its size.

During the index consultation, his left testis was found 7 cm x 7 cm x 5 cm in size, the surface was smooth and the overlying skin was not fixed, the spermatic could not be palpated. The right side of the scrotum was empty. Also, one of the left inguinal lymph nodes was palpable, which was approximately 2 cm X 2 cm in size, mobile, non-tender, having smooth surface and firm in consistency. Para-aortic lymph nodes, liver, spleen and Virchow's gland were not palpable.

CT scan revealed enlarged left testis with inhomogeneous enhancement, an enlarged lymph node in left inguinal region, no iliac or para-aortic lymphadenopathy, no liver metastasis, no mediastinal lymphadenopathy, no lung metastasis and pleural effusion. His β -hCG level was 6440.0 mIU/mL (normal upto 10 mIU/mL), α -fetoprotein 58.0 ng/mL (normal upto 13.6 ng/mL) and LDH was 233.00 U/L (normal <248 U/L).

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