Dear Editor,

Semiology of testicular tumor has been extensively reported in medical literature, and is circumscribed to the scrotum in most patients. The case reported here had an atypical presentation, and may therefore be of interest. It is also another example that complete physical examination is crucial for evaluation of a patient.

A 39-year-old male born in an Eastern European country with an unremarkable clinical history attended our emergency room reporting stabbing colic pain mainly in the lower half of abdomen, in the left iliac fossa, refractory to standard analgesics. He reported no prior trauma or other urological symptoms.

Physical examination revealed a tender mass in left iliac fossa. The right testis was normal, but two stone-hard nodules were palpated in the left testis.

A complete count showed a slightly decreased WBC count (10,900/µL) with 90.7% neutrophils, lymphopenia of 6,300 WBC/µL, and a platelet count of 464,000. No significant changes were seen in blood chemistry, and blood gas testing revealed respiratory alkalosis with a pH of 7.62. Based on these findings, abdominal ultrasound was performed, showing an image consistent with a precavaortic retroperitoneal adenopathic conglomerate approximately 11×6 cm in size. The bigger paraaortic nodule was 6×5 cm in size. A solid, hypoechoic, focal 8-mm lesion was seen in the right hepatic lobe. Scrotal ultrasound showed a right normal testis and a left testis with microlithiasis and two 14.3 mm and 8.5 mm hypoechoic nodules, as well as a 4 cm mass.

Left radical orchiectomy was successfully performed. The specimen was pathologically diagnosed as a classical seminoma with a marked sarcoid reaction and extension to testicular sheaths, epididymis, and proximal cord (fig. 1); Cis areas; sclerotic lesions consistent with burned tumor areas; and granulomatous vasculitis of epididymal and intratumoral vessels (pT3 classical seminoma).

Classical testicular seminoma that initiates as acute abdomen. A case report

Seminoma clásico testicular que inicia como abdomen agudo. A propósito de un caso
A CT scan ruled out the existence of thoracic nodular disease and lesions in lung parenchyma. No changes were found in liver, biliary tract, spleen, pancreas, adrenals, and kidneys. There was a significant retroperitoneal adenopathic conglomerate that encompassed major vessels and extended cranially from renal vessels to iliac bifurcation. The conglomerate showed homogeneous attenuation similar to muscle, except for a 4.6 × 4.4 cm area in the left anterolateral side having a low attenuation value suggesting a cystic-necrotic component (fig. 2). Cranio-caudal diameter of the conglomerate was 9 cm. No adenopathies of a significant size were seen in the territory of inguinal iliac arteries.

The patient was referred to the oncology department of our hospital and received three cycles of bleomycin, etoposide, and cisplatin, and a fourth cycle consisting of cisplatin and etoposide. Approximately one year later, a residual lymphadenectomy was performed. Pathological examination found necrosis and dystrophic calcification, marked fibrosis, and no tumor in any node. The patient continues to be monitored by both departments, and had no increased marker levels in this last visit (2/8/2008).

While the most common initial sign of testicular tumors is painless enlargement, up to 10% of patients with germ cell testicular tumors (GCTTs) have at diagnosis distant clinical signs including, amongst others, dyspnea due to pulmonary or mediastinal involvement or lumbar pain due to retroperitoneal nodal disease.1 In any of these locations, a sudden start of clinical signs, as occurred in our patient, would be due to an accelerated growth associated to secondary necrosis or tissue infarction. On the other hand, according to the few series available, tumor presentation as acute scrotum occurs in 0.01%2 to 10% of cases.3 By contrast, presentation as acute abdomen is extremely rare. A search in PubMed only found two cases with this clinical presentation,9,10 which is the unique feature of the case in hand. It is estimated that approximately 1% of GCTTs occur as a retroperitoneal mass associated to testes with no changes in clinical examination, which makes clinical diagnosis at the emergency room difficult. In some patients, a GCTT has been detected in testes with an apparently normal clinical examination from 5 months to 14 years after treatment for a retroperitoneal GCTT.4,5 Thus, in a historical series of 29 primary retroperitoneal GCTTs assessed by the Pathological Institute of the US army between 1942-1946, 15 turned out to be metastases from clinically undetectable testicular tumors, and 8 of these were found in burned tumor areas. Our patient had a palpable testicular mass, but the tumor specimen contained areas of both burned and viable tumor, which had already metastasized despite the fact that regression had started at the point of origin.

Germ cell tumors (GCTs) in the retroperitoneum may be metastatic, which is more common, or primary (due to germ cell migration during embryogenesis) because approximately 5% of GCTs originate outside the testis, in the preccocygeal, retroperitoneal, or mediastinal space or in the pineal body.6 Seminoma is the most common GCT in peritoneum, followed by embryonic carcinoma. Most patients with nodular disease at this level report low back insidious symptoms, and are therefore initially managed as if they had a musculoskeletal condition and referred to orthopedic surgery and rheumatology. This presentation form has been reported in many publications in medical literature,7,8 unlike the presentation as acute abdominal signs seen in the reported patient.

GCTs are the most common cause of retroperitoneal masses among males aged 15-35 years. Since a scrotal examination showing no changes is very rare in these patients, GCTs should be considered in differential diagnosis and a complete examination should be performed in any male from this age group with a palpable abdominal mass because, although genital examination of these patients may appear excessive, we may get an unpleasant surprise.

REFERENCES


M. Girón de Franciscoa,*, M. Álvarez Maestrob, M.Á. Pérez-Utrilla Pérezc, E. Collantes Bellidod

*Corresponding author.
E-mail: manolo_giron@hotmail.com (M. Girón de F