4. Tzelepi V, Zolota V, Batistatou A, Fokaefs E. Solitary fibrous tumor of the urinary bladder: report a case with long-term follow-up and review of the literature. Eur Rev Med Pharmacol Sci. 2007;11:101-6.
5. Ruiz de la Parte A, Cazorla A, Bouhajeb Y, Miguel MT, Sarasa JL. Tumor fibroso solitario. Revisión de 20 casos. XXVII Reunión SEAP. [consulted on 4 Oct 2007]. Available from: http://www.seap.es/reuniones/2004/partesblandas.htm
6. Kim SH, Cha KB, Choi YD, Cho NH. Solitary fibrous tumor of the urinary bladder. Yonsei Med J. 2004;35(3):573-6.
7. Joe BN, Bolaris M, Horvai A, Yeh BM, Coakley FV, Meng MV. Solitary fibrous tumor of the male pelvis: findingsat CT with histopathologic correlation. Clin Imaging. 2008;32:403-6.

*L. López Martín* and F. J. Calahorra Fernández*
*Department of Urology, Fundación Jiménez Díaz, Madrid, Spain*

**Author for correspondence.*
E-mail: lloarzt@hotmail.com (L. López).

# Adenomatoid tumor of the tunica albuginea. A case report

## Tumor adenomatoide de túnica albugínea. Caso clínico

*To the Editor,*

Paratesticular tumors account for a low percentage of intrascrotal tumors. Histologically, they are characterized as benign tumors originating from mesenchymal tissue. Of these, the most common form is adenomatoid tumor, followed by papillary cystadenoma and leiomyoma. These tumors can occur in many organs and in both sexes, although they are more common in males and in the genital area. The treatment of choice is local excision of the lesion. If there are doubts about malignancy, extemporaneous biopsy is performed and orchidectomy if this condition is confirmed.

We report the case of a paratesticular tumor. Diagnosis of these neoplasms is uncommon and usually occurs between the third and fifth decades of life[1]. Most of these tumors are benign in nature (80%)[1].They are usually located in the epididymis, although there are more rarely located in the tunica albuginea, in the spermatic cords, or even in the prostate[2].

The case reported is that of a 28-year-old male, with no medical or surgical history of interest, who presented to the emergency department with painful swelling in the left scrotum, starting one week before.

Physical examination of the penis and testes was normal. A nodule of increased consistency and painful on palpation was detected in the left epididymal tail.

The scrotal ultrasound showed normal parenchyma of the left testicle and a rounded image of 1 cm in diameter that appeared to arise from the testicular coverings or the epididymis. The patient was treated with antiinflammatory drugs and referred to the urology outpatient clinic to complete his assessment with magnetic resonance imaging (MRI).

MRI revealed a 7 mm in diameter extratesticular lesion in the caudal and lateral part of the left testis, which was isointense to testicular parenchyma in T1, hypointense in T2 and with intense contrast uptake, that appeared to be related to the tail of the epididymis and was located in more lateral area of the testis[3], the most probable diagnosis being that of a fibrous adenomatoid tumor

Tumor markers were normal.

Based on these findings, fine needle aspiration biopsy (FNAB) of the lesion was performed, where it was observed to have scanty cellularity of an epithelial or mesothelial appearance, with little or no nuclear atypia, cytologically suggesting an adenomatoid tumor.

Excision of the tumor lesion was performed, which was located in the tunica albuginea, following by extemporaneous biopsy of the lesion that was reported as a nonmalignant adenomatoid neoformation. The pathological result was an adenomatoid tumor of the tunica albuginea.

At two years of follow-up, the patient remains disease-free.

These tumors account for up to 5% of intrascrotal masses[4], and this is the most common form of presentation (60%) of paratesticular tumors. It is not a strictly urological tumor, as it may occur in other organs such as the uterus or fallopian tubes. However, a trend towards location in the pelvic organs has been described, as well as a greater frequency of occurrence in men, although it may occur in any organ of the body[5].

The usual location is the epididymis, mainly in the tail. Our patient had the lesion in the tunica albuginea, where an incidence of 14% has been reported. Other less common locations include the spermatic cords or the prostate[4].

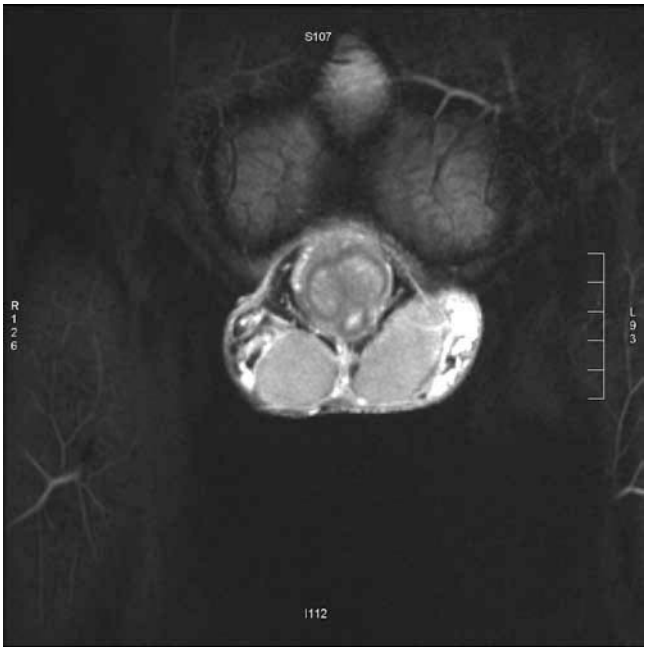


**Figure 1 – Ultrasonography identifying the paratesticular lesion.**

The usual form of presentation is a painless mass, identified by chance by the patient himself[1]. Less common is presentation as a painful mass, as would be the case that concerns us here. Clinically, the size at the time of diagnosis usually ranges from 2 to 3 cm[6]. In our case, the size was somewhat smaller, 1 cm, probably because it was a symptomatic tumor.

Among the imaging tests, scrotal ultrasound is useful to identify the origin of the lesion, since it clearly differentiates testicular from paratesticular lesions[7]. However, this technique is less effective for identifying the exact origin of the lesion. In our case, scrotal ultrasound was used to identify the lesion as paratesticular, but not to discern whether the origin was the epididymis or the testicular covering (Fig. 1). We can use computed tomography and MRI for this, which provide much better delineation of soft tissues and scrotal structures[8].

One of the most debated topics in this area is whether or not to use FNAB. Authors such as Flores et al[9] prefer not to perform it, because of the risk of tumor dissemination in case of a malignant lesion. However, since up to 80% of paratesticular masses are benign, other authors suggest this technique to perform a differential diagnosis with other entities or to complete it[10]. Based on MRI results, we chose to perform it, observing data suggesting the diagnosis of adenomatoid tumor (Fig. 2).

As regards treatment, the consensus is that local excision of the lesion is sufficient since they are benign lesions. In our case, we performed an extemporaneous tumor biopsy to confirm the absence of malignancy, since if this had not been the diagnosis, the therapeutic approach would have changed, and an orchidectomy would have been performed instead.

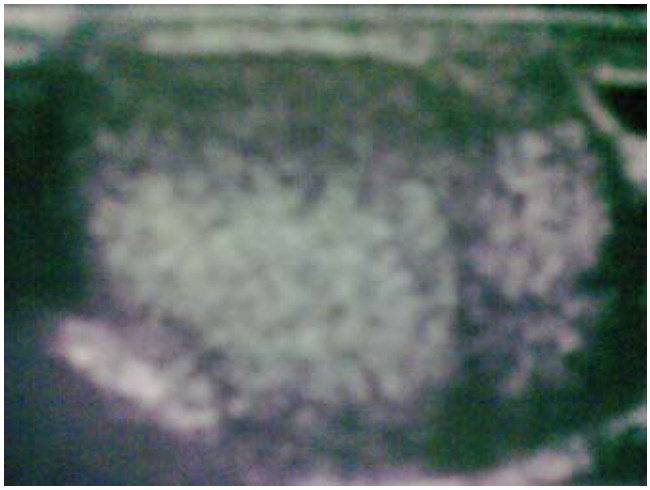

**Figure 2 – MRI showing the presence of an adenomatoid tumor.**

REFERENCES

1. Moyano Calvo JL, Giraldez Puig J, Sánchez de la Vega J, Dávalos Casanova G, Morales López A. Tumor adenomatoide de epidídimo. Actas Urol Esp. 2007;31(4):417-9.
2. Amin MB. Selected other problematic testicular and paratesticular lesions: rete testis neoplasms and pseudotumors, mesothelial lesions and secondary tumors Modern Pathol. 2005;18:S131-45.
3. Williams SB, Han M, Jones R, Andrawis R. Adenomatoid tumor of the testes. Urology. 2004;63(4):779-81.
4. Kontos S, Fokitis I, Karakosta A, Koritsiadis G, Mitsios K, Koutsikos S, et al. Adenomatoid tumor of epididymidis: A case report. Cases J. 2008;1:206.
5. Bestard Vallejo JE, Tremps Velázquez E, Blázquez Mañá C, Celma Doménech A, de Torres Ramírez I, Morote Robles J. Tumor adenomatoide de epidídimo: el tumor más frecuente de las estructuras paratesticulares. Actas Urol Esp. 2008;32(6):611-7.
6. Robert H. Young testicular tumors. Some new and a few perennial problems. Arch Pathol Lab Med. 2008;132:548-64.
7. Barry P, Chan KG, Hsu J, Quek ML. Adenomatoid tumor of the tunica albuginea. Int J Urol. 2005;12(5):516-8.
8. Patel MD, Silva AC. MRI of an adenomatoid tumor of the tunica albuginea. AJR Am J Roentgenol. 2004;182(2):415-7.
9. Flores N, Infante R. Tumores paratesticulares. In: Jiménez Cruz JF, Rioja Sanz LA, editors. Tratado de Urología. p. 2181-93.
10. Singh I, Dev G, Singh N. Chronic epididymitis (epididymal nodule) mimicking an adenomatoid tumor-case report with review of literature. Int Urol Nephrol. 2002;34(2):219-22.

***P. Bahílo Mateu*, A. M. Soto Poveda, C. Di Capua Sacoto, G. García Fadrique, G. Morales Solchaga, J. Morera and J. F. Jiménez Cruz***
*Department of Urology, Hospital Universitario La Fe, Valencia, Spain*

**Author for correspondence.*
E-mail: pilarbahilo@comv.es
(P. Bahillo Mateu).