Letter to Editor

Testicular Seminoma: Early Cutaneous and Inguinal Node Metastases. Clinically isolated case in a subject over 75 Years.

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A 75 year male patient presented with severe low back ache and unable to walk since two months. He had swellings in both the groin region and left scrotum for the last eight months, with history of loss of weight. He had undergone right sided herniorraphy for obstructed inguinal hernia one and half years back and was treated conservatively for blunt trauma to the left scrotum six months back. On examination the patient was pale. His blood pressure was 180/100 mm of Hg. He had bilateral enlarged inguinal nodes two on the right side and three on the left, each measuring 3x2 cm, hard, non tender. Skin over the swellings was free. Right inguino scrotal scar measuring 10x 2 cm, healed by primary intention was also seen. (Fig.1) Left testis was enlarged measuring 8 x3 cm, firm, and non-tender. There was no mass in the abdomen/organomegaly/ascites. He had grade-two prostatomegaly. Spine tenderness was elicited over the lumbosacral region. Straight leg raising test was positive. A 3x2 cm cutaneous non tender swelling was noted on the right forearm. (Fig.1 inset). Examination of the other systems was unremarkable. We made a diagnosis of left testicular tumor with bilateral inguinal lymph node metastases with secondaries in the lumbar spine and lipoma over the right. All the relevant laboratory investigations were within normal limits except for lactate de-hydrogenase which was markedly elevated (2165.00u/l).

Fine needle aspiration cytology of bilateral inguinal nodes, and right swelling also conformed as secondary deposits from seminoma left (Fig. 3 & inset). Computed Tomography of the abdomen and chest x-ray was normal, x-ray lumbosacral spine showed lytic lesions at L1, L2, L3 (lumbar) vertebrae suggestive of pathological fracture due to secondaries.(Fig.2). Left high orchidectomy with debulking of the inguinal nodes and excision biopsy of the soft tissue swelling followed by chemo-radiotherapy was offered. The patient's attendants were not willing for any surgical intervention. The patient received one cycle of inj. Carboplatin-450mg + inj. Dexamethasone, got discharged against medical advice and was lost for follow up.

The role of trauma in the aetiopatho-genesis of testicular tumours has always been controversial. Boyd considers that it plays no part, although it is possible that trauma may hasten the growth of pre existing tumour in some.[1] Divon and Morre in their study of

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Fig.1: Photograph showing right inguinal scar, bilateral nodes and left testicular swelling with a faint scar.

Fig.2: X-ray-Lumbosacral spine showing pathological fracture of L1, L2, L3 (Lumbar) vertebrae.

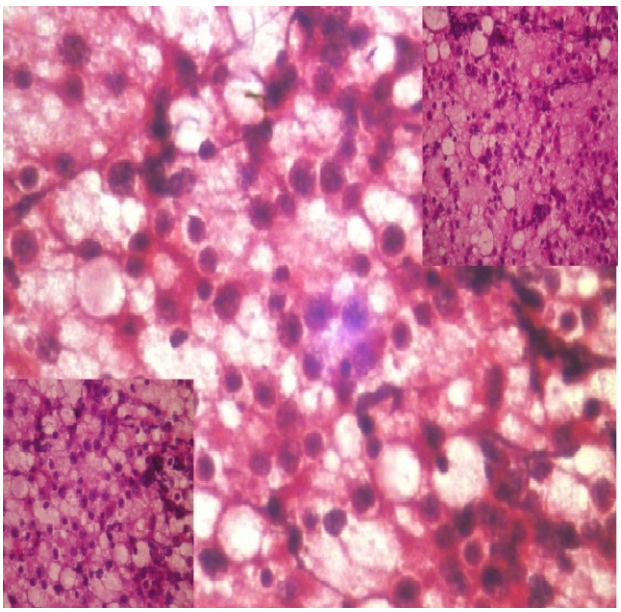

Fig.3: Microphotograph showing round to polygonal cells with vesicular nucleus and prominent nucleoli, vacuolated cytoplasm.(100x, H&E) inset bottom- Microphotograph showing tumour cells with interspersed lymphocytes(100x, H&E) inset top- Microphotograph showing uniform cells arranged in sheets in tigroid background (40X, H&E)

over 1000 army cases reported that, 30% of the patients gave history of trauma to the testis, preceding the tumour.[2] It is possible that in our patient the tumour was in its initial stage and surfaced after inguinal surgery. Metastases to inguinal lymph nodes are rare. The damage to testicular lymphatics during hernia surgery and collaterals formed after it, can explain the direct spread to the inguinal nodes. Ohtani and Gannon studied the microvasculature of the rat vas deferens and have described the arterial and venous drainage in detail.[3] They found a subepithelial capillary network and it has been postulated the same network exists in humans. Lockett et al postulated that seminoma may spread along similar capillary network along the vas. The deep inguinal nodes get lymphatic drainage from superficial lymph nodes which drain the skin over the lower abdomen, part of the buttocks, scrotum, perineum and the penis. However following inguinoscrotal surgeries, lymphatics are disrupted and form new collaterals for drainage. Injured lymphatics from scrotal incisions re anastomose with the testicular lymphatics and provide direct route of spread to inguinal nodes. Incidence of inguinal node metastases is unclear; series have reported incidence varying from 2% to 10%. Although diagnosis of inguinal lymph node metastases is made by excision biopsy, fine needle aspiration has also been used effectively.[4,5] Cutaneous metastates from testicular specimen have been documented in literature and they indicate poor prognosis. Injury to cord during surgery and subsequent fibrosis alters the normal route of lymphatic spread of disease. Modality of treatment for post inguinoscrotal surgery with positive inguinal lymph nodes is chemoradiotheraphy.[6]

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Source of Support: Nil Conflict of Interest: Nil