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AN INTERESTING CASE OF SCROTAL SWELLING

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Abstract : Paratesticularliposarcomas are extremely rare malignant tumours which account for approximately 3-7 of all paratesticular sarcomas. They are clinically indistinguishable from testicular tumours, which thus result in difficulty in diagnosis and management. We present a case of rare para testicular tumour with inguinal hernia who on process of evaluation developed features of obstruction which is very rare and emergency exploration done high inguinal orchidectomy with herniorrhaphydone. post op biopsy showed well differentiated liposarcoma from spermatic cord.. The inguinal radical orchidectomy with wide resection margin is the standard approach for sarcomas of the spermatic cord.. Since HPE report well differentiated liposarcoma, further treatment deferred.Surgery remains mainstay treatment when diagnosedsuspected pre operatively , radical orchidectomy with wide local excision is recommended Regardless of initial therapy, risk of local recurrence and subsequent increase in grade always necessitate long term follow-up Our patient is in regular follow up

Keyword :PARA TESTICULAR TUMOR, LIPOSARCOMA, HIGH INGUINAL ORCHIDECTOMY.

INTRODUCTION

Liposarcomas are one of the most common soft tissue sarcomas. The extremities and retroperitoneum are the most commonly affected locations accounting for about 70% of cases. Paratesticularliposarcomas are rare tumours which account for 12% of all liposarcomas. Probably there are about 100 cases which have been reported till date. They must be differentiated from tumours of testicular origin which have extension to the spermatic cord. They can be further subdivided into 4 types, including well-differentiated, myxoid, round-cell, and pleomorphic LPSs. Myxoidliposarcoma (MLPSs) are the most common type and account for about 50% of all LPSs. Among them, the well differentiated LPS has an indolent course, but the round-cell and pleomorphic variants are usually aggressive and frequently metastasize

CASE HISTORY

80 years old male admitted with complaints of swelling in leftinguinoscrotal region for past 6 months with no history of trauma , pain ,previous surgery. On examination a Swelling of size 5x4 cm ,pyriform shaped , extending from mid inguinal point to root of scrotum ,cough impulse present , Another swelling of size 10x7 cm ,extending 2 cm distal from proximal swelling to base of scrotum ,non tender , soft ,non trans illuminating. testis not felt separately.

Investigations X ray chest – normal USG –whole testes enlarged and hyper echoic p/o left testicular tumour abdomen – normal CT -9.5x5.5 cm , well defined mixed dense fat containing left para testicular mass with no significant contrast enhancement , displacing testes f/s/o left para testicular mass possibility of liposarcoma Provisionally diagnosed as left para testicular tumor with indirect inguinal hernia ,Planned for incisional biopsy and proceed. While on the process of evaluation patient developed features of obstruction and emergency exploration done

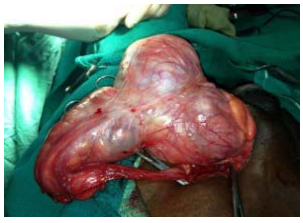
Procedure done – high inguinal orchidectomy with herniorrhaphy Biopsy -Section shows a tumour composed of sheets of mature fat cells and lipoblast , intervening fibrous stroma shows stromal cells exhibit marked nuclear pleomorphismSuggestive of well differentiated liposarcoma. Surgery remains mainstay treatment when diagnosed/suspected pre operatively , radical orchidectomy with wide local excision is recommended. In our case due to emergency situation we did high inguinal orchidectomy alone. Since HPE report – well differentiated liposarcoma further treatment deferred . Regardless of initialtheraphy, risk of local recurrence and subsequent increase in grade always necessitate long term followup. Our patient is in regular follow up

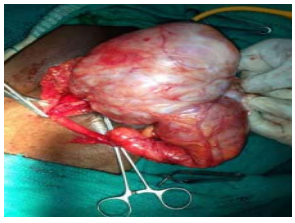
DISCUSSION

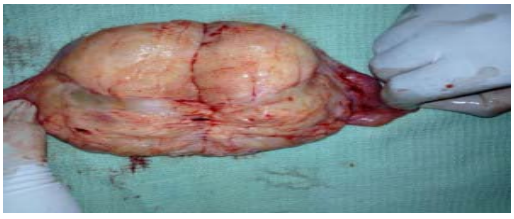
Paratesticularliposarcomas are rare tumors and are often reported as isolated cases (Montgomery, 2003). Paratesticularliposarcoma is extremely rare and only 100 cases have been reported in the literature (Littles, 1992). They refer to liposarcomas arising from the spermatic cord, testicular tunics and epididymes, and usually occurin men aged 41 years to 87 years (Montgomery, 2003).Paratesticularliposarcomas are extremely rare malignant tumours which account for approximately 3-7% of all paratesticular sarcomas. They are

clinically indistinguishable from testicular tumours, which thus result in difficulty in diagnosis and management. Myxoidliposarcomas account for 40-50% of all liposarcomas and the survival depends both on the histological appearance as well as their anatomical location (Gerber 1985; Mostafi 1973). This tumor is difficult to diagnose preoperatively and is often mistaken for incarcerated hernia, lipoma, or hydrocele.myxoid (most common; 40%), round cell, well differentiated (subdivided into lipoma-like, sclerosing, inflammatory and dedifferentiated), and pleomorphic) (Logan, 2010). Fluorescence in situ hybridization (FISH) for MDM2 amplification is a sensitive and specific tool which can be used for distinguishing difficult and doubtful cases of well differentiated liposarcoma/atypical lipomatous tumours from benign lipomatous neoplasms [6]. P16 an immunohistochemical marker, is sensitive for and is positive in atypical lipomatous tumours [7].

IHC analysis of liposarcomas shows S100 positivity, while CD 34, actin, keratin, desmin all show negativity Pathologic features that increase risk of recurrence include large tumour size, inguinal location, degree of nuclear differentiation, and depth of invasion. Positive surgical margin is a risk factor for early recurrence and distant metastasis . The optimum local and systemic treatment of paratesticular sarcomas in adults includes complete resection, including high ligation of the spermatic cord. The reported local recurrence rate in the scrotum and groin after orchidectomy is 25%-37%. Retroperitoneal lymph node dissection should be limited to patients with only radiologically suspicious lymph nodes [3].. The low grade, well-differentiated and myxoidliposarcomas have favourable prognosis, whereas tumors with multiple recurrences or metastases are likely to be of the high grade, round cell, pleomorphic, or mixed variety. Complete surgical resection offers the best chance of cure for these patients (Mondaini, 2004) and the established method for orchidectomy for testes/cord cancer is through an inguinal incision (Rowland, 2002). Liposarcomas are locally aggressive tumors and recurrence is quite common after incomplete excision. The inguinal radical orchidectomy with wide resection margin is the standard approach for sarcomas of the spermatic cord (Mondaini, 2004).







CONCLUSION

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