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Abstract:

Testicular cancer represents approximately 1% of all cancers diagnosed in males. Testicular cancer is the most commonly diagnosed cancer in male adolescents and young adults between 15–35 years of age. Bilateral presentation is rare with a reported rate of 0.8% for every 1,000,000 men between the age 15–40 years from which 0.5% are synchronous and .2–3% are metachronous (1).

We report a case of 42–year–old man with metachronous testicular seminoma within 8 years from the first testicular tumor. Patient was treated at the urology clinic with a left testicular mass causing painful swelling. He experienced discomfort in left side of testis before two weeks. He was on anti–inflammatory treatment by his GP doctor with recommendation to visit a urologist. It is the first time in our clinic of urology to treat a patient with metachronous testicle tumor.

The follow–up of patients with testicular tumor is very important for early detection of metachronous testicular tumor. In routine, after surgery treatment the strict follow–up of patients continue in Oncologic Institute. In the first 5 years it is biannual, then yearly with tumor markers and images of thorax, abdomen and pelvis. In our case the patient continued the follow–up for two years until he stopped by himself.

Keywords: TT, Testicular cancer, Kosovo

Background

Testicular cancer represents approximately 1% of all cancers diagnosed in males. Testicular cancer is the most commonly diagnosed cancer in male adolescents and young adults between 15–35 years of age. In the United States, according to the Cancer Society statistics of 2015, approximately 8430 new testis cancer patients have been diagnosed (2).

Most testicular tumors (95%) arise from germ cells and can be divided into two main groups: seminomas and non–seminomas. Bilateral testicular tumors that occur simultaneously are termed synchronous tumors, while those occurring at different times are termed metachronous tumors.

Metachronous testicular cancer is diagnosed when at least 6–months elapse between the appearance of the first tumor and the second tumor and when there is an ultrasound–documented absence of a contralateral mass at diagnosis of the first tumor. In cases of metachronous testicular cancer the second tumor usually occurs within 5 years after the first tumor (3).

The frequency of metachronous testicular cancer in men who have had previous testicular cancer is relatively high. Patients with a history of TGCT show a 23–27 times greater relative risk of developing a contralateral germ cell tumor (4).

Although risk estimates for synchronous and metachronous contralateral testicular cancers vary widely, many clinicians recommend routine biopsy of the contralateral testis for patients diagnosed with unilateral testicular cancer.

Case presentation

This case–study presents a 42–year–old man, treated at the urology clinic with a left testicular mass causing painful swelling. He experienced discomfort in left side of testis before two weeks. He was on anti–inflammatory treatment by his GP doctor with recommendation to visit a urologist. It is the first time in our clinic of urology to treat a patient with metachronous testicle tumor.

The follow–up of patients with testicular tumor is very important for early detection of metachronous testicular tumor. In routine, after surgery treatment the strict follow–up of patients continue in Oncologic Institute. In the first 5 years it is biannual, then yearly with tumor markers and images of thorax, abdomen and pelvis. In our case the patient continued the follow–up for two years until he stopped by himself.

Keywords: TT, Testicular cancer, Kosovo

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treatment by his GP doctor with recommendation to visit a urologist.

From medical records we notice a past history of right high orchiectomy, 8 years ago. The histological report confirmed pure seminoma (stage IS) without spermatic cord invasion. In postoperative treatment he was treated with radiotherapy at an Oncologic Institute.

Physical examination revealed a lump, which testicular ultrasound confirmed as a 30 mm × 12 mm × 23 mm heterogeneous hypoechogenic mass localized in left testicle (Fig. 1 and 2).

A computed tomography (CT) scan showed no evidence of abdominopelvic or thoracic metastases. The blood serum tumor marker levels were as follows: human chorionic gonadotropin (HCG) = 2.20 U/ml (normal is < 5.01 U/ml); α—fetoprotein (AFP) = 4.4 ng/ml (normal is < 7 ng/ml); and lactate dehydrogenase (LDH) = 499 IU/l (normal is 313–618 IU/l).

After careful discussion of his treatment options, the current patient opted for “biopsy ex tempore” in that left testicle (Fig. 1 and 2). After careful discussion of his treatment options, the current patient opted for “biopsy ex tempore” in that left testicle (Fig. 3.). The immunohistochemical H.P. (Fig. 4.) result confirms the presence of malignant tissue so we performed the left high orchiectomy.

The final pathological diagnosis was a pure seminoma of 3.3 cm × 2.6 cm, without lymphatic, vascular, or tunica albuginea infiltration.

Other new findings include our observation that patients with seminomatous unilateral testicular cancer had a higher risk of metachronous contralateral testicular cancer than patients with a non—seminomatous unilateral testicular cancer. Older age at the time of the first testicular cancer diagnosis was associated with a reduced risk of non—seminomatous metachronous contralateral testicular cancer as compared to seminomatous histology. Testicular cancer incidence rates nearly doubled in industrialized countries between 1975 and 2007, suggesting an influence of environmental factors.

The tumor node metastasis (TNM) classification was pT1pNxMx according to the Union for International Cancer Control (UICC) staging system.

Two weeks after the surgery and after thorough discussions with a multidisciplinary uro—oncology team we recommended that the patient should receive androgen replacement therapy (with long—acting testosterone undecanoate) and follow—up in accordance with our standard protocol. A bilateral testicular prosthesis was suggested. At the most recent visit the patient reported no adverse effects from the androgen replacement therapy and he continues to have a comfortable sexual activity and quality of life.

**Discussion**

Other new findings include our observation that patients with seminomatous unilateral testicular cancer had a higher risk of metachronous contralateral testicular cancer than patients with a non—seminomatous unilateral testicular cancer. Older age at the time of the first testicular cancer diagnosis was associated with a reduced risk of non—seminomatous metachronous contralateral testicular cancer as compared to seminomatous histology. Testicular cancer incidence rates nearly doubled in industrialized countries between 1975 and 2007, suggesting an influence of environmental factors.
Environmental factors are believed to cause changes in the male embryo’s primordial cells, from which the testes later develop. These prenatal influences are thought to be related to the initiation of carcinoma in situ and the subsequent development of invasive testicular cancer (6). European men with unilateral testicular cancer have a 12–38 times higher risk of developing a new testicular cancer compared with men from the general population (7). In this large, population-based series of nearly 30,000 patients with unilateral testicular cancer, shows for the first time that U.S. testicular cancer patients have a 12.4–times increased risk of developing a metachronous contralateral testicular cancer compared with the general population (8).

Our current case involved no-known environmental risk factors. A multidisciplinary team of urologists, medical oncologists, radiotherapists and a pathologist is a team which can have a big impact in patient’s quality of life.

References

