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Case Report

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Can a long time follow up in a resolute patient help us in testis sparing surgery decision?

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Abstract

All the urologists (surgeons), normally, perform orchiectomy in cases of malignancy with combined or not chemiotherapy or radiotherapy. In selected cases, if the tumour is bilateral, in cases of Leydig cell tumor, if the patient is monorchid, TSS (testis sparing surgery) is discussed. This paper presents a clinical history of a 24 years old patient that underwent TSS and after 16 years of follow up is in good health and happy dad.

Keywords: Testis, Seminoma, Testis Neoplasia, Sparing Surgery.

Case Report

Once upon a time, firstly in the millennium (2004) a young 24 years old, athletic, come into my office for a visit. There is a no palpable small left testicular mass at sonography. This sonographyc finding was performed as screening in a sport medicine evaluation. The lesion was, solitary, small, with a diameter of about 1.3 cm, well demarked; the other didimus is normal. He isn't married and has no children. After the urological evaluation markers (LH, alpha-fetoprotein, Beta HCG, LDH) and chest-abdominal Computed Tomography (resulted negative) are prescribed. At medical examination small left varicocele is found and nothing else was observed. No erectile dysfunction or libido decreases were declared. No cryptorchidism at birth was found.

Discussion

All the urologists (surgeons), normally, perform orchiectomy in cases of malignancy with combined or not chemiotherapy or radiotherapy [1]. In selected cases, if the tumour is bilateral, in cases of Leydig cell tumor, if the patient is monorchid, TSS (testis sparing surgery) is discussed [2,3,4].

In an office talk we indicate (recommend) orchifunicolectomy if tumour is detected. We also indicate the possibility of sperm frozen but both options were refused. Like others before, he initially refuses orchiectomy but on the contrary, of the others, he refuses orchiectomy even if I explains him the reasons for performing that. In the meet was discussed about the altered corporeal perception. The patient refuses the problem's correction by means of prosthesis insertion.

At surgery time, a small inguinal incision was performed. The funiculus was isolated and warm clamped (before inguinal external ring). Testis is extracted and tunica vaginalis opened. The intrasurgical ultrasound identified the lesion accurately [5]. A little iron needle is positioned while performing a resection of the small mass (maximum diameter about 1,3 cm.) [6]. The surgical margin, near the superior testicular left pole, was macroscopically and ultrasonografically well delimited. An intra surgical time biopsy was taken to evaluate the histological state of the edge (Figure 1).

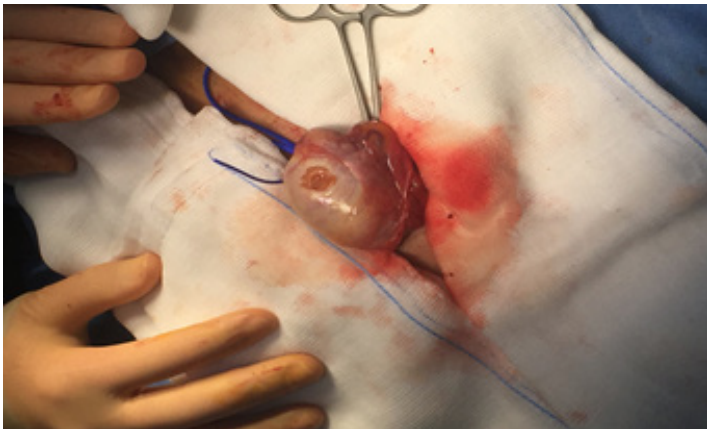

Figure 1: Example of TSS.

So the sample was send to our Surgical Pathology Unit for an ex tempore examination (FSE: frozen section examination) [7,8]. Our Pathologist answered "malignant neoplasia to be typed on definitive slides, formalin fixed, heamtoxilin-eosin and immunohistochemical prepared". The definitive diagnosis was "Pure seminoma" that is the most common pure germ cell tumour (30-45% of testicular germ cell tumours) composed by relative uniform cells with so many clear cytoplasm with glycogen particles demonstrable with the periodic acid- Schiff stain, well-defined cell borders, and polygonal nuclei with finely granular chromatin, frequently flattened edges and one or more prominent

nucleoli (Figure 2). Less commonly, the cytoplasm is dense and the nuclei more crowded. This may result in a plasmacytoid appearance. The seminoma cells are considered the neoplastic counterparts of the primordial germ cells/ monocytes present during early embryogenic development.

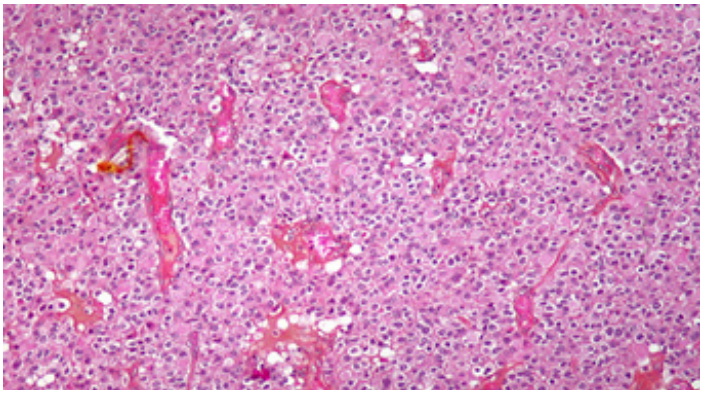

Figure 2: Patient's pure seminoma histological picture.

It's a well circumscribed and homogeneous mass, sometimes lobulated. It's grey-white, tan, creamy, fleshy, firm, with often bulging cut surface.

Microscopically fibrous septa divided sheets or nests of tumour cell into lobules. Tumour cells are evenly separated without nuclear overlap. We frequently observe a prominent cytoplasmic membrane that delineate distinct cell boundary. Often there is a lymphoplasmacytic infiltrate, occasionally extended with germinal centres in fibrous septae. In the 30% of cases we can observe granulomatous inflammation that can be extensive and create diagnostic pitfalls in recognizing tumour cells.

The patient, under spinal anaesthesia, was informed during surgery time about the FSE diagnosis. He yet refuses orchifunicolectomy.

Therefore, after the patient was informed again of a possibility of a delayed orchifunicolectomy [9], driven by the possibility that definitive histological diagnosis was not only of pure seminoma, we perform vaginal reversion and testis repositioning into the scrotum [10,11]. A Penrose's drainage was positioned for 24 hours and the skin was sutured by absorbable material.

The follow up was performed by general examination, serum markers, ultrasound examination /CT chest-abdominal scan (almost twice in a year) every three-four months. No relapse or metastasis were up to date observed (Figure 3).

We follow up the patient for the second year, after surgery time, with the same protocol and after five years, once a time, with CT chest-abdominal scan and serum markers.

After eight years from surgery he decided for fragmentary controls. The last control has been twelve years after surgery and demonstrate that no relapses neither distant metastasis were occurred.

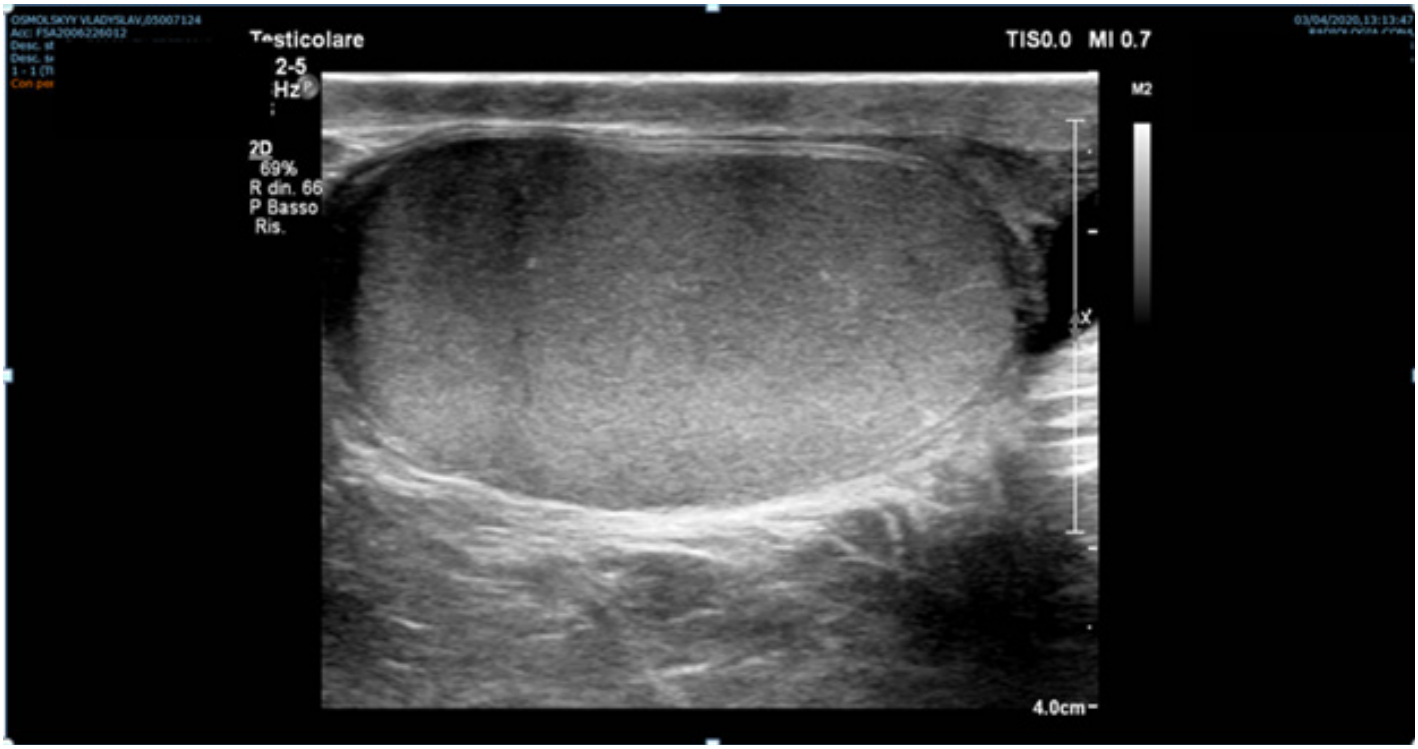

Figure 3: Ultrasound three months after TSS.

Conclusion

Today, the patient, occasionally evaluated for other reasons, demonstrate no relapse neither metastasis. He told us that he feels good. The erectile function is normal and he doesn't report any decrease of libido. There is also no hypogonadism. He has a healthy male son.

References

1. Albers P, Albrecht W, Algaba F et al. (2015) Guidelines on testicular cancer. Eur Urol 68:1054.
2. Gentile G, Brunocilla E, Francheschelli A et al. (2013) Can a testis-sparring surgery for small testicular masses be considered a valid alternative to radical orchiectomy? A prospective single center study. Clin Genitoturin Cancer 11:522.
3. Heindenreich A, Bonfig R, Derschum W et al. (1995) A conservative approach to bilateral testicular germ cell tumors. J Urol 153:10.
4. Ferretti L, Sargos P, Gross-Goupil M et al. (2014) Testicular sparing surgery for bilateral or monorchide testicular tumors: a multicenter study of long -term oncological and functional results. BJU Int 114:860.
5. Gentile G, Rizzo M, Bianchi L, Falcone M, Dente D, et al. (2019) Testis sparing surgery of small testicular masses: retrospective analysis of a multicenter cohort J Urol 203(4):760-766.
6. Keske M, Canda AE, Yalcin S et al. (2017) Is testis–sparing surgery safe in small testicular masses ? Results of a multicentre study- Can Urol Assoc J 11: E100.
7. Khan MJ, Bedi N, Rahimi MNC, Kalsi J (2018) Testis sparing surgery for small testicular masses and frozen section assessment. Cent European J Urol 71(3): 304-309.
8. Matei DV, Vartolomei MD, Renne G et al. (2017) Reability of frozen section examination in a large cohort of testicular masses: what did we learn? Clin Genitourin Cancer 15:e689.
9. De Stefani S, Isgrò M, Varca V, Pecchi A, Bianchi G, et al. (2012). Microsurgical Testis–sparing surgery in small testicular masses: seven years retrospective management and results. Urology 79(4):858-862.
10. La Rocca R, Capece M, Spirito L, Cumberbatch MK, Creta M, et al. (2019) Testis–sparing surgery for testicular masses: current perspectives. Minerva Urol Nefrol. 2019 Apr 5.
11. Moody JA, Ahmed K, Horsfield C, Pedersen MRV, Yap T, et al. (2018) Fertility preservation in testicular cancer–predictors of spermatogenesis BJU Int 122(2):236–242.