<table>
<thead>
<tr>
<th>Serial No</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Author 1</td>
<td>UGWUMBA, O.F.</td>
</tr>
<tr>
<td>Author 2</td>
<td>NNABUGWU, I.</td>
</tr>
<tr>
<td>Author 3</td>
<td>OLUSINA, D.B.</td>
</tr>
<tr>
<td>Title</td>
<td>Giant Seminoma following Ipsilateral Orchidectomy: A Rare finding. Case Report</td>
</tr>
<tr>
<td>Keywords</td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>Giant Seminoma following Ipsilateral Orchidectomy: A Rare finding. Case Report</td>
</tr>
<tr>
<td>Category</td>
<td>Health Sciences</td>
</tr>
<tr>
<td>Publisher</td>
<td>Journal Compilation</td>
</tr>
<tr>
<td>Publication Date</td>
<td>2008</td>
</tr>
<tr>
<td>Signature</td>
<td></td>
</tr>
</tbody>
</table>
Giant Seminoma following ipsilateral orchidectomy: a rare finding. Case report

CASE REPORT

In January 2008, a 55-year-old Nigerian man presented at the surgical emergency department with giant, firm, left hemiscrotal swelling that could be reached above, i.e., it was scrotal. The right testis and spermatic cord were palpable and normal on clinical transscrotal. An intrascrotal tear on the left groin was observed.

The patient gave a history of having undergone a left orchidectomy for a testicular swelling via the inguinal incision 2 years previously. He, however, claimed that the histology report was equivocal as to the state of the testicle. He had remained well until 1 month ago when he noticed a firm left hemiscrotal swelling, which progressively increased in size, with no lower urinary or gastrointestinal symptoms. There was no history of trauma in the area.

Investigations revealed a well-defined, hard, painless mass with a wide, superficial, gelatinous cystic area measuring 80 x 25 x 25 cm (Fig. 1). It was possible to reach above the swelling at wall firmly mobile (Fig. 2) under the normal skin, but not skin attachment. The right spermatic cord and testis were palpable and normal. The

Keywords: **

The patient gave a history of having undergone a left orchidectomy for a testicular swelling via the inguinal incision 2 years previously. He, however, claimed that the histology report was equivocal as to the state of the testicle. He had remained well until 1 month ago when he noticed a firm left hemiscrotal swelling, which progressively increased in size, with no lower urinary or gastrointestinal symptoms. There was no history of trauma in the area.

Investigations revealed a well-defined, hard, painless mass with a wide, superficial, gelatinous cystic area measuring 80 x 25 x 25 cm (Fig. 1). It was possible to reach above the swelling at wall firmly mobile (Fig. 2) under the normal skin, but not skin attachment. The right spermatic cord and testis were palpable and normal. The

Keywords: **

The patient gave a history of having undergone a left orchidectomy for a testicular swelling via the inguinal incision 2 years previously. He, however, claimed that the histology report was equivocal as to the state of the testicle. He had remained well until 1 month ago when he noticed a firm left hemiscrotal swelling, which progressively increased in size, with no lower urinary or gastrointestinal symptoms. There was no history of trauma in the area.

Investigations revealed a well-defined, hard, painless mass with a wide, superficial, gelatinous cystic area measuring 80 x 25 x 25 cm (Fig. 1). It was possible to reach above the swelling at wall firmly mobile (Fig. 2) under the normal skin, but not skin attachment. The right spermatic cord and testis were palpable and normal. The

Keywords: **

The patient gave a history of having undergone a left orchidectomy for a testicular swelling via the inguinal incision 2 years previously. He, however, claimed that the histology report was equivocal as to the state of the testicle. He had remained well until 1 month ago when he noticed a firm left hemiscrotal swelling, which progressively increased in size, with no lower urinary or gastrointestinal symptoms. There was no history of trauma in the area.

Investigations revealed a well-defined, hard, painless mass with a wide, superficial, gelatinous cystic area measuring 80 x 25 x 25 cm (Fig. 1). It was possible to reach above the swelling at wall firmly mobile (Fig. 2) under the normal skin, but not skin attachment. The right spermatic cord and testis were palpable and normal. The

Keywords: **

The patient gave a history of having undergone a left orchidectomy for a testicular swelling via the inguinal incision 2 years previously. He, however, claimed that the histology report was equivocal as to the state of the testicle. He had remained well until 1 month ago when he noticed a firm left hemiscrotal swelling, which progressively increased in size, with no lower urinary or gastrointestinal symptoms. There was no history of trauma in the area.

Investigations revealed a well-defined, hard, painless mass with a wide, superficial, gelatinous cystic area measuring 80 x 25 x 25 cm (Fig. 1). It was possible to reach above the swelling at wall firmly mobile (Fig. 2) under the normal skin, but not skin attachment. The right spermatic cord and testis were palpable and normal. The

Keywords: **

The patient gave a history of having undergone a left orchidectomy for a testicular swelling via the inguinal incision 2 years previously. He, however, claimed that the histology report was equivocal as to the state of the testicle. He had remained well until 1 month ago when he noticed a firm left hemiscrotal swelling, which progressively increased in size, with no lower urinary or gastrointestinal symptoms. There was no history of trauma in the area.

Investigations revealed a well-defined, hard, painless mass with a wide, superficial, gelatinous cystic area measuring 80 x 25 x 25 cm (Fig. 1). It was possible to reach above the swelling at wall firmly mobile (Fig. 2) under the normal skin, but not skin attachment. The right spermatic cord and testis were palpable and normal. The

Keywords: **

The patient gave a history of having undergone a left orchidectomy for a testicular swelling via the inguinal incision 2 years previously. He, however, claimed that the histology report was equivocal as to the state of the testicle. He had remained well until 1 month ago when he noticed a firm left hemiscrotal swelling, which progressively increased in size, with no lower urinary or gastrointestinal symptoms. There was no history of trauma in the area.

Investigations revealed a well-defined, hard, painless mass with a wide, superficial, gelatinous cystic area measuring 80 x 25 x 25 cm (Fig. 1). It was possible to reach above the swelling at wall firmly mobile (Fig. 2) under the normal skin, but not skin attachment. The right spermatic cord and testis were palpable and normal. The

Keywords: **

The patient gave a history of having undergone a left orchidectomy for a testicular swelling via the inguinal incision 2 years previously. He, however, claimed that the histology report was equivocal as to the state of the testicle. He had remained well until 1 month ago when he noticed a firm left hemiscrotal swelling, which progressively increased in size, with no lower urinary or gastrointestinal symptoms. There was no history of trauma in the area.

Investigations revealed a well-defined, hard, painless mass with a wide, superficial, gelatinous cystic area measuring 80 x 25 x 25 cm (Fig. 1). It was possible to reach above the swelling at wall firmly mobile (Fig. 2) under the normal skin, but not skin attachment. The right spermatic cord and testis were palpable and normal. The

Keywords: **

The patient gave a history of having undergone a left orchidectomy for a testicular swelling via the inguinal incision 2 years previously. He, however, claimed that the histology report was equivocal as to the state of the testicle. He had remained well until 1 month ago when he noticed a firm left hemiscrotal swelling, which progressively increased in size, with no lower urinary or gastrointestinal symptoms. There was no history of trauma in the area.

Investigations revealed a well-defined, hard, painless mass with a wide, superficial, gelatinous cystic area measuring 80 x 25 x 25 cm (Fig. 1). It was possible to reach above the swelling at wall firmly mobile (Fig. 2) under the normal skin, but not skin attachment. The right spermatic cord and testis were palpable and normal. The
pathology report confirmed the mass to be a seminoma (Fig. 2). The patient underwent an anterior external beam radiotherapy. He was, however, lost to follow-up 5 months later.

DISCUSSION

To our knowledge, the conditions of acute testicular seminoma following orchidectomy has not been reported in the surgical literature. A recent European report noted the downward trend in the size of primary malignant tumors with a mean size of 3 cm (Orobello et al., 2003).

This is at variance with the finding in our patient, where the mass was about 3 cm in diameter, in spite of the fact that the earlier surgery should have heightened the patient’s awareness to new swellings in the scrotum and that the patient was aware of this swelling for 4 months although this may be attributable in part to an immune response to a new malignancy, causing turtled and distal spread of possible chemotherapy (Franz et al., 1990) and possibly for hypoxia, thus delaying presentation until it became ineluctable on account of sheer size.

As to whether the reduced analyst was primary or a secondary one, it would appear that the history in the case does not make for reasoning that suggests the mass was a tumor following inguinal orchidectomy. It is possible that a microscopic deposit existed and gave rise to the tumor in question, thus affording some question as to the accuracy of the first pathology report.

Given the excellent prognosis of early-stage seminoma (Rowland and Horenstein, 2003), it is important that public enlightenment about the risk of testicular cancer and its potential morbidity is emphasized and disseminated to target boys and young men (Doroshow et al., 2003).

We also wish to highlight the fact that perhaps more sections are taken when preparing histopathological sections of testicular tumors to reduce the risk of possibly overlooking areas of tumors.

CONCLUSION

If a patient presents with a scrotal swelling following ipsilateral orchidectomy, the differential diagnosis of seminoma should be considered even when the pre-op histopathological report was benign. Comparison of such mass tumors can be carried out only by the use of an identical tumor extended in the normal size is needed. This will obviate possible rupture and local seeding at tumor sites.

A reference guide to be given to enlightenment of the populace in the developing world regarding testicular tumors.

REFERENCES

Intra-operative photograph. Scrotal skin showed no sign of inflammation or oedema. There was no palpable inguinal, axillary or supravacular lymphadenopathy. Abdominal examination did not reveal any masses, organomegaly or ascites. A left inguinal incision was also present. Abdominal ultrasonography was normal, and abdominal CT was not performed because the patient could not afford the fee of about $500. Other laboratory investigations, including alpha fetoprotein, beta HCG, HIV screening and full blood count and chest X-ray, were all normal. Scrotal ultrasonography, however, revealed a right testis measuring 31 x 15 mm and containing no masses. The left hemiscrotum harboured a large mass measuring 30 x 28 x 25 cm and containing irregular septic foci, with calcific foci in its core.

An incision was carried out via an inguinal incision extended as needed onto the scrotal skin to enable delivery of the mass. Findings at operation included no coaptational attachment to any remnant of the spermatic cord. There was, however, circumferential haemorrhagicisation from the scrotal wall (Fig. 3). We did not excise any redundant scrotal skin but closed the wound with a fenestrated tube drain in situ and compression dressing.

The excised mass measured 30 x 28 x 25 cm and weighed 2.9 kg. Its cut surface showed greyish white tissue, cystic areas and a central fibrous core radiating peripherally from the centre (Fig. 4).

Post-operative recovery was good, although wound drainage persisted on the 7th day, necessitating removal of all sutures and daily dressings. Complete wound healing was achieved on the 25th day post-op. The histo-