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SKILL AND TALENT

Vesiculectomy with laparoscopic partial prostatectomy in the treatment of primary adenocarcinoma of the seminal vesicle with carcinomatous transformation of the ejaculatory duct☆

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Abstract
Introduction: Primary adenocarcinoma of the seminal vesicle is an extremely rare condition. Some cases have been described in relation to congenital seminal vesicle cysts, which is often also associated with agenesia or ipsilateral renal disgenesia. The rareness of this type of lesions makes it difficult to plan a regulated surgical approach for them, although they are often treated by simple exeresis or exenteration, depending on their stage at the beginning.
Materials and methods: We present a new surgical technique that consists of radical vesiculectomy associated with laparoscopic partial prostatectomy (total segmentary) of the central area to successfully treat primary seminal vesicle adenocarcinoma in a young man who was diagnosed through an azoospermia study.
Results: A study of the scan (MRI) with diffusion and the transrectal biopsy of the mass allowed us to make a thorough preoperative evaluation of the case, confirming the malignity and precociousness of the lesion. The laparoscopic approach allowed us to perform a pelvic lymphadenectomy and transperitoneal exeresis, including the central prostate area and suture of the posterior face of the urethra at the height of the apex of the prostate. The wall of the seminal cyst lesion confirmed infiltrating clear cell adenocarcinoma and non-invasive adenocarcinoma in the prostate segment of the central gland in the light of the ejaculatory conduct with ''in situ'' growth. Thus, the surgical specimen allowed radical exeresis with negative margins, guaranteeing minimally invasive surgery with preservation of continence and erection.

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Conclusion: We describe a new integral approach for the radical surgery of localized primary adenocarcinoma of the seminal vesicle. Despite its exceptional nature, the case allowed for a double reflection: (a) the study of diffusion with MRI may suggest the diagnosis of malignity in this type of lesions; and (b) radical surgical treatment must include exeresis of the central portion of the prostate gland.

PALABRAS CLAVE
Vesícula seminal;
Adenocarcinoma de células claras;
Tratamiento quirúrgico;
Prostatectomía parcial;
Zona central;
Quiste de vesícula seminal;
CA-125;
Azoospermia

Vesiculectomía con prostatectomía parcial laparoscópica en el tratamiento del adenocarcinoma primario de vesícula seminal con transformación carcinomatosa del conducto eyaculador

Resumen

Introducción: El adenocarcinoma primario de la vesícula seminal es una condición extremadamente rara. Se han descrito algunos casos en relación con quistes congénitos de la vesícula seminal, que a menudo se asocian también con agenesia o disgenesia renal ipsilateral. La rareza de este tipo de lesiones dificulta la planificación de un planteamiento quirúrgico reglado de las mismas, aunque habitualmente se tratan mediante exéresis simple o exenteración, según el estadio de las mismas al comienzo.

Material y métodos: Presentamos una nueva técnica quirúrgica, consistente en vesiculectomía radical asociada a prostatectomía parcial laparoscópica (segmentaria total) de la zona central para tratar con éxito un adenocarcinoma primario de vesícula seminal en un varón joven, al que se le detectó por un estudio de azoospermia.

Resultados: El estudio de imagen mediante resonancia magnética (RM) con difusión y la biopsia transrectal de la masa permitió una evaluación preoperatoria minuciosa del caso, confirmando malignidad y la precocidad de la lesión. El abordaje laparoscópico permitió llevar a cabo linfadenectomía pélvica y exéresis transperitoneal, incluyendo la zona central prostática y suturando la cara posterior de la uretra a la altura del ápex prostático. La lesión quística seminal confirmó en su pared un adenocarcinoma de células claras infiltrante, y el segmento prostático de la glándula central un adenocarcinoma no invasivo en la luz del conducto eyaculador con crecimiento *in situ*. Así, el espécimen quirúrgico permitió la exéresis radical con márgenes negativos, garantizando el carácter de cirugía mínimamente invasiva, con preservación de la continencia y de la erección.

Conclusión: Se describe un nuevo abordaje integral para el planteamiento quirúrgico radical del adenocarcinoma primario de vesícula seminal localizado. A pesar de su carácter excepcional, el caso permite llevar a cabo una doble reflexión: a) el estudio de difusión con RM puede sugerir el diagnóstico de malignidad en este tipo de lesiones; y b) el tratamiento quirúrgico radical debe incluir la exéresis de la porción central de la glándula prostática.

Introduction

Primary tumors of the seminal vesicle (adenocarcinoma, sarcoma and lymphoma) are very rare lesions, which are often initiated by nonspecific symptoms.[1] Primary adenocarcinoma of the seminal vesicle usually occurs in patients aged more than 50 years. Detection by means of transrectal ultrasound, contrast CT or MRI of solid papillary mass in the seminal vesicle wall associated with palpable pelvic mass and elevation of serum CA-125 suggests the presence of these lesions, of which, at most, only several dozen cases have been reported with good clinical and histopathological correlation.[2,3]

The histopathological pattern that is characteristic of seminal vesicle adenocarcinoma comprises fine structures of complex anastomosing papillary branching, which consists mainly of clear cuboidal cells or partially granular cells with some ''hobnail'' cells of round nuclei and occasional mitotic figures.[2] In the light, these cells often produce Alcian blue epithelial mucin and positive mucicarmine. Immunohistochemical staining with CA-125 is typically positive while CEA, AFP, PSA and PAP are negative. This pattern helps to exclude other undifferentiated lesions of prostate or rectal origin with secondary infiltration of the seminal vesicle.[3]

The treatment of these lesions is determined by the level of extension to nearby organs and by the patient's age. Already in 1967, Smith et al. recommended the radical inclusion of the prostate in the specimen, because the ejaculatory duct is often affected.[4] It therefore seems reasonable to propose radical prostatovesiculectomy in these patients when the tumor appears localized, especially when prostate invasion is suspected. However, some cases were treated with isolated vesiculectomy[5,6] with good clinical evolution. At times it was also necessary to consider cystectomy.[7] Radiation therapy seems to have been indicated as palliative treatment in very advanced cases with very bad prognosis.[8] Other authors prescribed adjuvant therapy with