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Case Report

A case of spermatocytic seminoma in young individual

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Introduction

Testicular tumors are relatively uncommon and accounts for only 1–2% of all tumors in men. Spermatocytic seminoma (SS), a special form of seminoma, is a rare entity and constitutes only 2% of all seminomas.[1] Less than 400 cases of SS have been reported till date and most of them are elderly with mean age of presentation is 54 years.[2] We hereby report a case of SS, incidentally detected in a young individual, who presented with a large unilateral primary vaginal hydrocele.

Case report

A 30 years old healthy male patient presented with painless, progressive left hemi-scrotal swelling of six months duration.

Fig. 1 – 14 cm × 8 cm × 6 cm fluctuant, non-tender, trans-illuminant negative left hemiscrotal swelling.

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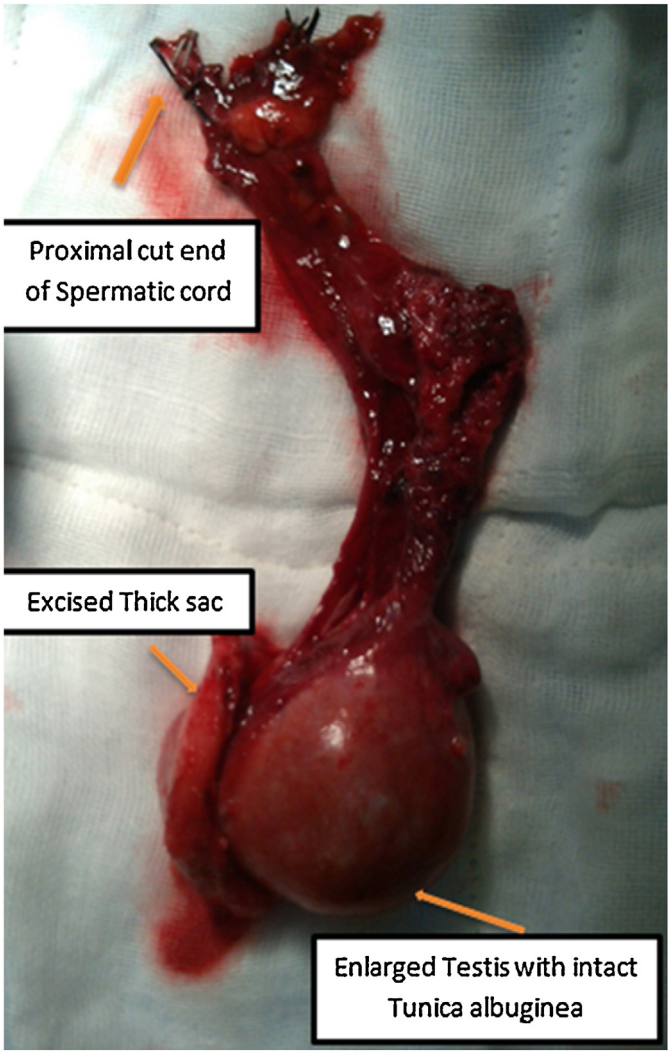

Fig. 2 – Radical Orchidectomy specimen.

It was associated with dull ache on prolonged standing and exertion but there was no association with fever, dysuria or trauma to the testis. General and systemic examinations were unremarkable. Scrotal examination revealed 14 cm × 8 cm × 6 cm fluctuant, non-tender, negatively transilluminant left hemiscrotal swelling (Fig. 1). Testis and epididymis were not palpable due to large hydrocele and examination of contralateral inguino-scrotal region was normal.

Ultrasound scrotum revealed enlarged left testis with hypervascular, multiple, hypoechoic nodular lesions varying in size from 2.5 to 3 cm and tense ipsilateral hydrocoele. Tunica albuginea, epididymis and cord were sonologically normal.

Patient was further evaluated with tumor markers (β-HCG, LDH and AFP), Chest radiograph and abdominal ultrasound which were found to be normal. After clinical, radiological and laboratory assessment testicular malignancy with secondary hydrocoele was suspected and planned for orchidectomy for tissue diagnosis.

Radical orchidectomy was performed through left inguinal approach. Residual cut ends of cord and vessels were marked with titanium clips and deep ring was closed with non-absorbable suture. Delivery of the testis into the inguinal wound was difficult due to large fluid filled sac. Hence, fluid was aspirated using 20 Fg needle through inguinal incision, taking adequate precaution to prevent spillage of contents in and around the operative field. Sac was thick walled, therefore, excised along with testis and resected specimen was sent for HPE evaluation.

Gross examination of specimen revealed testis of size 7 cm × 5.5 cm × 3 cm and weight of 158 g (Fig. 2). On cut section multiple well circumscribed nodules, largest measuring 3 cm in diameter, were seen without any area of calcification, necrosis or hemorrhage. Compressed normal testis was seen at the lower end (Fig. 3).

Microscopic examination of the tissue sections showed diffuse proliferation of polymorphous cells of three types: Large cells had uniform round nuclei with spireme chromatin, intermediate cells had perfectly round nuclei with evenly dispersed chromatin and eosinophilic cytoplasm and small cells were lymphocyte like with uniformly hyperchromatic nuclei and scant cytoplasm (Fig. 4). Mitotic figures were 1–2 per

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