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Case report

Cervical mass as the first clinical manifestation of unsuspected metastatic seminoma

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ABSTRACT

The authors reported a case of a 27-year-old man with a nontender left neck mass that had grown quite rapidly within few weeks. FNAB and CT were not consistent to establish the definite diagnosis. After excisional biopsy, the histopathological examination and the immunohistochemical study of the specimen revealed a cervical metastasis of seminoma. The patient was treated with chemotherapy with a complete clinical remission. This uncommon case-report can represent a great diagnostic and therapeutic challenge and should be considered in the differential diagnosis of every cervical masses occurring in young males patients. Diagnostic delays are unfortunately common and may lead to metastatic spread and worse prognosis.

1. Introduction

Testicular tumours represent only 1% of all cancers in males. Germ cell tumours account for 98% of all testicular neoplasms and can be split in two groups: seminomas and nonseminomatous germ cell tumours. The seminoma accounts for about 60% of all tumours derived from testicular germ cells. Testicular cancer occurs usually in young male adults, between 15 and 34 years of age [1]. However, reports of children (8 years) and elderly (73 years) also appear in the literature. The neoplastic diffusion to cervical lymph node is not an uncommon evolution of this tumour as 4.5–15% of such patients will develop neck metastases during the course of the disease, but it is very rare (estimated 5% of these patients) that occurs as the first clinical manifestation [2–10]. We report a case of a young male with a left cervical metastases of seminoma as the first presentation of the tumour, emphasizing the role of Otolaryngologist in the diagnostic process of an unsuspected primary testicular tumor, and reminding to all Otolaryngologists that metastatic seminoma must be kept in mind in the differential diagnosis of all cervical lymphadenopathy in an otherwise healthy male patient.

2. Case report

A 27-year-old white young male presented with an asymptomatic left cervical mass, appeared the first time 6 weeks previously, affecting initially the supraclavicular region and then extending to the lateral cervical region. There was no other symptoms or significant medical history. On physical examination a 5.0 × 3.5 cm nontender left supraclavicular swelling, hypomobile, covered by normal skin, was palpable. Upper aero-digestive endoscopy appeared normal. Blood tests showed increased levels of CRP, ESR, fibrinogen, gamma-GT. A cervical ultrasound confirmed the voluminous mass at the left base of the neck, with confluent lymph nodes, the eldest of 5.6 × 2.3 cm. A CT scan of neck, thorax and abdomen with contrast confirmed the remarkable 6 × 2.5 cm left lateral cervical lymphadenopathy at the base

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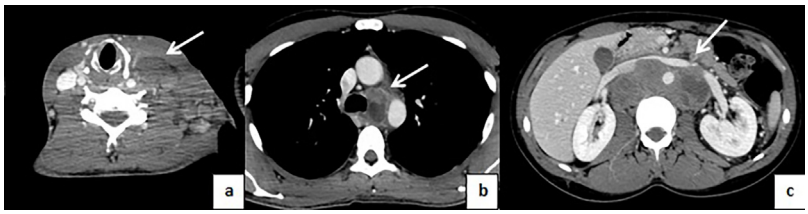

Fig. 1. A CT scan of neck (a), thorax (b) and abdomen (c) with contrast revealed the remarkable 6 × 2.5 cm left lateral cervical lymphadenopathy at the base of the neck compressing and displacing the jugular vein (see arrow); besides, it reported a mediastinal higher lymphadenopathy, in the left paratracheal region (the greater of 2.4 cm) (see arrow) and in almost all abdominal stations, with a voluminous retroperitoneal mass, largely colliquate, with overall diameter of 10.3 × 5 cm, enveloping and dislocating the abdominal aorta, the renal arteries, the inferior vena cava and the left renal vein (see arrow).

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After the diagnosis of seminoma the markers of testicular cancer were determined demonstrating high levels of β-human chorionic gonadotropin (β-hCG) and lactate dehydrogenase (LDH) and normal levels of α-fetoprotein and placental alkaline phosphatase (PLAP). A testicular ultrasonography showed a right, solid, hypoechoic, hypervascular neoplasm, measuring 12 × 9 mm. A Fluorodeoxyglucose Positron Emission Tomography (FDG-PET) revealed various hypermetabolic uptake and pathological accumulations of FDG in many contiguous regions, all suggestive of metastatic lymphonodal lesions: laterocervical, mediastinal, paratracheal, retroperitoneal, paravertebral (Fig. 2).

The patient was diagnosed with stage-3 seminoma and began adequate chemotherapy. He had an excellent response to chemotherapy and at the 6-months follow-up no evidence of disease was detected (Fig. 2).

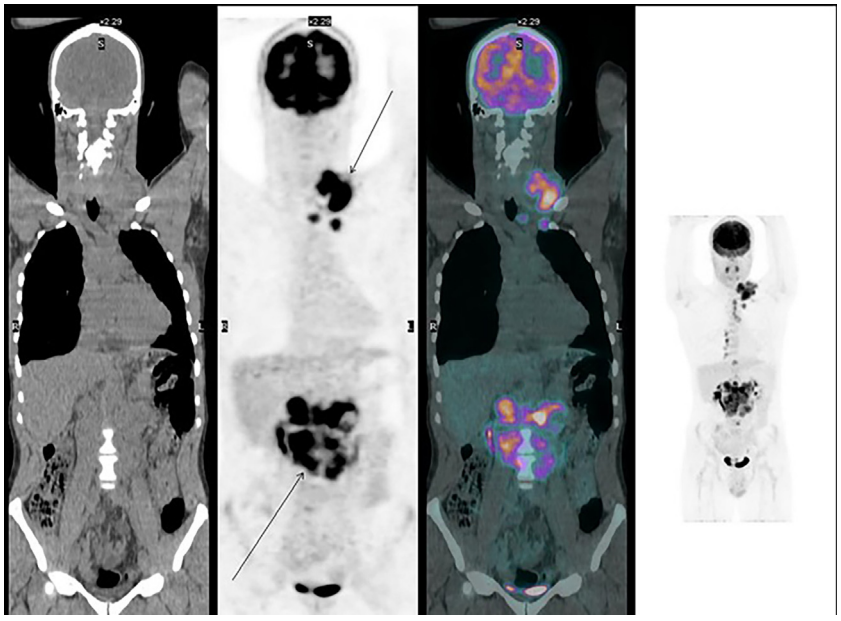

Fig. 2. A Fluorodeoxyglucose Positron Emission Tomography (FDG-PET) revealed various hypermetabolic uptake and pathological accumulations of FDG in many contiguous regions, all suggestive of metastatic lymphonodal lesions: laterocervical, mediastinal, paratracheal, retroperitoneal, paravertebral.

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