

Scrotal and inguinal mass

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CASE REPORT

A 47-year-old man presented with painless scrotal enlargement and bilateral inguinal masses. The lesions had progressed slowly over the last ten months. No weight loss, fatigue, fever or night sweats were reported, neither a history of visits to tropical countries. Physical examination revealed a large testicular mass with scrotal skin infiltration and bilateral massive ulcerative inguinal lymph nodes (*figure 1*). On laboratory investigation lactic dehydrogenase was elevated (11,355 U/l).

WHAT IS YOUR DIAGNOSIS?

See page 370 for the answer to this photo quiz.

Figure 1. Patient presented with a large testicular mass with scrotal skin infiltration and bilateral massive ulcerative inguinal lymph nodes



ANSWER TO PHOTO QUIZ (PAGE 367)
SCROTAL AND INGUINAL MASS

DIAGNOSIS

Further laboratory examination revealed elevated beta-human chorionadotrophin (β HCG, 42 U/l, normal <1 U/l), while alpha-fetoprotein was normal (α FP, 4.5 U/l, normal <10 U/l). Histopathological examination of an inguinal lymph node showed seminoma. Staging of the patient with CT scanning of brain, thorax and abdomen demonstrated para-aortal lymphadenopathy and impressive inguinal lymphadenopathy (*figure 2*). Treatment with bleomycine, etoposide and cisplatinum was started. After four cycles a complete pathological remission of both the lymph nodes and primary tumour was demonstrated by orchidectomy.

Figure 2. CT scanning of brain, thorax and abdomen demonstrated para-aortal and inguinal lymphadenopathy



Testicular cancer is the most common malignancy in men under the age of 50 years and its incidence is increasing.¹ Patients often present with a painless scrotal mass without systemic signs or symptoms. Typically, metastatic spread occurs via efferent lymphatic vessels following the spermatic cord towards iliac and retroperitoneal lymph nodes. Inguinal lymph nodes drain the scrotal skin, perineum and penis. Involvement of inguinal lymph nodes in testicular cancer is rare² and is generally related to either a history of locoregional surgery, local invasion of the tumour into the tunica vaginalis or scrotal skin, or bulky retroperitoneal lymph node metastases.²⁻⁴ Since surgical correction of cryptorchidism early in childhood has become common practice, the incidence of inguinal lymph node involvement in testicular cancer will probably increase. The occurrence of inguinal lymphadenopathy is not related to a specific histological subtype of testicular cancer. Our patient underwent surgery for a hydrocele 13 years ago but, given the bilaterality of the inguinal lymphadenopathy, the infiltration of the scrotal skin has probably contributed to this rare presentation.

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