



## TESTICULAR CARCINOMA IN A YOUNG MAN WITH DISSEMINATED METASTASIS- A CASE REPORT

### Surgery

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### ABSTRACT

Testicular cancer represents around 1-1.5% of male neoplasm and there is increased incidence of these tumours in the past 30 years with 3-10 new cases per 1,00,000 males. The predominant histology is germ cell tumours. The peak incidence of seminoma is in the fourth decade of life, while Non-seminomatous germ cell tumour being more common in the third decade of life. The risk factors include cryptorchidism, male factor infertility (including Klinefelter syndrome), familial history of testicular tumours among first grade relatives and the presence of contralateral tumour or Germ cell neoplasia insitu(GCNIS). Here reporting a case of Testicular carcinoma in a 29 year old male with disseminated metastasis.

### KEYWORDS

#### Case Presentation

29 year old male came with chief complaints of Cough with hemoptysis for 1 month, dyspnoea and easy fatigability for 1 week. He also had history of loss of weight and loss of appetite. He also had a history of vague abdominal pain for past 1 week. There is no significant personal and family History. On examination mild Icterus is present. He is tachypnoeic with a respiratory rate of 30/min and pulse rate of 120/min. His SpO<sub>2</sub> is 90% in RA and 96% in 10L O<sub>2</sub> of NRM. His BP is 110/70 mmHg. There is decreased breath sounds in both lungs with bilateral crepitus heard. Per abdomen showed mild distension with retroperitoneal mass of size 5\*5cm palpable in the periumbilical region. Liver is palpable 2cm below right costal margin with a liver span of 14 cm. B/L testis appears normal with mild tenderness in right testis. We proceeded with USG scrotum which showed cystic lesion of size 5\*6mm with peripheral calcification in the right Testis with right minimal hydrocele? Testicular carcinoma. Xray chest showed cannon ball metastasis. CT abdomen showed B/L Paraaortic nodes with multiple liver metastasis. CT chest showed multiple B/L lung metastasis. There is rise in total bilirubin of 2.5 mg/dl. Tumour markers showed an elevation of AFP and LDH. He is diagnosed with Stage 4 Non-seminomatous germ cell tumour. He started on Chemotherapy which consists of 3 cycles of BEP (bleomycin, Etoposide, cisplatin) and 4 cycles of EP (Etoposide and Cisplatin). Unfortunately he succumbed to death after 1st cycle of chemotherapy.



Figure 1: CT Chest Showing Cannon Ball Metastasis



Figure 2: CT Abdomen Showing Multiple Liver Metastasis With Bilateral Paraaortic Node Involvement.

#### DISCUSSION

The usual presentation of testicular cancer is Painless testicular lump. A sensation of heaviness can occur, but few patients experience pain. Occasionally, an episode of trauma calls attention. But the predominant symptoms are those of metastatic disease. Intra-abdominal disease may cause abdominal pain or lumbar pain. Lung metastasis cause chest pain, dyspnoea and haemoptysis and the primary tumour may not have been noticed by the patient, and indeed may be detected only by ultrasound. On examination there is an intratesticular solid mass. A secondary hydrocele may be present. Some cases may simulate epidymo-orchitis and rarely, acute painful enlargement of testis occur because of haemorrhage into the tumour, which can mimic testicular torsion. The diagnosis is confirmed by USG Testis. Blood levels of tumour markers are measured. A rise in LDH is seen in testicular cancer nonspecifically. A rise in AFP is seen in around 50-70% of NSGCT and a rise in HCG is seen in 40-60% of NSGCT and around 30% of seminoma. The tumour markers are used to see response to treatment and to detect recurrence and metastasis. While a chest radiograph can show the classical cannon ball metastasis CT scanning of chest, abdomen and pelvis used to detect metastasis and monitoring the response to treatment. The treatment options include Radical orchidectomy for Stage 1 (Non metastatic disease), followed by adjuvant radiotherapy for seminoma and adjuvant chemotherapy for NSGCT. For Stage 2 and 3 (Metastatic disease), for both seminoma and NSGCT, the mainstay of treatment is chemotherapy, which consists of 3 cycles of BEP or 4 cycles of EP. B-bleomycin, E-etoposide, P-cisplatin.