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Testicular Sarcoma Recurrence Surgery in an 18-Year-Old Person at the Dermatology Hospital of Bamako (HDB): About a Case

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Abstract

Testicular fibrosarcoma is an extremely rare testicular tumor with an indolent course, but it can metastasize to distant sites. Due to its rarity, its characteristics and progression are poorly understood. We report a case in an 18-year-old man with tumor recurrence, presenting with a large right scrotal tumor occupying almost the entire scrotum for approximately 24 months. We discuss the histogenesis, therapeutic approaches, follow-up, and prognosis in adulthood.

Keywords

Sarcoma, Testicular, Surgery, Recurrence, 18-Year-Old Man

1. Introduction

Testicular sarcomas are extremely rare tumors, the incidence of which is difficult to assess [1] [2]. Testicular cancer accounts for 1% of all malignant tumours in

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men and is most common between the ages of 15 and 34. Worldwide, the incidence of this cancer varies considerably from one country to another. The highest incidence is observed in the Scandinavian countries with 6.7 per 100,000 men [3]. The development of this pathology is linked to environmental and genetic factors, with cryptorchidism being the most common risk factor [4]. Clinically, most testicular cancers occur as a painless palpable testicular mass [4]. Ultrasound is the reference para-clinical examination [3]. The ultrasound image of testicular tumors is typically well delineated and hypoechogenic compared to normal testicular tissue. In case of diagnostic doubt, MRI can provide additional information [3]. The management of testicular fibrosarcoma is based on a multidisciplinary approach that improves survival chances by up to 80% by combining chemotherapy, radiotherapy or surgery [5].

2. Observation

This is an 18-year-old male patient who is a student in our department for the management of a recurrent testicular fibrosarcoma. The onset of the disease dates back 4 years, marked by the observation of painless scrotal swelling, which required a surgical consultation in a local hospital. After clinical and additional examinations, a surgical indication was established and performed according to the patient. undocumented. The result of the operative panel came back in favor of a Sertoli cell tumor that is poorly differentiated from the testis. To be completed by immunohistochemistry to eliminate an immature teratoma that could not be achieved. Two years later the patient was admitted to the medical oncology department for a tumor recurrence. On examination, the patient had an altered general condition OMS 3. There was the presence of a large testicular tumor taking almost all of the bursa with a large collateral circulation over the entire surface. and a necrotic ulceration at the center of the hard swelling measuring about 30 cm × 25 cm (**Figure 1**), the rest of the clinical examination was unremarkable. In view of this clinical picture, paraclinical examinations were requested and showed anemia with a hemoglobin level of 7 g/dl, hematocrit at 23%, and a platelet count of 439,000/mm^3. Normal αFP at 0.6 ng/ml Normal βHCG at 0.2 IU/l Slightly high LDH 378 IU/l A first requested abdominal-pelvic CT scan showed a large scrotal tumor with infiltrative pleuropulmonary, ganglionic, and bone metastases (vertebrae and ribs). The tumor was classified as T4N2M1. Primary testicular sarcomas are extremely rare, the vast majority of malignant testicular tumors being germline tumors for which the standard TNM classification applies: pT4 = tumor extended to the scrotum, N2 = lymph node extension 2 to 5 cm, M1b = other metastatic sites. The corresponding staging is Stage IIIb (AJCC). Thus, after the multidisciplinary consultation meeting (RCP), a first course of chemotherapy was selected. It consisted of 18 courses of chemotherapy with carboplatin + etoposis. This protocol was carried out based on the first histology in the absence of immunohistochemistry because the block was not found and despite the normality of biological assessments. After these chemotherapy courses, a control abdominopelvic com-

puted tomography (CT) scan showed persistence of the large metastatic malignant scrotal tumor (pulmonary, ganglionic, and bone) and a 35% regression in size of the right pulmonary nodule and lymphadenopathy. Given this clinical and paraclinical picture (the persistence of tumor volume and impossibility to walk) Palliative surgery was decided and consisted of a right orchiectomy with a large monobloc excision exposing the left testicle and an oncoplasty by the formation of a neo-scrotum (Figure 2). The surgical specimen was sent for anatomopathological examination, which concluded that testicular fibrosarcoma; the resection limits are healthy (Figure 3). Immunohistochemistry confirmed a grade II fibrosarcoma. Vimentin+, S100+. The immediate post-operative follow-up was simple. The patient received local care 1 in 3 days, antibiotics and painkillers. The clinical course was marked by mobilisation with normal walking. Healing was observed on D47 (Figure 4). The patient was referred to the medical oncology department, hence a new palliative chemotherapy protocol (Doxorubicin), but not accepted by the patient's family for socio-economic reasons. In front of this table, the patient was followed for palliative care.



Figure 1. Preoperative image (sarcoma).



Figure 2. Intraoperative image.



Figure 3. Image of the surgical specimen-sarcoma.



Figure 4. Scarring (sarcoma).

The post-operative local recurrence-free survival was 13 months.

3. Discussion

Testicular cancer is rare. Worldwide, the incidence of this pathology has been growing rapidly over the past 25 years. It varies between 0.2 and 9.2 cases/100,000/year [5]. Our patient was 18 years old. Several African studies have found a predilection of this cancer for young subjects, those of Sow *et al.* [6] and Goïta *et al.*, and R. Kane *et al.* [7], where the age groups were 32 to 40 years old and 21 to 40 years old, respectively. Our patient had initially consulted for the observation of a painless right scrotal swelling at first sudden, which was operated but not documented and then recurred two years later. The typical presentation includes a painless mass at the testicle or groin. This finding is confirmed by the results of other studies [3]-[5]. Testicular ultrasound is the reference examination, with great sensitivity. On ultrasound, testicular tumors are typically well delineated and hypoechogenic compared to normal testicular tissue [4]. In case of diagnostic doubt on ultrasound, MRI can provide additional information [4]. The requested abdom-

inopelvic computed tomography showed a large scrotal tumor with pleuropulmonary, ganglionic, and infiltrative bone metastases (vertebrae and rib). The tumor was classified as T4N2M1. In the literature, the most common route of metastasis is the lymphatic pathway to the internal iliac and para-aortic lymph nodes [1]. Distant metastases to the liver, lungs and bones by haematogenic route account for 20% of cases at initial presentation [6]. Our management consisted after 18 courses of chemotherapy with Carboplatin + etoposide at a right orchidectomy with monobloc excision exposing the left testis and an oncoplasty by the formation of a neo-scrotum and oncoplasty. According to Catton *et al.* [8] the orchidectomy alone is insufficient for testicular sarcomas. They found a local recurrence rate of 14% in patients who underwent local wide resection and/or radiotherapy after initial removal of testicular sarcoma.

4. Conclusion

Testicular fibrosarcoma is a rare and aggressive malignant tumor, developing in the mesenchymal tissue of the spermatic cord or the epididymis. Its management requires a dedicated multidisciplinary approach formalized by specialized RCP. The referral of these patients, who most often require complex surgeries, should be to a surgeon trained in sarcoma surgery, thus significantly improving the quality of resection and consequently their survival.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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