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Surgical Technique

Can a Long Time follow up in a Resolute Patient Help us in Testis Sparing Surgery Decision?

Gianni Ughi[1*] *and Massimo Pedriali*[2]

[1]Operative Unit of Urology, S. Anna Hospital Ferrara, Italy

[2]Operative Unit of Surgical Pathology, S. Anna Hospital Ferrara, Italy

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All the urologists (surgeons), normally, perform orchiectomy in cases of malignancy with combined or not chemotherapy or radiotherapy. In selected cases, if the tumour is bilateral, in cases of Leydig cell tumor, if the patient is monorchid TSS (testis sparing surgery) is discussed.

Once upon a time, firstly in the millennium (2004) a young 24 years old, athletic, come into my office for a visit. There is a no palpable small left testicular mass at sonography. This sonographyc finding was performed as screening in a sport medicine evaluation. The lesion was, solitary, small, with a diameter of about 1.3 cm, well demarked; the other didimus is normal. He isn't married and has no children. After the urological evaluation markers (LH, alpha-fetoprotein, Beta HCG, LDH) and chest-abdominal CT (resulted negative) are prescribed. At medical examination small left varicocele is found and nothing else was observed. No erectile dysfunction or libido decreases were declared. No cryptorchidism at birth was found.

In an office talk we indicate (recommend) orchifunicolectomy if tumour is detected. We also indicate the possibility of sperm frozen but both options were refused. Like others before, he initially refuses orchiectomy but on the contrary, of the others, he refuses orchiectomy even if I explains him the reasons for performing that. In the meet was discussed about the altered corporeal perception. The patient refuses the problem's correction by means of prosthesis insertion.

At surgery time, a small inguinal incision was performed. The funiculus was isolated and warm clamped (before inguinal external ring). Testis is extracted and tunica vaginalis opened. The intrasurgical ultrasound (dott. Limone, Radiologo dedicato) identified the lesion accurately. The edge was good, shown near the superior testicular left pole. A small needle is positioned while performing a resection of the small mass (1.3 cm). Then the other step is an ultrasound control of the resection.

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***Corresponding author:** Gianni Ughi, Operative Unit of Urology, S. Anna Hospital Ferrara, Italy, E-mail: gianniughi@ospfe.it

The sample was sending for ex tempore, FSE (frozen section examination) at our Surgical Pathology operative unit. The intraoperative response was "malignancy neoplasia to be typed on formalin fixed 7hematosilin-eosin stained slides". The definitive diagnosis was "Pure seminoma".

Seminoma: Is the most common pure germ cell tumour (30% to 45% of testicular germ cell tumours) composed by relative uniform cells with so many clear cytoplasms with glycogen particles demonstrable with the periodic acid - Schiff stain, well-defined cell borders, and polygonal nuclei with finely granular chromatin, frequently flattened edges and one or more prominent nucleoli. Less commonly, the cytoplasm is dense and the nuclei more crowded. This may result in a plasmacytoid appearance. The seminoma cells are considered the neoplastic counterparts of the primordial germ cells / monocytes present during early embryogenic development.

It's a well circumscribed and homogeneous mass, sometimes lobulated. It's grey - white, tan, creamy, fleshy, firm, with often bulging cut surface.

Microscopically fibrous septa divided sheets or nests of tumour cell into lobules. Tumour cells are evenly separated without nuclear overlap. We frequently observe a prominent Cytoplasmic membrane that delineate distinct cell boundary. Often there is a lymphoplasmacytic infiltrate, occasionally extended with germinal centers in fibrous septae. In the 30% of cases we can observe granulomatous inflammation that can be extensive and create diagnostic pitfalls in recognizing tumour cells.

The object of this study presented as a white nodule with a major diameter of 1.3 cm. It's diagnosed.

We inform the patient during surgery under spinal anesthesia of the FSE diagnosis. He yet refuses orchifunicolectomy.

Therefore beware of delayed orchifunicolectomy if the definitive histology was not pure seminoma, we perform vaginal reversion and testis was repositioned into the scrotum. The skin was sutured in absorbable material.

The definitive histological examination was seminoma (Figures 1-4).

The follow up was G.E., serum markers; ultrasound examination/ CT chest-abdominal scan (almost twice in a year) every three-four years. These were always negative for relapse or metastasis

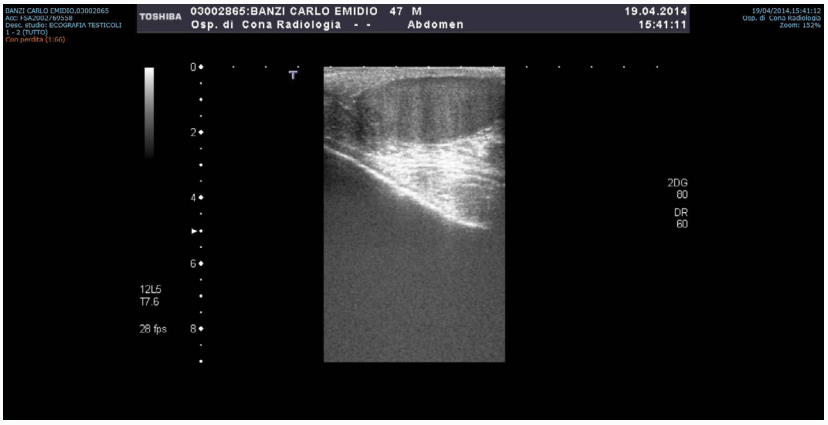

Figure 1: Banzi lesione ischemica.

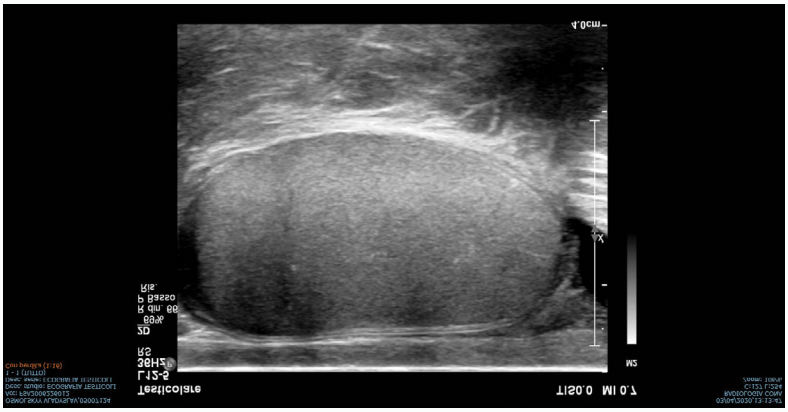

Figure 2: Osmolsky esiti.

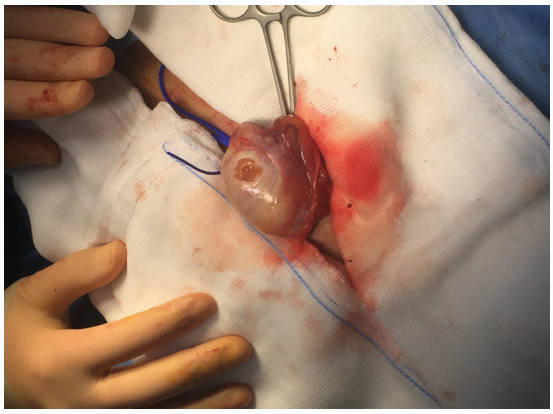

Figure 3: Germ cell tumour.

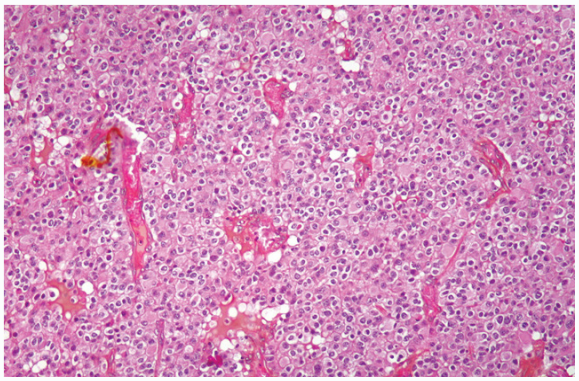

Figure 4: Seminoma.

After a year the follow up was two times in a year with the same examinations. After five years, the patient was followed yearly, with CT chest-abdominal scan and markers.

After eight years from surgery he decided for fragmentary controls. The last office control has been twelve years after surgery.

Today, occasionally valuated for other reasons, there aren't relapses or metastasis. He told us that he feels good. The Erectile Function is normal and it doesn't report any decrease of libido. There is also no hypogonadism. He has a healthy male son.