

Dev, Çift Taraflı, Testiküler Neoplaziyi Taklit Eden Spermatozel

Huge Bilateral Spermatocele Mimicking Testicular Neoplasia

Mücahit Kart¹, Mustafa Melih Çulha²

1Hendek Devlet Hastanesi, Üroloji Kliniği, Sakarya
2Kocaeli Üniversitesi Tıp Fakültesi, Üroloji Ana Bilim Dalı, Kocaeli

ÖZET

Testiküler neoplaziyi taklit eden çift taraflı spermatozeli olan bir olguyu, tanısını skrotal ultrason ve cerrahi olarak teyit ederek sunduk. 58 yaşında bir erkek sağ skrotal şişlik şikayeti ile kliniğimize başvurdu. Fizik muayene sonrası sadece sağ tarafta değil, ayrıca sol tarafta skrotal şişlik tespit edildi. Yapılan skrotal ultrasonografide sağda monoloküler, solda multiloküler kistik yapıda kitleler tespit edildi. Yapılan cerrahi tedavi ile her ikisi de epididimis yanında yer alan spermatozeller perforasyon olmadan eksize edildi. Hasta iyi bir şekilde iyileşip, post operatif ikinci gün taburcu edildi. Bir ay sonraki takibinde bir sorun izlenmedi.

Anahtar Kelimeler: Çift taraflı, dev, spermatozel

ABSTRACT

We describe a case of bilateral spermatocele mimicking testicular neoplasia, diagnosed at scrotal ultrasound with surgical correlation. A 58 years of man was admitted to our clinic suffering from right scrotal swelling. After physical examination, not only right sided but also left sided scrotal swelling was detected. Scrotal ultrasound revealed cystic fluid masses which are monolocular on right side and multilocular on left side. Surgical exploration was arranged and total excision of spermatoceles which are both located near the body of epididymis, was performed without perforation. The patient recovered well and discharged on the second day. No complication was observed in the follow up after one month.

Keywords: Bilateral, huge, spermatocele

İletişim (Correspondence):

Uzm. Dr. Mücahit Kart
Hendek Devlet Hastanesi Üroloji Kliniği, Hendek, Sakarya - Türkiye
Tel: 05052773032 / E-Mail: mucahitkart@gmail.com

INTRODUCTION

A spermatocele is a sperm containing cystic cavity, probably due to partially obstructed spermatic ducts above the epididymis. They are usually asymptomatic, single and smaller than 1 cm in size. However, spermatoceles sometimes become large enough to bother the patient and be suspected of being tumor(1,2). They can also mimic hydrocele in physical examination. Surgical exploration should be considered in the presence of persistent pain, disturbance of mass or on the grounds that testicular neoplasia can not be ruled(3). Herein we describe a bilateral, huge spermatocele, multilocular on left side and review the literature. Aim of this report is to keep in mind the differential diagnosis of a spermatocele to avoid missing a testicular neoplasia.

CASE REPORT

A 58 years old man was admitted to our urology outpatient clinic for swelling on his right testis which was disturbing him during normal physical activities such as walking and sitting. The duration of his complaints was started 5 years ago but for last 2 years it has restricted his activities gradually. There was no trauma, infection or surgery history. He had two children aged 32 and 35 and had no problem about fertility before. Physical examination revealed scrotal firm mass without tenderness, not only on the right side but also on the left side. Right scrotal mass was located superior to testis and extending over the spermatic cord and having a smooth surface while left scrotal mass was palpated over epididymis with a rough surface separately from left testis. In laboratory, serum tumor markers as beta hcg, AFP, LDH was evaluated and ultrasound was performed for differential diagnosis. Serum tumor markers was within normal limits and ultrasound revealed 60x40x25 mm in size cystic fluid mass over right testis and 55x40x20 mm in size multilocular cystic fluid mass on the body of epididymis(Figure1).

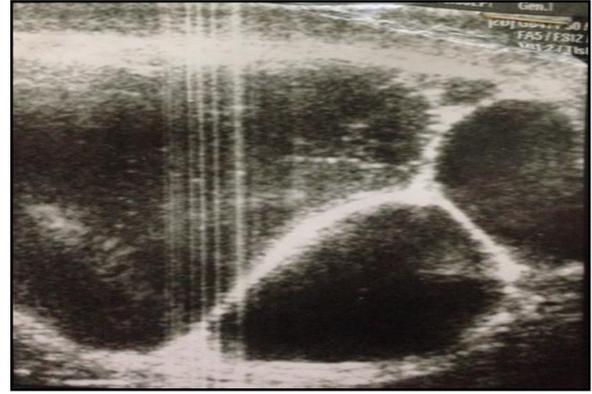


Figure 1. Ultrasound view of left multilocular spermatocele

Bilateral scrotal exploration was performed with right inguinoscrotal incision (Figure2) and left inguinal incision (Figure3), both spermatocele was resected completely due to clear plane between the masses and epididymis, testis or cord and excised without perforation.



Figure 2. Monolocular spermatocele on right testis



Figure 3. Multilocular (septated) spermatocele on left testis

After the excision testicles, epididymis and spermatic cords were within normal view on both sides. The patient was recovered well and discharged on the 2. post operative day. No

complication or recurrence was observed in the follow up after one month.

DISCUSSION

Spermatoceles can occur after infection, trauma, vasectomy or scrotal surgery however they can also occur without any particular reason(3). Development of spermatoceles without any history may be associated with advanced age since most of them occur in fourth or fifth decades of men life. Itoh et al has explained this with seminiferous epithelium shedding should probably cause an accumulation in aging tubules and this accumulation makes a stenosis resulted in proximal dilatation in efferent ducts as this shedding occurs through out life. These are in agreement with our case who was 58 years old and had an idiopathic development of bilateral spermatocele.

Differential diagnosis has particular importance before surgical treatment of spermatocele since false treatment, owing to false diagnosis may cause a progression in grade of disease in case of testicular or paratesticular tumor. Thus, after physical examination scrotal ultrasonography should be the proper investigation of choice which has a high accuracy on revealing hypoechoic lesions generally 1-2 cm in size with posterior acoustic enhancement(4). If ultrasound reveals a solid hypoechoic mass, this must be excised with associated testis and proximal cord whether serum tumor markers within normal limits. As distinct from solid hypoechoic masses, spermatoceles are seen as cystic hypoechoic mass on ultrasound. A spermatocele should also be differentiated from epididymal cyst and infection as orchitis, epididymitis. In this respect, beside history and physical examination findings, urinalysis is indicated to exclude genitourinary infection. Demonstration of sperm in cystic fluid could distinguish it from an epididymal cyst. In addition, chronic epididymitis is speculated to trigger secondary neoplastic epithelial changes in rete testis adenocarcinoma and may have similar presentation as a typical spermatocele(3,5). In this context, Yeh et al reported a case of giant spermatocele mimicking hydrocele, in which

scrotal exploration and pathologic diagnosis is recommended in definitive diagnosis to exclude neoplastic lesions. However, Médina et al reported a calcified spermatocele simulating a neoplasm diagnosed after an unnecessary orchidectomy(6). Thus, failure of definitive diagnosis by physical examination, ultrasound and surgical exploration requires intraoperative tissue biopsy examination before total excision to preserve genitourinary organs.

In conclusion, spermatoceles smaller than 1-2 cm in size, generally do not require any treatment. Large, disturbing or any other symptomatic spermatocele after differential diagnosis of scrotal disorders, should be excised.

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