Liposarcoma paratesticular region: A rare case report

Hakim Irfan Showkat*, Gul Mohammad Bhat, Mohmad Hussain Mir, Sheikh Ajaz Aziz, Arif Hussain Sarmast and Basharat Mujtaba

Liposarcomas of the paratesticular region are rare tumors that usually present as painless, slowly growing inguinal or scrotal masses. They are usually diagnosed as being an inguinal hernia or lipoma before surgical intervention. Paratesticular liposarcomas are rare tumors and are usually seen in patients in middle age or elderly. We report a case of paratesticular liposarcoma who presented with a gradually progressive inguinal region swelling.

Keywords: Liposarcoma, tumour, hernia, paratesticular, swelling

INTRODUCTION

Paratesticular liposarcomas are rare and typically reported as an isolated case or components of larger studies of liposarcomas. Paratesticular well-differentiated liposarcoma has a prolonged clinical course with recurrences in more than half the cases, sometimes late. There are no metastases and the overall prognosis is good (Wilson et al, 1994). Most paratesticular malignant tumors are usually sarcomas. Paratesticular liposarcoma most commonly originates in the spermatic cord.

CASE HISTORY

A 60 year-old male presented with a progressive, painless swelling in the left inguinoscrotal region from last 9 months. Systemic examination was normal. Local examination revealed a left inguinoscrotal swelling 10 x 8 cm, with penis pushed to opposite side. Cough impulse was negative. On palpation a firm, smooth-surfaced mild tender swelling was felt and testis was separate from the swelling. The swelling was irreducible with no fluctuation. The transillumination test was negative. There was no associated inguinal lymphadenopathy. Ultrasonography (USG) reported this mass to be inhomogeneous and hyperechogenic, 9.8 x 7 x 6.3 cm (Fig 1) and separate from the testis and epididymis as well and Doppler showing normal vasculature. Contrast enhanced computed tomography (CECT) pelvis and abdomen gave an impression of sarcoma in the paratesticular region with no lymphnode involvement (Fig 2).

Surgical exploration was done with wide excision of the mass and orchidectomy and the section sent for histopathology which revealed liposarcoma (Fig 3). Immunohistochemistry showed S-100 Protein positive and negative for SMA, Desmin, H-Caldesmin and myogenin. Other markers like alpha fetoprotein, HCG (human chorionic gonadotrophin), lactate Dehydrogenase (LDH), PSA (prostate specific antigen) were normal. The patient received chemotherapy (Adriamycin and Ifosfamide) and is on our regular follow up from past 8 months without any complaints. He is planned to be followed for a long time for any probable relapse.

*Corresponding author: Dr. Hakim Irfan Showkat, Senior Resident, Sher-I-Kashmir Institute of Medical Sciences, Srinagar, Jammu and Kashmir, India, Editor-in-chief JCCO, E-mail: docirfanshahi512@gmail.com, Tel: +91-9419028326


**DISCUSSION**

Paratesticular liposarcomas are rare tumors and are often reported as isolated cases (Montgomery, 2003). Paratesticular liposarcoma is extremely rare and only 41 cases have been reported in the literature (Littles, 1992). They refer to liposarcomas arising from the spermatic cord, testicular tunics and epididymes, and usually occur in men aged 41 years to 87 years (Montgomery, 2003). Myxoid liposarcomas account for 40-50% of all liposarcomas and the survival depends both on the histological appearance as well as their anatomical location (Gerber 1985; Mostafi 1973). This tumor is difficult to diagnose preoperatively and is often mistaken for incarcerated hernia, lipoma, or hydrocele. Liposarcomas in general have been classified into
myxoid (most common; 40%), round cell, well differentiated (subdivided into lipoma-like, sclerosing, inflammatory and dedifferentiated), and pleomorphic) (Logan, 2010). The low grade, well-differentiated and myxoid liposarcomas have favourable prognosis, whereas tumors with multiple recurrences or metastases are likely to be of the high grade, round cell, pleomorphic, or mixed variety.

Complete surgical resection offers the best chance of cure for these patients (Mondaini, 2004) and the established method for orchidectomy for testes/cord cancer is through an inguinal incision (Rowland, 2002). Liposarcomas are locally aggressive tumors and recurrence is quite common after incomplete excision. The inguinal radical orchidectomy with wide resection margin is the standard approach for sarcomas of the spermatic cord (Mondaini, 2004). When local recurrence has occurred, neoadjuvant chemotherapy with complete tumor excision is a useful method of achieving local control. Due to the rarity of the disease there is no definite universal consensus of opinion as regards the role of radiotherapy and chemotherapy (Haider, 2013)

Late recurrences in these patients may occur and a long follow up of these patients is mandatory (Wilson, 1994).

REFERENCES


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