# CASE PRESENTATION

# Testicular Tumours Following Orchiopexy

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**TWO patients with testicular malignancy following orchiopexy are reported. Although this procedure does not protect against malignant transformation of the maldescended testis it is advisable to perform orchiopexy before the age of 10 years. The careful examination of histological blocks of all testicular surgical material must also be made to detect early cellular atypia.**

The increased liability of patients with undescended testis to develop testicular malignant neoplasm is well known. The tumour which develops is usually a seminoma, less oftenly a teratoma (8). There is a good deal of evidence (1, 2, 3, 4) that surgical procedures to bring down the testis does not remove this liability. We report a patient with teratocarcinoma and another with seminoma who developed the tumours 2 years and 7 years respectively following orchiopexy.

**Case 1**

22 years old Irani peon admitted to Salmaniya Medical Centre on June 1980 with gradually enlarging painful swelling of the left groin of 2 months duration. Examination showed operative scar on the left groin and another on the anterior aspect of the left side of the scrotum. Hard, tender, beaded-like mass of about 5 x 7 cm was felt in the left inguinal region. There were no other palpable swelling in the body. Excisional biopsy of the mass showed metastatic papillary adenocarcinoma in the lymph node and the surrounding subcutaneous tissue (Fig. 1), the primary site of the tumour could not be identified histologically. The patient gave previous history of left inguinal herniorrhaphy and orchiopexy on September 1977 and on December 1979 he had sudden severe inguinal pain which was clinically diagnosed as torsion of the orchiopexed testis. Subsequently he underwent orchiodectomy which on histological examination showed extensive haemorrhage and necrosis of the seminiferous tubules consistent with testicular torsion. On admission, the patient was investigated to determine the primary site of the malignant neoplasm. Chest x-ray showed multiple opacities in the lung characteristic of metastasis and IVP showed medial and forward displacement of the left ureter suggestive of enlarged left iliac lymph nodes. Ultrasonography showed transonic and echogenic lesion at the upper pole of left kidney and pedal lymphangiography revealed enlarged left iliac and paraortic lymph nodes (Fig. 2). Examination of bone marrow aspirate showed folate deficiency. Barium meal and enema were normal and all other laboratory investigations were within normal limits. At this stage on August 1980, the histological sections of the left orchiodectomy were re-examined and on deeper cuts several degenerate and necrotic structures of papillary adenocarcinoma were revealed (Fig. 3). No organoid differentiation was seen. The diagnosis of teratocarcinoma was furtherly confirmed when the serum chorionic gonadotrophin was found positive.

The patient subsequently received combined chemotherapy in the form of Vinblastin, Actinomycin D, Methotrexate and Citrovorum. He received two courses of this regime with 3 weeks interval in between but with no improvement. The therapy was then changed to Vinblastin and Bleomycin and this has ameliorated 80% of his pain and regressed the pulmonary and abdominal metastasis by 40%. He was recommended to receive 5 further courses of this regime, one every

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