Letter to the editor re: Paratesticular sarcomas: a case series and literature review: Keenan et al

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Dear Editor,

We read with interest the recent paper by Keenan and colleagues 'Paratesticular sarcomas: a case series and literature review'.[1] The authors discuss the histological subtypes of paratesticular sarcomas and discuss the radiological diagnosis. They emphasize that MRI is a useful clinical adjunct if uncertainty exists following the initial ultrasound assessment. The surgical treatment is then discussed and it is mentioned that the key to oncological control is radical inguinal orchidectomy with high ligation of the cord and mandatory hemiscrotectomy if there is scrotal skin involvement.[1] Three separate cases are then presented and it is notable that two required radical orchidectomy plus hemiscrotectomy while one patient underwent groin mass excision as the mass was separate to the testis. The three separate pathologies were fibrous histiocytoma, high grade leiosarcoma and spermatic cord liposarcoma, respectively.

Myxoid liposarcomas, the second commonest variant of liposarcoma, account for approximately 3% of all liposarcomas.[2] The authors should acknowledge that this paratesticular sarcoma subtype has been successfully treated with primary excision and testis preservation alone in a 27-year-old man by McGuinness and colleagues with no recurrence detected at 5 years.[3] Three separate cases exist of testis-preserving surgery but with negative follow up to only 18 months.[4] They can be misdiagnosed as hernias and adjuvant radiotherapy has been successfully used as they are radiosensitive.[4] Therefore, although radical orchidectomy with hemiscrotectomy is the recommended surgical treatment for paratesticular sarcoma, testis preservation has been successfully reported.[5]

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Conflict of interest statement

The authors declare no conflicts of interest in preparing this article.

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