Urology Case Reports 21 (2018) 27–28

Contents lists available at ScienceDirect

Urology Case Reports

journal homepage: www.elsevier.com/locate/eucr

Oncology

About a case of paratesticular myxoid liposarcoma

Yassine Ayari[a,*], Ahmed Sellami[a], Hamza Boussaffa[a], Alia Zehani[b], Sami Ben Rhouma[a], Yassine Nouira[a]

[a] Department of Urology, La Rabta University Hospital, Tunisia
[b] Department of Anatomopathology, La Rabta University Hospital, Tunisia

ARTICLE INFO

Keywords:
Myxoid liposarcoma
Paratesticular
Scrotal mass

ABSTRACT

Paratesticular liposarcomas are relatively common sarcomas in the paratesticular region, however, the myxoid variant is considered very rare. Due to the infrequency of this malignant disease, no standard treatment would be available. Multiple treatments have reported in literature with different results. Herein, we presented a case of paratesticular myxoid liposarcoma in a 67-year-old man originating from the right paratesticular soft tissue.

Introduction

Paratesticular sarcomas are rare; they originate from the spermatic cord, testicular tunica, or epididymis. These tumors have a high local recurrence potential following inadequate extirpation. We report a case of paratesticular myxoid liposarcoma of the right soft tissue in a 67-year-old man.

Case report

A 67-year-old man presented with right and painless scrotal swelling evolving since 8 months, in an atraumatic context and the absence of fever. All laboratory tests were the normal. Scrotal ultra sound showed a solid extra testicular hypoechoic mass, measuring 4 cm, the right testis was normal (Fig. 1).

Due to a suspicion of malignancy a radical orchiectomy and high cord ligation were performed. Histological examination revealed that lipoblasts were proliferating in varying stages of differentiation and anatomizing with a capillary arrangement in a mucoid matrix (Figs. 2–3).

Eighteen months following radical surgery there was no evidence of tumor recurrence or metastases.

Discussion

Myxoid liposarcoma is a very rare tumor of the scrotal cavity. It represent approximately 3,3% of liposarcomas in this anatomic location.[1] It usually occurs in patients in middle age or older. Most of paratesticular liposarcomas are primary, but some can be metastasis for liposarcoma at other sites, such as thigh or the fatty tissue surrounding the testicle. A palpable scrotal or inguinal mass is the most common findings that are often been confused with benign diseases such as

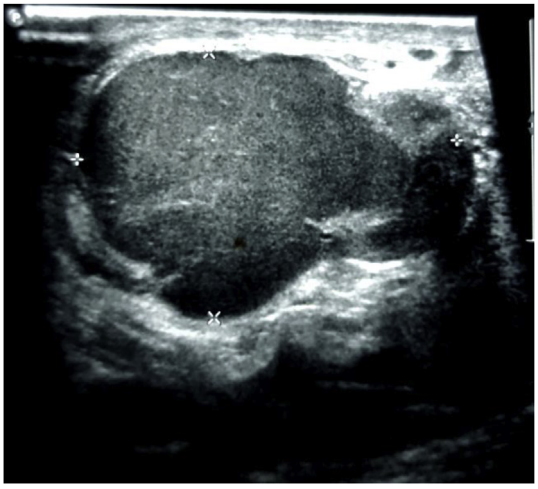

Fig. 1. Scrotal ultra sound showed a solid extra testicular hypoechoic mass, measuring 4 cm, the right testis was normal.

* Corresponding author.
E-mail address: yassine.ayari@fmt.utm.tn (Y. Ayari).

https://doi.org/10.1016/j.eucr.2018.08.011
Received 19 July 2018; Received in revised form 11 August 2018; Accepted 15 August 2018
Available online 22 August 2018

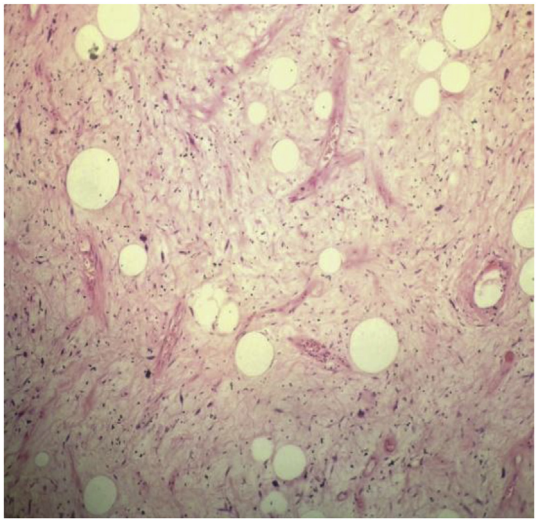

Fig. 2. H and E x 10, showing malignant lipomatous proliferation of cells with prexiform arrangement of capillaries in an abundant myxomatous matrix.

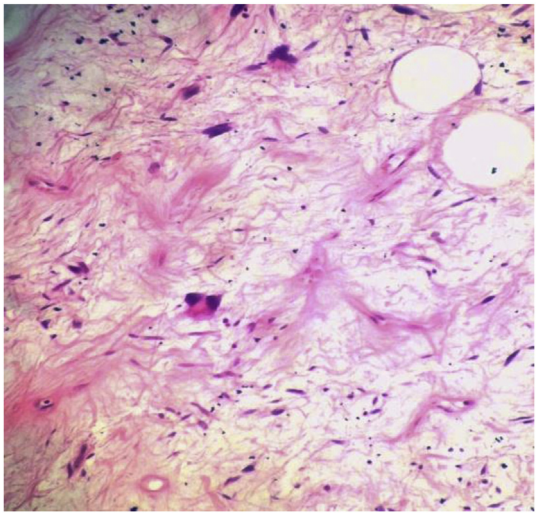

Fig. 3. H and E x 40, atypical cells with hyperchromatic nuclei.

hydroceles, inguinal hernias, germen cell tumors, epididymal tumors, scrotal lipoma, epididymitis, orchitis, epidermoide cyst, lymphoma, lymphedema, and metastases.[1] They are often diagnosed post operatively. Its local recurrence is due to its intermediate malignant behavior, but, it rarely metastasizes to distant organs. Several prognostic factors have been reported that significantly affect the overall survival such as: percent of round cell component, MIB-1Nlabeling index, necrosis, and mitosis and tumor grade.[2] Actually, there is no gold standard management for paratesticular myxoid liposarcoma, but radical orchiectomy with wide local resection of surrounding soft tissues and high ligation of the spermatic cord, offers the best results in the management of this disease[3] and reduces the risk of recurrence that is associated with incomplete excision. The established method of orchiectomy is through an inguinal incision. Retroperitoneal lymph node dissection is not recommended except for metastasis.[4] Due to their relative resistance against chemotherapy, routine adjuvant systemic therapy is not justified in myxoid liposarcoma. Adequate treatment of tumor recurrence often involves wide inguinal re-excision with complete orchiectomy if not performed previously. If complete tumor excision is not feasible, adjuvant radiotherapy apparently reduces the local recurrence rate.[5]

In conclusion, myxoid liposarcoma are often misdiagnosed preoperatively. When diagnosed or highly suspected preoperatively, radical orchiectomy with wide local excision and high ligation is the best treatment strategy, if the margin status is in doubt, adjuvant radiotherapy is recommended. Long-term follow up is recommended due to the risk of local recurrence and distant metastasis.

Appendix A. Supplementary data

Supplementary data related to this article can be found at https://doi.org/10.1016/j.eucr.2018.08.011.

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