

Cervical Lymphnode Relapse Taken for Tuberculosis 15 Years After Treatment of Testicular Seminoma

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Abstract

Case Report

Introduction: In case of adenopathy from cancer of unknown primary it may be very challenging, and integration between medical history and clinical, radiological, and cytological findings become fundamental. We will report the case of a 50-year-old patient treated 15 years ago for a testicular seminoma and who currently presents with isolated cervical lymphadenopathy. **Case Report:** This is a 50-year-old patient treated 15 Years ago for a testicular seminoma who benefited from surgery with adjuvant chemotherapy with complete remission until he presented recently with isolated cervical lymphadenopathy; the patient benefited from a biopsy of the cervical lymphadenopathy and the pathological study suggested a tuberculosis, second reading confirmed germinal origin. **Conclusion:** Late relapses of seminomas in the form of cervical lymphadenopathy although it is a rare possibility but it remains entirely possible which has been confirmed in the literature and through our case; a good histological study with immunohistochemical complement is necessary to confirm the diagnosis.

Keywords: Testicular seminoma, Late relapse, Cervical lymphadenopathy, Germinal origin, Immunohistochemistry.

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INTRODUCTION

Testicular germ cell tumors account for 90% to 95% of testicular cancers. Among these germ cell tumors, three tumor types have high metastatic capacity: seminoma (almost exclusively lymphatic), embryonal carcinoma and choriocarcinoma. In order of frequency, tumor metastases germinal cells are located in the lungs, liver, central nervous system and bone [1]. However, in case of adenopathy from cancer of unknown primary it may be very challenging, and integration between medical history and clinical, radiological, and cytological findings become fundamental. We will report the case of a 50-year-old patient treated 15 years ago for a testicular seminoma and who currently presents with isolated cervical lymphadenopathy.

CASE REPORT

This is a 50-year-old patient treated 15 Years ago for a testicular seminoma who benefited from surgery with adjuvant chemotherapy with complete

remission, good progress until he presented recently with isolated cervical lymphadenopathy without any other associated signs; a biological assessment showing no abnormality, in particular the tumor markers of germ cell tumors, a radiological assessment showed nothing apart from cervical lymphadenopathy suggesting lymph node tuberculosis, the patient benefited from a biopsy of the cervical lymphadenopathy and the pathological study suggested a tuberculosis, the patient started his anti-tuberculosis treatment after a month there was no improvement see an increase in the size of the lymphadenopathy or the thought of making a second reading of the biopsy taken previously and indeed after morphological study we suspected a germinal origin Figure 1 an immunohistological study confirmed the diagnosis after fixation of the PLAP marker Figure 2 a pet scan was done to complete the assessment of extension given the rarity and originality of the case thus showing lymphnodes fixations at the abdominal level; the patient received systemic chemotherapy and the disease regressed dramatically.

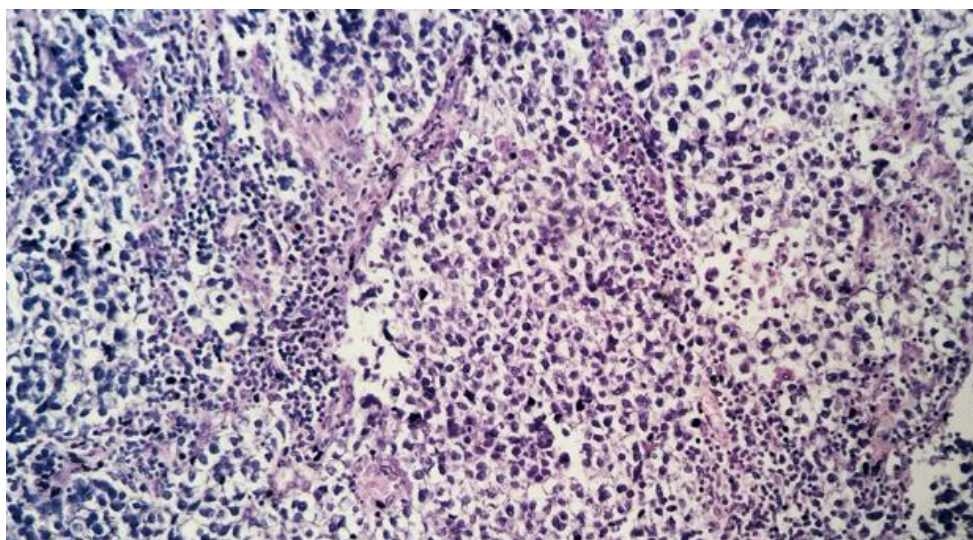


Figure 1: Microphotography demonstrating large cells with clear cytoplasm, distinct borders, squared off nuclei and prominent nucleoli admixed lymphocytes are present. hemateineosin x 200

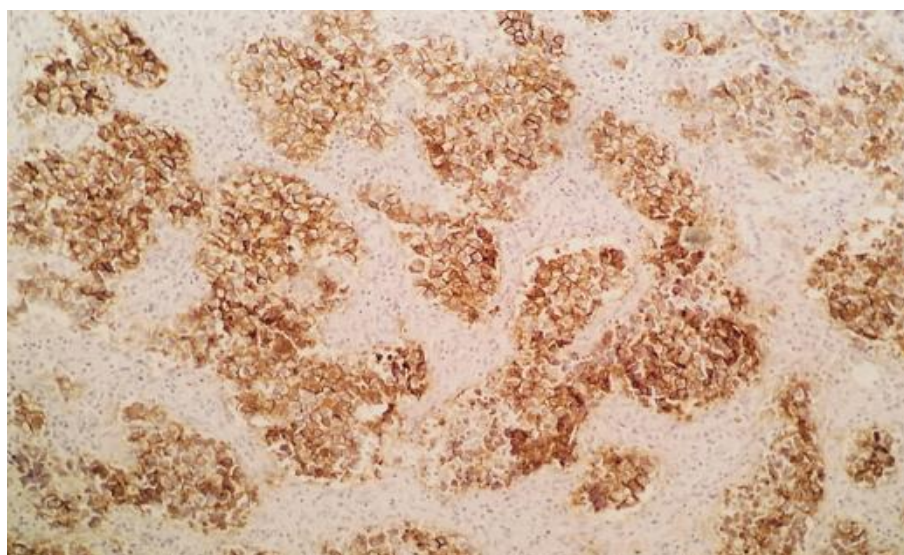


Figure 2: Microphotography showing a positive immunohistochemistry for PLAP 200x

DISCUSSION

In differential diagnosis of neck masses in adults, malignant tumours represent the most common cause, and neck involvement may frequently be the initial or unique clinical manifestation. Work up includes patient's oncologic history, clinical and endoscopic head and neck (H&N) examination, UADT, US with FNAC, contrast enhanced CT and/or magnetic resonance imaging (MRI), and PET. CUP cervical node metastases account for almost 3% of all H&N malignancies [2]. Tonsil and tongue base HPV-related SCC are reported to be the most common primaries responsible for CUP neck metastases [3]. Papillary thyroid carcinoma should also be considered, since it may present level II to IV metastases as primary and/or unique clinical manifestations [2]. Besides H&N cancers, levels IV and V are occasionally affected by metastases from tumours originating below the clavicle, such as breast, lung, gastrointestinal tract, kidney and genitourinary tract

cancers [2, 4]. Remote primary tumours are responsible for about 1% of all cervical node metastases. Breast cancer is the most frequent distant primary, even if only 2.3-4.3% of cases metastasise to the neck [5]. Trans-pectoral, internal mammary, and axillary routes are described as principal lymphatic drainage pathways from breast to low cervical nodes [6]. With low and uneven frequency, neck metastases from uterine, ovarian, prostate and testicular cancers have been reported. Ovarian cancers may determine cervical metastases at initial presentation and during recurrence, but generally after long time, with up to 20 years reported. In males, supraclavicular metastases may occur during progression of a prostate and testicular cancer, or as the first presentation of disease mainly in younger patients [4]. With regards to our case, seminoma is a malignant germ cells tumour that accounts for about 60% of germ cells tumours of the testicle and for 30% of all testicular tumours [7]. Late relapses of seminoma have been described as recurrences more than 2 years after

complete response to initial therapy, in the absence of a contralateral tumour [8]. Sharp reported 75 patients who were affected by late relapse of testicular germ cell tumours, mostly in the retroperitoneum; only 9 presented relapse at more than 15 years after initial treatment, and only 5 cases in the entire sample were seminoma, showing the low prevalence of the disease. FNAC represents the foremost exam for a cervical mass, and immunochemistry helps to confirm clinical suspicion [9]. Differential diagnosis of neck masses should always consider inflammatory, infectious and congenital disorders. Additional tests such as complete blood count, autoantibodies, thyroid and parathyroid function tests, Mantoux test and Bartonella titre may also be useful [10].

CONCLUSION

Late relapses of seminomas in the form of cervical lymphadenopathy although it is a rare possibility but it remains entirely possible which has been confirmed in the literature and through our case and the morality of things is that it must be taken with care the clinical history of patients when there is a history of neoplastic disease even after complete remission and a follow-up of more than a decade by carefully analyzing the biological, radiological and especially histology and the great contribution of immunohistochemistry in order to quickly take care of patients and avoid an erroneous diagnosis which can have harmful consequences for patients.

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