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Case Report

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Giant Paratesticular Liposarcoma: A Case Report

Karthik Vijay, Raghuveer and Shaurav Ghosh*

Ashraya Hospital, Chikkamagalurus, India

ABSTRACT

Less than 200 cases of Paratesticular Liposarcoma, a rare form of paratesticular sarcoma, have been documented in western literature [1-5]. Additionally, there are a few occurrences of Giant paratesticular liposarcomas that are beyond 10 cm in size. Prior to surgery, the condition is frequently wrongly diagnosed [1]. Ineffective management causes both distant metastases and local recurrence. A case of a middle-aged male with a large, painless right scrotal mass is presented in the current study. A heterogenous hypodense lesion was found during imaging examinations in the right scrotum. The current study focuses on the discussion of clinical characteristics, diagnosis, and treatment.

***Corresponding author**

Shaurav Ghosh, Ashraya Hospital,Chikkamagalurus, India. E-mail: shauravghosh@gmail.com

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Case Report

A 47-year-old gentleman presented with a scrotal mass. He Noticed it 7 months back which started as a small mass and progressed rapidly to its present size. On Examination a large right scrotal mass extending up to the right external ring, non-tender, soft to firm in consistency, able to get above the swelling at the external ring, no impulse on cough, not reducible, right testis not felt separately from mass, opposite left testis normal. scrotum showed right inguinal hernia and right testis normal.

Laboratory investigations including testicular tumor markers were normal. As clinical and Scrotal ultrasound findings were not correlating Computed tomography scan (Figure 1) was done which showed a large heterogeneous mass with fat content in Right Hemi scrotum extending up to the external ring, adjacent to the right testis.

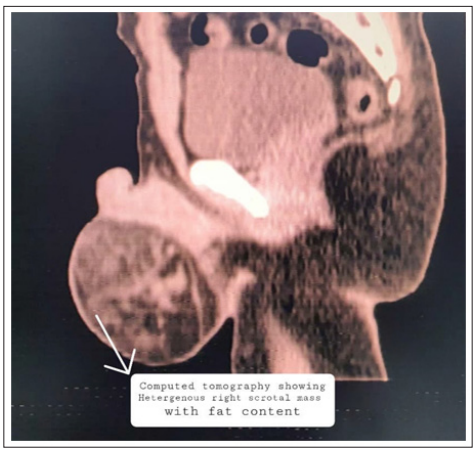

Figure1: Computed tomography scan of the scrotal mass

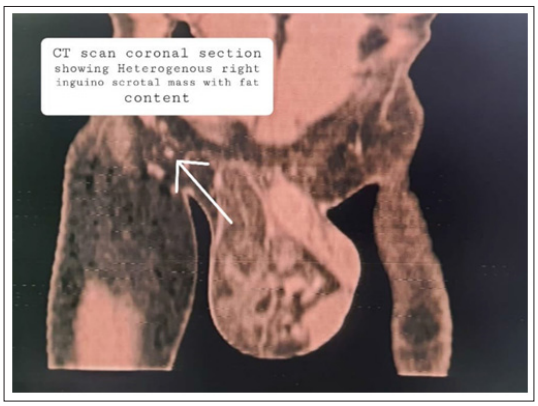

Figure 2: Computed tomography scan coronal section of the scrotal mass

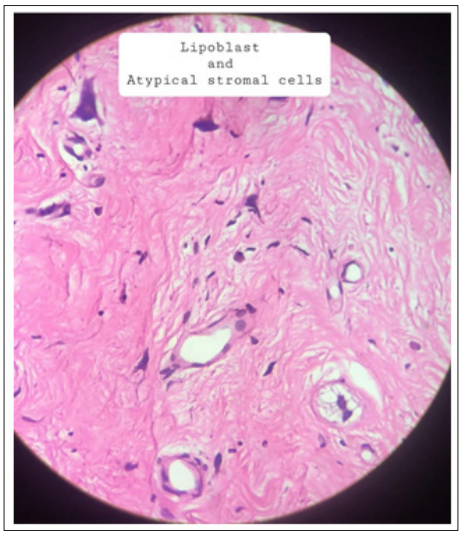

Figure 3: Histology of the mass (High power field) showing Lipoblast and atypical stromal cells

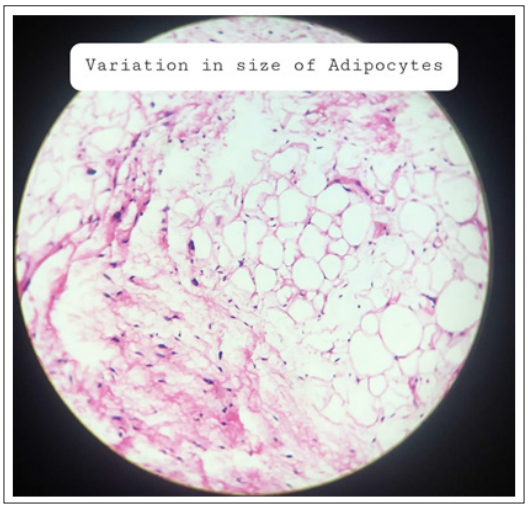

Figure 4: Histology of the mass showing variation in size of adipocytes.

Diagnosis of right paratesticular mass was considered and underwent high inguinal exploration for en-bloc excision of mass and radical orchidectomy.

On gross examination, the tumor was > 15 cms and multi lobulated indicating malignancy. On microscopy there were lipoblasts , atypical spindle cells and variation in size of adipocytes with sclerosis:Hence Well differentiated Liposarcoma (WDLPS) Sclerosing subtype- As sclerosing type occurs more in paratesticular location and Collagenous fibrous tissue with scattered adipocytes and atypical multinucleated stromal cells are seen.The recovery period was uneventful. The patient was discharged on the third post-operative day.

Discussion

Paratesticular liposarcomas (PLS), are mesodermal tumours that originate from adipose tissue and make about 7 to 10% of all intrascrotal tumours. 90% of cases originate from the spermatic cord. There have been a few reports of large PLS [2]. Japan has the highest PLS prevalence. Patients over the age of 50 and 60 were more frequently affected by the tumour [1]. The clinical presentation is typically characterised by a painless, slow-growing inguinal or inguinoscrotal mass that is occasionally accompanied by a feeling of heaviness [3]. Prior to surgical intervention, this clinical appearance is also characterised by the prevalence of erroneous diagnoses such scrotal lipoma, inguinal hernia, and epididymitis [3]. The majority of PLS are primary tumours, however some can metastasize from liposarcoma at other sites, like the thigh or the fatty tissue surrounding the testicles [5]. There aren't enough reliable, standardised recommendations for diagnosis and treatment of PLS patients, hence there isn't much of literature on the subject [4,5]. Ultrasonography (US), Computerized Tomography (CT), and Magnetic Resonance Imaging are used to document the diagnosis of PLS (MRI) [4,5]. Radical orchiectomy combined with high ligation of the spermatic cord at the inguinal ring are the local treatment strategies. Frequent recurrence is linked to incomplete excision [5].

According to studies, negative margins have a 3-year local recurrence free survival rate of 100 percent compared to 29 percent for positive margins. Retroperitoneal lymph node dissection should be limited to patients with only radiologically suspicious lymph nodes. Adjuvant radiotherapy is indicated when the tumour has positive margins or is less than 10 mm in size and is not resectable, because the risk of local recurrence following surgery alone is very high. The prognosis of PLS is determined by the histological cell type. The well-differentiated type has a better prognosis, but a high rate of local recurrence. The role of adjuvant systemic chemotherapy in adults with PLS is unclear due to a lack of cases [3-5].

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Ethics

Informed Consent: Written informed consent was obtained from the patient for the publication of this case report and any accompanying images.

Peer-review: Externally peer-reviewed.

Authorship Contributions

Design: KV, **Data Collection or Processing:** KV, **Analysis or Interpretation:** KV, RV **Literature Review:** SG, **Critical Review:** SG, KV, RV, **Writing:** SG

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