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Letter to Editors about:

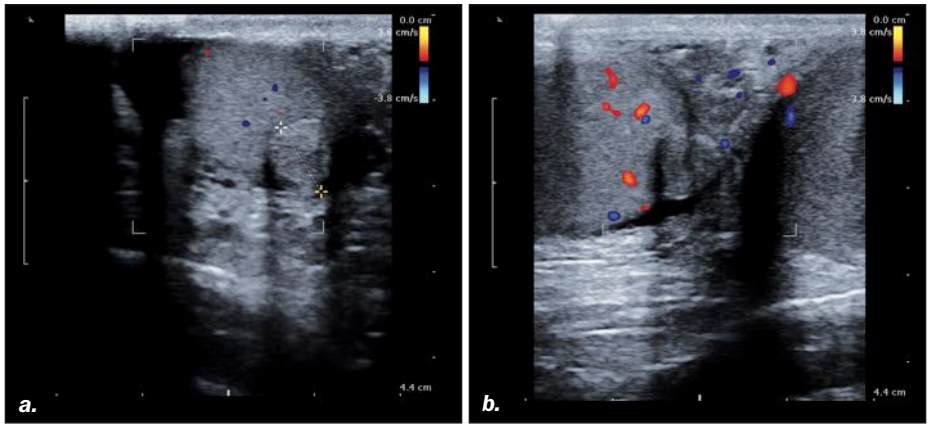
Rare case of intra-testicular adenomatoid tumour

Dear Editors,

We read with interest the article by *Migliorini et al.* (1). The authors reported a case of adenomatoid tumor of the testis with intratesticular growth describing the ultrasound, gross and pathologic characteristics of this entity. They reported only ten cases previously described in scientific literature.

From this publication, at the time of writing, Pub Med research conducted employing a key word "*adenomatoid tumor testis*" revealed two more cases (2) managed with limited testicular excision. We think that this pathological and clinical entity will come increasingly frequent thanks to greater awareness of the problem by clinicians and pathologists because of continuous signals. In December 2013 we managed a similar clinical condition in a 60 years old caucasian patient presented at Emergency Department (ER) complaining a recurrent right testicular pain poorly responsive to simple analgesics. Ultrasound evaluation conducted by radiologist at ER was unremarkable. We performed a scrotal ultrasound assessment again because of presence of a strongly painful small nodular mass on palpation of the right scrotum. The ultrasound revealed a nodular image with well-defined homogeneous limits, homogeneous hyperechoic echostructure and poorly capturing color signal. Lesion diameter was 8,8 mm (Figures 1a-1b).

Figure 1a-b.
Nodular image of the right testis with well-defined homogeneous limits, homogeneous hyperechoic echostructure and poorly capturing color signal. Lesion diameter was 8.8 mm.

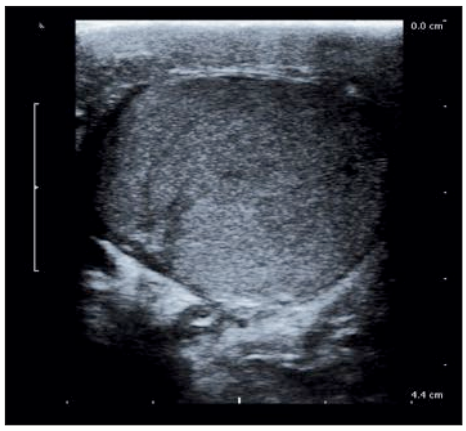


We prescribed a second level analgesic therapy (*tramadol 100 mg*) and the measurement of testicular tumor markers. A week later, the patient came to our attention again for a persisting of pain, poorly responsive to therapy prescribed. Tumor markers was negative. In agreement with the patient, we decided to perform a right testicular inguinal exploration.

The surgery was performed under spinal anesthesia.

The operation confirmed the presence of a solid capsulated nodular lesion of right testicular lower pole. We proceeded with enucleation of the nodule that was sent to the Pathologic Department for frozen section examination (FSE). The pathologist, taking into consideration the clinical information and the ultrasonographic appearance, suggested the benign nature of the lesion. Resection margins was free. The size of the lump and the absence of border infiltration addressed towards a testis sparing surgery (TSS). Surgical defect was sutured and the testicle was placed back into the scrotum. Definitive histological examination deposed for adenomatoid testis tumor. The painful symptoms declined. The patient was discharged in the second post operative day and three week later we performed an ultrasound control (Figure 2). With respect to the case reported by *Migliorini et al.*, there are several differences. First of all, patient's age was in our case higher than age reported in most of the recent report. In literature, the patients with an adenomatoid scrotal lesion ranged between 18 and 79 years (3). The sonographic appearance was hyperechoic and homogeneous, as previously experienced by one of the writers (AF) (4) and so as described in the literature. Although they may also be hypoechoic (5). Last, the surgical management in our case consisted in a TSS. We would argue as well as in the specific case reported by *Migliorini et al.*, it could be possible a conservative management, regardless of the ability of the pathologist to provide a diagnosis of malignancy in FSE, considering that the nodule dimensions was less than 1 cm and that the deferred surgical radical treatment did not compromise the oncological control of the disease (6).

Figure 2.
Ultrasound control after three weeks from testicular sparing surgery.



We think that the information provided to the pathologist about the sonographic appearance of the lesion, clinical presentation and the negativity of cancer markers are almost certainly aimed at the benignity of the diagnosis. The case described by *Migliorini et al.* and our experience must warn the urologists involved in the andrological field regarding the possibility of coming across this type of diagnosis. It required close clinical collaboration with the pathologist so as to minimize the invasiveness of surgical therapy to avoid a surgical overtreatment.

No conflict of interest declared.

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