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<td>Author(s)</td>
<td>Saha, Pabitra Kumar; Sakai, Hideki; Nomata, Koichiro; Minami, Yuzo; Kanetake, Hiroshi; Saito, Yutaka</td>
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<tr>
<td>Citation</td>
<td>泌尿器科紀要 (1991), 37(9): 1061-1064</td>
</tr>
<tr>
<td>Issue Date</td>
<td>1991-09</td>
</tr>
<tr>
<td>URL</td>
<td><a href="http://hdl.handle.net/2433/117276">http://hdl.handle.net/2433/117276</a></td>
</tr>
<tr>
<td>Type</td>
<td>Departmental Bulletin Paper</td>
</tr>
<tr>
<td>Textversion</td>
<td>publisher</td>
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Kyoto University
MALIGNANT LYMPHOMA OF THE TESTIS
PRESENTING AS PRIMARY TESTICULAR TUMOR

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A case of malignant lymphoma of the testis is presented. A 49-year-old male presented with swelling and dull pain of his left scrotal content. The initial clinical diagnosis was left testicular tumor. Left high orchiectomy was performed immediately after admission and histopathology showed malignant lymphoma, large cell type, B-cell type according to the Lymphoma Study Group (LSG) classification. Extensive investigations revealed clinical stage IE, with no evidence of metastasis. Chemotherapy was initiated with vincristine, prednisolone, adriamycin and methotrexate (VEPA-M). After therapy, the patient is doing well without any evidence of metastasis.

Key words: Malignant lymphoma, Testis, Chemotherapy

INTRODUCTION

Malignant lymphoma of the testis was first described by Malassez in 1877. The disease is relatively rare in younger men but it commonly affects elderly men and accounts for 25 to 50% of the testicular neoplasms among men more than 50 years old. A review of the Japanese literature revealed a total of 178 cases of primary malignant lymphoma of the testis reported until 1990. Histopathologically, malignant lymphoma of the testis has been reported to be comprised exclusively of non-Hodgkin's lymphoma, Immunological and immunohistological studies showed that extragonadal non-Hodgkin’s lymphoma was mostly of B-cell tumor type, especially in western countries. However, the incidence of T-cell lymphoma has been found to be more common in Japan than in western countries. Doxorubicin containing combination chemotherapy regimens are well-established chemotherapy treatments for advanced non-Hodgkin's lymphoma. In this case, the initial diagnosis was testicular tumor but histopathology showed malignant lymphoma and it responded well to combination chemotherapy (VEPA-M).

CASE REPORT

The patient first noticed dull pain and swelling of his left scrotal contents on 14th January, 1990. He visited a local hospital where the diagnosis of testicular tumor was made and the patient was referred to our department for further evaluation and treatment. On admission to our department, we found enlargement of the left testis (size: 7.0 x 5.0 x 5.5 cm) and there was slight tenderness. The consistency was hard, there was no skin adhesion and the skin colour was also normal. The epididymis, spermatic cord and the state of local lymph nodes all were normal. Ultrasonography of the scrotum showed a heterogeneous area (Fig. 1) in the left testis, However, the right testis was normal. No abnormalities were found on the chest X-ray, routine blood and other biochemical examinations. Thus, with the provisional diagnosis of left testicular tumor, left high orchiectomy was performed. The size of the resected tumor was 5.7 x 3.8 x 3.7 cm and the weight was 79.4 g. Fig. 2 shows the cut section of the tumor. Macroscopically, the tumor was homogenous and grayish white in appearance. The histological finding was malignant lymphoma (Fig. 3). Immuno-
histological examination revealed diffuse, large cell type, B-cell type and immunophenotyping revealed LCA (+), Pan B (-), S-100 (-), Vimentin (-), Desmin (-) (Fig. not shown). Markers for testicular tumor and LDH isoenzymes were measured, but showed no abnormalities.

To make a clinical staging, extensive investigations were performed, such as drip infusion pyelography, computed tomography, magnetic resonance imaging, Ga-scintigraphy, bone scan and lymphangiography, but no evidence of metastasis was found. Our final diagnosis was malignant lymphoma, stage IE.

After orchiectomy, the patient was treated with combination chemotherapy (one course) which is shown in Table 2. We have followed the patient for about 8 months and until now the patient is doing well without any evidence of local recurrence or systemic manifestation of malignant lymphoma.

DISCUSSION

Preoperative diagnosis of primary malignant lymphoma of the testis is difficult. Testicular lymphoma is frequently confused with seminoma and less often, as embryonal carcinoma. Other diseases that may be confused with testicular lymphoma include, granulomatous orchitis, pseudolymphoma and rhabdomyosarcoma. A final and definitive diagnosis is possible in almost all the cases by histopathological examination after operation. Tests using monoclonal antibodies that react selectively with non-Hodgkin's lymphoma but not with any other nonlymphoid neoplasms are now easily performed on routine paraffin sections to differentiate the disease. In this case also, the initial clinical diagnosis was testicular tumor but after orchiectomy the histopathological diagnosis was malignant lym-
phoma, diffuse, large cell type, B-cell type. Although cases of complete remission have been reported treatment of testicular lymphoma is still difficult. Surgery, radiotherapy and radiation plus chemotherapy have been used to treat stages I and II testicular lymphoma. In some cases, stage I testicular lymphoma has been treated by surgery alone, while in others it has been treated with orchectomy plus radiotherapy. However, due to the high incidence of relapse and frequent involvement of extragonadal sites such as, skin, bone, CNS, liver, lungs and Waldeyer's ring aggressive therapy like systemic chemotherapy is recommended even in early stage disease.

Previous experience showed that in most of the cases, recurrence occurred within one to two years of diagnosis of testicular lymphoma and 88% of the deaths occurred with in the first two years. Other observations suggest a chance for long-term survival and cure in patients with testicular lymphoma who are in complete remission and have been disease-free for two years or longer. However, recent clinical experience using new chemotherapeutic regimens suggested that chemotherapy alone or chemotherapy plus radiotherapy could provide an 85% survival rate free of disease. Roche et al. applied 3 courses of combination chemotherapy (cyclophosphamide, vincristine, doxorubicin, bleomycin and prednisone) and radiotherapy (30 Gy of limited field radiotherapy) to 10 patients and found only 10% recurrence at 30 months. In our case, although we did not find any evidence of local or distant metastasis (stage IE) by extensive investigation, we adopted systemic combination chemotherapy (Table 1) to prevent possible further recurrence. The followup period of this case was only 8 months, and not long enough to predict the final outcome of our treatment.

ACKNOWLEDGEMENT

The authors thank Associate Professor Nobuo Tsuda of Central Diagnostic Laboratory (Pathology Division), Nagasaki University Hospital for his help in the study of light microscopy and immunohistology.

REFERENCES


Table 1. Combination chemotherapy schedule

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<tr>
<th>VEPAM</th>
<th>Day 1</th>
<th>Day 8</th>
<th>Day 15</th>
<th>Day 22</th>
<th>Day 29</th>
<th>Day 36</th>
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<tr>
<td>Vincristine 1 mg/m² (iv)</td>
<td>↓</td>
<td>↓</td>
<td>↓</td>
<td>↓</td>
<td>↓</td>
<td>↓</td>
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<tr>
<td>Cyclophosphamide 350 mg/m² (drip iv)</td>
<td>↓</td>
<td>↓</td>
<td>↓</td>
<td>↓</td>
<td>↓</td>
<td>↓</td>
</tr>
<tr>
<td>Prednisolone 40 mg/m²/day (oral)</td>
<td>↓ →5 days</td>
<td>↓ →5 days</td>
<td>↓</td>
<td>↓</td>
<td>↓</td>
<td>↓</td>
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<tr>
<td>Adriamycin 40 mg/m² (iv)</td>
<td>↓</td>
<td>↓</td>
<td>↓</td>
<td>↓</td>
<td>↓</td>
<td>↓</td>
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<tr>
<td>Methotrexate 400 mg/m² (drip iv)</td>
<td>↓</td>
<td>↓</td>
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Received on October 15, 1990
Accepted on January 29, 1991

和文抄録

精巣悪性リンパ腫の1例

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南 祐三, 金武洋, 斉藤 泰

今回われわれは精巣悪性リンパ腫の1例を経験したので報告する。症例は49歳。男性で左陰嚢内容の腫脹および疼痛を主訴に当科初診。左精巣腫瘍の診断にて入院後、左高位精巣摘除術を行った。摘出標本の病理はL.S.G. 分類上 diffuse type, large cell type, B-cell type であり臨床病期はIE期であった。術後ビンクリスチン、サイクロフォスファマイド、プレドニゾロン、アドリアマイシン、メソトレキセートを併用した化学療法を1コース行ったのも退院し、現在外来にて経過観察中である。

（泌尿紀要 37: 1061-1064, 1991）