CASE REPORT

Unusual presentation of a scrotal tumour

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Accepted 16 April 2014

SUMMARY

A 59-year-old man had a wide excision of the right-sided scrotal cancer in the neck of the scrotum. On dissection it became apparent that the tumour had developed a blood supply from the right spermatic cord. Histology revealed G2T2 squamous cell carcinoma. A biopsy from an abnormal skin area from the opposite groin reported chronic folliculitis. He underwent an ultrasound scanning of the groin and fine-needle aspiration, which did not show any suspicious features. Follow-up CT of the abdomen and pelvis after 6 weeks did not show any evidence of intra-abdominal lymphadenopathy. Another CT has been arranged within the next 3 months to confirm that the spread of the tumour does not follow the pattern of a testicular tumour.

BACKGROUND

Lymphatic drainage of the testes follows the testicular arteries back to the para-aortic lymph nodes, while lymph from the scrotum drains into the inguinal lymph nodes. The patient's scrotal tumour had a clear blood supply from the testis, which is unusual. This patient needs to follow-up in future as he may present with a nodal metastasis to the para-aortic lymph nodes.

CASE PRESENTATION

The patient presented with a scrotal lesion on the right side with a diagnosis of well-differentiated squamous cell carcinoma (SCC) on biopsy

Figure 1 Presenting lesion.

Figure 2 Blood supply from testis.

(figures 1–3). This has been troubling him for at least 15 years, which could be a potential risk for cancer and sometimes resulted in abscess formation, which is increasing in size now and causing irritation. He has a history of hypertension, hypercholesterolaemia and gastritis for which he takes bisoprolol, statin and omeprazole. He is also known to carry sickle cell trait. He smokes 20 cigarettes a day, drinks socially and has no known allergies. On examination he had a 2 cm raised mobile ulcer at the junction of the scrotum and groin on the right. The underlying spermatic cord did not appear to be attached and his genitalia were otherwise normal with no palpable inguinal nodes.

INVESTIGATIONS

- ▶ Ultrasound scanning (USS) of the groin and fine-needle aspiration (FNA)—negative for cancer (figure 4).
- ▶ CT of the abdomen and pelvis—normal para-aortic nodes (figures 5 and 6).
- ▶ Chest X-ray—normal.

Figure 3 Clear blood supply from testis.

To cite: Sarkar D, Parr NJ.
BMJ Case Rep Published
online: [please include Day
Month Year] doi:10.1136/
bcr-2014-204476

Figure 4 Groin ultrasound scanning—normal.

TREATMENT

Wide excision of scrotal tumour.

OUTCOME AND FOLLOW-UP

Histology revealed G2T2 SCC. A biopsy from an abnormal skin area from the opposite groin reported chronic folliculitis. The patient underwent USS of the groin and FNA which did not show any suspicious features. Follow-up CT of the abdomen and pelvis after 6 weeks did not show any evidence of

Figure 5 CT of the abdomen and pelvis—normal para-aortic nodes.

Figure 6 CT of the abdomen and pelvis—normal groin nodes.

intra-abdominal lymphadenopathy. Another CT has been arranged in the next 3 months to confirm that the spread of the tumour does not follow the pattern of a testicular tumour. He is awaiting another follow-up in 3 months time.

DISCUSSION

Scrotal malignant tumours mainly fall into two categories: (1) basal cell carcinoma (scrotal ulcerated lesions) and (2) SCC (a papule or plaque that enlarges and ulcerates in older men) associated with occupational exposures (textile mills and metalworking) and PUVA therapy. Metastatic spread of scrotal tumour with unknown primary has been reported in the literature, but this scrotal tumour had blood supply from the testis and such a case has not been reported in the literature till now.

Learning points

- Need to follow the patient to avoid future risk of developing testicular cancer.
- It is possible that a scrotal tumour can be fed by a testicular vessel.
- Follow-up should be with CT of the abdomen and pelvis to check para-aortic nodes.

Acknowledgements The author wishes to thank Mr NJ Parr, Consultant Urologist, Arrowe Park Hospital Upton, Wirral, UK.

Competing interests None.

Patient consent Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

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