Ruptured Retroperitoneal Node Presenting as Hemoperitoneum—An Unusual Presentation of testicular tumour

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Abstract Herewith we are reporting an unusual presentation of testicular tumour. The patient is a 37 years old gentleman diagnosed with Stage III seminoma post orchidectomy on chemotherapy and had spontaneous rupture of retroperitoneal nodal mass and presented with hemoperitoneum and hypovolemic shock. He was successfully salvaged by aggressive resuscitation, emergency laparotomy and resection of ruptured nodal mass and is presently disease free. This article is aimed at highlighting this unusual presentation and complication of advanced testicular tumour and the need for aggressive surgery even in the so called hopeless situations. The need for multidisciplinary care in the cure of advanced testicular care is once again reemphasized

Keywords Chemotherapy · Testicular tumour · Retroperitoneal node · Hemoperitoneum · Laparotomy · Multidisciplinary care

Case Report

A 37 year old gentleman with a previous history of left orchidectomy for a left sided swelling in the scrotum 1 year before elsewhere presented to our hospital with complaints of pain abdomen of 6 months and mass palpable per abdomen of 2 months duration. Clinically, he was found to have a large retroperitoneal mass with normal serum AFP, HCG raised serum LDH of 1058 U/lit. CECT revealed heterogenous retroperitoneal nodal mass encasing IVC, Aorta, left ureter with left hydroureteronephrosis, mesenteric fat stranding and ascitis (Fig. 1). Chest X ray and CT chest was normal. He received 3 cycles of chemotherapy with Etoposide and Cisplatin. He was due for the 4th cycle when he presented with sudden onset shock. He was aggressively resuscitated and on evaluation was found to have hemoperitoneum. He was taken up for Laparotomy which revealed 4 l of hemoperitoneum with extensive clots with a 15×12 cm ruptured para aortic nodal mass with active bleeding and insignificant small intraaortocaval and pre-aortic nodes (Fig. 2). Bleeding from the nodal mass could not be arrested as the node was necrotic. The nodal mass was excised by carefully dissecting it off the Inferior Venacava and Aorta preserving the superior and inferior mesenteric vessels. He had an uneventful post operative recovery. Histopathology revealed only necrosis with no evidence of residual tumour. He completed one more cycle of EP chemotherapy and now he is on follow up and disease free for 5 months now (Fig. 3 CECT at follow up. Note : markers at follow up—normal).

Discussion

Haemoperitoneum is an unusual complication of malignant disease. Most reported cases involve liver

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Fig. 1 CECT prior to chemotherapy showing the large retroperitoneal nodal mass encasing the major vessels

carcinoma, either primary or secondary. The acute necrosis of tumour during antineoplastic chemotherapy can occur during the treatment of highly proliferating tumours. Haemorrhage from testicular cancer metastases is not surprising, as choriocarcinoma is pathologically described as ‘vascular cataclysm’ or ‘haemorrhagic disintegration’. This complication has not been reported in large trials of chemotherapy for

testicular cancer [1]. Late recurrences presenting as retroperitoneal hemorrhage have been reported [2]. Metastases to the gastrointestinal tract occur in 5 % of all patients and may cause bleeding. The duodenum and small bowel are involved most often, followed by the colon, stomach and oesophagus. Gastrointestinal disturbances, e.g. anorexia, nausea or vomiting, may be caused by a retroperitoneal tumour compressing and displacing the duodenum. Gastrointestinal haemorrhage is uncommon and may occur secondary either to haematogenous spread to the gastrointestinal tract or to direct invasion of the duodenal wall by the adjacent metastatic retroperitoneal lymph nodes and bleeding tumoral vessels [3]. Spontaneous hemoperitoneum secondary to rupture of metastatic foci of testicular germ cell tumor is a rare finding and is usually precipitated by the beginning of chemotherapy treatments [4]. This case report is essentially targeted at the nihilism attached to advanced testicular tumours presenting as emergency and the need for aggressive multidisciplinary care in necessitating cure. Surgery should be offered in such cases often deemed as hopeless too due to the improved cure rates and salvage chemotherapy

Fig. 2 Laparotomy at the time of hemoperitoneum revealing the necrotic large para aortic nodal mass

Fig. 3 CECT at follow up shows no residual/recurrent retroperitoneal nodes

regimens available for these chemotherapy responsive tumours especially in young men.

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