Haemangioma of the testis mimicking testicular malignancy in an adolescent

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Most testicular neoplasm in children and young adults are malignant tumors of germ cell origin (1). Benign tumors including hemangiomas are extremely rare (2).
Haemangioma of the testis is a very rare benign vascular neoplasm, mostly occurring in infant and young adults (2,3). Since 2000, there are only 38 reported testicular haemangioma cases in the literature.
Clinical appearance and diagnostic exams are usually not specific and sufficient for the diagnosis. Moreover, serum tumor markers (α-feto protein, β human chorionic gonadotropin) are usually within normal limits (1,4). Definite diagnosis requires histopathological confirmation (2). Although it is a rare tumor, that is the reason that the diagnosis is usually established only after the inguinal orchidectomy, surgeons and pathologists should be aware of it especially with the negative tumor marker findings. It should be considered in the case of young patient and/or solitary testicle, with normal tumor markers and hyperechoic lesion with increased vascularity. Intra-operative frozen section examination may be requested as tumor enucleation with testicular sparing surgery is considered adequate.
We report a case of testicular hemangiomain a 16-year-old man who presented with testicular painless masss.

Case Report
A 16-year-old man with unremarkable past history presented with a rapidly enlarging painless mass in the left testicle of 2 months duration. The patient denied any history of trauma, insect bites, or recent fevers. He had been in good health with no active or previous medical issues.

Physical examination revealed an elastic palpable mass inside the left testicle that was painless to touch. The right testicle and spermatic cord structures were unremarkable. No visible skin lesions were found in the genital or inguinal regions. No regional lymphadenopathy was present. No other pathological condition was identified. Other than age there were no risk factors for testicular cancer.
All **laboratory findings** were within the normal limits, as well as the testicular tumor markers (lactate dehydrogenase, α-feto protein and β human chorionic gonadotropin).
Scrotal ultrasonography revealed 25x20 mm hyperechoic spherical lesion surrounded with normal testicular tissue. Color Doppler ultrasonography showed increased peripheral vascularity around the lesion, but without increased signal inside the lesion. He was diagnosed with a left testicular tumor based on the physical examination and ultrasonography study.
CTScan revealed the absence of dissemination in the retroperitoneum and the lungs.
Considering the lesion to be most probably seminoma, left inguinal radical orchidectomy was performed. There was no attempt for surgical exploration neither for conservative surgery, in the presence of normal contralateral testis.

Pathologic examination of the orchidectomy specimen revealed a solitary intratesticular hemorrhagic nodule measuring 15 mm in diameter.
Histopathological examination showed a cavernous hemangioma composed of irregular dilated vascular spaces. These structures were lined by flat endothelial cells and containing red blood cells (Figure 1). The adjacent parenchyma presented ischemic and atrophic lesions (Figure 2). Necrosis and mitotic activity are absent.

Figure 1: Hematoxylin and Eosin stain showing vascular proliferation with cavernous spaces lined by flat endothelial cells and containing red blood cells (Original magnification ×100).

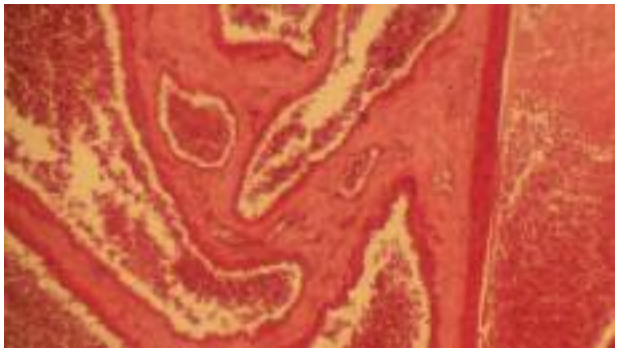
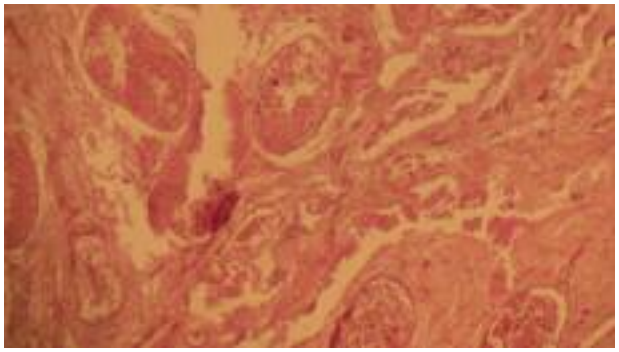


Figure 2 : Adjacent testis parenchyma atrophia (Original magnification ×100).



Immunohistochemical staining showed a positivity for the vascular markers (CD31, CD34, factor VIII) and for the vimentin epithelial markers (cytokeratin, epithelial membrane antigen) were negative.
On the basis of the characteristic morphologic and immunohistochemical findings, the diagnosis of intratesticular cavernous hemengioma was established. At the last follow-up, 6 months after the operation, the patient was well without any clinical evidence of recurrence.

Conclusion
Hemangioma of the testis is a very rare benign tumor. Clinical appearance and diagnostic exams are usually not sufficient for the definite diagnosis and requires a histopathological examination. However if the surgeons and pathologists are aware of it; especially with negative tumor marker findings, conservative surgical treatment with preservation of the testis may be considered.

References

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La gastrite lymphocytaire : caractéristiques cliniques, endoscopiques et anatomopathologiques

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La gastrite lymphocytaire est une entité anatomoclinique rare, représentant moins de 5 % des gastrites chroniques, individualisée par Haot en 1985 et qui demeure d'étiopathogénie indéterminée [1, 2, 3]. Elle se caractérise endoscopiquement par une gastrite varioliforme et histologiquement par l'augmentation du nombre de lymphocytres intra-épithéliaux au sein du revêtement de surface [4,5].
Nous rapportons cinq observations de gastrite lymphocytaire découvertes d'une part dans le cadre de l'exploration d'une anémie ferriprive et d'autre part dans un contexte de diarrhée chronique.

Observations
Nos observations concernaient des patientes âgées de 15 à 50 ans, sans antécédents pathologiques notables, ayant consulté pour l'exploration d'une anémie ferriprive associée dans 4 cas à des épigastralgies et dans un cas à une diarrhée chronique évoluant depuis 6 mois. L'endoscopie digestive montrait dans trois cas une gastropathie congestive et micronodulaire, « varioliforme », avec un aspect craquelé du duodénum. Dans 2 cas, la muqueuse gastrique présentait un aspect en fond d'œil avec une diminution de la hauteur des plis et une hypervisualisation de la vascularisation, sans atteinte duodénale associée. L'examen anatomopathologique des biopsies gastriques montrait chez toutes nos patientes une désorganisation architecturale de la muqueuse gastrique avec des cryptes allongées, tortueuses, pseudovilleuses, à fonds dédifférenciés, et une légère diminution du volume glandulaire. Le chorion était le siège d'un infiltrat inflammatoire à prédominance lymphocytaire épars ou en amas s'associant en surface à une nette augmentation du nombre de lymphocytes intraépithéliaux allant de 30 à 100 lymphocytes /100 cellules épithéliales se disposant en bande intraépithéliale, sans dépôt collagénique sous membranaire associé. Les lymphocytes intra-épithéliaux présentaient des noyaux denses parfois irréguliers entourés d'un halo clair avec un profil phénotypique T cytotoxiques CD3+/CD8+ (Figure 1+2). L'infiltrat inflammatoire du chorion intercryptique et interglandulaire d'aspect polymorphe comportait essentiellement des lymphocytes T helper (CD3+/CD4+).

Figure 1 : Infiltration du revêtement de surface par des lymphocytes entourés d'un halo clair (H&Ex400)

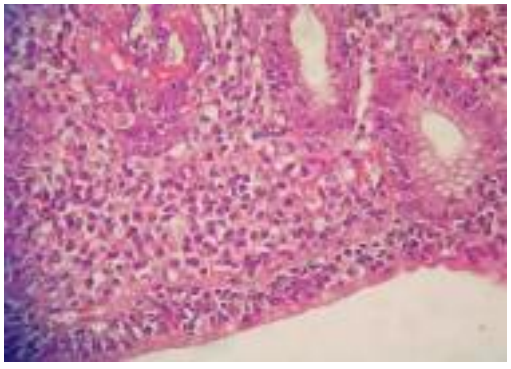

Figure 2 : Les lymphocytes intraépithéliaux sont majoritairement CD8 positifs (IHCx400)