

Malignant fibrous histiocytoma of the spermatic cord

A case report

J. P. BOTMA, M. L. S. DE KOCK, W. M. L. LAUBSCHER

Summary

A case of malignant fibrous histiocytoma of the spermatic cord treated by primary local excision, followed 5 days later by radical inguinal orchidectomy and hemi-scrotectomy is reported. At 30 months' follow-up the patient is free from local recurrence.

S Afr Med J 1987; 71: 326.

Although malignant fibrous histiocytoma (MFH) is the most common soft tissue sarcoma of late adult life,¹ only 11 cases involving the spermatic cord have been reported.²⁻³

Case report

A 57-year-old white man presented at a peripheral hospital after having fallen astride a beam and sustained an injury to his right testis. Although the scrotum was painful, swollen and discoloured, the patient did not seek medical advice and his symptoms subsided within 1 week. About 6 months later he noted a 'third testis' and decided to consult a physician. On examination a mass 2 x 3 cm was found superior to the right testis. The mass was non-tender, rubbery, well circumscribed and mobile. No inguinal glands were palpable and the rest of the physical examination was unremarkable. A chest radiograph, full blood count and urea and electrolyte measurements were within normal limits.

A trans-scrotal exploration was performed and a mass 3 cm in diameter, distinct from the right testis, but attached to the spermatic cord, was removed. Histological examination revealed a

fairly well-circumscribed fibroblastic mass with varying cellularity. There were areas of less differentiated spindle cells with mitotic activity and among these were large cells of various shapes and sizes showing marked anaplasia. Atypical mitoses were present. The better-differentiated areas displayed a storiform pattern consistent with MFH.

The patient was transferred to this hospital and 5 days after the initial procedure, a radical inguinal orchidectomy and hemiscrotectomy were performed. Histological examination showed no residual tumour.

At 30 months' follow-up no local recurrence could be detected on clinical examination.

Discussion

The correct treatment of MFH of the spermatic cord has not been defined because of the limited experience with this tumour. Radical orchidectomy has been suggested, with wide local resection and radio- and chemotherapy for local recurrences.⁴ The average survival reported in the literature is 25 months.³

Recently, however, Sclama *et al.*³ reviewed MFH of the spermatic cord, and reported 2 cases of their own treated with radical inguinal orchidectomy and retroperitoneal lymph node dissection (RPLND); this was negative in both cases. One of their patients is free of disease after 5 years, while the other had a retroperitoneal recurrence 6 years after RPLND.

Commenting on Sclama *et al.*,³ Malek raises the question whether stage IA tumours (well encapsulated with no microscopic invasion of adjacent structures) require RPLND. RPLND should be reserved for stage IB tumours (non-metastatic with local invasion) as proposed by Sclama *et al.*³

REFERENCES

1. Weiss SW, Enzinger FM. Malignant fibrous histiocytoma: an analysis of 200 cases. *Cancer* 1978; 41: 2250-2266.
2. Smailowitz Z, Kanett J, Sober I, Kruglial L, Sacks M. Malignant fibrous histiocytoma of the spermatic cord. *J Urol* 1983; 130: 150-151.
3. Sclama OA, Berger BW, Cherry JM, Young JD jun. Malignant fibrous histiocytoma of the spermatic cord: the role of retroperitoneal lymphadenectomy in management. *J Urol* 1983; 130: 577-579.
4. Williamson JC, Johnson JD, Lamm DL, Tio F. Malignant fibrous histiocytoma of the spermatic cord. *J Urol* 1980; 123: 785-788.

Department of Urology, University of Stellenbosch and Tygerberg Hospital, Parowvallei, CP

J. P. BOTMA, B.A., B.S.C. (PHARM.), M.B. CH.B., M.MED. (UROL.)

M. L. S. DE KOCK, M.B. CH.B., M.MED. (UROL.)

W. M. L. LAUBSCHER, M.B. CH.B., F.R.C.S.