Testicular mass in a resting cell

Q1: What does the ultrasound scan show?

The ultrasound scan shows bilateral hypoechoic intratesticular masses. The margins are well defined and the lesions are in close proximity to the rete testis (mediastinum testis).

Q2: Given the patient’s history, what is the diagnosis?

The diagnosis is bilateral adrenal rest tumours or testicular tumours of adrenogenital syndrome.

Q3: Describe the pathophysiology of these lesions?

An adrenal cortical cell rest, an interstitial cell, and a pleuripotent cell have all been suggested as the origin of testicular masses in congenital adrenogenital syndrome. Embryologically the development of the adrenal gland and the genital ridge occurs in close proximity. Adrenal cell rests are therefore known to occur in the spermatic cord, testis, broad ligament, and the ovary.

The normal pathway of synthesis of the steroids hormones is shown in fig 1. The commonest defect in adrenogenital syndrome or congenital adrenal hyperplasia is complete or partial deficiency of 21-hydroxylase followed by a deficiency of 11-β-hydroxylase. The enzyme 21-hydroxylase is crucial to the synthesis of both cortisol and aldosterone. A lack of this enzyme leads to excess synthesis of adrenal androgens and also stimulation of secretion of adrenocorticotropic hormone (ACTH). This ACTH in turn acts on the adrenal tissue, including the ectopic adrenal cell rests leading to hyperplasia and formation of testicular masses in male patients. Hyperplasia of testicular adrenal rest cells is also known to occur in patients with Nelson’s syndrome who have undergone adrenalectomy of the native glands.

Histologically the smaller lesions are located at the hilus in 86% as shown by Rutgers et al. The larger lesions are more commonly situated in the testicular parenchyma. They tend to be well demarcated, unencapsulated brown masses separated into lobules by bands of fibrous tissue. Microscopically the most important differentiating feature from a Leydig cell tumour is the absence of renke crystals. Clinically adrenogenital syndrome exists in three forms—that is, prenatal virilisation or congenital adrenal hyperplasia (21-hydroxylase deficiency).

Q4: What is the role of imaging in the management of these lesions?

The presence of testicular tumours in congenital adrenal hyperplasia is well known but their diagnosis and management have always been a dilemma because of the inability to accurately diagnose the benign nature of the tumours. With advances in imaging techniques it is now possible to more accurately categorise the lesions, though the differential diagnosis is difficult. However a study by Stikkelbroeck et al showed no significant correlation of the tumour size to the hormone replacement regimens or under treatment of these patients.

Hormonal replacement as they are known to reduce in size with treatment. However they can be unresponsive to steroid treatment and may also gain autonomy. Imaging can prove useful in assessing unresponsiveness provided the patient is compliant to medication. In such circumstances resection of the tumour with tests sparing surgery is advocated in order to retain fertility. Post-operative MRI and ultrasound can be used for evidence of recurrent disease.

Final diagnosis

Bilateral adrenal rest tumours or testicular tumours of adrenogenital syndrome.

References


Figure 1 Pathway of steroid hormone synthesis.  

Figure 2 T2 weighted MRI scan of both testis showing isointense masses.

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Pathological fracture in a pregnant woman

Q1: What is the differential diagnosis based on the history and the MRI (giant cell tumour, brown tumour, chondrosarcoma, secondaries in the bone)?

The differential diagnosis is giant cell tumour and brown tumour. A lytic lesion in a young woman with an associated pathological fracture and soft tissue mass raises several possibilities—for example, giant cell tumour, eosinophilic granuloma, brown tumour, or a primary bone tumour. Brown tumours are focal bone lesions caused by an increased osteoclastic activity and fibroblastic proliferation within primary hyperparathyroidism (PHP) or more rarely secondary hyperparathyroidism. They are named after their typical brown haemorrhagic stroma with, also typical, giant cell formations. A brown tumour should always be ruled out in such a clinical situation by serum calcium concentration and parathyroid hormone assay. A preparative biopsy may be mandatory for the other lesions. A finding of giant cells on histopathology does not exclude a brown tumour. A giant cell tumour is characterised by the presence of multinucleated giant cells. Although the tumour is regarded as benign and has an indolent course, up to 50% of cases may recur locally. Typical giant cell tumours are radiologically easily distinguished from other bone tumours. Giant cell tumours are lytic, subarticular, eccentric, and often lack a sclerotic rim.

Q2: What other relevant blood investigations should be ordered in such patients [calcium, parathyroid hormone, alkaline phosphatase, acid phosphatase]?

Other relevant blood investigations are calcium and parathyroid hormone. The final histopathology report raised the suspicion of hyperparathyroidism. On testing the patient’s blood, the corrected calcium concentration was 12.5 mmol/l, with an increased concentration of parathyroid hormone of 314 pmol/l. Ultrasonography of the neck revealed a parathyroid adenoma in the vicinity of the inferior pole of the right thyroid. The adenoma was successfully excised. In such a lytic lesion of the bone, the possibility of brown tumour should always be kept and blood calcium/parathyroid hormone assay should be mandatory to prevent surgical misadventure.

Discussion

In women of childbearing age the estimated incidence of PHP is eight per 100,000 population per year. Usually, pregnant women with PHP are asymptomatic or have minor complaints such as early fatigability, constipation, thirst, or depression. These are common complaints that are usually attributed to pregnancy by patients. It is mandatory to correct PHP before childbirth to prevent postpartum hypercalcaemic crisis in the mother and hypocalcaemic crisis in the fetus. The hypercalcaemia can manifest itself in symptoms such as hyperesthesia, pathological fractures, renal stones, pancreatitis, abortion, or fetal death. A hypercalcaemic crisis in the immediate postpartum period may be dangerous as the maternal efflux of calcium to the fetus is suddenly stopped. A neonate born to such a mother is at risk of tetany and convulsions within 3–14 days of the birth because of transient hypocalcaemia. Though PTH and calcium do not cross the placental barrier, calcium is actively transported across the placenta with the help of fetal 1,25-dihydroxycholecalciferol. Maternal PHP results in high concentrations of serum calcium that acts to suppress the fetus’s PTH concentration. If this is not corrected beforehand, at birth the neonate is suddenly deprived of calcium and this is compounded by an inability to mobilise calcium from bone because of the high concentrations of calcitriol. This will result in acute neonatal hypocalcaemia causing tetany and convulsions by 2 weeks of age but can be delayed if the infant is breast fed. All neonates with tetany or seizures in first few weeks of life should have their mother’s serum calcium concentrations checked to exclude PHP. Oral or parenteral calcium and magnesium are usually required for a short period only and it resolves within three to five months.

Final diagnosis

Hyperparathyroidism.

References


A man with abdominal pain

Q1: What does the chest radiograph show [fig 1 in questions, p 741]?  

The chest radiograph shows a homogenous round opacity in the left upper zone with erosions of the second, third, and fourth ribs.
painless cold abscess may be the only presentation, as was seen in the present case. A single site of tuberculous involvement is the rule; multiple locations are rare and it is common in the immunocompromised state. The combination of rib destruction and an extrapleural rib soft tissue opacity makes tuberculosis a highly likely diagnosis. The rib erosion and the soft tissue mass closely simulates secondaries of the rib. In a report by Adil et al, two of their four patients had a pseudotumorous lesion. Computed tomography of the chest is useful in diagnosis of osseous tuberculosis. Bone sclerosis, associated soft tissue abscess, osteolytic lesion, and a sequestrum suggests chest wall tuberculosis. In a study by Omari et al, 50% of biopsy samples were positive for acid fast bacilli; 64% had granulomatous lesions on histopathological examination. Fine needle aspiration cytology from lesions is not always diagnostic. In the present case, aspiration from the psoas abscess was negative for acid fast bacilli. The histopathological and microscopic examination of the biopsy material from the rib cage confirmed the diagnosis of tuberculosis.

Surgery has a limited role in the management of osseous tuberculosis. It is often indicated for correction of neurological deficit, spinal instability/deformity, or for draining an abscess not responding to treatment. At times it is indicated for confirmation of diagnosis, as was necessary in the present case.

In summary, while evaluating a patient with a destructive spinal lesion, there should be a heightened index of suspicion for spinal tuberculosis. Rib tuberculosis can present as a pseudotumorous lesion.

**Final diagnosis**

Multiple osseous tuberculosis.

**Reference**
