Benign Leydig cell tumour and germ cell carcinoma in situ in a young man with gynaecomastia

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Summary
A 21-year-old man presented with a 16-year history of recurrent pyrexial episodes and a 5-year history of gynaecomastia. Blood and urinary oestrogen levels were elevated and a mass was found in the upper pole of a retractile right testis.

After orchidectomy, oestrogen levels fell, gynaecomastia regressed and the pyrexial episodes ceased.

Histological examination of the right testis showed a benign Leydig cell tumour in the upper pole and a germinal cell carcinoma in situ in the remaining part of the testis. Thus a potentially lethal condition was detected at an early pre-malignant phase by virtue of a benign, endocrinologically active tumour. This would seem to be the first report of the co-existence of a Leydig cell tumour and germ cell carcinoma in the same testis.

KEY WORDS: Leydig cell tumour, testicular carcinoma, oestrogen, gynaecomastia, fever.

Introduction
Leydig cell tumours are rare, accounting for only 1-2% of testicular neoplasma (Collins and Pugh, 1964; Dixon and Moore, 1952). The age distribution is bimodal with peak incidences between 5-10 and 30-35 years. Feminizing signs are found in 20-25% (Dalgaard and Hasselberg, 1957; Gabrilove et al., 1975) but in the majority there are no endocrine manifestations. Although the overall incidence of testicular germ cell carcinoma in situ is not known, the condition is found in 8% of cryptorchid testes leading to invasive carcinoma in 70% of infertile men within 5 years of first biopsy (Skakkebaek and Berthelsen, 1978).

The unique features of the present case are the co-existence of a Leydig cell tumour and germ cell carcinoma in situ in the same testis and the 17-year history of intermittent pyrexial attacks resolving after orchidectomy.

Case report
The patient was referred at the age of 21 years complaining of bilateral gynaecomastia since the age of 17 years and frequent attacks of a pyrexial illness during the past 16 years.

He was born as a result of a normal pregnancy and there was no parental consanguinity. At the age of 5 years he first experienced a pyrexial illness, which then recurred regularly at 3- to 6-weekly intervals. Each pyrexial episode lasted 2 to 3 days and was accompanied by a sore throat and generalized aches and pains. Frequency and dysuria often occurred during the febrile attack. Innumerable medical consultations and full screening tests for pyrexia of unknown origin were made over 16 years but the cause of these episodes was never identified.

At the age of 10 years a school doctor noted that the right testicle was retractile, although similar in size to the left which remained firmly anchored in the scrotum. Secondary sexual characteristics developed at the age of 13 years and he then started shaving twice to three times a week. At the age of 17 years gynaecomastia developed over a period of 9 months. Several medical consultations were sought because of this and the general conclusion was that the gynaecomastia was a pubertal phenomenon. Libido was unimpaired, he reported regular heterosexual intercourse and participated freely in competitive athletics.

On examination he was 162 cm tall, weighed 50 kg and was effeminate in manner. Bilateral gynaecomastia with approximately 4 ml of glandular breast tissue was present but there was no galactorrhoea. Pubic, axillary and facial hair were satisfactory but there was little trunk hair. The left testis was 2 inches...
TABLE 1. Blood endocrine profile

<table>
<thead>
<tr>
<th></th>
<th>Pre-operative</th>
<th>Post-operative</th>
<th>Normal male range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oestradiol</td>
<td>320</td>
<td>130</td>
<td>37-129 pmol/l</td>
</tr>
<tr>
<td>Testosterone</td>
<td>8.5</td>
<td>25</td>
<td>11-44 nmol/l</td>
</tr>
<tr>
<td>Prolactin</td>
<td>300</td>
<td>290</td>
<td>30-360 µ/l</td>
</tr>
<tr>
<td>SHBG</td>
<td>55</td>
<td>28</td>
<td>17-55</td>
</tr>
<tr>
<td>LHRH test</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LH (basal)</td>
<td>8.4</td>
<td>23.0</td>
<td>1-10 µ/l</td>
</tr>
<tr>
<td>LH (20' post LHRH)</td>
<td>22.0</td>
<td>165.0</td>
<td></td>
</tr>
<tr>
<td>LH (60' post LHRH)</td>
<td>19.0</td>
<td>120.0</td>
<td></td>
</tr>
<tr>
<td>FSH (basal)</td>
<td>0.9</td>
<td>10.0</td>
<td>1-7 µ/l</td>
</tr>
<tr>
<td>FSH (20' post LHRH)</td>
<td>1.5</td>
<td>27.0</td>
<td></td>
</tr>
<tr>
<td>FSH (60' post LHRH)</td>
<td>1.4</td>
<td>24.0</td>
<td></td>
</tr>
</tbody>
</table>

Endocrine assessment (Table 1) showed elevated blood and urinary oestrogens, a low blood testosterone and impaired follicle stimulating hormone (FSH) response after administration of luteinizing hormone releasing hormone (LHRH). Blood concentrations of chorionic gonadotrophin, α-feto-protein and human placental lactogen were within the reference range.

In view of the testicular mass, he was referred for orchidectomy. The procedure and post-operative recovery were uneventful. Further examination of the right testis, as described under Fig. 1, 2 and 3, showed a Leydig cell tumour in the upper pole and a germ cell carcinoma in the body of the testis.

After orchidectomy there was a dramatic fall in plasma oestrogen and a marked rise in testosterone. The LH and FSH response to LHRH became exaggerated. Plasma concentration of sex hormone

non-motile spermatozoa only in the centrifuged deposit.

in length; the right testis was retractile 1 inches long and showed a nodular mass on its upper pole. There were no other abnormal clinical signs.

Semen analysis on two occasions showed a few

FIG. 1. Longitudinal slice of testis and epididymis showing a solitary well-defined lobulated yellow tumour nodule at the upper pole of the testis. The tunica albuginea overlaying the tumour is intact and the spermatic cord normal.

FIG. 2. High power view of the Leydig cell tumour which is composed of regular cells with rounded or oval nuclei with distinct nuclear membranes and one or more well-defined nucleoli. The cytoplasm is eosinophilic and granular and cytoplasmic borders are indistinct. Several blood vessels and two fibrous septae are also seen.
binding globulin (SHBG) fell post-operatively, but prolactin levels were unchanged (Table 1).

The gynaecomastia decreased and the patient became more masculine in attitude and bearing; he also developed facial acne.

Discussion

Germ cell carcinoma in situ is a pre-malignant condition, analogous to carcinoma in situ of the cervix, leading in previously cryptorchid testes, to invasive carcinoma within 5 years in 70% (Skakkebaek and Berthelsen, 1978). In our patient this dangerous, potentially lethal condition was detected at an early stage by virtue of the endocrinological effects of a benign Leydig cell tumour.

Some 5-2% of patients with germ cell carcinoma in situ show similar changes in the contralateral testis (Berthelsen et al., 1982). Unfortunately, our patient refused biopsy of the remaining left testis. We are therefore monitoring clinically and biochemically.

The precise nature of the pyrexial illness remains obscure but it is tempting to relate these symptoms to the presence of testicular neoplasia. Familial Mediterranean Fever is unlikely—there were no symptoms of abdominal pain or serositis and no family history of the condition. None of the known causes of a chronic intermittent pyrexia were identified, despite comprehensive investigation on several occasions when the patient was pyrexial. It is however of considerable interest that no pyrexial illness had occurred 14 weeks after orchidectomy. The neoplastic lesions might have secreted pyrogenic compounds, but why this should have recurred every 4 to 6 weeks is not clear.

The endocrine changes we observed probably resulted from elevated oestradiol levels, suppressing gonadotrophin release at hypothalamic level. Sub-normal FSH and LH concentrations, in combination with excess circulating and local oestradiol concentrations, could suppress both Leydig and germ cell activity resulting in low plasma testosterone levels and oligospermia.

Postoperatively, the LH response to LHRH was exaggerated suggesting relative Leydig cell insufficiency. Plasma oestradiol levels had decreased to within 1 pmol/litre of the reference range. The endocrine profile was otherwise normal postoperatively.

The histological appearance of the Leydig cell tumour accorded with previous descriptions (Gabrilove et al., 1975; Shimpius et al., 1977). Sheets of morphologically normal cells with acidophilic cytoplasm and round or slightly oval nuclei were seen, the cells in some instances exhibiting Reincke's crystals. Why morphologically normal cells should secrete increased quantities of oestrogen is not known. One suggestion is that aromatase activity is enhanced in such tumours, with consequent increased conversion of androgenic precursors to oestrogen, which in turn inhibits the activity of testosterone synthesizing enzymes, 17-hydroxylase and 17–20 lyase (Bercovich et al., 1981).

The first noticeable clinical change after orchidectomy was a subtle alteration in behaviour. The patient became more assertive and less effeminate.
He was delighted at the absence of pyrexial attacks but somewhat displeased at the development of facial acne. Regression of gynaecomastia started 4 weeks post-operatively.

This case showed an unusual clinical presentation and dual pathology in the testis. For once 'double trouble' worked to the advantage of the patient, as his benign lesion drew attention to a dangerous pre-malignant condition.

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References


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