

Late Relapse of Testicular Seminoma Revealed by Gastric Metastasis: A Rare Case

Zandirad E^{1*}, Sgroi A^{1,3}, Zufferey G¹, Chatelain V²

¹Department of Surgery, Division of Digestive Surgery, Nyon Hospital, Switzerland

²Department of Oncology, Nyon Hospital, Switzerland

³Department of Surgery, Vallee de Joux Hospital, Switzerland

Citation: Zandirad E, Sgroi A, Zufferey G, Chatelain V. Late Relapse of Testicular Seminoma Revealed by Gastric Metastasis: A Rare Case. *Int Jour Gastro Hepat.* 2024;3(1):1-4.

Received Date: 29 December, 2023; **Accepted Date:** 02 January, 2024; **Published Date:** 04 January, 2024

***Corresponding author:** Zandirad E, Department of Surgery, Division of Digestive Surgery, Nyon Hospital, Switzerland

Copyright: © Zandirad E, Open Access 2024. This article, published in *Int Jour Gastro Hepat (IJGH)* (Attribution 4.0 International), as described by <http://creativecommons.org/licenses/by/4.0/>.

INTRODUCTION

Testicular cancer is the most common neoplasia in young males. For seminoma, 80% are diagnosed with clinical stage I disease and presents excellent survival rate (>99%) with appropriate management plan [1]. Orchiectomy represents the standard of care, with surveillance in low-risk patient (0 or 1 factor) and surveillance versus adjuvant therapy (Carboplatin AUC 7 or 20-30 Gy if chemotherapy not achievable) according to higher-risk patient (both rete testis infiltration and lesion size > 4 cm) [2,3]. Metastases usually concerns retroperitoneal lymph nodes via lymphatic system and lungs, liver and bones via hematogenous spread. Gastric involvement is rare [4]. Late relapse (> 3 years) of clinical stage 1 seminoma is very rare with 0.2% patients only and chemotherapy (+/- surgery) appears to be the treatment of choice [5,6]. In clinical stage 1 non-seminoma testicular tumor, lymphovascular infiltration increases risk of recurrence and vascular invasion alone is considered the most important predictor of relapse and stratifies into low-risk (surveillance) or high-risk (adjuvant chemotherapy with one cycle of BEP) [7].

CASE DESCRIPTION

A man in his 40's presented with a 4-year history of epigastric discomfort with delay of digestion and sensation of slowed gastric emptying. He had a medical history of diabetes mellitus type 2 and testicular seminoma of the left side, diagnosed, and treated in 2011 by left orchiectomy and adjuvant retroperitoneal radiotherapy. The patient continued the follow-up with his general practitioner and was in remission for approximately 5 years. In 2017, the patient started to experience post-prandial epigastric pain. He had no other symptoms, specifically no melena, hematemesis, or constitutional symptoms. He had no medical history of hiatal hernia, NSAIDS use or obesity. There was also no change in bowel habit. A first CT-scan with contrast was performed in 2017 and showed no abnormality. Three years later, the patient underwent a TOGD following persistence of his symptoms that revealed a duodenal diverticulum, taken as responsible for his complaints. The symptoms first improved with PPI treatment, which delayed the realization of a gastroscopy. Symptoms became worse a year later and OGD was finally performed and revealed two ulcerated lesions (Figure S1) on the small gastric curvature of 1.5-2cm of

large axis, in contact with the antro-corpus junction and fundus, whose pathology was twice-tested and compared to the previous one in 2011.

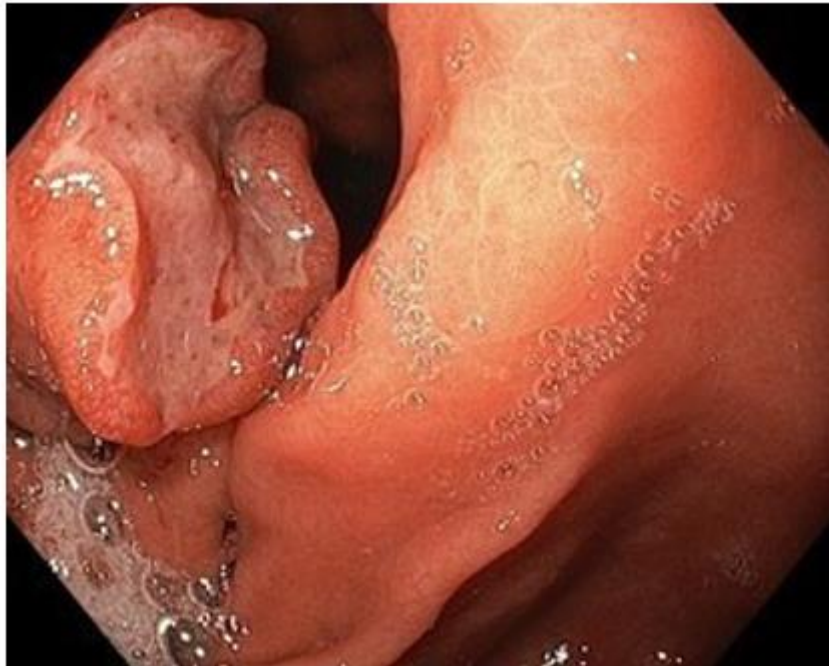


Figure S1: Macroscopic aspect of the recurrence.

Pathology is similar and consistent with a metastasis of a germ cell tumor compatible with a seminoma (CD117++, CD10+, OCT4++) (Figure S2).

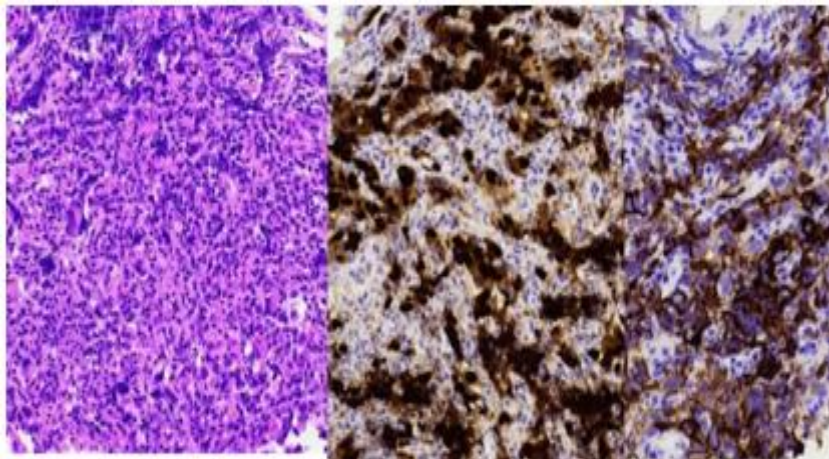


Figure S2: Immunohistochemical profile (HE, OCT4, PLAP).

Markers (LDH, AFP and HCG) were negative, PET-CT was carried out and confirmed hypermetabolism of the gastric fundus, which appeared thickened, without adenopathy or other distant lesions (Figure S3).

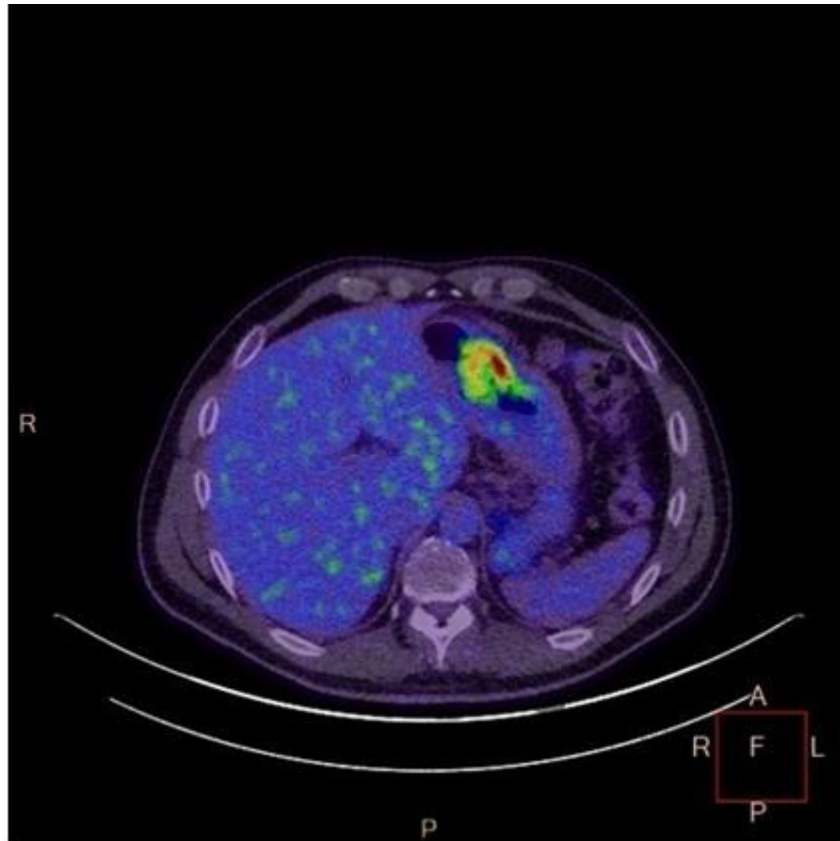


Figure S3: PET-CT in the axial plane showing thickened wall of stomach with high FDG uptake.

Testicular ultrasound showed normal right testis. The systemic work up confirmed the recurrence of testicular seminoma and 3 complete cycles of BEP chemotherapy were administered with interruption of Bleomycin during the 4th cycle due to DLCO decline.

PET, OGD with biopsy and last blood results after chemotherapy pointed towards complete clinical, radiological, and pathological remission of the gastric recurrence, thereby close follow-up is decided without surgical indication.

DISCUSSION

Metastasis of testicular seminoma are mainly retro-peritoneal/pelvic lymph nodes first, with an organ involvement in more advanced cases. The isolated presence of gastric metastasis without local recurrence is already unusual, and the presence of gastric recurrence alone without associated nodular involvement is pointing us towards an hematogenic route rather than lymphogenic.

CONCLUSION

Gastric metastasis remains very rare with testicular seminoma. Any epigastric pain lasting more than a month despite adequate treatment should require gastroenterologist appreciation. This case report provides a rare and unusual presentation of testicular seminoma relapse and will hopefully be helpful to physicians.

REFERENCES

1. Bernal F, Raman JD. Exploration of treatment options for the management of stage I testicular seminoma. Expert Rev Anticancer Ther. 2008;8(7):1081-90.
2. Aparicio J, Díaz R. Management options for stage I seminoma. Expert Rev Anticancer Ther. 2010;10(7):1077-85.
3. EAU Guidelines. Edn. presented at the EAU Annual Congress Amsterdam 2022. ISBN 978-94-92671-16-5.
4. Yuan R, Zhou C, Meneghetti V, Lavoie JM, Kollmannsberger C, Wang G. Seminoma presenting as a solitary metastasis in gastric mucosa with regressed testicular mass. Urology Case Rep. 2020;29:101083.
5. Schmoll HJ, Jordan K, Huddart R, Laguna Pes MP, Horwich A, Fizazi K, et al. Testicular seminoma: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. Ann Oncol. 2010;21:v140-6.
6. Mead GM, Fossa SD, Oliver RTD, Joffe JK, Huddart RA, Roberts JT, et al. Randomized trials in 2466 patients with stage I seminoma: patterns of relapse and follow-up. J Natl Cancer Inst. 2011;103(3):241-9.
7. Oldenburg J, Berney DM, Bokemeyer C, Climent MA, Daugaard G, Gietema JA, et al. Testicular seminoma and non- seminoma: ESMO-EURACAN Clinical Practice Guideline for diagnosis, treatment and follow-up. Ann Oncol. 2022;33(4):362-75.