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PSEUDOTUMORAL TESTICULAR TUBERCULOSIS: -A POTENTIAL DIAGNOSTIC PITFALL-

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Figure A. Macroscopy showing the aspect of the cut surface of the left testis

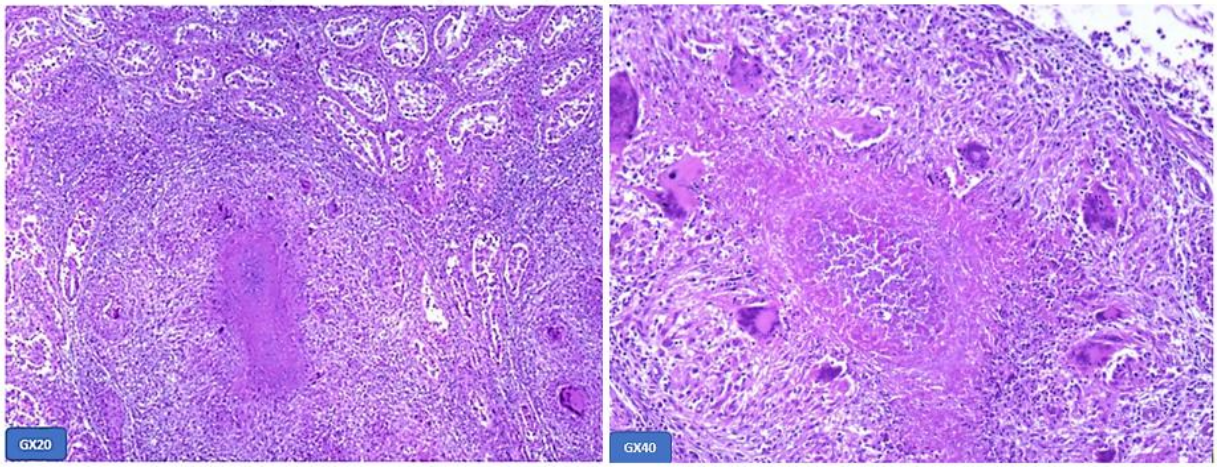

Figure B: Histopathological slides showing the features consistent with TB orchitis: Multiple granulomas with Langhans giant cells and extensive necrosis. Hematoxylin eosin stain: In low-power field [Gx20] and high-power field [Gx40]

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INTRODUCTION

Testicular tuberculosis (TB) or orchitis is a rare extra- pulmonary tuberculosis presentation (8-15% TB). It may account for 3% of genital tuberculosis [1-3]. TB orchitis can make a real differential diagnosis challenge with testicular tumors [1, 4-6] as they have the same presentation. We report a rare case of pseudotumoral TB misdiagnosed and managed as a testicular tumor.

CASE PRESENTATION

A 50 years old man presented to urology consultation with a history of left testicular mass associated to moderately and locally painful with progressive weight loss and no personal or familial antecedent of TB or cancer. General physical examination only found a firm, erythematous and non-transluminal left testicular mass. Scrotal ultrasound sonography showed a complex mass with multiple hypoechoic lesions measuring 5 cm x 4 cm. Laboratory findings showed elevated alpha-fetoprotein and ß HCG (bêta- human chorionic gonadotropin). The diagnosis of testicular cancer was made and left radical orchidectomy performed. The gross pathology showed a soft-to firm testicular tissue measuring 8 cm x 6 cm x 4 cm and weighting 65 grammes with a cut section showing a yellowish mass of 5 cm in diameter. In microscopy, the testicular tissue showed stratified squamous within the stroma, several granulomas and extensive caseous necrosis. Therefore, the histological diagnosis was testicular tuberculosis.

COMMENT

Genitourinary TB remain an uncommon extra pulmonary presentation of TB. The most reported mechanism of infection is retrograde spread of tubercule bacilli from an infected urinary tract to the prostate via reflux, hematogenous or lymphatic spread [7]. The presentation of TB can be challenging, mimicking testicular tumor [7-9]. Testicular tumors occur more frequently than TB orchitis which may bias the clinicians as in our case. Both entities may have similar clinical symptoms with a painless firm testicular mass. Ultrasonography is not helpful for the differential diagnosis. The confirmation is made by histology which shows epithelioid cell granulomas accompanied by multinucleated giant cells in a necrotic background and acid-fast bacilli on Ziehl-Nielsen staining in tissue obtained from fine needle aspirate specimen from testicular mass [10-11]. Histological study in our case revealed granulomatous epithelioid infection with caseous necrosis and multinucleated Langhans giant cells with abundant epithelioid histiocytes.

The concept of testicular biopsy raises controversy due to the risk of tumor spread. More evidence is needed regarding the role of ultrasound guided fine needle aspiration cytology (FNAC) for the diagnosis in cases where TB orchitis is suspected as this may prevent unwarranted orchidectomy [7, 9, 11]. Although it's a rare disease, testicular TB should be considered as a real possible differential diagnosis of testicular cancer especially in regions where TB is endemic. This can prevent unnecessary surgery and help in prompt diagnosis with medical management as a therapeutic option.

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