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Duodenal involvement by seminomatous tumors

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Dear Editor,

Testicular germ cell tumors (GCT), though rare (1%), represent the most common neoplasm among young men (1). Involvement of gastrointestinal (GI) tract in patients presenting such malignancies is due to three patterns: infiltration from affected retroperitoneal lymph nodes or, less frequently, by peritoneal seeding and direct hematogenous metastatic spread (2,3). Its usual symptoms are bowel obstruction and digestive bleeding (2,3). However, GI infiltration from GCT is uncommon, ranging from 3.6% (1) to 5.1% (3). The article by Fu (4), published in 2012, identified only 15 published cases.

A 30-year-old male patient with a history of mental retardation presented with a 4-week general syndrome, vomiting and black stools, as reported by relatives. Physical examination: 120 beats per minute without hypotension, temperature 37.7 °C, cutaneous paleness and a big pulsatile painless mass occupying left hemiabdomen without rigidity. Patient refused rectal examination. Laboratory study: Hemoglobin 5.3
g/dl, without abnormalities in leukocytes, platelets and coagulation study, normal creatinine and mild hyponatremia and hypocloremia. Computer tomography (CT) showed contrast-heterogeneous retroperitoneal mass extending from celiac axis to common iliac arteries, which probably infiltrated the third duodenal portion (Fig. 1A). After fluid resuscitation and transfusion, emergency gastroscopy revealed a partial duodenal stenosis with malignant aspect without current active bleeding. Biopsy was not performed because of suspected vascular component of the mass. Magnetic resonance imaging (MRI) reported giant bulky retroperitoneal lymph nodes as a possible origin (Fig. 1B). Finally, percutaneous CT-guided biopsy was performed, suggesting metastasis of seminoma. Testicular ultrasonography revealed a neoplasm in right testicle and the patient underwentinguinal radical orchietomy (histopathology reported as pure seminoma, pT3), followed by chemotherapy (etoposide plus cysplatin). Twelve months after surgery, our patient is alive without any more gastrointestinal bleeding episodes. New CT demonstrated a 1.5 cm residual retroperitoneal mass.

Involvement of GI tract from advanced GCT is rare and so it is a duodenal location, as our patient presented, though its real frequency is not well defined. A postmortem study by Johnson (2) including 78 patients, observed 2 cases of duodenal metastasis out of 21 cases with GI metastasis from GCT. A series by Chait (3) analyzing 487 patients, reported 7 cases over 25, and Sweetenham (1) presented 3 cases out of 6, in 166 patients with GCT. From 1984 to 1989, Nord (5) registered 3 cases of duodenal metastasis over 5 patients with GI involvement from GCT. Finally, a radiological series by Husband (6) found no involvement of duodenum out of 650 patients with GCT, only one patient presented a GI metastasis located in the stomach.

In relation to the affinity for GI tract among different histological types of GCT, it is well-known that seminoma, the one diagnosed in our patient, has a lower GI metastasis rate than non-seminomatous tumors (1-3,5). Because of that, there are actually few cases in literature reporting involvement of duodenum due to metastatic seminoma (7,8). We have also identified two similar cases, both of which corresponded, however, to metastatic choriocarcinomas (9,10).
We conclude that severe anemia due to gastrointestinal bleeding in the context of retroperitoneal bulky metastatic mass infiltrating duodenum as first manifestation of pT3 pure seminoma is an extremely rare case, and this condition must be suspected when a young male patient refers such a clinical condition.

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**References**


Fig. 1. A. CT showing contrast-heterogeneous retroperitoneal mass, at T12 vertebral body level. Yellow circle indicates this abdominal mass. Yellow arrow head indicates suspected infiltration area of duodenum. B. MRI, coronal section. Black arrow indicates retroperitoneal preaortic mass. Yellow arrow head indicates the mass contacting duodenum.