

Olgu-2

Dr.Fulya Ađaođlu

ÜROONKOLOJİ DERNEĐİ



- YG ,24 Y, sol testiste kitle ile müracaat
- 4.Ağus.2011: USG: soltestis 75*51*57* mm.(72ml) testisin hemen tamamını kaplayan yer yer nekroz ile uyumlu kistik alanlar içeren heterojen ve hipervaskuler solid kitle
- 4.Ağus.2011 tarihli
HCG: 437.10 (0-2)
AFP: 903.30 (0-14)
LDH: 362 (90-240)
- 5Ağus. 2011: Sol orşiektomi
- Patoloji raporu: Malignant mixed-germ hc. tumor (Yolk-sac, mature and immature teratoma). Tm tunica albugineaya invaze, tunica albuginea dışı yayılımı yok, epididim ve spermatik kordda tm yok.
- 12.8.2011 CT rapor: interaortakaval bölgede büyüğü 8mm çapında ve nispeten hypodens , sol paraaortik bölgede ise büyüğü yaklaşık 12*6mm fusiform ve hiperdens lenf nodülleri. sol paraaortik reaktif? İnteraortokavaldeki malignite şüphesi var , radyolojik takip önerilir.
- 12.8.2011
HCG: 25.70 (0-2)
AFP: 289.20 (0-14)
LDH: 179 (90-240)
- 06 Eylül 2011
HCG: <2 (0-2)
AFP: 15 (0-14)
LDH: 344 (90-240)
- 19.Eylül 2011
HCG: 0.10 (0-2)
AFP: 5.30 (0-14)

- Bu bulgular ile hastaya 2 k r BEP uygulanıyor.

24.Eyl l 2011

cisplatin 100mg/m²

etoposid 150mg/m²

bleomisin 30U

Takiplerde;

- 19 Oct 2012 T m Abdomen CT: Deęişiklik yok, 5. Agustos 2011 ile aynı olarak deęerlendiriliyor.

• 18.10.2012: HCG: 0.10 (0-2)

AFP: 2.60 (0-14)

- 05 Aralık 2013: HCG:173.50mIU/ml (0-2)
AFP:36ng/ml (0-9)

05.12.2013 Batın BT: Lenf nodları halen 12*6mm boyutları değişmeyen lenf nodulleri(2011 ile aynı boyutta)

05.12.2013 Skrotal renkli doppler USG:

Sağ testis 48*23*34mm(20ml) boyutlardadır. Sağ testis vaskülarizasyonu normal, parankim içi mikrokalsifikasyon mevcut .Sağ testiste alt pol lokalizasyonda 15*11*14mm boyutlarında heterojen hipervasküler solid tm, olarak raporlanıyor.

Bu bulgular ile hastaya

- 13.12.2013: Sağ testis inferiorundaki 1 cm kitle palpe edilerek parsiyel orşiektomi
- Pat.Raporu: **Mixt germ hc tm çapı: 1.4cm**
 - %65 embriyonel karsinom
 - %20 yolc sac
 - %10 teratom
 - %5 koryokarsinom

Lenfovasküler invazyon mevcut,tm çevre testis parankiminde intratubuler germ hc neoplazi alanları izlenmiştir. Tm çevre testis parankimine infiltre, eksizyonun cerrahi sınırında tm devamlılığı görülmemiştir. Yolc sac tm alanlarında AFP ve Glipikan 3 pozitif olup OCT3/4 ve PLAP embriyonel karsinom alanlarında sırasıyla diffüz nükleer ve membranöz pozitifdir.Çevre testis parankimindeki intratübüler germ hücreli neoplazi alanları PLAP ile membranöz OCT3/4 ile nükleer boyanma göstermiştir. Koryokarsinom komponenti mikroskopik odak şeklinde olup nekrotik odak çevresinde bifazik görünümde dir.IHK incelemede sinsityotrofoblastik beta HCG pozitif olup, sitotrofoblastlar HPL ile boyanmıştır.Sağ testis normal doku içinden alınan biyopsi materyallerinde intratübüler grem hc neoplazi alanları vardır.

20.12.2013

HCG:1715.50mIU/ml (0-2)

AFP:102.70ng/ml (0-9)

27.12.2013

HCG:3579mIU/ml (0-2)

AFP:178ng/ml (0-9)

06.01.2014

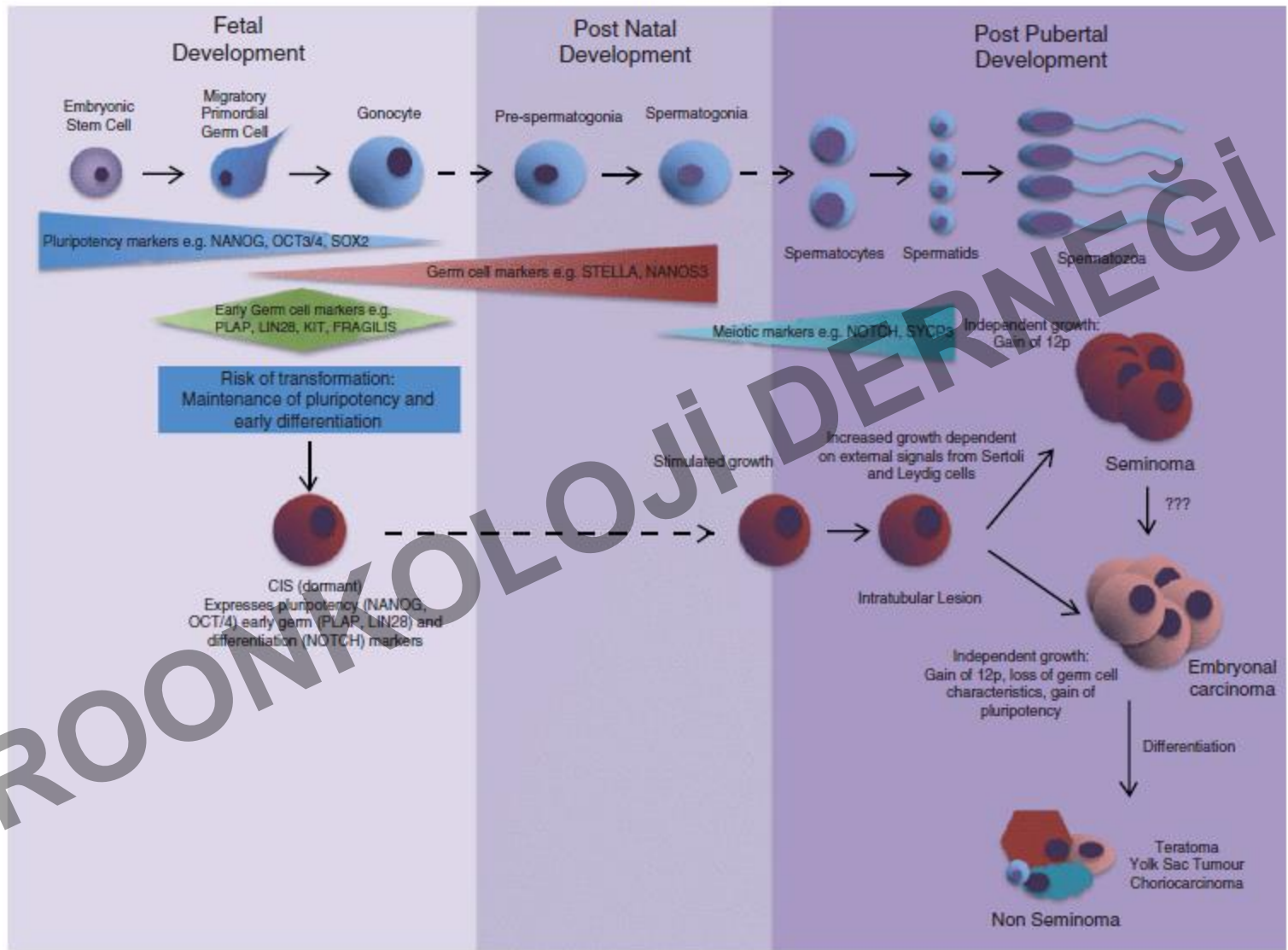
HCG:3600mIU/ml (0-2)

AFP:255.40ng/ml (0-9)

08.01.2014 PET-BT:

L4 vertebra seviyesinde patolojik
artmış LAP aktivitesi SUV Max:7, sol pelvis
SUVMax:2.6

- 09 Ocak 2014-22 Ocak 2014 Sađ testise ve skrotal bölgeye 20 Gy eşdeđeri RT tedavisi (Görüntü eşliđinde radyoterapi) uygulandı.
- Ve adjuvant 3 kür BEP protokolu tekrar uygulandı.



ÜROONKOLOJİ DERNEĞİ

İntratubuler Germ Hücreli Neoplazide (TIN) Testis Korunması ve Radyoterapinin Amacı

- Testis tümörlü hastalarda karşı testis tm gelişme olasılığı %5
- Parsiyel orşiektomi (maskülen beden bütünlüğü)
- Leyding hücrelerinin korunarak testosteron üretiminin devamı (%25-30 hipogonadizm)
- Kalan tetis dokusundaki ITGHN'nin tedavisi
- Fertilizasyon korunması mümkün değil

RT Alanı: Tüm Testis (6 MV, 2 obliq-wedgeli)

RT Dozu: 18-20 Gy

Partial orchiectomy and testis intratubular germ cell neoplasia: World literature review

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Abstract

Approximately 5% of all patients diagnosed with testicular cancer may have contralateral intratubular germ cell neoplasia (ITGCN) and may develop contralateral germ cell tumor. Here, we present a historical review and current literature regarding ITGCN and partial orchiectomy. The PubMed world literature search was performed for articles written in the English language. Search terms used were: Partial orchiectomy and ITGCN, with a return of 322 articles. Articles obtained were from the United States, Germany, Denmark and the Netherlands as well as a few case reports from Australia, France, Turkey and Spain. A critical review of the literature was performed. Partial orchiectomy is an option for the management of testicular malignancy in a select group of patients in whom radical orchiectomy is not desirable, including those with a solitary testicle, bilateral concurrent malignancies and a desire for paternity or being independent from androgen supplementation. Reports have demonstrated the feasibility of partial orchiectomy, but there are strict surgical criteria; tumor less than 2 cm in size, maintenance of cold ischemia, meticulous dissection to maintain testicular blood supply and biopsying of adjacent testicular parenchyma to ensure negative margins and absence of concurrent ITGCN. Partial orchiectomy is followed by testicular irradiation of 18-20 Gy; this radiation dose reduces fertility but maintains leydig cell function with androgen independence. Patients with a history of testicular carcinoma have a 5% chance of developing a metachronous contralateral tumor. Partial orchiectomy is a technically challenging procedure that requires close follow-up, but may represent a reasonable management option in selected patients.

Key Words: Intratubular germ cell neoplasia, partial orchiectomy, testicular carcinoma *in situ*

ITGHN'yi KT eradike edemez mi?

Neden ilave RT?

ÜROONKOLOJİ DERNEĞİ

Treatment of testicular intraepithelial neoplasia (intratubular germ cell neoplasia unspecified) with local radiotherapy or with platinum-based chemotherapy: A survey of the German Testicular Cancer Study Group

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Background: The treatment of testicular intraepithelial neoplasia (TIN), the progenitor of testicular germ cell tumours (GCTs), is based on little data.

Patients and methods: Two hundred and twenty-eight GCT patients with contralateral TIN were retrospectively enrolled. Ten had surveillance, 122 radiotherapy to testis with 18–20 Gy, 30 cisplatin-based chemotherapy (two cycles), 51 chemotherapy (three cycles), and 15 carboplatin. The study end point was a malignant event (ME), defined as detection of TIN upon control biopsy or occurrence of a second GCT. The Secondary end point was hypogonadism during follow-up.

Results: Numbers, proportions of ME, and median event-free survival (EFS) times were: radiotherapy $N = 3$, 2.5%, 11.08 years; chemotherapy (two cycles) $N = 15$, 50%, 3.0 years; chemotherapy (three cycles) $N = 12$, 23.5%, 9.83 years; carboplatin $N = 10$, 66%, 0.9 years; surveillance $N = 5$, 50%, 7.08 years. EFS is significantly different among the groups. Hypogonadism rates were in radiotherapy patients 30.8%, chemotherapy (two cycles) 13%, chemotherapy (three cycles) 17.8%, carboplatin 40%, surveillance 40%.

Conclusions: Local radiotherapy is highly efficacious in curing TIN. Chemotherapy is significantly less effective and the cure rates are dose-dependent. Though hypogonadism occurs in one-third of patients, radiotherapy with 20 Gy remains the standard management of TIN.

Key words: cisplatin, contralateral tumour, hypogonadism, radiotherapy, testicular biopsy, testicular neoplasms

Prowess Panther 5: GUVEN YIGIT / Image Series / VSIMStructureSet / Copy of "testis"

Model: CCCS
Normalize: Calc Pt #1
Enable/Disable Base Dose: []

Auto: []
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Show Isodose: []
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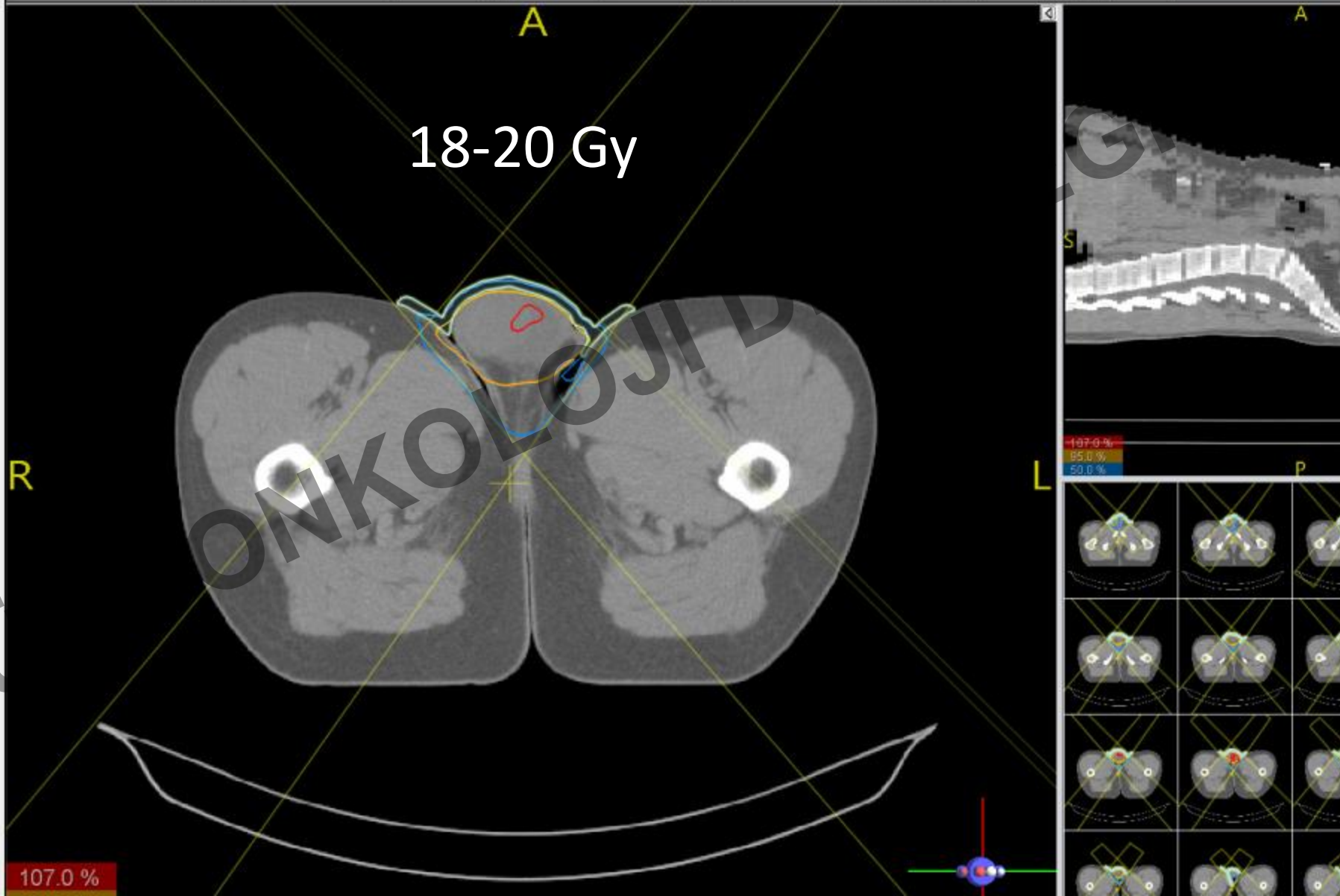
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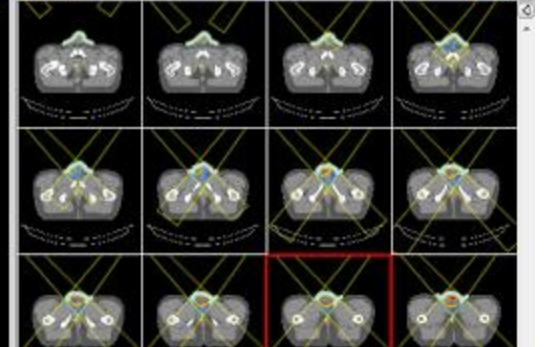
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Solus: []

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Plan Analysis: []
Calculation Points: []
Plan Summary: []





100.0%
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