

Mucinous Carcinoma of the Scrotum about a Case in Yaounde

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Abstract

Aim: This paper aims to report the second case of mucinous carcinoma of the scrotum revealed by scrotal fistulas listed in the literature and highlight the difficulties in the search and difficulties encountered in the management of urogenital cancers in developing countries. **Case presentation:** This was a 62-year-old patient who had consulted for fistulized lesions of the scrotum associated with urinary disorders. Physical examination found budding lesions in the scrotum from which mucus was leaking. The diagnostic assessment carried out consisted of a biopsy sample of the scrotal lesions, a blood analysis and medical imaging, which led to the diagnosis. The mutilating nature of the surgery proposed to the patient after multidisciplinary consultation meeting and the expensive cost of chemotherapy drugs constituted the limits of the patient's therapeutic management. **Conclusion:** Mucinous carcinoma of the scrotum is rare and primary lesion should always be sought. The presence of budding lesions of the scrotum with discharge of mucus should suggest the diagnosis.

Keywords

Scrotal Cancer, Mucinous Carcinoma, Scrotal Fistulas

1. Introduction

Malignant tumors of the scrotum are rare and constitute a heterogeneous group

of tumors whose histological types derive from the different constituents of the scrotum [1]. The most frequent histological types are squamous cell carcinoma, extra-mammary Paget's disease, basal cell carcinoma and sarcoma [1]. The mucinous type is very rare and has only been described once before this case [2]. Most often it is a digestive tumor (ano-rectal) that extends secondarily to the scrotum. Clinically, the symptomatology is not specific and the presence of scrotal and perineal fistulas can lead the diagnosis to wander towards a tuberculous etiology, thus delaying its management especially if there are associated urinary disorders. We report the second case of malignant mucinous tumor of the scrotum revealed by scrotal and perineal fistulas while highlighting the difficulties in diagnosing this tumour.

2. Observation

Mr. M. retired police officer, aged 62, had consulted for budding and fistulized lesions of the purse and perineum evolving for several years associated with dysuria, a feeling of incomplete bladder emptying and nocturia with 3 nocturnal lifts without urgency nor involuntary loss of urine through the anus. The past medical history had revealed nothing. The patient had a stage 2 WHO performance score, an enlarged bursa with the presence of 2 budding lesions through which malodorous urine was leaking, there was also a budding lesion in the perineum (**Figure 1**). The two testicles were palpated at the bottom of the purses without any anomaly, the digital rectal examination was normal. The general examination had not objectified superficial lymph nodes. The diagnosis of urethral stricture associated with scrotal tuberculosis was mentioned. The patient had a cystostomy associated with a biopsy of the scrotal lesion. The blood test performed revealed mild anemia at 11.3 g/dl, normal kidney function, normal tuberculin IDR, CRP at 96 mg/l, ECBU had revealed an ofloxacin-sensitive *Pseudomonas aeruginosa* urinary tract infection, and urine and sputum were negative for BK. The radiological assessment carried out had revealed the retrograde cystography: vesico-rectal and vesico-perineal fistulas (fistula between the right edge of the anal canal which communicates with the anal margin) with a permeable urethra and the CT scan which had confirmed this fistula showing a translevatorian fistulous path along the anal wall at 6 o'clock and 12 o'clock associated with an infiltration and a mass of the perineum without affecting the rectum and with preservation of the fatty cleavage. The thoracic and abdominal levels did not reveal any secondary-looking lesion or adenomegaly. The histological examination of the biopsy sample concluded to a malignant mucinous tumor of the scrotum or extended to the scrotum. The immunohistochemistry of the sample could not be performed due to financial problems. A radical scrotoectomy associated with an abdomino-perineal amputation and systemic chemotherapy had been proposed to him at the end of the multidisciplinary consultation, but the patient refused because of the mutilating nature of the procedure and the potential side effects of the chemotherapy despite the information provided on the prognosis of his disease.



Figure 1. Initial appearance of scrotal lesions.

3. Comments

First described by Sir Percival Pott, scrotal carcinoma was the first cancer linked to occupational exposure [3]. It is a rare tumor with an overall annual incidence of approximately 1.5/1,000,000 people in Western countries [4]. Currently, most cases are due to poor hygiene and chronic inflammation [4]. Wright and al had listed, on 471 patients, the different histological types of scrotal carcinoma and had not found any mucinous carcinoma [1]. To our knowledge, this is the second case of mucinous carcinoma of the scrotum described; only one study has reported the case of a mucinous carcinoma of the scrotum in the literature before ours [2].

In our case, the diagnosis of mucinous carcinoma of the scrotum was made on the occasion of the assessment of fistulized lesions of the scrotum and perineum in search of BK or tubercle bacilli and the secondary appearance of lower digestive fistulas objectified by the UCRM and CT suggested a primary digestive origin (rectal/anal) which could not be confirmed by colonoscopy because the patient refused for fear of sedation. Mucinous carcinomas of the anal canal are rare tumors that pose diagnostic problems, especially when associated with scrotal fistulas. Their non-specific symptomatology is often the cause of misdiagnosis which delays treatment. The diagnosis can be evoked in front of rectalgia and proctalgia although these signs are not specific. However, mucus coming out of the fistulous orifices is an important sign that could be suggestive [1]. However, the diagnosis of certainty is based on the histological analysis of the fistulous paths, as was the case in our case. Because of their rarity, there are no recommendations or expert opinion concerning assessment as well as the management of these cancers. Nevertheless, pelvic MRI seems to be the examination of choice

for the local evaluation of these cancers by precisely highlighting the anatomical relationships between the various fistulous tracts and the anal sphincter as well as the posterior wall of the bladder and the urethra [5]. Cystoscopy and colonoscopy are also indicated, particularly in the event of associated symptoms of the lower urinary tract and proctalgia. In our case, these examinations were offered to the patient who did not give his consent despite the information given to him on their diagnostic and therapeutic interest. The patient said he was financially exhausted. Therapeutically, the rarity of this cancer also means that there is no consensus in the literature. In our patient, after a multidisciplinary consultation meeting, we opted for a radical scrotoectomy associated with abdomino-perineal amputation then adjuvant systemic chemotherapy. But the patient refused the surgery judging the top gestures to be mutilating.

4. Conclusion

Scrotal carcinoma is a rare tumor; it is most often primary and is usually due to occupational exposure or poor hygiene with chronic inflammation of the scrotum. Mucinous carcinoma of the scrotum represents a rare entity of this cancer. The presence of scrotal fistulas should lead to evoke the diagnosis and perform a histological analysis of the lesions, especially if there is a discharge of mucus. The search for a primary lesion must be vigorous in order to propose an adequate treatment guaranteeing a satisfactory survival for this cancer whose evolution and prognosis are serious.

Contribution of the Authors

Boris AMOUGOU examined the patient and wrote the manuscript.

All the other authors participated in the discussions on the diagnostic and therapeutic management of the patient and participated in the drafting of the manuscript, read it and approved the final version of the manuscript.

Patient Consent

The patient gave his consent after we clearly explained to him the interest for the scientific community to publish his case.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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