
Case Report

Fibromatous Periorchitis
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Abstract
We report a case of diffuse fibrous pseudotumour/fibromatous periorchitis, in a 43 year old male, that completely encased the right testis and was adjacent to a hydrocele cavity. Although fibrous pseudotumours of this region are uncommon, they are reported to be the second most common benign paratesticular lesion after adenomatoid tumours. These comprise approximately 6 percent of paratesticular lesions, and are accepted as reactive lesions secondary to trauma, hydrocele, infections or inflammation. Fibrous pseudotumours have a peak incidence in the third decade of life but can occur at any age. Clinically these lesions mimic malignancy resulting in the treatment by radical orchidectomy. Fibrous pseudotumours should be considered in differential diagnosis when one encounters a predominantly fibrocollagenous lesion.

Introduction
Benign intrascrotal fibrous proliferations are uncommon with most arising from the paratesticular region and have generally been considered variants of fibrous pseudotumours as reflected in the numerous designations, including chronic proliferative periorchitis, inflammatory pseudotumours, nodular and diffuse fibrous proliferations, proliferative funiculitis, fibroma, benign fibrous paratesticular tumour, fibrous mesothelioma, pseudofibromatous periorchitis, nonspecific peritesticular fibrosis, and reactive periorchitis. Mostofi and Price suggested the term "fibrous pseudotumours" to encompass all reactive fibroinflammatory lesions of the testicular tunics.

These "tumours" are usually nodular and involve the testicular tunics. Even more uncommon are fibrous pseudotumours that form diffuse band like fibroinflammatory proliferations that encompass the testis, also termed as fibromatous periorchitis. Clinically these lesions mimic malignancy resulting in the treatment by radical orchidectomy.

We herein report another case of a fibromatous periorchitis/ diffuse fibrous pseudotumour that completely encased the right testis and was adjacent to a hydrocele cavity.

Case Presentation:
We received a specimen, from a remote area of Pakistan, of a 43 year old man with clinical history of gradual right testicular enlargement over a period of few months with no significant associated medical history. Provisional clinical diagnosis was Seminoma and a radical orchidectomy was performed. Radiology and Serum AFP levels were not ordered.

The specimen consisted of a right testicular mass that measured 11.5 x 7 x 4 cm, with an attached spermatic cord that measured 3.0 x 1cm. Sections revealed the testis, which measured 2.5 x 2.5 x 2.0 cm in greatest dimension, almost completely encased by a thick, firm, white fibrotic band like tissue involving the tunica albuginea and vaginalis and the epididymis but not the spermatic cord (figure 1). The testicular parenchyma was tan, soft.

Figure 1: Section through testis and paratesticular mass demonstrating a fibrous lesion, that completely encased the testis. A cystic space compatible with a hydrocele is present (arrow).
and unremarkable grossly. A hydrocoele cavity, was present adjacent to the testis with in the fibrous band, measuring 2.0 x 1.5 cm and filled with clear serous fluid.

Light microscopy showed a lesion composed of dense fibrous tissue with thick (keloid like) bands of collagen within which there were bland spindle cells and a mixed inflammatory infiltrate that almost totally encased the testis (figure 2). The inflammatory infiltrate consisted largely of lymphocytes, plasma cells, and histiocytes with scattered neutrophils and eosinophils and in some areas it was perivascular. In other areas, the inflammatory infiltrate was sparse, was more pronounced and scattered small lymphoid aggregates were noted. No necrosis, increased mitotic activity, or cellular pleomorphism was noted. The lesion involved the tunica albuginea and vaginalis and surrounded the epididymis but did not involve the testicular parenchyma (figure 3) or spermatic cord. The hydrocoele cavity was within the fibrous lesion and contained mixed inflammatory cells and cellular debris. The testis showed tubular atrophy.

**Discussion**

Fibromatous lesions of the testicular tunics were recognized first by Sir Astley Cooper in 1830.¹ The term fibrous pseudotumour, reflecting its non-neoplastic nature was introduced by Mostofi and Price.² Gross and microscopic differences, different opinion regarding the cell of origin and the neoplastic vs. non-neoplastic nature of these lesions has resulted in various terms including the following: nodular and diffuse fibrous proliferation, chronic proliferative periortichitis, inflammatory pseudotumour, proliferative funiculitis, fibromatous periortichitis, fibroma, benign fibrous paratesticular tumour, fibrous mesothelioma, pseudofibromatous periortichitis, nonspecific peritesticular fibrosis, and reactive periortichitis.³,⁵

Benign fibromatous proliferations occurring in the testicular tunics and paratesticular region are considered by most as reactive and non-neoplastic. But some authors including Purveen et al⁴ and Jones et al⁵ believe that at least some intrascrotal fibrous proliferations are truly neoplastic. The morphology of the reactive fibroblastic proliferations in this region may range from cellular pseudosarcomatous lesions to fibrotic hypocellular proliferations, often with calcifications or even with bone formation.

Jones et al⁵ proposed a classification for benign fibrous proliferations of the testis and paratesticular region based on the neoplastic or non-neoplastic nature of the lesion and separated the lesions/tumours into various categories based on clinical and pathologic features, location, and immunohistochemical studies.

Although fibrous pseudotumours are uncommon, they are reported to be the second most common benign paratesticular lesion after adenomatoid tumours.²,⁶ These lesions have been reported to comprise approximately 6 percent of para testicular lesions and tumours but the exact incidence is not known.⁷ Fibrous pseudotumours have a peak incidence in the third decade of life but can occur at any age; only 4 cases have been reported in patients younger than 18 years.³,⁸ They usually present as painless scrotal masses and range from 0.5 to 8.0 cm, but a 25.0 cm fibrous pseudotumour has also been reported. Forty-five percent of cases are associated with a hydrocoele, and 30 percent are associated with trauma or epididymo-orchitis.² They have also been reported to occur in patients with testicular infarction, schistosomias haematobium infection, retroperitoneal fibrosis, and Gorlin syndrome (nevoid basal cell carcinoma syndrome).³

Macroscopically, a clear distinction has been drawn by some investigators between the cases that show nodularity with nodules sometimes reaching several centimeters in diameter and those that show diffuse thickening of the tunics encasing the testis, although these tumours exhibit the same histopathologic
chronic total left main coronary artery occlusion

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Abstract

A 65 year old man, smoker, presented with a history of exertional shortness of breath over the last 4 months. He denied any chest discomfort. On examination jugular venous distension was noted with bilateral basal crackles.

He got symptomatic relief after treatment with diuretics and nitrates. His echocardiogram revealed global hypokinesia of left ventricle with severe mitral regurgitation.

He was planned for mitral valve replacement and pre-procedural diagnostic angiogramme was performed which showed occluded left main coronary artery. Aortogramme showed filling of left coronary system from right coronary artery. He was sent for urgent aortocoronary bypass surgery with mitral valve replacement.

Introduction

Complete occlusion of left main coronary artery is an unusual manifestation of coronary atheromatous disease. Prevalence of complete left main occlusion is unknown.