



Transverse Testicular Ectopia: A Case Report

Caner Ediz¹, Bayram Kahraman², Cemal Tasdemir¹

¹ Inonu University Medical School, Department of Urology, Malatya, Turkey

² Special Malatya Hospital, Department of Radiology, Malatya, Turkey

Abstract

Transverse testicular ectopia (TTE) is a rare scrotal anomaly occurring consequent to the migration of both gonads to the same hemiscrotum. In this case we aim to present a 24 years old male patient who has pain and swelling its diagnosed Transverse Testicular Ectopia in our clinic.

Key Words: Transverse testicular ectopia, diagnosis, treatment

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Corresponding Author: Cemal Tasdemir, Inonu University Medical School 44280, Malatya, Turkey

E-mail: cemal.tasdemir@inonu.edu.tr

Phone Number: +90 422 341 06 60 - 5803

Introduction

Transverse Testicular Ectopia (TTE) is rarely seen. It was first described by Von Cenhossek in 1886. This congenital anomaly is defined both of testes migrate towards the same hemiscrotum. The ectopic testis may be located on the inner inguinal ring, in the inguinal canal, or in the contralateral hemiscrotum [1,2]. In addition, it appears characteristically as an ipsilateral inguinal hernia.

This report includes discussion case of with TTE in a 24 years old male patient in the present of literature.

Case report

A 24 years old man was admitted with the complaints inguinal pain and swelling. About five years ago left inguinal hernia surgery was detected and TTE wasn't diagnosed before, although the patient underwent left inguinal hernia in the story of patient. On physical examination there was left inguinal swelling. Right hemiscrotum was empty. Right testis wasn't diagnosed. There was two swelling in the left hemiscrotum. Left testis was detected inferior of left hemiscrotum and there was a swelling on this testis the right to inguinal ring from hemiscrotum. There were no findings for inguinal hernia. Testicular tumour markers and urinalysis was normal

Scrotal Doppler ultrasound scan at this time showed findings for diagnosis. In right hemiscrotum, inguinal ring and abdominal area were empty. Both of testis were in left hemiscrotum. These of inferior-medial testis were 40x20 mm and superior-lateral testis was 32x12 mm (Transverse Testicular Ectopia). There was attendant bilobular cystic lesion which was 25x10 mm between of both testis (Figure 1a and 1b).

Also right seminal vesicle was not detected (Agenesis?) (Figure 2). There was a hypoechoic and vascularized lesion about length 120-130 mm and width 20 mm from left seminal vesicle to left inguinal ring and left hemiscrotum (Persistent Mullerian Duct Syndrome?)

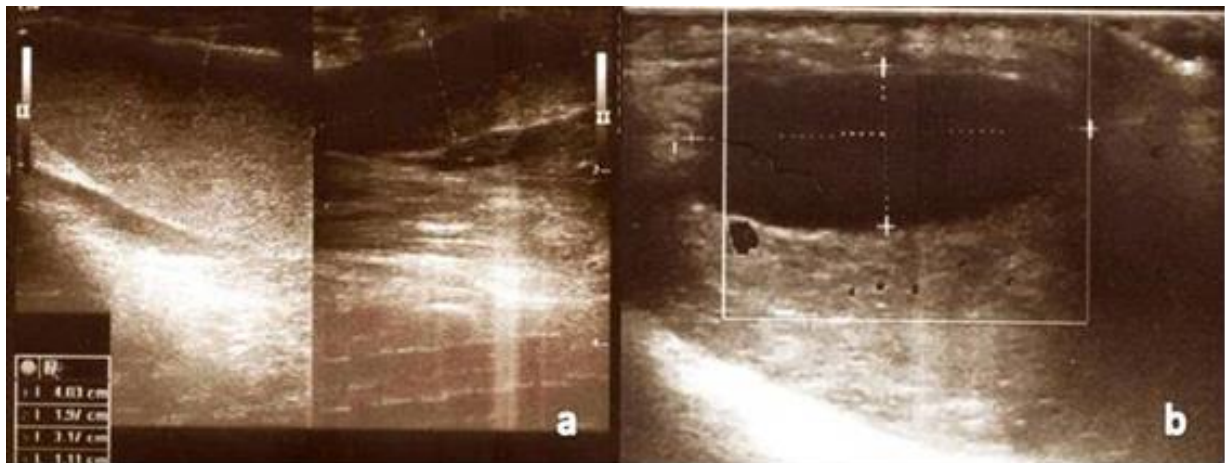


Figure 1. a) Both of testis were in left hemiscrotum. b) Bilobular cystic lesion which was 25x10 mm.



Figure 2. Right seminal vesicle was not seen.

We want to evaluate this patient with scrotal Magnetic resonance imaging (MRI). In right hemiscrotum, inguinal ring and abdominal area was empty. Both of testis were in left hemiscrotum. These of inferior-medial testis were 40x20 mm and superior-lateral testis was 32x12 mm (Transverse Testicular Ectopia) (Figure 3a). There was attendant bilobular cystic lesion that was T1 a hypointense, T2 a hyperintense after contrast substance about 25x10 mm between of testes. There was a lesion that was T1 a hypointense, T2 a mild hypointense and central of this lesion was a linear hyperintense shown signal intensity and vascularized after contrast like endometrial cavity about length 120-130 mm and width 20 mm from left seminal vesicle to left inguinal ring and left hemiscrotum (Persistent Mullerian Duct Syndrome?) (Figure 3b).

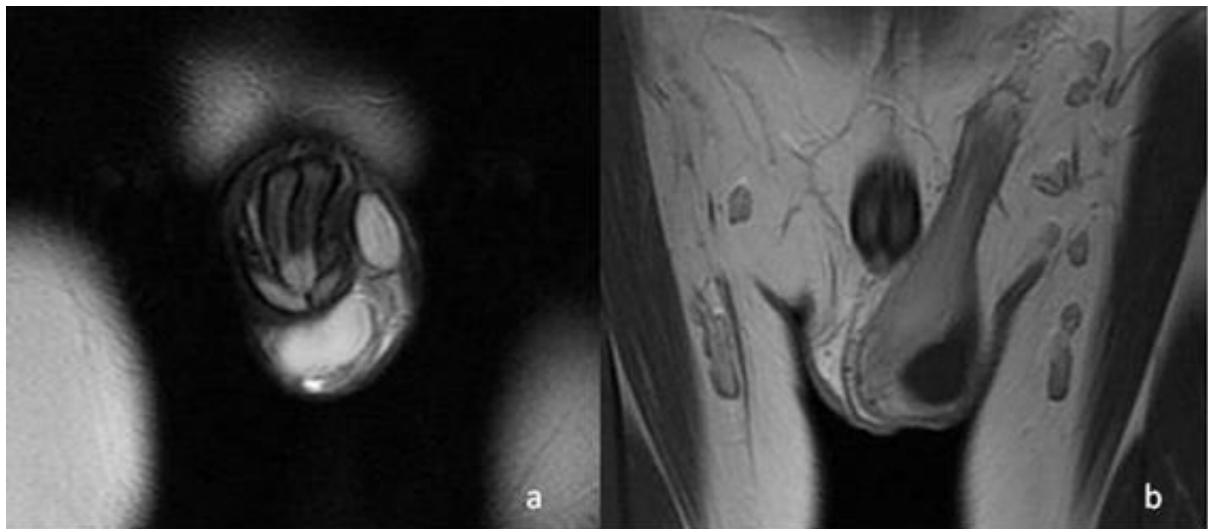


Figure 3. a) Both of testis were in left hemiscrotum. b) Persistence of mullerian duct extending from the left inguinal canal left scrotum.

Discussion

Transverse Testicular Ectopia is a well-known congenital anomaly occurring secondary to the migration of both testes to the same hemiscrotum. This finding was first reported by Lenhossek in 1886, as an autopsy finding [3]. There are many theories attempting to explain the embryonic development of this anomaly, but there is no uniform agreement.

A classification of this abnormality is defined according to the associated anomalies. In type I, TTE is associated with an inguinal hernia alone (40-50%) type II is associated with persistent

or rudimentary Müllerian duct remnants (30%) and type III is associated with disorders of genito-urinary anomalies (hypospadias, scrotal abnormalities, and disorders of sex development) (20%) [4]. The typical one side story of inguinal hernia surgery with an empty contralateral hemiscrotum and persistent or rudimentary Müllerian duct remnant was present in our case. No other associated anomaly was detected.

Although the mean age at presentation was reported as 4 years, our patient was 24 years old [4]. In many cases, the diagnosis may be established during the operation. However, there are also articles reporting that preoperative diagnosis may be established by ultrasound, computerized tomography, magnetic resonance imaging or magnetic resonance venography [5,6].

Treatment is decided according to the presentation and associated anomalies of the patients. So, we preferred surgical exploration of TTE in our patient.

Conclusion

As a result it must always be kept in mind in patients by palpation both of testes in the same hemiscrotum.

References

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