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Editorial

Cumulative and Big C-Adenocarcinoma Epididymis

Anubha Bajaj*

Department of Histopathology, Panjab University/A.B. Diagnostics, India

***Corresponding Author:** Anubha Bajaj, Department of Histopathology, Panjab University/A.B. Diagnostics, India.

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Adenocarcinoma epididymis emerges as an extremely exceptional, de novo neoplasm confined to the epididymis. Tumefaction is additionally designated as papillary adenocarcinoma, cystadenocarcinoma or papillary cystadenocarcinoma. Adenocarcinoma epididymis demonstrates mean age of disease emergence at 67 years with neoplastic appearance between 27 years to 82 years [1,2].

Adenocarcinoma is preponderantly centred upon the epididymis or may be confined to epididymis. Alternatively, neoplasm may infiltrate the abutting soft tissue [1,2].

Tumefaction is posited to arise from metaplastic epithelium layering the epididymis [2,3]. Clinically, neoplasm represents as a palpable tumefaction confined to the scrotum. Scrotal pain and hydrocele may or may not concur [2,3]. Grossly, neoplasm appears to infiltrate circumscribing soft tissue or may be confined to the epididymis. Tumour magnitude varies from one centimetres to 7 centimetres. Cut surface is tan to grey/white. Foci of haemorrhage or necrosis are frequently encountered [3,4]. Upon microscopy, tumefaction expounds tubular, cystic, papillary or tubulopapillary pattern of neoplastic evolution. Frequently, a combination of aforesaid patterns is exemplified. Besides, variable architectural complexities may appear. Additionally, an undifferentiated, sheet-like pattern may emerge [3,4]. Tumefaction is composed of glycogen rich, preponderantly clear cuboidal to columnar epithelial cells. Frequently, tumour infiltrates into surrounding smooth muscle of epididymis or adjacent soft tissue. Tumour necrosis is commonly discerned. Psammoma bodies are exceptionally observed [3,4].

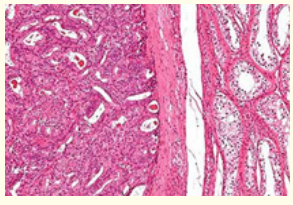

Figure 1: Adenocarcinoma epididymis depicting tubules and papillae layered by cuboidal to columnar epithelial cells imbued with clear to eosinophilic cytoplasm. Infiltration into surrounding stroma and focal necrosis is observed [8].

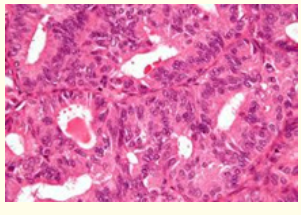

Figure 2: Adenocarcinoma epididymis delineating tubules and papillae lined by cuboidal to columnar epithelial cells pervaded with clear cytoplasm. Tumour cell infiltration into circumscribing soft tissue is encountered [9].

Adenocarcinoma epididymis is immune reactive to cytokeratin AE1/AE3 or epithelial membrane antigen (EMA). Tumour cells appear immune non reactive to prostate specific antigen(PSA), carcinoembryonic antigen (CEA), S100 protein, alpha fetoprotein (AFP), BerEp4, LeuM1 or B72.3 [5,6]. Adenocarcinoma epididymis necessitates distinction from lesions as various primary neoplasms

of epididymis or para-testicular region, adenomatoid tumour, carcinoma rete testis, mesothelioma, serous cystadenoma of epididymis, serous papillary carcinoma and distant metastasis from prostatic carcinoma or gastrointestinal adenocarcinoma [5,6].

Neoplasm is devoid of specific or diagnostic biochemical parameters. Serum markers indicative of sex cord tumours as inhibin, calretinin or CD56 and germ cell tumours as alpha fetoprotein (AFP), human chorionic gonadotropin (HCG) and lactate dehydrogenase (LDH) appear absent. Pathognomonic confirmation of the neoplasm and segregation from diverse regional malignant tumours may be obtained upon histological evaluation [6,7].

Adenocarcinoma epididymis may be suitably subjected to surgical manoeuvers as high inguinal orchidectomy along with dissection of retroperitoneal lymph nodes. Additionally, adjuvant chemotherapy or radiation therapy may be beneficially employed [6,7]. Prognostic outcomes of the exceptionally discerned neoplasm remain obscure. Notwithstanding, quantifiably significant neoplasms demonstrate distant metastasis upon initial presentation or delayed emergence of distant metastasis [6,7].

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8. Image 1 Courtesy: Libre Pathology.

9. Image 2 Courtesy: Wikimedia commons.