Clinicopathological Correlation of Germ Cell Tumours in Gonads

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Authors’ contributions

This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

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ABSTRACT

Ovaries are paired pelvic organs located on the sides of the uterus. Although it is rare in the general population, between the age group of 20-40 years in males, testicular germ cell neoplasms are the most common form of malignant tumour reported. In young women ovarian tumours rank second among the ovarian germ cell tumors and in males, the testicular germ cell tumors serve as the leading percentage of tumors among all the testicular tumors seen in the early and late adulthood (3rd and 4th decade) of life. The people of reproductive age group are most vulnerable to gonadal germ cell tumours. Curing this age group without affecting their fertility is a challenging task. The risk of malignancy increases in existence of cryptorchidism/undescended testis as in our study, 1 case of classical seminoma presented with undescended testis. To study germ cell tumors in gonads in relation to age, parity and mode of presentation and the correlation of biochemical markers and immunohistochemical markers at places in gonadal germ cell tumors.

Keywords: Testicular germ cell neoplasms; ovarian germ cell tumors; gonadal germ cell tumors; malignancy.

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1. INTRODUCTION

Germ cell tumors, a rare and complex group of heterogeneous neoplasms, comprise both benign and malignant histology. These tumors can occur anywhere in the body, most commonly in ovaries and testis and possess diagnostically and challenging issues for the pathologist [1]. The totipotent primordial germ cells of the embryonic gonad [2] serve as the birthplace of these tumors. Ovarian germ cell tumors accounts for 15% to 20% and constitute 2nd largest group of ovarian tumours, and accounts for only 2 - 5% [3] of all malignant ovarian neoplasms. The most of tumours being benign mature cystic teratomas [2]. The young women are relatively more affected by this tumour. It also occurs in infants and older women. Among the ovarian germ cell tumours dysgerminoma, immature teratoma, yolk sac tumour and mixed germ cell tumours are most malignant. Embryonal carcinomas, choriocarcinoma and malignant struma ovarii are less malignant.

19 years is the mean age of ovarian GCTs. The occurrence of TGCTs is much higher than that of OGCT. At 19 years of age GCT occurs in 44.5 per million in males but only 10.4 per million in females. These tumours present mostly with abdominal pain, abdominal mass, menstrual disturbances with 10% of patients exhibiting acute abdomen as a result of torsion, haemorrhage or tumour rupture. The other symptoms found commonly are abdominal distension, fever and vaginal bleeding [4]. Usually, these tumours are unilateral and bilateral in few cases. In order to preserve fertility in young patients, surgery should be conservative. Since most of the cases reported are benign, there is excellent prognosis. With appropriate management the aggressive malignant cases can also be controlled.

The malignant tumour that predominantly affects the 20-40 years age group in adult males are testicular germ cell neoplasms. This tumour is rare in general population [5] with a worldwide incidence rate of 0.0015% with considerable variations between countries [6]. One of the studies revealed that in the US the incidence of testicular germ cell tumours has increased among black men [7]. Making it one of the leading causes of death [8] and accounting for 1% to 1.5% of all testicular tumours.

The familial testicular germ cell tumours mostly occur among first degree relatives and accounts for 1% to 3% only [9,10] insisting the significance of genetic susceptibility in this disease [9,11,12,13]. Pathologically, the testicular germ cell tumours can be categorized as seminomatous (resembling primordial germ cells (PGCs)) and non-seminomatous (resembling undifferentiated or extraembryonic pattern [14-17]).

The most common presentation is unilateral scrotal mass and testicular pain. 1% - 2% of testicular GCTs can present bilaterally.

Testicular swelling and other clinical history like painful or painless, change in size, sexual history, symptoms of UTI, history of surgery, infertility or mumps or family history of testicular cancer [16,18-22] should be evaluated thoroughly with clinical examination and in order to rule out the malignancy that incidence of benign testicular tumours is relatively less common.

2. MATERIALS AND METHODS

This prospective study conducted at Sree Balaji Medical College and Hospital, Chromepet, in the Department of Pathology. The study was undertaken during the period April 2015 to September 2016. The material was received as surgically resected specimen from patients admitted in Department of General Surgery and Department of Obstetrics and Gynaecology at Sree Balaji Medical College and Hospital, Chromepet.

Clinical details like age, sex, signs and symptoms, serum tumour markers and radiological findings were included. A Total of 30 germ cell tumours were studied, 25 out of 86 ovarian specimens were germ cell tumours and 5 out of 58 orchidectomy specimens were germ cell tumours. The gross photographs were taken and specimens were allowed to fix in 10% formalin for 24 – 48 hours. On receiving the specimen, the gross features such as size, shape, colour, external appearance, findings on cut section were noted and multiple bits were taken from representative areas, processed for Histopathological Examination.

Paraffin blocks were made and cut at 4 microns thickness and stained with Hematoxylin and Eosin, Periodic Acid Schiff and Immunohistochemical stains were done wherever necessary. A detailed microscopic examination of the tumour was done to arrive at a histopathological diagnosis. The data compiled was analysed for various parameters like age,
sex, parity, clinical signs and symptoms, gross features of the tumours and the incidence of different histological types.

3. RESULTS

The Department of Pathology, Sree Balaji Medical College and Hospital, Chennai received 86 cases of ovarian tumours and 58 cases of orchidectomy specimens during the period of April 2015 to September 2016. 30 cases of germ cell tumours (GCT) were studied in total. Out of 86 ovarian tumours, 25 cases were germ cell tumours and out of 58 orchidectomy specimens 5 cases were found to be germ cell tumours.

The 25 cases of ovarian germ cell tumours comprised of 19 benign cystic mature teratoma, 2 immature teratoma, 1 yolk sac tumour, 2 dysgerminoma and 1 carcinoid tumour. Out of 5 cases of testicular germ cell tumours, 2 cases were classical seminoma and 3 cases were mixed germ cell tumours (first was a yolk sac tumour with seminoma, second was embryonal carcinoma with yolk sac tumour and the third was embryonal carcinoma with immature teratoma).

Out of 2 cases of classical seminoma, 1 case presented at the age of 28 years, which is younger than the normal range of age. This case had history of orchiopexy done at 12 years of age. So the risk of malignancy at younger age was seen. The serum tumour markers were seen with many raise for malignant cases preoperatively and immunohistochemical stain were used to identify histological subtypes and also in case of mixed germ cell tumours.

In this study, the most commonly found tumour were benign cystic mature teratoma (19 cases) out of 25 ovarian germ cell tumours, followed by immature teratoma (2 cases) and dysgerminoma (2 cases).

3.1 Immature Teratoma

Cases of immature teratoma of ovary were observed in this study. 1 case at 18 years years with raised AFP level 647 IU/ml and hCG negative. 2nd case at 21 years with CA 125 level 115 U/ml and hCG negative. Tumour size measuring 7x6x4.5 cm and 13x8x3 cm respectively.

Chart 1. Distribution of histological types of ovarian germ cell tumours
Grossly, both solid and cystic areas, containing pultaceous material with tuft of hair follicles seen (Figs. 1, 2). Microscopically, Section shows ovarian stroma with tumour composed with solid and cystic areas. The solid areas showing mature elements composed of skin with adnexal components, bone, cartilage, smooth muscle, neuroglial tissue, respiratory epithelium with mucous glands, adipose tissue. The cystic spaces are lined by columnar epithelium. Areas of immature neuroepithelial tissue and immature mesenchymal tissue are seen with few mitosis (Figs. 3-10).

3.2 Carcinoid Tumour
Case was observed at 33 years of age with tumour size 4x2.5x1 cm. Grossly, solid, homogenous yellow with cystic gelatinous material. Microscopically, Section shows well demarcated nests of small, uniform round cells with clumped chromatin in insular pattern admixed with fibrous stroma (Fig: 12).
Chart 4. Percentage distribution of benign cystic teratoma according to age group

Chart 5. Percentage distribution of testicular germ cell tumours according to age group

Chart 6. Percentage distribution of ovarian germ cell tumours according to size
Chart 7. Percentage distribution of testicular germ cell tumours according to size

Chart 8. Distribution of ovarian germ cell tumours according to parity

Chart 9. Distribution of presenting symptoms of ovarian germ cell tumour
Chart 10. Distribution of presenting symptoms of testicular germ cell tumours

Chart 11. Percentage distribution of germ cell tumours among gonads in this study

Chart 12. Radiological findings of ovarian germ cell tumours
Fig. 1. Gross picture of immature teratoma: E/S – Breached capsule with solid and cystic areas

Fig. 2. Gross: Cut surface showing solid and cystic spaces with hair follicle
Fig. 3. LPF (100x): H & E: Skin with pilosebaceous units in teratoma

Fig. 4. LPF (100x): H & E: Picture showing bone tissue with adipose tissue and blood vessels in teratoma
Fig. 5. LPF (100x): H & E: Islands of immature glial tissue in immature teratoma

Fig. 6. LPF (100x): H & E: Primitive neuroepithelium with hyperchromatic nuclei arranged in rosettes in immature teratoma
Fig. 7. HPF (400x): H & E: Intestinal type of glands in teratoma

Fig. 8. LPF (100x): H & E: Island of cartilage, respiratory epithelium and glandular tissue in teratoma
Fig. 9. LPF (100x): H & E: Primitive neuroectodermal elements in immature teratoma

Fig. 10. HPF (400x): H & E: Primitive neuro epithelium in immature teratoma
Fig. 11. HPF (400x): H & E: Large vesicular tumour cells with clear cytoplasm arranged in nests separated by fibrous stroma with lymphoctres

Fig. 12. LPF(100x): H & E: Nests of round to oval cells with clumped chromatin - Carcinoid tumour
Fig. 13. HPF (400X): H & E: Neoplasm composed of pleomorphic cells arranged in glandular pattern

Fig. 14. HPF (400X): H & E: Immature myxomatous stroma surrounding tubular structure in immature teratoma
3.3 Gender Distribution

Out of 30 cases of gonadal germ cell tumour present in this study, 25 cases occurred in females and 5 in males.

4. DISCUSSION

A total of 30 germ cell tumours of gonads were included in the study. The ovarian tumours in the study comprised of 86 cases. Among these 25 germ cell tumours, 19 benign cystic mature teratoma, 2 immature teratoma, 1 yolk sac tumour, 2 dysgerminoma and 1 carcinoid tumour were observed.

Out of 58 orchidectomy specimens received, 5 cases were found to be testicular germ cell tumours. 2 cases were classical seminoma and 3 cases were mixed germ cell tumours, with a combination of yolk sac tumour with seminoma, embryonal carcinoma with yolk sac tumour and embryonal carcinoma with immature teratoma.

Clinical history, routine investigations, radiological findings and serum tumoursmarkers were noted. Immunohistochemical staining is done at places.

In the current investigation, 6 cases of malignant ovarian germ cell tumours, 2 cases (33.3%) of dysgerminoma, 2 cases (33.3%) of immature teratoma, 1 case (16.7%) of yolk sac tumour and 1 case (16.7%) of carcinoid tumour were observed. In this study, 33.3% (2 cases) were seminoma and 3 cases (50%) were mixed GCT Abubaker et al 37 reported similar results.

4.1 Age Distribution of Ovarian Germ Cell Tumours

Ovarian germ cell tumours are predominantly found in the 14 years to 58 years age group. Jadhav et al 103 observed that the age group range of ovarian germ cell tumours varied from 13 to 50 years and also observed 3 cases of malignant ovarian GCTs were between 13 to 22 years which is similar to this study. In the present study, the majority of the benign tumours were for the most part seen in the early adulthood (3rd decade) of life but also involving a wide range of age groups.

The malignancies predominantly occurred at younger age i.e. < 30 years in this study, followed by 4th decade.

Out of 5 cases of testicular germ cell tumours, 2 cases (33.3%) were classical seminoma and 3
cases (50%) were mixed germ cell tumours. In the testis, the 3 cases of mixed germ cell tumours comprises of yolk sac tumour and seminoma (case 1), embryonal carcinoma and yolk sac tumour (case 2) and embryonal carcinoma and immature teratoma (case 3).

Out of 2 cases of classical seminoma, 1 case presented at the age of 28 years, which is younger than the normal. This case had history of orchiopexy done at 12 years of age for undescended testis. All the malignant ovarian and testicular germ cell tumours had raised serum tumours markers preoperatively.

Majority of the testicular tumours included in the study were malignant germ cell tumours (5/6 cases) which belong to 30 – 40 years of age group. In this study, out of 25 ovarian germ cell tumours, 17 patients were parous (14 benign, 3 malignant) and 8 cases were nulliparous (5 benign and 3 malignant). Out of 5 cases of testicular germ cell tumours, 1 case had history of infertility [23-28,22].

3 cases of benign cystic mature teratoma were found was incidental finding during appendicectomy, hysterectomy and Emergency LSCS.

The most common presenting symptom of ovarian germ cell tumours were abdominal mass with pain (44%), followed by abdominal pain (20%). The most common presenting symptom of testicular germ cell tumours were scrotal swelling, followed by scrotal pain.

Out of 25 ovarian GCTs, 22 cases were unilateral and 3 cases were bilateral. Majority of the unilateral cases occurred in right side. Out of 5 testicular GCTs, all were unilateral, 4 cases were right and 1 case was left side. No bilateral cases were seen. The ovarian germ cell tumour had a mean age of 30. 08 years with peak incidence noted in 3 rd decades. The testicular germ cell tumour had a mean age of 35.4 years with peak incidence noted in 4 th decade.

Among the ovarian tumours, the ovarian germ cell tumours ranked second and affects young women. Among the testicular tumours seen in the early and later adulthood of life (3rd and 4th decade), the testicular germ cell tumours exhibit the highest percentage. The people of reproductive age group are most vulnerable to gonadal germ cell tumours. Curing this age group without affecting their fertility is a challenging task. The risk of malignancy increases in existence of cryptorchidism/ undescended testis as in our study, 1 case of classical seminoma presented with undescended testis.

Karki S et al. [18] 96 reported 40% (2 cases) of mixed GCT of testis of all testicular tumours, 1 case comprised of teratoma with embryonal carcinoma, which is similar to this study. M. T. Zvetkov et al reported mixed germ cell tumour of the testis with four different types of tumours, Teratoma, seminoma, embryonal carcinoma and yolk sac tumour in a 15 year old male.

Naseer et al reported 2 cases of mixed GCT of testis in old patients, one case comprised with components of seminoma + teratoma with malignant transformation+ yolk sac tumour and another case comprised with components of teratoma + yolk sac tumour. Rankawat et al 89 6 cases (17.64%) of mixed GCT, out of it 5 cases were found to be teratocarcinoma and 1 case comprised with components of yolk sac tumour with embryonal carcinoma.

In this study, 3 cases of mixed germ cell tumours were reported, 1 case were found to be with components of seminoma and yolk sac tumour, 1 case of teratocarcinoma and 1 case of embryonal carcinoma with yolk sac tumour.

In this study, the incidence and distribution of germ cell tumours of gonads were noted according to age, parity, mode of presentation and also the many fold raise in serum tumour markers like CA 125, AFP, beta hCG and immunohistochemistry is done to find out the histological types in both pure form and mixed germ cell tumours. [27,28-33]

5. CONCLUSION

The careful clinical evaluation with other investigations like serum tumour markers, radiological findings and immunohistochemical study will be helpful in order to arrive at possible definitive diagnosis. Thus, Histopathological examination plays essential role in confirming the diagnosis in these tumours.

CONSENT

As per international standard or university standard, patients' written consent has been collected and preserved by the author(s).
ETHICAL APPROVAL

The study was approved by the Institutional Ethics Committee.

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COMPETING INTERESTS

Authors have declared that no competing interests exist.

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