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CASE REPORTS
IDIOPATHIC GRANULOMATOUS ORCHITIS

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Abstract. A case of granulomatous orchitis in a 52-year old negro male is reported. The distinction between granulomatous orchitis and cancer is important in particular in coloured people where the former is not rare while testicular cancer is uncommon.

Key words: granulomatous orchitis; Trinidad

Case Report

In January, 1979 a 52-year old negro male presented to the Port-of-Spain General Hospital with a painful scrotal swelling of three weeks duration. The pain, mild at onset, increased steadily as the testis became larger and more indurated. He had no history of trauma and there were no other urinary symptoms.

On examination, the cardiovascular and respiratory systems and the abdomen were normal. The right testis was unaffected but the left testis was hard, tender and $10 \times 6 \times 6$ cm in size. The surface was smooth and the scrotal skin was freely movable over it. There was no groin or palpable retroperitoneal lymphadenopathy. Chest X-ray was normal, VDRL and Mantoux tests were negative. A left orchidectomy was performed because of suspicion of malignancy.

Pathology. The specimen consisted of testis, epididymis and spermatic cord.

On cut surface, the testis was bulging and yellowish brown in colour. Microscopically, the whole testis was replaced by a granulomatous process. The tubules were filled with Sertoli cells and no spermatogenic cells were identified. The interstitium was infiltrated with chronic inflammatory cells, mainly lymphocytes; there were no giant cells. There was no evidence of tuberculous, syphilitic or fungal infection. Michaelis Gutman bodies were absent and there were no features of lymphoma. The epididymis was normal and there was fibrous thickening of the testicular tunics and spermatic cord. Histologic diagnosis: granulomatous orchitis, unknown cause.

The patient recovered uneventfully and when reexamined four years later, he was well with no local or systemic disease.

Discussion

Granulomatous orchitis is a chronic inflammatory lesion of uncertain aetiology leading to a hard swelling of the testis which usually simulates a neoplasm [1]. Although, most patients fall between the age range of 40-70 years, cases as young as 25 years have been reported.

Granulomatous orchitis may be regarded as uncommon if not rare [2-4] and its incidence is difficult to assess. In our analysis of testicular masses over a 14-year period, this is the only case of granulomatous orchitis. In a 38-year review by Kahn and McAninch [3], 17 cases were described. Of 2.000 testes submitted to the Testicular Tumour Research Panel of the United Kingdom over a 10-year period, only 32 (1.6%) were classified as granulomatous orchitis [1].

The differential diagnosis of granulomatous orchitis should include mumps, bacte-

rial and tuberculous orchitis, syphilitic infection of the testis, sperm granuloma and testicular tumour. There were no clinical or histological features of these disorders in our case. An association between this condition and local trauma and urinary tract infection have been described; the significance of these remain problematical. The differential diagnosis from cancer is not easy, hence the importance of orchidectomy and early rapid diagnosis.

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ACTINOMYCOSIS OF THE LIVER

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Abstract. We present our first case of actinomycosis in Trinidad and we believe this is also the first reported case of hepatic actinomycosis in the West Indies

Key words: actinomycosis; liver; Trinidad

Case Report

In February 1984 a 35-year-old Trinidadian of Spanish descent presented to the Port-of-Spain General Hospital with right-sided upper abdominal pain and fever. His symptoms started 4 weeks before and became progressively worse. He was a labourer by occupation and was involved in raising common fowl.

On admission, he had a temperature of 38°C. Clinical examination was essentially normal except for tender hepatomegaly extending 6 cm below the right costal margin. He had no previous abdominal surgery. Laboratory investigations were all normal except for an elevated white blood cell count of 12.000 with 70% polymorphonuclears. Blood cultures were negative. Repeated stool examinations and serologic tests for amoebiasis were negative. Roentgenograms of the chest and abdomen were normal.

At exploratory laparotomy, all viscera and organs were normal except for a hard, nodular 12×8 cm size mass in the right lobe of the liver; it was adherent to the anterior abdominal wall and diaphragm. Biopsy of this hepatic lesion showed classical actinomycotic granules (*Figure 1*). Aerobic and anaerobic cultures of the