Paratesticular Osteosarcoma—A Rare Tumor with Distinctive Imaging Findings

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Abstract

Extraosseous osteosarcoma (EOO) is a rare mesenchymal malignancy representing 4% of all osteosarcomas and 1% of soft tissue sarcomas. The testes, its supporting structures, that is, paratestes, and the spermatic cord are among the rarest sites for EOO, with only 11 published English language reports to date. We report our experience with a 73-year-old male presenting with left hemiscrotal swelling, noted to have extensive amorphous intratumoral calcification on imaging. He underwent left high inguinal orchidectomy with en bloc hemiscrotectomy, with a final pathologic diagnosis of primary paratesticular osteosarcoma. Our literature review corroborates this distinctive, hitherto overlooked imaging feature.

Keywords

► osteosarcoma  
► paratestis  
► calcification  
► spermatic cord  
► orchidectomy

Introduction

Extraosseous osteosarcoma (EOO), also known as soft tissue osteosarcoma, refers to osteosarcoma occurring in soft tissue rather than bone. EOOs are uncommon, accounting for only 4% of all osteosarcomas and 1% of soft tissue sarcomas.1 Osteosarcoma arising from the testis, its supporting structures, that is, paratestis or spermatic cord are exceedingly rare, with only 11 published English language reports to date. In this report, we present a 73-year-old male presenting with left hemiscrotal swelling, noted to have extensive amorphous calcification on imaging. Exirpative pathology revealed primary paratesticular osteosarcoma. We also review published literature with particular emphasis on imaging characteristics.

Case History

A 73-year-old patient presented with progressively enlarging left hemiscrotal mass of 2 months duration. He denied history of trauma. Physical examination revealed a 15 cm bony hard mass in the left hemiscrotum infiltrating overlying skin. The left testis was palpable separately at the inferior pole of the mass. Contralateral testis was normal. Physical examination was otherwise unremarkable. Serum tumor markers (alpha fetoprotein, beta-human chorionic gonadotropin and lactate dehydrogenase) were normal. Ultrasonogram of the scrotum revealed a 10 cm mass with heterogenous echotexture and multiple calcifications. Computed tomography (CT) revealed an ill-defined heterogeneously enhancing mass with extensive amorphous intratumoral calcifications (►Fig. 1). Both testes...
were noted separate from the mass and appeared normal. Metastatic evaluation was negative. With a provisional diagnosis of malignancy, we performed a metastatic evaluation, including a CT of the chest, abdomen, and pelvis, which was negative.

He underwent left high inguinal orchidectomy with en bloc hemiscrotectomy. Intraoperatively, a discrete bony hard swelling, with the left testis adherent to its lower pole, was noted. Gross pathology showed a 16.5 × 10 × 7.8 cm variegated tumor adjacent to the testis, with cut surface showing solid and cystic areas. Calcified areas and necrosis were also seen. Histology revealed spindle to polyhedral cells with scant eosinophilic cytoplasm and hyperchromatic nuclei, with 14 mitoses per 10 high power field. Foci of osteoid formation, calcification, and osteoclast-like multinucleated giant cells were also noted (►Fig. 2), suggesting a diagnosis of high-grade osteosarcoma arising from the paratestis. This was corroborated on immunohistochemistry, which was positive for vimentin, variable positivity for CD 99, and negative for SATB2, S100, desmin, CD34, and keratin.

After discussion in a multidisciplinary tumor board, considering the lack of evidence for benefit of adjuvant therapy in localized disease, the patient was advised surveillance. He remains disease free at 8 months of follow-up.

Discussion

EOOs are rare malignant mesenchymal neoplasms that produce osteoid, bone, and occasionally cartilage. To be characterized as EOo, these tumors must (i) have a unified sarcoma pattern (excluding mixed malignant mesenchymal tumor), (ii) produce bone-like and/or cartilage matrix, (iii) be primarily located in soft tissues without skeletal attachment, and (iv) a metastasis from a primary skeletal osteosarcoma elsewhere must be excluded.1 The soft tissues of the lower extremity are most commonly affected, and visceral involvement is rare. To the best of our knowledge, only 11 published reports in English language, of EOO of the testis, paratestis, or spermatic cord exist (►Table 1).

EOO is hypothesized to arise from neoplastic transformation of sequestered primitive mesenchymal cells or embryonic osteogenic tissue. In the testis, EOO must be distinguished from sarcomatous transformation of germ cell tumors by excluding the presence of the later in the resected specimen by meticulous pathologic examination, as was performed in our case.

Based on the available data, common clinical presentation in the fourth to eight decades of life, with a large, hard, hemiscrotal or groin mass, that developed over the course of a few weeks to months (►Table 1).

No pathognomic imaging features have been described to date. We reviewed all published reports, with particular attention to findings on imaging studies. At presentation, the tumor tends to be large with longest tumor diameter ranging between

![Fig. 1](image1) Computed tomographic images showing a large left paratesticular tumor with extensive amorphous calcification. (A) Cross-sectional imaging, (B) sagittal image, and (C) coronal image through the tumor.

![Fig. 2](image2) Histopathology. (A) Sheets of tumor cells with intervening osteoid matrix undergoing focal mineralization (hematoxylin and eosin [H&E 100X]). (B) H&E 200X. (C) Tumor cells with hyperchromatic pleomorphic nuclei with adjacent osteoid and chondroid matrix (H&E 200X). (D) Spindle-shaped tumor cells with hyperchromatic, pleomorphic nuclei with intervening osteoid matrix following decalcification (H&E 200X).
<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Age at presentation (years)</th>
<th>Primary organ of origin</th>
<th>Time to presentation (weeks)</th>
<th>Tumor LTD (cm)</th>
<th>Calcification on Imaging</th>
<th>Treatment</th>
<th>Adjuvant therapy</th>
<th>Outcome</th>
<th>Follow-up duration (months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mathew et al²</td>
<td>1981</td>
<td>73</td>
<td>Testis</td>
<td>8</td>
<td>3.5</td>
<td>NA</td>
<td>Orchidectomy</td>
<td>None</td>
<td>No recurrence</td>
<td>2.5</td>
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<tr>
<td>Zuerberg et al³</td>
<td>1990</td>
<td>30</td>
<td>Testis</td>
<td>52</td>
<td>6.0</td>
<td>NA</td>
<td>High inguinal orchidectomy</td>
<td>None</td>
<td>No recurrence</td>
<td>66</td>
</tr>
<tr>
<td>Lee et al⁴</td>
<td>2004</td>
<td>78</td>
<td>Testis</td>
<td>2</td>
<td>4.0</td>
<td>Calcified mass</td>
<td>High inguinal orchidectomy</td>
<td>None</td>
<td>No recurrence</td>
<td>44</td>
</tr>
<tr>
<td>Tazi et al⁵</td>
<td>2006</td>
<td>60</td>
<td>Testis</td>
<td>16</td>
<td>12.0</td>
<td>Calcified mass</td>
<td>High inguinal orchidectomy</td>
<td>None</td>
<td>No recurrence</td>
<td>16</td>
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<tr>
<td>Resorlu et al⁶</td>
<td>2018</td>
<td>63</td>
<td>Testis</td>
<td>NA</td>
<td>16.0</td>
<td>NA</td>
<td>High inguinal orchidectomy</td>
<td>None</td>
<td>No recurrence</td>
<td>12</td>
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<tr>
<td>Al-Masri et al⁷</td>
<td>2007</td>
<td>52</td>
<td>Paratestis</td>
<td>16</td>
<td>17.0</td>
<td>NA</td>
<td>High inguinal orchidectomy</td>
<td>Adjuvant cisplatin, doxorubicin, and methotrexate</td>
<td>Expired due to retroperitoneal metastasis</td>
<td>6</td>
</tr>
<tr>
<td>Hong et al⁴</td>
<td>2012</td>
<td>52</td>
<td>Paratestis</td>
<td>52</td>
<td>6.5</td>
<td>Calcified mass</td>
<td>High inguinal orchidectomy</td>
<td>None</td>
<td>No recurrence</td>
<td>9</td>
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<tr>
<td>Spirtos et al⁷</td>
<td>1991</td>
<td>55</td>
<td>Spermatic cord</td>
<td>1</td>
<td>4.0</td>
<td>NA</td>
<td>High inguinal orchidectomy</td>
<td>None</td>
<td>No recurrence</td>
<td>24</td>
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<tr>
<td>Beiswanger et al⁵</td>
<td>1997</td>
<td>54</td>
<td>Spermatic cord</td>
<td>NA</td>
<td>7.0</td>
<td>Calcified mass</td>
<td>Wide local excision + high inguinal orchidectomy</td>
<td>None</td>
<td>No recurrence</td>
<td>9</td>
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<tr>
<td>Stella et al⁶</td>
<td>2007</td>
<td>59</td>
<td>Spermatic cord</td>
<td>260</td>
<td>25.0</td>
<td>Calcified mass</td>
<td>High inguinal orchidectomy</td>
<td>Inguinal and pelvic radiation (60Gy)</td>
<td>Expired due to lung metastasis at 9 years</td>
<td>132</td>
</tr>
<tr>
<td>Ugidos et al¹¹</td>
<td>2010</td>
<td>62</td>
<td>Spermatic cord (liposarcoma + osteosarcoma)</td>
<td>NA</td>
<td>9.0</td>
<td>NA</td>
<td>High inguinal orchidectomy</td>
<td>None</td>
<td>No recurrence</td>
<td>8</td>
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Abbreviations: LTD, longest tumor dimension; NA, not available; RPLND, retroperitoneal lymph node dissection.
3.5 and 25.0 cm (Table 1). Modest heterogenous enhancement is usually observed. Imaging is often remarkable for extensive amorphous intratumoral calcification. This likely results from ossification by osteosarcoma tumor cells. Although observed in previously published reports, these unique imaging findings have not been not emphasised. 4–8 Calcification may occur in other testicular tumors such as nonseminomatous germ cell tumors, particularly teratomas, and nongerm cell tumors such as large-cell calcifying Sertoli cell tumor. However, this is usually focal and/or heterogenous and not as pronounced as seen in osteosarcoma. 10,12

Calcification may also be noted in long-standing hydrocele or hematocoele, in which case it is usually peripheral and shell like. 13

Unlike EOO at other sites which commonly present with metastatic disease, 1 majority of reported EOO arising from testis, paratestis or spermatic cord have presented with localized disease. As with our patient, surgical resection, comprising high inguinal orchidectomy with wide local excision of the tumor has been the mainstay of management in most reports. Due to rarity of disease, the value of adjuvant chemotherapy, radiation, or prophylactic retroperitoneal lymphadenectomy in localized disease remains unknown. However, despite the lack of any adjuvant treatment, regional or metastatic recurrence has been reported in only two instances, 9,14 suggesting a favorable prognosis in majority of patients with localized disease.

Conclusion

Although EOOs of testis, paratestis, or spermatic cord are exceedingly rare, they should be included in the differential diagnosis of a male in the fourth to eight decades of life presenting with a hard hemiscrotal or groin mass with extensive amorphous intra-tumoral calcification on imaging. Surgical resection remains the mainstay of management.

Note

The study was conducted at the Cancer Institute Chennai, India.

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None.

Conflict of Interest

None declared.

References