

# Quick Reference Guide

## PATIENT EDUCATION AND AWARENESS

- Testicular germ cell tumours are relatively rare (7.5 cases per 100,000 of the male population) but are the most common cancer in men aged 20-30
- The majority of cases are curable, even when metastasised (5 year survival ≈90%)
- Delay in presentation is a greater problem than delay in referral

**C** Education aimed at young men to inform them of the disease and its curability should be supported

## REFERRAL

- 86% of patients present with an *enlarged testicle* or a *lump* in the testicle
- In 97% of patients a lump is present on examination
- A *decrease in testicular size* may also occur
- Other symptoms include *pain, inflammation, a dragging sensation, and a recent history of trauma*
- Abnormal masses in the epididymis are unlikely to be testicular tumours
- Ultrasound, if available, may help in distinguishing between lumps arising from the body of the testis and other intrascrotal swellings

**C** Patients suspected of harbouring a testicular malignancy should be referred urgently for urological assessment

**B** Patients should be seen urgently (within two weeks) by a specialist

## PRIMARY TREATMENT

- Measurement of tumour markers is necessary for staging and follow up
- One or more markers are raised in 75% of cases of patients with teratoma
- Ultrasound, of both testes and the abdomen, and chest x-ray may show evidence of disease

**C** Preoperative investigations should include assay of AFP, HCG, LDH, an ultrasound of both testes and the abdomen, and a chest x-ray

Patients who are ill with high markers and widespread metastases should be referred for immediate chemotherapy

**C** Where possible an inguinal orchidectomy should be performed

**C** A testicular prosthesis should be offered to all patients

**C** Contralateral testicular biopsy should be considered in patients at high risk of carcinoma in situ (small remaining testis (≤16 ml), low sperm count, ultrasound abnormality, age < 30 years, or history of maldescent)

KEY: **A** **B** **C** indicates grade of recommendation

Good practice point

## INVESTIGATION AND STAGING

- Treatment of testicular cancer in a specialist centre leads to improved results

**C** Following confirmation of a germ cell tumour, all patients should be referred to a specialist centre for the management of testicular tumours and seen by an oncologist within 1-2 weeks

**C** Marker levels (AFP and HCG) should be used along with imaging techniques (CT of thorax, abdomen and pelvis) for staging and to allocate a prognostic group for patients with teratoma

**C** All staging should be completed and reviewed within three weeks of surgery

**C** Specialist nurse involvement is recommended at all stages of management

**C** Pathology and radiology should be reviewed by specialists at the referral treatment centre

**C** When appropriate, sperm storage should be offered to men who may require chemotherapy or radiotherapy

## MANAGEMENT

### CARCINOMA IN SITU (CIS)

**B** Consider testicular radiotherapy

### SEMINOMA

Stage I

**B** Radiotherapy to para-aortic nodes (unless risk factors for pelvic node disease)

Stage I with risk factors  
Stage IIA

**B** Radiotherapy to para-aortic nodes and pelvic lymph nodes ('dog-leg')

Stage IIB

**C** Radiotherapy or chemotherapy

Stage IIC, IID, III, IV

**B** Chemotherapy with BEP (consider omitting bleomycin if age > 40)

### TERATOMA (including mixed seminoma/teratoma)

Stage I

**B** Surveillance unless high risk (blood vessel / lymphatic invasion)

if high risk

**B** Chemotherapy (two courses BEP)

Stage II, III, IV

**B** Chemotherapy (standard treatment: four cycles BEP)

## FOLLOW UP

**C** Surgery not routinely considered, but monitor regressing masses

**B** Radiotherapy not routinely given to residual masses

## FOLLOW UP

**C** In specialist clinic, adhering to strict surveillance protocol

**B** One post treatment CT scan as routine only

**B** Post treatment CT scan  
Resect residual masses if markers normal

## RELAPSED DISEASE

- Salvage chemotherapy is curative in 25% cases

**C** Refer to specialist centre for entry into clinical trial

**C** Consider surgery for late relapse

## CENTRAL NERVOUS SYSTEM (CNS) METASTASES

**C** Surgical resection of accessible lesions  
Radiotherapy may be given with curative or palliative intent