

key points

SELECTED BY

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Testicular cancer accounts for 1% of all malignancies in males.

It is the most frequently occurring solid tumour in men between the ages of 15 and 34 years. Testicular germ cell tumours are classified into two main types: pure seminomas and non-seminomas which are also called non-seminomatous germ cell tumours (NSGCTs). NSGCTs are more clinically aggressive than seminomas so those patients who have both seminoma and non-seminoma components are managed according to NSGCT guidelines.

Testicular tumours have excellent cure rates, even in

those with metastases, as they are extremely sensitive to chemotherapy and radiotherapy. Early diagnosis is, however, very important as treatment is more successful and less intensive, and long-term health consequences can be minimised.

It is recommended that men, particularly those with risk

factors, undertake monthly testicular self-examination. Men should be taught that the best time to check their testicles is during, or right after, a warm bath or shower when the scrotal skin is relaxed. A normal testicle should feel firm and smooth, but not hard.

Unilateral cryptorchidism is associated with an increased

risk of testicular cancer in both testes, even after orchidoplexy. The risk of testicular cancer is higher in males with testicular atrophy or dysgenesis and the highest rates are reported in industrialised countries, particularly Western and Northern Europe and New Zealand/Australia.

Treatment options for men with testicular cancer include

surgery, chemotherapy, radiotherapy, or a combination of the above, depending on the histology, presence of tumour markers and radiological staging. Raised levels of tumour markers should fall after orchidectomy. Patients with clinical stage I disease in whom serum tumour marker levels fail to normalise after orchidectomy are presumed to have metastatic disease, even if their CT scan appears normal.

Some patients become hypogonadal after orchidectomy

and require testosterone replacement. Others will experience chronic side effects from chemotherapy which may be permanent. These include hearing loss, peripheral neuropathy, Reynaud's phenomenon, renal impairment and ototoxicity (hearing loss and tinnitus). In most patients, there is recovery of spermatogenesis two years after completion of chemotherapy but in all patients, sperm banking should be offered before chemotherapy.

The risk of developing a secondary malignancy is increased

in patients treated for testicular cancer. Men who have been treated with infradiaphragmatic radiotherapy or chemotherapy also have an increased incidence of cardiovascular disease and metabolic syndrome. Patients should be screened for cardiovascular risk factors, given healthy lifestyle advice and advised not to smoke.