A rare cause of bilateral sudden deafness

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Introduction:Diagnostic delay in relapsing polychondritis (RP) is in part explained by the fact that, by definition, the disease has to relapse before the diagnosis can be made, but also by its pluriform clinical presentation: auricular chondritis, arthritis and respiratory tract involvement are the most common signs in RP. Sensorineural hearing loss and vestibular areflexia, as observed in the case we will describe, are less common, and facial nerve involvement is rare. Furthermore, this case is one of very few in which a cochlear implant was indicated after sudden deafness caused by RP.

Case description: In this case, we describe a 62-year-old female with recurring episodes of sudden deafness, vertigo and facial paresis. Within a month’s time, this resulted in bilateral deafness and vestibular areflexia. Erroroneously, the patient was diagnosed and treated as having sudden deafness of unknown origin and subsequently neuroboreliosis (Lyme disease). The true diagnosis of RP was revealed 9 months after initial presentation after the patient was referred to our department for cochlear implantation. At this time, an episode of a red and swollen ear occurred, which prompted further examination and subsequent diagnosis. During cochlear implantation, the base of the cochlea was found to be partially calcified. Insertion and hearing rehabilitation were however successful.

Results and conclusions: Timely identification of RP as the cause of this profound sensorineural hearing loss proved to be important. Not only in order to provide suitable follow-up, but because of the risk of cochlear obliteration, which had already begun in our patient and might have hampered optimal hearing rehabilitation. Our recommendation is to urgently refer any patient with bilateral sudden deafness to a cochlear implant center, especially when signs of postinflammatory calcification of the cochlea are identified, like it was in this case of RP.

Take-home message: Due to the pluriform presentation and relapsing nature of RP, patients almost never present with the ‘full clinical picture’ of RP. Because of this, different doctors of different disciplines (mostly general practitioners, otolaryngologists, ophtalmologists and rheumatologists) see different symptoms at different moments in time. Frequently, symptoms have initially been attributed to other forms of disease, and only careful history taking with attention to symptoms beyond the scope of one’s own specialty, will reveal the diagnosis.

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An incidental finding of a paratesticular leiomyoma on varicocele repair

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Introduction: The paratesticular region is composed of spermatic cord, epididymis, vestigial remnants, and tunica vaginalis. Although paratesticular neoplasms are rare, they are clinically significant lesions that affect patients of all ages. Epididymal tumours, both primary and secondary, whether benign or malignant are extremely rare and the incidence is at most 0.03% of all male cancers. Benign tumours account for 75% of epididymal tumours cases. The most common benign epididymal tumour are adenomatoid tumors, followed by leiomyoma and papillary cystadenoma. Thus, we report a case of leiomyoma in a 51-year-old male who presented with a long standing history of gradual growing scrotal swelling.

Case description: A 51-year-old gentleman referred to the outpatient clinic with left scrotal pain and gradual swelling for more than 7 years. There were no associated obstructive lower urinary tract symptoms, trauma, fever or constitutional symptoms. The patient had a background surgical history of left varicocele repair 7 years ago. He has an unremarkable past medical history. On examination, no masses were felt in the abdomen. There was an old scar at the left groin from the previous surgery and a hard non tender swelling was felt in the left scrotal sac inseparable from the left testes and epididymis, which was irreducible and not translucent. Dilated and tortuous veins above the testicle (‘bag of

Atypical coexistence of genitourinary tuberculosis, metastatic prostate cancer and non-muscle invasive bladder cancer: A case report

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Introduction: Prostate cancer is the second most common cancer in men and the fifth most common cancer worldwide. Screening is based on Prostate Specific Antigen (PSA) blood test and digital rectal examination. The actual diagnosis of prostate cancer can only be made with a prostate biopsy. According to WHO reports, about 30% of the world’s population has latent tuberculosis. Urogenital tuberculosis is responsible for one third of extrapulmonary cases. Bladder cancer is highly aggressive malignancy that causes significant morbidity and mortality. It is the most common malignancy of the urinary tract. Globally it is the 9th most common cancer diagnosed worldwide.

Case description: A 70-year-old male was admitted to undergo fourth in his life transrectal prostate biopsy. He had a Prostate Specific Antigen level of over 1000ng/ml in a routine evaluation. Digital rectal examination revealed asymmetric enlargement of the prostate, with palpable nodules. Patient had medical history of non-muscle invasive bladder cancer, and received intravesical bacillus Calmette-Guerin immunotherapy, MRI of the spine revealed multiple metastases. All four biopsies were negative for prostate cancer. Nevertheless patient received hormonal treatment. Five months after last biopsy purulent fistula of both testes occurred and patient underwent bilateral orchietomy. Histopathology revealed genitourinary tuberculosis and patient received treatment.

Results and conclusions: Prostate cancer should always be considered in elderly men with elevated PSA level and abnormal direct rectal examination findings. Both prostate cancer and tuberculosis may have unusual presentation. Despite negative Mantoux test, normal chest X-ray and negative MGIT BACTEC test patient suffered from genitourinary tuberculosis. Despite the fact that PSA serum level exceeded the norm by 250 times, the rectal examination was abnormal and metastases were well documented, the prostate cancer that was confirmed in the 5th biopsy.

Take-home message: Urogenital tuberculosis is a forgotten clinical problem. Despite the progress in prevention, diagnosis and treatment of tuberculosis it still constitutes a major challenge in everyday clinical practice. Moreover tuberculosis is well known for its’ ability to masquerade as other infectious diseases and mimick cancer.

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