

PEDIATRICS: YOLK SAC/TERATOMA

20-30: SEMINOMA

35-40: SEMINOMA

>50: 1 LYMPHOMA, 2 SPERMATOCYtic SEMINOMA

RISK FACTORS: CRYPTORCHIDISM (x3-8), GONADAL DYSGENESIS, FAMILY HISTORY

	AFP	B-HCG	ORIGIN	OTHERS
SEMINOMA 35%				SENSITIVE TO CHEMO-RT MOST FREQUENT
A) CLASSIC 85%	---	20%Mild	SPERMATOCYTE	A) Most likely to bone mtx
B) ANAPLASTIC 10%	---	---		B) Prognosis same as classic
C) SPERMATOCYTIC 5%	---	---		May have mild B-HCG ↑ C) >50 years. No MTX.
MIXED GERM CELL TUMOUR 40%	SEMINOMA + NON SEMINOMA: TREATED AS NON SEMINOMA			
NON SEMINOMA 25%				20-30 YEARS OLD MEN USUALLY MIXED
1.EMBRYONAL CELL CARCINOMA 80%	+	+	BLASTOCEL (early embryo)	AGGRESSIVE, MTX BAD PROGNOSIS
2.TERATOMA 5%	+	---	EMBRYO (endoderm, ectoderm, mesoderm elements)	Bimodal: <4y/ 20-40 Mature teratoma: benign CHEMO-RT RESISTANT
3.CHORIOCARCINOMA 1%	---	~100%	CHORIONIC VILLUS	Usually mixed HEMATOGENOUS MTX (BRAIN, LUNG) WORST PROGNOSIS ALL TESTICULAR TUMORS, MOST LETHAL
4.YOLK SAC TUMOR 1%	~100%	---	EMBRIO YOLK SAC	Bimodal:1-2y (pure) 20-25y(mixed) MOST COMMON PEDIATRIC TESTICULAR CARCINOMA
GONADOBlastoma Very rare	---	---	MIXURE GONADAL ELEMENTS	May transform malignant (seminoma) DISORDERS SEXUAL DEVELOPMENT, DYSGENETIC GONADS (TURNER)
LEYDING TUMORS 3%	---	---	LEYDING (INTERSTITIAL CELLS)	1/3 Gynecomastia, precoc. puberty ↑ urinary DHEA, androsterone CHEMO/RT resistant
SERTOLI TUMORS <1%	---	---	SERTOLY CELLS	1/3 Gynecomastia, no virilization CHEMO/RT resistant
LYMPHOMA	---	---		>50 years. Non Hodgkin only. Bilateral. Most common mtx to testis.

BIOMARKERS:

AFP: half-life **5-7 DAYS** **NEVER ELEVATED IN PURE CHORIOCARCINOMA AND PURE SEMINOMA**

Normally: <10 ng/ml **S1: <1000 S2: <10-000 S3: >10000**

B-HCG: half-life **24-36 hours** Secreted by syncytiotrophoblasts.

MAY BE ELEVATED IN EMBRYONAL, CHORIOCARCINOMA AND 20 % CLASSIC SEMINOMA

Normally: : <5 mIU/ml **S1: <5000 S2: <50-000 S3: >50000**

LDH: Enzyme secrete by many tissues. Bulky disease.

S1: <1.5 ULN S2: <10 ULN S3: >10 ULN