GYNECOMASTIA – A RARE ETIOLOGY

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INTRODUCTION

Gynecomastia is a frequent reason for Endocrinology consultation and its correct investigation is pivotal towards a precise diagnosis. We present a clinical case of a rare cause of gynecomastia.

CASE REPORT

ANAMNESIS

56-year-old male

Increased breast size for a year, initially tender to palpation, and unquantified weight loss. Neither galactorrhea, nor any nipple discharges were observed. He reported no decreased libido and no erectile dysfunction.

PAST HISTORY

Past medical history: mumps in childhood.
Family history: 4 children, all healthy.
No medication.
No nonprescription medications, anabolic steroids and dietary supplements were taken.

PHYSICAL EXAMINATION

Body mass index: 26 Kg/m^2
Normal hair distribution, with beard.
Breast examination: **bilateral retro-areolar gynecomastia.**
Testicular examination: both testes were found in the scrotal pouch, with approximate sizes of 20 mL (right) and 12 mL (left).

MANAGEMENT AND FOLLOW-UP

	Result	Reference range
β-HCG (mUI/mL)	< 0.01	< 0.01
FSH (mUI/mL)	3.9	1.37-13.58
LH (mUI/mL)	5.2	1.26-10.05
Estradiol (pg/mL)	**70**	**< 62**
Total testosterone (ng/mL)	6.42	3-10.6
α-fetoprotein (ng/mL)	2.25	< 10
Prolactin (ng/mL)	11.2	4.6-21.4
TSH (µUI/mL)	2.52	0.4-4.0
T_4L (ng/mL)	1.3	0.8-1.9

Scrotal ultrasound: a hypoechoic, hypervascularized nodule, 3 cm in size, within the right testicle.

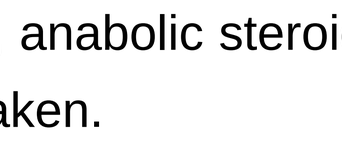

Figure 1

Testicular biopsy: **Leydig cell carcinoma**

Right orchiectomy performed

Regression of Gynecomastia

CONCLUSION: This case report illustrates the importance of a complete medical history, with a good physical examination, and an adequate workup management, to avoid underestimation of rarer, but potentially more severe causes of gynecomastia.