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Dr. Sugawara et al reply

To the Editor:

We sincerely thank Dr. Wang et al for their comments[1] in response to our manuscript, "IgG4-related Disease Mimicking a Paratesticular Tumor and Pelvic Lymph Node Metastasis."[2] Our case report demonstrated IgG4-related paratesticular pseudotumor and lymph node metastasis-like pelvic fibrosis.

As Dr. Wang et al pointed out, testicular involvement of IgG4-related disease is relatively rare; therefore, it is sometimes misdiagnosed as testicular malignancy. Specifically, our patient had fibrotic mass in pelvis, mimicking a metastatic obturator lymph node.[2] If there had been fibrotic mass in a more atypical location, the urologist might have considered IgG4-related disease. Since the majority of patients with IgG4 testicular involvement will visit urologists first, collaboration between urologists, rheumatologists, and pathologists is required for appropriate diagnosis and treatment. Although serum IgG4 levels are useful for screening, their specificity and sensitivity are limited. Approximately 20% of patients with IgG4-related autoimmune pancreatitis have normal serum concentration.[3] On the other hand, elevated serum IgG4 was observed in 22% of the non–IgG4-related disease population.[4] We should not overestimate serum IgG4 concentration as a marker of IgG4-related disease. As Dr. Wang et al commented, orchiectomy could have been avoided if preoperative testicular puncture biopsy had been performed in our patient. In addition to testicular puncture biopsy, the usefulness of magnetic resonance imaging[5] and intraoperative frozen section assessment[6] have been reported for differentiating benign pseudotumor from malignancy.

Again, we thank Dr. Wang et al for giving us an opportunity to discuss our case report. We believe that this case report will alert rheumatologists to the importance of differentiating IgG4-related disease from malignancy to avoid unnecessary surgical interventions.

Eri Sugawara[1], MD, PhD
Taiki Sato[1], MD, PhD
Kazuaki Katsumata[1], MD, PhD
[1]Department of Rheumatology, Tonan Hospital, Sapporo, Japan.

The authors declare no conflicts of interest relevant to this article.

Address correspondence to Dr. E. Sugawara, 060-0004 N4W7, Chuo-Ku, Sapporo, Japan. Email: e.sugawara@huhp.hokudai.ac.jp.

REFERENCES

1. Wang G, Zhuo N, Wen Z[1]. IgG4-related disease with testicular involvement: association or coincidence? J Rheumatol 2023;50:715.
2. Sugawara E, Sato T, Katsumata K. IgG4-related disease mimicking a paratesticular tumor and pelvic lymph node metastasis. J Rheumatol 2022 Jun 15 (Epub ahead of print).
3. Sah RP, Chari ST. Serologic issues in IgG4-related systemic disease and autoimmune pancreatitis. Curr Opin Rheumatol 2011; 23:108-13.
4. Carruthers MN, Khosroshahi A, Augustin T, Deshpande V, Stone JH. The diagnostic utility of serum IgG4 concentrations in IgG4-related disease. Ann Rheum Dis 2015;74:14-8.
5. Cassidy FH, Ishioka KM, McMahon CJ, et al. MR imaging of scrotal tumors and pseudotumors. Radiographics 2010;30:665-83.
6. Subik MK, Gordetsky J, Yao JL, di Sant'Agnese PA, Miyamoto H. Frozen section assessment in testicular and paratesticular lesions suspicious for malignancy: its role in preventing unnecessary orchiectomy. Hum Pathol 2012;43:1514-9.