CASE REPORT

Giant intrascrotal lipoma

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SUMMARY

Intrascrotal lipomas are rarely seen. Scrotal lipomas originate from the spermatic cord. We present a 64-year-old male patient, in the light of the literature, with painless swelling on the left half of the scrotum, histopathologically diagnosed with scrotal lipoma.

BACKGROUND

Benign mesenchymal tumours of the scrotum are rarely seen. Mesenchymal scrotal lipomas originating from the spermatic cord, epididymis and tunica vaginalis may also originate from the subcutaneous adipose cells of the scrotum. Lipomas originating from the adipose cells of the scrotal wall are named 'primary scrotal lipomas.

CASE PRESENTATION

A 64-year-old male patient presented to our hospital with a painless swelling of the left scrotal region that he had had for the past 10 years, but continuously started growing the last 2–3 months. The physical examination revealed an elastic, non-tender, irreducible, regularly shaped mass on the left side of the scrotum apart of the testicle. Both testicles and spermatic cords were normal. Serum β -hCG, α -feto protein and lactate dehydrogenase levels were in normal ranges. Ultrasonography (US) revealed a heterogeneous hyperechoic solid mass with $10 \times 9 \times 5$ cm in dimension, isoechoic with adipose tissue, neighbouring the left inguinal canal, pushing the testicle to the right side (figure 1). No vascularisation was detected on the Doppler imaging. Surgery was planned with the initial diagnosis of intrascrotal lipoma. The testicle, epididymis and cord structures were intact, and the tumour dissected. The pathology results report revealed benign lipoma with regular thin capsule. The specimen dissected weighed 550 g. The histopathology report stated lobulated, yellow-coloured, encapsulated lipomatous appearance. Microscopic cross-sectional report stated encapsulated primary scrotal lipoma consisting of mature adipose cells and fibrotic tissue with no sarcomatous structures.

DIFFERENTIAL DIAGNOSIS

Lipomatosis, lipoblastoma and liposarcoma.

OUTCOME AND FOLLOW-UP

When evaluating large scrotal masses, lipoma should be kept in mind, as well as testicular tumour and hernia.

DISCUSSION

Although benign neoplasms of the spermatic cord and intrascrotal tissues are common, lipomas are

rare.¹ The regions of origin in scrotal lipomas are not fully detectable. They are classified into three groups: (1) originating from the adipose tissue of the spermatic cord evolving towards the scrotum; (2) developing in the spermatic cord and (3) originating within the scrotal wall (primary scrotal lipoma). The second type comprises half of all cord tumours.² Despite being benign, they might also be malignant. Primary scrotal lipomas originating from the isolated adipose lobules of the scrotal subcutaneous tissue may vary in size (225 g to 9 kg).² The specimen dissected was 550 g and consistent with the data from the literature. Symptoms vary with mass size, weight and the pressure caused with growing. Clinically, it imitates inguinal herniation and haematoma. US and MRI play an important role in the evaluation of these masses.¹ Scrotal US provides information of the localisation, cystic or solid nature of the mass.^{1–3} Even though the majority of solid extratesticular masses are benign, it is hard to distinguish malignancy. In conditions like these MRI may be of use.¹ The histopathology of primary scrotal lipoma may be confused with lipomatosis, lipoblastoma and liposarcoma. Lipoblastoma is generally seen in early childhood. Lipomatosis may induce proliferation of mature adipose tissue and infiltration to surrounding tissues such as muscles, while lipomas are encapsulated.⁴ Primary scrotal liposarcoma is rare. Sometimes lipoma like well-differentiated liposarcomas can be seen and the differential diagnosis is complicated.

Figure 1 On ultrasonography, a heterogeneous hyperechoic solid mass, isoechoic with adipose tissue, neighbouring the left inguinal canal, pushing the testicle to the right side was detected.

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Liposarcomas are differentiated because they infiltrate to deep tissues.^{5 6} Being encapsulated and not infiltrated to the surrounding tissues helped us differentiate it from lipomatosis, and the presence of mitosis and atypia helped us differentiate it from liposarcoma. No malignancy was present in the case reported. On the third and sixth months of follow-up no local relapse was seen. We presented this case as a rare phenomenon.

Learning points

- ▶ Scrotal lipomas are seen rarely.
- ▶ Clinically, it imitates inguinal herniation and haematoma.
- ▶ It is hard to distinguish malignancy.

Competing interests None.

Patient consent Obtained.

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