

Intrascrotal Capillary Haemangioma – Case Report and Literature Review

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Abstract

Intrascrotal capillary haemangiomas are very rare benign tumours. They usually present as a scrotal mass, which requires scrotal exploration and tumour excision for definitive diagnosis. They can be easily misinterpreted as testicular tumours, epididymal cysts or sarcomas. Imaging is usually of limited diagnostic value, but can reliably exclude testicular cancer. Their identification is important as they have a tendency of recurrence. We present a 16 year old male patient who had an intrascrotal capillary haemangioma, which was fully excised upon scrotal exploration for a suspicious scrotal mass.

Keywords: Haemangioma; Scrotum; Benign tumour

Introduction

Haemangioma are benign vascular neoplasms which can be found in any part of the body. The most common locations are muscle, liver and spleen. Scrotal haemangiomas are very rare accounting for only 1% of all haemangiomas [1].

In general haemangiomas may be classified into capillary, cavernous, arteriovenous, venous, and mixed and those with abnormal vessels that cannot be determined [2]. In the scrotum venous [3], capillary [4] and cavernous [5, 6] haemangiomas have been described and these may be cutaneous or intrascrotal. Rarely do they track to other areas including the anterior abdominal wall, perineum or the thigh [7]. They are either congenital or secondary to neoplasm or trauma.

They present, usually in childhood, as a lump related to the testes which may or may not have pain associated [8]. They have been known to mimic inguinal hernia [9] and it may not be possible to differentiate them from sarcoma or testicular malignancy prior to surgical exploration [10].

However, imaging can characterise a scrotal mass

in preparation for treatment detailing associated abnormalities [6]. The imaging involved includes ultrasound scan which may show a hypoechoic, hyperechoic or heterogeneous structure [8]. Doppler studies can be done although lack of blood flow does not rule out haemangioma. Cavernous haemangiomas present as soft tissue mass containing phleboliths, which is best seen on CT or plain film [9].

Case Presentation

We present the case of a 16 year old male who was referred by his GP with a painful lump in his right hemiscrotum that had been increasing in size for the last 8 months. Upon chaperoned genital examination in the urology clinic there was a visible lump in the right hemiscrotum with no skin changes. Palpation revealed a tender, non-translucent mass confined to the scrotum and examination of the external inguinal ring was unremarkable, making the diagnosis of an inguinal hernia very unlikely. The testicle was of normal consistency, but the epididymis was not palpated due to the tender encroaching mass.

An urgent ultrasound scan of the scrotum was performed, which showed a large soft tissue mass measuring approximately 3cm surrounded by multiple fluid filled cysts seen with maximum diameter of approximately 2cm, and a further 1.7 cm soft tissue mass is also seen adjacent to the previous one (See Figures 1 and 2). The left hemiscrotum was unremarkable. Testicular tumour markers were sent, and were within acceptable limits.

The patient was consented and booked for a scrotal exploration, with a potential orchidectomy in case the mass couldn't be safely separated from the testicle. Upon scrotal exploration, the testicle was entirely normal but, arising from the inner Dartos layer of the scrotal wall, there was a large, blood filled mass, which was carefully dissected and excised *en bloc*. The pathology report confirmed a scrotal capillary haemangioma measuring 64x35x15 mm, containing a cystic cavity within. He was followed up regularly and has not had not developed recurrence of the haemangioma.

Figures 1and 2: Ultrasound scan of the right hemiscrotum. E- Epididymis, RT – Right Testis, CM – Cystic mass

Figure 1:

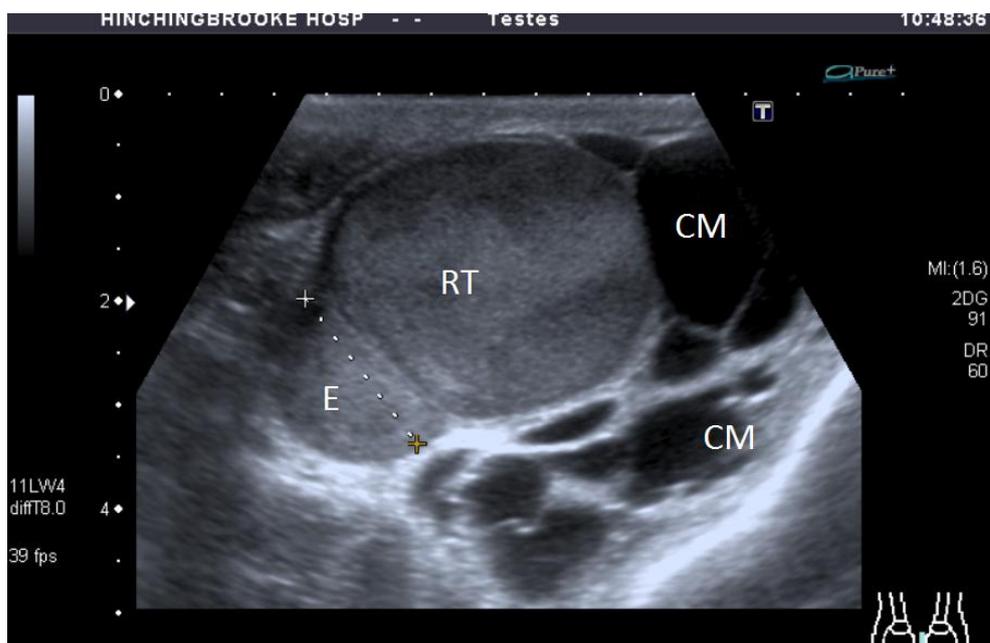
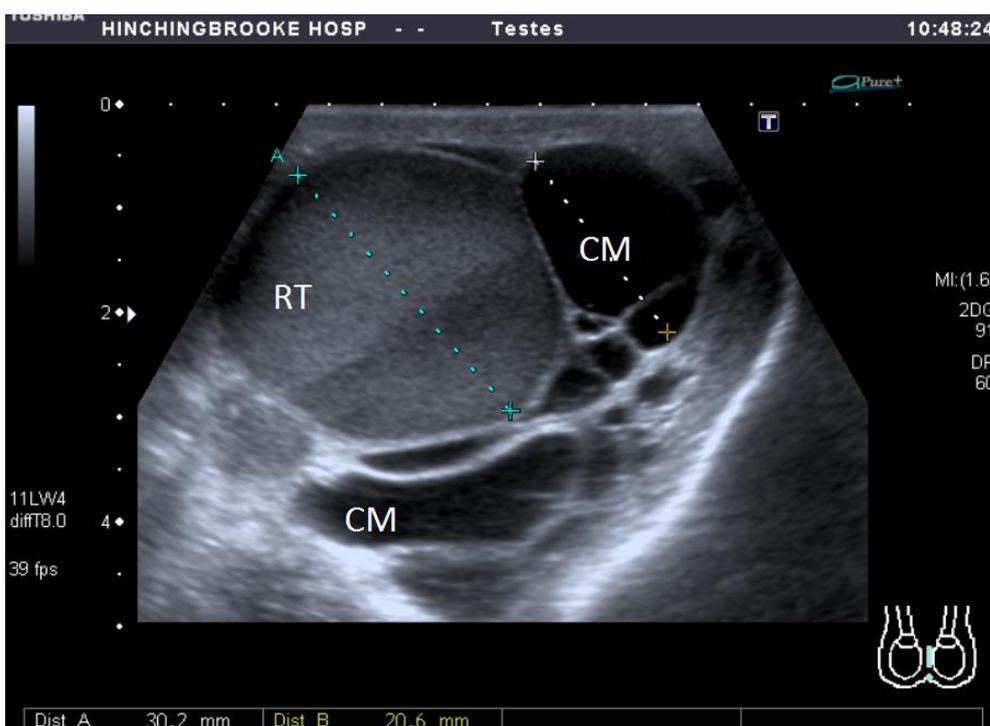


Figure 2:



Discussion

Scrotal haemangiomas are very rarely suspected on clinical examination of a scrotal lump. A testicular tumour is the most common cause of a scrotal lump in a young male. Epididymo-orchitis and testicular torsion should always be excluded, as they do present a clinical emergency. In this case imaging was not particularly helpful as the cystic structures were not characteristic for haemangioma and could have been misinterpreted as epididymal cysts, while the mass could have been mistaken for a sarcoma, or an inguinal hernia.

Treatment options depend on whether the haemangioma is cutaneous or intrascrotal. Cutaneous

haemangioma involute and therefore conservative management is indicated [1]. For masses within the scrotum definitive treatment is necessary. This may involve exploration and surgical excision, laser therapy or the use of solarising agents [6]. In one case report, orchidectomy was needed as the haemangioma was difficult to separate from the testis [3]. Testicular damage was reported as a long term consequence secondary to a large scrotal haemangioma. It was thought to be due to the heat produced by the haemangioma [10]. The normal testicular echo structure in our case allowed for a safe scrotal exploration.

Intrascrotal capillary haemangiomas are very rare benign tumours that do not metastasise but carry the risk of recurrence and bleeding and can easily be overlooked.

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