Haemorrhage in a scrotal lymphangioma in a child: A rarity

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ABSTRACT

We report here a case of cystic lymphangioma of scrotum presenting as acute scrotum due to haemorrhage. The diagnosis was confirmed on ultrasonography and magnetic resonance imaging and managed successfully by surgical excision. There was past history of bilateral congenital cataract for which the patient had undergone surgery with complete visual recovery. Scrotal cystic lymphangioma complicated by haemorrhage is rare; hence, the case is being reported with a review of literature.

Key words: Haemorrhage, scrotal lymphangioma, child

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INTRODUCTION

Lymphangiomas or cystichygromas are congenital lymphatic hamartomas predominantly occurring in neck and axilla.[1] Scrotum is one of the unusual sites of lymphangiomas,[2] where it can arise from the scrotal wall, tunics, testis, epididymis, spermatic cord, or Colle's fascia.[3,4] Haemorrhage in a cystic scrotal lymphangioma is extremely rare, misdiagnosis is common, although ultrasonography (USG) is usually diagnostic. Complete surgical excision is curative. We present this case to indicate that bleeding into cystic lymphangioma of the scrotum, though a rarity, should be considered in the differential diagnosis of an acute swollen scrotum.

CASE REPORT

A three-year-old boy presented to us with progressive enlargement of left hemiscrotum for four months. Initially the swelling was diagnosed as hydrocoele by some private practitioner and was being managed conservatively, but for last seven days there was sudden increase in size along with bluish discoloration of overlying skin and the child presented to us with an acute scrotum. There was no history of prior trauma, fever, or any bleeding diasthesis.

Examination revealed a nontender, multiloculated, nontransilluminant scrotal swelling, measuring 10 × 8 cm on left hemiscrotum, with normal local temperature and bluish discoloration [Figure 1]. Cough impulse was negative. The left testis and spermatic cord felt normal and separate from the swelling; the right scrotum was normal. USG and MRI supported a clinical diagnosis of scrotal lymphangioma with haemorrhage. Coagulation profile of the child was within normal limits.

The child was blind since birth and had been diagnosed to have bilateral congenital cataract for which he had successful surgical caract extraction.

Surgical scrotal exploration revealed a multiloculated swelling arising from the tunics and measuring 10 × 8 cm with haemorrhage in many loculi; a few of the loculi contained clear fluid [Figure 2]. The testis and spermatic cord were separate from the swelling [Figure 3]. Total excision of the swelling was done and wound was closed over a drain. Postoperative period was uneventful and the diagnosis was confirmed at histopathology as cystic lymphangioma of the scrotum.

DISCUSSION

Lymphangiomas are basically lymphatic hamartomas which result from inadequate drainage of lymph from sequestrated lymphatic vessels. These are usually congenital and result from atresia of the efferent lymphatics or lack of communication between lymphatics and venous channels.[1,5] Sometimes, these can be acquired because of destruction of lymphatics after inflammation, trauma, or degeneration.[6] Based on histological appearance, these are of three types: Capillary, cavernous, and cystic, with cystic form being the most common.

Approximately 95% of these occur in neck or axilla; scrotum, retroperitoneum, gluteal region, mediastinum, groin, pelvis, mesentery, omentum and spleen are

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Figure 1: Clinical photograph showing left lobulated scrotal swelling with bluish discoloration of overlying skin



Figure 2: Haemorrhage in cystic hygroma

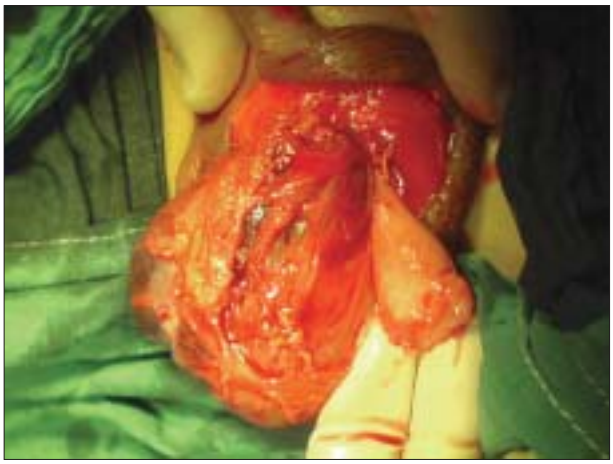


Figure 3: Cord and testis separate from the lesion

very rare sites.[2,7,8] Scrotum is an extremely rare site for lymphangioma. Singh *et al*.[2] reported 32 cases of cystic lymphangiomas in children of which only one was located in scrotum.

Haemorrhage into scrotal lymphangioma is an extremely rare complication, and when it occurs the patient presents with acute scrotum which may lead to inadequate treatment with a risk of recurrence.[2,9] If the diagnosis is made preoperatively, the approach for exploration would be scrotal to ensure complete excision. Hurwitz *et al*.[9] reported seven cases of scrotal cystic lymphangioma over a period of ten years, all of which were misdiagnosed preoperatively.

USG usually shows a multicystic extratesticular mass with internal septae. Colour doppler sonography further characterises the lesion by showing blood flow within the septae. When haemorrhage has occured in the cysts, it will be seen as moving internal echoes within the hypoechoic lesions.[10,11] As cystic lymphangiomas do not communicate with the lymphatic system, lymphography is not useful.[12] MRI may be helpful in the diagnosis but usually not needed.

The gold standard for treatment is complete surgical excision of the mass along with the overlying skin. Incomplete excision can result in recurrence.[9] Other modalities of treatment such as injection of sclerosants, extensive fulguration, and cryotherapy have not yielded impressive results.[12]

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