Pediatric Surgery LATAM

Open access · CC BY 4.0
pediatricsurgerylatam.org
Vol. 1, No. 1 · 2026
ISSN 2838-5608
doi: https://doi.org/10.68838/psl.2026.00005

CASE REPORT

A case report of congenital accessory scrotum with perineal lipoma and hemiscrotal hypoplasia in an infant

Lisseth Alexandra Torres Aguilar[a,*], Adriana Lucia Castillo Santin[b], Kevin Andrés Encalada Castillo[c], Pamela Lucia Encalada Castillo[c]

a Hospital Santa Inés, Loja, Ecuador
b Consultorios Médicos Santa Marianita, Cuenca, Ecuador
c Universidad Católica, Azogues, Ecuador
* Corresponding author: Lisseth Alexandra Torres Aguilar (lis.alejandra93@gmail.com)

ARTICLE INFO

Article history
Received 13 August 2026
Accepted 1 October 2026
Available online 28 October 2026

Keywords
accessory scrotum
perineal lipoma
congenital anomaly
scrotoplasty
hemiscrotal hypoplasia
case report.

Palabras clave
escroto accesorio
lipoma perineal
anomalía congénita
escrotoplastia
hipoplasia hemiescrotal
reporte de caso.

License
CC BY 4.0

ABSTRACT

Background: Accessory scrotum is a rare congenital anomaly in which scrotal-like skin develops outside the normal scrotal sac and contains no testis. Association with a perineal fatty mass and with an abnormal native scrotum requires careful anatomical assessment to distinguish the accessory tissue from the testes and to plan reconstruction.
Case presentation: A one-month-old male infant, born at term from a singleton pregnancy, was evaluated at a specialty medical center in Loja, Ecuador. Examination showed left hemiscrotal hypoplasia, an elastic perineal mass, and a small pedunculated scrotal-like skin appendage; both testes were in the scrotum. Abdominal ultrasonography was normal. Scrotoperineal ultrasonography showed that the mass had adipose characteristics and that the right testis moved into the inguinal canal during examination. At eight months of age the accessory scrotum and perineal mass were excised and the left hemiscrotum was reconstructed in a single operation. Histopathology showed a 4.2 × 3.4 × 1.5 cm fibroadipose specimen and a polypoid skin specimen with subcutaneous tissue, without neoplasia. The available follow-up is a photograph taken four months after surgery.
Conclusion: Accessory scrotum with a lipomatous lesion should be considered when a congenital perineal mass is accompanied by scrotal-like skin without gonadal content. Clinical and ultrasonographic findings supported simultaneous excision and reconstruction. Histology was consistent with a benign adipose lesion but did not document dartos muscle, so the diagnosis of accessory scrotum remains clinical. Functional outcome and long-term safety could not be assessed.

RESUMEN

Escroto accesorio congénito con lipoma perineal e hipoplasia hemiescrotal en un lactante: reporte de un caso

Resumen
Antecedentes: El escroto accesorio es una anomalía congénita rara en la que se desarrolla piel de aspecto escrotal fuera del saco escrotal normal, sin contener testículo. Su asociación con una masa grasa perineal y con un escroto nativo anormal exige una evaluación anatómica cuidadosa para distinguir el tejido accesorio de los testículos y planificar la reconstrucción.
Presentación del caso: Un lactante masculino de un mes de edad, nacido a término de un embarazo único, fue evaluado en un centro médico de especialidades en Loja, Ecuador. El examen mostró hipoplasia del hemiescroto izquierdo, una masa perineal elástica y un pequeño apéndice cutáneo pediculado de aspecto escrotal; ambos testículos estaban en el escroto. La ecografía abdominal fue normal. La ecografía escrotoperineal mostró que la masa tenía características adiposas y que el testículo derecho ascendía al conducto inguinal durante el examen. A los ocho meses de edad se extirparon el escroto accesorio y la masa perineal, y se reconstruyó el hemiescroto izquierdo en una sola operación. La histopatología mostró una muestra fibroadiposa de 4,2 × 3,4 × 1,5 cm y una muestra de piel polipoide con tejido subcutáneo, sin neoplasia. El seguimiento disponible es una fotografía tomada cuatro meses después de la cirugía.
Conclusión: Debe considerarse el escroto accesorio con una lesión lipomatosa cuando una masa perineal congénita se acompaña de piel de aspecto escrotal sin contenido gonadal. Los hallazgos clínicos y ecográficos respaldaron la escisión y la reconstrucción simultáneas. La histología fue compatible con una lesión adiposa benigna, pero no documentó músculo dartos, por lo que el diagnóstico de escroto accesorio sigue siendo clínico. No fue posible evaluar el resultado funcional ni la seguridad a largo plazo.

Please cite this article as: Torres Aguilar LA et al., A case report of congenital accessory scrotum with perineal lipoma and hemiscrotal hypoplasia in an infant. Pediatr Surg Latam (2026) 1(1):1–5. doi:10.68838/psl.2026.00005

Introduction

Accessory scrotum is a rare congenital anomaly in which scrotal-like skin develops outside the normal scrotal sac and contains no testis. It is recognized by examination of the external genitalia and perineum, where it may appear as a pedunculated appendage or as rugose skin overlying a subcutaneous mass[1–3]. The literature consists mainly of case reports and small series, so the frequencies of associated anomalies reported in these publications are not population estimates.

The association with perineal lipoma is clinically relevant because a mass resembling genital tissue may be mistaken for another malformation or for a mesenchymal tumor. Heaton et al. described a presentation mimicking penoscrotal pseudoduplication, and the series of Park and Hong and of Tocchioni et al. show that perineal adipose tissue may coexist with several external genital anomalies[4–6]. Assessment should establish the position of each testis, the configuration of the native scrotum, and the relationship of the mass to the anus and adjacent structures.

Proposed developmental mechanisms include abnormal migration, division, or fusion of the labioscrotal swellings and interposition of mesenchymal tissue. These explanations remain hypothetical, because accessory scrotum can also occur without a fatty mass[7,8]. When hemiscrotal hypoplasia is present, management must address both excision of the accessory tissue and the need to reconstruct the native scrotum.

We report an infant with accessory scrotum, perineal lipoma, and left hemiscrotal hypoplasia treated by simultaneous excision and scrotoplasty. The report follows the applicable items of the CARE guidelines[9].

Case presentation

Patient information and clinical findings

A male infant was first evaluated at one month of age at a specialty medical center in Ecuador. He was born at term from a singleton pregnancy with a birth weight appropriate for gestational age. The penis was normally formed and the right hemiscrotum appeared normal. The left hemiscrotum was hypoplastic. Both testes were palpable in the scrotal sac. In the perineum there was an elastic mass and a small pedunculated, rugose, scrotal-like skin appendage with no palpable contents. The anus was normally positioned and configured. The preoperative anatomy is shown in Figure 1. A clinical diagnosis of accessory scrotum associated with a perineal mass was made at this first visit.

Diagnostic assessment

Abdominal ultrasonography showed no pathological findings. Scrotal ultrasonography located the left testis in the scrotal sac (6.2 × 8.1 × 12.5 mm) and showed the right testis (7.1 × 9 × 12.3 mm) moving into the inguinal canal during the examination. Both testes had homogeneous echogenicity. The perineal mass was described as subcutaneous tissue with adipose characteristics. Scrotal-like skin without gonadal content, a perineal fatty mass, and hemiscrotal hypoplasia together supported a clinical diagnosis of accessory scrotum associated with perineal lipoma.

Therapeutic intervention

At eight months of age the accessory scrotal tissue and the perineal lipoma were excised, and the left hemiscrotum was reconstructed during the same operation. A Redon drain was placed and removed on the first postoperative day. The immediate postoperative appearance is shown in Figure 2.

Histopathological findings

The specimen labeled lipoma was a 4.2 × 3.4 × 1.5 cm fragment of fibroadipose tissue. The cutaneous appendage consisted of polypoid skin with subcutaneous tissue and showed no evidence of neoplasia. The pathology report did not describe dartos muscle or the distribution of skin appendages, and no immunohistochemical studies were performed. The findings therefore indicate a benign lesion but do not provide microscopic evidence of scrotal differentiation.

Follow-up and outcomes

The available follow-up is a photograph taken four months after surgery, at approximately twelve months of age (Figure 3). It documents the appearance of the reconstructed region. No standardized clinical assessment of wound healing, symmetry, testicular position, or function was recorded, and no adverse events were documented.

Timeline

The sequence of assessment and treatment is summarized in Table 1.

Discussion

This case shows the value of assessing the accessory skin, the perineal mass, and the native scrotum together. Excision of the ectopic tissue treats one component of the anomaly, whereas the left hemiscrotal hypoplasia adds a reconstructive problem. The clinical diagnosis rested on the scrotal-like appearance of the appendage, the absence of a gonad within it, and the presence of both testes in the scrotal sac. This correlation is more useful for surgical planning than the external appearance of the mass.

Accessory scrotum must be distinguished from ectopic scrotum, in which native scrotal tissue is displaced and may contain the ipsilateral testis, and from penoscrotal transposition and bifid scrotum, which alter the arrangement of the native scrotum. Park and Hong documented lipomas associated with several scrotal anomalies in five patients, which shows that perineal adipose tissue alone does not define a specific malformation[5]. In our patient, left hemiscrotal hypoplasia is an abnormality of the native scrotum; it does not imply testicular absence, and the perineal appendage cannot be interpreted as a functional hemiscrotum.

The differential diagnosis of the mass includes lipoma, hamartoma, and lipoblastoma, and a more complex perineal lesion may raise the possibility of sacrococcygeal teratoma. Heaton et al. illustrated that a lipomatous lesion can resemble genital pseudoduplication and require imaging and histological correlation[4]. Here the elastic consistency and adipose

Please cite this article as: Torres Aguilar LA et al., A case report of congenital accessory scrotum with perineal lipoma and hemiscrotal hypoplasia in an infant. Pediatr Surg Latam (2026) 1(1):1–5. doi:10.68838/psl.2026.00005



Fig. 1. Preoperative photograph showing a perineal mass and accessory scrotum associated with left hemiscrotal hypoplasia. Surgery was performed at eight months of age. The photograph is reproduced with the consent of the patient's legal guardians.



Fig. 2. Immediate postoperative appearance after excision of the perineal lipoma and accessory scrotum and reconstruction of the left hemiscrotum, at eight months of age. The photograph is reproduced with the consent of the patient's legal guardians.



Fig. 3. Appearance of the scrotoperineal region four months after surgery, at approximately twelve months of age. The image documents morphology only and does not replace a clinical assessment of function.

appearance on ultrasonography favored a lipomatous lesion, but ultrasonography cannot replace histology in separating mesenchymal lesions. The pathology report did not comment on lipoblasts, which is relevant because lipoblastoma is the main fatty tumor of infancy.

Ultrasonography documented testicular position and size and the adipose nature of the mass. Magnetic resonance imaging has been used in published cases to define anatomical relationships when the extent or composition of the lesion was uncertain[1,4]. In perineal lipomas, imaging of the spine and pelvis is also relevant to exclude extension into the pelvis or an associated spinal dysraphism. Such imaging is not documented in the records available for this patient. The normal anal position and normal abdominal ultrasonography are findings of the assessment performed; they do not exclude the full spectrum of associated malformations.

A plausible explanation for the association is that adipose tissue interferes with the continuity or fusion of the labioscrotal swellings. Chatterjee et al. reviewed proposed developmental mechanisms, and Iida et al. studied the differentiation of accessory tissue through androgen receptor expression[7,8]. The hemiscrotal hypoplasia in this patient may reflect a local developmental disturbance, but this case does not show that the lipoma caused it or suggest an underlying hormonal or genetic abnormality.

Histology distinguishes the benign nature of a specimen from the identification of scrotal tissue. In other reports, smooth muscle consistent with dartos supported the diagnosis[7,8]. In the present case the description of polypoid skin and subcutaneous tissue without neoplasia did not document it. Accessory scrotum therefore remains a clinical diagnosis, and perineal lipoma a clinicopathological interpretation consistent with the fibroadipose specimen. Review of the slides for dartos and skin appendages could settle this point.

Excision of both the appendage and the perineal mass,

Please cite this article as: Torres Aguilar LA et al., A case report of congenital accessory scrotum with perineal lipoma and hemiscrotal hypoplasia in an infant. Pediatr Surg Latam (2026) 1(1):1–5. doi:10.68838/psl.2026.00005

Table 1. Timeline of assessment and treatment.

Time point	Event
1 month of age	Initial assessment: left hemiscrotal hypoplasia, elastic perineal mass, and pedunculated scrotal-like appendage; both testes in the scrotum. Clinical diagnosis of accessory scrotum.
Preoperative period	Abdominal ultrasonography: no abnormalities. Scrotoperineal ultrasonography: adipose perineal lesion; right testis moving into the inguinal canal during examination.
8 months of age	Excision of the accessory scrotum and perineal lipoma with left scrotoplasty; Redon drain placed.
Postoperative day 1	Redon drain removed.
4 months after surgery (about 12 months of age)	Photographic documentation of the reconstructed region.

with reconstruction of the hypoplastic hemiscrotum, is consistent with the individualized anatomical correction described in the literature. Kavecan et al., Iida et al., and Shimotake et al. report operations at different ages and in different anatomical configurations[2,8,10], so no optimal age for surgery can be asserted. In this patient surgery was performed at eight months of age. The details of the reconstructive technique were not available for description.

The movement of the right testis into the inguinal canal during ultrasonography is a dynamic finding. Without a clinical record of its position, of whether it could be brought into the scrotum, and of whether it stayed there, it is insufficient to diagnose cryptorchidism or a retractile testis, and no additional category is assigned. Follow-up should document the position of both testes together with the progress of the reconstruction.

Limitations

The main limitations are the summarized pathology description, the absence of a detailed operative report, and postoperative documentation limited to a single photograph at four months. Spinal or pelvic imaging, functional outcome, a standardized cosmetic assessment, the caregivers' perspective, and longitudinal data on complications and recurrence are not available. A single case cannot estimate risk or show the superiority of a technique. The contribution of this report is therefore limited to describing the anatomy and the treatment performed.

Conclusions

Accessory scrotum with a lipomatous lesion should be considered when a congenital perineal mass is accompanied by scrotal-like skin without gonadal content. In this infant, physical examination and ultrasonography supported combined excision and reconstruction of the left hemiscrotum. Histology was consistent with benign adipose tissue but did not document scrotal differentiation. The four-month photograph provides morphological information only; assessment of the outcome requires clinical follow-up of wound healing and testicular position.

Ethical considerations and informed consent

Ethics approval for this case report was granted by the responsible institutional ethics committee, and the approval document was submitted to the journal with the manuscript. Written informed consent was obtained from the patient's parents or legal guardians for clinical care, use of clinical data, and publication of this case report, including the photographs; the signed consent was also submitted to the journal. Patient confidentiality was protected by omitting personal identifiers.

Declarations

Author contributions: Provided in the submission form and the title page.

Funding: This case report received no funding.

Conflicts of interest: The authors declare no conflicts of interest.

Data availability: Individual clinical data are not publicly available because they contain confidential information about a minor. Reasonable requests may be directed to the corresponding author and will be considered in accordance with the consent provided and applicable regulations.

Ethical considerations

The ethics approval document is attached in the system.

Informed consent. Written informed consent was obtained from the patient's parents or legal guardians for clinical care, use of clinical data, and publication of the case, including the photographs. Minor's assent: not applicable, as the patient was an infant (1 to 12 months of age during follow-up). The signed document is attached in the system.

Conflict of interest

None. The authors declare no conflicts of interest.

Funding

This case report received no funding.

Author contributions (CRediT)

L.A.T.A.: Conceptualization, Methodology, Investigation, Writing – original draft, Writing – review & editing.

A.L.C.S.: Methodology, Investigation, Data curation, Formal analysis, Writing – review & editing.

K.A.E.C.: Conceptualization, Investigation, Data curation, Formal analysis, Writing – original draft.

P.L.E.C.: Methodology, Investigation, Interpretation of results, Writing – original draft, Writing – review & editing.

Please cite this article as: Torres Aguilar LA et al., A case report of congenital accessory scrotum with perineal lipoma and hemiscrotal hypoplasia in an infant. Pediatr Surg Latam (2026) 1(1):1–5. doi:10.68838/psl.2026.00005

Use of generative artificial intelligence

Generative AI was not used.

Data availability

Individual clinical data are not publicly available because they contain confidential information about a minor. They may be requested from the corresponding author and will be considered in accordance with the consent provided and applicable regulations.

References

1. Murase N, Uchida H, Hiramatsu K. Accessory scrotum with perineal lipoma diagnosed prenatally: case report and review of the literature. Nagoya J Med Sci. 2015;77(3):501–506. PMID: 26412897.
2. Kavecan II, Jovanovic-Privrodski JD, Dobanovacki DS, Obrenovic MR. Accessory scrotum attached to a peduncular perineal lipoma. Pediatr Dermatol. 2012;29(4):522–524. doi:10.1111/j.1525-1470.2011.01524.x. PMID: 21692841.
3. El-Mefleh N, Al-Hussein H, Othman E, Darwish H, Alsaleh M. Accessory scrotum in neonate: a rare congenital scrotal anomaly. Urol Case Rep. 2025;60:103021. doi:10.1016/j.eucr.2025.103021. PMID: 40248515.
4. Heaton PA, Shalaby MS, Vaina CL, Brown SE, Gradhand E, Paul SP. Accessory scrotum with perineal lipoma/hamartoma mimicking penoscrotal pseudoduplication. Sudan J Paediatr. 2021;21(2):219–223. doi:10.24911/SJP.106-1597356690. PMID: 35221438.
5. Park KH, Hong JH. Perineal lipoma in association with scrotal anomalies in children. BJU Int. 2006;98(2):409–412. doi:10.1111/j.1464-410X.2006.06244.x. PMID: 16879688.
6. Tocchioni F, Caporalini C, Buccoliero A, Facchini F, Ghionzoli M, Morini F. Case report: congenital perineal lipoma associated with additional external genitalia anomalies. Front Pediatr. 2022;10:923801. doi:10.3389/fped.2022.923801. PMID: 35844732.
7. Chatterjee S, Gajbhiye V, Nath S, Ghosh D, Chattopadhyay S, Das SK. Perineal accessory scrotum with congenital lipoma: a rare case report. Case Rep Pediatr. 2012;2012:757120. doi:10.1155/2012/757120. PMID: 22919527.
8. Iida K, Mizuno K, Nishio H, Moritoki Y, Kamisawa H, Kurokawa S, et al. Accessory scrotum with perineal lipoma: pathologic evaluation including androgen receptor expression. Urol Case Rep. 2014;2(6):191–193. doi:10.1016/j.eucr.2014.08.006. PMID: 26958486.
9. Gagnier JJ, Kienle G, Altman DG, Moher D, Sox H, Riley D; CARE Group. The CARE guidelines: consensus-based clinical case reporting guideline development. J Med Case Rep. 2013;7:223. doi:10.1186/1752-1947-7-223. PMID: 24228906.
10. Shimotake T, Tokiwa K, Yanagihara J, Iwai N. Accessory scrotum with lipoma in an infant. Z Kinderchir. 1990;45(4):255–256. doi:10.1055/s-2008-1042596. PMID: 2238856.

Copyright and license

Copyright © 2026 Lisseth Alexandra Torres Aguilar, Adriana Lucia Castillo Santin, Kevin Andrés Encalada Castillo, Pamela Lucia Encalada Castillo.

This work is licensed under a Creative Commons Attribution 4.0 International license (CC BY 4.0): https://creativecommons.org/licenses/by/4.0/. The authors retain copyright and grant the journal the right of first publication; others may use the published work provided they credit its authorship and its first publication in this journal. Authors may enter into separate agreements for the non-exclusive distribution of the published version, stating that it was first published in this journal.

Please cite this article as: Torres Aguilar LA et al., A case report of congenital accessory scrotum with perineal lipoma and hemiscrotal hypoplasia in an infant. Pediatr Surg Latam (2026) 1(1):1–5. doi:10.68838/psl.2026.00005