

True Giant Spermatic Cord Lipoma Mimicking Irreducible Inguinal Hernia: A Case Report

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Abstract

True giant spermatic cord lipoma (TGSCCL) is an uncommon finding. We are reporting a case of 40-year-old male who presented with right groin swelling initially diagnosed as irreducible inguinal hernia. On exploration a TGSCCL was found which was associated with small direct inguinal hernia. Excision of lipoma and mesh hernioplasty was done. Post-operative course was uneventful. True lipoma of spermatic cord is defined only if there is no connection to the extra-peritoneal fat and it is confined to the inguinal canal in contrast to fatty protrusion of spermatic cord which is due to retroperitoneal fat insinuating itself through the internal ring. Differentiation between irreducible inguinal hernias from lipoma is difficult during physical examination. Diagnosis is confirmed by ultrasonography and computed tomography scan. Treatment is excision and biopsy of the lipoma of the cord with repair of any associated hernia.

Keywords: Inguinal hernia, Giant lipoma, Spermatic cord lipoma.

Introduction

Lipoma is the most common benign tumour in the body but lipoma of spermatic cord is seldom encountered. The overall incidence of spermatic cord lipoma in a series of those explored for hernia repair was 3.4% (1). The term giant lipoma of the spermatic cord is used for tumours whose size exceeds 10cm (2). We are reporting a case of giant true lipoma of spermatic cord which presented as irreducible inguinal hernia.

Case Report

A 40-year-old male presented with progressively increasing swelling in right groin for two years associated with mild discomfort for one month. The swelling had no relation with posture or exertion. The general physical examination was normal. Local examination of right inguinal region showed a 13x10 cm size well defined, non-tender, irreducible inguinal swelling with smooth surface and soft in consistency present with no cough impulse. Left inguinal region was normal. Ultrasonography (USG) was suggestive of right inguinal hernia containing fatty tissue. A clinical diagnosis of

irreducible right inguinal hernia with omentocele was made and the patient was prepared for surgery. On exploration of inguinal canal under spinal anaesthesia 10.5x9x5 cm sizes well defined, encapsulated fatty lump was found deep to cremasteric fascia in right spermatic cord with no connection to extra peritoneal fat (Fig.1). There was normal sized deep ring with posterior wall weakness and a small direct inguinal hernia. The lump was dissected out from the spermatic cord (Fig.2) and mesh hernioplasty was done. The lump was confirmed as lipoma on histopathological examination (Fig.3). Postoperative course of the patient was uneventful.



Fig.1: Intra-operative photograph showing the well encapsulated lump (held by Babcock forceps) attached to cremaster muscle fibre (curved artery forceps) which is far from the deep ring (Thumb forceps)



Fig.2: Excised specimen showing well encapsulated fatty lump size 10.5x9x5 cm.

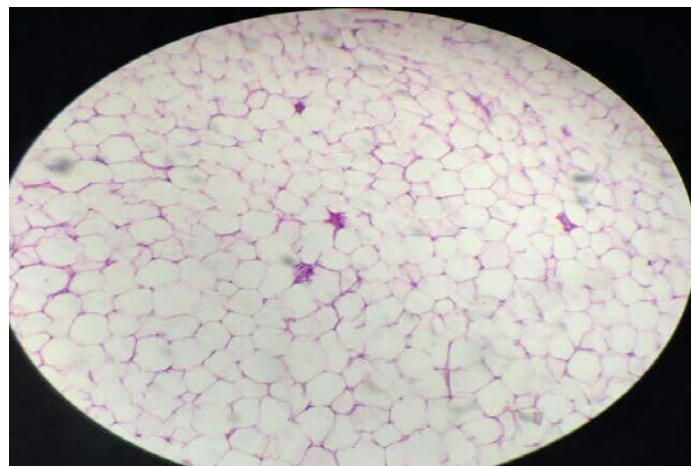


Fig.3: Histopathological specimen showing fat cells on Microscopy

Discussion

Fatty protrusion and true lipoma of cord are loosely defined terms for spermatic cord lipoma. Fawcett and Rooney performed a prospective examination of 140 hernia repairs, finding 46 fatty protrusions of the extra-peritoneal fat and only one “true” lipoma. They made a distinction that a “true” lipoma was identified only if there was no connection to the extra-peritoneal fat and it was confined to the inguinal canal (3).

Fatty protrusion of spermatic cord is due to retroperitoneal fat (i.e., lipoma of cord) insinuating itself through the internal ring and over time dilates it. This could then predispose to indirect hernia formation. It lies on lateral aspect of the cord structures. The blood supply usually comes from beneath the internal spermatic fascia. Both fatty protrusions and true lipoma can cause hernia-like symptoms. Differentiation between irreducible inguinal hernias from lipoma is difficult during physical examination (4).

Diagnosis is confirmed by USG. On USG lipoma of cord appears homogeneous, a little hyper echoic compared with the adjacent testis. It is difficult to differentiate between irreducible inguinal hernia and lipoma of cord even on USG then computed tomography scan is helpful.

The histology is confirmatory after excision. This benign tumor can be clearly seen during laparoscopic exploration of the preperitoneal space tissue but can be easily overlooked, a unique pitfall, at the time of transabdominal preperitoneal laparoscopic hernia repair and this can lead to an unsatisfactory result (4, 5). Excision of the tumour results usually in uneventful recovery.

Conclusion

All lipomas of the spermatic cord must be removed because of the risk of recurrence after inguinal hernia repair. Treatment is excision and biopsy of the lipoma of the cord with repair of any associated hernia.

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