Scrotal Lipoblastoma with Radiological and Histological Correlation

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Abstract
Lipoblastomas are rare benign mesenchymal tumors comprised primarily of mature adipocytes, which are most commonly found in infants and children younger than 3 years. They are usually found in the extremities, trunk, head, neck, and retroperitoneum, although cases occurring in the scrotum have been reported. Due to its rarity, there is a relative paucity of literature describing its imaging and management. We present a rare case of a scrotal lipoblastoma, and discuss the current imaging strategies to differentiate this adipocytic tumor from other common paratesticular masses, including aggressive neoplasms such as rhabdomyosarcomas. Knowledge of the radiological appearance of lipoblastoma can provide the correct diagnosis and prevent unnecessary orchiectomy.

Keywords
► adipocytic tumor
► lipoblastoma
► mesenchymal tumors
► paratesticular mass
► rhabdomyosarcoma

Introduction
Lipoblastomas are rare benign pediatric mesenchymal tumors, and are the second most common pediatric adipocytic tumor after lipomas. Ninety percent will present before the age of 3 years, with a median age at presentation of 12 months. Lipoblastomas occurring in the scrotum are very rare, with only 18 cases being reported in the literature to date. Treatment in all previous cases of intrascrotal lipoblastoma has been tumor excision with or without orchiectomy. If the diagnosis is certain before surgery, a less invasive scrotal approach can be used, as reported in two cases previously, rather than an inguinal approach. There have been no reported cases of metastasis.

The differential diagnosis of intrascrotal lipoblastoma in an infant also includes rhabdomyosarcoma, which is the most common pediatric paratesticular mass. Unlike lipoblastoma, rhabdomyosarcoma is a highly aggressive malignancy, with more than 40% having metastasized by the time of presentation. Intrascrotal rhabdomyosarcomas require radical orchiectomy, and in patients older than 10 years, retroperitoneal lymph node dissection.

Because of its rarity, there is little awareness of intrascrotal lipoblastoma, its imaging characteristics, and its appropriate management. Previous prospective studies demonstrated a lack of consistent imaging protocols of the lesion. Moreover, lipoblastomas can be difficult to diagnose preoperatively due to similarities in location, clinical presentation, and patient demographics with rhabdomyosarcoma. As a result, all but two previous cases were excised via an inguinal approach.

Knowledge of current testicular imaging paradigms, including ultrasound (US) and magnetic resonance imaging (MRI), as well as newer, advanced US techniques such as contrast-enhanced ultrasonography (CEUS), and sonoelastography, can assist the radiologist in making the diagnosis, and ensuring the proper surgical approach of the lesion.

Evaluation revealed a lipoblastoma (orchiectomy with tumor excision was performed. Pathologic for rhabdomyosarcoma remained high, and a right radical formed. Despite the indeterminate imaging including MRI, CEUS, and sonoelastography were not per-
subcutaneous fat, or a typical lipoma. Imaging modalities to the adjacent testicle, but hypervascular compared with
Doppler demonstrated the lesion to be hypovascular relative
to the right testicle (arrowhead). Transverse (B) and
demonstrated intratumoral vascularity (arrows).

Case Presentation

A 14-month-old previously healthy boy presented with a
growing right scrotal mass, present for 1 month with no
associated symptoms. The mass was firm, nontender, and
separate from the right testicle. Laboratory values, including
α-fetoprotein and beta human choriionic gonadotropin
tumor markers, were within normal limits. The patient
was referred to pediatric oncology and urology. Scrotal US
demonstrated a heterogeneous, hyperechoic, solid, lobulat-
ed, oval, well-circumscribed paratesticular mass measuring
2.9 × 1.7 × 1.7 cm (→ Fig. 1). Ultrasonography with color
Doppler demonstrated the lesion to hypovascular relative
to the adjacent testicle, but hypervascular compared with
subcutaneous fat, or a typical lipoma. Imaging modalities
including MRI, CEUS, and sonoelastography were not per-
duced. Despite the indeterminate imaging findings, concern
for rhabdomyosarcoma remained high, and a right radical
orchiectomy with tumor excision was performed. Pathologic
evaluation revealed a lipoblastoma (→ Fig. 2).

Discussion

Intrascrotal lipoblastomas are extremely rare, with fewer
than 20 ever reported.1–3 They usually present as a painless,
growing scrotal mass within the first year of life.1–2 Although
benign, they can demonstrate locally invasive features or
mass effect on adjacent structures.2,9 Up to 61% of cases
demonstrate a chromosomal rearrangement involving the
8q11–13 region.11

The differential diagnosis includes rhabdomyosarcoma,
hibernoma, and lipoma. Rhabdomyosarcoma is the most
common paratesticular mass, and also classically presents
as a painless, growing scrotal mass, frequently presenting in
the first year of life.6,7 Hibernomas are rare tumors derived
from brown fat, and usually occur in middle-aged adults.12
They rarely arise in the scrotum, but can have a similar
appearance to lipoblastoma on imaging, and therefore also
warrant consideration.12 Lipomas are the most common
adipocytic tumor in children, and also share similar imaging
finding with lipoblastoma.13

US with color Doppler is the preferred initial imaging
modality for any intrascrotal mass, although CEUS and
sonoelastography have recently demonstrated promise as
adjunct modalities.10,14 Lipoblastomas usually demonstrate
an homogenously hyperechoic, well-circumscribed paras-
testicular mass with scant blood flow on Doppler.3,9,10 However,
they may also have focal hypoechoic regions on US, with
areas of increased vascularity, owing to their myxoid com-
ponent.9,10 As a general rule, the younger the patient, the
greater the myxoid component, and the greater the vascu-
arity.11 Likewise, CEUS may demonstrate heterogenous
enhancement due to higher vascularity of the myxoid com-
ponent of the tumor.13,15 Sonoelastography of lipoblastoma
typically demonstrates an elastic pattern as seen with other
adipocytic tumors, in contrast with malignant neoplasms,
which virtually always typically appear firmer.10,14

Lipomas and hibernomas may have similar sonographic
findings, owing to their fatty composition, but with several
key differences. Unlike lipoblastomas, lipomas are more
consistently homogenously echogenic, avascular, nonen-
hancing lesions that are well defined, and do not have
posterior acoustic enhancement.13,14 Bright linear interfaces
that separate fat lobules may be present.13 While hiberno-
mas have a similarly echogenic appearance on US, they have
increased vascularity compared with lipoblastomas or lipo-
mas, related to the increased metabolic demand of brown fat.
This is well demonstrated by their avid 18F-FDG uptake on
positron emission tomography/computed tomography.11,16
By contrast, rhabdomyosarcomas demonstrate large, ill-
defined, heterogeneously echogenic masses due to
hemorrhage, cystic degeneration, and necrosis. Hypervascularity relative to the testicle on Doppler (Fig. 3) and contrast-enhanced US are hallmarks of the malignancy. MRI is the next modality to consider in cases that are inconclusive on US, and is the gold standard for determining the composition and extent of tumor. MRI usually demonstrates heterogeneous intensity on T2- and T1-weighted imaging (T2WI and T1WI), owing to its variable composition and extent of tumor. There is marked heterogeneous enhancement of the nonfat portion on MRI, similar to CEUS. Hibernomas have similar MR appearance of increased signal intensity, not quite equal to subcutaneous fat, with increased vascularity that may be well demonstrated on MR angiography. By comparison, lipomas are more homogeneously T1 and T2 intense, and do not enhance. MRI of rhabdomyosarcoma has characteristic but nonspecific findings, and demonstrates intermediate to hypointense signal on T1WI, and intermediate to hyperintense signal on T2WI, with marked enhancement. MRI with fat suppression can be helpful in cases of diagnostic uncertainty between rhabdomyosarcoma and adipocytic tumors, as adipocytic tumors will show an attenuated signal. If rhabdomyosarcoma is suspected, MRI should be performed to determine the stage of disease before surgery.

Overlapping imaging characteristics of rhabdomyosarcomas and lipoblastomas include their paratesticular location, solid nature, and hypervascularity compared with lipomas. Moreover, overlapping patient demographics can make the preoperative diagnosis of lipoblastoma exceedingly difficult. Lipoblastomas have been mistaken for rhabdomyosarcomas and hemangiomas in previous case reports, even when MRI is employed.

The key features that differentiate lipoblastoma from rhabdomyosarcoma include its decreased vascularity on Doppler US, higher elasticity on sonoelastography, reduced enhancement on both CEUS and MRI, and fat suppression MRI sequences. The correct diagnosis is critical, as rhabdomyosarcomas require radical orchiectomy via an inguinal approach. The presence of vital organs is the gold standard treatment. Increased awareness of this entity and use of additional imaging modalities such as CEUS, sonoelastography, and MRI, as well as intraoperative frozen section analysis may prevent unnecessary orchiectomy. The prognosis is excellent even with large tumor size and local invasion.

Conclusion

Lipoblastoma should be considered in the differential diagnosis of a growing intrascrotal mass, especially in patients younger than 3 years. Although it is a benign entity, it can be difficult to differentiate from malignant paratesticular rhabdomyosarcoma due to overlapping imaging characteristics and patient demographics. Total excision with preservation of vital organs is the gold standard treatment. Increased awareness of this entity and use of additional imaging modalities such as CEUS, sonoelastography, and MRI, as well as intraoperative frozen section analysis may prevent unnecessary orchiectomy. The prognosis is excellent even with large tumor size and local invasion.

Declaration of Patient Consent

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflict of Interest

None declared.

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