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CASE REPORT

Antenatal Idiopathic Scrotal Haematoma: A Case Report

Anusha Gaddam,[1] Tejo Pratap Oleti,[1] Sunil Pawar,*[1] Geeta Kolar,[2] Bhuvaneswar Rao Nadipally,[3]

1 Department of Neonatology, Fernandez Hospital, Hyderabad, India

2 Department of Fetal Medicine, Fernandez Hospital, Hyderabad, India

3 Department of Pediatric surgery, Fernandez Hospital, Hyderabad, India

ABSTRACT

Neonatal scrotal haematoma is a rare entity which requires prompt diagnosis and management. Mostly the diagnosis is confirmed at exploration. A male baby was delivered by Caesarean section with antenatally identified scrotal mass. Examination and work-up pointed to idiopathic scrotal haematoma which was drained surgically. No cause of scrotal haematoma could be identified. The baby is doing fine postoperatively.

Key words: Scrotal haematoma; Antenatal scan; Scrotal swelling; Spontaneous haematoma

INTRODUCTION

Fetal scrotal swellings are very rare. The common causes include inguinal hernias, hydroceles, neoplasms, testicular torsions etc.[1] The rare reported causes include adrenal haemorrhage presenting with scrotal haematoma due to seepage of blood through processus vaginalis, traumatic vaginal delivery, iatrogenic injury during cordocentesis, or spontaneous haemorrhage. We are reporting a newborn with idiopathic scrotal haematoma which was identified on antenatal scans as fetal scrotal swelling.

CASE REPORT

A male baby was born to a 27-year-old mother at 37th week gestation by elective caesarean section (SC)which was done in view of previous CS (the outcome of which was a preterm syndromic baby that could not be survived). First trimester scan was unremarkable. Mother has undergone anomaly scan at 20+2 weeks of gestation which was also unremarkable. Growth scan done at 29 weeks, revealed a scrotal selling with weight being appropriate for gestational age. Repeated growth scan done at 31, 34, and 36 weeks of gestation, revealed appropriate for gestational age fetus (85th centile) and persistent large scrotal swelling in the perineal region (suspected organized haematoma)(Fig.1).

The index baby cried immediately after birth. Other anthropometric measurements revealed the length of 49cm and head circumference of 32cm. On examination, the baby had a 4x5cm swelling in the scrotal region. A haemorrhagic spot was noticeable at the dependent part of swelling (Fig.2). On palpation scrotal walls appeared thickened but the testes were not palpable. Our initial differential diagnoses were bleeding haemangioma, haematoma secondary to underlying bleeding disorder, and testicular tumour.

Baby was initially kept nil per oral and started on intravenous fluids. Work-up revealed normal complete blood cell count (CBC), C-reactive proteins was 0.7 mg/dL, normal prothrombin (PT: 21sec) and activated partial thromboplastin time (APTT:41sec). X-ray abdomen was unremarkable. USG abdomen and pelvis showed thickened scrotal walls with loculated collection and internal septations, minimal perihepatic and splenic collections with normal adrenal glands. No doppler changes suggestive of torsion of testes. Other work up including 2D ECHO, metabolic screen, and Tandem Mass Spectroscopy (for congenital adrenal hyperplasia, fatty acid oxidation disorders, organic acidurias, galactosemia and others)

Correspondence*: Dr Sunil Pawar, Consultant Neonatologist, Stork Home, Fernandez Hospital, Hyderabad
E mail: drsunilpawar1@gmail.com

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were within normal limits. Last 2 investigations were done as there was previous sibling neonatal death.

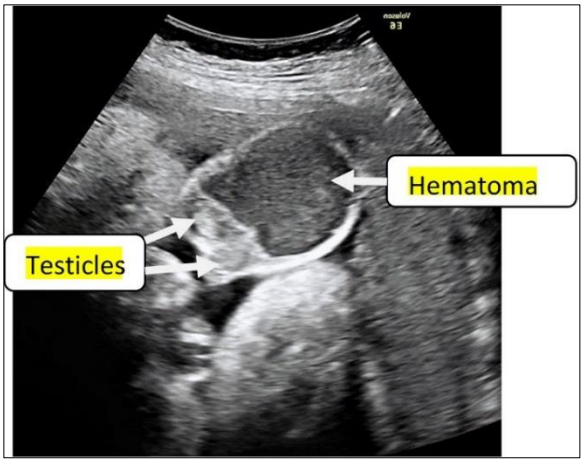

Figure 1: Antenatal Ultrasound Image (36-weeks) showing well organized haematoma and testicular differentiation.

Pediatric Surgeon consultation was taken, and haematoma was drained surgically at bedside. Under local anaesthesia incision was taken on most dependent part around 1 cm. Haematoma was evacuated; and about 40 to 50 ml of blood clot was removed. There was no source or local site of bleeding. No blood transfusion was required. Regular dressings were done during the stay and follow-up. Antibiotic cover was given during draining and continued for a period of 5 days. The size of the swelling was gradually decreased and finally normalized by 2 weeks. The baby is doing fine on follow-up with complete resolution of haematoma.

Figure 2: A (Inferior view) and B (lateral view) of scrotal swelling with noticeable bleeding spot.

DISCUSSION

Various causes of scrotal haematoma have been described in literature such as adrenal haemorrhage, scrotal trauma, postsurgical, coagulopathy, or idiopathic etc.[2-4] In the index case, we could not find any obvious sign of haemorrhage in abdomen. Only minimal fluid accumulation in peri-hepatic (confined to sub-diaphragmatic region) and peri-splenic region was observed. Similarly, any coagulopathy or thrombocytopenia were also not present in the index case thus ruling out coagulopathy as an etiology of scrotal haematoma.

Few neonatal cases of visceral bleeding presenting as scrotal haematoma have been reported in literature.[4-6]We can speculate that adrenal or some visceral haemorrhage occurring before 28 weeks of gestation might have extended to scrotum and resolved with no sonographical features; or it could be idiopathic in etiology. Extensive work-up including MRI or CT scan imaging can point to the diagnosis. In the index case, CT scan or MRI was not done due to financial constraints. Smaller haematomas are usually managed conservatively however, for large size haematomas open surgical drainage is advised.[7,8] Similarly, in the index case, haematoma was considerable in size thus open surgical drainage was done which worked well.

Consent: Authors declared that they have taken informed written consent, for publication of this report along with clinical photographs/material (if any used), from the legal guardian of the patient with an under-standing that every effort will be made to conceal the identity of the patient however it cannot be guaranteed.

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