

## QUIZ SECTION

### A Soft Lesion on the Scrotum: A Quiz

Min Young Park and You Chan Kim\*

Department of Dermatology, Ajou University School of Medicine, 5 Wonchon-Dong, Yeongtong-Gu, Suwon 443-721, South Korea. \*E-mail: maychan@ajou.ac.kr

An 18-month-old boy presented with an asymptomatic skin lesion of the scrotum that had been present since birth. Physical examination revealed a flesh-coloured, large, soft gyrate plaque with a few overlying scattered pores on the left side of the scrotum (Fig. 1A and B). There was no family history of a similar condition. In addition, the parents reported that the left testis was not palpable under the scrotal lesion. A skin biopsy specimen from the plaque, including a pore, showed epidermal papillomatosis as well

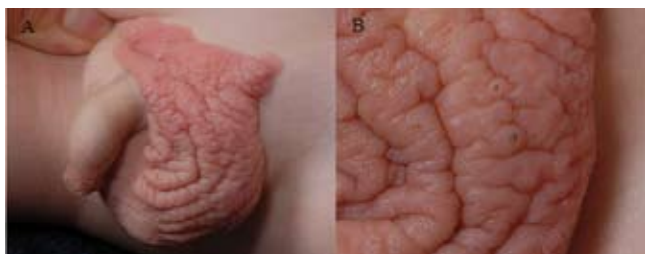


Fig. 1. (A) A large, soft, skin-coloured, gyrate and wrinkled plaque on the left side of the scrotum. (B) Scattered pores noted on the skin lesion.

as dermal deposition of mature adipocytes among collagen fibres (Fig. 2A and B). The pore lesion showed features of a comedone. On physical examination, the right testis moved spontaneously out of the scrotum, but could be returned to the scrotum with manipulation (retractile testis).

*What is your diagnosis?* See next page for answer.

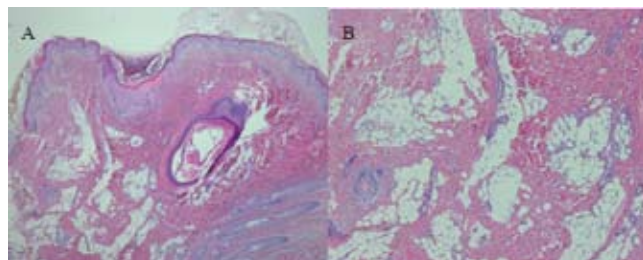


Fig. 2. (A and B) The epidermis shows mild papillomatosis, and a dermal cystic structure is noted. Groups of adipocytes are interposed between the thick collagen bundles in the dermis. (A and B, Haematoxylin-eosin stain; original magnifications: (A)  $\times 40$ , (B)  $\times 100$ ).

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**A Soft Lesion on the Scrotum: Comment**

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**Diagnosis: Nevus lipomatosus superficialis**

Nevus lipomatosus superficialis (NLS) is a rare idiopathic abnormality that was first described by Hoffmann & Zurhelle in 1921. Clinically, it presents as a flesh-coloured or yellow papule or plaque with either a smooth or wrinkled surface (1). Histologically, NLS is characterized by dermal embedding of mature fat cells among collagen bundles without connection to the subcutaneous fat tissue (2), and is sometimes associated with comedones and dilated follicular ostia (3).

Two clinical types of NLS have been described; a classic (multiple) type and a solitary type, which we report here (1). The classic type usually appears from birth over the first two decades of life, most commonly in the pelvic girdle region. By contrast, the solitary forms have no predilection for a specific age group or favoured location. The presence of a solitary NLS at unusual sites, such as the clitoris or in the inguinal region, have been reported (4, 5); however, involvement of the scrotum has not been described previously.

There are only a few case reports describing associated abnormalities with NLS, including pigmentary abnormalities or increased hair over the lesion (6, 7). Surprisingly, in the present case, a retractile testis was identified under the scrotal lesion. Retractable testes have some risk for becoming permanent ascending or undescended testes (8, 9). In our case, it might be speculated that the scrotal NLS might have interrupted the positioning of the testis. Generally, treatment for a NLS is not necessary; simple surgical excision may be performed without recurrence (10, 11). However, in the present patient, the NLS occupied

a relatively large part of the scrotum, and more complicated surgical assessment will therefore be needed.

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