



Evaluation of inguinal swelling in children

Author: [David J Mathison, MD, MBA](#)

Section Editor: [George A Woodward, MD](#)

Deputy Editor: [James F Wiley, II, MD, MPH](#)

[Contributor Disclosures](#)

All topics are updated as new evidence becomes available and our [peer review process](#) is complete.

Literature review current through: Dec 2021. | **This topic last updated:** May 21, 2021.

INTRODUCTION

This discussion will be limited to an approach to swelling of the inguinal area.

Evaluation and treatment of hernias, lymphadenopathy, cryptorchidism, and isolated scrotal swelling in children are discussed separately:

- (See ["Inguinal hernia in children"](#).)
- (See ["Peripheral lymphadenopathy in children: Evaluation and diagnostic approach"](#).)
- (See ["Undescended testes \(cryptorchidism\) in children: Clinical features and evaluation"](#) and ["Undescended testes \(cryptorchidism\) in children: Management"](#).)
- (See ["Causes of painless scrotal swelling in children and adolescents"](#) and ["Evaluation of nontraumatic scrotal pain or swelling in children and adolescents"](#).)

INGUINAL ANATOMY

The inguinal area can be generally described as the region between the anterior superior iliac spine to the pubic symphysis. It contains a variety of structures that surround the inguinal and femoral canal. The key landmarks of the inguinal canal include ([figure 1](#)):

- The inguinal ligament
- The internal and external inguinal rings

- The spermatic cord in males
- The round ligament in females

The anatomic region known as Hesselbach's triangle helps differentiate indirect hernias, which pass outside this triangle through the inguinal canal, from direct hernias which protrude into this space ([figure 1](#) and [figure 2](#)). Hesselbach's triangle is defined laterally by the inferior epigastric artery, medially by the lateral border of the rectus muscle, and inferiorly by the inguinal ligament. The femoral canal contains the femoral artery, nerve, and vein that exit the femoral ring into the proximal thigh.

Indirect hernias result from two anatomic defects: weakening of the fascia of the transversalis muscle fibers at the internal abdominal ring and the potential space from a persistent processus vaginalis ([figure 3](#)). In males, the obliteration of the processus vaginalis occurs during the first two years of life, but as many as 40 percent remain patent, 20 percent of which will later develop into inguinal hernias. Indirect inguinal hernias in males and females occur more frequently on the right, the side where the migration of the testicle or round ligament occurs last. The female counterpart of the processus vaginalis commonly disappears by eight months of gestation, although patency may persist into childhood. If patency persists, the patent processus is termed the canal of Nuck. Embryology of the testes and ovaries are discussed in greater detail separately. (See ["Inguinal hernia in children", section on 'Embryology'.](#))

Inguinal lymph nodes are important structures adjacent to the inguinal canal that are present in the superficial and deep planes. The medial portion of the superficial nodes drain lymph from the skin in the perineum, gluteal region, and lower abdominal wall as well as the vaginal mucosa, penis, scrotum, and anal canal. The lateral group and the vertical superficial nodes drain the lower back below the iliac crest, the anterior leg, lateral upper leg, and medial foot. The deep inguinal nodes lie beneath the fascia and medial to the femoral vein and drain the superficial nodes in addition to the clitoris, the glans of the penis, and the medial ipsilateral leg.

CAUSES OF INGUINAL SWELLING

The causes of inguinal swelling are listed in the table ([table 1](#)). Pediatric inguinal swelling occurs mostly from inguinal hernias, especially in boys, who are affected six times more

often than girls [1]. However, it is important to consider the different features and characteristics of masses in the inguinal or groin area to exclude other causes, such as congenital anomalies, infections, and neoplasms. In most instances careful clinical evaluation with selected use of ultrasonography can rapidly establish the etiology.

Inguinal hernia — Inguinal hernias in children may present as intermittent, reducible, or incarcerated inguinal masses. Inguinal hernias may be indirect or direct ([figure 1](#) and [figure 2](#)) with indirect hernias occurring much more frequently than direct hernias and much more commonly in males than females. (See ['Inguinal anatomy'](#) above and ['Inguinal hernia in children', section on 'Epidemiology'](#).)

Indirect hernias appear when abdominal contents pass lateral to the epigastric artery, through the inguinal canal, and into the scrotum or labia through the external inguinal ring ([figure 1](#)). They may contain omentum, bowel, and rarely, the appendix (also called an Amyand hernia). In males, the scrotum is full which helps differentiate inguinal hernias from retractile, ectopic, or undescended testes ([picture 1](#)). In females, reproductive organs are often present, including the ovary, fallopian tube, and rarely, the uterus ([picture 2](#)). It can be difficult to differentiate a sliding hernia of the ovary from a hydrocele of the canal of Nuck since both can present as non-painful, palpable, movable inguinal masses in females. The ovary, however, can become incarcerated within the canal, presenting as a painful mass. (See ['Inguinal hernia in children', section on 'Clinical features and diagnosis'](#) and ['Inguinal hernia in children', section on 'Inguinal mass in a female'](#).)

Diagnosis and treatment of inguinal hernias varies by gender and presenting features, and is discussed in greater detail separately. (See ['Inguinal hernia in children', section on 'Management'](#).)

Femoral hernia — Femoral hernias are very uncommon. In children, a hernia in the groin area is almost 250 times more likely to be an indirect hernia than a femoral one [2]. Children with femoral hernias have swelling in the upper thigh, below the inguinal ligament and medial to the femoral artery, often in association with crampy abdominal pain ([figure 4](#)). Despite the difference in anatomic location, pediatric femoral hernias can be clinically difficult to distinguish from the inguinal variety and are frequently misdiagnosed preoperatively by surgeons and referring physicians [2-4]. Femoral hernias are less likely to be incarcerated than the inguinal variety, but incarcerated femoral hernias are often complicated by sliding ovaries, especially in female infants [5]. In adults, femoral

hernias are more common in older women. (See "[Classification, clinical features, and diagnosis of inguinal and femoral hernias in adults](#)".)

When suspected, prompt surgical consultation is warranted as femoral hernias are more apt to present with strangulation and to require emergency surgery. (See "[Overview of treatment for inguinal and femoral hernia in adults](#)".)

Spermatic cord hydrocele — A hydrocele of the spermatic cord occurs when fluid accumulates along the cord in the inguinal canal or upper scrotum, but is separated from the testes ([figure 5](#)). Whereas an indirect hernia occurs from a failure of the processus vaginalis to close, a cord hydrocele occurs from an abnormal closure of the processus vaginalis where the distal portion closes and midportion remains patent along the cord. Cord hydroceles are much less common than indirect hernias. In a large series of ultrasounds performed to evaluate for inguinal masses or swelling, a cord hydrocele was present in only 1.5 percent of children [\[6\]](#).

Although mixed forms have been reported [\[7\]](#), cord hydroceles are typically classified into one of two types [\[8\]](#):

- **Non-communicating (encysted)** – This is the most common variety and is characterized by fluid pooling along the length of the cord but not communicating with the peritoneal cavity or tunica vaginalis. Since the encysted type does not communicate with the peritoneal cavity, the size does not change with increases in intra-abdominal pressure, such as crying fits or coughing, nor is this type reducible.
- **Communicating (funicular)** – Unlike the encysted type, the funicular type communicates freely with the peritoneal cavity at the internal ring. Therefore, the swelling in the inguinal area can enlarge with increased intra-abdominal pressure, and can decrease in size when the patient relaxes. Communicating cord hydroceles can be difficult to distinguish from indirect inguinal hernias on physical examination, and ultrasound is frequently required to establish the diagnosis.

Regardless of type, children with spermatic cord hydroceles warrant referral to a surgeon with pediatric and genitourinary expertise. Herniotomy is frequently performed to prevent later development of an indirect inguinal hernia [\[7,8\]](#).

Inguinal lymphadenopathy — Lymphadenopathy is characterized by non-tender swelling

or enlargement of the lymph nodes. Lymph node swelling can occur secondary to a generalized or localized process. (See ["Peripheral lymphadenopathy in children: Etiology", section on 'Localized lymphadenopathy'](#) and ["Peripheral lymphadenopathy in children: Etiology", section on 'Generalized lymphadenopathy'.](#))

Although inguinal adenopathy may arise adjacent to the inguinal canal, it can be differentiated from an indirect inguinal hernia because of the characteristic rubbery and limited movement of the swelling and its location outside of the inguinal canal. In addition, the enlarged lymph node will produce a mass that does not extend into the scrotum or labia. Direct and femoral hernias may be confused with lymphadenopathy because the bulge is either above (direct) or below (femoral) the inguinal canal ([figure 2](#) and [figure 4](#)) and the swelling does not extend into the genitalia. However, unless incarcerated, these hernias will have a cystic quality on palpation.

- **Generalized lymphadenopathy with inguinal involvement** can be associated with infectious disease (HIV, EBV, miliary tuberculosis, etc), metabolic disease (Gaucher, Niemann-Pick, etc), rheumatologic disease (eg, JIA, SLE, etc), immunologic disease (eg, chronic granulomatous disease, serum-like sickness reaction, etc), malignancy (eg, leukemia, lymphoma, etc), inflammatory disease (eg, sarcoidosis, eosinophilic granulomatosis with polyangiitis [Churg-Strauss], etc), lymphoproliferative disease (eg, hemophagocytic lymphohistiocytosis, Castleman's disease) or medication reaction. (See ["Peripheral lymphadenopathy in children: Etiology", section on 'Generalized lymphadenopathy'](#) and ["Peripheral lymphadenopathy in children: Etiology", section on 'Uncommon but important causes'.](#))
- **Localized inguinal lymphadenopathy** can be associated with nearby skin and soft tissue infections that drain to the inguinal lymph nodes, which can include regional sites, such as the buttocks, genitals, groin, or the ipsilateral lower extremity. Localized infections causing inguinal lymphadenopathy can include fungal disease (eg, tinea corporis), parasitic disease (eg, filariasis, etc), bacterial skin disease (eg, furuncle, cellulitis, impetigo), and venereal disease (eg, herpes simplex, primary syphilis, lymphogranuloma venereum). (See ["Peripheral lymphadenopathy in children: Etiology", section on 'Inguinal'.](#))

Inguinal lymphadenitis — Lymphadenitis can be differentiated from lymphadenopathy by the presence of tenderness, often accompanied by erythema and fluctuance. Tender

lymph nodes in the groin (or axilla) are sometimes termed “buboes”, derived from the exudative lymph nodes characteristic of bubonic plague. The term is now used to describe the tender and swollen lymph nodes associated with local skin infections or ulcerative lymphadenitis caused by venereal diseases, often in conjunction with genital ulcerative lesions. If secondary swelling from the lymphadenitis involves the genitalia, differentiating this condition from an incarcerated inguinal hernia may be difficult, especially when pain limits the inguinal examination. In these instances, ultrasonography can be diagnostic.

Inguinal lymphadenitis can be divided into the following categories:

- **Animal and tick vectors** – Infections spread by animal or tick-borne transmission to the lower extremity can cause a regional lymphadenitis from draining lymph proximal to the area of entry. These infections can cause lymphadenopathy, but typically the nodes are tender. Examples of these diseases include: tularemia, plague, brucellosis, and cat-scratch disease. (See ["Tularemia: Clinical manifestations, diagnosis, treatment, and prevention"](#) and ["Brucellosis: Epidemiology, microbiology, clinical manifestations, and diagnosis"](#) and ["Clinical manifestations, diagnosis, and treatment of plague \(Yersinia pestis infection\)"](#) and ["Microbiology, epidemiology, clinical manifestations, and diagnosis of cat scratch disease"](#).)
- **Direct skin-borne infection** – Skin bacteria (eg, strep, staph, etc) can directly infect the inguinal nodes causing a primary bacterial lymphadenitis, similar to but much less common than cervical lymphadenitis that frequently occurs in young children. (See ["Cervical lymphadenitis in children: Etiology and clinical manifestations"](#), section on 'Pathophysiology'.)
- **Venereal disease (buboes)** – Buboes are caused by either *Hemophilus ducreyi* (Chancroid) or the L1, L2, and L3 serovars of *Chlamydia trachomatis* (lymphogranuloma venereum). Both of these diseases have characteristic ulcerative lesions associated with the buboes ([picture 3](#) and [picture 4](#)). (See ["Chancroid"](#) and ["Lymphogranuloma venereum"](#).)

Granuloma inguinale — Granuloma inguinale (donovanosis) is a genital infection that is usually sexually acquired and is most prevalent in tropical regions including India, Papua New Guinea, the Caribbean, South America, and Australia.

Infection with *Klebsiella granulomatis* *comb. nov.* (previously *Calymmatobacterium*

granulomatis), the causative agent of granuloma inguinale, can cause pseudo-buboes in the inguinal area which are typically associated with ulcers on the genitalia. Pseudo-buboes may feel like swollen or obstructed lymph nodes but are caused by subcutaneous granulation and are eventually broken down and replaced by ulcers. There are several types of ulcers, but the ulcero-vegetative variety is most common and is characterized by a beefy-red non-tender ulcer that bleeds readily ([picture 5](#)). (See ["Approach to the patient with genital ulcers"](#), [section on 'General approach'](#).)

Evaluation and treatment of granuloma inguinale is discussed in greater detail separately. (See ["Approach to the patient with genital ulcers"](#).)

Testes: Retractable, ectopic, or undescended — If a testicle is not located in the scrotum, it may be retractile, ectopic or undescended:

- **Retractable testes** – A nontraumatic, non-tender inguinal mass in the presence of an "empty" hemi-scrotum is suggestive of a retractile testis if it can be brought back into the scrotum. The testes can move up into the inguinal canal as a result of an exaggerated cremasteric reflex. The retractile testis can be "milked" back into the scrotum by gently applying downward pressure across the top of the palpable mass. Testicular retraction can recur, and no treatment is necessary if the testis is freely movable. However, these patients warrant referral to an urologist for follow-up because approximately one-third of retractile testicles can become undescended with time.
- **Ectopic or undescended testes** – An ectopic testis is characterized by a testis that naturally descends through the external ring, but then becomes lodged outside of the natural path, most commonly in a superficial pouch near the external ring or less commonly in the suprapubic region, femoral canal, perineum, or contralateral scrotal compartment ([figure 6](#)). Undescended testes can be one-sided (70 percent) or bilateral ([picture 6](#) and [picture 7](#)) (30 percent) and may present as a mass in the inguinal canal. Undescended testicles are associated with an underdeveloped scrotum. (See ["Undescended testes \(cryptorchidism\) in children: Management"](#), [section on 'Natural history'](#).)

The goal of the genital examination is to determine if a suspected testicular mass in the inguinal canal of a patient without significant blunt scrotal trauma is a retractile, ectopic, or undescended testis. If the testicular mass cannot be moved into the scrotum, and the

hemi-scrotum is empty, then an ectopic or undescended testis is suggested. An undescended testis can lodge anywhere along its line of descent, including the inguinal canal, the external inguinal ring, or intra-abdominally ([picture 8](#)). While an intra-abdominal testis will not be palpable, remnants of the gubernaculum or dissociated epididymis and vas deferens may be present in the inguinal canal. (See ["Undescended testes \(cryptorchidism\) in children: Clinical features and evaluation", section on 'Evaluation'](#).)

If the testicular mass is tender or causes pain, this suggests a torsion of an undescended or ectopic testis, sometimes referred to as a cryptorchid testicular torsion, and is a surgical emergency. The evaluation and management of this condition is described separately. (See ["Undescended testes \(cryptorchidism\) in children: Management", section on 'Testicular torsion'](#).)

Differentiation between a retractile and a truly undescended testis can be difficult in some patients and may require consultation with a pediatric urologist. The genital examination in a male with retractile versus suspected ectopic or undescended testis is discussed in greater detail separately. (See ["Undescended testes \(cryptorchidism\) in children: Clinical features and evaluation", section on 'Examination'](#).)

Testicular dislocation — Testicular dislocation is an uncommon event that occurs in the setting of acute or recent blunt genitourinary trauma, especially straddle injuries sustained in a motorcycle collision. With significant force to the pelvis, the testes can become displaced, often into a superficial pouch anterior to the external oblique aponeurosis, and rarely into the penile, pubic, canalicular, or perineal areas.

Clinical findings typically consist of a unilateral tender mass present in the inguinal area in association with an empty hemiscrotum in a patient without a prior history of cryptorchidism or orchiectomy. Rarely, bilateral dislocations may occur [\[9-11\]](#). A traumatic testicular dislocation can be difficult to recognize on initial examination, especially when associated with swelling, ecchymosis, obesity, and pelvic injury. As an example, in an observational study of 1967 abdominal blunt trauma patients over a 15 year period, nine testicular dislocations were reported and all were missed on initial evaluation. Most were not diagnosed until 3 to 60 days post-injury [\[12\]](#). When testicular dislocation is suspected, prompt surgical consultation should be obtained. (See ["Scrotal trauma in children and adolescents", section on 'Indications for subspecialty consultation or referral'](#).)

Surgical repair is often necessary since manual reduction is successful in only 15 percent of

cases [13]. A previously dislocated testis has impaired spermatogenesis and may have an increased risk for malignancy.

Tumor — A variety of different tumors have been reported in the inguinal area, ranging from benign to malignant. Benign lesions of the inguinal canal can include, but are not limited to lipomas, hematomas [14], mesothelial cysts [15], dermoid cysts [16,17], lymphangiomas [14], venous malformations [18], and fibrous hamartomas [19].

Careful attention is necessary to distinguish features of malignant lesions which could include systemic symptoms (eg, weight loss, fever, or masses in other regions) or a non-cystic, non-lipomatous feeling mass which may be associated with fixed (unmovable) lymph nodes. The most common malignant lesions of the groin are soft tissue sarcomas; however, only 2 percent of both rhabdo- and non-rhabdomyosarcomas arise in the groin [20,21]. Hodgkin and non-Hodgkin lymphoma may rarely present with inguinal lymphadenopathy. (See ["Overview of Hodgkin lymphoma in children and adolescents", section on 'Lymphadenopathy'](#) and ["Overview of non-Hodgkin lymphoma in children and adolescents", section on 'Signs and symptoms'.](#))

Other malignancies, such as primary neuroblastoma, have also been reported in the inguinal canal [22]. In addition, neuroblastoma can spread into the spermatic cord [23].

Malignant lesions in the pelvis can metastasize or locally spread to the canal by pushing through the internal ring. Malignancies with lymphatic spread can involve the inguinal lymph nodes. But despite the close proximity, inguinal lymph node metastases from testicular cancers are rare.

Appendicitis — The presence of the vermiform appendix, whether inflamed or not, inside a hernial sac is known as Amyand hernia. Amyand hernia complicates 1 percent of all inguinal hernias with one-third of these cases having associated acute appendicitis [24]. It is unclear whether appendicitis is an incidental finding or rather if there is a causal relationship with these cases. But a ruptured appendicitis can present with a tender inguinal mass secondary to localized abscess formation [25].

Treatment is as for perforated appendicitis. (See ["Acute appendicitis in children: Management", section on 'Advanced appendicitis'.](#))

EVALUATION

In most patients, a careful history and physical examination establish the underlying cause of an inguinal swelling. In selected patients, ultrasonography is a helpful diagnostic tool.

History — Important aspects of the history in children with inguinal swelling include the following:

- **Duration of symptoms** – Is the onset acute, subacute, or chronic?
- **Pain** – Is the mass painful (in infants, this can be characterized by excessive fussiness, irritability, or an abnormal cry)? (See ["Inguinal hernia in children", section on 'Incarcerated mass'](#).)
- **Signs of obstruction** – Has there been vomiting, abdominal distension, or lack of bowel movements? (See ["Inguinal hernia in children", section on 'Incarcerated mass'](#).)
- **Signs of systemic disease** – Are there associated symptoms of fever, night sweats, weight loss greater than 10 percent of body weight, or other systemic disease in the absence of an obvious cause? (See ["Inguinal lymphadenitis"](#) above and ["Tumor"](#) above.)
- **Signs of localized infection** – Are there any skin lesions located in the upper thigh or lower abdominal regions? (See ["Inguinal lymphadenopathy"](#) above and ["Inguinal lymphadenitis"](#) above.)
- **Change in size of the mass** – Does the mass grow larger with increase in intra-abdominal pressure (eg, cough, straining, vomiting, Valsalva, etc)? Commonly an intercurrent illness such as a URI with cough or a child who is constipated with straining and encopresis can make a hernia more pronounced. (See ["Inguinal hernia"](#) above.)
- **Trauma** – Has the patient suffered significant genitourinary trauma? (See ["Testicular dislocation"](#) above.)
- **Past medical history** – Key questions include the following:
 - Does the child have a history of conditions that predisposed to indirect inguinal hernias (eg, previous repair, prematurity, abdominal wall defects [eg, prune belly

syndrome], connective tissue disorders [eg, Ehlers-Danlos syndrome], abnormalities of the genitourinary system [eg, bladder exstrophy]]? (See ["Inguinal hernia in children", section on 'Associated conditions'.](#))

- Was scrotal location of the testes documented in the neonatal period (retractile versus ectopic or undescended testes)? (See ["Testes: Retractable, ectopic, or undescended"](#) above.)
- Is there a history of tick or animal exposure (eg, cat scratch, rabbit, or rodent)? (See ["Inguinal lymphadenitis"](#) above.)
- Is the patient sexually active? Has the patient traveled to areas endemic for granuloma inguinale (eg, India, Papua New Guinea)? (See ["Inguinal lymphadenitis"](#) above and ["Granuloma inguinale"](#) above.)
- **Family history** – Pertinent family history includes the following:
 - Are there family members who have had an inguinal hernia?
 - Is there a history of unexplained genital anomalies, abnormal pubertal development, or infertility (all suggestive of cryptorchidism)? (See ["Undescended testes \(cryptorchidism\) in children: Clinical features and evaluation", section on 'Epidemiology and risk factors'.](#))

Physical examination — The following aspects of the physical examination should be noted:

- **Visualization and palpation** – The inguinal canal should be assessed for tenderness, compressibility, warmth, feel, color, and size change with maneuvers such as Valsalva or patient relaxation.
- The hallmark of an indirect inguinal hernia is a firm mass that emerges through the external inguinal ring and enlarges with increased intra-abdominal pressure ([figure 1](#) and [figure 3](#) and [picture 1](#) and [picture 2](#)). A bulge that is above the inguinal ligament and not located in the inguinal canal indicates a direct hernia ([figure 2](#) and [figure 7](#)). A swelling that is more pronounced in the upper thigh is suggestive of a femoral hernia ([figure 4](#)). Both direct and femoral hernias are much less common than indirect hernias. (See ["Inguinal hernia"](#) above and

['Femoral hernia'](#) above.)

- In the female patient with a palpable hernia, the ovary with or without the fallopian tube may appear as a round mass although it can also slide in and out of the hernia and not be palpable on examination. When a tender mass is present, ovarian torsion is suggested. (See ["Inguinal hernia in children", section on 'Inguinal mass in a female'](#).)
- A cord hydrocele will show swelling along the inguinal canal without extension into the scrotum. The encysted (non-communicating) type will not fluctuate in size with Valsalva or relaxation maneuvers whereas the funicular (communicating) type should. Transillumination can show a translucent swelling suggesting a fluid-filled cord, however this is not a sensitive test to evaluate the inguinal area. (See ['Spermatic cord hydrocele'](#) above.)
- Normal lymph nodes should be ≤ 2 cm diameter and are oval, firm, slightly movable, and non-tender. Lymph nodes > 2 cm are consistent with lymphadenopathy. Fixed (unmovable) lymph nodes are suspicious for malignancy or granulomatous disease. Inguinal lymphadenopathy should prompt evaluation of other lymph chains (cervical, axillary, etc) to differentiate signs of a localized or systemic disease. (See ["Peripheral lymphadenopathy in children: Evaluation and diagnostic approach", section on 'Inguinal lymphadenopathy'](#).)
- Localized tenderness to the lymph nodes is consistent with lymphadenitis. Tender inguinal nodes should prompt thorough evaluation of the genitals for presence of ulcers or other lesions suggestive of a sexually transmitted infection. Additionally, evaluation of the ipsilateral lower extremity is required to evaluate for bite or scratch marks suggestive of vector-borne diseases, although the bites can occur from days to months prior to lymph node involvement, depending on the disease. (See ['Inguinal lymphadenitis'](#) above.)
- **Reduction** – If a hernia is suspected, manual reduction is both diagnostic and therapeutic. Inability to reduce the hernia is suggestive of an incarcerated hernia. In a female patient, an incarcerated inguinal hernia should be presumed to have associated torsion of the ovary until proven otherwise. Signs of a strangulated hernia are an irreducible mass with necrotic discoloration secondary to venous and lymphatic obstruction. (See ["Inguinal hernia in children", section on 'Incarcerated](#)

[inguinal hernia'](#) and ["Inguinal hernia in children", section on 'Inguinal mass in a female'.](#))

- **Inspection of scrotal contents (in males)** – The presence of an empty hemiscrotum differentiates ectopic or undescended testes from masses, other than those with a testicular origin, that occur in the inguinal region. In the setting of inguinal swelling, the presence of an **empty** hemiscrotum suggests a dislocated, retractile, ectopic, or undescended testes.

These findings can be differentiated as follows:

- Dislocated testicles occur after acute, high force trauma. (See ['Testicular dislocation'](#) above.)
- If the testes can be successfully milked into the empty hemi-scrotum, then the diagnosis of a retractile testes is made. (See ['Testes: Retractable, ectopic, or undescended'](#) above.)
- If the testicular mass cannot be moved into the scrotum in the absence of trauma, then an ectopic or undescended testes is suggested. An undescended testes can lodge anywhere along its line of descent, including the inguinal canal, the external inguinal ring, or intra-abdominally ([picture 8](#)). While an intra-abdominal testes will not be palpable, remnants of the gubernaculum or dissociated epididymis and vas deferens may be present in the inguinal canal. If the testicular mass is tender or causes pain, this suggests a torsion of an undescended or ectopic testes, sometimes referred to as a cryptorchid testicular torsion. (See ["Undescended testes \(cryptorchidism\) in children: Clinical features and evaluation", section on 'Evaluation'](#) and ["Undescended testes \(cryptorchidism\) in children: Management", section on 'Testicular torsion'.](#))

Ancillary studies — Laboratory testing is usually unnecessary in the evaluation of inguinal swelling caused by indirect inguinal hernia, trauma, uncomplicated lymphadenopathy, or lymphadenitis due to a localized skin infection.

The diagnostic approach to children with peripheral lymphadenopathy or lymphadenitis varies from observation and reassurance to comprehensive diagnostic testing and aggressive medical and surgical therapy, depending upon the findings from the history

and physical examination ([table 2](#) and [table 3](#)). It is not necessary to identify the underlying etiology in every patient since most cases are benign and self-limited. The pace of the evaluation is dictated by how ill the patient appears. (See "[Peripheral lymphadenopathy in children: Evaluation and diagnostic approach](#)", section on 'Inguinal lymphadenopathy'.)

Boys with ectopic or undescended testicles warrant additional evaluation depending upon the age of presentation. Laboratory testing for these patients is discussed in greater detail separately. (See "[Undescended testes \(cryptorchidism\) in children: Clinical features and evaluation](#)", section on 'Diagnostic approach'.)

Patients with localized inguinal adenopathy secondary to ulcerative venereal disease require pathogen-specific testing for syphilis and herpes simplex virus in addition to testing for chlamydia and gonorrhea. Additional testing may be necessary for signs of chancroid, lymphogranuloma venereum, and granuloma inguinale. (See "[Approach to the patient with genital ulcers](#)", section on 'Diagnostic testing'.)

Masses suspicious for malignancy warrant additional evaluation to establish the diagnosis. (See "[Overview of common presenting signs and symptoms of childhood cancer](#)", section on 'Lymphadenopathy'.)

Imaging

- **Ultrasound with Doppler** – While ultrasound is highly technician dependent, it is the best study for the majority of causes of inguinal swelling in females. In males, most indirect inguinal hernias can be diagnosed and managed without specific testing. However, ultrasound can be useful for evaluation of spermatic cord hydroceles and undescended or ectopic testes. Ultrasound can readily differentiate the features of hernias, hydroceles, atypical masses, testes, and the female reproductive organs. Doppler flow offers additional utility and is indicated for the emergent evaluation of torsion in the displaced testes, testicular dislocation, or incarcerated and entrapped ovary.
- **Point-of-care ultrasound (POCUS)** – The utilization of POCUS continues to evolve as a diagnostic option in acute care settings. POCUS provides rapid assessment and may be a valuable tool to identify time-sensitive pathology such as a testicular dislocation in the setting of traumatic inguinal swelling and an empty hemi-scrotum [26]. The use of POCUS is limited by the expertise required to both acquire and interpret the

images. Use of POCUS should therefore be restricted to trained and experienced providers and should not replace traditional ultrasonography to confirm findings when appropriate. Because the minority of cases of painless inguinal swelling require emergency surgical correction, POCUS may be a reasonable option to expedite emergency department care or to guide coordinated outpatient care when traditional US evaluation may be unnecessary or not readily available. More research is needed to evaluate the impact of POCUS on efficacy, medical decision making, and potential cost savings in children with inguinal swelling [\[27-31\]](#).

- **Computed tomography (CT)** – CT is typically **not** necessary but may offer some utility in the setting of blunt abdominal trauma with testicular dislocation or when evaluating inguinal masses suspicious of malignancy, both for staging and to help better define the mass and its tissue of origin.

APPROACH

The approach to inguinal swelling differs in boys versus girls.

Male — The approach to inguinal swelling starts with recognizing the potentially emergent conditions that require acute management or immediate intervention, which are always signified by the presence of pain ([algorithm 1](#)). In boys, a painful inguinal lump may indicate an incarcerated or strangulated indirect inguinal hernia, lymphadenitis, torsion of an undescended testis, or when occurring after major genitourinary trauma, a testicular dislocation. An incarcerated or strangulated femoral hernia is identified by a painful lump that is located below the inguinal ligament in the mid- or upper- thigh. Other differentiating features include the presence of fever, erythema, or induration which suggests localized cellulitis with lymphadenitis and an empty scrotum in patients with a dislocated or torsed undescended testicle. (See '[Physical examination](#)' above.)

Boys with incarcerated indirect or direct inguinal hernias or incarcerated femoral hernias should undergo prompt manual reduction followed by elective surgical repair. Emergency surgery is necessary for incarcerated hernias that cannot be manually reduced or for strangulated hernias with signs of bowel obstruction. Timely surgical consultation is also indicated for patients with, testicular dislocation or torsed undescended testis. (See '[Inguinal hernia in children](#)', [section on 'Incarcerated inguinal hernia'](#) and '[Femoral hernia](#)'

above and ['Testicular dislocation'](#) above and ["Undescended testes \(cryptorchidism\) in children: Management", section on 'Testicular torsion'.](#))

Causes of inguinal swelling that are not painful include lymphadenopathy, retractile testis, undescended or ectopic testis, a reducible indirect inguinal hernia, spermatic cord hydrocele, or soft tissue tumor. Typically the presence of lymphadenopathy and a reducible inguinal hernia are obvious upon physical examination. The other causes usually require ultrasound to diagnose and delineate the condition. (See ['Imaging'](#) above.)

Further evaluation and treatment depend upon the condition:

- Boys with a reducible inguinal hernia or spermatic cord hydrocele should be referred for elective surgical repair. (See ["Inguinal hernia in children", section on 'Reducible mass'](#) and ['Spermatic cord hydrocele'](#) above.)
- The diagnostic approach to children with peripheral lymphadenopathy or lymphadenitis varies from observation and reassurance to comprehensive diagnostic testing and aggressive medical and surgical therapy, depending upon the findings from the history and physical examination ([table 2](#) and [table 3](#)). It is not necessary to identify the underlying etiology in every patient since most cases are benign and self-limited. The pace of the evaluation is dictated by how ill the patient appears. (See ["Peripheral lymphadenopathy in children: Evaluation and diagnostic approach", section on 'Inguinal lymphadenopathy'.](#))
- Ulcerated lesions require further diagnostic testing for sexually transmitted diseases. (See ["Approach to the patient with genital ulcers", section on 'Diagnostic testing'.](#))
- Boys with ectopic or undescended testicles warrant additional evaluation depending upon the age of presentation and should be referred to a pediatric urologist. Males with suspected torsion of the undescended testis warrant prompt surgical consultation and emergency management. (See ["Undescended testes \(cryptorchidism\) in children: Clinical features and evaluation", section on 'Diagnostic approach'](#) and ["Undescended testes \(cryptorchidism\) in children: Management", section on 'Management of undescended testes'.](#))
- Masses suspicious for malignancy warrant additional evaluation to establish the diagnosis followed by treatment according to the specific neoplasm identified. (See

["Overview of common presenting signs and symptoms of childhood cancer", section on 'Lymphadenopathy'](#) and ["Overview of common presenting signs and symptoms of childhood cancer".](#))

Female — In girls, painful inguinal swelling is caused by an incarcerated or strangulated inguinal hernia, cellulitis, or lymphadenitis ([algorithm 2](#)). An incarcerated or strangulated femoral hernia is identified by a painful lump that is located below the inguinal ligament in the mid- or upper- thigh. Other differentiating features include the presence of fever, erythema, or induration which suggests localized cellulitis with lymphadenitis. (See ['Physical examination'](#) above.)

Because incarcerated or strangulated indirect inguinal hernias in girls frequently contain reproductive organs (eg, ovary or fallopian tube), the clinician should attempt a gentle reduction and then obtain an US if not successful. If the US shows that reproductive organs are not present, then further efforts at reduction are appropriate. Prompt surgical consultation is warranted for symptomatic girls with entrapped hernias that cannot be reduced. (See ['Physical examination'](#) above and ['Imaging'](#) above.)

Infant females in particular, may have herniated reproductive organs that are **not** incarcerated or strangulated [[1](#)]. This is characterized by a palpable, often pearly, movable mass in an asymptomatic female infant. Gentle reduction in these patients will not be successful and further delineation by ultrasound followed by elective referral to a surgeon with pediatric expertise is warranted.

Other causes of non-painful inguinal swelling in girls include reducible inguinal hernias, lymphadenopathy, or soft tissue tumors. As in boys, a reducible inguinal hernia should be referred for elective repair. Additional evaluation of lymphadenopathy depends upon the degree of illness in the patient ([table 2](#) and [table 3](#)), the presence of genital ulcers, or clinical suspicion for malignancy. (See ["Peripheral lymphadenopathy in children: Evaluation and diagnostic approach", section on 'Inguinal lymphadenopathy'](#) and ["Approach to the patient with genital ulcers"](#) and ["Overview of common presenting signs and symptoms of childhood cancer".](#))

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and

regions around the world are provided separately. (See "[Society guideline links: Inguinal hernia in children](#)".)

SUMMARY

- The causes of inguinal swelling in children are listed in the table ([table 1](#)). (See '[Causes of inguinal swelling](#)' above.)
- In most patients, a careful history and physical examination establish the underlying cause of an inguinal swelling. In selected patients, ultrasonography is a helpful diagnostic tool. (See '[Evaluation](#)' above.)
- The approach to an inguinal mass is largely determined by the patient's sex and the presence of pain ([algorithm 1](#) and [algorithm 2](#)). Most masses arise from either an indirect inguinal hernia or from inflammation of the inguinal lymph nodes. (See '[Approach](#)' above.)

REFERENCES

1. [Huang CS, Luo CC, Chao HC, et al. The presentation of asymptomatic palpable movable mass in female inguinal hernia. Eur J Pediatr 2003; 162:493.](#)
2. [Ollero Fresno JC, Alvarez M, Sanchez M, Rollán V. Femoral hernia in childhood: review of 38 cases. Pediatr Surg Int 1997; 12:520.](#)
3. [Chapman WH, Barcia PJ. Femoral hernia in children: an infrequent problem revisited. Mil Med 1991; 156:631.](#)
4. [Nayeem N. Femoral hernia in children. Br J Clin Pract 1990; 44:383.](#)
5. [Tsushimi T, Takahashi T, Gohra H, et al. A case of incarcerated femoral hernia in an infant. J Pediatr Surg 2005; 40:581.](#)
6. [Rathaus V, Konen O, Shapiro M, et al. Ultrasound features of spermatic cord hydrocele in children. Br J Radiol 2001; 74:818.](#)
7. [Chang YT, Lee JY, Wang JY, et al. Hydrocele of the spermatic cord in infants and children: its particular characteristics. Urology 2010; 76:82.](#)
8. [Martin LC, Share JC, Peters C, Atala A. Hydrocele of the spermatic cord: embryology and ultrasonographic appearance. Pediatr Radiol 1996; 26:528.](#)

9. [Tsurukiri J, Kaneko N, Mishima S. Bilateral traumatic testicular dislocation. Urology 2011; 78:1306.](#)
10. [Tsai HN, Wu WJ, Huang SP, et al. Bilateral traumatic testicular dislocation--a case report. Kaohsiung J Med Sci 2002; 18:95.](#)
11. [Bromberg W, Wong C, Kurek S, Salim A. Traumatic bilateral testicular dislocation. J Trauma 2003; 54:1009.](#)
12. [Ko SF, Ng SH, Wan YL, et al. Testicular dislocation: an uncommon and easily overlooked complication of blunt abdominal trauma. Ann Emerg Med 2004; 43:371.](#)
13. [Singer AJ, Das S, Gavrell GJ. Traumatic dislocation of testes. Urology 1990; 35:310.](#)
14. [Poenaru D, Jacobs DA, Kamal I. Unusual findings in the inguinal canal: a report of four cases. Pediatr Surg Int 1999; 15:515.](#)
15. [Aarabi S, Drugas G, Avansino JR. Mesothelial cyst presenting as an irreducible inguinal mass. J Pediatr Surg 2010; 45:e19.](#)
16. [Leeming R, Olsen M, Ponsky JL. Inguinal dermoid cyst presenting as an incarcerated inguinal hernia. J Pediatr Surg 1992; 27:117.](#)
17. [Prada-Arias M, Ortiz-Rey JA, Fernández-Eire P, et al. Dermoid cyst of the spermatic cord in children. J Pediatr Surg 2010; 45:2058.](#)
18. [Daigle HJ, Sakharuk IA, Hatley RM. Venolymphatic Malformation : An Uncommon Pediatric Inguinal Mass. Am Surg 2021; 87:152.](#)
19. [Zampieri N, Carabaich A, Corroppolo M, et al. Two patients with tumours presenting as inguino-scrotal masses. Eur J Cancer Care \(Engl\) 2008; 17:205.](#)
20. [Karplus G, Krasin MJ, Rodriguez-Galindo C, et al. Retrospective study of the surgical management and outcome of nonrhabdomyosarcoma soft tissue sarcomas of the groin and axilla in children. J Pediatr Surg 2009; 44:1972.](#)
21. [Raney RB Jr, Crist W, Hays D, et al. Soft tissue sarcoma of the perineal region in childhood. A report from the Intergroup Rhabdomyosarcoma Studies I and II, 1972 through 1984. Cancer 1990; 65:2787.](#)
22. [Leo ME, McManus MJ, Strawbridge LR, Kramer SA. Bilateral primary neuroblastomas in the inguinal canal. J Urol 1992; 148:135.](#)
23. [Köseoğlu V, Akata D, Kutluk T, et al. Neuroblastoma with spermatic cord metastasis in a child: sonographic findings. J Clin Ultrasound 1999; 27:287.](#)

24. [Cankorkmaz L, Ozer H, Guney C, et al. Amyand's hernia in the children: a single center experience. Surgery 2010; 147:140.](#)
25. [Kynes JM, Rauth TP, McMorow SP. Ruptured appendicitis presenting as acute scrotal swelling in a 23-month-old toddler. J Emerg Med 2012; 43:47.](#)
26. [Matzek BA, Linklater DR. Traumatic testicular dislocation after minor trauma in a pediatric patient. J Emerg Med 2013; 45:537.](#)
27. [Blaivas M, Sierzenski P, Lambert M. Emergency evaluation of patients presenting with acute scrotum using bedside ultrasonography. Acad Emerg Med 2001; 8:90.](#)
28. [Cannis M, Mailhot T, Perera P. Bedside ultrasound in a case of blunt scrotal trauma. West J Emerg Med 2013; 14:127.](#)
29. [Bomann JS, Moore C. Bedside ultrasound of a painful testicle: before and after manual detorsion by an emergency physician. Acad Emerg Med 2009; 16:366.](#)
30. [Blaivas M, Batts M, Lambert M. Ultrasonographic diagnosis of testicular torsion by emergency physicians. Am J Emerg Med 2000; 18:198.](#)
31. [Thimann D, Badawy M. 7-month-old male with scrotal swelling. Emerg Med J 2014; 31:521.](#)

Topic 13883 Version 12.0

© 2022 UpToDate, Inc. All rights reserved.