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Perineal Ectopic Testis in a Four-Year-Old Boy: Surgical Anatomy and Orchidopexy — A Case Report

Fatima Zahra Bougueddach[1*], Anas Abouelkheir[2], Imane Boussouab[3], Fadoua Idrissi Fawzi[4], Nadir Ferram[5], Zineb Hammoumi[6]

[1,2,3,4,5,6]Department of Pediatric Visceral Surgery, Abderrahim Harouchi Mother and Child Hospital, Ibn Rochd University Hospital Center, Casablanca, Morocco

ABSTRACT

Perineal ectopic testis is an uncommon anomaly of testicular descent that may be overlooked when examination is limited to the inguinal canal. We describe a four-year-old boy with an empty left hemiscrotum and a mobile superficial perineal mass. Ultrasonography identified testicular tissue at the ectopic site. A combined inguinal and scrotal surgical approach demonstrated a normally formed testis, epididymis, and vas deferens, an unusually long spermatic cord, and an aberrant gubernacular attachment to the perineum. No patent processus vaginalis was identified. After division of the ectopic gubernacular attachment, the testis was transferred and fixed in the left scrotum. At approximately one year, both testes were clinically scrotal and symmetric. This case highlights the diagnostic value of perineal palpation and the importance of identifying the gubernacular attachment during orchidopexy.

KEYWORDS: Perineal ectopic testis; Testicular ectopia; Gubernaculum; Orchidopexy; Pediatric surgery.

INTRODUCTION

Perineal ectopic testis is an uncommon form of testicular maldescent in which the gonad lies outside its normal path of descent, typically in the perineum rather than the ipsilateral hemiscrotum. Although the diagnosis is usually clinical, it may be missed unless the perineum is examined in a child with an empty scrotum [1,2]. We report a case managed by orchidopexy, emphasizing the operative anatomy and the abnormal gubernacular attachment.

CASE PRESENTATION

A four-year-old boy was evaluated for absence of the left testis from the scrotum. Examination showed an empty left hemiscrotum and a mobile, superficial mass in the ipsilateral perineal region, clinically suggestive of an ectopic testis (Figures 1 and 2). Ultrasonography identified a testicular structure at this site.

Orchidopexy was performed through a combined low inguinal-crease and scrotal approach. Exploration demonstrated a morphologically normal left testis, epididymis, and vas deferens. The spermatic cord was unusually long, and no patent processus vaginalis was found. The gubernaculum was attached to the perineal tissues, accounting for the ectopic location (Figures 3 and 4). The abnormal gubernacular insertion was divided, allowing mobilization of the testis without undue tension. The testis was repositioned in the ipsilateral scrotum and secured with interrupted absorbable polyglactin sutures between the skin and dartos, as documented in the operative record.

At approximately one year of clinical follow-up, the testis remained in the scrotum, and both testes appeared symmetric on examination. No objective postoperative volume measurements were available.

DISCUSSION

Perineal ectopic testis should be differentiated from a testis arrested along its usual route of descent. The key diagnostic combination is an empty hemiscrotum and a

palpable testis in an ectopic perineal position. Jlidi et al. described four pediatric cases, all managed successfully by orchidopexy [1]. Jensen and Chen similarly emphasized systematic palpation of ectopic sites in boys referred for cryptorchidism [2].

Abnormal gubernacular development or attachment is considered an important mechanism of perineal ectopia. In published surgical cases, the gubernaculum has frequently been found fixed to perineal structures [2,3]. This was the principal anatomical abnormality

in our patient. The long spermatic cord permitted tension-free relocation, consistent with previous reports [1,2]. No patent processus vaginalis was identified in our patient.

Surgical treatment consists of mobilization of the ectopic testis, division of the aberrant gubernacular attachment, and fixation within the corresponding hemiscrotum. Both inguinal and scrotal approaches have been reported [2,4]. In our patient, the combined approach provided exposure of the ectopic attachment and allowed secure scrotal fixation. The favorable clinical position at approximately one year is reassuring, although clinical symmetry alone cannot establish normal future fertility or endocrine function. The main limitation of this report is the absence of objective sonographic measurements during follow-up. Nevertheless, the operative photographs illustrate the distinctive perineal attachment and provide an educational demonstration of the anatomy.

CONCLUSION

Perineal ectopic testis should be considered whenever a child has an empty hemiscrotum and a palpable perineal mass. Careful examination and recognition of the abnormal gubernacular attachment allow appropriate surgical planning. Orchidopexy can achieve satisfactory scrotal positioning when cord length is adequate.

DECLARATIONS

Conflicts of interest: The authors declare none.

FIGURES



Figure 1. Preoperative appearance showing an empty left hemiscrotum and the marked perineal location of the palpable mass.

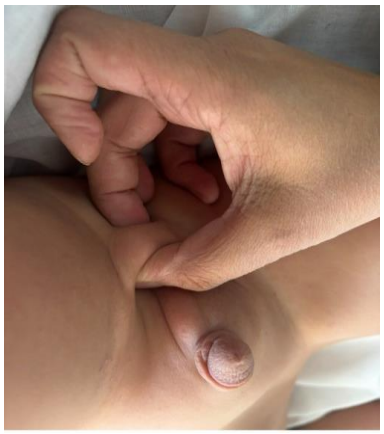


Figure 2. Clinical examination demonstrating the superficial perineal swelling corresponding to the ectopic testis.



Figure 3. Operative exposure of the perineal ectopic testis and its attachments.



Figure 4. Mobilized ectopic testis and elongated spermatic cord during orchidopexy

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