ACTA SCIENTIFIC CANCER BIOLOGY

Volume 3 Issue 1 January 2019

Case Report

Lipoma of the Infraorbital Region - A Rare Case Report

Prashant Pandilwar[1]*, Kanchan Shah[2], Prashant Raktade[2], Suday G Rajurkar[3], Abhishek Akare[3] and Priyanka Chawle[4]

[1]*Professor and HOD, GDC Aurangabad, India*

[2]*Associate Professor, GDC Aurangabad, India*

[3]*Assistant Professor, GDC Aurangabad, India*

[4]*Clinical Assistant, GDC Nagpur, India*

***Corresponding Author:** Prashant Pandilwar, Professor and HOD, GDC Aurangabad, India.

Received: December 17, 2018; **Published**: December 28, 2018

Abstract

Lipomas are one of the most common soft-tissue mesenchymal tumors seen in all parts of the body. Their occurrence in the head and neck region is however relatively rare. Although benign and non-aggressive in nature, lipomas may present as a slow growing tumors causing an unaesthetic appearance. We present here a rare and unique case of lipoma in the infraorbital region in a 46 years old female which was managed by complete surgical excision. Post-operative follows up of one year shows no recurrence. The rarity of the anatomical site makes it a unique case. The diagnosis mainly relied on the postoperative histopathological findings. Along with the case report, the pathogenesis, histopathological features and the treatment have been discussed.

Keywords: Lipoma; Infraorbital Region

Introduction

Lipomas are a group of slow growing, benign mesenchymal tumors comprising of mature adipocytes [1,2]. Lipomas can be seen in almost any body part; but their occurrence in the head and neck region is rarer. In the head and neck region, common site is subcutaneous tissues in the neck. Multiple lipomas usually are associated with genetic disorders or syndromes [3]. We report here a rare case of solitary lipoma in the infraorbital region.

Case Report

A 46 years old female reported to the Department of Oral and Maxillofacial surgery with a complaint of slow-growing, progressive painless swelling in the right infraorbital region for 2 years. Patient was asymptomatic as such apart from the aesthetic concern she had regarding the facial swelling. On examination, the swelling was soft in consistency, freely mobile approximately 2.5 X 2.5 cm roughly ovoid in shape; no attachment to the overlying skin was seen. Overlying skin was normal; no discolouration or abnormal vascularisation. No evidence of any pus discharge was seen. No lymphadenopathy was seen. Intraoral examination revealed no evidence of any dental focus of infection. A slight bulge was seen in the maxillary right buccal sulcus. A provisional diagnosis of lipoma and neurofibroma was considered. Routine blood investigations carried out and surgical excision was done under local anesthesia. The specimen after excision and placement in formalin was found to be floating which suggested the likelihood of the diagnosis of lipoma. Histopathological examination revealed that the tissue was composed of a blend of mature adipocytes with fibrous tissue and plenty of blood vessels. Patient is kept under observation. Long term follows up of one year shows no recurrence.

Discussion

Lipomas are considered to be hamartomatous proliferations of mature adipose tissue and are one of the most common soft-tissue mesenchymal tumors seen in the head and neck region in 15 - 20% cases and only 1 - 4% cases affecting the oral cavity [4]. Their occurrence in the head and neck region is however relatively rare. Although benign and non-aggressive in nature, lipomas may pres-

ent as a slow growing tumors causing an unaesthetic appearance. Lipomas are seen in an age range of 30 – 60 years of life [5]. There is no sex predilection [6]. Although etiopathogenesis of lipoma is yet unclear, the presence of a genetic link, trauma, chronic infections, obesity, alcohol addiction, liver disease, hormonal changes etc are considered to be associated with their occurrence. Lipomas are thought to occur more frequently in obese people with their metabolism being independent of the body fat. Chromosomal aberrations also have been considered to be involved in some cases. Patients usually present with a long-standing, well-circumscribed nodular mass for the aesthetic concern due to the swelling. Lipomas usually present as an asymptomatic soft, non-tender, sessile or pedunculated masses of submucosal tissues. Cheek is the most common site of occurrence followed by tongue, floor of mouth, buccal sulcus, palate, lip and gingiva. Diagnosis is based on clinical examination. Magnetic Resonance Imaging is very useful in diagnosis; Computed Tomography and ultrasound imaging being less reliable. On ice application a lipoma lesion hardens which was true in our case. Also, the excisional biopsy mass floated in the formalin jar which gave a likelihood of the diagnosis of lipoma. For larger lesions, incisional biopsy may be needed. Direct complete excision can be carried out for smaller lesions. Histopathologically, lipomas do not differ much from the microscopic appearance of the surrounding adipose tissue. Lipomas are composed of mature fat cells which are slightly larger in size and variable in shape. A lobular pattern is more commonly seen subcutaneous lipomas. The yellowish tinge is also seen in superficial lipomas whereas the skin colour over the deep seated lipomas is unaltered. It is important to distinguish lipomas from liposarcoma as they share similar characteristics. But however, liposarcomas pose greater risk to the patients. Medical management of lipomas include administration of steroids to cause atrophy of adipose tissue. Liposuction may be used for larger lesions. Treatment of lipomas is simple surgical excision. Recurrence rate is low [7-9].

Figure 1: PExtraoral swelling in right infraorbital region.

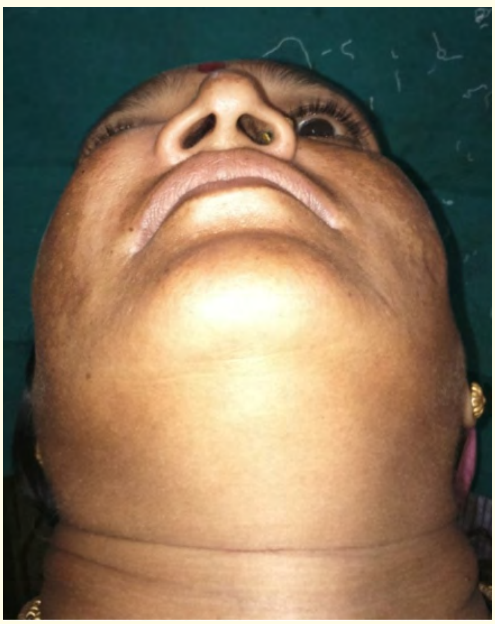

Figure 2: Worm's view.

Conclusion

Being usually asymptomatic, lipomas remain neglected quite often and hence may attain larger dimensions and cause facial disfigurement and mild discomfort and the need for surgical excision. In our case which was managed by surgical excision, no recurrence has been seen till post-operative one year.

Figure 3: Exposed Tumour mass.

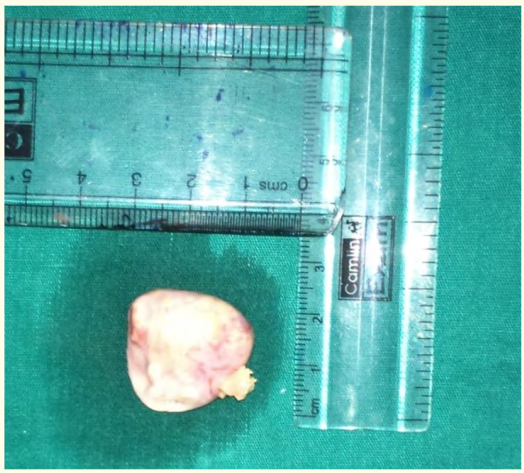

Figure 4: Excised Tumour mass.

Figure 5: Wound Closure.

Bibliography

1. Taira Y., *et al*. "Oral Lipoma extending superiorly from mandibular gingivobuccal fold to gingival: a case report and analysis of 207 patients with oral lipoma in Japan". *Odontology* 100 (2012): 104-108.

2. Pattipatti S., *et al*. "Palatal lipoma: a case report". *JCDR - Journal of Clinical and Diagnostic Research* 7 (2013): 3105-3106.

3. Lawoyin JO., *et al*. "Lipoma of the oral cavity: clinicopathological review of seven cases from Ibadan". *Nigerian Journal of Medicine* 10.4 (2001): 189-191.

4. Cawson RA., *et al*. 4th edition. New York: Churchill Livingstone; Lucas's Pathology of Tumors of the Oral Tissues (1984): 176-179.

5. Epivatianos A., *et al*. "Benign tumors of adipose tissue of the oral cavity: a clinicopatghologic study of 13 cases". *International Journal of Oral and Maxillofacial Surgery* 58.10 (2000): 1113-1117.

6. Furlong MA., *et al*. "Lipoma of the oral and maxillofacial region: Site and subclassification of 125 cases". *Oral Surgery, Oral Medicine, Oral Pathology, and Oral Radiology* 98.4 (2004): 441-450.

7. Fregnani ER., *et al*. "Lipomas of the oral cavity: clinical findings, histological classification and proliferative activity of 46 cases". *International Journal of Oral and Maxillofacial Surgery* 32.1 (2003): 49-53.

8. Studart-Soares EC., *et al*. "Oral Lipomas in a Brazilian population: A 10-year study and analysis of 450 cases". *Medicina Oral, Patología Oral y Cirugía Bucal* 15.5 (2010).

9. Gnepp DR. 1st ed. Philadelphia: Saunders. Diagnostic Surgical Pathology of the Head and Neck (2010): 192.

Volume 3 Issue 1 January 2019