ORIGINAL RESEARCH PAPER

Volume-8 | Issue-6 | June-2019 | PRINT ISSN No. 2277 - 8179

INTERNATIONAL JOURNAL OF SCIENTIFIC RESEARCH

RECURRENT LARGE SUBCUTANEOUS CAVERNOUS HEMANGIOMA OVER RIGHT SHOULDER - CASE REPORT

General Surgery

Dr Saurabh Singh Department of General Surgery-Saraswati Medical College, UP

Dr Vivek Maurya* Department of General Surgery-Saraswati Medical College, UP *Corresponding Author

Dr. Satendra yadav Department of General Surgery-Saraswati Medical College, UP

KEYWORDS

INTRODUCTION

Hemangiomas are benign vascular neoplasms most often in infancy and childhood, and commonly involve skin and subcutaneous tissue. Subcutaneous cavernous hemangioma is a varient of venous malformations[1]. It is more common in females[2]. This type malformation does not spontaneously regress. Subcutaneous hemangioma is an aggressive growth pattern that have higher recurrence rate even after excision[4]. It involves various layers of skin with purple or bluish hue and presence of dilated vein over it.[5,6]

CASE REPORT

A 19-year-lady presented with a painless large swelling seated over right shoulder , which recurs in last 3 years(fig-1). Patient attendant gave the history of excision of swelling from the same site at the age of 2 years. During examination of swelling it is found 32 × 18 cm with thinned out skin, presence of dilated vein and old scar. The swelling was firm in consistency, nontender, non translucent with the presence of scar.

Fig-1 Preoperative lesion

Investigations

Ultrasonographic findings- It is seen as an ill-defined hypoechoic mass of heterogeneous echo texture with multiple cystic spaces within

Color Doppler- images demonstrated showed low-resistance arterial flow with forward flow during both systole and diastole.

magnetic resonance imaging (MRI) scan- was performed which revealed a 33.5×22 cm ovoid mass seated over trapezius, infraspinatus muscles but not invades in the intramuscular plane. The lesion had isointense signals on T1 weighted sequences and a high signal of T2 weighted sequences.

Fine needle aspiration biopsy (FNAB) of the lesion was non diagnostic on account of the bloody specimen.

These findings led to a strong suspicion of haemangioma.

Surgical management

The patient underwent surgical exploration of the right side shoulder and excision of the mass via a elliptical incision along the border of the lesion including normal skin. The lesion was densely adherent to trapezius, infraspinatus, teres minor muscles. During excision of lesion multiple tortuous dilated vein noted which ligate at base, but no known artery identified. Even its wide extension of lesion it removed completely without damaging any important structures. After excision of lesion most difficult things was primary closure of excision site, which was done by skin mobilization in subcutaneous plane from all the site(Fig-2).

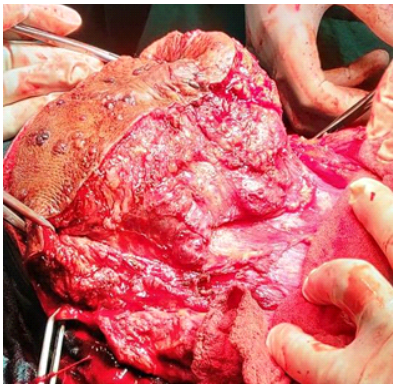

Fig-2 mobilization of swelling

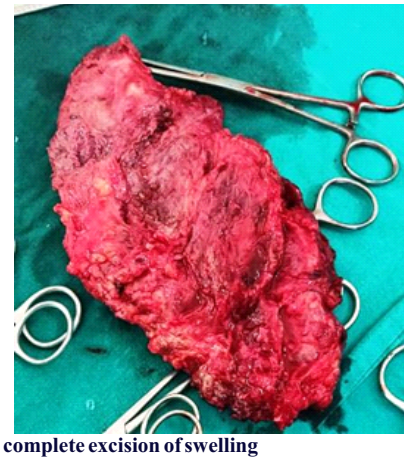

Fig-3 after complete excision of swelling

Macroscoply- the lesion are a sponge like consistency with dark red colour was weighted 2.63 kg and size around 34×23×8 cm(Fig-3,4)

Microscopically- there are presence of multiple vascular channels lined by endothelium and fibrous tissue, few seprate fibro-collagen nodule also noted.

Fig-4 primary skin closure

Fig-5 healed scar

Post-operative period-

Post-operatively the patient recovered well with except few area of skin necrosis found at the junction which was anastmose under tension. No signs of any neurological or functional dysfunction noted, even there is no significant complain or sign of any recurrence noted during follow up to 6 months(Fig-5).

DISCUSSION

Soft tissue hemangioma is benign neoplams. They are the most common of the angiomatous lesions and represent up to 7% of all benign soft-tissue tumors in the general population [7]. They are most commonly present in children. Histological it can be divided into capillary, cavernous, arteriovenous, venous, and mixed variations [8].Cavernous hemangiomas usually occurs in later life they are larg usually seated deep, calcification is also common [8].Cavernous hemangioma initially known as angioliopma because it is associated with growth of adipose tissue[9].There are various way of treatment of cavernous hemangioma like laser, sclerosing agent, embolisation but in this case where the lesion is recurrent with bad scar complete excision is better approach[10,11].

REFERENCES

1. Enjolras O. Rio de Janeiro, Brazil: Elsevier; 2011. Malformações vasculares; pp. 1581–1595
2. Gorlin R J, Kantaputra P, Aughton D J, Mulliken J B. Marked female predilection in some syndromes associated with facial hemangiomas. Am J Med Genet. 1994;52:130–135.
3. Casanova D, Norat F, Bardot J, Magalon G. [Cutaneous hemangioma: clinical aspects] Ann Chir Plast Esthet. 2006;51:287–292.
4. Boon L M, Mulliken J B, Enjolras O, Vikkula M. Glomuvenous malformation (glomangioma) and venous malformation: distinct clinicopathologic and genetic entities. Arch Dermatol. 2004;140:971–976.
5. Hochman M, Adams D M, Reeves T D. Current knowledge and management of vascular anomalies: I. Hemangiomas. Arch Facial Plast Surg. 2011;13:145–151.
6. Antaya R J Ortonne J P Wells M J Perry V Gelfand J M James W D Infantile hemangioma In: Emedicine. Updated May 20, 2013. Available at: Accessed August 20, 2013
7. Murphey MD, Fairbairn KJ, Parman LM, Kirkman GB, Parsa MB, Smith WS.Musculoskeletal angiomatous lesions: radiologic-pathologic correlation.RadioGraphics 1995; 15:893-917.
8. Resnick D. Vascular and lymphatic tumors.In: Draud LA, Fix CF, eds. Diagnosis of bone and joint disorders. 4th ed. Philadelphia, Pa: Saunders, 2002; 4186-4195.
9. Wild AT, Raab P, Krauspe R. Hemangioma of skeletal muscle. Arch Orthop Trauma Surg 2000; 120:139-143.
10. Capote A, Acero J, García-Recuero I, Rey J, Guerra B, de Paz V. Infratemporal-preauricular-cervical approach for resection of a cavernous intramasseteric hemangioma: a case report. J Oral Maxillofac Surg. 2008;66:2393–2397.
11. Scheinfeld NS, Silverberg NB, Weinberg JM, Nozad V. The preauricular sinus: a review of its clinical presentation, treatment, and associations. Pediatr Dermatol. 2004;21:191–196.