INTRODUCTION:

Lipomas are benign tumors composed of mature white adipocytes and are the most common mesenchymal neoplasms in the adults. Microscopically they are composed of lobules of mature adipocytes, identical to the surrounding adipose tissue except for slight variation in the size and shape of the cells in lipomas [1]. They are relatively common in the upper back, neck, shoulder and abdomen, followed in frequency by proximal portions of the extremities, buttocks and upper thigh, some times lipomas are found in face, hands, lower legs and feet [2]. This neoplasm rarely occurs in the parotid or para-parotid region [3] and according to several authors, lipomas account for less than 4.4% of the benign parotid gland tumours [4,5]. The preferred treatment is surgical excision and recurrence is approximately 5% [6]. Lipomas seem to arise from metaplastic transformation of fibroblasts to lipoblasts [7], but other theories have been proposed [8,9].

CASE REPORT:

A 45 year old female patient presented to the ENT OPD, MMIMSR, Mullana with a painless swelling on the left side of face of 10 years duration. The swelling was progressively increasing in size since then. Physical examination revealed a mass of the right parotid region which was elastic, soft, mobile, regular, non-tender, non-fluctuant, non-pulsatile and non transilluminant superficial mass.

The overlying skin was found to be normal. There was no other mass palpable in head and neck region. There was no facial Asymmetry. It was associated with deep boring pain in right ear although, rest of the otolaryngological examination was normal.

A high frequency ultrasonography visualized a large well defined hypoechoic lesion measuring 5 x 2.5cm with thin echogenic strands in right parotid gland? Lipoma. No significant cervical lymphadenopathy seen. (Figure 1).

We subjected the patient for CT scan which revealed low attenuation homogeneous mass with sharp margins on right side with no underlying enchancement. Parotid tissue appeared normal (Figure 2).

We performed tumor excision with facial nerve preservation, under general anesthesia, using a modified Blair's incision. Intraoperatively, a large mass was located in the right parotid region deep to the subcutaneous tissue but superficial to the right parotid gland. The tumor comprised a well circumscribed, elastic, soft, yellow, lobulated fatty mass covered with a thin fibrous capsule (Figure 3,4). It was easily removed without injury of any major neurovascular structures.
discrete lipomas have a benign clinical presentation and are most often confused clinically with Warthin’s tumors or pleomorphic adenomas. The lesions vary in size from 1 to 8 cm, are more common in females by a 10:1 ratio, and are not associated with lipomas elsewhere in the body [25]. Complete excision is curative. The differential diagnosis is again limited by the unique low attenuation of the lipoma. Branchial cleft cysts, cystic Warthin’s tumors, and abscesses are conceivably in the differential diagnosis, but can be distinguished by the higher central attenuation, the presence of a rim, and associated clinical findings.

In our case lipoma was found superficial to parotid gland without any apparent involvement of parotid gland and other surrounding tissues. Peri parotid lipomas may not be clinically distinguishable from parotid lesions. However, in most cases, CT can easily resolve the true origin of the process.

REFERENCES