



PERI-PAROTID LIPOMA, A RARE CASE REPORT

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ABSTRACT

Lipoma is a common benign tumor affecting the soft tissues arising in every location where fat is normally present. Only 13% of them arise in the head and neck region and most of these occur subcutaneously in the posterior neck. Rarely, they can develop from deeper planes in the anterior neck, infratemporal fossa, in or around the oral cavity, pharynx, larynx, and parotid gland. They usually present as a benign, slowly growing and rarely recur Clinically, they can be confused with other benign lesions; however, CT and Ultrasonography allows a specific diagnosis to be made in virtually all cases. The aim of this article is to report a unique case of a lipoma with benign microscopic appearance located deep to the subcutaneous tissue in the para-parotid area of a 45 years-old female patient.

KEYWORDS

Lipoma, Parotid Gland, excision

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 enhancement. 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, 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.



Figure 1: Ultrasonography visualized a large well defined hypoechoic lesion measuring 5 x 2.5cm with thin echogenic strands in right parotid gland.



Figure 2: CT scan showing low attenuation homogeneous mass with sharp margins on right side with no underlying enhancement.



FIGURE 3: Surgical approach: Lipoma excision with facial nerve preservation, under general anesthesia, using a Modified Blair's incision.



FIGURE 4: Surgical approach: lipomatous lobulated mass being holded with forceps.

DISCUSSION:

Lipoma is a most common benign tumour arising from mesenchymal tissue [10,11]. It constitutes five percent of all benign tumour of body and can be found anywhere in the body [12]. Lipoma in head and neck region are uncommon [13,14]. Thirteen percent of lipomas are seen in head and neck region [15]. Anterior neck is an uncommon location for head and neck lipoma. Histopathologically lipoma is composed of mature adipose tissue surrounded by fibrous capsule [16]. Lipoma is seen in all age group though mostly seen in fifth and sixth decade [17]. Clinically, lipoma presents as painless, mobile, non fluctuant swelling having rubbery consistency. Most of the patients are asymptomatic. Patient with neck lipoma extending to mediastinum may present with complaint of dyspnoea. Ultrasonography acts as the initial imaging modality in diagnosis of head and neck lipoma [12]. Sonographic appearance of head and neck lipomas is characteristic [18,19]. In most cases, they are well defined, elliptical masses parallel to the skin surface and hyper echogenic relative to the adjacent muscle. They typically have linear echoes at right angle to ultrasound beam and display no distal enhancement or attenuation [20]. Computed tomography is modality of choice to confirm lipoma. Lipomas appear as homogenous low density areas with a CT value of 60 to 120 HU with no contrast enhancement [21]. Few septations can be seen within lipoma in CT scan in some cases. Fine needle aspiration cytology or CT is indicated if the diagnosis is doubtful with the clinical impression or if the entire extent or outline of the lipoma is not delineated on the USG [18]. On CT scans capsule of lipoma is barely visible or adjacent mass effect may be only clue to its presence [22].

In the parotid gland and the periparotid area, at least 40 cases of lipomatous lesions have been reported [23-29], of which 57% were intraparotid and 43% arise in the region around this gland [24]. About 90% of the cases were ordinary lipomas and the rest were examples of diffuse fatty infiltration or lipomatosis of the parotid gland [26]. The

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.

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