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INTRAORAL FIBROLIPOMA – AN UNUSUAL PRESENTATION

Maxillofacial Surgery

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ABSTRACT

Lipomas are most common tumours of mesenchymal origin in human body but are rare in oral and maxillofacial regions. They arise from the mature adipose tissues. The aetiology and pathophysiology remain ununderstood. Various theories have been proposed to explain the pathogenesis of this adipose tissue tumour. A case of intraoral fibrolipoma occurring in vestibular region in a 50-year-old female is reported. Excision was performed under local anaesthesia and one-year follow-up showed excellent healing with no signs of recurrence. Various histological patterns of lipoma have been explained in literature. Most of them are asymptomatic, resulting in delay to seek treatment.

KEYWORDS

Lipoma, Fibrolipoma, Adipocytes, Excision

INTRODUCTION

Lipomas are soft tissue neoplasms of mature adipocytes which are benign mesenchymal in origin1. Incidence of 1 to 4% is seen among all benign tumors affecting oral cavity. They usually present as soft, nodular, asymptomatic and long-standing swellings covered by normal mucosa2. Oral lipomas can occur in various anatomic sites including the lip, tongue, major salivary glands, buccal mucosa, floor of mouth, palate and vestibule3. The aetiology and pathogenesis remain unclear, although endocrine, mechanical and inflammatory influences have been reported4. Histopathologically, benign tumors of adipose tissue can be classified as classic lipoma, intramuscular lipoma, fibrolipoma, spindle-cells lipoma, angiolipoma, myxoid lipomas, salivary gland lipoma and atypical lipomas4. Here we present a case of fibrolipoma arising from intra oral vestibular region.

CASE PRESENTATION

A 50-year-old female patient reported to unit of Oral & Maxillofacial Surgery with a chief complaint of swelling in left lower back tooth region for three years. The swelling was small initially, later there was slow, continuous gradual enlargement. The patient had difficulty in mastication. Intraoral examination revealed a pinkish, well-defined oval swelling measuring 3.5 x 1 cm2 present in the left mandibular posterior vestibule. The swelling was above the level of the occlusal plane and indentations of maxillary molar teeth were seen on the swelling (Figure 1a). On palpation, the swelling was soft, pedunculated on the vestibular mucosa, mobile, non-tender and the margins were slippery under the palpating finger. A provisional diagnosis of intraoral lipoma was established. Contrast enhanced computed tomography (CECT) showed polypoidal lesion with fat density component and marginal enhancing soft tissue thickening (Figure 1b). The lesion was excised under local anesthesia and primary closure was achieved (Figure 2a). The excised specimen was sent for histopathological examination. Cut surface was soft and yellow in color (Figure 2 b & c). Microscopic examination revealed circumscribed lesion composed of mature adipose tissue along with interspersed thin-walled blood vessels, lobules were separated by fibro-collagenous bands (Figure 3a). The overlying epithelium was stratified squamous tissue with focal ulceration. Based on the clinical and histopathological findings a final diagnosis of fibrolipoma was made. The postoperative course was uneventful and healing was satisfactory at 1 month follow up (Figure 3b). No recurrence of the lesion has been observed at 1 year follow up.

DISCUSSION

The first description of an oral lipoma was provided by Roux in 1848, in a review of alveolar masses which he referred to as - yellow epulis[5]. Lipoma is a slow growing benign neoplasm composed of mature fat cells[6]. When the fibro-collagenous bands or stroma surround the adipocytes, it is referred as fibrolipoma. Lipomas constitute 15- 20 % cases of head and neck region and rare in oral cavity (1-4 %)[2,7]. The second most common variant among subtypes of lipoma in oral cavity is fibrolipoma (18.9 %)following simple lipoma (42 %)[8].

Lipomas commonly present as a mobile, soft, lobulated mass of yellow color. Some tumors are covered by normal mucosa which are situated submucosally. In some cases, the overlying lining mucosa is thick and the underlying adipose tissue is not distinguishable and appear as pink swelling like our case[9]. These tumors are usually found in adult patients between the age of 40 and 60 years[3], and females (58.9 %) are more affected than males (42.2 %)[8].

Studart-Soares *et al.*, reviewed 450 intraoral lipomas between 1966 and 2009, and the most common site was buccal mucosa (n=174; 38.7%), followed by vestibule (n=35; 7.8%), retromolar area (n=21; 4.7%), and other sites (n=220; 48.8%)[9].

The differential diagnosis for oral lipoma includes fibroma, mucocele, dermoid cyst, minor salivary gland tumors, lymphangioma, hemangioma, rhabdomyoma or neuroma and liposarcoma[6,8]. The management includes complete surgical removal of the lesion with excisional biopsy[4]. Lesions outside the oral cavity have greater tendency to recur (5%) after surgical excision (generally attributed to inadequate resection), but intraoral intramuscular lipomas rarely show recurance[6,10]. James F Reibel et al reported a case of liposarcoma arising in pharynx nine years after fibrolipoma excision[10]. This transformation could be due to malignant degeneration of fibrolipoma.

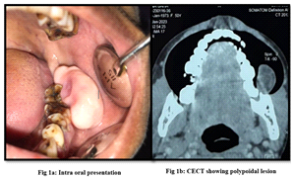

Fig 1a: Intra oral presentation Fig 1b: CECT showing polypoidal lesion

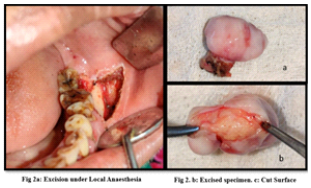

Fig 2a: Excision under Local Anaesthesia Fig 2. b: Excised specimen. c: Cut Surface

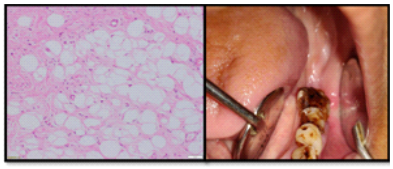

Fig 3a: Mature adipocytes interspersed in fibro-collagenous stroma

Fig 3b: Healing at 1 month follow up

CONCLUSION

Lipomas found in the oral and maxillofacial region are usually painless, slow growing lesions. The clinical course is usually asymptomatic until they get larger in size and interfere with mastication or phonation. In our case, surgical excision was done immediately with histological analysis and found to be fibrolipoma. No signs of recurrence have been observed at 1 year follow up. Though the recurrence rate is very low, complete excision with histopathological examination and adequate follow up are mandatory.

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