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GIANT CHEST WALL LIPOMA IN AN ADULT MALE MASQUERADING AS UNILATERAL GYNECOMASTIA

Plastic Surgery

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ABSTRACT

Lipoma of the chest wall is a relatively rare entity. A large lipoma over the chest wall around the nipple areola complex can mimic unilateral gynecomastia and may create a diagnostic dilemma. Here we present the case of a patient who was concerned about the growing size of his left breast and sought medical attention. Ultrasonography and FNAC were suggestive of lipomatous swelling. Excision of the swelling was done through an anterior axillary fold incision. Post-operatively course was uneventful, and the patient recovered well. Histopathological examination of the excised specimen confirmed the diagnosis of a benign lipoma. This case highlights an uncommon presentation of a common condition.

KEYWORDS

Gynaecomastia, lipoma, Benign neoplasm

BACKGROUND

Lipomas are the most common benign neoplasms of mesenchymal origin and may arise anywhere in the body.[1] They commonly present in the 5th and 6th decades of life and are usually sporadic.[2] Lipomas can have variety of clinical presentation depending on their size, location and duration. Rarely, these tumours may reach a size greater than 10 cm. Such lipomas are referred to as giant lipomas. The most common presentation of lipoma is a painless, well-circumscribed mass with gradual increase in size over time.[3] Despite their common occurrence, lipomas at unusual anatomic locations may cause diagnostic dilemmas. The diagnosis is usually made by typical findings on clinical examination, however imaging studies may be indicated in cases where there is a diagnostic dilemma, or to assess the depth and infiltration of large or deep-seated tumours. Surgical management is indicated for painful lipomas and aesthetic concerns. When excising a lipoma, it is important to plan the incision for an optimal aesthetic outcome.

Case Presentation

We describe the case of a 37-year-old patient with a giant lipoma over the left anterior chest wall. The tumour had been evolving over 10 years and was mimicking enlargement of the left breast. The lipoma was otherwise asymptomatic; hence the patient did not seek treatment earlier. As the lipoma enlarged to the current size, patient had difficulty in wearing tight clothes and had started to distance himself from social gatherings due to the stigma of an enlarged male breast. On persuasion of a neighbour who was a nurse working at our hospital, the patient finally sought medical attention and attended our outpatient clinic. On examination, we found a swelling in the left anterior chest wall which had displaced the nipple-areola complex inferolaterally. The swelling was soft, had well-defined margins and was free from the chest wall and overlying skin. No sub-areolar button was felt.(Figure 1,)

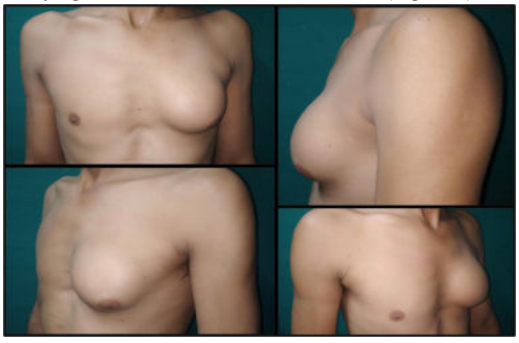

Figure 1 showing Pre-operative view

Investigations

Although a diagnosis of lipoma was made clinically, an FNAC and an ultrasonography were performed due to the unusual presentation. FNAC showed moderately cellular smear with benign fibrofatty tissue fragments. Ultrasonography was done not only to confirm the diagnosis, but also to assess the depth of the tumour and to look for any intra-thoracic extension. Ultrasonography showed a well-defined hetero-echoic lesion in the left anterior chest wall deep to the subcutaneous plane and it was displacing the pectoralis major muscle posteriorly. Routine pre-operative blood investigations were also performed.

Treatment

The pros and cons of surgical excision of the lipoma were explained to the patient. The patient was operated in supine position under general anaesthesia. The lipoma was excised through a 5cm incision along the anterior axillary fold. The excised tumour measured 10x12 cm and weighed 550 grams.(Figure 2, 3)

Figure 2 showing intra-operative marking

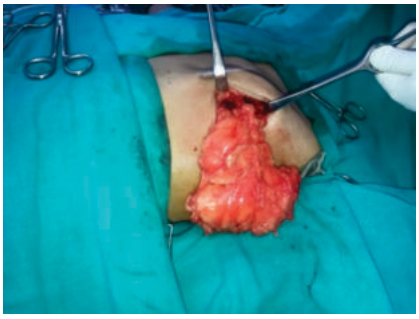

Figure 3 showing Intra-operative picture

Outcome And Follow-up

Post-operative recovery was uneventful. Drain was removed on the 4th post-operative day, and the sutures were removed on the 14th post-operative day. Histopathology was reported as a well encapsulated tumour composed of sheets and lobules of mature adipose tissue without any breast tissue, suggestive of a lipoma.(Figure 4,5)

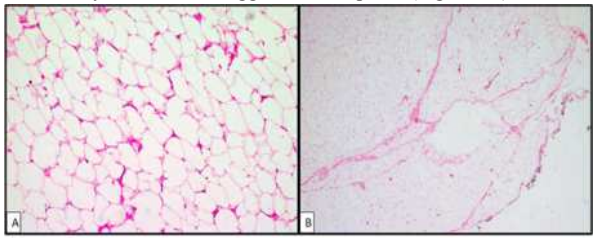

Figure 4 Showing Histopathological Report

Figure 5 showing post-operativepic

DISCUSSION

Despite being the commonest tumour in humans, certain rare locations of lipoma can have interesting clinical presentations. Lipomas have no difference in prevalence across genders and the common age of presentation is 40–60 years.[4] The diagnosis of superficial lipomas is usually obvious after clinical examination. However, imaging is often required if there is a diagnostic dilemma. The first step in imaging is ultrasonography[5], MRI or CT scan may be necessary for deeper and larger lipomas.[6] The characteristic sonographic appearance is that of an elliptical or rounded mass just below the skin that is hyperechoic relative to adjacent muscles. Since echogenicity is influenced by the volume of surrounding non-fat tissue it may appear as isoechoic or even hypo-echoic.[7] Surgical treatment can be suggested for mechanical or aesthetic concerns. Open surgical excision is the most common treatment, and is especially indicated for deep seated or visceral lipomas. Liposuction is often an appropriate treatment[8] wherever available, albeit with a risk of incomplete removal of lipoma. In this case, the giant lipoma over anterior chest wall gave the appearance of an enlarged male breast (gynaecomastia). A lipoma presenting in this manner is quite uncommon, and we could only find one such reported case in literature.[9] In that particular case however, the lipoma was deep to the pectoralis muscles, unlike the subcutaneous plane in our patient. An enlarged breast in males is often a source of embarrassment and social stigma. Surgical excision provides the best outcome in these patients. An appropriate site of incision should be chosen for a good aesthetic outcome. A scar over the anterior chest is not only more visible, but is also prone to keloid formation. Hence, an anterior axillary fold incision is preferable.