

Fibrolipoma Oral Cavity : Case ReportMamadou Diatta^{1,2*}, Babacar Tamba^{1,2}, Mouhammad Kane¹, Mamadou Lamine Ndiaye³, Abdou Ba¹, Sylla S², Soukeye Dia Tine^{1,2}¹Oral Surgery Service, Department of Odontology Cheikh Anta Diop University of Dakar Senegal²Dental Service of the General Hospital of Grand-Yoff, Dakar Senegal³Dento-maxillo-facial radiology, Department of Odontology Cheikh Anta Diop University of Dakar Senegal***Corresponding author**

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**Abstract:** Fibrolipoma, the most rare histo-pathological form of lipoma, is a benign tumour of rare oral localization, slow and progressive growth, often asymptomatic. This work reports a case of fibrolipoma of the oral cavity in a 66-year-old woman, neglected since early childhood and whose consultation was motivated by functional discomfort due to the increase in volume of the tumour. The management consisted of surgical excision under general anaesthesia. The good after-effects allowed the patient to regain normal oral functions.**Keywords:** Lipoma, Buccal Mucosa, Adipose Tissue Neoplasms.**INTRODUCTION**

Lipomas represent 1 to 5% of all benign tumors in the oral cavity [1]. Fibrolipoma, the most rare histo-pathological form of lipoma, is a benign tumour of rare oral localization, slow and progressive growth, often asymptomatic [2]. This tumour most often affects the elderly, with a higher peak between 40 and 70 years of age, the female predominance is noted [3]. Fibrolipoma can progress in all regions of the oral cavity [1]. When located in the oral floor area, diagnostic orientation may be difficult due to its similarity to some more common benign tumors.

The objective of this work was to report the clinical aspects and the therapeutic management of a rare case of fibrolipoma of the oral floor.

OBSERVATION

A 66-year-old woman was referred to the Dentistry Department of the Grand Yoff General Hospital in Dakar, Senegal, for a tumour of the oral floor region that appears to have been developing since early childhood.

During questioning, the patient reported a disturbance in chewing and swallowing, also a speech disorder was noted. The general state was maintained and the exo-buccal examination revealed no peculiarities. Palpation did not reveal the presence of adenopathy, and the mouth opening was of normal amplitude. The endo-oral examination showed poor oral hygiene, characterized by the presence of plaques and dental plaques. A unilateral tumour mass located on the left anterior buccal floor covered with an apparently healthy mucosa was objective. The tumor lesion lifted the tongue from the right side (Figure 1). It measured approximately 3cm in its major axis and extended from the 31 to the 37. On palpation, the lesion was painless, mobile in relation to the deep plane and of fluctuating consistency that motivated the needle puncture, which was white. Ultrasonography had revealed a tumour formation of a tissue nature, well limited, measuring

30mm of major axis with a submandibular gland of normal size and structure without dilation of the channel facing it (Figure 2). The analysis of clinical and paraclinical signs allowed to establish a diagnostic orientation in favour of benign tumour of the oral mucosa of the dermoid, squamous cyst or lipoma type. Given the extent of the lesion, given the patient's age and in order to intervene safely, enucleation under general anaesthesia was decided. The surgical protocol included a lateral supra-mucosal incision 2.5 cm long, 2 cm from the left alveolar ratio. Then progressive dissection with foam-tipped scissors allowed the tumour to be exposed, followed by total removal (Figure 3). Hemostasis was performed by electrocoagulation with an electric scalpel. After site revision and dakin rinsing, hemostasis was performed by closing the surgical wound with simple stitches (Figure 4). On macroscopy, the surgical specimen was whitish in colour, well encapsulated and dissected to reveal a white fleshy tissue (Figure 5). The postoperative prescription was antibiotic-based (amoxicillin + clavulanic acid) 2g daily in two doses, antiseptic mouthwash (Chlorhexidine) after meals and corticosteroid (Prednisone 20mg) 2 tablets daily in a single morning dose for 5 days. Controls were performed at 24 hours, 7 days then 15

days with ablation of the sutures performed and the postoperative outcomes were simple (Figure 6). The anatomopathological examination showed a lesion with a fibrous wall coated with a squamous epithelium consisting of fat cells and adipocyte lobules with

mesenchymal proliferation. The result was a fibrolipoma (Figure 7). The control at 6 months had shown an absence of recurrences and no alteration of the anatomical structures of the neighbourhood was noted (figure 8).



Fig-1: intraoral view showing the tumour of the oral floor



Fig-2 : Echography showing a non-vascularized tissue nodule in the left anterior buccal floor



Fig-3: Tumour evidenced after incision – dissection



Fig-4: Surgical site sutures after tumour resection



Fig-5: the operating tissue



Fig-6: control at 15 days

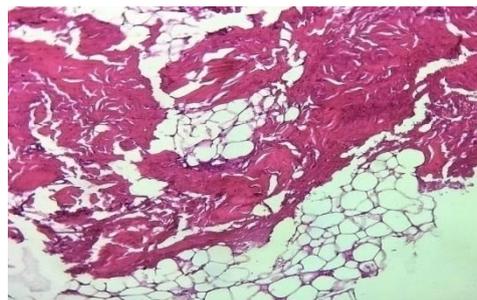


Fig-7: Histological section showing fat cells and fat cell lobules



Fig-8: Control at 6 months

DISCUSSION

Fibrolipoma is a tumour, rarely observed in the oral cavity, whose etiology is poorly known [1]. However, genetic, hormonal, traumatic, infectious or degenerative factors appear to be involved in pathogenesis [4, 5]. It is a tumour that can be observed

at any age according to Melikoglu *et al.* [6], with a higher frequency between the 5th and 7th dekad of life and a female predominance [1,3].

In the reported case, the lesion was observed in a 66 year old female subject. The most commonly

reported reasons for consultation are functional impairment [7,8]. In this clinical observation, the consultation was motivated by functional impairment during chewing, swallowing and phonation. Fibrolipoma is a slow progressive lesion resulting in a progressive increase in tumor volume [1, 8]. The duration of evolution can vary from a few months [1, 4] to several years [4, 7, 9]. The duration of progression for this clinical observation was more than 40 years, given that the lesion has evolved since the patient's early childhood. This delay in consultation could be explained by ignorance and poverty, which sometimes cause patients to turn first to traditional healers [10]. For the reported case, the patient who was unemployed consulted traditional practitioners first because of lack of means, so she was unaware of the complications she might face. In the oral cavity, the locations most reported by other authors are the lips [1], the inner face of the cheeks, the buccal vestibule, the tongue, the buccal floor, the palate and the retro molar region [4, 9, 11]. In the reported observation, the lesion was located at the mouth floor area. Clinically, it was a well defined and asymptomatic lesion, [1, 9] often covered with a healthy mucosa [1] and sometimes showing a yellow colour in superficial locations [2,4]. The size of the tumour varies, reaching tens of centimetres in diameter with a major axis according to Laconetta et al. [11]. In the majority of cases, the lesion is deeply localized, well encapsulated, with a variable consistency from soft to firm depending on the quantity and distribution of fibrous tissue as well as the depth of the lesion[9]. Moreover, on palpation, a pasty[4] or more rarely fluctuating consistency[12] has been reported. The fluctuating consistency found in this observation had suggested a dermoid or squamous cyst of the oral floor. Ultrasonography had made it possible to visualize a homogeneous mass well limited to the sharp contours. Clinically, the differential diagnosis will be made with benign tumours of the oral floor region including the squamous cyst[13] and those of identical clinical aspects including dermoid cysts and lipomas [12]. In superficial localizations, the lipomas show a yellow color unlike these other lesions. However, in deep localizations clinical diagnosis is often difficult because of the absence of this sign suggestive of lipomas [2, 4]. Treatment is usually surgical excision under local anaesthesia [7] or general anaesthesia [2]. In the reported observation, surgical excision was performed under general anaesthesia for the following reasons:

- The large size of the lesion, which would have been very difficult to remove under local anaesthesia because of the significant haemorrhagic risk associated with the surgical procedure
- The need to operate in a comfortable and safe environment for the patient.

The surgical technique used first preserved the anatomical elements of the oral floor area, which could be damaged during the operation. Macroscopically, the

lesion appears as a solid or multilobulated encapsulated mass [9, 14], showing a yellowish colour [11], as in the reported observation. The histology of the reported case showed a lesion whose fibrous wall was coated with a squamous epithelium consisting of fat cells and adipocyte lobules with mesenchymal proliferation in favour of a fibrolipoma. Recurrence is rare after complete surgical excision in oral locations [1, 9, 11]. In the reported observation, the decrease is certainly small but no recurrence was noted after six months of monitoring.

CONCLUSION

Fibrolipoma is the most rare subtype of lipoma. Its preferred location in the oral cavity is the floor area. Diagnostic orientation may be difficult because of its similarity to some benign tumours in this area. The diagnosis of certainty remains histological. The treatment of choice is surgical removal.

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