

A Rare Case of Parotid Lipoma

Shayee Kalyee Shanjeev P. B*, Vimala G, Kannan R

Institute of General Surgery, Madras Medical College and Rajiv Gandhi Government General Hospital, Chennai, Tamilnadu, India

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*Corresponding author: Shayee Kalyee Shanjeev P. B

Abstract

Case Report

Lipomas of parotid are rare benign neoplasms. The diagnosis is made with preoperative imaging and confirmed by post operative histopathological analysis of resected specimens. Here we report a case of 46 year old male presenting with a painless slow growing neck mass. Preoperative computed tomography revealed a lipoma arising from the superficial lobe of the left parotid gland. Enucleation of the lesion was done. Postoperative histopathological analysis confirmed the diagnosis.

Keywords: Lipoma, parotid, enucleation.

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INTRODUCTION

Lipoma is the most common mesenchymal tumour with an ability to occur at almost any part of the body with a few exceptions. The distribution of the lipoma is not uniform, in that less than 20% occur in the head and neck. Within the parotid gland, lipoma accounts for 0.6 to 4.4% of all parotid tumours, making it one of the rare parotid tumours. Painless slow growing mass is the most common presentation. Accurate Preoperative evaluation using ultrasound (US), magnetic resonance imaging (MRI) and computed tomography (CT) have enabled a more a rational approach to their management. Concerning treatment, surgical excision of parotid masses is always mandatory for definitive diagnosis, but it is challenging because of the facial nerve.

CASE REPORT

A 46 year old male presented with complains of insidious onset; slow growing swelling in the left side of neck for past 10 years. There was no pain associated with the swelling. Clinical examination revealed a single 6*4 cm swelling which of soft

consistency, not warm, not tender, mobile, skin over the swelling freely movable and located deep to deep fascia. There was obliteration of retroauricular sulcus and lifting of ear lobule. There was no palpable cervical lymphadenopathy and examination of facial nerve revealed no weakness. Contrast enhanced CT of neck showed a well defined oval nonenhancing fat density (-120HU) lesion in the inferior part of superficial lobe of left parotid gland. These features were consistent with lipoma.

Proceeded with surgical excision of the lesion. Intraoperatively the tumour was a well circumscribed, capsulated soft yellow fatty lesion. The lesion was excised and facial nerve was preserved. Wound was closed in layers without any drains. Histopathological examination of specimen showed homogenous proliferation of mature adipocytes without cellular atypia and mitotic figures suggestive of lipoma. Postoperative period was uneventful. The patient had no facial weakness (House-Brackmann grade 1). At 10 months follow up patient had no freys syndrome or recurrence and was satisfied with the facial contour.



Fig 1 and 2: Anterior and lateral view of the swelling

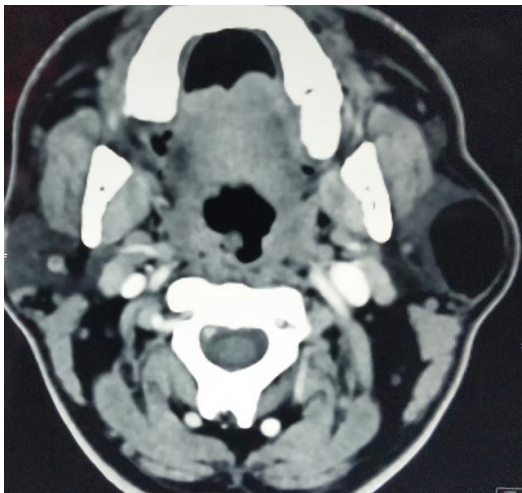


Fig-3: Contrast enhanced CT image showing homogenous non enhancing lesion arising from left parotid



Fig-4: Intraoperative picture showing the yellowish lesion surrounded by a thin capsule arising from the superficial lobe of left parotid

DISCUSSION

Lipomas of the parotid are an unusual group of tumours and are seldom considered in the differential diagnosis of parotid swellings because of their rarity. Though adipocytes are a normal component of parotid gland the occurrence of lipomas have been very low [1]. The reported incidence varies from 0.6% to 4.4% in different series [2]. Many factors like genetics, increased BMI, radiation exposure, diabetes mellitus, steroid use and trauma have been proposed as risk factors for development of parotid lipoma [3]. They have been reported to be more common in males (male female ratio of 5:1) with peak incidence after 50 years of age [4]. They are usually solitary lesions with 75% of them involving only the superficial lobe. 16.5% of them were dumbbell lesions involving both the lobes. Isolated deep lobe involvement was rare at 6.5%. This follows the pattern of distribution of other more common parotid tumours [5]. The presence of a fibrous capsule helps to distinguish them from simple fat aggregations.

Most parotid lipomas present as asymptomatic slow growing masses in the neck though pain and facial palsy have been reported [6]. Lipomas of deep lobe usually presents as dysphagia or as a parapharyngeal mass. The principle consideration of an intraparotid mass is to differentiate between benign and malignant salivary gland neoplasia. There is no specific clinical feature by which the lipoma can be differentiated from other more common parotid gland tumours.

Evaluation is similar to other parotid lesions. Imaging modalities include ultrasound, CT and MRI, of which MRI is preferred as it can reliably differentiate benign and malignant lesions based on soft tissue features. Lipomas show a homogeneous mass with few separations within a range of negative scale of -50 and -150 HU in routine CT scan. FNAC can be done but

reports often tend to be inconclusive and hence unreliable [7].

Lipoma being a benign tumour can be managed conservatively with surgery being offered only for facial nerve palsy or cosmetic purposes. As it is well encapsulated, enucleation rather than formal parotidectomy can be done after dissecting the branches of facial nerve away from the lesion. Intraoperative neuromonitoring can reduce the facial nerve injury. The complications of parotidectomy such as altered facial contour, salivary fistula and Frey syndrome have not been reported with enucleation. The recurrence rate is around 5% [8, 9].

CONCLUSION

Lipomas of the parotid are interesting as they rarely occur and are not considered in the preoperative differential diagnosis. The essential factor in the differential diagnosis of a mass in the parotid glands is whether it is benign or malignant. Although lipomas of the parotid rarely occur, they should be taken into consideration in the preoperative differential diagnosis. Surgical management is simple enucleation for well encapsulated lesions.

Conflict of Interest: No

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