Intraoral Palatal Lipoma: A Rare Case Report

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ABSTRACT

Lipomas are the commonest occurring benign neoplasms of the human body originating from adipose cells. Intraoral lipomas are rare, contributing to less than 5% of all head and neck neoplasms. Even so, lipoma should be considered as a differential diagnosis in swellings of the oral cavity. Surgical excision is the mainstay of treatment in the case of intraoral lipoma. In this case report, the lipoma was seen originating from the soft palate. It was surgically excised in toto and was subjected to histopathological investigations to reach a definitive diagnosis.This case is being reported as it is uncommon for a lipoma to have an intraoral origin and even more rare for it to be seen occurring in the palate.

Keywords: *Adipocytes, Benign, Intraoral, Lipoma, Palate.*

Lipoma or "Yellow Epulis" was first described in 1848 by Roux [1]. It is the most commonly occurring benign tumour of the human body. It occurs as a smooth, non-ulcerated growth in varying shape, size and contour. It may be sessile, pedunculated or submerged. It is equally predominant in males and females; although, some studies have shown male predominance or vice versa [2]. Although the exact etiopathogenesis of a lipoma is unclear, certain factors like heredity, fatty degeneration, hormones, trauma, chronic irritation, congenital factors and progressive infection have been observed to be contributory [3]. They are commonly seen in the 4th and 5th decades of life.

Fine needle aspiration cytology (FNAC) is the mainstay investigation as it is a confirmatory test to achieve a definitive diagnosis. FNAC is a very commonly performed investigation in cases of intraoral masses. Intraoral lipomas are a rare entity (<4% of benign neoplasms of oral cavities) due to which such cases need to be reported to understand differential diagnoses better in cases of intraoral palatal swellings. We report the case of a 25-year-old female who presented with a soft, non-tender swelling over the left side of soft palate since 1 year. After a detailed clinical examination, the patient was subjected to pathological investigations and radio-imaging studies which confirmed the mass to be an intraoral palatal lipoma.

CASE REPORT

A 25-year-old female came to the E.N.T. OPD with complaints of swelling over the palate since 1 year which was gradual in onset and slowly progressed to the current size in the past year. She had previously taken consultation for the same from a general physician where she was advised contrast-enhanced computed tomography (CECT) neck which revealed the mass to be a lipoma following which she came to our OPD for further management. The swelling did not increase in size on deglutition/salivation. The patient gave no history of trauma or any congenital abnormality. She did not suffer from any dyspnoea or dysphagia due to the swelling. There was no history of tobacco chewing or any other addictions. Past, personal and family histories were non-contributory.

The general condition was fair. All vitals were within normal limits. Pulse was 82/minute, regular; blood pressure was 120/70 mmHg and respiratory rate was 13/minute. All systemic examination was normal. On inspection, the swelling was seen as a diffuse, yellow mass arising from the soft palate, more on the left side, pushing the uvula to the opposite side, partially obstructing the oropharynx (Fig. 1). On palpation, it was a soft,

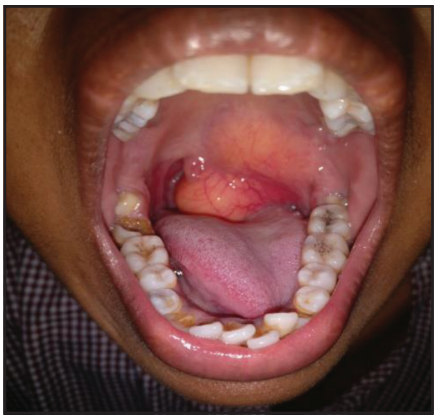

Figure 1: Yellow-colored swelling arising from the soft palate.

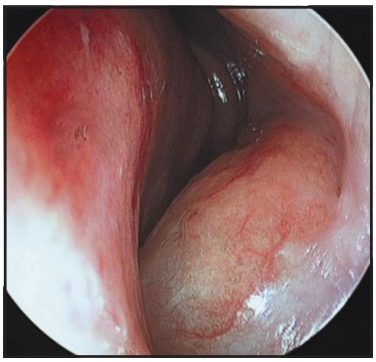

Figure 2: Diffuse bulge seen on Diagnostic nasal endoscopy.

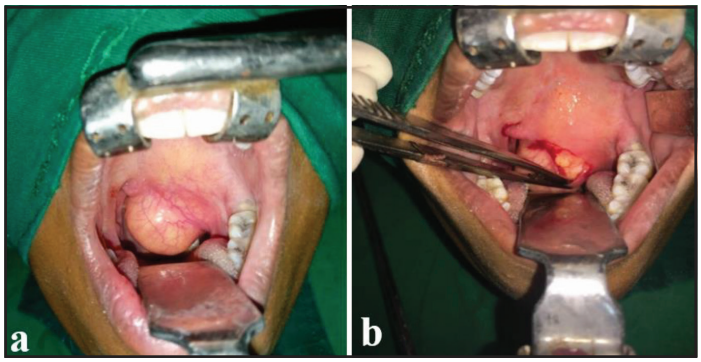

Figure 3: (a) Well-exposed mass prior to incision; (b) Incision taken.

non-tender, mobile swelling with a smooth surface. There was no discharge on applying pressure to the mass.

Diagnostic nasal endoscopy of the left nasal cavity revealed a diffuse bulge over the dorsal surface of the soft palate (Fig. 2). Indirect laryngoscopy was normal. CECT of the neck showed a well-defined, hypodense, non-enhancing, fat density lesion measuring 2.6x2.5x4.2 cm arising from soft palate on the left side adjacent to left pharyngeal wall, growing inferiorly into the oropharynx, closely abutting the epiglottic cartilage. Fine needle aspiration cytology (FNAC) of the swelling revealed the mass to be a lipoma. All routine pre-operative blood and radiological investigations were normal.

Under all aseptic precautions, the patient was taken up for surgery under general anesthesia and was ventilated through a preoperative tracheostomy. The mass was well-exposed using a Boyle's and Davis mouth gag (Fig. 3a).The incision was taken along the upper border of the growth (Fig. 3b) and the mass was excised in toto (Fig. 4a).The incision site was sutured closed using absorbable sutures.The wound healed well post-operatively (Fig. 4b).The mass was sent for histopathological examination. The diagnosis was confirmed to be a lipoma and this correlated well with the CECT neck and FNAC findings.

The patient was kept on the postoperative prophylactic antibiotic cover – Inj. Augmentin 1.2gm three times a day. Tracheostomy care was done by suctioning the tube and changing the wound dressing regularly. The decannulation of the tracheostomy tube was done on the second post-operative day. The patient was stable post-operatively and had no complications. She has been on a regular follow-up for 1 year in our ENT. OPD and has no signs or symptoms of any complication or recurrence.

DISCUSSION

The lipoma is the most commonly occurring benign tumour of the human body but its occurrence on the palate is very rare. Approximately, 145 cases of intraoral lipomas were reviewed by Hatziotis et al., from 1945 to 1967 of which only 6 cases were found to occur in the palate [4]. Out of 46 cases of lipomas reviewed by ER Fregnani, none were found to be occurring in the palate [5]. Certain cases of small soft tissue lipomas have been treated by monthly injections of steroids (1:1 combination of lidocaine & triamcinolone acetonide) causing atrophy of the adipose tissue and reduction in the tumour size [6].

Mature adipocytes having a clear cytoplasm and a flat nucleus at the periphery in the absence of vascularity, atypia or metaplasia give a classical histological picture of a lipoma [7] (Figure 5). They have a thin fibrous capsule and are mostly well-circumscribed [8]. Benign tumours of adipose tissue may be classified into simple lipoma, fibrolipoma, angiolipoma, intramuscular lipoma, pleomorphic lipoma, sialolipoma, myxoid lipoma and atypical lipoma [9]. Extraoral lipomas are commonly seen in subcutaneous tissues of the trunk, neck, back and limbs [10]. The commonest site of an intraoral lipoma is buccal mucosa due to the abundance of fat, followed by the tongue, lips, floor of the mouth and gingiva, making palate the rarest due to lack of adipose tissue [11]. Intraoral lipomas are a rare phenomenon contributing to less than 5% of all head and neck neoplasms. Of all benign neoplasms of the oral cavity, lipomas comprise of only 0.5-4% [12] sex, location, clinical appearance, duration, recurrence and histological diagnosis are reviewed. The data gave a slightly higher incidence of oral lipomas in comparison with lipomas of the whole body (2.2 %).

Intraoral lipomas may pose a threat if they increase to a substantial size to cause airway obstruction or if they develop into liposarcomas. The recurrence rate of an intraoral lipoma is very low unless there is muscle infiltration [13] 2 fibrolipomas, and 2 infiltrating lipomas of the oral cavity. In addition, 10 cases of infiltrating lipoma of the oral cavity previously reported in the literature were reviewed. Materials and Methods: All cases were retrieved from the archives of the Department of Oral Medicine/ Pathology of the University of Thessaloniki, Greece. Data on age, sex, location, clinical appearance, duration, recurrence, and histologic appearance were evaluated. Results: This study showed that the sex distribution of the simple lipomas was approximately equal, and the mean age of patients was 60.2 years. The buccal mucosa was the most frequent location of the tumors. Their size ranged from 0.2 to 1.5 cm, with an average rate 0.8 cm. In 3 cases, the tumor was not encapsulated. The sex distribution of the infiltrating lipomas was equal, and the mean age of the patients was 36.8 years. The most frequent location was the tongue. Conclusions: Tumors of adipose tissue represent rare neoplasms of the oral cavity. The diagnosis is based on both the clinical and histologic characteristics. Caution is required during their

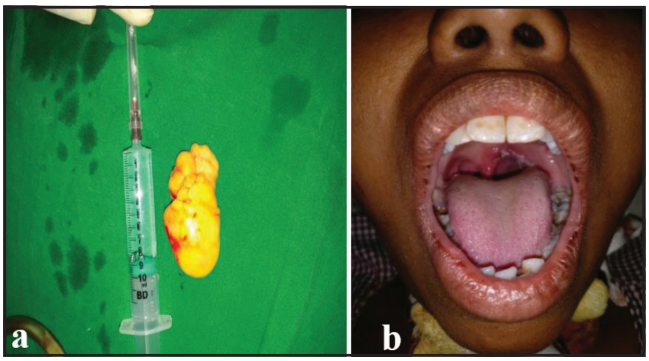

Figure 4: (a) Excised mass; (b) postoperative slough formation and well-healed wound.

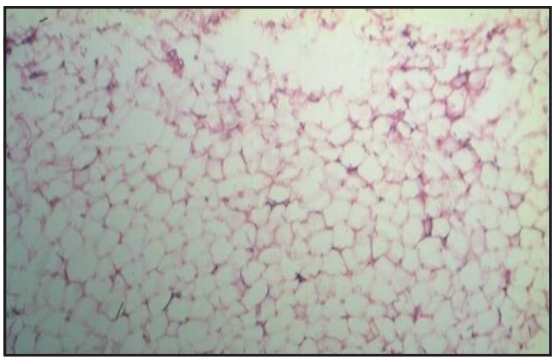

Figure 5: Histological picture of Lipoma.

surgical excision to avoid recurrence, especially with infiltrating lipomas. (C. Malignant change from a lipoma to a liposarcoma is a rare entity [14]. The differential diagnoses in a case of intraoral swelling are as follows: minor salivary gland tumour, mucous retention cyst, lipoma, liposarcoma, oral dermoid and epidermoid cyst, oral lymphoepithelial cyst, lymphoma, ranula, mucoepidermoid carcinoma and angiolipoma. The treatment of choice in a case on intraoral lipoma is complete surgical excision.

CONCLUSION

Even though a rare occurrence, lipoma should be considered as a differential diagnosis in a case of palatal or intraoral swelling.

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