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INTERESTING CASE OF PAROTID LIPOMA

SARAVANAN M
Department of General Surgery, MADURAI MEDICAL COLLEGE AND HOSPITAL

Abstract : 59 years old male was admitted in Government Rajaji Hospital Madurai with the complaints of swelling of the right side of neck for 2 years duration. On evaluation he was found to have lipoma of Right patotid gland lipoma involving both superficial and deep lobes. After completing necessary investigations, it was decided to excise the tumor by total parotidectomy. Post operatively patient is uneventful.
Keyword : Parotid lipoma, parotidectomy, facial nerve

Case history

A 59year-old male presented with a right cheek mass of 5 years duration. It was a slow-growing, painless mass that was not associated with any overlying skin changes. It did not increase in size with mastication and it was not associated with any facial asymmetry. On physical examination, it was found to be a 6 x 4 cm, shape, well circumscribed, rubbery, non compressible, non tender mass over the left parotid area; the mass extend to the angle of the mandible. slippage sign positive. Facial nerve function was intact with no facial muscle weakness observed. The patient was otherwise healthy and was not taking any medications.

FIGURE 1

CT (FIGURE 2) revealed a 6.5 x 4.1 cm measuring fat dense lesion in the right parotid gland with involvement of superficial and deep parts and causing lifting of right ear lobule .

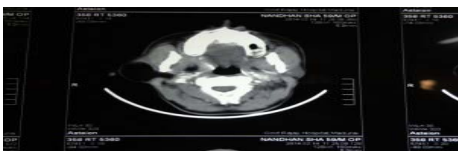

FIGURE 2

Fine Needle aspiration cytology - Fat cells seen The provisional diagnosis was Parotid Lipoma.

FIGURE 3

He underwent Right Total parotidectomy and excision of lipoma. (FIGURE 3) The facial nerve was identified and preserved. Intraoperatively, the mass was found to be a well-localized lipomatous lesion investing the parotid gland, superficial to the facial nerve except for minimal deep lobe extension at the lowest margin . It was dissected off of the facial nerve and excised as a whole with no complications (FIGURE 4). complete hemostasis secured. Then a negative suction drain was placed, which was removed 2 days later. The patient was discharged home on 5th Post Operative Day in good condition.

FIGURE 4

FIGURE 5

POST OP BIOPSY (FIGURE 6) - LIPOMA OF PAROTID GLAND

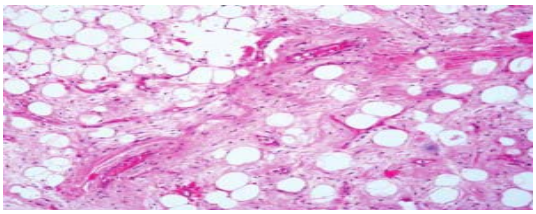

FIGURE 6

D**ISCUSSION**

Lipomas are benign tumors of adipose tissue and can occur anywhere in the human body. Well recognized locations for intraglandular lipomas include the pancreas, breast, and kidneys. Intraglandular lipomas of the parotid gland are rare benign lesions that have been described mainly in case reports. They are thought to occur in about 1.2% of all parotid tumor cases, although there have been studies reporting 0.5 to 4.4% in individual series (1). The prevalence of intraglandular lipomas has been reported to be 10 times higher in males than in females, occuring most commonly during the 5th and 6th decade of life (2). The typical history of patients with intraglandular lipoma is that of a slowly growing painless mass over the parotid area. There might be associated ductal obstruction leading to sialadenitis, depending on the type of lipoma present.

The two reported types include the more common *well circumscribed lipoma* and the less commonly occurring *diffuse lipomatous type* (2). High resolution CT scan imaging is often diagnostic even though MRI shows better soft tissue definition. The presence of a well-encapsulated mass on CT with a density typically of 50 to 150 Hounsfield units is diagnostic of a lipoma(3). Proper diagnosis and localization of the mass is necessary for preoperative planning and intraoperative decisions. An intraglandular lipoma arising from the deep lobe of the parotid is also well-recognized (4, 5, 6). While FNA is of great value in the diagnosis of parotid tumors (3), its accuracy drops to less than 50% in the case of lipomatous lesions of the parotid gland (1,5). Failure to detect malignant cells in the FNA does not exclude a malignant tumor. Hence, many surgeons tend to shy away from attempting an FNA for the diagnosis of such masses. Superficial parotidectomies are the usual surgical treatment for parotid gland lipomas with near total absence of recurrence. However, there have been rare cases reported of lipomas with deep lobe extension, thus necessitating a total parotidectomy with facial nerve preservation. The case reported here of a well-encapsulated lipoma could be removed surgically through limited total parotidectomy with facial nerve preservation.

CONCLUSION

The most common presentations of these lesions were painless masses, with progression in size over time. FNA was noticeably inaccurate in preoperative diagnosis. However, CT and MRI can be useful for diagnosis. Preoperative imaging can be particularly useful in identifying size, location, and even the histologic characteristics of lipomatous lesions. Imaging can assist in planning the extent of the surgery, particularly in periparotid lesions that require extracapsular dissection. Treatment of benign lipomatous lesions is indicated to correct cosmetic reports due to unpleasant physical appearance or when preoperative diagnosis is inconclusive. Intraparotid lipomas require standard parotidectomy procedures. Complications are rare and recurrences even more so.

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