International Journal of Current Advanced Research
ISSN: O: 2319-6475, ISSN: P: 2319-6505, Impact Factor: SJIF: 5.995
Available Online at www.journalijcar.org
Volume 6; Issue 11; November 2017; Page No. 7677-7680
DOI: http://dx.doi.org/10.24327/ijcar.2017.7680.1203

Case Report

RECURRENT INTRAORAL RETROMOLAR LIPOMA - A RARE CASE REPORT

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A R T I C L E I N F O

Article History:
Received 6th August, 2017
Received in revised form 25th September, 2017
Accepted 3rd October, 2017
Published online 28th November, 2017

Key words:
Lipoma, Intraoral, Retromolar, Recurrent

A B S T R A C T

Lipomas are slow growing, fat containing benign neoplasms which can occur anywhere in the body. They are extremely rare in the oral cavity with an incidence rate of 1-4% among all benign intraoral tumors. The intraoral site preference according to fat deposition, are buccal mucosa, tongue, floor of mouth and palate. They may grow to a large size causing difficulty in speech and mastication. Histopathological examination confirms the diagnosis, revealing a well circumscribed tumor, with lobular proliferation of sheets of mature adipocytes having clear cytoplasm and flattened, eccentric nuclei, intervened by fibrous connective tissue septae. Wide surgical excision remains the gold standard of treatment to prevent recurrence. We present a rare case of recurrent retromolar oral lipoma in which the patient reported with a chief complaint of painless swelling in the left cheek region behind the last tooth, which had progressively increased in size for the past six months to the present size. The patient gave history of similar swelling of much smaller size in childhood at the same location, which disappeared eventually. Intraoral examination revealed a round, solitary, sessile, lobulated swelling, 2x3 cm in size, which on palpation was soft, fluctuant, non-tender, non-pulsatile, mobile and the margins were slippery under the palpating finger. A provisional diagnosis of lipoma was established and a blunt surgical dissection was performed and the mass was extirpated. The histopathological picture confirmed lipoma. Neither recurrence nor any secondary swelling was observed after one year of follow up. The take home message by this case report is that a clinician should be able to correctly diagnose intraoral lipoma inspite of their rare occurrence and must confirm it histopathologically. Wide excision with routine follow up remains the gold standard of treatment for lipomas. To best of our knowledge a case of retromolar recurrent lipoma is being reported for the first time in literature.

INTRODUCTION

Lipomas are the most common benign soft tissue tumors of mesenchymal origin, which can occur at any body part containing fat and are composed of mature adipocytes encapsulated by thin fibrous capsule. Initially described as "yellow epulis" by Roux in 1848, oral lipoma presents itself as a long-standing, slow growing, mobile, soft, nodular, asymptomatic swelling which may be sessile or pedunculated and single or lobulated tumor of variable size. Intraorally they represent only 0.1 to 5% of all benign tumors of the mouth. Out of the 15-20% cases involving the head and neck region, only 1-4% of the lipomas are seen in the oral cavity, thus notifying them as a rare entity in the mouth [1].

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It can occur at various intraoral anatomic sites including the major salivary glands, buccal mucosa, lip, tongue, palate, vestibule, and floor of the mouth and is extremely rare if it occurs apart from these intraoral sites [2]. Etiology and pathogenesis of oral lipomas remains unresolved, although mechanical, endocrine and inflammatory causes have been reported earlier [3]. Lipomas other than the oral cavity may show greater recurrence rates but an extremely low rate of recurrence has been attributed to oral lipoma after its adequate surgical excision [4]. We report a rare case with patient's written consent, of recurrent intraoral lipoma at retromolar area which to the best of our knowledge has not been reported yet.

This case in unique and rare because as cited above that 1st of all intraoral lipomas are very rare [1], over that it occurred at a different location apart from generally cited intraoral sites [2].

As mentioned in literature [4] about rare recurrence of intraoral lipomas, our reported case gave a history of occurrence of similar swelling exactly at the same location in childhood with gradual involution which strongly forces us to consider it as a recurrent lipoma.

Case Report

A 47 year old male patient presented with a chief complaint of painless swelling in the left cheek region behind the last tooth, which had progressively increased in size for the past six months to the present size.

palpation the swelling was soft, fluctuant, non-tender, non-pulsatile, mobile and the margins were slippery under the palpating finger. Slip sign and transillumination tests were positive. Regional lymph nodes were not palpable. A provisional diagnosis of lipoma was established with a differential diagnosis of traumatic fibroma, neurofibroma and mucocele. The patient's medical history revealed good health and the hematological and biochemical parameters were within normal limits. After obtaining a written consent from the patient surgical excision of the lipomatous mass was planned.

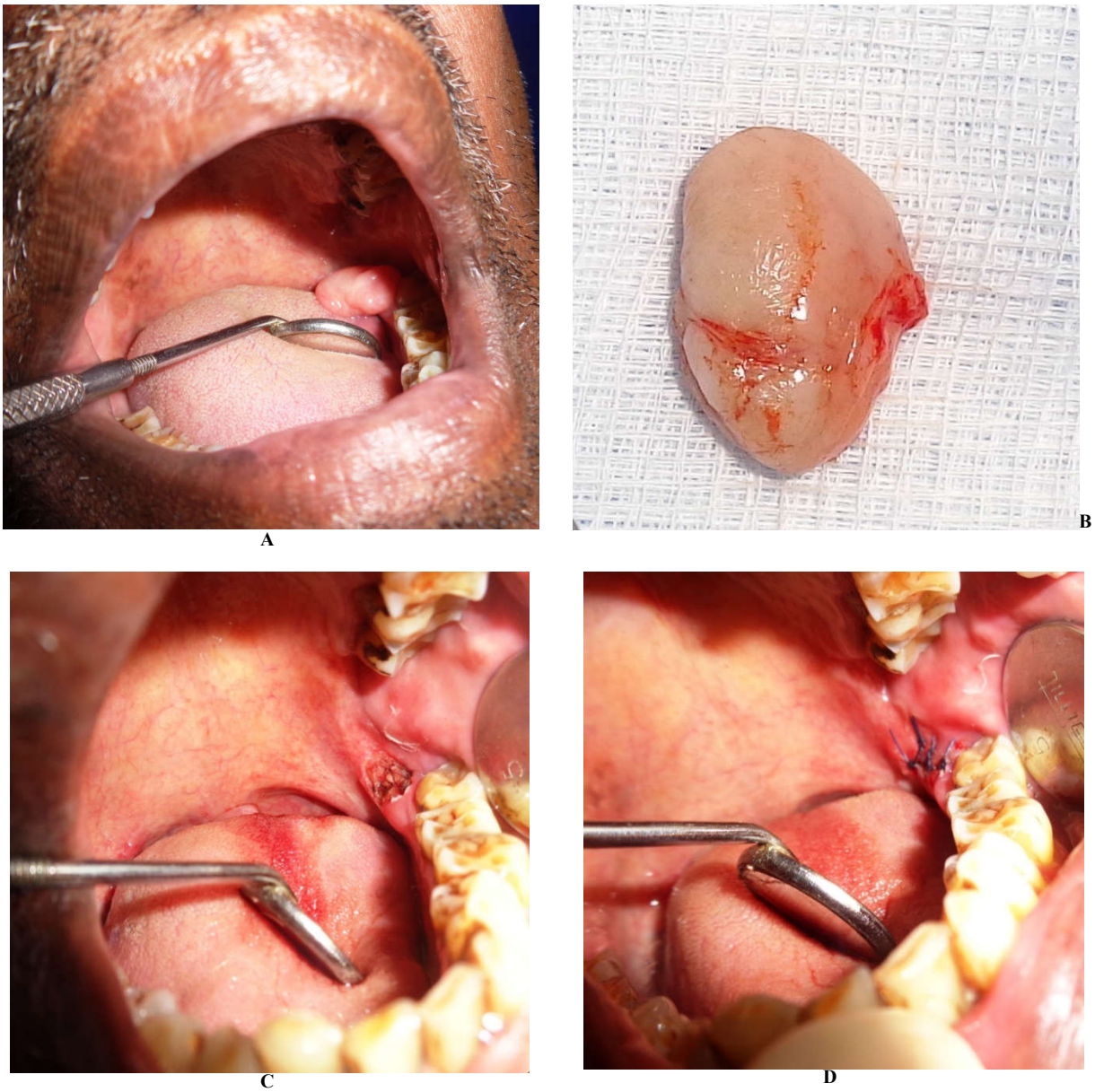
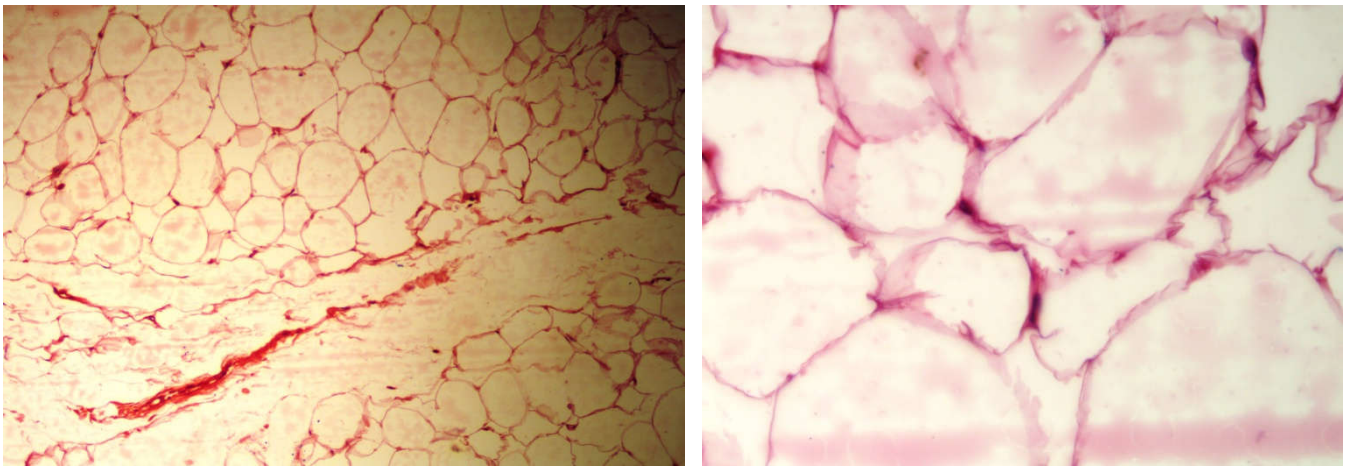


Figure 1 (A) The figure shows intraoral retromolar lipoma on the left side, disto-lingually to 3rd molar (B) The figure shows lipomatous excised mass as biopsy specimen (C) The figure highlights surgical wound post excision after achieving haemostasis (D) The figure shows surgical defect sutured with absorbable sutures.

The patient gave history of similar swelling of smaller size in childhood exactly at the same location, which disappeared gradually. There was no history of associated symptoms like paresthesia, ulceration or discharge. The swelling caused discomfort with tongue movements during swallowing and speech. Extra oral examination was unremarkable. Intraoral examination revealed a round, solitary, sessile, lobulated swelling, 2x3 cm in size located at the left retromolar area, disto-lingually to 3rd mandibular molar (Figure 1 A). On

With administration of local anesthesia (2% lidocaine with 1:80000 adrenalin), a blunt surgical dissection was performed and the mass was extirpated. Macroscopically, the surgical specimen consisted of a well circumscribed mass of 2 × 1.5 × 1.5 cm, pale yellow in colour and lobulated on cut section (Figure 1 B). Excised mass was fixed in 10% buffered formalin and was seen to be floating in formalin, thus depicting its lipomatous nature. After achieving complete haemostasis, resorbable sutures were given to hasten the

cicatrization process (Figure 1 C & D). Microscopic examination revealed, well circumscribed, lobular proliferation of sheets of mature adipocytes, with clear cytoplasm and flattened, eccentric nuclei, intervened by fibrous connective tissue septae. No cellular atypia or metaplasia was seen in the sections examined (Figure 2). A final diagnosis of lipoma was confirmed. Neither recurrence nor any secondary swelling was observed after one year of follow up.



A B

Figure 2 (A) H & E (10x) The histopathological picture shows lobules of tumor cells with intervening fibrous connective tissue septa. (B) The figure highlights mature adipocytes containing clear cytoplasm and eccentric nucleus.

DISCUSSION

Lipoma is significantly known as a "universal or ubiquitous tumor" as it can occur anywhere in body containing fat whether superficial, deep or periosteal. It is a slow growing, benign, encapsulated, soft tissue tumor made of adult adipose tissue. Oral lipomas have equal gender distribution and its mean age of occurrence is 60 years [5], our case being a male patient of 47 years age.

Most common location of oral lipoma is the buccal mucosa, a region rich in fatty tissue, followed by the tongue, lips, floor of the mouth and palate, corresponding to the quantity of fat deposits in the oral cavity. Very rarely oral lipomas occur apart from these sites. An extensive study on 450 cases of oral lipoma was done for a long period of 10 years by Studart-Soares EC *et al* in Brazilian population and they could report only one case at retromolar region and that too it was not recurrent. [6]. Another mega retrospective study of 33 years done by Naruse T *et al* in 603 oral lipoma cases showed extreme rare occurrence of oral lipoma at retromolar area and didn't observed any recurrence in any case [7]. It makes our case report unique as it is not only at retromolar site but also recurrent in nature.

Ideally it is difficult to differentiate lipoma of buccal mucosa from a herniated buccal fat until there is a lack of history of trauma as trauma proliferates the fatty tissue thus resulting in lipoma [8]. History of similar swelling exactly at same site in our reported case may would have involuted due to trauma and thus proliferating the fatty tissue at same site to recur as lipoma after many years. Clinically other important differential diagnosis includes traumatic fibroma, neurofibroma, lymphoepithelial cyst, ranula and mucocele.

The histopathological picture being the gold standard for diagnosis markedly depicts sheets of mature adipose tissue with lobular proliferation having clear cytoplasm and peripherally placed nuclei. Lipomas are well encapsulated but sometimes the capsule may be missing or broken. As reported in many previous studies that appearance of a circumscribed but not encapsulated aggregate of mature adipocytes with large clear cytoplasm in the absence of vascularity is diagnostic of a classical lipoma, thus matching with our case histological finding [9].

They can be elaborately classified into simple lipoma, fibrolipoma, angiolipoma, infiltrating (intramuscular) lipoma, pleomorphic lipoma, osseolipoma, sialolipoma, chondrolipoma, myxolipoma, and spindle cell lipoma [10].

Considerably the growth of intraoral lipomas is usually limited, but at times they can reach great dimensions, interfering with speech and mastication as it happened in our case. Complete surgical excision irrespective of its histological type remains the treatment of choice to prevent its recurrence. Suction assisted lipectomy has also been suggested by some studies for medium size (4-10 cm) and large size (>10cm) lipomas.

The uniqueness of this case builds up its strength to be assimilated in the pool of limited literature on oral lipoma and the only weakness of this case is that a major study is required on oral lipomas in Indian subcontinent to know more about its variance.

CONCLUSION

The take home message by this case report is that a clinician should be able to correctly diagnose intraoral lipoma inspite of their rare occurrence and must confirm it histopathologically. Wide excision with routine follow up remains the gold standard of treatment for lipomas. Histopathological examination of oral lipomas are imperative in order to detect the absence of a capsule, which requires constant follow up, owing to a high probability of recurrence.

References

1. De Castro AL, De Castro EV, Felipini RC, Ribeiro AC, Soubhia AM. Osteolipoma of the buccal mucosa. *Med Oral Patol Oral Cir Bucal* 2010 1; 15(2):e 347-49..
2. Rajendran R. Benign and Malignant tumors of the oral cavity. In, Rajendran R, Sivapathasundaram B (ed).

Shafer's Textbook of Oral Pathology, 6th edition. Elsevier, 2009; 137-138.
3. Kaur RP, Kler S, Bhullar A. Intraoral Lipoma: Report of three cases. *Dent Res J*(Isfahan) Winter 2011; 8(1):48-51.
4. Rafieiyan, Hamian N, Anbari M, Abdolsamadi F. Lipoma of the tongue: A case report. DJH 2011; 2(1).
5. Manor E, Sion-Vardy N, Joshua BZ, Bodner L. Oral lipoma: analysis of 58 new cases and review of the literature. *Ann Diagn Pathol* 2011; 15(4):257-61.
6. Studart-Soares EC, Costa FW, Sousa FB, Alves AP, Osterne RL. Oral lipomas in a Brazilian population: a 10-year study and analysis of 450 cases reported in the literature. *Med Oral Patol Oral Cir Bucal*. 2010 Sep 1;15(5):e691-6.
7. Naruse T, Yanamoto S, Yamada S, Rokutanda S, Kawakita A, Takahashi H *et al*. Lipomas of the oral cavity: Clinicopathological and Immunohistochemical study of 24 cases and review of literature. *Indian J Otolaryngol Head Neck Surg*. 2015 Mar; 67(Suppl 1): 67-73.
8. Sahni P, Nayak MT, Sharma A, Kumar R. Superficial intraoral lipoma in a geriatric edentulous male: A case report with review of literature. *Med J DY Patil Univ* [serial online] 2014 [cited 2017 Sep 13];7:396-9
9. Hoseinin AT, Razavi SM, Khabazian A. Lipoma in Oral Mucosa: Two Case Reports. *Dent Res J* 2010; 7(1):41-43.
10. Bakshi SS, Priya M, Coumare V N, Vijaysundaram S, Karanam L. A Common Tumor In An Uncommon Location: Lipoma of the Palate. *Ann Maxillofac Surg* 2015; 5:237-9.

How to cite this article:

Priyankar Singh *et al* (2017) 'Recurrent Intraoral Retromolar Lipoma - A Rare Case Report', *International Journal of Current Advanced Research,* 06(11), pp. 7677-7680. DOI: http://dx.doi.org/10.24327/ijcar.2017.7680.1203

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