International Journal of Science and Research (IJSR)
ISSN: 2319-7064
SJIF (2022): 7.942

A Case Report on Giant Axillary Lipoma

Dr. Aparajita Singh[1], Dr. J. P. Dave[2], Dr. J. G. Bhatt[3]

[1]Junior Resident; Department of General Surgery, P. D. U. Govt. Medical College and Civil Hospital Rajkot, India (Corresponding Author)

[2]Associate Professor; Department of General Surgery, P. D. U. Govt. Medical College and Civil Hospital Rajkot, India

[3]Professor and Head; Department of General Surgery, P. D. U. Govt. Medical College and Civil Hospital Rajkot, India

Abstract: ***Lipomas are one of the most common mesenchymal tumours. Most of the lipomas are small, discrete swelling usually asymptomatic occurring most commonly on the trunk and extremities. Axilla is unusual site for lipoma. Here, we report a rare case of a giant lipoma in Axilla with rapid progression. The presentation and related literature is discussed.***

Keywords: Lipoma, Axillary, giant

1. Introduction

Lipomas are very slow growing, most common mesenchymal tumours with an estimated incidence of nearly 10% in general population (1). The solitary subcutaneous lipoma accounts for approximately one - quarter to one - half of all soft tissue tumours (2). They can occur as either solitary or multiple tumours located in almost any organ of the human body. The preferred locations include the trunk, shoulder, upper arm and the neck. Giant lipomas are defined by Sanchez et al as size of atleast 10 cm in one dimension or weighs a minimum of about 1000 gms (3). The largest subcutaneous lipoma ever reported was published by Brandler in British Medical Journal (BMJ) in 1894. A 22.7 - kg lipoma was removed from the left scapula of a 26 - year - old male patient. In this study, we present a 35 year old female patient with a giant axillary lipoma. The tumour had a total weight of 5.1 kg. It had been present since 1 year. The case is of interest due to its benign pathology in spite of rapid progression, the size, location, anatomical changes and surgical challenge.

2. Case Report

A 35 year old female with presented with right sided axillary swelling (Fig.1) since 1 year. It was asymptomatic initially, however since last 3 months she started experiencing pain and tingling numbness in right hand on lifting weight. Physical examination revealed a giant tumour in the right axilla which measured approximately 30 cm x 20cm with dilation of superficial veins of right upper limb. Skin over swelling was ulcerated. MRI was done and was suggestive of lipoma. Fine needle aspiration cytology (FNAC) of swelling was suggestive of Lipoma.

The patient was operated under general anaesthesia. A lazy - S skin incision was made over the tumour in the axillary region. The tumour was dissected out of axilla taking care of axillary vein. The specimen weighed 5100g. Histological examination of the specimen revealed a benign lipoma.

There were no signs of liposarcoma transformation. The postoperative course was uneventful with no neurological dysfunction. Patient is disease and symptom free at end of 1 year.

3. Discussion

Lipomas are often small, and most have a diameter <2 cm. They rarely grow larger than 10 cm (4). A lipoma is categorised as ‘giant’ when it reaches a weight of at least 1000 g or a diameter more than10 cm (3). Most common site of giant lipoma are back and thigh (5, 6). Due to the size of giant lipomas, many patients experience mechanical dysfunction, pain or altered sensation resulting from compression of neighbouring structures. Many seek treatment because of social embarrassment or the inability to hide the tumour from society.

The aetiology of lipomas is unknown. They can be sporadic or part of an inherited disease such as familial multiple lipomatosis (7). Traumas have been reported to cause lipomas due to rupture of the fibrous septae inducing adipose tissue migration and proliferation.

Although lipoma is often a benign neoplasm, the likely transformation to liposarcomas is well known. Rydholm et al. concluded that a tumour larger than 5 cm, located either in the thigh or sub - fascially, is relatively more likely to be a sarcoma (2). These criteria may be useful in the selection of patients who should be referred to a tumour centre preoperatively. A definitive diagnosis can only be made by histopathological examination, but ultrasonography, CTI or MRI can help categorise the tumour. The latter set of diagnoses, being the gold standard, should be performed preoperatively in accordance with national Danish guidelines regarding sarcomas.

The primary treatment is surgery. Suction - assisted lipectomy through small incisions is preferred by some surgeons due to a superior aesthetic outcome and decreased morbidity compared to open surgery. However, liposuction has also been associated with a higher risk of nerve damage and a higher recurrence rate. Lipomas with fibrous capsule formation are likely to make liposuction more difficult.

Axillary lipomas are rare (7). De Andrade presented 31 cases of axillary masses, of which only one was diagnosed as a lipoma. A total of 38.7 per cent of the masses originated from lymph tissue. Sixteen per cent of patients had ectopic breasts, and ruptured infundibular follicular cysts, nodular fibromatosis, inflammatory tuberculous, and inflammatory rheumatoid lymphadenitis were detected. Only one patient had axillary lipoma (3 per cent) in their study. This shows that lipomas are not frequently seen in axilla (8). Symptoms localised to the axilla include pain, restricted movement of the arm, stretching or compression of adjacent nerves and compartment syndrome.

In our study, the patient had tumorsince 1 year and she had no history of traumas associated with the occurrence of the tumour.

In conclusion, the best treatment for giant axillary lipomas is open surgery. The surgeon should be aware of anatomical changes in the axilla and displacement of vital structures, when lipomas reach giant proportions. The patient should be followed up regularly for recurrence.

References

[1] Meson H. Lipoma in clinical dermatology. Clin dermatol, 1991, 4: 1 - 2.
[2] Rydholm A, Berg NO. Size site and clinical incidence of lipoma. Acta Orthop Scand.1983; 54: 929e934.
[3] Sanchez Giant lipomaL case report and review of the literature. J Am Acad Dermatol 1993; 28: 266.
[4] Schmookler BM, Enzinger FM. Pleomorphic lipoma: a benign tumor simulating liposarcoma: a clinicopathologic analysis of48 cases. Cancer.1991; 47: 126e133.
[5] Aydogdu E, Yyldyrym S, Eker G, Akoz T. Giant lipoma of the back. Dermatol Surg 2004; 30: 121.
[6] Terzioglu A, Tuncali D, Yuksel A, Bingul F, Aslan G. Giant lipomas: A series of 12 consecutive cases and a giant liposarcoma of the thigh. DermatolSurg 2004; 30: 463.
[7] Vandeweyer E, Scagnol. Axillary giant lipoma: a case report. Acta Chir Belg 2005; 105 (6): 656 - 7.
[8] de Andrade JM, Marana HR, Sarmento Filho JM, et al. Differential diagnosis of axillary masses. Tumori.1996; 82: 596e599.