

Lipoma Tongue – A Rare Site For A Common Neoplasm

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ABSTRACT

Lipomas are among the most common mesenchymal neoplasms, however, only 15%-20% involve the head and neck and 1%-4% affect the oral cavity. Lipoma of the tongue represents about 0.3% of all benign lesions of the oral cavity. A 12-year-old boy presented with a globular swelling

over the middle of dorsum of tongue since last 4 months duration. The swelling was apparently non-progressive. It was excised under local anaesthesia and histopathologically diagnosed as lipoma tongue. The case is being presented due to its rarity.

Key Words: Lipoma, Benign tumour, Tongue

INTRODUCTION

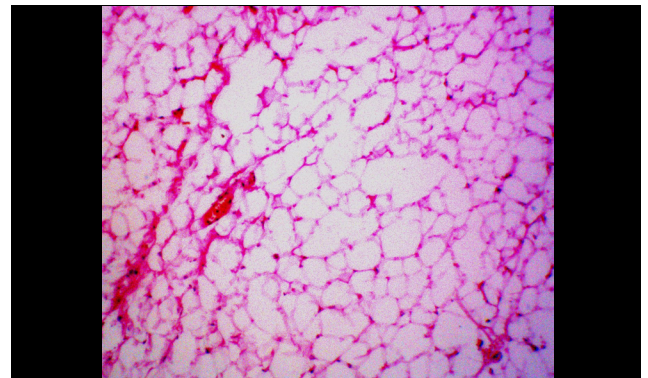
Lipoma is a benign tumour of adult adipose tissue. Its incidence as a whole is common, but occurrence in the oral cavity is rare. Lipomas of the oral cavity are rare. Lipomas of the tongue accounts for 0.3% of all benign lesions of the oral cavity and 13% to 20% of all oral lipomas [1-3]. They usually affect the lateral border of the anterior two-third region, beneath the mucosa. Lingual lipomas are often more deeply seated than those located elsewhere in the oral cavity. Generally, oral lipomas have been reported to occur in all ages but are frequently seen after 40 years of age with a higher incidence in men than women [3,4]. A case of lipoma occurring in the tongue in a 12-year old male patient is presented due to its rarity.

CASE REPORT

A 12-year old boy presented with a globular growth having an outer glistening surface, over the middle of the dorsum of tongue. It was noticed since 4 months. The growth was painless and apparently not increasing in size. It did not interfere with his airway, oral intake, or speech. Examination revealed a non-tender, well demarcated mass. The swelling did not blanch on pressure and had the same colour as the rest of the tongue mucosa. There were no lymphadenopathy. Pre-operative baseline investigations were all within normal limits.

The lesion was excised surgically under local anaesthesia and subjected to histopathological examination. On gross examination there was a yellowish glistening nodular tissue measuring 0.6 cm in diameter. Cut-surface revealed yellowish fatty areas. Microscopic examination showed an intact but thinned stratified squamous epithelium covering the surface with

underneath lobules of mature adipocytes and varying sized vessels separated by fibrous septae [Table/Fig-1].



[Table/Fig-1]: Microphotograph showing Mature fat cells with lobular arrangement and varying sized vessels (H&E x 40)

No cellular atypia, necrosis, mitotic activity, vascularization or lipoblastic proliferation was observed. The diagnosis of lipoma tongue was offered. The patient had no perioperative problem. 2 year post-operative period was uneventful.

DISCUSSION

The incidence of lipomas in the oral cavity is between approximately 1% to 4.5% of all benign oral lesions [1,5]. 15% to 20 % of lipomas are known to involve the head and neck region Only 0.3% of all the tumours involving tongue are lipomas [2,3].

The most common location for lipomas in the maxillofacial region is cheek followed by buccal sulcus, tongue, floor of the mouth, lips, gingiva and palate [6]. In the tongue they are usually located immediately beneath the mucosa and seen

at the lateral edge and anterior 2/3rd region. The lesion is most common after the 4th decade, but cases of congenital lipomas in the oral cavity have also been reported [3]. Simple lipoma occurs in all age groups but is more frequently seen after the age of 40 years. It is unusual for children to have classic lipomas but lipoblastoma and lipoblastomatosis are more often diagnosed in the paediatric age group [2,5]. Currently, there is no consensus on the gender distribution of oral lipomas. A slight female predilection has been noticed for fibrolipomas and male predilection for simple lipomas. This finding is in contrast with the whole body where lipomas are twice as common in females as in males [5,6].

It usually presents as longstanding soft nodular asymptomatic swelling. Oral lipomas are reported to be solitary, well-defined submucosal, painless and slow growing lesion. The colour, often yellow in tone, depends on the thickness of the overlying mucosa [2]. The surface is typically smooth and non-ulcerated except when traumatized. The size of tumour ranges from 0.6 to 6 cm in diameter. Majority of oral lipomas rarely grow greater than 2.5 cm in diameter [5]. Lipomas generally grow slowly and since pain is not a feature in many cases, many years elapse before patients consult their dentist or physician.

World health organization (WHO) classification of benign lipomatous tumours recognises conventional lipoma, fibrolipoma, angiolipoma, spindle cell/pleomorphic lipoma, myxolipoma, chondroid lipoma, osteolipoma, myolipoma, lipomatosis, lipomatosis of nerve, lipoblastoma / lipoblastomatosis and hibernoma. Conventional lipomas comprise the majority with the exception of parotid region and lips where the spindle cell lipoma is the most common. Additionally, secondary degenerative changes and atrophy can occur and shouldn't be confused with the malignant histologic features of liposarcoma. Recurrence and malignant transformations are rare [6]. The aetiology of lipoma is still obscure. Lipoblastic embryonic cell nest in origin, metaplasia of muscle cells, fatty degeneration of fibroblasts, hereditary, hormonal changes, trauma, infection, chronic irritation and/or infarction may be responsible for the

formation of mature fat cells [1,2,7].

Clinical diagnosis of oral lipoma is not always easy. Where the overlying mucosa is thin and the yellow colour of the tumour appears through it, the diagnosis is easily made. However in the deep-seated cases, the diagnosis is seldom made clinically and the tumour often attains appreciable size before it becomes symptomatic. In such situations, other possibilities such as a cyst, encapsulated abscess or other benign tumours need to be considered [5]. Histopathology remains the gold standard in the diagnosis of lipoma. Treatment of lipomas consists of simple surgical removal, irrespective of the histological subtype [5,6].

CONCLUSION

When a painless, slow growing, well demarcated lesion occurs on the tongue, although it is uncommon, one must remember lipomas. Only a few cases have been reported, with the same histological and clinical appearance, well-differentiated liposarcoma must be excluded and surgical excision followed by histopathological confirmation should be done.

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