Infiltrating Oral Lipoma a Rare Variant

Dear Editor,

Intramuscular infiltrating lipoma is a rare variant of lipoma first defined by Regan and his colleagues in 1946.[1] There are only few cases reported in literature. We report an unusual case of intramuscular lipoma of the tongue, present on the posterior lateral aspect, emphasizing the clinico-pathologic features.

A 50-year-old female patient reported to the outpatient department of the Seema Dental College and Hospital, Rishikesh, India, with a chief complaint of swelling on the posterior lateral border of the tongue, present for 2 years [Figure 1]. Clinical examination revealed a well-defined oval swelling measuring 2 × 1 cm present on the lateral border of the tongue. On palpation, the swelling was soft, fluctuant, non-tender and mobile. A provisional diagnosis of intraoral lipoma was made. After routine blood examination, an excisional biopsy was performed under local anaesthesia and was further subjected to histopathological examination. The haematoxylin and eosin-stained slides showed a lipomatous tumour composed of mature adipocytes, uniform in size and shape, diffusely infiltrating the striated muscle fibres of the tongue, further confirmed by Masson's trichome stain [Figure 2]. There was no recurrence at a follow-up period of 1 year.

The first description of an oral lipoma was provided by Roux in 1848, who referred to it as a "yellow epulis."[2] There is lack of consensus regarding its pathogenesis. Hormonal factor, trauma and chronic irritation are thought to play a role in the development of lipoma. However, trauma is widely accepted as a causative factor in the discovery of the lesion rather than the aetiology.[3]

It is usually found in adults and there is no gender predilection.[2] The clinical course of oral intramuscular lipomas is usually asymptomatic, but, on rare occasions, it can cause muscle dysfunction or sensory changes due to pressure on the nerve trunks.[4] In the present case, the tumour interfered with speech, mastication and movement of tongue.

Intramuscular lipomas are of primary importance because of their differential diagnosis with liposarcoma due to their large size, deep location and their ability to infiltrate the adjacent muscles and recur locally. Therefore, a detailed histological examination is essential for all intramuscular lipomas. Our case had no areas of lipoblastic proliferation, nuclear atypia and mitosis.

Conservative surgical removal is the treatment of choice and the prognosis is good as recurrence is rare. In our case, although adipocytes infiltrated the striated muscle fibres, they were all mature and uniform in shape and size. In addition, no morphological features of liposarcoma were identified.

To conclude, although rare, intramuscular lipomas can occur in the oral cavity. Complete resection should be emphasized during the first surgical operation, which is the key factor to avoid recurrence. This case reported here was unique because, firstly, it occurred on the posterior third of the tongue and not on the anterior two-third, as usually reported and, secondly, intramuscular or infiltrating lipomas are very rare.

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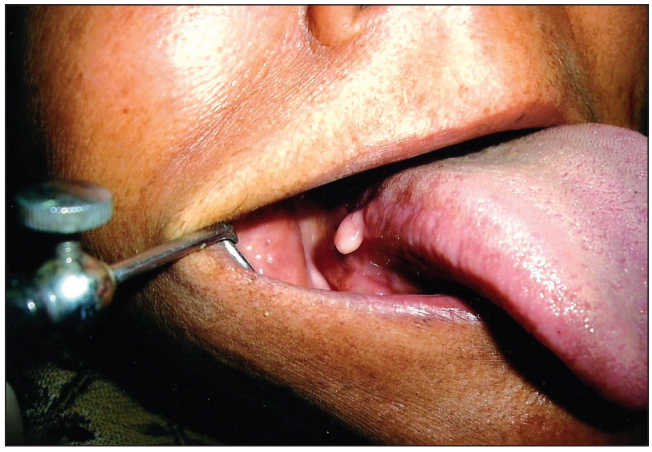

Figure 1: Clinical picture showing the growth over the lateral aspect of the posterior tongue

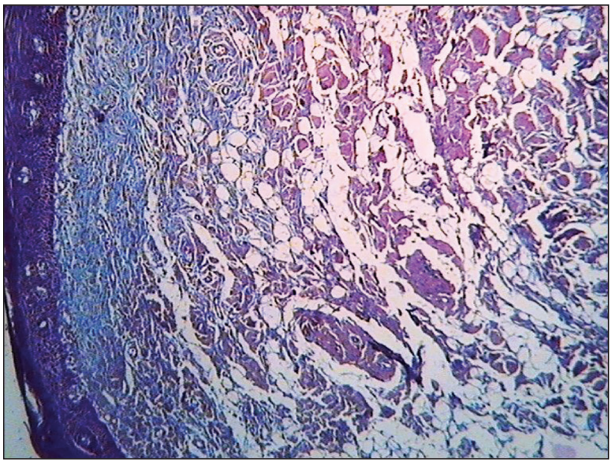

Figure 2: Photomicrograph showing adipose tissue infiltrating muscle (Masson trichome, 10×)

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Website: www.jcasonline.com

DOI: 10.4103/0974-2077.150789