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Letter to the Editor

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Atypically located lipomas in the head and neck region: two case reports and a review of the literature

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Dear Editor,

Since lipomas seen in the head and neck region are quite rare, treatment approaches are also important. Lipomas are the most frequently encountered benign tumors and can develop anywhere in the body that contains fatty tissue. They consist of mature fat cells and are generally enclosed within a capsule. Histologically, they are categorized as diffuse lipoma, fibrolipoma, osteolipoma, angiolipoma, spindle cell lipoma, myelolipoma, and chondroid lipoma.[1] In some case reports, it has been stated that lipomas can undergo malignant transformation, although very rarely, and studies are ongoing to suggest that this may be a sequential process.[2]

Approximately 13% of all lipomas are seen in the head and neck region.[3] These are most commonly located in the posterior cervical region of the head and neck. The majority of lipomas are smooth surface, painless, asymptomatic masses immediately beneath the skin. Lipomas located in the upper aerodigestive tract can cause symptoms such as dysphagia, odynophagia, voice restriction, dyspnea, and a foreign body sensation in the throat.[4] Retropharyngeal space lipomas may not be identified until they achieve a large size and become symptomatic. Buccal space lipomas may be overlooked until they cause swelling and asymmetry in the face. Imaging methods can be used in diagnosis, thus also excluding other potential pathologies. The treatment of symptom-producing lipomas is surgery. Cases of retropharyngeal and buccal space lipomas in the literature are limited. We present two distinct cases of lipoma, one retropharyngeal and one buccal, treated with intraoral surgery.

Our first patient, a 78-year-old male, applied to our clinic with complaints of increasing feeling of obstruction and dysphagia while eating for the last two years. He experienced no pronounced symptom with liquid foods, but reported difficulty in swallowing solids. In addition, he reported a constant sensation of an object in his throat and a need to swallow. He described no voice limitation or dyspnea. Oropharyngeal examination revealed a well-circumscribed mass protruding into the lumen and covered in intact mucosa. Magnetic resonance imaging (MRI) of the neck was performed with a preliminary diagnosis of a retropharyngeal mass (Figure 1). The MRI report described an image compatible with probable lipoma with smooth borders, approximately 49*18 mm in size, with left-side predominance, beginning from the level of the hard palate and extending to the upper end of the epiglottis, located between C2 and C6 in the pharyngeal region. The mass was also reported to exhibit close contiguity to the vertebral artery close to the left neural foramen at the C2 level. The lipoma in the retropharyngeal region was totally excised intraorally with the patient under general anesthesia (Figure 2). No postoperative complications were observed. The pathology report identified the mass as a lipoma, and no recurrence was observed at annual postoperative follow-ups.

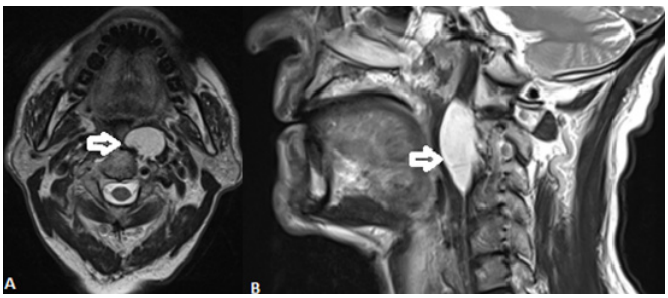

Figure 1. MRI images of the retropharyngeal space lipoma in the axial (A) and sagittal (B) planes, and its relationship with neighboring structures

MRI: Magnetic resonance imaging

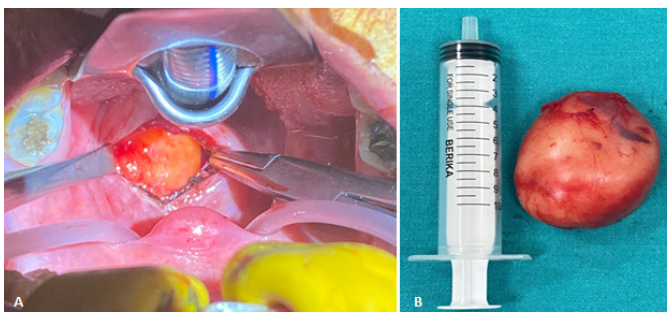

Figure 2. Intraoperative excision of the retropharyngeal space lipoma (A) and its postoperative appearance (B)

Our second patient, a 51-year-old male, applied with the complaint of a growing mass in the left buccal region that had been present for three years. His history was unremarkable. Examination revealed a palpable, painless mass with a smooth surface and a soft consistency causing facial asymmetry, beginning from the left buccal region and extending to the preauricular area. With-contrast facial MRI was performed. The report described a well-circumscribed, 42x34 mm space-occupying structure (lipoma?) exhibiting a fat signal in the anterior of the left masseter muscle (Figure 3). The patient was operated on under general anesthesia. Intraoral excision of the mass was planned. A vertical intraoral incision was made, preserving Stenon's duct. The mass was accessed and the lipoma was totally excised (Figure 4). Postoperative cold therapy was applied. The pathology report identified the mass as a fibrolipoma, and no recurrence was observed in the postoperative first year.

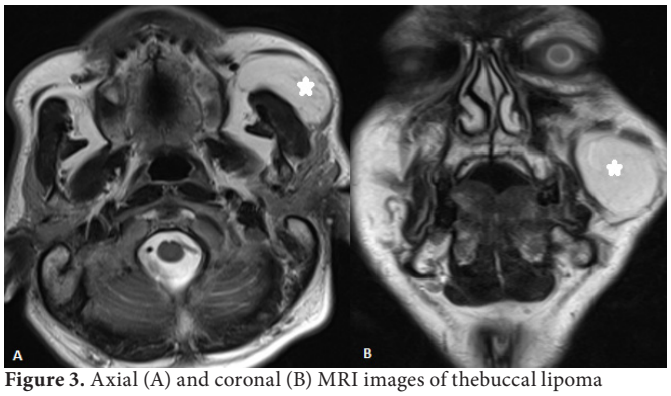

Figure 3. Axial (A) and coronal (B) MRI images of thebuccal lipoma

MRI: Magnetic resonance imaging

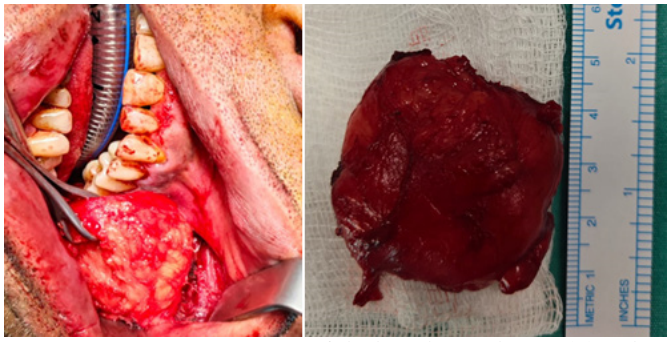

Figure 4. Intraoperative excision of the buccal space lipoma (A) and its postoperative appearance (B)

Lipomas are benign tumors of mesenchymal origin.[5] Retropharyngeal space lipomas represent less than 1% of benign tumors in the airway. While small tumors are asymptomatic, growing tumors can cause local pressure. Chrysovitsiotis et al.[6] examined 79 patients with retropharyngeal space lipoma in their systematic analysis and reported that the most common symptom was dysphagia at 65.2%. This was followed by snoring in 37.9% of cases, dyspnea in 34.8%, and dysphonia in 30.3%. Our patient was a 72-year-old man with dysphagia. Lipomas in the oral cavity are rare, representing 1-4% of all benign tumors.[7] Lipomas in that cavity are most commonly seen in the buccal mucosa, tongue, the floor of the mouth, the vestibular area, the lower lip, and the hard and soft palates, and rarely in the buccal fat pad. There are few reports of buccal space lipoma in the literature. Our patient was a 51-year-old man with a painless swelling in the buccal region.

It may not always be easy to diagnose lipomas located deep in the head and neck region since these produce symptoms in the late period. Computed tomography (CT) and MRI are the most frequently employed methods in diagnosis and differential diagnosis. These are important in terms of differentiating the mass from neighboring tissues and from other potential masses. MRI is 100% specific for diffuse lipoma and 100% sensitive and 83% specific in differentiating liposarcoma.[8] Biopsy material collection before surgery from masses suggestive of lipoma at radiological imaging is not a recommended procedure.[9] Symptomatic lipomas are treated surgically, although patients who refuse surgery, with severe bleeding diathesis, or severe comorbidities representing a risk for surgery can be observed.[10] The intraoral excision of retropharyngeal lipomas and those in the oral cavity is advantageous as it does not result in scarring.[11] It is important to protect Stenon's duct during surgery to the buccal area. In addition, every tissue removed must be sent for pathological examination. Unexpected conditions may be encountered, albeit rarely.

In conclusion, Lipomas are relatively rare pathologies in the head and neck region. Retropharyngeal and buccal space lipomas are rarely reported masses. Excising these using an intraoral approach is generally sufficient.

ETHICAL DECLARATIONS

Informed Consent

All patients signed and free and informed consent form.

Referee Evaluation Process

Externally peer-reviewed.

Conflict of Interest Statement

The authors have no conflicts of interest to declare.

Financial Disclosure

The authors declared that this study has received no financial support.

Author Contributions

All of the authors declare that they have all participated in the design, execution, and analysis of the paper, and that they have approved the final version.

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