Recurrent Laryngeal Lipoma

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A rare case of laryngeal lipoma is reported with review of literature. We describe our technique of intra laryngeal excision of this tumour by microlaryngeal dissection.

INTRODUCTION

Lipomas of the larynx are rare (Paparella and Shumrick, 1973). They are usually seen in males, the peak incidence being the seventh decade (Jones et al, 1984). They account for less than 2% of all laryngeal tumours (Batsaki, Fox 1970) and have an incidence of 1 per 1000 of benign laryngeal tumours (New, Erick, 1938). Though benign these tumours may be recurrent, and malignant transformation has been reported (Dindale et al, 1990).

We report a case of recurrent laryngeal lipoma and our technique of excision.

CASE REPORT

A 48 year old male presented with symptoms of change of voice for one year, intermittent respiratory obstruction especially on lying on the left side and occasional feeling of food sticking in the right side of the throat. He had no other swellings elsewhere on the body. He had undergone endoscopic excision of laryngeal growths 15 and 11 years prior to presenting to our hospital. He was a professional speaker and singer. On indirect laryngoscopy a large pink smooth surfaced cystic swelling arising from the right aryepiglottic fold was seen. This swelling was mobile and on deep inspiration obstructed the laryngeal inlet causing stridor. He had no other lipomata on general examination. Lateral neck radiograph showed a well defined round

soft tissue density in the supraglottic compartment of the larynx. He underwent micro laryngoscopy and excision of the tumour after a preliminary biopsy. The tumour was broad based and arising from the right vestibule of the larynx. For excision an incision was made on the mucosa overlying the superior aspect of the base of the tumour and a mucosal flap was elevated by submucosal dissection using the left turned microlaryngeal scissors. Microlaryngeal scissor was used to separate the base of the tumour from the underlying thyroarytenoid muscle while retracting the tumour medially using the microlaryngeal alligator forceps. Hemostasis was achieved using thermo coagulation. Post-operative period was uneventful and the laryngeal mucosa healed well. At the time of discharge he had no dysphagia or difficulty in breathing and his voice was restored to normal.

HISTOPATHOLOGY

The excision biopsy consisted of a circumscribed tumour composed of mature adipocytes demarcated into lobules by fibrous septa, containing thin walled vascular channels. Focal myxoid change was noted (in the preliminary biopsy) containing mildly pleomorphic spindle to stellate cells with dark staining nuclei. There was no increase in mitotic activity. Overlying laryngeal mucosa showed mild epithelial atypia (Fig. 1).

DISCUSSION

Laryngeal lipomas are rare and only less than one hundred cases have been reported in medical literature (Zakroewski, 1965). More than three quarters of laryngeal lipomata occur in the

supraglottis where fatty deposits occur (Jones et al, 1984). They occur more often in elderly males and are typically slow growing, presenting often

Fig. 1
Photomicrograph showing lipomatous tumour
(H&E-40 x)

with symptoms of dysphagia and voice change. Occasionally they may be large and may cause airway obstruction.

Lipomas may undergo degenerative with a resultant myxoid appearance. Such degenerative changes may be difficult to differentiate from myxoid liposarcomas.

Pedunculated lipomas usually are excised endoscopically while the broad based large lipomas and submucosal lipomas require lateral pharyngotomy for complete excision. However, in our case we were able to achieve complete excision using the microdissection technique described above, despite the tumour being submucosal and having a broad base.

Regular and close follow up is essential as lipomata are usually recurrent and potentially malignant.

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