LIPOMA OF TONGUE – A RARE SITE FOR A COMMON TUMOUR

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Abstract : Lipoma is the commonest benign tumour occurring at any anatomical site where fat is present. In oral cavity and oropharynx it is a relatively uncommon neoplasm.. Tongue which is totally devoid of fat cells is also a site for lipoma albeit very rarely. This is one such rare case of the universal tumour, presenting at the lateral margin of the tongue, for which complete tumour excision was done.

Keywords : Lipoma, Tongue

INTRODUCTION

Lipomas are the most common subcutaneous benign tumours multilobulated and vary greatly in size. Usually they are not tethered to the underlying fascia or muscles. But submucosal lipomas are rare. Still rarer is the occurrence of the lipomas in the oral cavity. In this sense, literature references are mainly case reports in which lipomas of the buccal mucosa and the tongue are the cause of orofacial deformities. The benign tumours of the tongue that are mentioned in the literature are :

- 1) Papilloma
- 2) Fibroepithelial polyp
- 3) Pregnancy tumour
- 4) Hemangioma
- 5) Lymphangioma
- 6) Plexiform neuroma
- 7) Neurofibroma
- 8) Sublingual varicosities
- 9) Lipoma
- 10) Osteoma, Chondroma
- 11) Juvenile fibroma

The first description of an oral lipoma was provided in 1848 by Roux, in a review of alveolar masses. He referred to it as a “ Yellow Epulis “. (Ref 2) The incidence of lipomas in the oral cavity is between approximately 1.0% and 4.5% of all benign oral lesions. (Ref 3). Oral lipomas occur at various sites including the major salivary glands, buccal mucosa, lip,

tongue, palate, vestibule and floor of mouth. Only 0.3% of all the tumours involving tongue are lipomas (Ref 1). Though there are many case reports describing lipomas in these locations only very few reports describe lipoma of the tongue . The most common anatomic site in the oral cavity has frequently been reported as the buccal mucosa followed closely by the parotid region. In the oral and maxillofacial region, these tumours have a slight predilection for adult males.

Aetiology of lipoma remains a mystery. The possible aetiologies are :

- a) Lipoblastic embryonic cell nest in origin.
- b) Metaphase of muscle cells
- c) Fatty degeneration
- d) Hereditary
- e) Hormonal cause
- f) Trauma
- g) Infection
- h) Chronic Irritation
- i) Infarction

Benign lipomas are classified as : Classic lipoma; lipoma variants (e.g. angiolipoma, chondroid lipoma, myolipoma, spindle cell lipoma); hamartomatous lesions; diffuse lipomatous proliferations; and hibernoma. Histological variants of lipoma are reported from other sites. Lipomas are well circumscribed, with a smooth overlying surface, yellowish in colour, soft in consistency and freely mobile. They usually arise in the

Fig 1 – Smooth mass seen with a yellowish hue.

Fig 2 - Tumour mass showing fatty tissue.

Fig 3 Photomicrograph showing a fibrocollagenous capsule with underlying adipose tissue.

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superficial submucosal connective tissue. Rarely, lipomas can be associated with syndromes such as hereditary multiple lipomatosis, adiposis dolorosa, Gardner's syndrome and Madelung's disease.

Lipomas are treated by surgical excision and do not yield recurrences (non infiltrating type) due to the well defined demarcation by the capsule. As with all fatty tissues a lipoma will float on the surface of formalin, rather than sink to the bottom of a biopsy specimen jar. Microscopically lipomas are composed of mature adipocytes arranged in lobules, many of which are surrounded by a fibrous capsule. Occasionally, a nonencapsulated lipoma infiltrates into muscle, in which case it is referred to as an infiltrating lipoma.

CASE REPORT

A 34 year old female presented to us with a mass at the right lateral margin of the tongue, which was noticed by her when it was like a size of a pea eight years back. This had been gradually increasing in size for last eight years. Local examination revealed a yellowish, soft, sessile mass of the size 3.5 x 3.5 cm with a well defined margins (Fig.1).

After routine investigations excision of the mass under GA was planned. Incision was given at the junction of the mass and the mucosa after infiltrating with 2% xylocaine with 1 in 200000 adrenaline. This encapsulated mass was then removed in toto (Fig 2). After cauterizing the bleeding points the defect in the tongue mucosa was sutured. Postoperatively the tongue wound healed well. The cut surface of the mass showed fatty tissue. This mass was sent for histopathology which showed squamous epithelium and an underlying zone shows a lesion enclosed by a thin fibrocollagenous capsule and composed of lobules of mature adipose tissue consistent with a picture of lipoma. (Fig 3) The cut surface of the mass showed fatty tissue. This mass was sent for histopathology which showed squamous epithelium and an underlying zone shows a lesion enclosed by a thin fibrocollagenous capsule and composed of lobules of mature adipose tissue consistent with a picture of lipoma. (Fig 3)

CONCLUSION

Although lipomas are one of the most frequent tumour of the body, the oral location is a rarity. Tongue being an entirely mucomuscular structure devoid of fat, lipomas at this site are an intriguing phenomenon. Of the benign tumours of tongue, lipoma constitutes a very small proportion and only a very few cases are reported. Prevalence rate of lipoma in the oral and oropharyngeal region is 1/5000 adults. The appearance

and the consistency of the tumour are quite definitive indicators of diagnosing a lipoma even though they are uncommon in the oral cavity. A painless, soft slow growing tumour, either sessile or pedunculated with a smooth surface and well defined margins should be given a benefit of doubt of being a lipoma. The yellowish hue of the lesion as in this case report clinches the diagnosis effectively ruling out hamartomas. In well encapsulated lesions like this, excision with total preservation of the tongue musculature should be accomplished.

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