Giant Vulval Lipoma in a Post Menopausal Woman

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Authors’ contributions
This work was carried out in collaboration between all authors. Author HAU designed the study, managed the literature searches and wrote the final draft of the manuscript. Authors AUA and HM managed the first draft. All authors read and approved the final manuscript.

ABSTRACT
Lipoma is the second most common mesenchymal tumour in the vulva. It is rare and not commonly seen at the Gynaecological clinic. Perineal lipomas have been reported in females with accessory labioscrotal folds. The site of the tumour and its painless nature delays patient’s presentation. Giant tumours in the perineal region can be uncomfortable and may even obstruct flow of urine and vaginal penetration. Surgical excision and cosmetic approximation of the skin is the treatment of choice for giant vulval lipomas.

We present a case of giant vulval Lipoma in a 60-year-old woman. She presented because of embarrassing sexual relationship and urinary difficulties. She had surgical removal of a 900 gms mass.

Keywords: Vulval lipoma; giant lipoma; benign vulval tumour.
1. INTRODUCTION

Benign tumours of the vulva are classified into two major categories, epithelial and mesenchymal tumours. Lipomas are the 2nd most common benign mesenchymal tumours. Lipomas of the vulva arise from the fatty tissue in the vulva and are composed of mature lipocytes with thin capsule on histology [1,2]. Lipomas are found equally in men and women commonly in bony areas around the trunk and the extremities. Congenital perineal lipomas though very rare, are commoner in males with an accessory scrotum. Perineal lipomas have equally been reported in female patients with accessory labioscrotal folds [3]. We report a case of giant Lipoma of the labium majus to highlight the problems of these tumours concerning sexual and urinary difficulties. The excision of 900 grams of vulval Lipoma is one of the first reported from the region to the best of our knowledge.

2. CASE REPORT

A 60-year-old woman, 10 years postmenopausal presented to the Gynaecology clinic of the Federal Medical Center Nguru with 6 years history of painless slowly growing mass in the left labia majora. There was associated discomfort after walking for a long distance because of the presence of the mass in between her thighs. There was an associated progressive difficulty in voiding; the mass has to be moved laterally to allow free flow of urine when voiding. She had equally been avoiding coitus in the past three years prior to presentation. The site of the mass made penetrating sexual intercourse difficult, uncomfortable and embarrassing. She had no history of trauma to the vulva. There was no dysuria or fever. Examination revealed a 15 x 10 x 10 cms, rubbery, non-tender, pedunculated mass in the left labia majora. It was non-reducible and non-fluctuant and does not transilluminate (Fig. 1). There were no inguinal lymph nodes enlargements and no lumps in other parts of the body. Urine culture yielded no bacterial growth and there was no protein or glucose in her urine. Her packed cell volume was 35% and the blood chemistry result was within normal limit.

She had surgical excision of the tumour under spinal anaesthesia. An incision was made on the lateral edge to enucleate the Lipoma with its capsule. The tumour weighed 900 grams of fat lobules covered with a thin capsule (Fig. 2). The redundant skin fold was trimmed to give a cosmetic near normal appearance of the external genitalia. She made remarkable recovery. She was last seen three months after surgery. She was in high morale and had no more urinary difficulties. She had equally resumed coitus with no difficulties.

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Fig. 1. Left vulval lipoma

Fig. 2. Lipoma covered with thin capsule
(Weight 900 Grams)
Histology revealed matured adipocytes in keeping with the diagnosis of a Lipoma.

3. DISCUSSION

Lipomas are the second most common benign tumours of mesenchymal origin. There had been reports from various regions of the world and in various age groups from birth through old age with the peak age being 40 to 60 years [4-8]. The common sites for Lipoma are the upper back, shoulder, the nape of the neck, buttocks, hips, thigh and the abdomen. Lipomas of the perineal region are being reported more and more in recent times after the fist report by De Lima Filho et al. in [9]. This could be attributed to more awareness on the part of the patients.

The etiology of Lipoma is unknown. Most cases have been shown to be present from birth. Trauma has been implicated, but these have been shown to be because of translocation of the fat from ruptured septaes due to repeated trauma. Lipomas along surgical incisions such as episiotomy have been reported in various literature [4,8]. Most vulval lipomas are in the labia majora because of the fat distribution in the vulva. They are superficial in location.

Lipomas are asymptomatic. Most symptoms relate to the site and size of the tumour. Large vulval lipoma such as seen in our patient may cause discomfort during physical activities such as walking and sexual intercourse. It can also hinder free flow of urine as seen in this patient.

Diagnosis of vulval Lipoma is clinical in most cases. They are well demarcated or pedunculated, soft to rubbery, non-fluctuant and non-reducible painless masses. Vulval lipomas may be misdiagnosed as inguinal hernias or cystic swelling of the Bartholin’s gland or canal of Nuck [6]. Other differential diagnoses include vulval fibroma, fibroblastoma and angiomofibroblastoma [10]. Liposarcoma is a very rare differential of vulval Lipoma. Where such diagnostic dilemma occurs, imaging techniques such as Ultrasound scan, plain X-ray, computed tomography (CT) scan and MRI can differentiate the various tumours [4-7].

The treatment of Lipoma generally is surgical excision. Reports of alternative treatments such as liposuction and steroid injections are coming up in the literatures [11]. However, these are associated with incomplete removal with risk of recurrence and lack of representative tissue for histological diagnosis.

4. CONCLUSION

Giant vulval Lipoma can cause embarrassment and discomfort during physical activities such as walking and sexual intercourse. Urinary outflow obstruction may occur with large vulval Lipomas. These calls for detailed review of the psychosexual and urinary symptoms in patients presenting with vulval lipomas.

CONSENT

All authors declare that informed consent was obtained from the patient for publication of this paper and accompanying images.

ETHICAL APPROVAL

It is not applicable.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

REFERENCES

1. Horbelt D, Delmore J. Benign neoplasms of the vulva. Glob. Libr. Women’s Med; 2008. Available: http://www.glowm.com/ [Cited 2015 Dec 28]
2. Mentzel T. Cutaneous lipomatous neoplasms. Semin Diagn Pathol. 2001;18: 250.
3. Numajiri T, Nishino K, Sowa Y, Konoshi K. Congenital vulvar lipoma within an accessory labioscrotal fold. Pediatric Dermatology. 2011;28(4):424-8.
4. Lee JH, Chung SM. Large vulvar lipoma in an adolescent: A case report. J Korean Med Sci. 2008;23(4):744-746.
5. Kherisat B, Uraiqat A. Vulvar lipoma: A case report. Journal of the Royal Medical Services. 2012;19(2):79-81.
6. Kehagias DT, Smyriotis VE, Karvounis EE, Goulimos AD, Creatsas G. Large lipoma of the vulva. Eur J Obstet Gynecol Reprod Biol. 1999;84:5-6.
7. Odoi AT, Owusu-Bempah A, Dassah ET, Darkey DE, Quayson SE. Vulvar lipoma: Is it so rare? Ghana Med J. 2011;45(3):125-127.
8. Agu PU, Okeke TC, Ezugwu EC, Obi SN. Large vulvar lipoma following episiotomy:
A case report. Niger J Med. 2012;21(3):357-358.

9. De Lima Filho O, Cogliati A, Reitzfeld G. Lipoma of the vulva. Rev Paul Med. 1969;75:165-176.

10. Ajibona OO, Richards CJ, Davies Q. A distinctive vulval fibroma of so-called prepubertal type in a postmenopausal patient. J Clin Pathol. 2007;60:437-438.

11. Libby R. Copeland-Halperin, Vincenza Pimpinella, Michelle Copeland. Combined liposuction and excision of lipomas: Long-term evaluation of a large sample of patients. Plastic Surgery International. 2015;1-5.