Case report

Giant gluteal lipoma surgical management

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SUMMARY
Surgical treatment of lipomas is typically only considered when they are painful or unsightly. We present the case of a massive hip lipoma; with this extreme case, we show that the global prolongation of life expectancy can lead to other indications of removal.

BACKGROUND
Lipomas are benign and common soft-tissue tumours with many different clinical presentations. Surgical management can sometimes be tricky, and surgeons must keep in mind the potential risk of malignancy with large tumours.

CASE PRESENTATION
We describe the case of a 90-year-old patient with a giant gluteal lipoma having evolved over more than 20 years. The patient was well aware of this slow-growing painless mass on his right hip but refused any treatment. He was addressed to our surgical consultation by his family doctor for lameness and unbalanced walking. (figure 1A, B).

INVESTIGATIONS
Even though a benign lipoma was clearly suspected, a CT scan was performed. However, the lesion was so large that it could not be scanned entirely (figure 2). The tumour-like lipoma seemed to be in contact with the sacrum, the tuber ischiadicum and the greater trochanter. Furthermore, there was a suspicion of an infiltration of the flexor’s muscles of the right leg. Vascularisation of the lipoma was mainly provided by an enlarged superior gluteal artery.

TREATMENT
After discussing the pros and cons of an intervention with the patient and his family, the decision was taken to remove the mass surgically. The patient was installed in a dorsal decubitus position (figure 3A). The operation resulted in the removal of a 30×60 cm² 20 kg lipoma (figure 3B).

OUTCOME AND FOLLOW-UP
The pathology report confirmed that the tumour was benign. Skin was preserved in order to allow a functional reconstruction of the gluteal region. Wound management was simple, and follow-up was unremarkable. Additionally, the patient received intensive physiotherapy for walk recovery and after 5 weeks he could achieve completely independent walking.

DISCUSSION
What makes this case interesting is the fact that even a benign pathology such as a lipoma progressed into a situation requiring delicate surgical management, both due to the technical aspect of the operation itself, and because of the patient’s advanced age.

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Various pathologies imitating lipomas, such as lipomatosis or lipodystrophy, should be distinguished from it. The WHO gives a standard classification for all types of lipomas.\(^8\) In order for a lipoma to be called ‘giant’, the lesion must be at least 10 cm in size and weight cut-off given by Sanchez et al.\(^9\) The transformation of a large lipoma (>10 cm) to a liposarcoma is rare.\(^10\) Giant lipomas are above all aesthetics concerns but in one dimension or weigh a minimum of 1 kg. Based on recent literature, the case we report here is the second largest subcutaneous lipoma ever described (table 1).

### Learning points

- Giant lipomas are above all aesthetics concerns but in advanced form a functional problem.
- Benign tumours with low risk of malignant evolution.
- Surgery as if aesthetic or functional disorders.
- The transformation of a large lipoma (>10 cm) to a liposarcoma is rare.

### Contributors

AL wrote the article; MM, FC and BE verified the analytical methods and supervised the findings of this work. All authors discussed the results and contributed to the final manuscript.

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None declared.

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Obtained.

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#### Table 1 Largest giant lipomas in French/English-language literature (>10 cm and >1000 g)

| Reference | Year | Localisation | Pathology | Size (cm)/weight (kg) |
|-----------|------|--------------|-----------|-----------------------|
| Current case | 2017 | Gluteal | Unknown | 30×60/20 |
| Emegoak et al.\(^a\) | 2017 | Lower limb | Unknown | 22×17?? |
| Mascareñas et al.\(^b\) | 2017 | Gluteal | Liposarcoma | 17?? |
| Guler et al.\(^c\), 13 | 2016 | Back | Unknown | 38×22×21/3.575 |
| Grimaldi et al.\(^d\) | 2015 | Back | Lipoma | 36×40×24/5.75 |
| Dabloun et al.\(^e\) | 2015 | Back | Unknown | 25×25×18?? |
| Silistrelli et al.\(^f\) | 2004 | Back | Unknown | ??12.350 |
| Martin et al.\(^g\) | 1928 | Neck | Unknown | ??12.5 |
| Brandler et al.\(^h\) | 1894 | Back | Unknown | ??12.7 |

? represents that others authors did not provide a number for this specific information.

Figure 3 (A) Dorsal decubitus surgical position. (B) Lipoma total dissection.

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