Case Report

Solitary lipoma in the retromandibular region

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INTRODUCTION

Lipomas are benign adipose tumors of mesenchymal origin usually present subcutaneously. They are the most common adult type-fat cell tumor, often referred to as “universal tumor” or a “ubiquitous tumor.” Lipomas have been identified in all age groups, but usually appear between 40 and 60 years of age. Solitary lipomas are common in women and multiple tumors (lipomatosis) are common in men. Lipomas are classified as subcutaneous type, subfascial type or intermuscular type.[1] While about 80% of lipomas are less than 5 cm in diameter, some can reach more than 20 cm and weigh several kilograms. They are usually asymptomatic but can cause pain when they compress the nerves. Lipomas tend to occur on the trunk, shoulders, posterior neck and axillae.[2]

We report a case of solitary lipoma in the retromandibular region in a young male patient.

CASE REPORT

A 21-year-old male presented with a history of swelling, which was gradually increasing since 2 years, in the left preauricular region, inferior to the lobule of the ear, and associated with dull intermittent nonradiating type of pain with no aggravating and relieving factors. The pain increased in intensity on turning his head to the right side. He did not complain of dyspnea or dysphagia.

On examination, fullness was seen in the parotid and retromandibular regions on the ipsilateral side with raised ear lobe. The swelling measured about 6 cm × 4 cm [Figure 1]. Margins of the swelling were diffused, extending up to 1 cm superior to the ear lobe, 3 cm inferior to the inferior border of the mandible, anteriorly up to the level of the body of the mandible and posteriorly to the mastoid region.

Neck movements were unrestricted. Skin over the swelling was pinchable, with no local rise in temperature, but mildly tender on palpation. Mouth opening was unrestricted. Oropharyngeal examination did not reveal any abnormalities. His general physical examination and medical history did not show the presence of any co-morbid conditions. Routine laboratory tests were within the normal limits.

A computed tomography (CT) scan of the parotid region with intravenous contrast was performed, which showed a hypodense fat-attenuated lesion with linear strands measuring 52 mm × 37 mm in the retromandibular region deep to the sternocleidomastoid muscle, inferior to the parotid gland extending to the submandibular region. Medially the carotid vessels, supero-laterally the parotid gland and antero-superiorly the submandibular gland were displaced. Based on the

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above findings, the lesion was provisionally diagnosed as lipoma in the retromandibular region [Figure 2]. The patient was planned for excision of the lesion under general anesthesia.

A Risdon’s incision extending up to the retromandibular region [Figure 3] was placed and a subplatysmal dissection was performed to approach the mass. Intraoperatively, the extent of the swelling confirmed the CT findings. The dissection was carried out to expose the sternocleidomastoid muscle, which was retracted laterally as the lesion was found beneath the muscle. The inferior aspect of the lesion was found to be in close proximity to the external carotid artery. Hence, careful dissection was performed to separate it from the vessel to prevent any injury to the same [Figure 4]. Because the lesion was well-encapsulated, blunt dissection was performed to free its margin and the mass was excised in toto. Hemostasis was achieved in the field. The excised mass [Figure 5] was soft, yellow, smooth, shiny and ovoid, measuring about 5 cm × 4 cm, which was sent for histopathological examination. A suction drain was placed and the site was closed in layers. The biopsy report revealed lobular growth of large mature fat cells with clear cytoplasm and thin strands of connective tissue, scanty inflammatory cells and few blood vessels [Figure 6]. The above findings confirmed it as lipoma.

Postoperatively, symmetry of the face could be appreciated [Figure 7] without any facial nerve palsy and other complications. The patient was discharged 1 week postoperatively. He is on follow-up for the last 2 years with no evidence of recurrence till date.

**DISCUSSION**

Lipomas are hamartomatous proliferations of mature fat cells.[3] These are most common in obese patients, usually in the fourth to sixth decades of life, but our patient was aged only 21 years old with an average built and weighing 60 kgs. Solitary lesions are most common in females (80%), but

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**Figure 1:** Preoperative

**Figure 2:** Computed tomography scan of the lesion

**Figure 3:** Incision

**Figure 4:** Intra-operative, lesion exposed in the neck
here we came across a solitary lesion in a young male person.

Approximately 25% of lipomas and their variants arise in the head and neck region. The cheek is the most favored site in the head and neck region, followed by the tongue, floor of the mouth, buccal sulcus, vestibule, lip, palate and gingival, but we found the lesion in the retromandibular region.

The diagnosis of lipoma is often dependent on the history and clinical examination with the use of aids such as ultrasonography, CT, magnetic resonance imaging techniques and fine needle aspiration biopsy. If lipomas infiltrate into the surrounding muscles then they are termed as infiltrating lipomas. Rarely, lipomas can become malignant or, from benign, can become liposarcoma.

Lipomas histologically resemble mature adipose tissue, but the presence of a fibrous capsule helps to differentiate them from simple fat aggregations. Lipomas do not show any familial occurrence. Conventional lipomas have characteristic chromosomal abnormalities of 12q14-15,6p and 13q9. Treatment modalities can be divided into nonexcisional and excision therapy. Nonexcisional techniques involve steroid injections, which result in fat atrophy, and liposuction, which destroys the adipose tissue but not the fibrous capsule and hence will not eliminate lipoma completely. Steroid injections are used for patients who have small lipomas or do not desire excision. Disadvantages include the need for multiple injections and possible depigmentation of the overlying skin. Liposuction may be used for small or large lipomas; however, removal of the entire tumor is difficult and hence surgical excision is the most preferred unless it is highly avoided due to some expected complications. Complications after excision of a lipoma are hematoma formation, surgical infection, cellulitis, fasciitis, ecchymosis and injury to the nearby nerves with permanent paraesthesia/anesthesia, injury to nearby vessels/vascular compromise, seroma, fat embolus and muscle injury irritation, but careful execution of surgery with sound knowledge of regional anatomy aid in the success of the excisional therapy with uneventful recovery of the patient.

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