A Rare Case of Superficial Parotid Lipoma

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Abstract

The occurrence of lipomas in the parotid gland is extremely rare, and impossible to differentiate clinically. The entity’s incidence is about 0.6-4.4% of parotid gland mass lesions and history of previous trauma in the area is the most common pathophysiological mechanism described. We present a case of a 54-year-old man with parotid lipoma treated with superficial parotidectomy with facial nerve preservation. The diagnosis of parotid lipoma is based on clinical, radiological and histological arguments. CT and/or MRI evaluation of the head and neck is very important, although histological confirmation is critical.

Keywords: Parotid gland; Lipoma; Superficial parotidectomy

Introduction

Lipomas are common mesenchymal tumors consisting of fat, although the occurrence of such in the parotid gland is extremely. They represent between 0.6 and 4.4% of the benign parotid tumors [1]. They are seldom considered in the initial differential diagnosis of a parotid mass and are often mistaken for other parotid neoplasms [2]. We present a case of a 54-year-old man with parotid lipoma treated with superficial parotidectomy through our case, we describe the different steps that led to the diagnosis of liposarcoma, as well as a review of the literature.

Case Report

Figure 1: An axial and coronal image from the CT scan shows a large intraparotid mass of fat density measured 60 x 55 x 32 mm.

Figure 2: Intra-operative inspection revealed a regular lipomatous mass.
The patient underwent a superficial parotidectomy with a cervical-parotid approach. The lower pole of the parotid was dissecting from the anterior margin of the sternocleidomastoid muscle; a yellowish mass appears at the lower pole of the superficial lobe parotid surrounded with a smooth intact capsule which measured 6 x 6 x 3 cm (Figure 2). The excision was easily performed according to a cleavage plan. The post-operative follow-up was simple without facial paralysis. Pathological examination of the mass found a well differentiated adipose tissue without cellular atypies surrounded by a fibrous capsule confirming the diagnosis of lipoma (Figure 3). The patient had no recurrence after 6 months of follow up.

**Discussion**

Lipomatous lesions of the parotid gland are rare and are seldom considered in the initial diagnosis of a parotid swelling. Previous reports have suggested an aggregate frequency of 1.2% of parotid tumors, although the frequency in individual series has varied from 0.6% to 4.4% [1,2]. Clinical diagnosis of parotid lipoma is very difficult. There is no clinical sign to distinguish of the other benign tumors of the parotid gland. They are in general asymptomatic except the deformation of the preauricular area. When they become voluminous fleeting pain are described, probably related to tensions in the parotid region with displacing of the tonsils, larynx and lateral pharyngeal wall. Exceptionally, in an atypical case of superficial parotid lipoma, segmental facial paralysis was noted [3].

Imaging modalities and especially CT scan and MRI can achieve high accuracy in the preoperative diagnosis [4], giving valuable information for the malignant potential of the lesion and the exact location, which helps for the surgical strategy design. The presence of a well-encapsulated mass on CT with a density typically of -50 to -150 Hounsfield units oriented towards the diagnosis of lipoma. However this aspect is not pathognomonic and can be confused with a parotid tuberculous abscess.

MRI remains the exam of choice with greater sensitivity and specificity; it gives a precise localization of the tumor thanks to high tissue contrasts and orientates its nature without however replacing a formal histological diagnosis that only the surgery will bring [5]. Histopathologically and according to the amount and distribution of adipose tissue and epithelial component [6], tumours are categorized into three groups: ordinary lipoma, which is identical to soft tissue lipoma, oncocytic lipoadenoma, which consists of oncocytes with variable fat, and nononcocytic sialolipoma. The presence of a thin fibrous capsule around the lipoma is essential to distinguish the lesion from a simple fat aggregation.

Surgical treatment is based on a superficial parotidectomy with dissection of the facial nerve [7]. According to the authors, the rate of postoperative facial paralysis varies from 8 to 65% in the surgery of the benign tumors of the parotid gland [7]; this rate increases to 80% for the deep lobe lipomas [8]. Other therapeutic approaches are enucleation or tumorectomy with a healthy tissue margin but neglected because the risk of recurrence is very important. The rate of recurrence of intraparotid lipomas, all locations and all techniques combined, is of the order of 5% [7].

**Conclusion**

Parotid lipoma is a benign parotid pathology, which should be considered in the differential diagnosis of gland’s mass lesions and clinical suspicion combined with appropriate imaging, without the aid of preoperative biopsy leads to efficient diagnosis. Meticulous surgical excision should be performed to avoid disturbing adverse events.

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