

Case Report

Giant multilobular axillary lipoma

Mubashir Gani*, Asif Iqbal, Ajaz Ahmad Rather

Department of General Surgery, SKIMS Medical College Bemina, Srinagar, Jammu and Kashmir, India

Received: 12 December 2023

Accepted: 11 January 2024

***Correspondence:**

Dr. Mubashir Gani,

E-mail: mubashir.gani72@gmail.com

Copyright: © the author(s), publisher and licensee Medip Academy. This is an open-access article distributed under the terms of the Creative Commons Attribution Non-Commercial License, which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.

ABSTRACT

Lipomas are common benign soft tissue tumours. Lipomas are usually small in size. Giant lipomas are uncommon. Large tumours can cause compression to the surrounding nerves and vessels. Axilla is an uncommon site of lipoma and giant axillary lipomas are rare. In this report we present a case of a 60-year male with giant multilobular axillary lipoma. The lipoma was unusual in its size, its appearance and site of occurrence. Histopathology revealed it to be a lipoma.

Keywords: Axillary lipoma, Multilobular, Giant, Tumour

INTRODUCTION

Lipomas are the most common mesenchymal soft tissue tumours. They are usually benign in nature. Although most of lipomas are small in size and asymptomatic. Rarely they can grow to a very large size producing symptoms such as nerve compression syndrome. Giant lipoma is defined as a lesion that is over 10 cm in length or that weighs over 1000.¹ Several cases of giant lipoma have been reported. We have a case report of Giant multilobulated axillary lipoma in a 60-year-old male patient.

CASE REPORT

A 60-year-old man presented with a growing painless mass in the right axillary region that has been enlarging for 10 years with no symptoms. Physical examination revealed multiple, mobile, soft masses filling the right axilla (Figure 1a-c). The neurological examination of the right upper extremity was normal. Computed tomography (CT) chest was done which showed a homogenous soft-tissue tumour located in the right axillary region between the chest wall, the pectoralis major and minor, and the latissimus dorsi muscles (Figure 2). Fine needle aspiration cytology (FNAC) of swelling revealed a benign lipoma. The patient was operated under general anaesthesia. Following a lazy-S incision over the axillary region. The lesion was well delineated by the fibrous capsule. The tumor was adjacent

to the axillary vessels and the brachial plexus but did not invade the neurovascular bundle (Figure 3) and could be totally excised without exposure of the brachial plexus or the subclavian vessels (Figure 4). However, the long thoracic nerve and thoracodorsal neurovascular bundles were attached to the tumor capsule, which were carefully dissected from the tumor and preserved. The excised specimen measured 15×20×20 cm (Figure 5). Histologically, the lesion was composed of, mature adipose cells enclosed within a capsule, which led to diagnosis of benign lipoma. The postoperative course was uneventful and there was no sign of neuromuscular dysfunction.

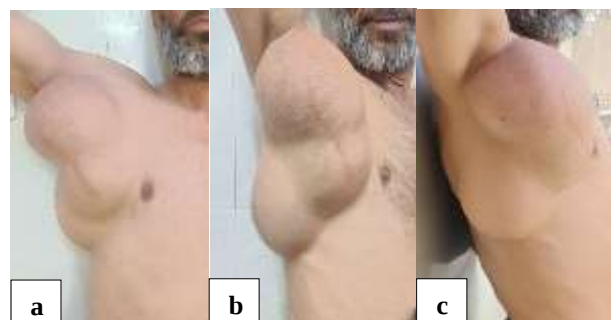


Figure 1: (a) Soft multilobulated mass filling the right axilla (anterior view), (b) axillary view of tumour, and (c) lateral view of tumour.



Figure 2: CT chest showing the location of tumour in relation to chest wall.

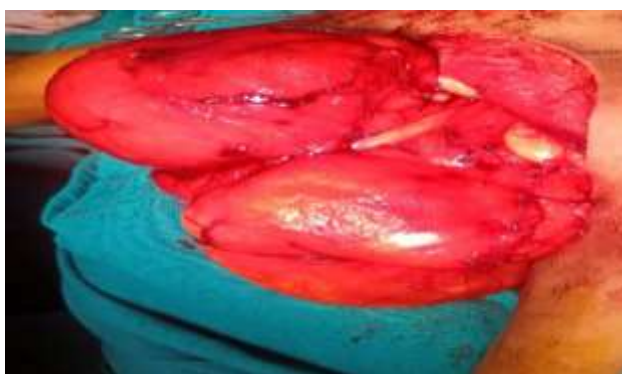


Figure 3: Intraoperative picture of the giant lipoma.



Figure 4: View of axilla after clearance of tumour.



Figure 5 Excised specimen of giant tumour.

DISCUSSION

Most lipomas are benign and arise mainly in any part of the body where adipose tissue is present.² They also have been reported in various internal organs, such as the liver, kidney and lungs, where there is no or very little adipose tissue.² In contrast, giant lipomas are comparatively rare. Giant lipomas can cause pain and nerve compression syndrome, although subcutaneous and subfascial giant lipomas arising in the back, thigh, forearm, chest and posterior neck also have been reported.²⁻⁴ The axilla is a rare location for development of giant lipomas: only four cases of axillary giant lipoma have been reported.⁵⁻⁸ The mechanism for the uncontrolled growth of giant lipomas is still unknown. Trauma is thought to be an important factor in the pathogenesis of lipoma.⁹ It has been proposed that rupture of the fibrous septa after trauma accompanied by tears of the anchorage may result in proliferation of adipose tissue.¹⁰ It also has been assumed that local inflammation secondary to trauma may induce differentiation of pre-adipocytes and disrupt the normal regulation of adipose tissue.⁹

The main problem in the diagnosis of giant lipomas is to rule out liposarcomas. Generally, differential diagnosis between lipomas and liposarcomas is impossible by the clinical appearance alone. Giant internal lipomas were reported to show sarcomatous transformation; however, such a transformation in other parts of the body is extremely rare.³ Computed tomography and magnetic resonance imaging (MRI) are well-established methods of diagnosis.¹¹ In addition, fine-needle aspiration biopsy and/or incisional biopsy can aid in establishing a preoperative diagnosis.²

The histological evaluation of the entire lesion is essential for diagnosis. Because even giant lipomas usually have a well-defined fibrous capsule, dissection around the lesions can be easily performed and they can sometimes be squeezed out through short incisions.^{3,12} Some authors performed liposuction of the lipoma through tiny incisions, even for a huge lesion.^{13,14}

CONCLUSION

In conclusion, axillary giant lipoma is a rare condition preferably treated by surgical excision to avoid damage caused by tumour compression to the major vessels or nerves, to offer better control against local recurrences and to establish a correct diagnosis.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: Not required

REFERENCES

1. Sanchez MR, Golomb FM, Moy JA, Potozkin JR. Giant lipoma: case report and review of the literature. *J Am Acad Dermatol.* 1993;28(2 Pt 1):266-8.

2. Di Benedetto G, Aquinati A, Astolfi M, Bertani A. Giant compressing lipoma of the thigh. *Plast Reconstr Surg.* 2004;114:1983-5.
3. Terzioğlu A, Tuncali D, Yuksel A, Bingul F, Aslan G. Giant lipomas: a series of 12 consecutive cases and a giant liposarcoma of the thigh. *Dermatol Surg.* 2004;30:463-7.
4. Schmidt J, Schelling M, Lerf B, Vogt M. Giant lipoma of the breast. *Breast J.* 2009;15(1):107-8.
5. Copcu E, Sivrioglu N, Culhaci N. Axillary giant lipoma. *Plast Reconstr Surg.* 2004;114:1982-3.
6. Pop D, Venissac N, Leo F, Mouroux J. Acquired chest wall deformity: huge axillary lipoma. *Eur J Cardiothorac Surg.* 2005;27:514.
7. Vandeweyer E, Scagnol I. Axillary giant lipoma: a case report. *Acta Chir Belg.* 2005;105:656-7.
8. Singal R, Jora MS, Mittal A. An unusual presentation of giant extrathoracic tumor in a child—managed successfully. *Turk J Pediatr.* 2012;54:191-3.
9. Copcu E, Sivrioglu NS. Posttraumatic lipoma: analysis of 10 cases and explanation of possible mechanisms. *Dermatol Surg.* 2003;29:215-20.
10. Meggitt BF, Wilson JN. The battered buttock syndrome—fat fractures. A report on a group of traumatic lipomata. *Br J Surg.* 1972;59:165-9.
11. Dooks GC, Hricak H, Sollitto RA, Higgins CB. Lipomatous tumors and tumors with fatty component: MR imaging potential and comparison of MR and CT results. *Radiology.* 1985;157:479-83.
12. Born G. Gigantic lipomas. *Plast Reconstr Surg.* 1995;96:1750-1.
13. Rubenstein R, Roenigk HH Jr, Garden JM, Goldberg NS, Pinski JB. Liposuction for lipomas. *J Dermatol Surg Oncol.* 1985;11:1070-4.
14. Nichter LS, Gupta BR. Liposuction of giant lipoma. *Ann Plast Surg.* 1990;24:362-5.

Cite this article as: Gani M, Iqbal A, Rather AA. Giant multilobular axillary lipoma. *Int Surg J* 2024;11:293-5.