Parotis Bezi Derin Lobtan Kaynaklanan Dev Lipom: Olgu Sunumu

Giant Lipoma Arising From The Deep Lobe of The Parotid Gland: Case Report

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Lipomas in the head and neck region are uncommon. Rarely, they can develop in the parotid gland with reported incidence ranges from 0.6 to 4.4% among parotid tumors. The deep lobe of parotid gland lipoma is even rarer clinical entity. They are mostly a painless, asymptomatic and slow growing swelling. Because of their rarity, they are not often considered in the differential diagnosis of parotid tumors. Therefore, surgical management of lipomas in the parotid gland is controversial. In this article we described a case of giant lipoma arising from the deep lobe of the parotid gland and also extended to the parapharyngeal space.

Keywords: Lipoma, parotid gland, deep lobe, parapharyngeal space
Introduction:
Lipomas in the head and neck region are relatively rare entities. They are most commonly presenting in the posterior subcutaneous neck.\(^1,2\) Rarely, they can develop in the parotid gland with reported incidence ranges from 0.6 to 4.4% among parotid tumors.\(^3\) The deep lobe of parotid gland lipoma is even rarer clinical entity. They are mostly a painless, asymptomatic and slow growing swelling. They appear most frequently in the fifth and sixth decades of life with a definite male predominance.\(^1,3\) Because of their rarity, they are not often considered in the differential diagnosis of parotid tumors. Therefore, surgical management of lipomas in the parotid gland is controversial.

In this article we described a case of giant lipoma arising from the deep lobe of the parotid gland and also extended to the parapharyngeal space.

Case:
An informed consent form signed by the patient. A 57 year old male patient applied to our clinic with a nonpainful lump on the left side of his face (Figure 1). He has had this lump for three years. Clinical examination revealed a mobile, soft and nontender mass, measuring 8 x 7 cm, over the region of the left parotid area. The surface of the mass was smooth and the overlying skin was normal without any signs of discoloration or tumor adhesion. Oropharyngeal examination revealed that left lateral pharyngeal wall was pushed medially without any airway compromise. There was no cervical lymphadenopathy and other head and neck examination was normal. Bilateral facial nerve and all lower cranial nerves (IX-XII) were intact. There was no history of trauma or infection.

The contrast enhanced high resolution computerized tomography (HRCT) scan of upper neck region showed a homogenous, lobulated low density mass in the parotid gland with extension in the left parapharyngeal space (Figure 2). Fine needle aspiration biopsy was performed and fibrofatty tissue were seen histopathologically. Under general anesthesia, a modified Blair incision was performed and then the main trunk of the facial nerve was identified at the stylomastoid foramen. The mass was exposed all around and was found to be well encapsulated. The anterior-inferior portion of the tumor was extending to the deeper plane of the facial nerve. It originated from the deep lobe of the parotid gland. The mass was removed with a little part of deep lobe, preserving the branches of the facial nerve. The surgical specimen was well encapsulated measuring 8 x 7 cm. The histopathologic examination reported it as a lipoma (Figure 3). The patient had an uneventful recovery with a satisfying facial contour and intact facial nerve function postoperatively (Figure 4). Neither tumor recurrence nor Frey’s syndrome was observed 15 months after the surgery.
Lipomas represent 20% of all benign mesenchymal tumors of the salivary glands and were defined by Nagao et al. in 2001. Rarely, they can develop in the parotid gland with reported incidence ranges from 0.6 to 4.4% among the parotid tumors. The deep lobe of parotid gland lipoma is even rarer clinical entity, nearly 10 cases in literature. They appear most frequently in the fifth and sixth decades of life with a male dominance. Our patient was 57 year old and his tumor was originated from the deep lobe of the parotid gland.

Regarding the pathogenesis, Nagao et al. suggested that the glandular component had become entrapped during lipomatous proliferation and believed that it was not of neoplastic origin. Heredity, obesity, diabetes, trauma, radiation, endocrin disorders, insulin injection and corticosteroid therapy are sometimes implicated as possible etiologic factors. We didn’t find any etiologic factor in our patient. Lipoma in the parotid gland can be difficult to diagnose clinically probably due to low index of suspicion. Ultrasonography can also be used for parotid masses as a first step imaging technique. HRCT or magnetic resonance (MR) imaging can aid the diagnosis and the extension of the tumor. A homogeneous and well-capsulated hypodense mass in contrast to the hyperdense normal parotid tissue was seen in HRCT. In our patient, a 8 x 7 cm, homogeneous, well-capsulated and lobulated mass found in contrast enhanced HRCT. There was no evidence about malignancy like heterogeneous density, intraluesional hemorrhage and necrosis, irregular margin or extension into the surrounding tissues.

The deep lobe parotid lipomas may extend to the connective tissues of the neck, between the sternocleidomastoid and digastric muscles or into the parapharyngeal space. Pain and facial paralysis are uncommon. In our patient lipoma was extended to the left parapharyngeal space and an asymmetry was seen in oropharyngeal examination.

Fine-needle aspiration is useful in determining parotid gland masses, but its accuracy drops to lower than 50%. In our case fine needle aspiration biopsy was performed and the fragments of adipose tissue and mucinous material were revealed.

Surgical management of parotid lipoma is controversial. Enucleation, superficial parotidectomy and total parotidectomy were performed by different researchers. Wu and Kim reported sialolipoma of parotis and performed enucleation and they have had no recurrence postoperatively. Ryu et al. treated the lipoma of the parotis by superficial parotidectomy. Doğan et al. reported that superficial parotidectomy is the usual surgical treatment for parotid gland lipomas with near total absence of recurrence. Chakravarti et al. reported a deep lobe lipoma and they performed total parotidectomy; postoperatively, their patient had grade III facial nerve paresis which improved in 6 weeks. Analysis of previous series reveals that around 50% of the reported cases have developed transient or permanent facial weakness postoperatively. We excised the giant mass with a little part of deep lobe, preserving the facial nerve branches. Postoperatively there was no complication such as facial paralysis, hemorrhage, infection or Frey’s syndrome.
Conclusion:
Giant lipomas involving the deep parotid lobe are extremely rare. Surgical management of deep lobe lipoma is controversial and challenging and should be performed by experienced surgeons. We suggest that the lipoma can be enucleated or excised with a little part of the gland despite the giant size when the preoperative radiologic and the intraoperative findings that have a clear margin and benign.