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Giant Axillary Lipoma - A Case Report and Review of Literature

Dr Jayaraman Seetharaman[1], Dr Ambikavathy M[2], Dr Vivithashree[3], Dr Anusha[4]

[1]Junior Resident General Surgery MVJ Medical College and Research Hospital

[2]Professor General Surgery MVJ Medical College and Research Hospital

[3]Junior Resident General Surgery MVJ Medical College and Research Hospital

[4]Junior Resident General Surgery MVJ Medical College and Research Hospital

Abstract: ***Lipomas are common benign tumors composed of adipose tissue, typically small and asymptomatic. However, giant lipomas, particularly in the axillary region, are rare and can present unique clinical challenges. Giant lipomas are extremely uncommon entities and contribute to only 1% of all cases of lipomas. Such a large size (more than 10 cm) always involves a possibility of malignancy. [1] Imaging techniques like USG, MRI, and cytopathology should be used to confirm diagnosis and rule out malignancy. Lipoma is managed by complete surgical excision.***

Keywords: giant lipoma, lipoma axillary swelling, accessory breast

1. Introduction

Lipomas are one of the most common, benign, slow - growing tumors. Lipomas can occur anywhere in the body, but they are most commonly found on the neck, shoulders, back, abdomen, arms, or thighs. Lipomas are generally small, ranging from less than an inch to a few inches in diameter. When a lipoma grows to a size larger than 10 cm and weighing more than 1 kg, it is referred to as a giant lipoma comprising of about 1 %. [2] Usually they are benign however in giant lipomas it is essential to rule out the possibility of malignancy.

2. Case Report

The 53year old female patient came to the hospital with complaints of swelling in the left axillary region since 11 yrs. insidious in onset gradually progressive in size over the years. Patient gives history of sudden increase in size of the swelling since 1 year. No history of pain, discharge from the swelling, ulcers over the swelling No history of any comorbidities No history of previous surgeries. Post menopausal status since 10 years. Obstetric score of P2L2Tubectomy done 25 years ago. History of beetle nut/leaf chewing for more than 20 years

On clinical examination, a single swelling of size 20 x 15 cm from anterolateral chestwall, 2nd intercoastal extending up to 9 - 8 intercoastal space vertically, horizontally 4 - 5 cm from midclavicular line up to posterior axillary line, superiorly from 2nd intercoastal space. Skin over the swelling appears normal Ovoid in shape moves with respiration, Firm to hard in consistency, swelling is corresponding from the chest wall, mobile in horizontal and vertical plane and no fixity to underlying tissue. No palpable lymph nodes.

Sonomamography breast: A very large, focal, encapsulated mass lesion in the left anterolateral chest wall, lateral to the left breast which shows predominantly hyperechoic echotexture with multiple linear strands and few small hypoechoic foci within - suggestive of liposarcoma. Fibrocystic disease of bilateral breast as described above. Small, focal echogenic thrombus within the distal left basilica vein measuring about 10X5mm in size located a few centimeters proximal to its termination into the left axillary vein.

CECT A large, focal, well defined, encapsulated, fat density lesion of non - homogenous attenuation measuring 15.1X12.4X20.9cm in size in the left anterolateral chest wall lateral to the left breast with local extensions as described above. Multiple thin and thick fibrous strands and few vessels are noted traversing within the lesion. The lesion appears to be arising from and in continuity with the left axillary fat. Acute focal thrombus/thrombosed varix within the distal aspect of the basilic vein measuring about 1.4X2cm in size. Mild cystic bronchiectasis in the posterior segment of the right lower lobe and the inferior lingula segment of the left lung

The patient underwent wide local excision of the tumour under general anaesthesia. The excised tumour weight 3.2kg Post operative period was uneventful. The patient was discharged and followed up regularly until suture removal. Histopathological examination of the tumour in toto confirmed the specimen to be a lipoma

3. Discussion

Giant lipomas are extremely uncommon entities and contribute to only 1% of all cases of lipomas. Such a large size (more than 10 cm) always involves a possibility of malignancy. The malignancy can be suspected due to clinical features like large size, rapid growth, pain, and immobility. Imaging techniques like USG, MRI, and cytopathology should be used to confirm diagnosis and rule out malignancy. Lipoma is managed by a complete surgical excision. [3] The axilla is an extremely rare location for development of giant lipomas. Giant lipoma can cause pain and nerve compression

syndrome. liposuction and suction - assisted lipectomy have also been proposed as a viable alternative therapy for giant lipomas with a cosmetic advantage. The possible drawbacks of this procedure are limitations to visualizing the tumor, fragmentation of specimen confounding the histopathology, and incomplete resection increasing chances of recurrence. [4]

Figure 1: Pre Operative Clinical Presentation by the Patient

Figure 1A

Figure 2: CECT Findings of the Tumour

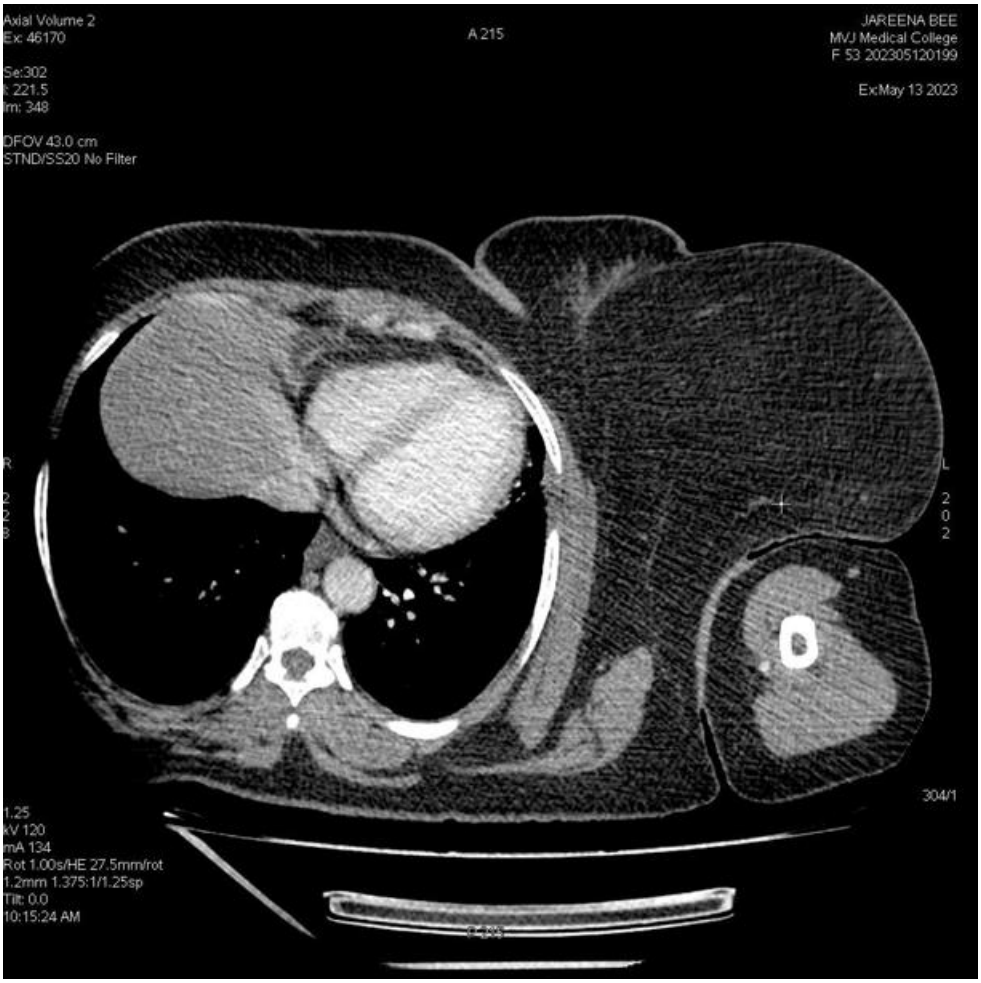

Figure 2B

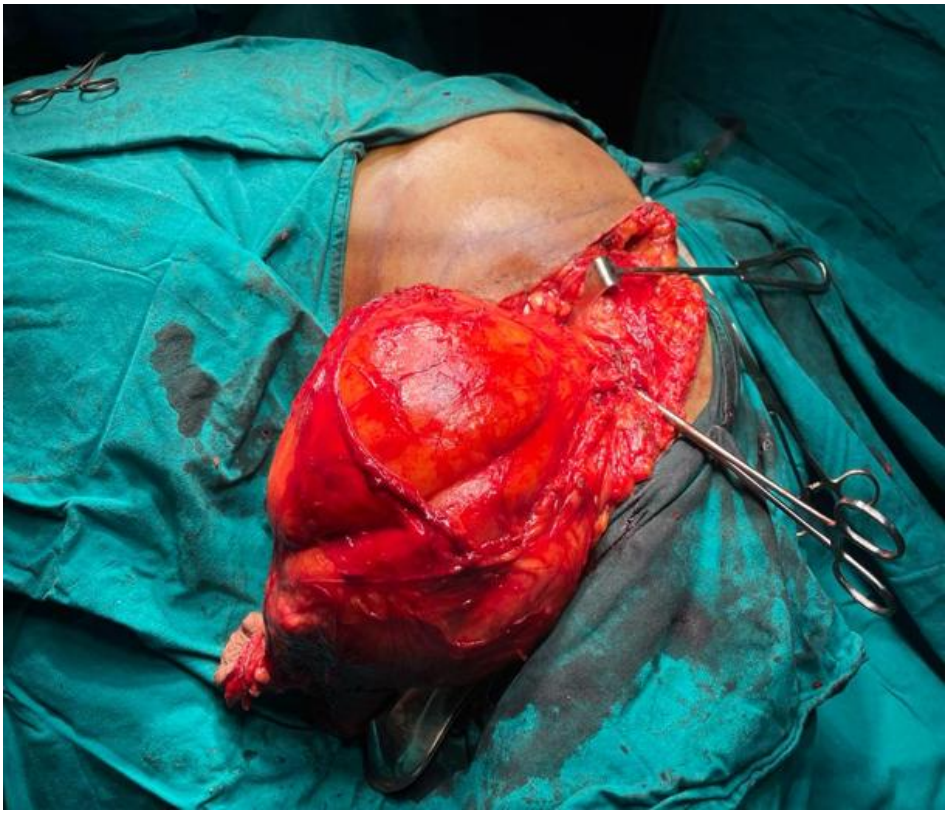

Figure 3: Intra Operative Image of the Tumour

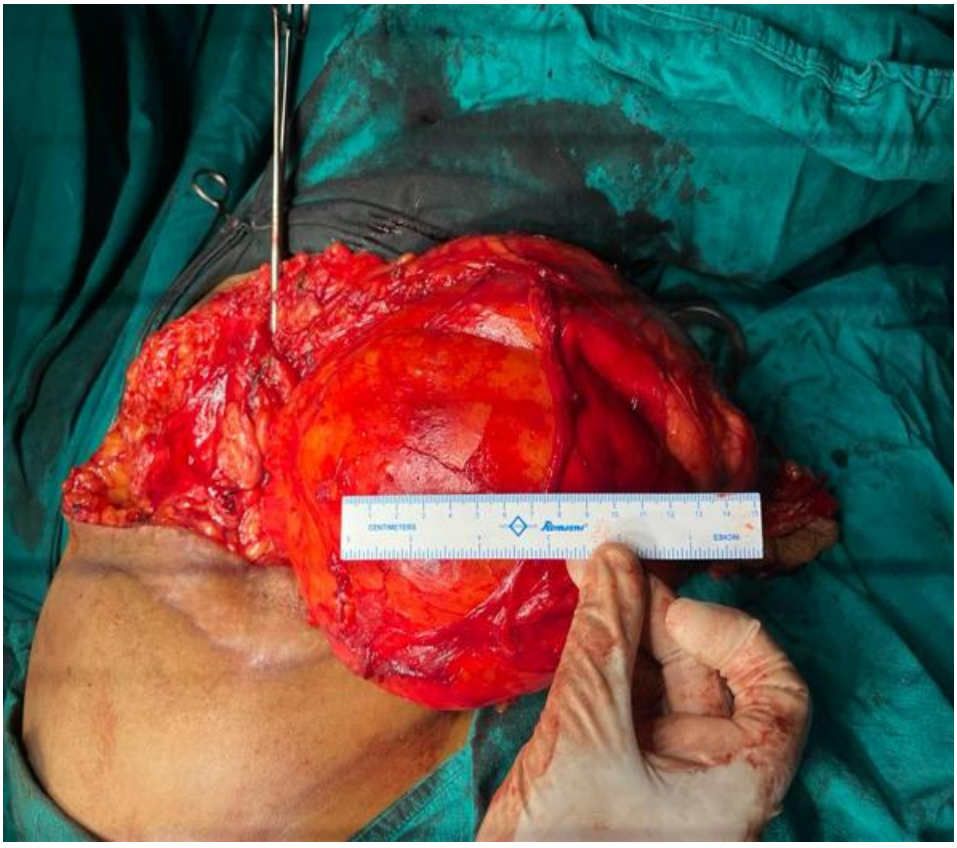

Figure 4: Measuring the Length of the Tumour Intraoperatively

Figure 5: Posy Extraction Specimen Weighing 3.2 KG

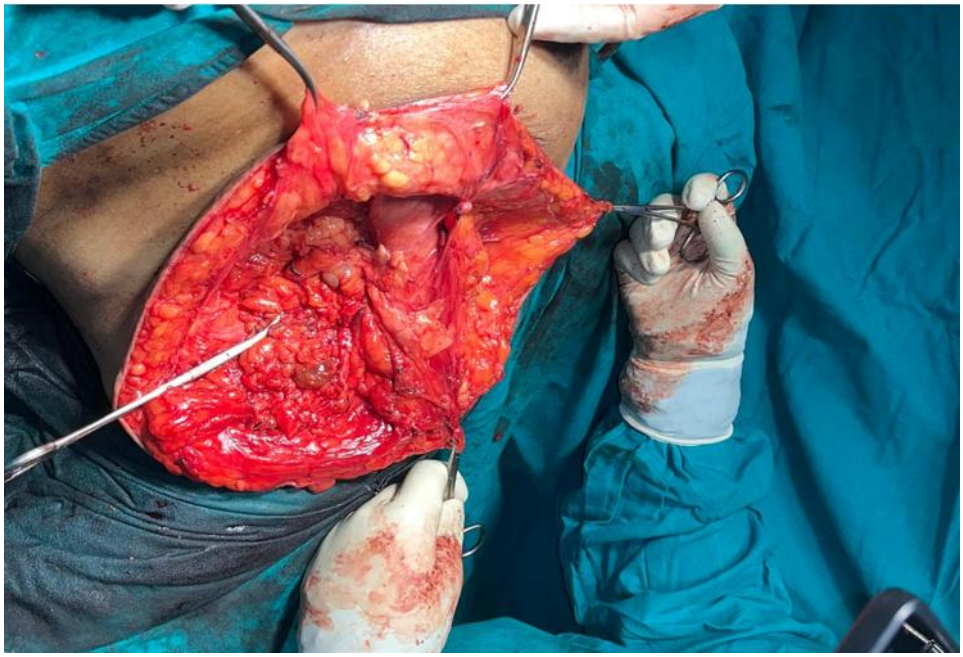

Figure 6: Post Specimen Extraction Dead Space

Figure 7: Post Operative Image of the Patient with the Drain Insitu

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