

Oral Fibrolipoma

Deepa Das Achath, Prachi Ravikant Naik, Jaya Jayanta Mukherjee

ABSTRACT

Lipomas are benign soft tissue mesenchymal neoplasms of the oral cavity. Among its histological variants, fibrolipoma is a rare entity and is comprised of neoplastic fat cells embedded in dense collagen. Although, fibrolipomas may occur at various sites in the oral cavity, its etiology is obscure. The importance of differentiating an intraoral fibrolipoma from a mucocele, fibroma and pleomorphic adenoma is discussed through a case report of fibrolipoma in the buccal sulcus with review of literature.

Keywords: Fibrolipoma, Fibroma, Mucocele, Benign oral neoplasm.

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INTRODUCTION

Lipomas are rare soft tissue neoplasms in the oral cavity and accounts for 1 to 4% of oral benign tumors.¹ Oral lipoma was first described by Roux in 1848, who referred it as 'Yellow epulis'.² The etiology of lipomas is obscure, although mechanical, endocrine and inflammatory causes have been attributed to.³

Lipomas are histologically classified into fibrolipoma, spindle cell lipoma, intramuscular or infiltrating lipoma, angioliipoma, sialoliipoma, pleomorphic lipoma, myxoid and atypical lipoma.⁴

Fibrolipoma of the oral cavity is a rare entity among them, with only 35 cases reported in the literature.⁵ Extraorally, fibrolipomas have been reported in the esophagus, pharynx, colon, trachea and larynx.⁶ Intraorally, they can occur at various sites, such as buccal mucosa, lips, tongue, palate, buccal vestibule, floor of the mouth and retromolar area.⁷ A case of an intraoral fibrolipoma in the buccal vestibule is reported here.

CASE REPORT

A 55-year-old male patient reported to the outpatient Department of Oral Medicine and Radiology with a chief complaint of dislodged bridge in the upper right posterior jaw since past 4 days. The bridge was placed about 4 years back after he underwent extraction of decayed teeth in the same quadrant.

The patient was hypertensive and on medication from past 2 years. He had no ill-healthy habits and followed

proper oral hygiene measures. He was well-built, of normal gait and posture. Vital signs were normal. Extraoral examination revealed no abnormality.

On intraoral examination of the soft tissues, there was a small nodular soft tissue mass in the left lower posterior buccal vestibule in relation to 35, 36 area. 36, 37 were missing. The nodular mass was oval in shape, well-circumscribed, sessile and about 0.5 cm in diameter. It extended anteroposteriorly from distal aspect of 35 to the edentulous space of 36 and superoinferiorly from mucogingival junction of 35, 36 to the buccal mucosa (Fig. 1). The mass was pale pinkish yellow in color with a smooth surface and no sign of any discharge or bleeding. It was nontender, soft and compressible on palpation (Fig. 2). The adjacent teeth were nontender to percussion. There was a



Fig. 1: Intraoral swelling on the left buccal vestibule



Fig. 2: Intraoral ovoid, pale pinkish swelling on the left buccal vestibule

dislodged fixed partial denture in the upper posterior quadrant. All the teeth presented with generalized attrition and gingival recession. A provisional diagnosis of a benign soft tissue tumor was considered for the nodular mass in the buccal vestibule. Mucocele, fibroma, benign salivary gland or mesenchymal tumor were included in the differential diagnosis. The intraoral periapical radiograph of 35, 36 was insignificant. Routine hematological investigations were uneventful. The nodule was surgically excised and the specimen was sent for histopathological examination (Fig. 3). Postoperative instructions were given and antibiotics were also prescribed. Healing was found to be satisfactory upon recalling the patient after 1 week. The diagnosis was confirmed based on the histopathological report.

Histopathological report revealed, a covering of a non-keratinized stratified squamous epithelium spongiosus and proliferation into the connective tissue forming arcading pattern. The underlying connective tissue was fibrous with few ectopic sebaceous gland tissue and many dilated and engorged blood vessels. There was abundant adipose tissue consisting of signet ring-shaped adipocytes seen with intertwining muscle (Fig. 4). The histopathological report of the specimen was fibrolipoma.

DISCUSSION

Oral lipomas are slowly growing benign neoplasms presenting as a well-circumscribed, painless, submucosal nodule with a yellowish tinge. Oral lipomas are found commonly in males above 40 years of age.⁸ The buccal mucosa and the buccal vestibule are common sites where oral lipomas occur.⁹

Lipomas are occasionally altered by the admixture of other mesenchymal elements, mostly fibrous connective tissue which is often hyalinized and may or may not be associated with a capsule. These are fibrolipomas.¹⁰ Fibrolipomas, classified as a variant of conventional lipoma by the WHO occurs commonly on the buccal mucosa and the buccal vestibule, followed by tongue, floor of mouth and lips.⁴ Fibrolipoma differs from the classic variant because the mature adipose tissue is interspersed by bands of connective tissue.¹¹

A recent study revealed that 27% of 41 cases of oral lipomas were fibrolipomas,⁹ whereas previous studies have reported a lower incidence.¹² The nodular mass presented in our case was diagnosed as fibrolipoma due to presence of mature adipocytes interspersed with dense collagen fiber bundles. The adipose and fibrous tissue matures to form strands of collagen separating fat cells into lobules.¹⁰ The other variants of lipomas are angioliipomas in case of excess

vascular channels, myxolipoma if there is myxoid background stroma, chondroid lipoma or osteolipoma in case of chondroid or osseous metaplasia.¹²

The treatment of oral lipomas and all histological variants is surgical excision. Recurrence is rarely reported. Since, a clinical diagnosis of fibrolipoma cannot be made, due to its similarity to other benign neoplasms, it is important to surgically excise the lesion and send it for histopathological examination.

CONCLUSION

Oral fibrolipomas are very rare in the oral cavity with few cases documented so far. Since the proliferative activity of fibrolipoma is greater than the other variants, the need for accurate diagnosis is important.⁵

Due to the similarity of clinical picture of all lipomas, the histopathological examination of the excised tissue is the gold standard for diagnosis. The prognosis of fibrolipoma is good and recurrence is rare.

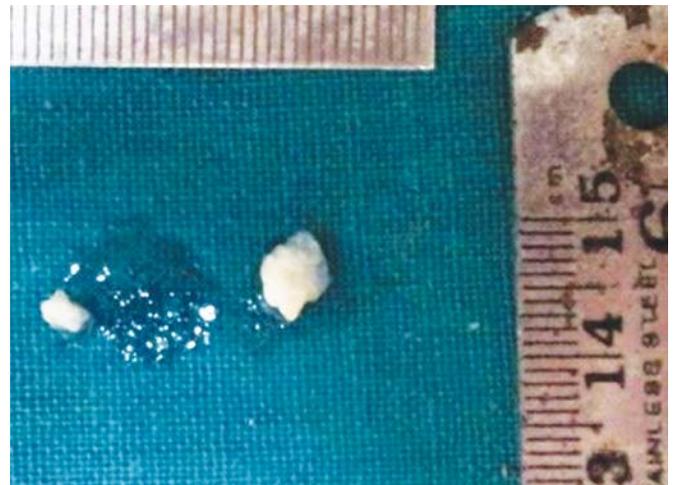


Fig. 3: Gross specimen of the tissue excised

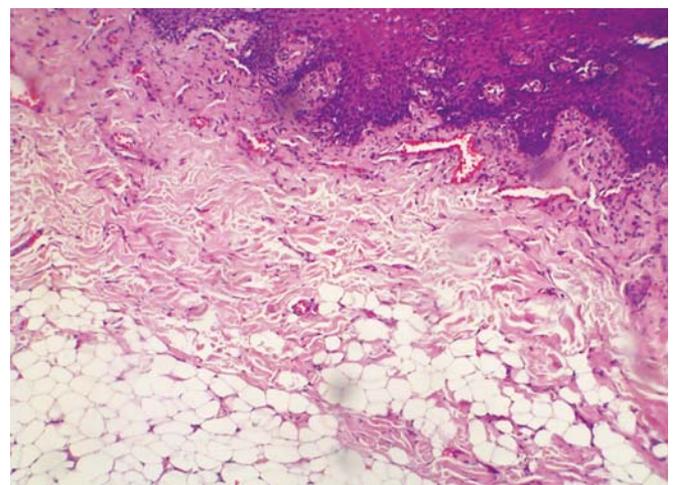


Fig. 4: Histopathological picture showing nonkeratinized stratified squamous epithelium, fibrous connective tissue and adipocytes

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ABOUT THE AUTHORS

Deepa Das Achath (Corresponding Author)

Professor, Department of Oral Medicine and Radiology
YMT Dental College and Hospital, Navi Mumbai, Maharashtra, India
e-mail: hari.kuttan1@gmail.com

Prachi Ravikant Naik

Postgraduate Student, Department of Oral Medicine and Radiology
YMT Dental College and Hospital, Navi Mumbai, Maharashtra, India

Jaya Jayanta Mukherjee

Postgraduate Student, Department of Oral Medicine and Radiology
YMT Dental College and Hospital, Navi Mumbai, Maharashtra, India