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Giant Thigh Lipoma: About a Case at Sikasso Hospital

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Abstract **Case Report**

Introduction: Lipoma is a benign tumor consisting of fat. This is a fairly common pathology that affects men and women alike, more rarely children. It can occur at any age but remains more common after 40 years. It is called giant when its size exceeds 10 cm or it weighs more than 1000g. The giant lipoma can be a source of physical and aesthetic inconvenience, which can cause many complexes. We report a case of giant lipoma of the anterior aspect of the left thigh. Patient and observation: This was a 72-year-old patient with no known pathological history who consulted for a tumor of the left thigh evolving since22 years old. The tumor was bulky, unsightly with signs of compression leading to functional impotence of the limb. A computed tomography of the left thigh was suggestive of a bulky remodeled lipoma. The standard biological assessment was normal. Total excision of the tumor to a healthy zone was performed. The weight of the operating piece was 12 kilograms. The anatomo-pathological examination of the surgical specimen concluded to a fibrolipoma of the thigh. The postoperative course was simple. *Conclusion:* The giant lipoma is a benign pathology that can be a source of physical and aesthetic inconvenience. Treatment is essentially surgical excision.

Keywords: giant lipoma-benign tumor-surgery.

INTRODUCTION

Solitary lipoma is the most common soft tissue tumor. It is called giant when its size exceeds 10 cm or it weighs more than 1000g [1,2]. It happens when certain cells in the fatty tissue grow so much that they end up forming a lump, called a lipoma. "It is therefore a benign tumor in the vast majority of cases [3]. These tumors can appear at all ages, but mainly in adults between 40 and 60 years old [3]. Lipoma, affects as well men than women, regardless of lifestyle [1, 3]. We don't really know the origin. Indeed, the appearance of the lipoma is above all of a genetic nature [4]. The family and hereditary context can help to better identify the phenomenon [4].

The diagnosis of lipoma is usually clinical as it is easily recognized by its soft and mobile consistency in relation to surrounding structures, non-inflammatory and well demarcated [4]. A lipoma usually causes almost no complications. However, in certain locations and/or in the case of large lipomas, the compression of the surrounding tissues can cause pain [5]**.** In case of superficial lipoma, an ultrasound can confirm the diagnosis and identify a possible risk of malignant evolution [6]. Deep lipomas may require the use of computed tomography (CT) or magnetic resonance imaging (MRI)[7.8]**.**Only if the lesion changes or grows rapidly may a biopsy be indicated. A fragment of tumor is then removed and then analyzed [1, 9].

PATIENT AND OBSERVATIONS

Mr. DF, was 72 years old, male, retired teacher, with no known pathological history. The patient had consulted for a tumor sitting on the anterior face of the left thigh evolving for more than 22 years. This swelling of the left thigh gradually increased in volume until reaching the current size without any notion of trauma. The patient was moving in a wheelchair because not only of the heaviness of the tumor, but also the associated pain leading to functional impotence. Faced with this symptomatology, he would have carried out translational treatments based on herbal medicine, fumigation, and massage without any improvement. The Karnofsky index was estimated at 80%, blood pressure: 120/80mmhg and heart rate: 90 cycles/min. The body mass index was 18.5.

On clinical study, examination found a bulky tumor 71cm in circumference, 47cm in width, 52cm in length, elongated and circular in shape. This mass was bothersome, of firm, regular consistency, not beating, well circumscribed. The tumor was mobile relative to the superficial and deep plan, without inguinal lymphadenopathy. The operability assessment was unremarkable. The result of the CT scan was a large remodeled lipoma of the anterior aspect of the left thigh. The left thigh radiograph was normal. General anesthesia with orotracheal intubation was used. Antibiotic prophylaxis was done with ceftriaxone. The incision was arcuate. On exploration we found a large tumour, the anterior and posterior detachment, dissection and ligation of the feeder pedicle.

We carried out a total resection of the tumor and the excess skin was resected allowing aesthetic closure on a Redon drain (suction). The weight of the operative part was 12 kilograms. The operative follow-up was simple. The anatomo-pathological examination of the surgical specimen concluded to a fibrolipoma of the thigh. The post-operative follow-up at one month, three months and 6 months was simple.

Figure1: Giant lipoma of the left thigh

Figure 2: Arcuate incision

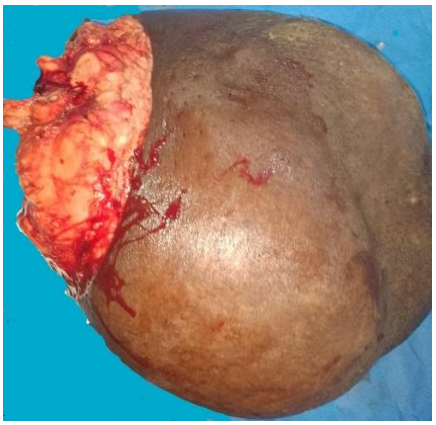

Figure 3: 12 Kg operating piece

Figure 4: start of healing

Figure 5: Complete healing

DISCUSSION

Lipoma is a relatively common lesion [10]. It is called giant when its size exceeds 10 cm or it weighs more than 1000g [1,2]. The medical literature estimates the number of people affected at around 2%a day in their life by this affection [10]. According to some authors, this frequency varies from 1.1 to 2.5/1000,000 occurring between 50 and 70 years [1, 11]. The authors estimate that there is no predominance of sex when the lipoma is solitary [12-14]. We do not really know the origin of lipomas, but some authors incriminate genetic predispositions [4], else from endocrine disorders or traumatic causes [15].

Lipoma is often painless and usually results in a soft, regular, mobile tumor [12,16]. The presence of pain, tension or compression of neighboring structures in the patient has been described in the literature [12]. The tumor was large, mobile, of firm consistency, unsightly, unsightly, and a source of physical inconvenience. These different aspects were also mentioned by the authors [12,17,18]. A lipoma usually causes almost no complications [17]. However, in certain locations and/or in the case of a large lipoma, the compression of the surrounding tissues can lead to pain.[17]**.** In very rare cases, the tumor progresses to cancerization [17]. Computed tomography (CT) of the tumor allows diagnostic orientation by objectifying a fat-like density with or without a fibrous capsule [17].

The reference imaging examination remains magnetic resonance imaging (MRI), which clearly defines the limits of the lipoma and surrounding adipose tissue. Thus at the MRI the giant lipoma appears as a homogeneous mass, well limited with a hyper signal (similar to subcutaneous tissue) both in weight sequence T1 and T2 and very well individualized compared to neighboring muscles not taking contrast after gadolinium injection. It also allows them to be classified according to the number of septa and the presence of nodular component [1, 11]. A primary biopsy for histological confirmation is the conventional methodology according to the authors [1, 18].

The most appropriate technique is total surgical excision, which can be performed under local or general anesthesia depending on the size and location of the lipoma. This attitude has been proposed by many authors [1,12,17,18]. Once operated, the surgical specimen is systematically sent for anatomopathological examination. Confirmation of the diagnosis is carried by histology. Microscopically, the lesions show lobular growth of mature adipocytes with demarcated borders, a fibrous capsule and a central vacuole [17]. Some authors opt for primary liposuction to reduce the tumor volume [12,19].

Liposuction involves sucking the fat out using a special device. Liposuction has the advantage of being fast but it does not allow the nature of the lesion to be studied, unlike ablation. Liposuction results in less (or no) scarring, but it leaves the envelope of the lipoma in place and therefore exposes you to a high risk of recurrence [19]. The evolution is generally good, recurrences occur in 4 to 5% of cases[17]. After 6 months of follow-up, the evolution was favorable in the patient, without relapse. The giant lipoma, due to its size and excessive weight and depending on its anatomical situation in the limbs, can compress the adjacent vascular-nervous structures and lead to a limitation of mobility.

CONCLUSION

The giant lipoma is a benign pathology that can be a source of physical and aesthetic inconvenience. Treatment is essentially surgical excision.

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