**ABSTRACT**

Lipoma is a growth of fat cells in a thin, fibrous capsule usually found just below the skin/mucous membrane. Lipoma is found most often on the torso, neck, upper thighs, upper arms, and armpits, but they can occur almost anywhere in the body. Tongue which is totally devoid of fat cells is a rare site for lipoma. This paper reports a case of lipoma in a 40-year-old male patient that appears as a mass in the tip and ventral surface of the tongue.

Keywords: Lipoma; Lipomas; Benign Tumor; Tumor like growth

**Introduction**

Lipoma is a very common benign moor of adipose tissue, but its presence in the maxillofacial region is relatively uncommon. The first description of an oral lesion was in 1848, by Roux who referred to it as a ‘yellow epulis’. Although most lesions are considered as developmental anomalies, those that occur in the maxillofacial region usually arise late in life and are presumed to be neoplasms of adipocytes, occasionally associated with trauma. Lipomas are benign, slow growing tumours composed of mature fat cells. Usually they are not tethered to the underlying fascia or muscles. But sub mucosal lipomas are rare. Still rarer is the occurrence of the lipomas in the oral cavity. Approximately 15-20% of lipomas occur in the head and neck region. Among the reported infra-oral lipomas, 50% occur in the buccal mucosal region without any tendency or predilection, contrary to the extra oral lipomas, which show a female predilection. The medical literature reports many cases of lipoma in various locations but only very few reports describe lipoma of the tongue. This paper reports a case of lipoma in a 40-year-old male patient that appears as a mass in the tip and ventral surface of the tongue.

**Case Report**

A 40-year-old male patient with a mass in tip and ventral surface of the tongue was referred to the Surgical Department of Dentistry College, Pharos University. Patient complains of a mass, which gradually increases in size beneath his tongue for the last one year. The history reveals a slow growing nature of the mass. Medical history was non-contributory. The vitals were under normal limits. The extra oral examination shows normal skin and facial symmetry. The lymph nodes were palpable. Intraoral examination reveals a 1 cm x 3 cm swelling underneath the mucosa involving the tip and ventral aspect of tongue (Figure 1). On palpation the mass was movable, soft and rubbery consistency and non-tender. The oral hygiene was poor with heavy calculus and stains. Based on the clinical examination and routine investigations a provisional diagnosis of Lipoma was made and excisional biopsy under local anesthesia was planned. Following the establishment of local anesthesia incision was given at the junction of the mass and the mucosa. This encapsulated mass was then removed in toto (Figure 2). After cauterizing the bleeding points the defect in the tongue mucosa was sutured. Postoperatively the tongue wound healed well (Figure 3). The cut surface of the mass showed fatty tissue. The surgical specimen was sent for histopathology, which showed squamous epithelium, and an underlying zone shows a lesion enclosed by a thin fibroclagenous capsule and composed of lobules of mature adipose tissue consistent with a picture of lipoma. The cut surface of the mass showed fatty tissue.

**Discussion**

An intramuscular lipoma or infiltrating lipoma is a slow growing painless lesion, typically found in the large muscles of the extremities, usually characterised by diffuse infiltration of the striated muscle fibres, but is exceedingly rare in the tongue. Lipomas occur in all age groups but most often appear in middle age (40-60 years). Single lipomas occur with equal frequency in men and women. Multiple lipomas occur more frequently in men. Clinically, the oral intramuscular lipoma presents as a well-circumscribed, painless, solitary, rubbery, submucosal swelling. Although it arises in the deeper tissues of the tongue, a protrusion from the lingual mucosa can be documented in a large-sized lesion. In the present case, although the size of tumour was small, it interfered with the speech and swallowing, and because of these complaints, the case was clinically misdiagnosed as carcinoma. Similar findings have been reported in other series. However, larger sized giant intramuscular lipomas with sizes of up to 10 cm have been reported. Surgical excision is the mainstay of treatment for these lesions. The recurrence rate for infiltrating lipomas has been reported to be 3 – 62.5%. They have the propensity to recur without adequate surgery. Therefore, complete surgical excision is mandatory. However, it rarely recurs in the oral cavity after complete removal. Prevalence rate of lipoma in the oral and oropharyngeal region is 1/5000 adults. The appearance and the consistency of the tumour are quite definitive indicators of diagnosing a lipoma even though they are uncommon in the oral cavity. A painless, soft slow growing tumour, either sessile or pedunculated with a smooth surface and well defined margins should be given a benefit of doubt of being a lipoma. The yellowish hue of the lesion as in this case report clinches the diagnosis effectively ruling out hamartomas.
Unusual site for a lipoma

capsulated lesions like this, excision with total preservation of the tongue musculature should be accomplished. 3

Conclusion
In conclusion, dentist must be aware of the clinical characteristics and progression in order to differentiate malignant and benign tumours, as well as to plan the correct treatment of oral lesions.

Authors Affiliations
1. Shady A. M. Negm BDS, Lecturer, School of Dentistry, Pharos University in Alexandria, Egypt, Diploma of Clinical Implant from Seville University, Spain, Professional Diploma of Infection Control from Oxford College, UK, 2. Ahmed S. M. El-Mallah, Bachelor’s Degree School of Dentistry, Pharos University, Alexandria, Egypt, Diploma of Clinical Implant from Seville University, Spain.

References

How to cite this article

Address for Correspondence
Dr. Shady A. M. Negm BDS, Dip. Clinical Implant, Seville University, Spain, Professional Dip. Infection Control, Oxford College, UK, Implantologist, Smile Dental Center Infection Control Consultant, Royal Dental Center, Pharos University, Alexandria, Egypt.
Email: smngm@msn.com

Source of Support: Nil
Conflict of Interest: None Declared