



Giant lipoma of the vulva in a primary care setting: a case report

Lipome géant de la vulve dans un contexte de soins primaires : à propos d'un cas

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Résumé

Les lipomes géants de la vulve sont rares. Nous présentons une femme préménopausée para-4 de 49 ans qui se présente avec une masse indolore à croissance progressive qui s'est révélée comme un lipome vulvaire après histopathologie. Une discussion détaillée est présentée et met en évidence la nécessité de l'histopathologie même dans les cas où l'imagerie pré-chirurgicale est une limitation

Mots-clés : lipome vulvaire, incision chirurgicale, histopathologie

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Summary

Giant Lipoma of the vulvar are rare. We present a 49-year-old para-4, premenopausal woman who presented with a painless progressively growing groin mass which was revealed as a vulvar lipoma after histopathology. A detailed discussion is presented and highlights the need to for histopathology even in cases where pre-surgical imaging is a limitation.

Keywords: vulvar lipoma, surgical incision, histopathology

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Introduction

Lipomas are composed of mature fat cells and are the commonest benign tumors (1-2). They commonly occur at the back, shoulders, chest and thigh regions (3). Their aetiology is unclear though linked to genetic factors and trauma. They rarely present in the vulval region. Only a few cases of vulval lipomas have been described elsewhere (1,4-5) with two cases reported in Ghana over a decade ago in a tertiary care centre (6). Due to their location in the groin, they are an important differential diagnosis of other benign lesions such as inguinal hernia, femoral hernia and Bartholin cysts (7). They may also mimic vulval carcinomas, ductal carcinomas and mucinous carcinomas (1).

We present a case of a woman with left vulvar mass that had progressively increased in size.

She had a surgical excision and histology examination confirmed it as a lipoma.

Case Report

A 49-year-old para-4 presented with a painless left groin swelling which she noticed in her late teens. The mass initially small, had grown to now cover the introitus. The skin over the mass did not show any discoloration or ulcerations. On examination a soft non-tender egg-shaped mass measuring about 16cm x 9cm was found in the left vulvar extending into the femoral region below the inguinal ligament. It was, fluctuant, irreducible and its edges were sharply demarcated and had no visible or palpable cough impulse. The overlying skin was stretched but not attached to the mass and it completely covered the introitus. There were



no palpable inguinal lymph nodes. This is depicted in **Figure 1**.



Figure 1: left labial swelling extending over the introitus

The patient underwent a successful surgery under local anesthesia with 1% xylocaine infiltration and a para-inguinal block. The findings were; a butterfly shaped lobulated, soft yellow tissue, weighing 330 g and measuring 25 cm x 15 cm across the widest spans. Individually ‘each wing’ measured about 15-17cm x12 cm with an interconnecting isthmus of about 3cm as shown in **Figure 2**. A histopathology of the sample confirmed it as composed of mature fat cells consistent with a diagnosis of lipoma.



Figure 2: macroscopic appearance after excision

Discussion

Lipomas are soft tissue swellings derived from mesenchyme (1). They have a prevalence of 1 % and are the commonest benign tumors of mesodermal tissue. They rarely present in the vulvar region, when present they occur mostly in women aged between 40 and 60 years although vulvar

lipomas have been described in the teenage and infant groups. Very large vulvar lipomas have been previously described and ours which measure about 25cm x 15cm is considerably bigger than the other two described in Ghana and may be bulkier than one described as the third largest in literature (8), possibly because of the late presentation for medical care. The onset of the vulvar swelling in our patient in her teens is similar to another instance in Morocco (4), although the latter was managed in the teen ages. Concerns about stigma (4) and finances (6) explain why she reported for medical care after a long time. Due to their location not only do they affect the quality of sexual life, they may also pose challenges to successful vaginal delivery even though such was not reported in the index case. The physical examination findings of a soft fluctuant non-tender mass, non-transilluminant, with no visible or palpable cough impulse was very suggestive of a lipoma as in another instance (1), even though other differential diagnosis such as femoral hernia were not completely ruled out. We did not request a computed tomogram (CT) or the much-preferred Magnetic Resonance Imaging (MRI) (2) scan due to their unavailability, the patient’s limited finances and the fact that the travel to obtain this service is a common challenge to adequate presurgical workup (6) especially in remote primary care settings. The alternative imaging technique, ultrasonography, although sensitive, specific and reliable was not considered because of its user-dependency (5) and the fact that specialist radiology services was about 50 km away and also expensive in the long run. The lack of imaging was a major drawback to management as it could have guided management decisions such as the type of incision. Even though General or spinal anaesthesia are possible choices, we relied on local block of the inguinal and iliohypogastric nerve with 1% lidocaine that we routinely use for groin hernia surgeries in this case. In the literature, different approaches to surgical excision of vulvar lipomas have been used. In our case, an



incision 1cm below the inguinal ligament was chosen to allow easier exploratory surgery because of the differential diagnosis that included femoral and labial lesions. In cases where imaging workup was more extensive, a para-labial elliptical, or longitudinal incision were used (1,4-5,8) and might have been more appropriate in our case too. In some cases, a cosmetic repair of the vulvar was carried out and the results were acceptable (1,4-5) similar to our case. The authors also recommend that, a histopathology is necessary to confirm the diagnosis (2) and allow for follow up radiotherapy in cases where the sample turns out to be a liposarcoma (9), even in resource poor settings and primary care settings.

Conclusion

Lipomas of the vulvar though rare should be considered as a differential diagnosis of groin swellings such as inguinal or femoral hernias. A thorough pre surgical evaluation including imaging should be conducted to help guide surgical management and we recommend a histopathology of excised specimen to confirm this rare diagnosis.

Conflict of interests

The authors declare no conflict of interest

Contribution of Authors

JKY was the lead physician and drafted the manuscript, FKA reviewed the manuscript, MBB reviewed the manuscript and ES also reviewed the manuscript. All authors approved the final manuscript.

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