

Giant lipoma of the male breast: case report and review of literature

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Received: 8 January 2011 / Accepted: 28 April 2011 / Published online: 27 May 2011
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Introduction

Lipomas are the most common soft tissue tumours, 16% of all mesenchymal neoplasms [1]. They occur in all parts of the body and are mostly small. Twenty percent are located in the chest wall [2]. The case presented is of interest because of size, location and clinical course.

Case report

A 38-year-old man with a large asymptomatic swelling of the right breast was presented on the outpatient clinic (Fig. 1). He underwent two liposuctions of the swelling in another hospital. Physical examination showed a large, painless unilobed swelling of the right breast with continuation to the axilla. There was axillary asensibility due to neurotmesis of the lateral cutaneous branch of the second intercostobrachial nerve. MRI showed a lipoma-

tous tumour of the right breast without signs of malignancy (Fig. 2).

The lipoma was excised diagonal to the level of the pectoral fascia and extended partly subpectoral beyond the latisimus dorsi muscle. Nipple reconstruction with a cranial dermal pedicle was performed. For symmetry a small liposuction of the surrounding tissue was performed.

Pathohistological examination showed a specimen that measured 24×20×6 cm with a total weight of 1,670 g without malignant signs (Fig. 3). After a 3-year follow-up, there was no recurrence (Fig. 4).

Discussion

Lipomas are the most common soft tissue tumours with a prevalence of 2.1 per 1,000 people [3]. A giant lipoma is defined as a lesion that measures at least 10 cm in one dimension, or weighs more than 1,000 g [4]. Locations of preference are the thigh, shoulder and trunk [5]. The first publication of a giant lipoma of the male breast was in 1935 [6].

Liposuction of lipomas is preferable in places where larger scars should be avoided (facial lipomas). It allows the incision to be placed in an inconspicuous location [7]. Although Habib et al. [8] showed no sign of recurrence after liposuction in a 6-year follow-up (maybe due to additional capsule extraction), endoscopic-assisted suction of lipomas could offer an even better entire removal through direct visualization [9].

However Raemdonck et al. [10] reported a high percentage of recurrence after liposuction compared to surgical excision. Silistrelli, Sanchez and Copcu et al. [3–

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Fig. 1 Preoperative photo: large swelling of the right breast

5] state that standard treatment should be excision. The usual pseudo-capsule even enhances this. This fibrous capsule can also render liposuction to be feasible [3]. Liposuction can be complicated by large haematomas and regrowth [4]. Silistrelli et al. mentioned in a review that liposuction may have a slightly higher risk of recurrence due to incomplete removal. Voulliaume et al. presented two cases in which liposuction of a gynaecomasty proved to be breast cancer and a lipoma of the ankle was in fact a liposarcoma [11]. Suction lipectomy can also create sensory loss. The larger the treated area, the larger is the area and degree of sensory loss [12]. Furthermore, histopathological examination is not reliable in case of liposuction. And

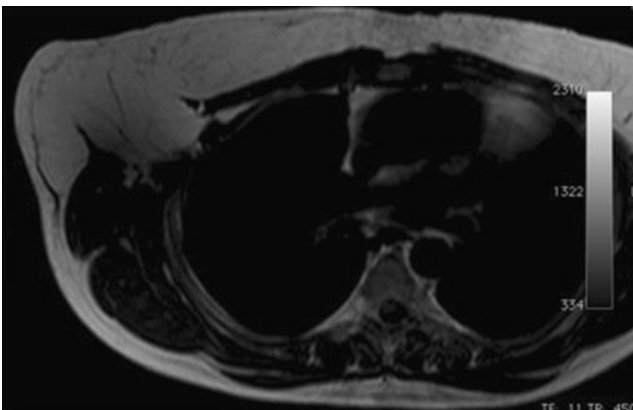


Fig. 2 MRI scan showing lipomatous tumour

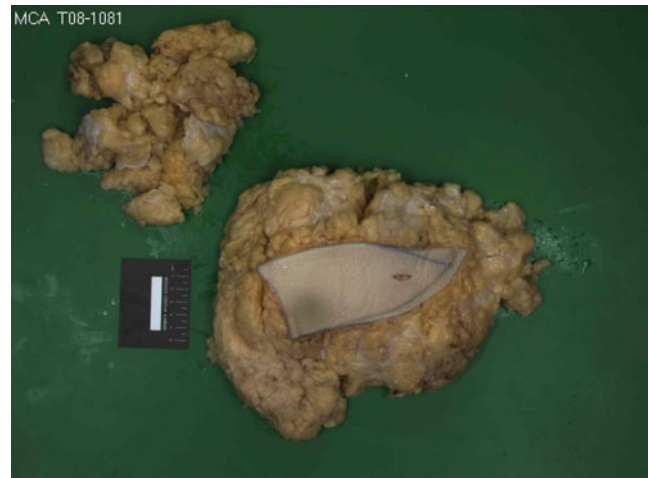


Fig. 3 Histopathology after resection

liposuction can disseminate tumour cells in surrounding tissues.

Conclusion

It is our conclusion that removal of giant lipoma should be performed through open surgery. It allows better visualization for complete removal, shows less recurrence, decreases risk of dissemination of a malignancy and may prevent damage to vital structures.



Fig. 4 Postoperative photo: 3 years after surgery

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