Large vulvar lipoma coexisting with cervical cancer in a 66-year-old woman

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Abstract

Lipomas are the most common benign mesenchymal tumor, composed of mature adipocytes. Vulvar lipomas are rare, making its association with neoplasia even rarer. We present a case of vulvar lipoma in a 66-year-old woman coexisting with cervical cancer. When admitted, the major issue of this case was whether the vulvar tumor, is a benign or malignant one and whether it can be linked to the cervical neoplasia.

Keywords: *cervical cancer, vulvar lipoma, surgical excision*

Introduction

Benign and malignant lipomatous tumors are the most common neoplasia of subcutaneous and deep soft tissues in adults[1]. Lipomas, as benign fatty tumors, are slow-growing and form soft, lobulated masses enclosed by a thin, fibrous capsule. Although it has been hypothesized that lipomas may rarely undergo sarcomatous change, this event has never been convincingly documented and it is more probable that lipomas are at the benign end of the spectrum of tumors, which, at the malignant end, include liposarcomas[2,3].

We report a rare case of a large vulvar lipoma coexisting with cervical cancer.

Case Report

A 66-year-old female patient, from rural area, referred to the hospital for three days vaginal bleeding and a lump at the right labia majora.

Clinical examination revealed a 12/11 cm well defined tumor at the right labia majora, cystic-renitent in consistency, mobile on the deep and superficial planes, without retracting the overlying skin cells, with no skin discoloration over it (Figure 1). The patient's history revealed that the labial tumor had a slow growth during the last 30 years, without affecting the skin's color and without any discharge from the mass. She was in post-menopause for 11 years and she experienced small vaginal bleeding during the last month, prior to the admission. Pelvic exam followed by cervix biopsy revealed a stage IIA moderately differentiated cervical squamous cell carcinoma (Figure 2).

Computed tomography (CT) of abdomen and pelvis reveals the cervix tumor and describes the right labial tumor as situated along the vaginal wall, extending along the internal edge of the proximal portion of the thigh, with fatty content, well defined, with thin walls, showing very small calcification in the lower and inferior aria; the described labial tumor has 10.5/6.5 cm in axial diameter and 9.7 cm in cranial-caudal diameter (Figure 3). The patient followed the proper oncologic treatment starting with teleradiotherapy 50Gy divided into 25 fractions. Surgical treatment for the labial tumor was taken in consideration one week after the radiotherapy ended; under general anesthesia a longitudinal elliptical incision of the right labia majora was performed incorporating an extra skin fold. The fatty lump was enucleated and excised (Figure 4). Histopathological serial sections of the vulvar tumor revealed lobulated mature adipose tissue, and the final diagnosis was lipoma, variant- fibrolipoma (Figure 5). The postoperative evolution had no incident and six month follow-up showed perfect recovery (Figure 6). The patient continued oncology treatment protocol for cervical cancer with 3 cycles of taxol plus carboplatin based chemotherapy and two sessions of brachytherapy.

Six weeks after the teleradiotherapy ended, the patient underwent the surgical treatment of cervical neoplasia - Wertheim's radical hysterectomy with pelvic lymphadenectomy was performed.

Discussion

The difficulty of this case regarding the vulvar tumor comes from the fact that it could be easily thought to be malignant.

Clinically, vulvar lipoma must be differentiated from Bartholin's cyst and can be misinterpreted as inguinal hernia[4,5]. The diagnosis can be sustained by using ultrasonography, computed tomography or magnetic resonance imaging, especially in differentiating the vulvar lipoma from a cyst.

Microscopically, vulvar lipomas need to be differentiated from liposarcoma or lipoma-like variants[6,7] aggressive angiomixoma[8], benign lipoblastoma like tumors[9] and granular cell tumors[10].

Although nonsurgical treatment for lipoma (like injecting steroids and liposuction) have become com-

Received: *February 14, 2013*
Revised: *March 17, 2013*
Accepted: *April 02, 2013*

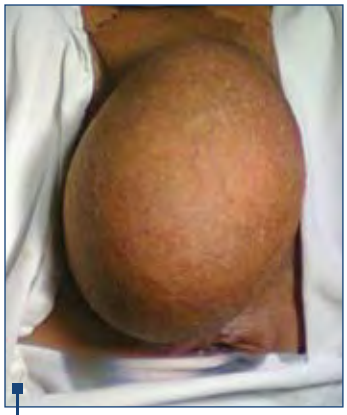

Figure 1. Right labia major tumor

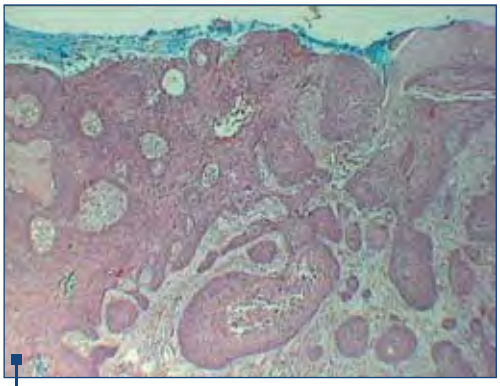

Figure 2. Cervix tumor section, moderately differentiated keratinized cervical squamous cell carcinoma (HEx100)

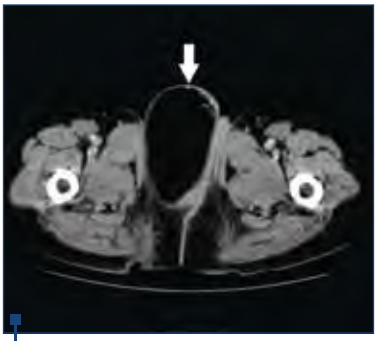

Figure 3. Computed tomography of abdomen and pelvis, showing right labial tumor well defined, thin walls, fatty content and very small calcification - white arrow

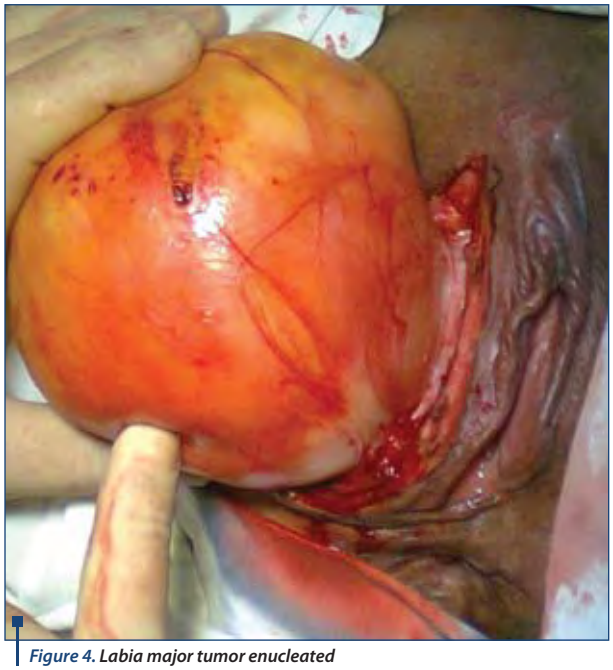

Figure 4. Labia major tumor enucleated

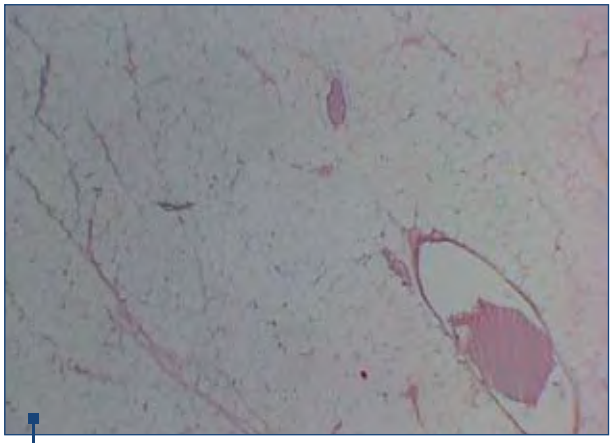

Figure 5. Section with mature adipocytes surrounded by fibrous connective capsule (HE x40)

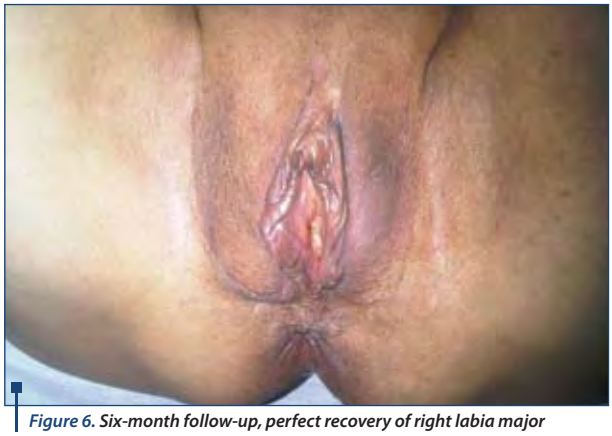

Figure 6. Six-month follow-up, perfect recovery of right labia major

mon, complete surgical excision remains the first choice treatment for vulvar lipoma[11].

Conclusions

The complexity of this case arises from this particular association between cervical cancer and vulvar lipoma, making it difficult to establish the correct diagnosis and to choose the best treatment method and its sequencing. ■

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