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World J Clin Cases 2019 September 6; 7(17): 2413-2657



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ABOUT COVER

Editorial Board Member of *World Journal of Clinical Cases*, Marianna Luongo, MD, Doctor, Surgeon, Department of Neurosurgery, Azienda Ospedaliera Regionale San Carlo, Potenza 85100, Italy

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The primary aim of the *World Journal of Clinical Cases (WJCC)* is to provide scholars and readers from various fields of clinical medicine with a platform to publish high-quality clinical research articles and communicate their research findings online.

The *WJCC* mainly publishes case reports, case series, research results and findings in the field of clinical medicine covering a wide range of topics including diagnostic, therapeutic, and preventive modalities.

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The *WJCC* is now indexed in PubMed, PubMed Central, Science Citation Index Expanded (also known as SciSearch®), and Journal Citation Reports/Science Edition. The 2019 Edition of Journal Citation Reports cites the 2018 impact factor for *WJCC* as 1.153 (5-year impact factor: N/A), ranking *WJCC* as 99 among 160 journals in Medicine, General and Internal (quartile in category Q3).

RESPONSIBLE EDITORS FOR THIS ISSUE

Responsible Electronic Editor: *Yan-Xia Xing*

Proofing Production Department Director: *Yun-Xiaojuan Wu*

NAME OF JOURNAL

World Journal of Clinical Cases

ISSN

ISSN 2307-8960 (online)

LAUNCH DATE

April 16, 2013

FREQUENCY

Semimonthly

EDITORS-IN-CHIEF

Dennis A Bloomfield, Sandro Vento

EDITORIAL BOARD MEMBERS

<https://www.wjnet.com/2307-8960/editorialboard.htm>

EDITORIAL OFFICE

Jin-Lei Wang, Director

PUBLICATION DATE

September 6, 2019

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INSTRUCTIONS TO AUTHORS

<https://www.wjnet.com/bpg/gerinfo/204>

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GUIDELINES FOR NON-NATIVE SPEAKERS OF ENGLISH

<https://www.wjnet.com/bpg/gerinfo/240>

PUBLICATION MISCONDUCT

<https://www.wjnet.com/bpg/gerinfo/208>

ARTICLE PROCESSING CHARGE

<https://www.wjnet.com/bpg/gerinfo/242>

STEPS FOR SUBMITTING MANUSCRIPTS

<https://www.wjnet.com/bpg/GerInfo/239>

ONLINE SUBMISSION

<https://www.f6publishing.com>

An extremely rare pedunculated lipoma of the hypopharynx: A case report

Qiang Sun, Chun-Lin Zhang, Zhao-Hui Liu

ORCID number: Khaled Algashaamy (0000-0002-4339-4404); Monica Garcia-Buitrago (0000-0003-1146-4284).

Author contributions: Liu ZH designed the study; Liu ZH, Liang YZ, and Sun Q contributed surgical treatment and follow-up data collection; Sun Q wrote the paper; Zhang CL revised the manuscript; all authors read and approved the final manuscript.

Informed consent statement: The patient gave informed consent. Consent was obtained from the patient for publication of this report and any accompanying images.

Conflict-of-interest statement: The authors have no conflicts of interest to declare. None of the authors have received funding from any organization with a real or potential interest in the subject matter, materials, equipment, software, or devices discussed.

CARE Checklist (2016) statement: The authors have read the CARE Checklist (2016), and the manuscript was prepared and revised according to the CARE Checklist (2016).

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Qiang Sun, Chun-Lin Zhang, Zhao-Hui Liu, Department of Otolaryngology Head and Neck Surgery, Affiliated Hospital of Zunyi Medical University, Zunyi 563000, Guizhou Province, China

Corresponding author: Zhao-Hui Liu, MSc, Chairman, Chief Doctor, Doctor, Full Professor, Senior Lecturer, Department of Otolaryngology Head and Neck Surgery, Affiliated Hospital of Zunyi Medical University, 149 Dalian Road, Huichuan District, Zunyi 563000, Guizhou Province, China. rzent@163.com

Telephone: +86-851-28608114

Abstract

BACKGROUND

Hypopharyngeal lipoma is a rare disease that can lead to asphyxiation after aspiration. Sclerotic lipoma in the hypopharynx is an extremely rare histological type. Hypopharyngeal lipoma should be resected in time after diagnosis.

CASE SUMMARY

An 86-year-old female patient presented to our department with a long pedunculated mass protruding from her mouth. Until this time, the patient had no dyspnea, dysphagia, or throat discomfort. Physical examination showed stable vital signs and clear consciousness. The pedicel was derived from the posterior wall of the hypopharynx. The tumor was smooth, hyperemic and dark red, about 10 cm long, and 4 cm wide. In order to prevent airway obstruction, the hypopharyngeal tumor was excised in emergent operation. The pharyngeal cavity was exposed by a mouth gag during the operation. A disposable plasma knife was used to completely remove the tumor along the base of the new organism, and no active bleeding occurred. The postoperative pathological results were sclerotic lipoma.

CONCLUSION

Lipoma in the pharynx is relatively rare. Patients with this condition must be referred immediately to Ear-Nose-Throat specialists and complete surgical excision should be performed as soon as possible to prevent serious complications, such as airway obstruction and death.

Key words: Hypopharynx tumor; Sclerotic lipoma; Plasma; Case report

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Manuscript source: Unsolicited manuscript

Received: April 22, 2019

Peer-review started: April 23, 2019

First decision: June 12, 2019

Revised: June 16, 2019

Accepted: June 26, 2019

Article in press: June 26, 2019

Published online: September 6, 2019

P-Reviewer: Bellan C

S-Editor: Cui LJ

L-Editor: Filipodia

E-Editor: Xing YX



Core tip: Sclerotic lipoma in the hypopharynx is extremely rare. We report a case of hypopharyngeal sclerotic lipoma in a female patient. The lipoma was removed with plasma radiofrequency at low temperature under general anesthesia. The patient had no discomfort in the hypopharynx after surgery. The pathologic findings, clinical feature, and treatment of the disease are presented and discussed.

Citation: Sun Q, Zhang CL, Liu ZH. An extremely rare pedunculated lipoma of the hypopharynx: A case report. *World J Clin Cases* 2019; 7(17): 2652-2657

URL: <https://www.wjgnet.com/2307-8960/full/v7/i17/2652.htm>

DOI: <https://dx.doi.org/10.12998/wjcc.v7.i17.2652>

INTRODUCTION

Up to date, less than 100 cases of pedunculated lipoma of hypopharynx have been reported^[1]. Most of them are fibrous lipoma, as shown in histopathology. We here report a rare case of sclerotic lipoma. The first case of pedunculated lipoma of hypopharynx was reported by Colchester in 1952 in a patient who died of asphyxiation due to sucking in the lipoma^[2]. Hypopharyngeal pedunculated lipoma grows slowly and generally has no obvious symptoms. When respiratory aspiration occurs, it can block the upper airway and kill the patient easily. The key to treatment is timely surgical resection.

CASE PRESENTATION

Chief complaints

An 86-year-old female patient presented to our department with a long pendulous mass protruding from her mouth (Figure 1).

History of present illness

The patient coughed up the mass in the morning and had no dyspnea or dysphagia until entering the hospital.

History of past illness

She had no history of surgery, chronic diseases, or allergies.

Personal and family history

She gave birth to two daughters, both *via* vaginal delivery, and she had no history of smoking or drinking. There was no similar history in the family.

Physical examination upon admission

A thick pendulous mobile mass was hanging outside the mouth, and the root was derived from the back wall of the hypopharynx. The surface of the mass was smooth and hyperemic. Other tests were normal.

Laboratory examinations

No abnormality was found in routine blood tests, biochemical tests, or electrocardiogram.

Imaging examinations

Postoperative chest computed tomography showed widened esophagus.

FINAL DIAGNOSIS

Sclerotic lipoma in the hypopharynx.

TREATMENT

The lipoma was removed with plasma radiofrequency at low temperature under



Figure 1 Mass protruding from the patient's mouth.

general anesthesia (Figures 2 and 3). The postoperative pathological results were fibrosclerosing lipoma, and immunohistochemistry was positive for vimentin, S100, and CD34 (Figure 4).

OUTCOME AND FOLLOW-UP

Electronic laryngoscopy showed good white membrane growth in the operative area 4 d after surgery. The patient had no discomfort in the hypopharynx.

DISCUSSION

Lipoma in the pharynx is relatively rare^[3], and accounts for 0.6% of the benign tumors of the pharynx^[4]. Lipoma is associated with endocrine factors, infection, chronic disease, infection, and heredity^[5]. Lipoma of the hypopharynx grows slowly and generally has no obvious symptoms. Only a few patients may present with dysphagia, reflux foreign body sensation, or cough^[6], but sudden airway blockage may occur^[7]. Most of the patients do not visit the emergency department for treatment until a rapidly increased abdominal pressure appeared, such as cough, and the tumor came out of the mouth. Our patient, who had no special sensation for a long time, was admitted to the emergency department of our hospital after coughing out the mass. To our surprise, the large tumor did not cause swallowing and breathing difficulties. The reason may be that the narrow peduncle of the lipoma can pass through the pharyngoesophageal sphincter, and the tumor body grows slowly in the esophagus, resulting in expansion of the esophagus. The slow process makes the body adaptable to the tumor in this patient. Enlarged esophagus was seen on postoperative chest computed tomography (Figure 5).

The most serious complication of hypopharyngeal lipoma is asphyxia death. Once the tumor is diagnosed, the patient is likely to suffer from airway obstruction within a short period of time, which should be monitored closely. The first reported patient with hypopharyngeal lipoma died of asphyxia due to aspiration^[4]. Therefore, timely surgical treatment is necessary. Currently, there are a variety of surgical approaches. Some authors recommend endoscopic resection for small lesions, while for tumors larger than 2 cm, open surgery is preferred^[7]. Others suggest that endoscopic surgery has advantages of quick recovery and less trauma to patients, and endoscopic resection may also be used for larger masses^[5,8]. In contrast to previous reports of similar cases, we used the plasma knife as the resection tool. The plasma knife has a good hemostasis function during the operation, keeping the field clear, and low temperature can minimize the damage to the surrounding tissues. Therefore, we recommend the plasma knife as a tool for tumor resection in similar cases. Specific tumor resection should refer to the size, location, and scope of the tumor as well as the experience of the surgeon. Considering that our patient was old and complicated with systemic diseases such as heart disease, we selected the plasma resection combined with endoscopic resection for tumor exposure by mouth gag. After the surgery, the patient was transferred to the ordinary ward and able to take a fluid diet. The patient and her family were satisfied with the treatment effect.

In this case, the pathologic type is sclerotic lipoma, which is a variant type in the pathological classification of lipoma and was first reported by Zelger *et al*^[9] in 1997. It

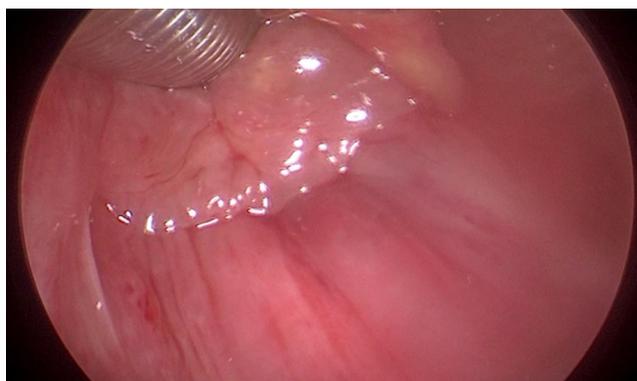


Figure 2 Root of lipoma was located in the posterior wall of the hypopharynx.

is characterized by spindle cells or fibroblast-like cells and dense intercellular matrix microscopically, in which fat cells are distributed^[10]. The structure is similar to fibroma, except that there are different numbers of fat cells in the background of fibrosclerosis. To date, less than 30 cases of sclerotic lipoma have been reported worldwide^[11], most of which occur in the limbs and scalp, and no literature has reported one on pharynx.

CONCLUSION

We report a rare case of hypopharyngeal pedunculated lipoma, and the pathological type is sclerotic lipoma. We recommend timely resection to prevent airway obstruction and death. Plasma resection is a good option during surgery.



Figure 3 Lipoma in contrast with a 20 mL syringe.

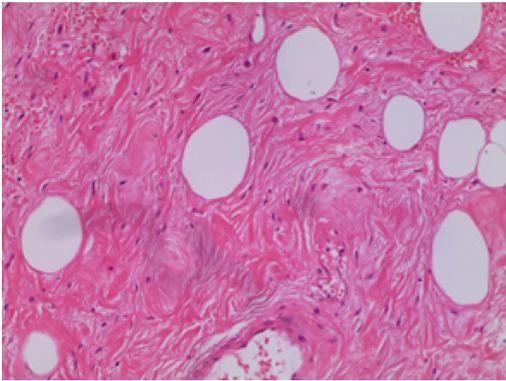


Figure 4 Histopathology revealed the distribution of adipocytes in dense fibrous tissue.

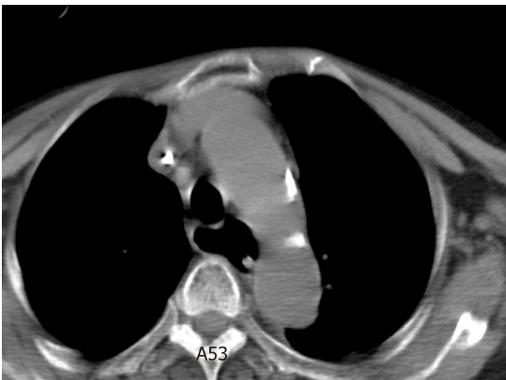


Figure 5 Postoperative chest computed tomography shows enlarged esophagus.

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