



Rare presentation of a giant occipital lipoma: A case report

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Abstract

Lipoma is a benign tumour arising from adipose tissue and is the most common mesenchymal tumour. We report a rare case of a large occipital lipoma in a 70 year old patient with a 20 year history of a slowly growing, painless occipital mass. On examination, the mass was soft, mobile, and about 10 cm in size. Ultrasound showed a well-defined, hypoechoic, non-vascular subcutaneous mass measuring around 11 cm, suggesting a lipoma. As the findings supported a benign nature of the mass, surgical excision under local anaesthesia was performed. The dissection was completed with meticulous haemostasis, allowing for complete removal of the tumour without any notable complications, and the postoperative course was uneventful. Lipomas are often diagnosed clinically, but radiological tests can help with larger lesions. Surgical excision is the preferred treatment since the presence of a pseudocapsule makes it relatively simple. Our case highlights that this tumour can grow large in unusual locations and that complete surgical excision gives a satisfactory outcome and prevents recurrence.

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Cite as: Othmane B, Omar L, Khedid YZA. Rare presentation of a giant occipital lipoma: A case report. *Impact Case Reports*, 1(1), 1-3. <https://doi.org/10.62463/icr.260>

Introduction

Lipoma is a benign tumour that develops from adipose tissue, making it the most common mesenchymal tumour¹, with an incidence of 1 in 1,000². It frequently occurs in areas rich in subcutaneous fat, such as the trunk, shoulders, and limbs, with less frequent involvement of the head and neck³. We report a rare case of a giant occipital lipoma, treated surgically with good postoperative outcomes. This article aims to highlight the potential development of this tumour, which can reach considerable sizes in unusual locations.

Case description

We report the case of a 70 year old patient with no notable medical history, who presented with a 20

year history of a slowly growing occipital mass. The swelling had progressively increased in size without pain or other associated symptoms.

Clinical examination revealed a soft, painless, mobile mass in the deep plane, measuring approximately 10 cm in its largest diameter, with no signs of inflammation (Figure 1). An ultrasound was performed, which identified a well-defined, hypoechoic, non-vascularised subcutaneous mass measuring about 11 cm in its largest diameter, suggestive of a lipoma. Given the clinical and radiological findings supporting the benign nature of the mass, we decided to proceed with surgical excision under local anaesthesia. We began infiltration with adrenaline-lidocaine, then a



horizontal skin incision of approximately 10 cm was made. The underlying muscular plane was dissected to access the tumour, and the dissection was then completed with meticulous haemostasis, allowing for complete removal of the tumour without any notable complications (Figure 2). The surgical site was irrigated with betadine saline solution, and closure was performed layer by layer. The postoperative course was uneventful, and the histopathological examination of the excised specimen confirmed the diagnosis of a lipoma.



Figure 1: Preoperative image of the occipital tumour

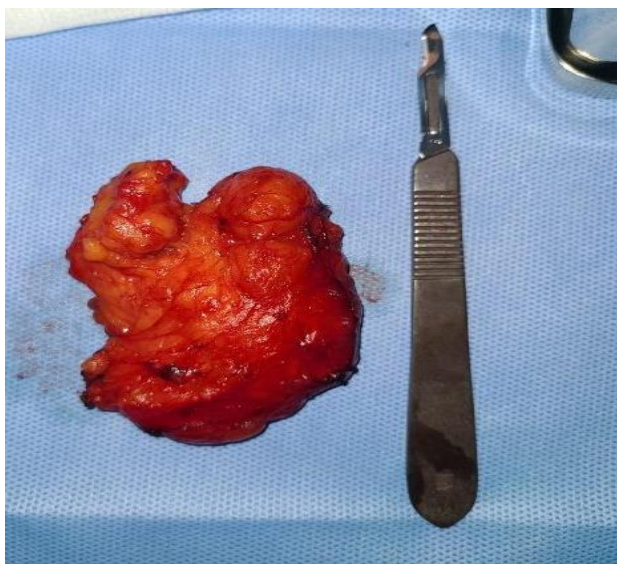


Figure 2: A lipoma measuring approximately 11 cm, which was completely excised.

Discussion

A lipoma is a benign adipocytic tumour that develops from adipose tissue. Two types of lipomas can be distinguished: superficial (subcutaneous) lipomas and deep lipomas⁴. It is a painless, slow-growing tumour that can develop in any fatty region of the body, although its occurrence in the cervical and head regions remains relatively rare. In fact, the tumour can develop at varying depths within soft tissues, and its clinical appearance can range from a small, well-defined mass to a large, poorly circumscribed, and lobulated mass⁵. The diagnosis of a lipoma is most often clinical; however, in certain cases, radiological tests such as ultrasound, CT scans, or even MRI may be used, particularly for large lesions or diagnostic uncertainty. In our case, an ultrasound was performed, confirming the benign nature of the lesion. The imaging revealed a hypoechoic, well-circumscribed mass with well-defined borders and no hypervascularisation, measuring 11 cm in its largest diameter. CT scans may reveal a fatty-density lesion with or without a capsule, while MRI shows a lesion with the same signal intensity as subcutaneous fat⁷.

The treatment of choice for lipomas is surgical excision, which is relatively straightforward due to the presence of a pseudocapsule⁷. In our patient, the excision was performed along a cleavage plane, step by step, while preserving adjacent structures, along with meticulous bipolar haemostasis. The procedure was uneventful, and the immediate postoperative outcome was satisfactory.

Histopathological examination of the lesion confirmed the diagnosis of a lipoma, which macroscopically appeared as a soft, yellow, encapsulated mass. Microscopically, it showed a tumourous proliferation of well-differentiated adipocytes without atypical mitoses⁸.

Conflict of Interest Statement: The authors declare that there is no conflict of interest regarding the publication of this article.

GAIT for Generative AI use: Generative AI was not used in the preparation or editing of this article. The authors take full responsibility for the accuracy and integrity of the work.

Patient Consent Statement: The authors have obtained full written and informed consent from the patient for the publication of this case report, including all accompanying images.



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