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Giant vulvar lipoma grossly mimicking inguino-scrotal hernia: A case report and literature review

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Abstract
Lipoma is a benign soft tissue lesion of the subcutaneous fat that can affect different parts of the body. The lipoma of the vulva is rare with only few cases reported so far. The affected females may also delayed presentation due to the location in the external genitalia that are usually covered with clothing and also due to shyness in exposing the site of the lesion for clinical examination and imaging evaluation. Sometimes, lipoma that is located in the vulva may also lead to sexual deprivations from spouses of the affected females for aesthetic reasons. The clinical diagnosis is usually based on history of progressive vulvar swelling over a period of time, clinical examinations, imaging modalities (such as ultrasound, computed tomography and magnetic resonance imaging) and subsequent histopathological confirmation. Herein, we present a case of giant left vulvar lipoma that grossly mimics an inguinoscrotal hernia at a rural hospital in South-Western Nigeria.

Keywords: Vulvar lipoma, giant, inguinoscrotal mimicry, surgical excision, rural hospital, case report

Introduction
Lipomas are benign tumours arising from the subcutaneous tissue in any parts of the body. Vulvar lipoma is very rarely seen with only few cases reported in the past years [1, 2]. The aetiological factors are generally unkmown but lipomas are seen in all age groups but common between the 4th and 6th decades of life [1, 3]. The clinical presentation is typically in form of progressive swelling and discomfort in the affected part of the body [3, 4]. Lipomas are usually painless but may be associated with pain depending on the size, location (especially around joints), compression on nerves and deprivation of blood supply [5]. In addition, lipoma located in the vulva may be distressing to young women due to aesthetic concerns [3, 6]. The diagnosis is usually through the history of slowly progressive swelling, clinical examination, imaging evaluation and histopathological confirmation [3, 7, 8]. In low and middle income countries where resources are limited, imaging such as Magnetic Resonance Imaging (MRI) may be too expensive but this should not in a way hamper the clinical skills and ultrasound scan imaging in the diagnosis of lipoma [3, 7]. We present this case due to the giant size, the location, the inguinoscrotal hernia mimicry and marital disharmony that resulted from the lesion due to aesthetic concerns.

The Case
A 32 year old para 1 + 0, 1 alive presented to the general outpatient department of the Federal Teaching Hospital, Ido-Ekiti with history of progressive left vulvar swelling of 0 years duration. She had no history of trauma to the perineum and no abdominal pain, vomiting or constipation. There was no similar swelling in other part of her body or in any of her siblings. She had no remarkable past medical, obstetric and gynaecological findings. Social history revealed that her husband had separated from her on account of this vulvar lesion stating aesthetic concerns. She then presented to the outpatient department due to the giant size and the need to reunite with her husband. She was subsequently referred to the gynaecological clinic where she was further evaluated clinically and a working diagnosis of Giant (about 12cm long) left vulvar lipoma was made with differentials of inguinoscrotal hernia, femoral hernia and liposarcoma. She was counseled on the need to have surgical excision with specimen send for histopathological evaluation.

Preoperative workup

Patient vital signs were stable. Within the ambit of the available resources, she had full blood count, fasting blood glucose and serological screening with results within normal limits. Ultrasound scanning of the lesion showed no evidence of communication with intraabdominal cavity. She could not do MRI due to financial constraint. She subsequently gave her consent for surgical excision.

Intraoperative care and findings

Regional anaesthesia in form of saddle block was administered and she was put in lithotomy position followed by aseptic skin preparations and drappings. Patient had surgical excision with complete removal of the capsule (Figures 1 and 2). The defect from the operative site was surgically closed in layers with skin repair interruptedly using a non-absorbable suture (Nylon 2/0). She had intravenous antibiotics and parenteral analgesics. She was then transferred to the recovery room. Her vital signs were within normal limits. The procedure was well tolerated. She was moved to the gynaecological lying-in ward to continue post-surgical care.

Postoperative care

On postoperative day 1, she had her medications changed to tablet amoxicillin clavulanic acid 625mg twice daily, tablet metronidazole 400mg three times daily and oral multimodal analgesics. Wound dressing was changed due to blood stain and urethral catheter was removed. She was given appointment for follow-up clinic visit for two weeks. Her histology report was available which confirmed lipoma (Figure 3).

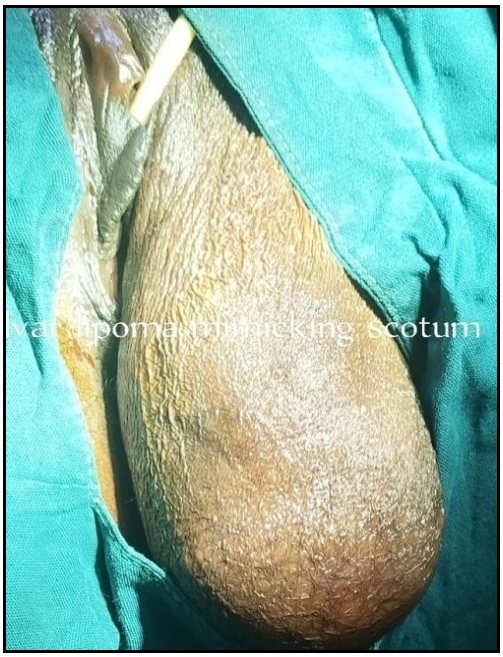
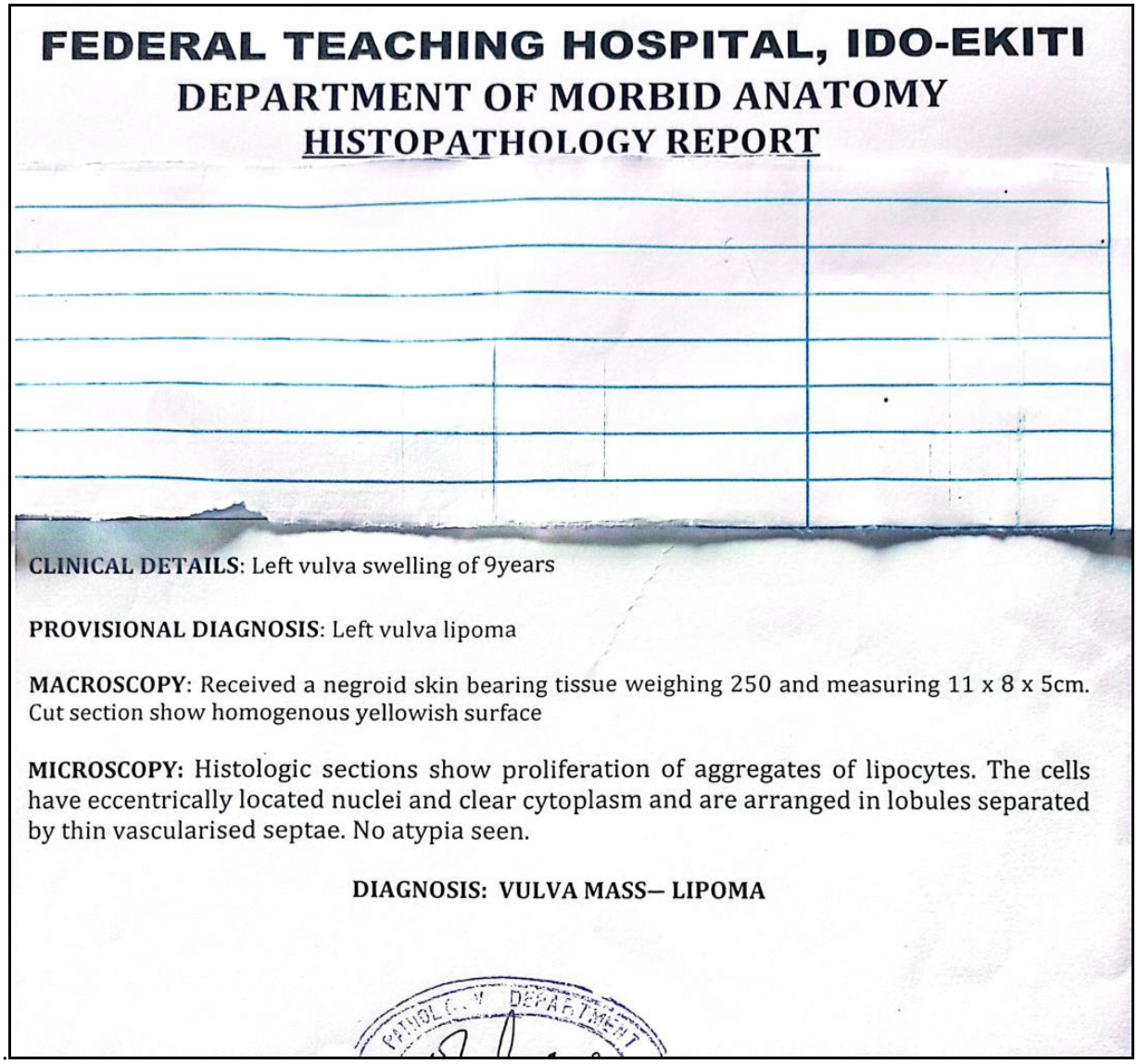


Fig 1: Giant left vulvar lipoma

Fig 2: Intraoperative picture of surgical site



FEDERAL TEACHING HOSPITAL, IDO-EKITI
DEPARTMENT OF MORBID ANATOMY
HISTOPATHOLOGY REPORT

CLINICAL DETAILS: Left vulva swelling of 9years

PROVISIONAL DIAGNOSIS: Left vulva lipoma

MACROSCOPY: Received a negroid skin bearing tissue weighing 250 and measuring 11 x 8 x 5cm. Cut section show homogenous yellowish surface

MICROSCOPY: Histologic sections show proliferation of aggregates of lipocytes. The cells have eccentrically located nuclei and clear cytoplasm and are arranged in lobules separated by thin vascularised septae. No atypia seen.

DIAGNOSIS: VULVA MASS– LIPOMA

Fig 3: Report of histology confirming the mass to be lipoma
(Non-identification seal applied for ethical reasons)

Discussion

Vulvar lipoma is a rare benign tumour arising from the subcutaneous tissue of the vulva and characterized by its slowly progressive growth [1, 2, 3]. This tumour is considered harmless but affected young women may be uncomfortable and have aesthetic problems with low self esteem [1, 3].

Our case presented with left labial, soft, non-tender, mobile mass that mimic inguinoscrotal hernia. The aetiological factors are not certain but genetic predisposition and trauma may be risks for its development [9, 10]. The differentials of the diagnosis of vuvar lipoma include liposarcoma, epidermoid cysts, Bartholin's gland cyst inguinoscrotal hernia, angiomyofibroblastoma-like tmours, among others [11]. The gross appearance in this case has a resemblance of inguinoscrotal hernia. Her mode of presentation clearly showed a progressive, slowly growing swelling which was not affected by supine or upright positions. Imaging modalities needed for the diagnosis included ultrasound scanning, Computer Tomography (CT) and MRI [3, 7, 8]. This patient had only ultrasonographical evaluation that revealed benign features in keeping with lipoma. Magnetic Resonance Imaging has high specificity for soft tissue and hence the preferred imaging modality [5], but our patient could not do this due to financial constraint. Therefore, her diagnosis was mainly clinical with ultrasound imaging support to arrive at the working diagnosis of giant left labial (vulvar) lipoma.

The gold standard of treatment is surgical excision with complete removal of the capsule to prevent recurrence [3, 12]. This patient had a surgical excision of the whole lipoma and the repair of the dead space defect left behind after the removal of the mass. Other options of care are expectant (conservative) especially for asymptomatic, liposuction and laser treatment depending on the symptoms, size, available medical facilities and aesthetic issues [12]. It is important to exclude malignancy in any growth despite benign-looking appearance, making histological evaluation to be impeccable [3]. The specimen removed from this patient was sent for histological review which confirmed a lipoma. Finally, this patient was seen in the follow up gynaecological clinic with satisfactory wound healing.

Conclusion

Benign lesions of the vulva are commonly seen in females across all age groups but when they occur in young married women, they have implications on the reproductive health of

the affected individuals as seen in our case with giant left vulvar lipoma making sexual penetration challenging and scaring her spouse due to the big size and gross appearance. She did not present for medical care as a result of the shyness and negative feelings of being mocked. This perception was debunked by the expertise of the managing team. We, thus, report this case to the scientific world to sensitize our female folks and health professionals about early presentation and prompt referral respectively, of surgically amenable lesions to the hospital for expert care.

Limitations: This is a case report in which the history, examination findings and surgical intervention might be due to individual patient's peculiarity and that of the managing team. Preoperative investigations were also limited by the available resources leading to MRI not being carried out in the reported case. Findings cannot be true for all cases. Further studies may be necessary to justify steps taking in the surgical management of this case.

Authors' Contribution

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Postoperative care: Mathew Olumide Adebisi, Olalekan Oladipupo Rosiji, Oluwasesan Bamidele Afolabi, Adewale Amerijoye

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All authors read and approved the final manuscript

Additional Information

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