CASE REPORT

Case of a Giant Necrotic Fibrolipoma inducing Early Sepsis

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Abstract:

Very few cases of giant fibrolipomas are listed in literature and there are none upon our review that list abscess and necrosis within the mass. Fibrolipomas represent a rare benign skin growth that typically are small in size.[1] These lesions classically grow very slow, cause no systemic problems, and rarely require more than simple excision. In this case review, we discuss a rare case in which an ulcerated and infected mass caused sepsis with hypotension, tachycardia, and a leukocytosis of 31,000. This fibrolipoma was also much larger than any mass mentioned in present day literature and a staged closure including negative pressure therapy and delayed local advancement flaps were required to get complete closure.

I. Introduction:

Giant fibrolipomas are masses greater than 10cm or 1000 grams and have the composition of mature fatty tissue with extensive fibrous tissue on histopathology.[2] They are a subset of the very common lipoma and as such can be

located anywhere but tend to have a predisposition for the oropharynx, esophagus, intestinal mesentary, and pancreas.[3] Fibrolipomas are histologically similar to lipomas containing mature adipose tissue but contain abundant amounts of fibrous tissue. There can be varying degrees of fibrosis depending on the lesion itself accounting for the variances in appearance.[2]

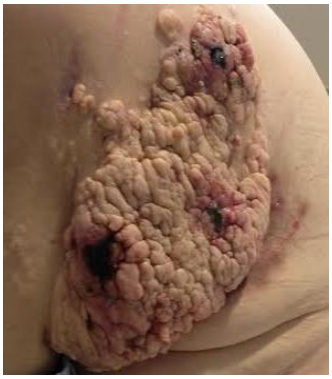

Figure 1: Left Posterior Fibrolipoma

II. Patient Case Presentation:

This is a case of a 59-year old female with a history of diabetes presents with a large left sided upper back mass extending to the lateral edge of the axilla. Pt reports the mass has been present since the 7th grade but over the last couple of weeks it has begun to ulcerate, drain, become tender, and developed a malodorous smell. She also complained of nausea, vomiting, and subjective fevers on presentation. She was found to have a white blood cell count of 31,000, intermittent tachycardia and hypotension. The patient was resuscitated and we discussed treatment options. Due to the sepsis and infected nature of this mass surgical excision was agreed upon. Neither chemotherapy nor radiation play a role in the treatment of fibrolipoma other than the rare circumstance the lesion is proven malignant. Once in the operating room the mass was confirmed to be fungating and measured 31cm x 16cm x 7cm with multiple areas of malodorous myonecrosis and abscess pockets extending deep into the triceps, teres major, teres minor, proximal biceps, and infraspinatus muscles. Extensive debridement including muscle was carried

out and a wound vac placed. Later the patient was brought back and underwent further debridement and primary closure using local advancement flaps with drain placement. Final pathology revealed a fibrolipomatous polyp with ruptured epidermal cyst, secondary abscess formation, and focal necrotic lesions, all negative for malignancy.

Figure 2: Delayed Primary Closure

III. Discussion:

There has been very scarce information relating to giant cutaneous fibrolipomas to date. These masses are a variant of the very common (2.1 per 1000 people) lipoma. They tend to be nonmalignant, slow growing, and predominantly affect men (with a male to female ratio 3:1) in their 40's to 60's.[4,2,5,6] Fibrolipomas are much more commonly found internally in mucosal surfaces of the oropharynx. Based on the literature review fibrolipomatous masses of the skin are exceedingly uncommon. These lesions tend to be slow growing and very rarely convert to their malignant counterpart, the liposarcoma, however the larger the lesion the greater the risk.[2] Our case appears to be rare in nature for multiple reasons. First is the morphology of the lesion. Current literature reports primarily mucosal lesions and scarce cutaneous lesions. None have a fungating and ulcerated morphology characteristic of this lesion. Also the nature of presentation is very different. No papers appear to have a presentation of myonecrosis and infection of these lesions as a source of sepsis.

IV. References:

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