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Retropharyngeal lipoma

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A RETROPHARYNGEAL swelling is a rare and interesting condition. Only seventeen cases of retropharyngeal lipoma (Putney and Fry., 1940, 15 cases; McFarland, 1948, 1 case; Kurilion, 1976, 1 case) and one of fibrolipoma (Toppazada and Gaafar, 1975) have been described in the literature. A further case of a large retropharyngeal lipoma is reported.

Case report

C.M., a 71-year-old man, was referred by his general practitioner with a history of noisy breathing for eighteen months which had become worse over the last two months. This was insidious in onset and was not accompanied by dysphagia, hoarseness, pain or loss of weight. He had also been aware of a feeling of a lump in his throat for two years. Eleven months earlier he had consulted his doctor but no cause was found for his symptoms. An X-ray of the chest at that time had shown tracheal compression, possibly due to an enlarged thyroid. The patient, being a very active man, was not bothered by his symptoms and did not report to his doctor again until a week before presenting to us.

There was no other relevant history except difficulty in breathing noticed nearly two years earlier while recovering from anaesthesia after prostatectomy. He was re-intubated with an endotracheal tube and observed in the Intensive Care Unit for 24 hours. His breathing improved as he regained consciousness. The anaesthetist had noticed at the time of intubation a 'collapsed hypopharynx' and had recommended an E.N.T. opinion which was not sought as the patient had had no further breathing problems.

E.N.T. examination was normal except for a large, smooth, soft cystic retropharyngeal mid-line mass which was covered with normal intact mucosa. This mass occupied part of the oropharynx and extended into and below the hypopharynx, pushing the larynx forwards. The lower limit of the mass could not be seen. There were a few lipomas on his trunk and arms but these were neither tender nor painful.

X-rays of the soft tissues of the neck revealed a large retropharyngeal soft-tissue mass which was pushing the larynx and trachea forwards (Fig. 1). There was no evidence of bony erosion. Tomography of the thoracic inlet (Fig. 2) suggested that the mass extended into the thorax with its lower limit at D.2.

Taking into consideration the long history it was assumed that the mass was benign so it was decided to explore the neck through an external approach rather than to take a per-oral biopsy. At operation the mass was found to have splayed open the carotid sheath, and the internal jugular vein had to be divided to dissect out the soft lobulated mass by blunt dissection. The mass measured 12 cm × 8 cm × 4 cm and histological examination proved it to be a lipoma.

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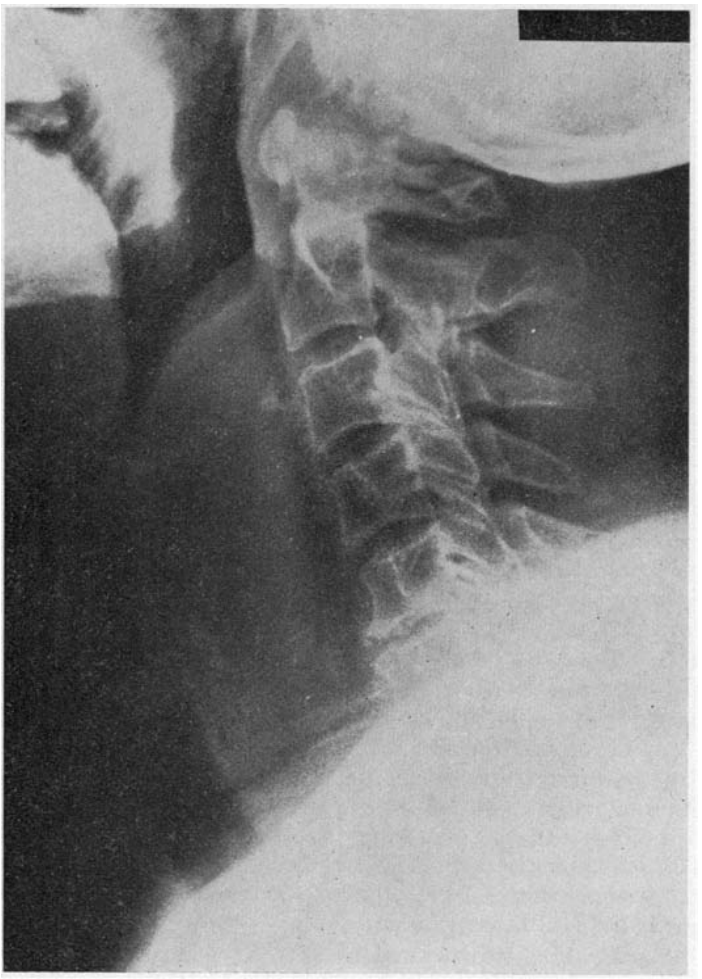


FIG. 1
Lateral view of neck showing the mass.

Discussion

Anatomically, the retropharyngeal space of Gillette is bound by the pharynx anteriorly and the prevertebral cervical fascia posteriorly. Superiorly it is limited by the base of the skull, while inferiorly it is continuous with the posterior mediastinum through the superior mediastinum. Antero-laterally lies the parapharyngeal space which communicates with the posterior triangle through the space behind the carotid sheath and its contents. This space is divided by a tough median raphé which connects the prevertebral fascia with the fascia covering the pharynx. It is filled with loose cellular tissue and contains paired median and lateral lymph glands which tend to disappear in early childhood. Swellings appearing in this space can arise from any of these struc-

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FIG. 2
Tomogram of soft tissue in neck showing the lower limit of the mass.

tures, or may be part of a swelling of the parapharyngeal space. A swelling of the posterior pharyngeal wall can be classified as:—

(A) *True retropharyngeal swelling* when it arises *in situ* from structures normally present in the space. These can be

(i) *Developmental*—Angiomatous lymphoid hamartoma (Lee *et al.*, 1974), chordoma (Despons *et al.*, 1970)

(ii) *Traumatic* —Foreign body abscess (Gupta, 1972).
Haematoma (Kurilion, 1976; Lee *et al.*, 1974; Miller, 1970).

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(iii) *Infective* —Acute retropharyngeal abscess.
Chronic retropharyngeal abscess.
Hyperplastic lymph glands seen in children with chronic adenoiditis.

(iv) *Neoplastic* —(a) *Benign* Lipoma (Kurilion, 1976; McFarland, 1948; Putney and Fry, 1940).
Fibroma
Fibrolipoma (Toppozada and Gaafar, 1975).
Osteoma
Osteochondroma (Paulsen, 1972)

(b) *Malignant*
Primary —Fibrosarcoma (Goldman, 1970).
Lymphoma
Leiomyosarcoma
Metastatic—from carcinoma of maxillary antra and post-nasal space.

(v) *Iatrogenic* —Haematoma (Owens *et al.*, 1975).

(B) *Parapharyngeal* swelling extending into the retropharyngeal space—
Aneurysm (Figi and Hunt, 1927)
Thyroid papillary adenoma (Cavazzani, 1968)
Parotid gland tumour (Work *et al.*, 1963)
Neurofibroma

(C) *Submucosal lesions* of the pharynx can also be confused with a true retropharyngeal swelling.
—Ectopic pleomorphic salivary adenomas
Plasmacytoma
Nasopharyngeal carcinoma (Lee *et al.*, 1974).

Summary

A rare case of lipoma of the retropharyngeal space is reported and an attempt has been made to classify swellings arising in the retropharyngeal space.

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