Retropharyngeal lipoma

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Lipoma of the pharynx is very rare. Toppozada *et al.* (1973) found 48 cases in the literature, and reported 4 more cases of their own. They summarized the aetiology, symptomatology and treatment of their cases. The site of origin of pharyngeal lipomata may be in practically any site of the pharyngeal wall: pharyngo-epiglottic, ary-epiglottic, glosso-epiglottic folds, valleculae, rarely the choanal edge, palato-pharyngeal fold or the lateral hypopharyngeal wall, the nasopharyngeal vault, the region of the torus tubaris or the upper surface of the soft palate (Laskiewicz, 1962).

The present case is reported for its rarity, and for being the first to arise in the retropharyngeal space.

Case report

A female, aged 37 years, presented in February 1974, complaining of slowly progressive dysphagia to solids and altered speech of one and half years' duration. Examination revealed a smooth bulge of the posterior pharyngeal wall, by a swelling extending through the oro-, naso-, and hypo-pharynx. Upwards it reached above the soft palate to the level of the eustachian tubes and downwards to the level of the post cricoid region. It occupied the posterior pharyngeal wall on the left side, reaching to the posterior pillar but not displacing the tonsil. It crossed the mid-pharyngeal line to the right side. The soft palate was displaced slightly forwards by the swelling. The mucosa of the pharynx was normal, smooth and intact. The swelling was fleshy in consistency, but no fluctuation was elicited. No definite borders were identified as the swelling sloped gradually to the pharyngeal walls. No enlarged cervical lymph nodes were detected. Blood picture was normal. Radiograms demonstrated a soft tissue shadow in the region of the posterior pharyngeal wall extending from the base of the skull to the upper border of the fourth cervical vertebra (Fig. 1).

As no definite diagnosis could be made, the condition suggesting a benign tumour, excisional biopsy was undertaken.

Under general peroral endotracheal anaesthesia, using gas and oxygen, a Doughty's slotted mouth gas was introduced. A self-retaining soft palatal retractor (Toppozada, 1962) was fitted in place. Submucosal infiltration with adrenaline solution 1/10,000 behind the left posterior pillar was done. An incision along this line was deepened until a capsular layer was located. Dissection was carried out smoothly around the capsule being a little more adherent in the part overlying the prevertebral muscles. The tumour was removed in one piece (Fig. 2), it measured 9×7 cm. in diameter. The pharyngeal wall was repositioned and stitched with 000 catgut to include the mucosal and muscle layers. The patient was given general antibiotics and recovery was uneventful.

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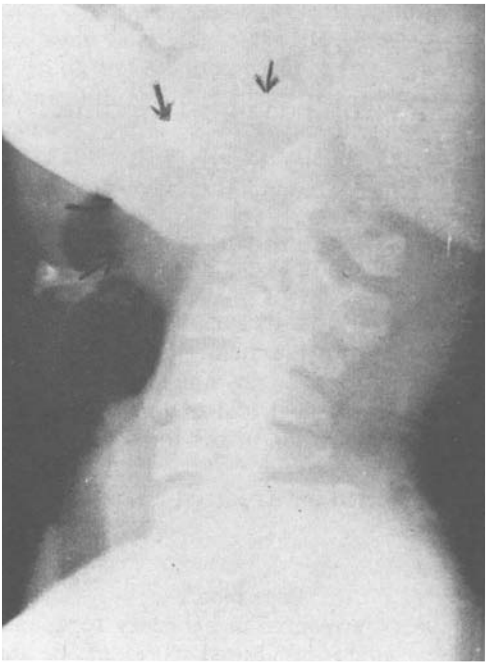


FIG. 1.
Plain lateral soft tissue radiography of the pharynx showing the shadow of a soft tissue retropharyngeal lipoma.

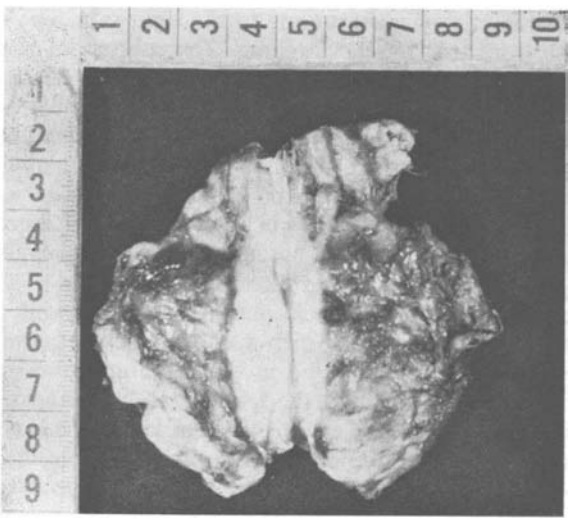


FIG. 2.
Removed lipoma with cut surface.

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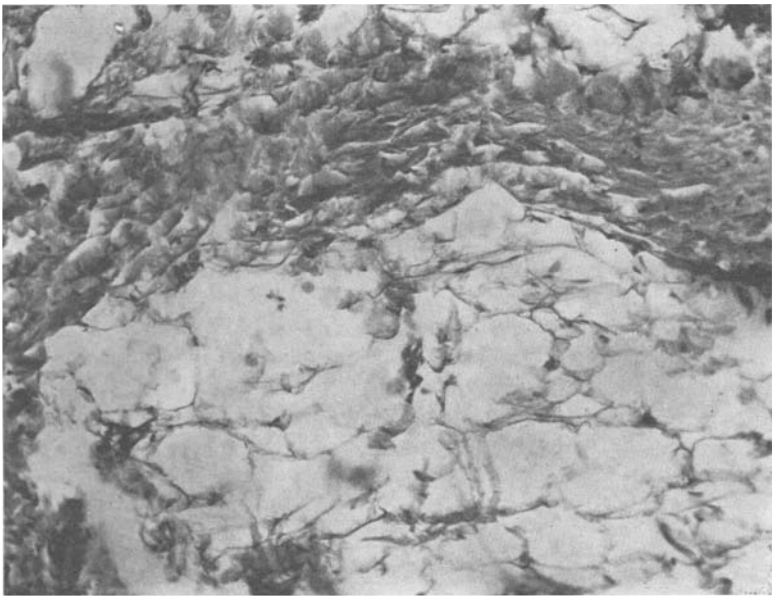


FIG. 3.
Fibrolipoma. Fat cells intersected by fibrous strands.

Pathological examination of the mass removed revealed fat cells intersected by fine fibrous strands (Fig. 3) with a dense fibrous tissue, capsule, a picture of fibrolipoma.

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