

Spindle Cell Lipoma of The Spermatic Cord Accompanying Pheochromocytoma

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ABSTRACT

Spindle cell lipoma is a rare lipoma, originates from subcutaneous tissue and mostly seen at back region. In this case report we represent a case with inguinal mass misdiagnosed as inguinal hernia and then diagnosed as spindle cell lipoma. There are two cases in literature with spindle cell lipoma originating from spermatic cord. This case is unique as having both pheochromocytoma and inguinal spindle cell lipoma mistaken as inguinal hernia.

Key words: Lipoma, diagnostic error, spermatic cord, inguinal hernia

Feokromasitoma'nın Eşlik Ettiği Spermatic Kordun İğsi Hücreli Lipoması

ÖZET

İğsi hücreli lipom subkutan dokulardan kaynaklanan genellikle sırt ve ensede görülen nadir bir lipom çeşididir. Bu olgu sunumunda sol kasığında fıtıkla karışan kitlesi mevcut olan ve daha sonra bu kitlenin iğsi hücreli lipom olduğu saptanan hastayı sunduk. Literatürde daha önce 2 defa spermatic kord kaynaklı iğsi hücreli lipom bildirilmiştir. Bu olgu sunumu feokromasitomayla birlikte olan ve kasık fıtığıyla karışan literatürdeki ilk iğsi hücreli hücreli lipom olma özelliğine sahiptir.

Anahtar kelimeler: Lipoma, tanısız hata, spermatic kord, inguinal herni

INTRODUCTION

Spindle cell lipoma (SCL) is a rare kind of lipoma that is originated from the subcutaneous tissue and first defined in 1957. It is mostly located at back and shoulders. It is mostly seen in man over 40 years (1). Besides its common localizations SCL was reported to locate in rare localizations like reitsius cavity, breast and mouth (2-4). At literature search, there were only 4 case reports about SCL (5-7). We present our case as the first case of SCL accompanying pheochromocytoma and mimicking inguinal hernia.

CASE

58 years old male patient admitted to hospital with complaint of swelling in left inguinal region for 4 years. The swelling had been growing during last 4 years.

Three months ago, he was operated with a diagnosis of left inguinal hernia, under spinal anesthesia. During the process of operation, the surgeon had told him that orchietomy had been needed to excise the lump. The patient did not accept the operation and the operation had been stopped. He was discharged from the hospital.

At physical examination there was operation scar and a lumb of 10x10x5 cm, located at inguinal region. At magnetic resonance imaging (MRI) there was a mass lesion spreading from the inguinal region to scrotum, measuring 7,5x7x4,5 cm. The lesion had hypointense fibrous capsule in T2A and T1A images, hypointense fibrous septations and seen as suppressed at fat suppressed sequences (Figure 1,2). We performed through-cut biopsy and it was diagnosed as SCL. During the evaluation of the patient he had hypertensive attacks. With endocrinologic evaluation, the pheochromocytoma at left surrenal gland was identified. The patient kept normoten-

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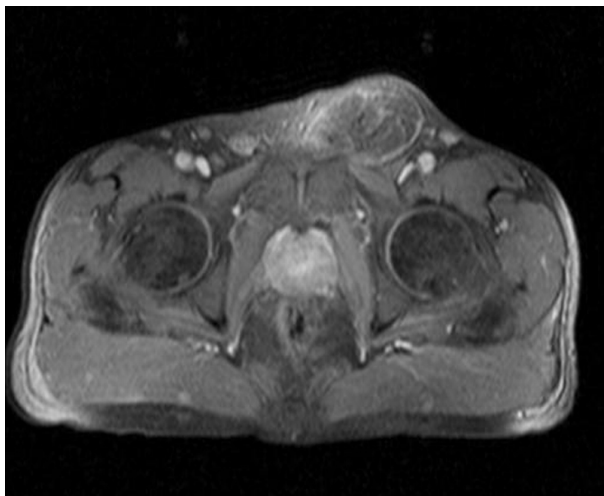


Figure 1. MR image of lipoma

sive with medical treatment. Left adrenalectomy was planned. The patient wanted to get rid of the mass at inguinal region in despite of orchiectomy. Laparoscopic left adrenalectomy was performed and at the same session the mass was excised with left testis and the spermatic cord. The histopathologic evaluation revealed the diagnosis of SCL and pheochromocytoma. The histopathological examination of the tumor revealed a well-circumscribed lesion with features of spindle cell lipoma. This tumor displayed mature adipose tissue mixed with uniform spindle cells within the vascular stroma (Figure

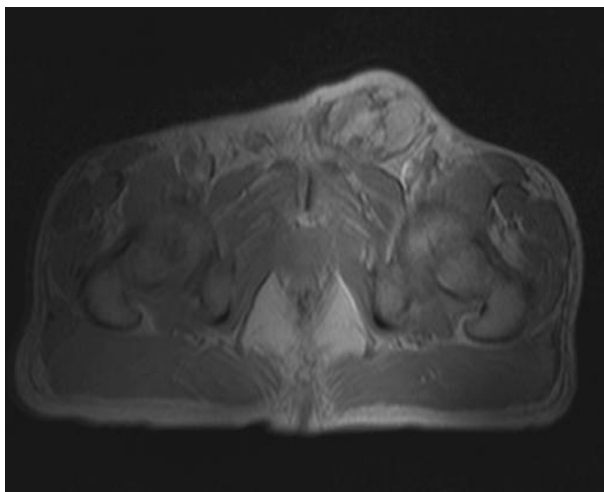


Figure 2. MR image of lipoma

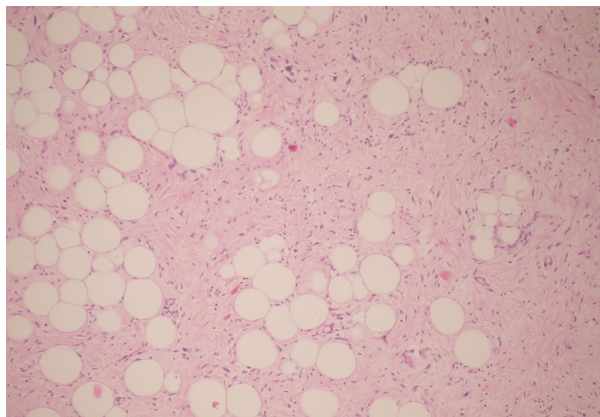


Figure 3a. H&E staining shows adipose tissue and spindle cells

3a). Immunohistochemical studies showed that spindle cells stained positively for CD34 (Figure 3b) and vimentin, helping to confirm the diagnosis of spindle cell lipoma. Spindle cells were not positive for S-100 protein.

DISCUSSION

SCL is a solid benign neoplasia mostly seen in old men and located at back and shoulders (1). More than 75% of the SCL is seen in men between 40-60 years. Classical lipomas are seen 60 times more than the SCL and SCL consists 1,5% of the adipocytic neoplasia (6). Üstündağ et al. classified the lipomatous tumors according to Ezginger and Weiss classification. There were 843 lipo-

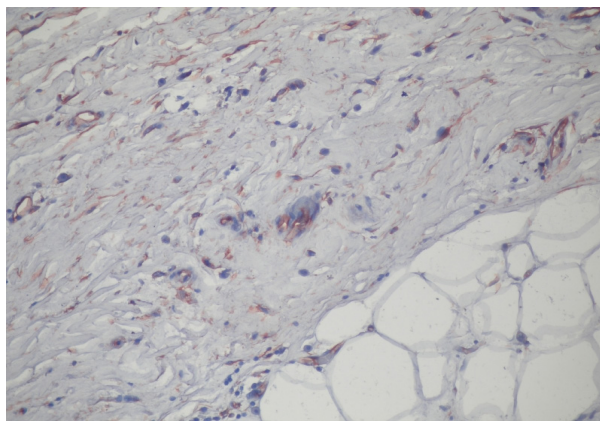


Figure 3b. CD 34 expression in spindle cell lipoma

matous tumors and 799 of the were benign whereas 44 were malignant. Ten (1%) of the cases were diagnosed as SCL. Assuming the cases with SCL, the mean age was 58, male to female ratio was 4, mean diameter was 7.1 cm, the largest diameter was 21 cm and the most common localization was head and neck region (43%) (5). Although SCLs are benign tumors they are mostly mixed with malignant tumors like spindle cell liposarcoma, myxoid liposarcoma and well differentiated liposarcoma. In recent studies, all SCLs are detected as CD34 positive and actin, laminin and desmin negative (9). In present case the cells were immunopositive for CD34 and vimentin. Liposarcomas are CD34 negative therefore, easily differentiated from SCL. In cytogenetic studies, deletions in 16q and 13q are detected in SCL (10).

As the most of the liposarcomas located in spermatic cord are well differentiated but have a high rate of local recurrence, differentiation of SCL located in spermatic cord from liposarcoma is very important (8). It is kept in mind that, besides the histopathological differential diagnosis they can be mistaken as inguinal hernia. Our case was operated with a diagnosis of inguinal hernia. The mass had been detected peroperatively and orchiectomy was advised to the patient. However, the patient didn't accept the procedure and the operation was stopped. In literature there are two cases of SCL in spermatic cord (6,7). In both of the cases the tumor was located in right scrotum, however, our case differs with location in inguinal channel. Therefore operated as inguinal hernia. In literature review there was no case with SCL and pheochromacytoma together. There is no information about association of these two mesenchymal tumors. Our case is the first case in literature as SCL accompanying pheochromacytoma.

One of the cases in literature was treated with orchiectomy (6). Although SCLs are well bordered lesions they can infiltrate the surrounding tissue (11). Furthermore, Üstündağ et al found that most of the lesions were infiltrative rather than encapsulated (5). In our case tumor couldn't be dissected from spermatic cord due to infiltration.

It was resected by orchiectomy according to patient's desire. Furthermore, he had pheochromacytoma and it was resected by laparoscopic adrenalectomy at the same session. This case is the first SCL case with pheochromacytoma. SCL is a rare and benign tumor. Although it is seen in many regions, in literature review, there are only 2 cases located in spermatic cord. Our case is the third case of SCL of spermatic cord but, it differs with accompanying pheochromacytoma and to be mistaken as inguinal hernia. SCL are mostly seen as well bordered and slowly growing tumors but, can infiltrate the surrounding tissue. Total excision of the tumoral tissue is enough for curative surgery. As seen in our case preoperative diagnosis is very important in planning of the treatment.

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