

SPINDLE CELL LIPOMA OF THE SCROTUM

Muhammad Iqbal¹, Sanjay Agarwal,^{1,2} Iqbal S. Shergill^{1,2}

¹The Alan de Bolla Urology Department, Wrexham Maelor Hospital, Wrexham, North Wales

²North Wales and North West Urological Research Centre, Wrexham, North Wales

Corresponding Author: driqbal83@hotmail.com

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ABSTRACT

Spindle cell lipoma (SCL) in the scrotum is a very rare presentation with only a few cases reported in the literature. The most common sites for this benign lesion are the neck, shoulder, and back. We present a 72-year-old male patient with painless swelling on the left half of the scrotum with a histopathological diagnosis of SCL.

Keywords: *lipoma, liposarcoma*

CASE REPORT

A 72-year-old patient presented to a urology outpatient department with a history of left scrotal swelling for four years without any symptoms. He denied any history of trauma, pain, or increase in size. On physical examination, he had a firm mass in the left hemi-scrotum with hard consistency arising from the scrotum but separate from the testis and spermatic cord. There was no cough impulse and transillumination. Scrotal ultrasonography showed a 3.5 × 1.5 cm complex lump in the region of the spermatic cord. Tumour markers including beta human chorionic gonadotrophin (β-HCG), alpha-fetoprotein (AFP), and lactate dehydrogenase (LDH) were within normal limits. A magnetic resonance imaging (MRI) with contrast showed a 3.4 × 2.7 × 3.4 cm extratesticular benign mass with patchy enhancement. Scrotal exploration was performed where a lump was excised in toto separate from the testis and spermatic cord. Post-operative recovery was uneventful and the patient is symptom-free now. The mass was excised with surrounding normal wall of scrotum leaving behind an intact right testis. Macroscopic analysis revealed well circumscribed ovoid greyish lump

40 × 35 × 25 mm weighing 16 grams. On sectioning, cut surface reveals a partly solid and partly myxoid area with no area of hemorrhage or necrosis. Microscopic examination showed benign encapsulated spindle cell lipoma (SCL).

DISCUSSION

Spindle cell lipoma usually occurs as a solitary, subcutaneous, circumscribed lesion in the back, posterior neck, or shoulders of older men. In comparison, spindle cell lipoma in the scrotum is extremely rare. Grossly, the tumour is well circumscribed and resembles a lipoma except for a grey-white gelatinous foci that represent areas of spindle cell proliferation.¹ The exact nature of spindle cells is uncertain, as it is difficult to distinguish early fibroblasts and prelipoblasts even by electron microscopy. SCLs have 3 basic histologic components: mature adipocytes, uniform spindle cells, and bundles of collagen. Prominent myxoid matrix is occasionally seen.² Mitotic figures are scarce. Variants of SCL have been reported such as pseudo angiomatous variant, a fibrous spindle cell lipoma, and a vascular variant in an intramuscular (sub fascial) location and fibro histiocytic lipoma. A portion of diagnostic difficulty lies which can be overcome using ultrasound

(US) and MRI in the evaluation of these masses. Scrotal US provides information on the localisation and the cystic or solid nature of the mass. Even though the majority of solid extra testicular masses are benign, it is hard to distinguish malignancy. In conditions like these MRI may be of use. On imaging studies, lesions consist of 0–95% fat. Enhancement of SCL is reported to be significantly more intense which helps in differentiating this lesion from others. Problems still arise in differentiating SCLs from myxoid liposarcoma or well-differentiated liposarcoma on clinical and pathological examinations.³ Enzinger and Harvey found that SCL lacks the hallmark cell of liposarcoma, the lipoblast. Comunoglu et al noted that CD34 positivity is a characteristic feature of SCL and rarely seen in liposarcoma.⁴ Unlike liposarcoma, SCL is a benign lesion. Two studies followed patients for up to 22 and 25 years after local surgical excision

of the SCL. They reported a benign clinical course and concluded that treatment with local excision was curative.

CONFLICT OF INTEREST

Authors have no conflict of interest.

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