THE CORRECTIONS COULD BE MADE ARE MARKED IN RED. THE WORDS/ SENTENCES WHICH ARE NOT NEEDED AS PER MY BELIEF ARE STRUCK OFF. THE INSTRUCTIONS ARE MARKED IN GREEN.

Case report

A rare presentation of solitary pedunculated lipofibroma of the thigh: A Case report and review of literature

Title suggested by me- Solitary pedunculated lipofibroma of the thigh- A rare case presentation with review of literature.

ABSTRACT

Background: Nevus lipomatosus cutaneous superficialis (NLCS) is a rare benign hamartomatous idiopathic condition.

Case Representation: This case report describes a solitary and pedunculated lipofibroma, a rare variant of NLCS with a review of the literature.

Conclusion: Early recognition of this benign condition will result in less morbidity amongst the patients with regards to cosmesis.

The changes suggested in the abstract are also mentioned in the reviewer's comments.
The abstract should have been more comprehensive. It should start with definition/ small description of 'solitary pedunculated lipofibroma' and then it should mention about Nevus lipomatosus cutaneous superficialis (NLCS). Also, write about its tissue of origin. You can also mention approximately how many cases are published till date in the abstract. The last paragraph of the abstract should mention about how did you manage this case in one sentence. You can keep the last sentence of the abstract as it is you have written.

Keywords: Pedunculated lipofibroma, solitary, NLCS, lipoma

INTRODUCTION

Hoffman and Zuhrelle in 1921 first described a rare benign hamartomatous idiopathic condition called nevus lipomatosus cutaneous superficialis (NLCS). [1] It is characterized by the presence

of ectopic mature adipose tissue within the dermis. Literature describes its two clinical variants - the classical form, consisting of multiple skin-colored cerebriform, pedunculated nodules that most often combine to form a plaque and the second ~~one~~ form which is relatively a rare form, presenting as a solitary sessile papule or nodule usually dome- shaped. [2,3] This case report describes a solitary and pedunculated lipofibroma, a rare variant of NLCS with a review of the literature. (You can mention about its incidence here.)

CASE REPORT

A young ~~gentlewoman~~ female aged 27 years presented to our department with a four-year-old history of a swelling on the inner side of left upper thigh. The swelling had originally appeared without any trigger and gradually increased to the present size over a period of time. There was no significant family history. Physical examination showed a pedunculated, solitary nodule measuring 40×40 mm. The prominent stalk was 10 mm long. The swelling was skin-colored, nodular in appearance, soft in consistency, non-tender, with no sinuses or ulceration. (Fig 1A) Surrounding skin appeared normal. No other associated swellings were noted. Fine needle aspiration of the swelling reported scattered mature adipocytes with many fibrous strands against a hemorrhagic background. Under local anesthesia, an elliptical incision was marked around the stalk and deepened to completely excise the swelling. (Fig 1B) Incision was closed using non-absorbable sutures (polyethelene 4-0). Histopathological examination (HPE) of the swelling showed infiltration of the epidermis and dermis with chronic inflammatory cell infiltrate. The dermis showed presence of mature adipocytes ~~were seen~~ in lobules separated by fibrocollagenous stroma. Blood vessels were also seen in the stroma. No ~~malignancy~~ ~~noted~~ dysplastic features present. (Fig 2A,2B,2C) The findings were suggestive of NLCS, solitary pedunculated variant. Post-operative period was uneventful. Sutures were removed in two weeks after the surgery. One year follow-up showed no recurrence.

DISCUSSION

Pedunculated lipofibroma is a rare, benign connective tissue neoplasm. It is solitary, slow growing and is distinctively diagnosed by the presence of ectopic adipose tissue in the dermis. Mehregan et al., suggested the term “pedunculated lipofibroma” for the solitary form of nevus

lipomatosus, in a view of its characteristic clinicopathological features.[4] (The first sentence of the discussion could be written after the second sentence.) (Write in short about NCLS first.) The ~~histological features are like~~ NLCS ~~which~~ was originally classified into two clinical types, a multiple form, and a solitary form.[1] In the multiple type of NLCS, the lesions are either congenital or develop during the first three decades of life. The common sites of occurrence are usually the gluteal region, lower back, and the superior, posterior thighs. The solitary nodular, papular or pedunculated lipofibroma occurs later in life (usually over 20 years of age) and is found in unusual sites like axilla, knee, eyelid, nose, ear/pinna, clitoris, scrotum, or skin of the scalp.[5,12,13]

NLCS are slow growing and asymptomatic in nature. However, large lesions tend to ulcerate with superimposing bacterial infections.[2] Ulnar neuropathy due to compression by a large NLCS has been reported where a partial excision of the lesion was done due to its benign nature.{9} There is no documented genetic predilection, but one study has reported the association of 2p24 deletion.{10}

The pathogenesis of pedunculated lipofibroma is unknown. Various theories have been postulated vis-a-vis degenerative changes in the collagen and elastic tissue resulting in the displacement of subcutaneous adipose tissue into the dermis. Another theory explains origination and differentiation of lipoblasts to adipose cells from the walls of dermal capillary vessels. [5,8]

The main histological abnormality in either type of NLCS is ectopic fatty tissue in the upper dermis, distinct from the normal subcutaneous fat. In many cases, the connective tissue has been seen to be organized irregularly. Foci of adipocytes are seen around the dermal blood vessels.[6] Staining with alcian blue shows increased deposition of mucopolysaccharides in the reticular dermis and fatty tissue in majority of the cases.[7]

Clinically, the differential diagnosis for a pedunculated lipofibroma includes other benign papillomas, including acrochordons, seborrhoeic keratosis, nevocellular nevi, verrucae, neurofibromas, fibroepithelioma of Pinkus, and eccrine poroma.[5] HPE will form the key contributor to the final diagnosis.

The treatment of pedunculated neurofibroma involves complete excision for both therapeutic and cosmetic reasons. Excision of large sessile plaques may result in the need for skin grafts or a combination of tissue expansion and flap advancement surgery to cover the post-excision defects. Other non-surgical modalities such as cryotherapy, carbon dioxide ablative laser,

corticosteroids topical applications and intralesional phosphotidylcholine and sodium deoxycholate injections have been used for the removal of these lesions.[11,14,15] Recurrences have been reported ~~noted~~ following these modalities, when surgical excision becomes an absolute necessity.[14] Although there are no reports in the literature about any malignant transformation of pedunculated lipofibroma, it is prudent to examine these swellings for malignancy considering the incidence being rare.

CONCLUSION

NLCS is a rare skin pathology and pedunculated lipofibroma appears to be a rarer variant. Early recognition of this benign condition will result in less morbidity amongst the patients with regards to cosmesis. The comprehensive review of the literature has suggested that surgical excision remains to be the gold standard treatment to prevent recurrence and early intervention will prevent the need for large reconstructive options unless indicated.

STATEMENTS AND DECLARATIONS

Informed consent

Informed consent was obtained from the patient for the use of photographs for publication. The consent has been formally documented in the medical record.

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FIGURE LEGENDS

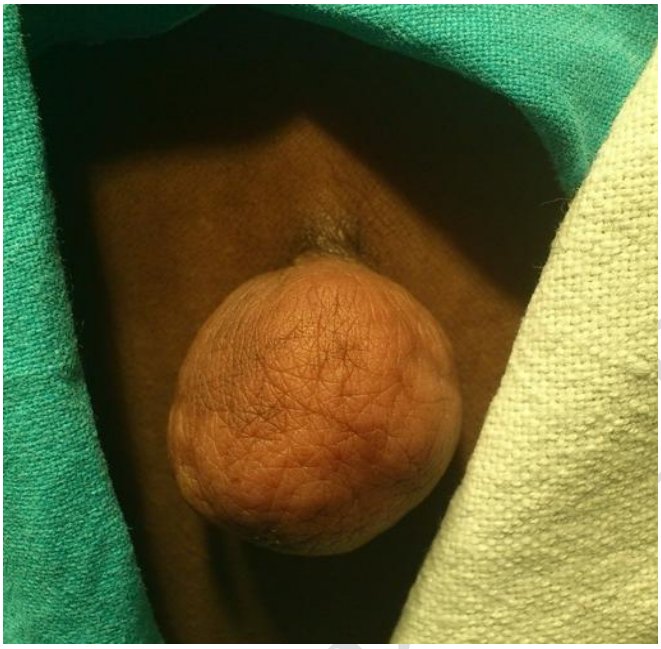

Figure 1A: Pre-operative image of the pedunculated, solitary nodule measuring 40×40 mm with a prominent stalk measuring 10 mm long. The swelling was skin-colored, nodular in appearance, with no sinuses or ulceration.

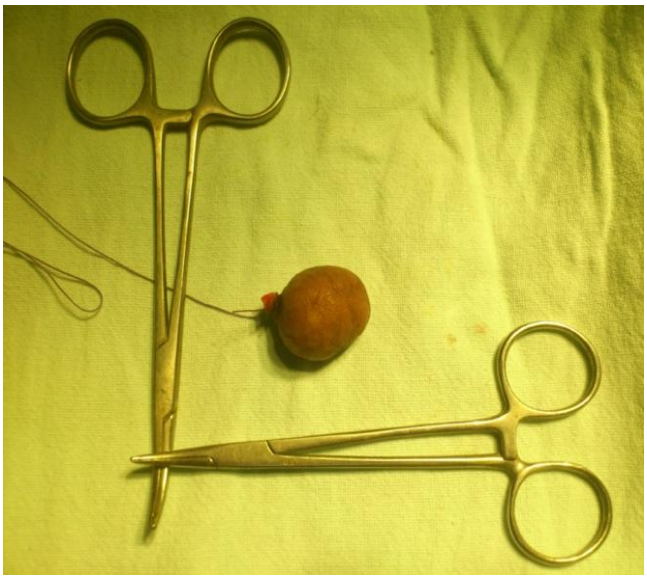

Figure 1B: Excised swelling with the stalk

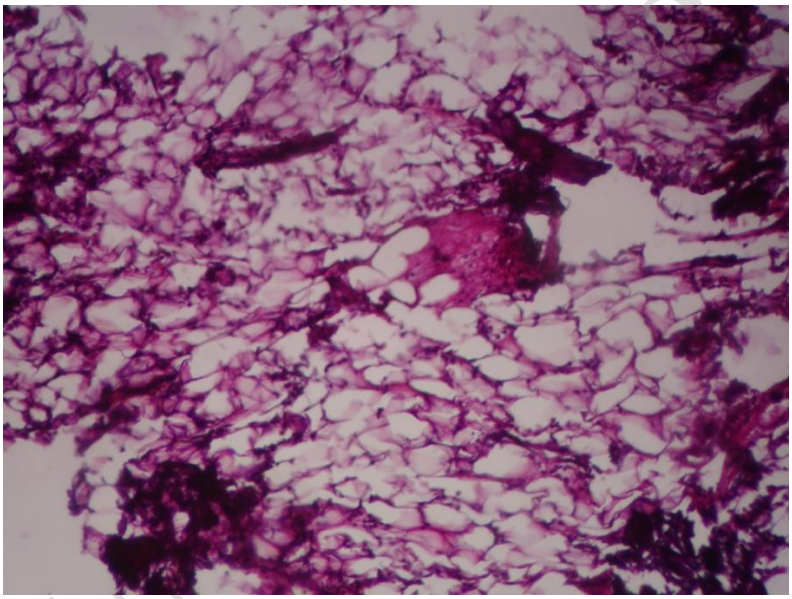

Fig 2A – Low power view showing hyperkeratosis, irregularly organized connective tissue and presence of mature adipocytes in the dermis.