Case Report

Subconjunctival orbital fat herniation mimicking lipomatous tumors

Shunsuke YUGE1, Tomayoshi HAYASHI1, Hirofumi KINOSHITA2, Eo TORIYAMA1, Naoe KINOSHITA1, Kuniko ABE1, Takashi KITAOKA2

1Department of Pathology, Nagasaki University Hospital, Japan
2Department of Ophthalmology and Visual Science, Nagasaki University Hospital, Japan

Subconjunctival fat herniation is rarely described in the literature, but it is common in clinical practice. It represents prolapse of the intraconal fat to the subconjunctiva, mainly from aging. It usually occurs in the superotemporal quadrant of the globe, and rarely causes symptoms. Microscopically, multinucleated giant cells that frequently have a floret-like appearance (floret-like cells), and also bizarre adipocytes with nuclear vacuoles (Lochkern cells) are seen. We present a case of a 68-year-old Japanese man with subconjunctival fat herniation that showed floret-like cells and Lochkern cells. The differential diagnosis included lipomatous tumors of the orbit such as pleomorphic lipoma, liposarcoma, as these resemble subconjunctival fat herniation macroscopically. It is important to make a histopathological diagnosis for fat herniation to avoid overlooking malignant tumors and over-treating benign lesions.

Keywords: Orbit, fat herniation, floret-like cell, Lochkern cell, subconjunctiva

Introduction

Orbital fat herniation (orbital fat prolapse) occurs in the subcutaneous region of the eyelid and bulbar conjunctiva. The former situation is common in the elderly, because aging causes extraconal fat to prolapse through the orbital septum. This frequently takes place at the lower eyelid, resulting in so-called “baggy eyelid”. The latter situation is subconjunctival fat herniation (SFH). It usually occurs in the superotemporal quadrant of the globe (bilaterally or unilaterally) by the prolapse of intraconal fat from the weakest point of Tennon’s capsule, and is rarely reported in the literature. This is also caused by aging or sometimes by trauma. Typically it appears as a yellowish soft mass with superficial vessels. On the other hand, since lipomatous tumors resemble SFH in clinical findings and microscopic features, it is sometimes difficult to distinguish between these two conditions. We report a case of SFH which required pathological differentiation from lipomatous tumors, and review the literature.

Case report

A 68-year-old Japanese man with no ophthalmologic history noticed a small lesion in the left superotemporal conjunctival fornix. It was clinically diagnosed as lipoma, and was followed-up for 3 years. Since the mass had gradually enlarged, the patient decided to have it resected for cosmetic reasons. He was overweight, with a height of 167.5 cm, weight of 79.2 kg, and body mass index (BMI) of 28. He had been treated for 7 years for diabetes mellitus,
hypertension, and hyperlipidemia.

Ophthalmologic examination revealed orthophoria, and visual acuity was 20/20 in both eyes. His eye movements were normal and he had no pain or diplopia. Slit lamp biomicroscopy showed a soft yellowish mass located in the superotemporal fornix of the left eye; it measured 15 mm and had a smooth surface and superficial blood vessels (Figure 1). He also had a small white protrusion in his right superotemporal fornix.

Axial T1-weighted magnetic resonance imaging (MRI) revealed that the mass in the left eye had signal intensity as high as intraconal fat in the lateral portion of the left globe (Figure 2). There was no obvious septum between the lesion and the intraconal fat. These characteristics led to the clinical diagnosis of SFH. MRI revealed no remarkable findings for the right lesion.

Surgical excision of the left mass lesion was decided. Surgical findings showed that the mass was continuous with the orbital fat, with no evident capsule. We decided on expectant management for the right eye lesion.

One year after the operation, the patient had orthophoria and eye movement was normal as before. There has been no recurrence of herniation in the left eye, and the right eye lesion has not increased in size.

Pathological findings

The specimen was lobulated with fibrous connective tissue. The resected material consisted of mature adipocytes (Figure 3).

Small amount of myxomatous stromal change were located near the fibrous septa. Multinucleated giant cells with the nuclei in a semicircle (floret-like) arrangement and eosinophilic cytoplasm, so called 'floret-like cells', were scattered throughout the lesion. The nuclei of these cells were normochromatic to slightly hyperchromatic, and some showed intranuclear vacuoles. Some adipocytes also demonstrated similar intranuclear vacuoles, consistent with so-called Lochkern cells (Figure 4). In the fibrous area, there were a few eosinophilic collagen fibers and a mild inflammatory infiltrate containing lymphocytes and mast cells.

Immunohistochemically, the floret-like cells, Lochkern cells, and fibroblasts were positive for CD34 (Figure 5).

The pathologic findings suggested pleomorphic lipoma.
However, the findings of mild nuclear hyperchromatism, intranuclear vacuoles of floret-like cells, presence of Lochkern fat cells, and little interstitial myxomatous change, indicated the degenerate nature. In addition, the lesion was not separated from the intraconal adipose tissue by MRI. Therefore, the lesion was diagnosed as SFH, non-neoplastic degenerative lesion.

Discussion

SFH is rarely reported, and its histopathology has been described in only three cases, in the PubMed literature. It occurs unilaterally or bilaterally, mainly in elderly, obese men. Katayoon et al. reported 72 cases of SFH, in which 16 (22%) were bilateral, 29 (40%) occurred in men, and 30 (41%) appeared in the superotemporal quadrant of the eye. In bilateral cases, the lesions are generally unequal in size. Therefore, the location of floret-like cells was characteristic of SFH, as were the presence of intranuclear vacuoles and Lochkern cells. Liposarcoma often presents with proptosis and sometimes diplopia, reduction in visual acuity, and displacement of the globe. Pathologically, necrosis and hemorrhage are often seen in liposarcoma, and there are also multivacuolar neoplastic lipoblasts. In particular, well-differentiated sclerosing liposarcomas can resemble pleomorphic lipoma and SFH, because floret-like cells may occur. So it is difficult to distinguish these entities with precision. Lochkern cells should be distinguished from lipoblasts. Lipoblasts show abnormal-sized and hyperchromatic nuclei with asymmetric shape and mitotic figures. They are also negative for CD34. In contrast, the nuclei of Lochkern cells are normal in size, normochromatic, symmetric in shape, and positive for CD34. Moreover, they do not show mitotic figures.

MRI and surgical findings can also hint at the diagnosis. The mass lesion of SFH is continuous with the intraconal fat, while lipomatous tumors have wispy septations. Lipomatous tumors are visualized as expansive masses with capsules and septa, and there is a recognizable border with the normal surrounding fat. Because SFH is rarely surgically removed, specimens are rarely examined pathologically. However, microscopy is necessary to perform a differential diagnosis between benign...
and malignant lipomatous tumors and SFH. If pathological diagnosis is not performed for this presentation, we may overlook malignant neoplasms that can recur and metastasize to other organs, and we also risk over-treatment of non-neoplastic lesions. Since most of the lipomatous lesions in the orbit are benign, they can be followed up. However, when the lesion is suspected for malignancy, i.e. rapid growth or invasive pattern, the surgical treatment and pathological examination is essential.

References


