Vertebral lipoma

Vertebral lipoma is extremely rare and a search of the English literature has revealed 20 patients in 16 reports.

Intraosseous lipoma in the vertebra may occasionally mimic haemangioma and osteoporotic bone with increased fatty marrow $^{1)}$.

Sahinturk et al. from the Department of Neurosurgery, Baskent University School of Medicine, Ankara, Turkey, report a 32-year-old female patient admitted to there neurosurgery department with the chief complaint of low back pain that had lasted nearly 1 year. A lumbar MR suggested a hemangioma and the patient was operated on.

On microscopic examination, the lesion was seen to have a widely infiltrating appearance of mature fat tissue between bone trabeculae diagnosis was intraosseous lipoma.

They believe that the management should be surgical total removal of the lesion even in incidentally found cases in order to obtain histologic diagnosis and pain relief ²).

Sen et al. reported a 35-year-old male patient presented with chronic low backache of one year duration that was insidious in onset, moderate in intensity and aggravated by prolonged standing. The patient did not have radiculopathy or neurogenic claudication. There was no history of any comorbid condition, medication or spinal trauma. The patient's vital parameters were normal. Lower paraspinal muscle spasm was noted. There was no point tenderness, swelling, evidence of sacroiliitis or neurological deficit. All laboratory investigations were normal.

Lateral radiograph of the lumbosacral spine showed an ill-defined transradiant lesion in the superior part of L4 vertebral body. Computerized Tomography (CT) revealed a sharply marginated ovoid intraosseous lesion of fat attenuation (–70 Hounsfield Units) at the same location. The lesion had a thin rim of sclerosis. A punctate calcific focus was noted within the lesion. The overlying endplate cortex was thinned without any obvious disruption. Degenerative changes in the form of marginal osteophytes and semilunar-shaped areas of endplate sclerosis were present. Magnetic Resonance Imaging (MRI) confirmed the CT findings and revealed a lesion of fat intensity (hyperintense on both T1- and T2-weighted images). A thin rim hypointense on both T1- and T2-weighted images consistent with marginal sclerosis was present. Disc desiccation and Modic changes were also noted (Fig.3). There was no evidence of sacroiliitis. Based on these findings a diagnosis of lumbar spondylosis with intraosseous lipoma of L4 vertebral body was made ³⁾.

A 54-year-old Japanese man presented with a three-month history of lumbar pain. Magnetic resonance imaging of the L3 vertebral arch and spinous process revealed high intensity on T1- and T2-weighted imaging, and it was suppressed on fat-suppression imaging and no enhancement showed on gadolinium contrast-enhanced imaging. Computed tomography imaging revealed an osteolytic change accompanied by marginal osteosclerosis in his third lumbar vertebral arch and spinous process, as well as a thinned and bulging bone cortex. An analgesic had been administered prior to his visit, but low back pain had persisted, so we performed curettage and filled the defect with hydroxyapatite bone. His low back pain was improved immediately after surgery, and no recurrence

of tumor has been observed on computed tomography imaging as of three years postoperatively.

Symptomatic intraosseous lipoma of spine is very rare, but the patient may be surgically well-treated by curettage and reconstruction of the benign tumor $^{4)}$.

Pande et al reported a very unusual case where adjacent vertebrae are involved and the plain radiographic and scintigraphic appearances gave cause for some concern. The findings on plain films, scintigraphy, computed tomography and magnetic resonance imaging are discussed ⁵⁾.

1) 5)

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