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Neuroradiology

Liposarcoma of the glottis: A report of an unusual diagnosis in an unusual location

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ABSTRACT

Liposarcoma of the larynx is a rare entity, typically well differentiated with a good prognosis. We present a patient who presented to ENT clinic with a 3-month history of hoarseness. Contrast-enhanced computed tomography of the neck demonstrated a 2.5-cm mass of the true vocal cord, which biopsy demonstrated to be dedifferentiated liposarcoma of the larynx. The patient went on to total laryngectomy with planned adjuvant radiation therapy. The presentation and imaging findings of laryngeal liposarcoma are nonspecific, but this neoplasm should be considered in the differential of masses in the head and neck.

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Introduction

Liposarcoma of the larynx can be difficult to diagnose because of vague symptoms, nonspecific imaging findings, and the rare nature of the disease. It is often not on the differential diagnosis of either clinicians or radiologists. We present a case of liposarcoma that is unusual both in its histology and location, as the liposarcoma was of the dedifferentiated subtype, and the tumor was glottic in origin.

Case report

A 55-year-old man presented to ENT clinic with a 3-month history of hoarseness. The patient denied any dysphagia, odynophagia, weight loss, precipitating factors, or additional symptoms. The patient had a 40 pack-year smoking history. Flexible laryngoscopy performed in the ENT clinic demonstrated a large, firm, fibrous appearing mass on the right true vocal cord, extending into the anterior commissure and into

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Fig. 1 – Axial CT of the neck demonstrates the 2.5-cm oval-enhancing mass along the true vocal cords with involvement of the anterior commissure, marked by arrow. The lesion does not demonstrate evidence of extralaryngeal spread, cartilage erosion, or paraglottic invasion. CT, computed tomography.

the subglottis, causing moderate to severe airway obstruction. The patient underwent contrast-enhanced computed tomography of the neck, which demonstrated a 2.5-cm oval-enhancing mass along the true vocal cord extending along the anterior commissure (Figs. 1-3). No cartilage erosion,



Fig. 2 – Coronal CT of the neck demonstrates the 2.5-cm oval-enhancing mass along the true vocal cords with involvement of the anterior commissure, marked by arrow. The lesion does not demonstrate evidence of extralaryngeal spread, cartilage erosion, or paraglottic invasion. CT, computed tomography.

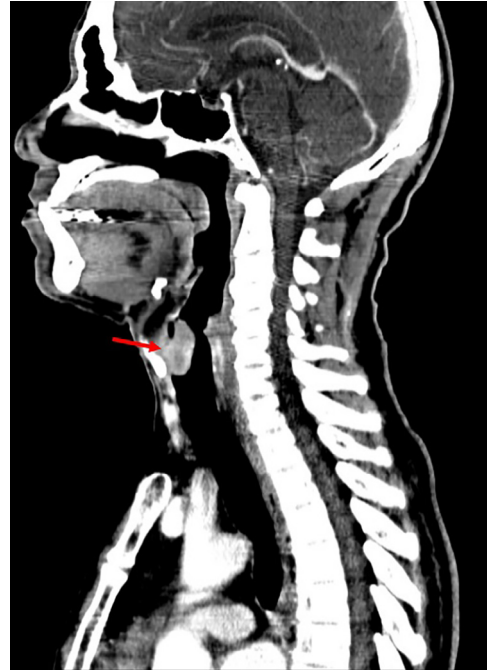


Fig. 3 – Sagittal CT of the neck demonstrates the 2.5-cm oval-enhancing mass along the true vocal cords with involvement of the anterior commissure, marked by arrow. The lesion does not demonstrate evidence of extralaryngeal spread, cartilage erosion, or paraglottic invasion. CT, computed tomography.

extralaryngeal spread, or lymphadenopathy was present. Of note, the lesion did not contain fat. Subsequently, the patient underwent direct laryngoscopy (Fig. 4) and biopsy forceps were used to take multiple biopsies of the mass and debulk the lesion to alleviate airway obstruction. Pathology demonstrated dedifferentiated liposarcoma. The patient had no metastatic disease at the time of presentation and went on to total laryngectomy. Surgical pathology demonstrated a 3.5-cm polypoid tumor arising from the submucosa with overlying mucosal ulceration. Histologically, the tumor was poorly demarcated with

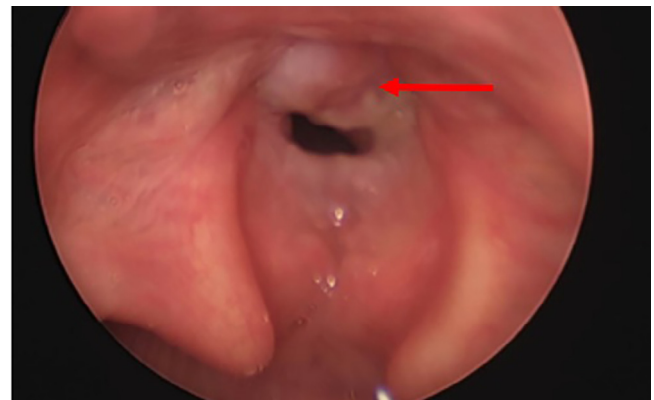


Fig. 4 – Image from direct laryngoscopy demonstrates a large, fibrous appearing mass arising from the right true vocal cord, causing airway obstruction.

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