

## Letters to the Editor

**Extra-Vascular Lipoma of the Subclavian Artery<sup>☆</sup>****Lipoma extravascular de la arteria subclavia**

To the Editor:

Intravascular lipoma is defined as a lipoma arising in the media layer of blood vessels with low adipocyte content; an extravascular or extraluminal lipoma may be formed by invagination of adjacent fatty tissue. Only 9 cases of lipoma in the vascular wall have been described.<sup>1</sup>

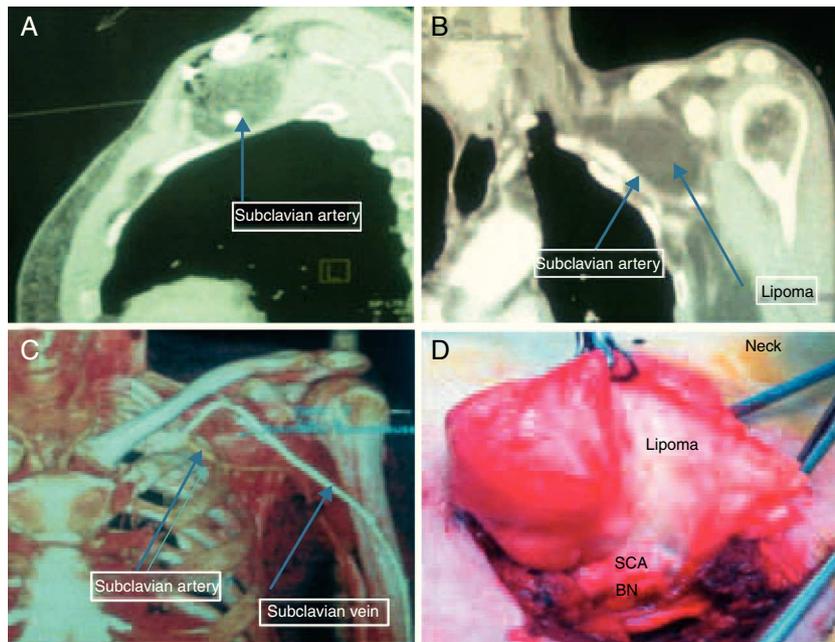
We present the case of a lipoma located in the left subclavian artery. We have found no similar cases in the literature.

A 65-year-old male was admitted due to a mass in the region of the left subclavian artery. Physical examination showed a deep mass, 6 mm in size, along the subclavian artery with no neurological or vascular deterioration. Sonography and computed tomography (CT) of the chest (Fig. 1A–C) revealed a well-defined mass that was

thought to possibly be an extremely rare subclavian lipoma. There was extensive contact along the subclavian artery but no intravascular mass. The tumor was excised via an incision in subclavian region, after being safely separated from the adjacent subclavian artery and vein and brachial nerve structures (Fig. 1D). The subclavian vein sustained a minimal injury that could be rapidly repaired. The patient's progress was incident-free. Histopathological examination revealed mature adipocytes.

Lipomas are very uncommon primary vascular tumors arising in venous walls, particularly in the inferior vena cava, and are found in 0.5% of abdominal CT examinations.<sup>2</sup>

Extravascular lipomas are very rare, and intravascular lipomas are extraordinarily rare. A hypothesis to explain the formation of these lipomas has been proposed: the tumor may arise in the vascular wall or in the perivascular adipose tissue. When the lipoma arises in the vascular wall, intravascular growth may be seen even when the vascular media layer is underdeveloped and contains few adipose cells.<sup>3</sup> This suggests that our patient's tumor arose in the perivascular tissue and subsequently penetrated the artery via



**Fig. 1.** (A) Chest CT showing a hypodense mass in the subclavian region (transversal projection). (B) Sagittal chest CT showing slight contact of mass with left subclavian artery. (C) CT reconstruction showing subclavian vein and artery separated by the lipoma. (D) Preoperative image of lipoma with persistent adherence to the subclavian artery. BN: brachial nerve; SCA: subclavian artery; SCV: subclavian vein.

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mechanical intrusion or invagination rather than by infiltration of the vascular wall.

Most vascular lipomas are asymptomatic and are revealed on incidental CT or magnetic resonance imaging (MRI). Symptomatic tumors may cause thrombosis or venous occlusion.<sup>4</sup>

Although the presence of a lipoma may be confirmed by sonography, the magnitude and depth of the subclavian lesions cannot be appropriately assessed with this technique. Both CT and MRI are useful for the evaluation of subclavian lipomas. Advocates of MRI believe that it provides reliable confirmation of the adipose character of the mass and a more accurate definition of the magnitude of the lesion and its relationship with surrounding structures. We, however, agree with the CT defenders who claim that most of the clinically relevant information on most lesions can be accessed by CT just as clearly as with MRI, but CT is preferable for reasons of cost, availability and ease in obtaining images.

Differential diagnosis includes angiomyolipoma, poorly encapsulated, containing mature adipocytes and small vessels with heterotopic calcifications, cavernous hemangioma, a vascular mass with small serpiginous vessels and phleboliths, cystic hemangioma, mixed-fibrous tumors and lipomatous hemangiopericytoma.<sup>5</sup>

Symptomatic lipoma or suspected malignancy are indications for surgical intervention.

Lipomas located in atypical sites are not easy to operate. Careful planning is necessary and the patient must be referred to a cardiothoracic surgeon. Adverse consequences of treatment, such as vascular lesions in a conscious patient or injuries caused by an inexperienced surgeon must be avoided.

## Conflict of Interests

The authors have no conflict of interests to declare.

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## Do Right What Is Right<sup>☆</sup>



### Hacer correctamente lo que es correcto

To the Editor:

Modern medicine offers us a vast range of diagnostic and therapeutic techniques, and the cost-effective use of these is one of the greatest challenges facing the clinician. In some of the more recently introduced and complex clinical areas, such as non-invasive mechanical ventilation (NIV), it is not uncommon to hear opinions voiced that may be not only debatable and confusing, but may even lead to dubious or inappropriate treatment, including the following approaches:

- Discuss local procedures and protocols without providing results from the overall population.
- Conclusively recommend unproven indications for NIV, e.g., in patients with stable chronic obstructive pulmonary disease or obesity hypoventilation syndrome.
- Accept the sum of individual practices as a general criterion for indication.
- Propose the positive benefits seen in a patient subgroup as a criterion for indication, even when the overall results of the study are negative.

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- Assume that the results of observational studies represent the best evidence.
- Fail to consider that actions have both organizational and financial consequences.

Variability in clinical practice is a problem that has been recognized for years.<sup>1</sup> It is also true that clinical practice is constructed not only from scientific evidence but also from local circumstances, professional skills and patient values.<sup>2</sup> Decision-making is a complex issue, and it is clear that certain specific problems need to be managed with prescriptions that are not strictly in line with established protocols: this is the realm of compassionate use. A certain degree of flexibility is necessary to stimulate innovation, but it is surprising to see data from the Respiratory Therapy Observatory of Catalonia suggesting that NIV prescription in patients over 65 years of age can vary as much as 40-fold between areas of minimum and maximum prescription.

It is important to remember that professional credibility depends on the consistency of shared values. Sharing real world results, not only those from clinical trials, accepting compassionate treatments for what they are, without converting them into a canon for daily practice, and the critical review of collective clinical practices are key elements in consolidating this credibility. Moreover, credibility is essential if we are to set an example for new generations and contribute to the sustainability of the public health system. This is an area in which scientific societies must be the first to engage in self-criticism and adapt to the demands of our times, in which the practice of medicine should always