Huge localised fibrous tumour of the retroperitoneum

Sir,

Localised fibrous tumours of serous membrane, which usually arise in the pleura, are rare neoplasms. The tumours have been termed benign local fibromas, localised fibrous mesotheliomas, and submesothelial fibromas, because there is still controversy as to their cellular origin. Occasionally, cases have been reported in other sites such as the lung, the mediastinum and pararnal sinuses, which led to some confusion and difficulty in diagnosis. We present a rare case of localised fibrous tumour of the retroperitoneum, which was probably derived from submesothelial mesenchymal cells.

An 81-year-old man was admitted to our hospital because of abdominal fullness. On physical examination, he appeared healthy and no abdominal mass was palpable. Laboratory investigations revealed no abnormalities and serum levels of tumour markers were within normal ranges. Computed tomographic scan of the abdomen, however, showed a giant contrast-enhanced mass behind the urinary bladder, and urinary cys
toscopy demonstrated an extraluminal compression in the posterior wall of the bladder. Exploratory operation revealed a well
circumscribed huge tumour in the retroperi
toneum, with an intact layer of mesothelium overlying the tumour. Histologically, the tumour was composed of uniform spindle cells separated by thick bands of collagen fibres with some pleomorphism and mitosis (figure).

The patient was diagnosed as suffering from localised, benign, fibrous tumour of the retroperitoneum. Immunohistochemical analysis of the tumour showed positive staining for vimentin but not for keratin, suggesting that it probably originated from submesothe
thelial mesenchymal cells.

In conclusion, we should always remember localised fibrous tumours of serous membranes when we consider the differential diagnosis of asymptomatic huge tumours, even if the tumour arises in unusual sites, such as the retroperitoneum.

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Pituitary mass and inflammatory pseudotumours of lung and retroperitoneum

Sir,

Alvarez et al, in this journal, described the unusual association of two inflammatory pseudotumours: retroperitoneal fibrosis and lymphoctic hypophysitis. Both lesions had a histological appearance of lymphocytic inflammation with densely textured fibrosis, and, presumably, a similar autoimmune pathogenesis. We report the case of a white man who successively exhibited an inflammatory pseudotumour of the lung, idiopathic retroperitoneal fibrosis, and a pituitary mass.

At age 47 years, a routine chest X-ray examination revealed a 4 × 6 cm round lesion in the right lung. Fine needle aspiration cytology yielded a few inflammatory cells. Subsequently, the pulmonary lump was resected. The histologic features were consistent with an inflammatory pseudotumour composed of a predominantly lymphocytic infiltrate, many plasma cells, and a densely textured connective tissue. The mass was resected en bloc together with the left ureter and kidney. The histologic appearance of the retroperitoneal specimen was similar to the pulmonary mass excised 2 years earlier. Flow cytometric DNA analysis exhibited a DNA diploid pattern indicating normal DNA content. The post-operative course was complicated by head

ache, visual disturbance, and hyponatraemia, leading to the diagnosis of a pituitary tumour measuring 32 mm on computed tomograp
h. Pituitary function tests were all within normal values: free thyroxine was 1.1 ng/dl, free testosterone 12.5 pg/ml, prolactin 18 ng/ml, basal and adrenocorticotropin-stimulated cortisol levels were 6.0 and 20.1 ug/dl, respectively. Results of blood cell count, kidney and liver function tests, antinuclear, anticientromere, antiposomoserine antibodies, and complement fractions were within normal range. Nailfold capillaro
coscopy showed no significant abnormalities.

In view of the patient's apparent susceptibility for the development of inflammatory masses, we assumed that the pituitary lesion could be of inflammatory nature. At surgery, a non-functioning pituitary adenoma was found and partially resected. No signs of inflammation were noted in the resected specimen. Pituitary irradiation with 4500 rad was then given. Four years later there is no evidence of residual tumour on repeated magnetic resonance imaging. The patient went into complete pituitary insufficiency and receives replacement therapy with thyroxine, cortisone and testosterone.

This patient history teaches two lessons: first, in a patient with an inflammatory pseudotumour a subsequent mass may be another pseudotumour, with similar histologic features. Second, tissue sampling from a new lesion is mandatory, even if inflammatory pseudotumours have been previously demonstrated in more than one site.

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