Case reports

Late recurrence of an abdominal haemangiopericytoma

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We report a patient with a recurrence of an abdominal haemangiopericytoma 24 years afer excision of the primary lesion from the pelvic retroperitoneum. Review of a representative slide of the original lesion confirmed this.

Case report

A 61-year-old woman presented in July 1985 with a brief history of abdominal discomfort. Examination revealed a 15 cm diameter smooth, hard, mobile mass in the right upper abdomen. Her serum electrolytes, full blood count, blood sugar and liver function tests were normal. An ultrasound scan demonstrated no intrahepatic deposits. At laparotomy, a solitary, smooth, well-defined vascular tumour was excised from the anterior leaf of the greater omentum. No other lesion could be found. Previously, in March 1961, she had had a palpable tumour excised from the pelvic retroperitoneum, followed by a course of radiotherapy and a hysterectomy in July 1961 for menorrhagia. She then remained completely well until 1985.

We were fortunate to trace a slide of the 1961 lesion which showed a haemangiopericytoma with a mitotic rate of 1–2 nuclei per 20 high power fields (HPF). Applying the criteria of McMaster *et al.*[1], the appearances were of a tumour of borderline malignant potential. The 1985 tumour had an identical architecture, but a mitotic rate of 20 nuclei per 20 HPF. The appearances are of a malignant haemangiopericytoma (Figure 1).

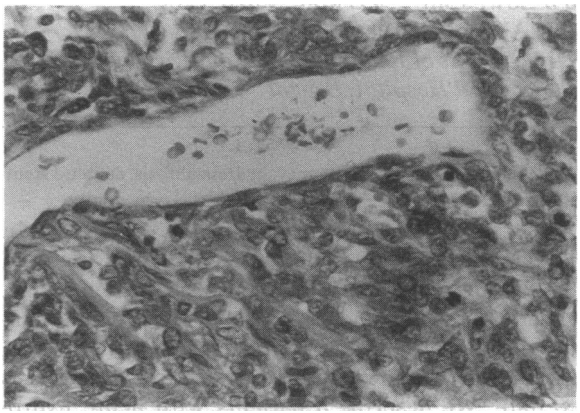

Figure 1. Photomicrograph of the recurrent haemangiopericytoma: several mitoses are seen. (× 40; reduced 45%).

Discussion

Since the first description of a haemangiopericytoma by Stout in 1942, many individual case reports, series and reviews have appeared in the literature[1–4]. The tumour has carefully defined histological features[2], although it has similarities to other connective tumours such as the synovial sarcoma. The sites of distribution of haemangiopericytomas are widespread. The tumours occur most commonly on the upper and lower limbs, and in the abdominal cavity including the retroperitoneum and pelvis. Other sites are the head and neck, chest and trunk. The most common presentation is the discovery of a mass, and pain is often present. Mechanical effects on local structures such as nerve roots, ureters, iliac veins and bowel may produce specific symptoms. Rarely, an association with hypoglycaemia has been reported[5]. The peak incidence of the tumours is in the 40–60 age group, but cases have been reported in patients of all ages.

Tumour behaviour varies from benign to malignant and is often indolent. Of 60 cases followed up for between one and 22 years[1], 11 of 12 patients with benign tumours survived more than 5 years, whereas, only one of 23 malignant cases was alive over the same period. Lung metastases were common. Very late recurrences[6] have rarely been reported.

The mainstay of treatment is adequate local excision. Backwinkel and Diddams[2] found radiotherapy to be of no benefit, either in combination with surgery or alone. Chemotherapy has been used sporadically in isolated cases, but its role has yet to be established.

In the present case there is fully documented evidence of tumour recurrence after 24 years, and we would emphasize the value of the long-term retention of histological specimens to aid the study of the behaviour of these rare tumours.

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