Pelvic sarcoma arising from chronic osteomyelitis

Gulmann et al reported on a case of chronic osteomyelitis presenting as a right chest mimicking a soft tissue sarcoma. The authors suggested that, although chronic osteomyelitis is a known cause of confusion with bone tumours, a definitive diagnosis is feasible by specific immunohistochemical staining.

However, the potential risk of transformation of chronic osteomyelitis into a malignant lesion is an unforgettable point both for the clinician and the pathologist. Two years ago we encountered a patient developing a rapidly aggressive sarcoma with an uncommon onset. He was a 23 year old man, with a 16 month history of chronic osteomyelitis of the left hip bone, referred to the urological department. Three years before, he had been involved in a road accident with a bilateral fracture of the thigh bone and left acetabulum. On admission to the ward the patient repeated fever, dysuria, and suprapubic pain. Physical examination demonstrated an osteocutaneous fistula with foul smelling drainage on the lateral aspect of the left hip bone. On standard computed tomography a large abscess and fatty tissue was found. Cause of the complaints was thought to be osteomyelitis. As reported in a large series by McGrory et al, squamous cell carcinoma is by far the most common type of associated malignant disease, whereas sarcoma has been reported only rarely.1 The latency period between the onset of osteomyelitis and the development of neoplasia may be as short as one year, or it may be decades. In general, the neoplasia occurs in the osteomyelitic sinus or in a chronic draining fistula. The most frequent clinical findings of malignancy in chronic fistulating osteomyelitis are persistent foul discharge, pain, and bleeding.1 In this case, the osteocutaneous fistula was connected to the left iliac area where the sarcoma arose and spread to pelvic lymph nodes. In conclusion, even though chronic osteomyelitis may be a cause of difficult differential diagnosis with bone tumours, we would emphasise the need to maintain a high index of suspicion in a case of chronic osteomyelitis with an unusual presentation.

References

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www.jclinpath.com
Prepubertal testicular tumours in Kashmir: a histopathological report of 15 cases

Prepubertal testicular tumours are very rare and occur at an incidence of 0.5–2/100 000 children. Of all the paediatric malignancies they rank seventh in frequency and represent only 1% of all paediatric solid tumours. We conducted a study to see the pattern of prepubertal testicular tumours in Kashmir.

The material for our study was obtained from the files of the histopathology section of the department of pathology, Government Medical College, Srinagar, Kashmir, India. The records of all prepubertal testicular tumours reported from January 1984 to December 1998 were studied. Routine and special stains were done on fresh sections from formalin wax embedded blocks wherever required. Fifteen prepubertal testicular and teratocarcinomas were recorded in the 15 year period of our study. Germ cell tumours predominated: there were 12 germ cell tumours and only three non-germ cell tumours. There were 10 yolk sac tumours, two teratomas (mature), two rhabdomyosarcomas (paratesticular), and one non-germinoma-Burkitt's lymphoma. The youngest patient was 10 months old and the oldest was 14 years old. Ten patients presented at or below the age of 4 years. The youngest patient (10 months of age) had a yolk sac tumour and the oldest (14 years old) had rhabdomyosarcoma. In two patients both teratoma were involved, with one of these two patients having bilateral undescended testes. Prepubertal testicular tumours most commonly occur within the first 4 years of life. Although the cut off age for our analysis was 14 years, most patients presented at or below the age of 4 years. Most of the germ cell tumours were yolk sac tumours (10 of 12), followed by teratoma (two of 12). Mostofi recorded 15 cases of yolk sac tumour (embryonal cell carcinoma) in a total of 22 cases and seven cases of teratoma.

Wolff's sarcoma is widely accepted today as the most common prepubertal germ cell tumour. Rhabdomyosarcoma was the second most common tumour recorded in our series. It is the most common mesenchymal type and a synonym of paratesticular tissue in the prepubertal age group. We found one case of Burkitt's lymphoma in a 5 year old child involving both the testes. Although rare, cases of Burkitt's lymphoma involving the testis have been reported in the literature.

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Reduced bone formation in UK Gulf War veterans: a bone histomorphometric study

We read the paper by Compston et al on bone loss in Gulf War veterans' with concern and interest. However, if taken to represent the problems of unwell Gulf veterans it is open to serious misinterpretation because of problems in design, factual accuracy, and certain conclusions.

The 17 cases are potential litigants who are highly unlikely to be representative of the Gulf veteran population. Apart from very brief demographic details, smoking and alcohol consumption histories, no clinical information is given about the indications for bone biopsy except that 16 complained of unspecified arthralgia and other musculoskeletal symptoms. The 13 controls were taken from a study, one of which are not uncommon in Gulf veterans. The authors point to associations with other conditions which are not uncommon in Gulf veterans. The attribution of these findings to possible exposures in the Gulf deserves comment.

The clinical relevance of these findings is unlikely to be representative of the Gulf veteran population. Apart from very brief demographic details, smoking and alcohol consumption histories, no clinical information is given about the indications for bone biopsy except that 16 complained of unspecified arthralgia and other musculoskeletal symptoms. The 13 controls were taken from a study, one of which are not uncommon in Gulf veterans. The authors point to associations with other conditions which are not uncommon in Gulf veterans. The attribution of these findings to possible exposures in the Gulf deserves comment.

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Journal of Clinical Pathology

Diagnostic Cytopathology, 2nd edition


It is a daunting task to produce a contemporary and comprehensive textbook of cytopathology that adequately deals with the full expanse of the topic. This difficulty is compounded by the need to write a text that is not only appealing, but functional as a desk reference for a diverse group of practitioners, from student cytotechnologists to expert cytopathologists. Yet, the second edition of Diagnostic Cytopathology manages to accomplish much of this task.

This single volume book is organised into a systems based review of general cytopathology. The second edition maintains its focus on the dermatological features of vascular skin lesions, and the book fills that void.

The book has black and white clinical and histopathological illustrations but is supplemented by a CD with colour versions. This companion CD is much better, although some illustrations are very out of focus, especially the lower power pictures. I suppose if the reader is prepared to revert from the book to computer images, then the CD is a useful substitute. But that may not always be possible.

Most, if not all, vascular cutaneous lesions are covered in this book. The text is brief and in some areas, disappointing. In particular, haemangiopericytoma is covered in a very superficial manner. My impression is that the text has to be supplemented by reading other textbooks containing vascular lesions for more detail. The most disappointing feature of the book is that some of the illustrations are not informative at all. The small size format allied to black and white do not do justice to the book. Better quality black and white pictures may have obviated the need for colour. Most benches are used to "wallpaper" match and because many of the illustrations are of such low magnification, even this becomes difficult.

However, this is a useful book that has all the lesions in one compendium. I think that dermatologists, who dabble in histopathology, and trainees will find this book more useful than fully fledged dermatopathologists. I think there is an opportunity to improve the book in future editions.

R Chetty

Diagnostic Cytopathology, 2nd edition

Full details of events to be included should be sent to

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Practical Pulmonary Pathology

22–25 July, 2003, Brompton Hospital, London, UK
Further details: Professor B Corrin, Brompton Hospital, London SW3 6NP, UK. (Fax: +44 (0) 20 7 351 8293; Email: b.corrin@ic.ac.uk)

ACP Management Course for Pathologists, 2003

10–12 September 2003, Hardwick Hall Hotel, Sedgefield, County Durham, UK
Further details: Ms Valerie Wood, ACP Central Office, 189 Dyke Road, Hove, East Sussex, BN3 1TL, UK. (Tel: +44 01273 775700; Fax: +44 01273 773303; Email: valerie@pathologists.org.uk)

Dermatopathology Update

10–13 September 2003, Fairmont Copley Plaza Hotel, Boston, Massachusetts, USA
Further details: Tel: +1 617 384 8600; Email: hms-cme@hms.harvard.edu; website: www.cme.hms.harvard.edu

Predictive Oncology Meeting

15–16 September 2003, Solent Hotel, Fareham, Portsmouth, UK
Further details: Professor Ian A Cree, Translational Oncology Research Centre, Department of Histopathology, Michael Darmady Laboratory, Queen Alexandra Hospital, Cosham, Portsmouth PO6 3LY, UK. (Tel: +44 (0)23 92 286378; Fax: +44 (0) 23 92 286379; Email: ian.cree@portosp.nhs.uk)

Medicare India

6–8 April 2004, Pragati Maidan, New Delhi, India
Further details: Rob Grant, Kinex Log, 5 New Quebec Street, London W1H 7DD, UK (Tel: +44 (0) 207 723 8020; Fax: +44 (0) 207 723 8060; Email: rob.grant@kinexlog.com; Website: www.medicare-expo.com or www.kinex-log.com)