Inflammatory myofibroblastic tumour of paranasal sinuses with fatal outcome: reactive lesion or tumour?

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Inflammatory myofibroblastic tumours (IMTs) are clinicopathologically distinctive but biologically controversial entities, which have been described in the lungs, abdomen, retroperitoneum, and extremities, but rarely affect the head and neck region. IMT usually follows a benign clinical course after radical excision, but invasive, locally recurrent, and metastatic forms of abdominal and mediastinal IMT have also been described. This report describes a case of IMT of the paranasal sinuses with a fatal outcome. A 22 year old woman was admitted to hospital as a result of epistaxis. Computed tomography scan and magnetic resonance imaging showed an expansive process in the paranasal sinuses, extending into the nasal cavity, orbita, and endocranium. The tumour progressed despite several surgical procedures. Radiotherapy, corticosteroids, and chemotherapy were unsuccessful, and the patient died four years after diagnosis, as a result of extensive intracranial spread of the tumour. This is the first known case of an IMT of the head and neck region with a fatal outcome. It shows that the aggressive behaviour of IMTs is not limited to abdominal and mediastinal locations, and supports recent observations that at least a subset of IMTs represents true neoplasia rather than reactive myofibroblastic proliferation.

A n inflammatory myofibroblastic tumour (IMT) is a clinicopathologically distinctive but biologically controversial entity that was originally described as a non-neoplastic lesion in the lung and designated initially as an inflammatory pseudotumour. Since then, similar lesions have been seen in diverse extrapulmonary sites, most commonly the abdomen, retroperitoneum, and extremities. In most cases, IMTs behave as benign lesions, but invasive, locally recurrent, and metastatic forms of abdominal and mediastinal IMT have also been reported.

"An inflammatory myofibroblastic tumour is a clinicopathologically distinctive but biologically controversial entity that was originally described as a non-neoplastic lesion in the lung"

IMTs rarely affect the head and neck region. To date, 19 cases of IMT have been described in the nasal cavity and maxillary sinuses, nine have been described in the oral cavity (with the mandible as the site of predilection), and only a few well documented IMTs have been found in the larynx. In general, they have followed a benign clinical course, with favourable outcome after radical local excision.

We report a case of IMT in a 22 year old woman, occurring in the paranasal sinuses, with a fatal outcome.
pattern, and inflammatory cells (fig 2). The nuclei of the spindlge cells were elongated, slightly polymorphous, and contained one or more small nucleoli and pale eosinophilic cytoplasm. Occasional regular mitoses in the spindle cell component were seen. No necroses or ganglion-like cells were seen. Inflammatory cells were mainly lymphocytes and plasma cells, unevenly distributed within the lesion. Lymphocytes were polyclonal. Polymorphonuclear cells, predominantly eosinophils, were also admixed in the inflammatory infiltrate.

Immunohistochemically, the spindle cells were consistent with a myofibroblastic phenotype. They were vimentin and smooth muscle actin positive, but desmin and cytokeratin negative. In addition, the spindle cells were not reactive with antibodies specific for cyclin D1, p53, bcl-2, or ALK. Stains for microorganisms, including mycobacteria and fungi, in addition to viruses (Epstein-Barr virus in situ hybridisation), were negative.

**DISCUSSION**

The most common clinical presentation of IMT is as an incidentally discovered mass, followed by specific symptoms related to the site of origin. Intraorally, these tumours present as a painless swelling of relative short duration, which is firm and indurated on physical examination. In the nasal cavity and paranasal sinuses, the initial presenting sign is usually a non-specific sinonasal mass, which had been growing over a period of months or years. The clinical or endoscopical findings may demonstrate a tumor mass covered by normal mucosa, a polyp, an edematous mucosa, hypertrophic concha, or a haemorrhagic rhinorhoea. IMTs located in the paranasal sinuses are usually associated with at least one sinus wall destruction.

Although IMTs of the nasal cavity and maxillary sinuses have no age preference, children or young adults with oral IMTs are usually younger than children with nasal or paranasal sinuses. IMTs located in the nasal cavity and maxillary sinuses are also more frequent in young age groups, and are composed of nodular fascicliitis. However, IMTs are generally larger than nodular fascicliitis, tend to occur in younger age groups, and are composed of longer fascicles of spindle cells in an inflammatory association with clinical behaviour, have been described, namely: (1) myxoid/vascular pattern, resembling inflammatory granulation tissue; (2) compact spindle cell pattern with fascicular and/or storiform areas and variation of cellular density; and (3) hypocellular pattern, densely collagenised and reminiscent of a fibrous scar. The three patterns may well be equally represented within the tumour, often blending into one another, with one or two patterns predominating. Lymphocytes are polyclonal. Immunohistochemistry confirms the myofibroblastic phenotype of the spindle cells, which are typically reactive to vimentin (99%), smooth muscle actin (92%), and muscle specific actin (89%). In addition, the spindle cells may also be positive for desmin (69%) and cytokeratin (36%).

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Treatment and clinical outcome are generally favourable. Most reports and series of extrapulmonary IMTs indicate that these tumours pursue an innocuous clinical course, with a frequency of local recurrence of approximately 25%. Radical excision is therefore curative in more than 90% of extrapulmonary IMTs, including head and neck IMTs. In the head and neck region, only one case of IMT of the maxillary sinus showed extension to pterygopalatine fossa after oral corticosteroid treatment. Very large lesions, or those arising in areas difficult to excise completely, such as mesenteric, omental, peritoneal, pelvic, or retroperitoneal sites, and paranasal sinuses, tend to recur, with a potential for metastatic spread in rare instances. Indeed, a metastatic potential has been noted, although in only one series involving 35 patients with abdominal and mediastinal IMTs; two patients had lung and one had brain metastases. Reliable histological criteria for the prediction of the clinical outcome have not been firmly established so far. The combination of cellular atypia, the presence of ganglion-like cells, p53 expression, and DNA aneuploidy might help to identify IMTs that have the potential for aggressive clinical behaviour with recurrence or malignant transformation. Our case is unique in its clinical course, because it is the first and only known case of IMT of the paranasal sinuses with a fatal outcome as a result of extensive intracranial spread of the tumour, despite several surgical procedures and additional radiotherapy, corticosteroids, and chemotherapy.

The aetiology and pathogenesis of IMT still remain unknown. Cytogenetic and molecular studies point to the possibility that at least some subsets of IMT are in fact true neoplasms. Clonal rearrangements of the short arm of chromosome 2, involving the ALK receptor tyrosine kinase locus region, have been detected in up to 50% of soft tissue IMTs. However, a subset of IMTs is most probably infection associated. Namely, Epstein-Barr virus has been detected in some splenic and hepatic IMTs, actinomyces and nocardia in some hepatic and pulmonary IMTs, and mycoplasma in some pulmonary IMTs. In addition, the essential role of human herpesvirus 8 in triggering the development of seven IMTs (five in the lung, one in a limb, and one in the retroperitoneal lymph node) has also been suggested.

The differential diagnosis of IMTs in the oral cavity and paranasal sinuses mainly includes lesions composed of myofibroblasts and fibroblasts, which may pose considerable challenges because of their morphological overlap with IMTs. When myofibroblasts are set in a loose or myxoid stroma, the histological pattern may be indistinguishable from nodular fascicliitis. However, IMTs are generally larger than nodular fascicliitis, tend to occur in younger age groups, and are composed of longer fascicles of spindle cells in an inflammatory...
background rich in plasma cells. In contrast, nodular fascities usually lacks the striking inflammatory infiltrate characteristically present in IMT. Fibromatosis of the oral cavity is characterised by broad interlacing fascicles of mature fibroblasts, with a variable degree of collagenisation, and by the absence of an inflammatory component. Follicular dendritic cell tumour, also described in the oral cavity, is composed of whorls or fascicles of plump spindle shaped to ovoid cells, showing morphological and phenotypical (CD21+, CD35+, CD23+) features of follicular dendritic cells, set in an inflammatory background of lymphocytes and histiocytes. When IMT contains enlarged histiocyte-like cells, inflammatory malignant fibrous histiocytoma has to be taken into consideration, characteristically containing a “sea” of neutrophils. Compact cellularity, a fascicular pattern, and nuclear atypia should also raise the suspicion of other neoplasms with a spindle cell appearance, such as sarcomatoid carcinoma, high grade angiosarcoma, leiomyosarcoma, and fibrosarcoma.

In conclusion, IMT of the head and neck region is a distinct clinicopathological entity, characterised histologically by fascicles of spindle cells in an inflammatory background rich in plasma cells. Clinically and radiologically, it may simulate a pseudotumour. We report the first known case of an inflammatory myofibroblastic tumour (IMT) of the oral cavity. When confronted with an unexpected clinical presentation, especially in the neck, clinicians should consider the possibility of an IMT, which, even if benign, may require radical surgery to prevent local recurrence and symptomatology.

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REFERENCES