Extraabdominal Desmoid Tumor Appearing Following Resection of Thoracolumbar Schwannoma

Torakolomber Schwannom Cerrahisi Sonrası Ortaya Çıkan Ekstraabdominal Desmoid Tümor

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INTRODUCTION

Aggressive fibromatosis (desmoid tumor) that develops from muscle connective tissue, fascia and aponeuroses, was first described by McFarlane in 1832. It accounts for 0.03% of all neoplasms (2,4). Desmoid tumors rarely show malignant transformation. They do not metastasize but are very invasive locally.

CASE REPORT

A 55-year-old woman underwent evaluation at our clinic for a painful thoracic paraspinous mass located 3 cm above the scar of a previous skin incision. This mass had existed for nearly six months. She had a history of lumbar disc surgery four years ago. Three years after disc surgery, she underwent a T10-L1 laminectomy for the resection of a spinal schwannoma. She was discharged uneventfully. The patient's neurological examination was unremarkable. Lumbar and thoracolumbar verticomedian incision scars were noticed on the back. A firm, tender paraspinous mass measuring approximately 6x4 cm was palpated just cranial to the upper skin incision. Magnetic resonance imaging (MRI) of the thoracic spine revealed a mass lesion originating from the right paravertebral muscles at the thoracic level. Any communication with the spinal canal or bone destruction was not evident (Figure 1A, B, C). She was operated upon. The tumor was very invasive to the surrounding muscle tissue. It was completely resected with wide margins due to lack of an obvious tumor cleavage. Histopathologic examination revealed an extraabdominal desmoid tumor (Figure 2A, B).

DISCUSSION

The exact pathogenesis of desmoid tumor is unknown, however, genetic abnormalities (Familial adenomatous polyposis and Gardner's syndrome), sex hormones and trauma, especially surgical trauma have been considered as causative factors (1-5). The majority of cases occur between puberty and 40 years. MRI is the imaging method of choice for both preoperative planning and post-treatment monitoring.
Unexplained etiology and the various locations make desmoid tumor treatment extremely difficult. At present there is no definite and effective method of treatment. Frequently, a wide surgical excision is made with a margin of clean tissues (1-2 cm), although sometimes this is impossible and remains the principle therapeutic maneuver (2,3). However, a high recurrence rate after surgery has led to more conservative therapeutic management. Gronchi et al. reported that function-sparing surgery might be a reasonable choice without leaving macroscopic residual disease (1). Dalen et al concluded that desmoid tumors have probably been overtreated in the past. Many of them tend to regress spontaneously and might have a high capacity for self-limitation. Conservative therapy should be considered in symptom-free patients (1).

There are also many reports describing a good response of desmoid tumors to irradiation. Cytostatic agents, hormonal drugs, non-steroid anti-inflammatory drugs and anti-viral preparations are drugs that can be used in desmoid tumor treatment (2-5).

Our literature survey revealed that the presented case is the first desmoid tumor growing after resection of a spinal schwannoma. Although de novo development of the tumor is possible, we think that the tumor developed in response to previous spinal surgery.

**CONCLUSION**

In conclusion, a desmoid tumor should be considered in the differential diagnosis of any rapidly growing mass that arises...
around a previous surgically-treated site. Many treatment options are available and individualizing the management of the desmoid tumor would be the best policy.

REFERENCES


