Abteilung für
CHIRURGIE &
GEFÄSSCHIRURGIE
Vorstand: Prim. Dr. Gerhard Jenic

KABEG
LKH VILLACH

„Giant abdominal metastatic sarkoma-like tumor “

R. van de Haar, M. Vouk, R. Foditsch, E. Spuller, E. Trampitsch, G. Jenic

Introduction

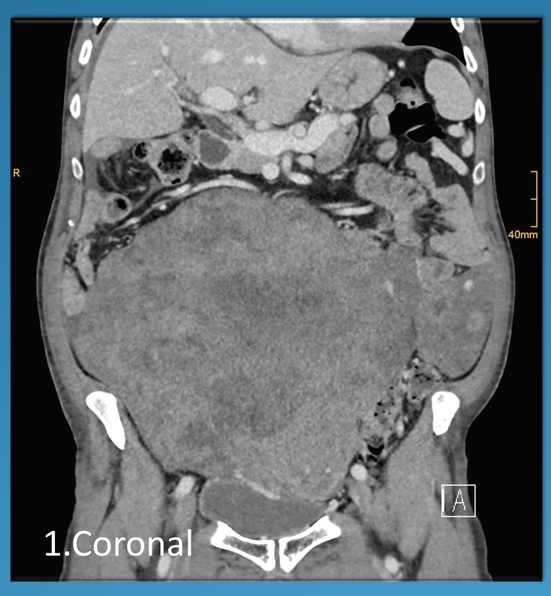
Despite the diagnosis of a rare metastatic sarkoma-like tumor, considerations to surgical removal should always be made.
We report a rare case with giant tumor recurrence.

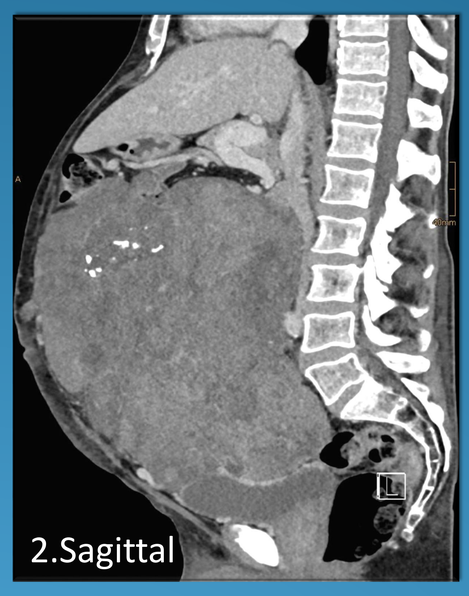
Casereport

A 65 year old male patient, with a long history of malignant solitary fibrous tumor was presented in our department to get a second opinion. After an initial surgery in 2012, an abdominal recurrence of about 30x30x26 cm was classified inoperable. No chemotherapy could control the tumor-progression. With no signs of extraabdominal metastatic disease, but symptoms of intestinal obstruction, abdominal compartment, iliac vein obstruction and inferior vena cava syndrome, surgical removal was performed.
An approximately twelve kilo tumor, mainly infiltrating the abdominal wall was succefully removed. After an inhospital stay of 10 days, the patient could be discharged in good general condition with no signs of the preexisting inferior vena cava syndrome or paraneoplastic hypoglycemia. Histopathological result showed a malignant solitary fibrinous tumor NAB2 – STAT6. Our patient recovered well and further follow up showed no signs of recurrent disease in the first 6 months.

Conclusion

Due to perfoming a second opinion, a life-sustaining surgery with excellent outcome could be accomplished. Questioning results and reffering cases to specialists should always be considered in interest of our patients.





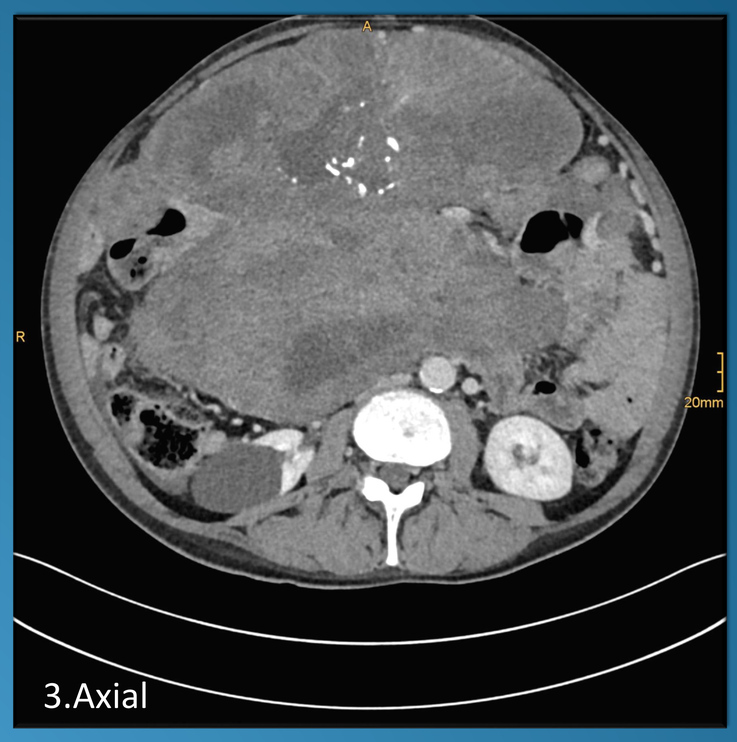


Image 1-3 Preoperative CT Scan

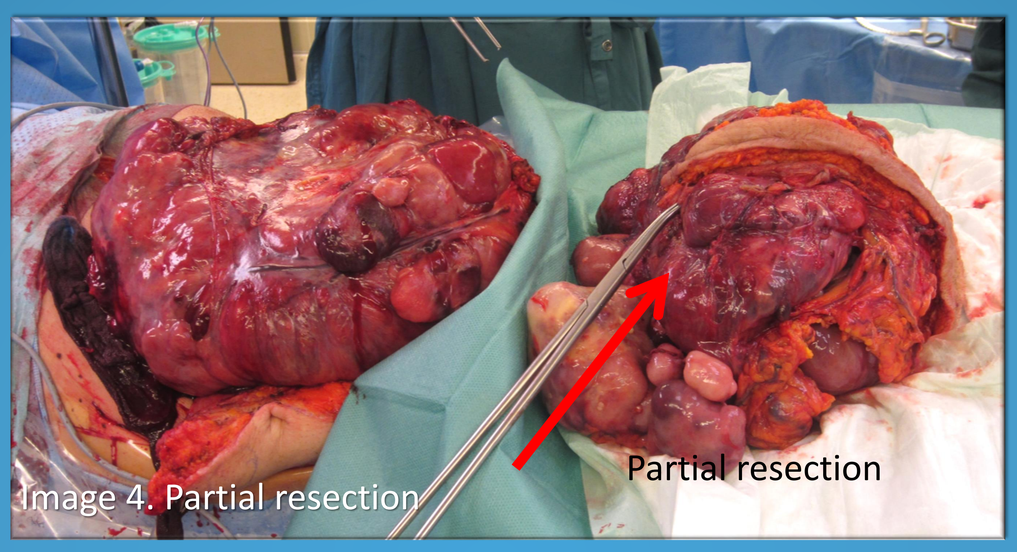


Image 4. Partial resection

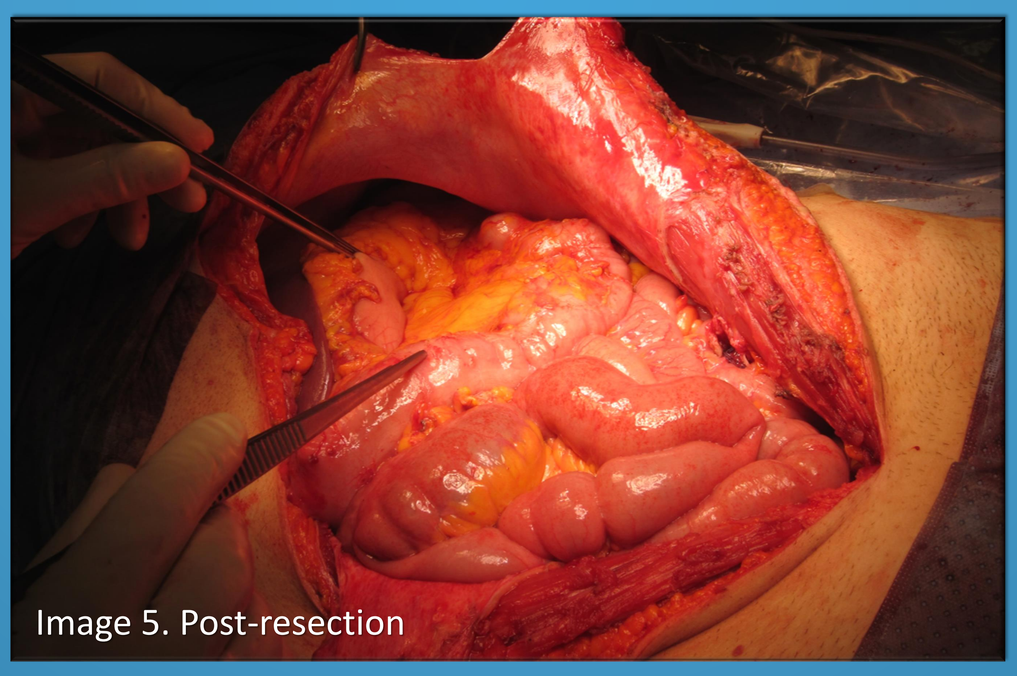
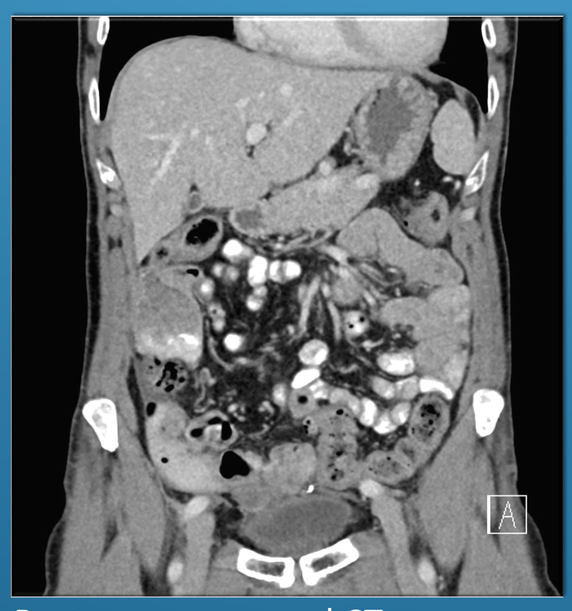
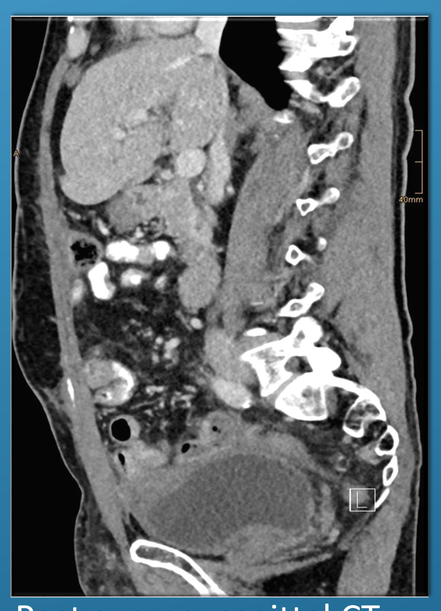


Image 5. Post-resection



Post surgery coronal CT



Post surgery sagittal CT

1) Travis et al. Mesenchymal tumours. In: Tumours of the Lung, Pleura, Thymus and Heart, IARC Press, Lyon 2004.
2) Fletcher et al. Extrapleural solitary fibrous tumor. In: WHO Classification of Tumours of Soft Tissue and Bone, IARC Press, Lyon 2013
3) Demicco et al. Solitary fibrous tumor: a clinicopathological study of 110 cases and proposed risk assessment model. Mod Pathol. 2012 Sep
4) Cranshaw et al. Clinical outcomes of extra-thoracic solitary fibrous tumours. Eur J Surg Oncol. 2009 Sep
5) Cardillo et al. Solitary fibrous tumors of the pleura. Curr Opin Pulm Med. 2012 Jul

Background

Solitary fibrous tumor (SFT) comprises a histologic spectrum of rarely metastasizing fibroblastic mesenchymal neoplasms. Although they are commonly thought of as intrathoracic tumors, 50 to 70 percent of SFTs arise outside the thorax. SFTs are thought to be rare overall and accounted for less than 2 percent of all soft tissue tumors and may arise at any age but are most common in the fifth to seventh decades.
Approximately 30 percent arise in the peritoneal cavity, retroperitoneal soft tissue, or pelvis.
Small tumors are typically asymptomatic, therefore intraabdominal SFTs may attain large sizes (>20 cm) prior to presentation.
The majority of SFTs behave in an indolent fashion and do not recur locally or distantly. However, 10 to 25 percent of tumors recur, and reported 10-year disease-specific survival rates for both pleural and extrapleural SFTs are between 73 and 100 percent.
The prognostic value of molecular biomarkers (eg, NAB2-STAT6) is under study in patients with SFTs, but none is ready for clinical use. Prolonged survival after an SFT recurrence is possible, particularly for those who are amenable to reresection.
Complete en bloc surgical resection is the mainstay of therapy for all localized SFTs.