Imaging of benign solitary fibrous tumor of the pleura: a pictorial essay

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Abstract

Solitary fibrous tumor of the pleura (SFTP) is a mesenchymal tumor that tends to involve the pleura, and is also described in other thoracic and extrathoracic sites. SFTP usually presents as a peripheral mass abutting the pleural surface, to which it is attached by a broad base or by a pedicle that allows it to be mobile. SFTPs exist in benign and malignant forms. A precise pre-operative diagnosis can be arrived at with a cutting-needle biopsy, although most cases are diagnosed with post-operative histology and immunohistochemical analysis. In this pictorial essay, we review a large series of cases, with emphasis on the radiographic appearance of these lesions and their findings from computed tomography, magnetic resonance imaging, ultrasonography and positron emission tomography.

Introduction

Solitary fibrous tumor of the pleura (SFTP), first described as a distinct clinical entity by Klemperer and Rabin in 1931,1 is a mesenchymal neoplasm which usually involves the pleura, but it can occur in other thoracic areas (mediastinum, pericardium, and lung) as well as in extra-thoracic areas (meninx, epiglottis, salivary glands, thyroid, kidneys and breast).1,2 SFTP occurs with equal frequency in both sexes and is more commonly found in the fourth, fifth, and sixth decades of life.1

Most of the patients are asymptomatic at the time of diagnosis, and SFTP is discovered only on routine roentgenograms of the chest. In the remaining patients, the most common clinical symptoms are chest pain, cough and dyspnea.1,2 SFTP may occur in benign and malignant forms, these latter showing locally invasive behavior. Pre-operative diagnosis can be obtained by a transthoracic cutting needle biopsy, but in most cases only pathological evaluation of the resected specimen supported by immunoreactivity of neoplastic cells for CD34 or CD99 allows confirmatory diagnosis.2,7

Concerning microscopic features, the most common architectural pattern is the so-called “patternless pattern”, in which spindle cells with bland ovoidal vesicular nuclei and scarce cytoplasm, and connective tissue are arranged in a random pattern characterized by a combination of alternating hypocellular and hypercellular areas. In the second most common pattern, tumor cells lie in contiguous tissues with irregular branching small vessels that result in a hemangiopericytoma-like appearance. Hypercellular areas may alternate with hypo-cellular fibrous areas, hemorrhagic, mixoid or necrotic areas.8 Tumor cells are immunoreactive for CD34 and CD99, and are also variably positive for Bcl-2; usually cytokeratins and desmin are negative.6

In this pictorial essay we present a large series of SFTP, all surgically resected, with some emphasis on the radiographic appearance of these lesions and their findings at computed tomography (CT), magnetic resonance (MR), ultrasonography (US), positron emission tomography (PET), with histological correlation. We selected the most significative images in a series of 50 patients from 1990 to 2009. The aim of our paper is to help radiologists and chest physicians to become familiar with the broad spectrum of imaging appearances of SFTP.

Chest radiograph

Chest radiographs of patients with small SFTP typically demonstrate a well defined, lobular, solitary mass, which may be visualized in the lung periphery and typically abuts a pleural surface or is located within a fissure (Figures 1 and 2).

“The incomplete border sign” of extrapleural lesions is useful to differentiate SFTPs from lung masses (Figure 3a). Because extrapleural lesions may exhibit tapered borders, postero-anterior radiography results in an ill-defined margin. Focal pleural masses may also exhibit this “incomplete border” in addition to sharply defined margins when imaged tangentially.5

Figure 1. Benign SFTP in 2 asymptomatic patients. Postero-anterior (PA) chest radiograph shows smooth marginated masses abutting pleural surfaces (arrows).

Figure 2. Incidental finding of a small thoracic mass on the magnification of chest X-ray. PA (a) and lateral (b) views of a 52-year old man, suggesting an intrathoracic location. During surgery, the lesion presented as a solid mass located within the fissure.
Larger tumors or tumors arising from the mediastinal portion of the parietal pleura may be indistinguishable from primary pulmonary or mediastinal masses (Figure 4a and 5a). Occasionally, changes in location of a pedunculated mass may be demonstrated.5,10

Computed tomography

CT findings are strictly dependent on tumor size. In case of small SFTP, CT more frequently typically demonstrates a homogeneous well-defined, non-invasive, lobular, soft-tissue mass, usually adjacent to the chest wall (Figures 6a, b, and c) or within a fissure, showing an obtuse angle with the pleural surface (Figure 7).10

Larger lesions are typically heterogeneous and may not exhibit CT features suggestive of focal pleural tumors (Figure 8). Such lesions usually form acute angles with the adjacent pleural surface mimicking a subpleural pulmonary mass that could be misdiagnosed as peripheral lung cancer.5

Dedrick et al.11 stated that a “smoothly tapering angle” of the tumor with the adjacent pleura (seen in 5 of their 6 cases) was a highly characteristic finding that could help in establishing the pleural location of the masses (Figure 9). Tumors that are localized within an interlobar fissure can sometimes be interpreted as a pulmonary mass when they appear completely surrounded by the pulmonary parenchyma.

However, multidetector CT provides improved visualization of interlobar fissure and its relationship with the tumor (Figure 10). SFTP that have a mediastinal pleural origin can mimic a mediastinal neoplasm; differential diagnosis from a true mediastinal tumor is often impossible (Figure 5b and c). Furthermore, multidetector and volumetric reformatted CT images are crucial in the differential diagnosis of SFTP originating from the mediastinal pleura, which may mimic a thymic or a germ cell tumor.

SFTP have been reported to exhibit intermediate to high attenuation on unenhanced CT scans (Figure 11a). This attenuation has been attributed to the high physical density of collagen and the abundant capillary network within these lesions.3

Intralesional calcifications (punctate, linear or coarse) are constantly associated with areas of necrosis and more easily seen in larger tumors or tumors arising from the mediastinal portion of the parietal pleura may be indistinguishable from primary pulmonary or mediastinal masses (Figure 4a and 5a).

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In the case of large masses with calcification, enhancement after contrast medium is typically intense and heterogeneous with central areas of low attenuation (Figure 4b). Such intralobular geographic pattern has been shown to correlate with myxoid changes and areas of hemorrhage, necrosis, or cystic degeneration (Figure 4f and Figure 11b and c). Magnetic resonance imaging

SFTPs show variable signal intensity on MRI. Signal intensity has been described as isointense to muscle on T1, and hypointense on T2-weighted images. Ferretti et al. reported 4 cases of SFTP with heterogeneous signal intensity on T2-weighted images (Figure 4c and d). Signal intensity increased with intravenous gadolinium (Figure 3b, c and d). It has been suggested that this variable signal intensity mainly depends on the relative amount of collagen and fibroblasts, and presence of areas of hemorrhage, necrosis, or cystic degeneration in the tumor. Intense enhancement of an SFTP is generally due to high vascularity.

Ultrasonography

SFTPs appear as well-circumscribed non-calcified homogeneous low echogenicity or heterogeneous tissue masses (Figure 3e and f, 4e). In a previous case report, 6 out of 9 lesions were heterogeneous and exhibited hypoechoic and hyperechoic areas in the absence of cystic degeneration and of intralesional calcifications.

Positron emission tomography

Data concerning the role of positron emission tomography (PET) with 18F-fluoro-2-deoxy-D-glucose (FDG) in the evaluation of patients with SFTP are scarce. Cortes and coworkers reported no FDG uptake in 2 patients and only minimal FDG uptake (SUV 2.1) in one patient.
Conclusions

SFTP is usually discovered incidentally on chest radiographs of asymptomatic patients. The pre-operative differential diagnosis of any mass lesion of the chest ranges from the carcinoma of the lung to various intrapleural sarcomas and pleural mesothelioma, but SFTP should also be considered.

The usual well-circumscribed appearance of the SFTP mass generally rules out malignant pleural mesothelioma since the latter invariably consists of multiple scattered pleural masses or a more diffuse mass encasing the lung.

A posterior paraspinal location might suggest a neurogenic tumor, while a more anterior and para-mediastinal location might raise the possibility of a thymic neoplasm, germ cell tumor, or teratoma.

When SFTP reaches a large size the diagnosis should be considered in consideration of the absence of local invasion, lymphadenopathy, or metastatic spread in patients usually presenting in good health.

References