Primary leiomyosarcoma of the distal fibula: A case report and review of the literature

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Abstract

We describe a primary leiomyosarcoma of bone located in the distal fibula in a 67-year-old man. Plain radiographs and computer tomography scan revealed a lytic destructive lesion in the distal metaphyseal region of the left fibula with little involvement of the surrounding soft tissues. The lesion was composed of proliferating spindle-shaped cells with very slim cytoplasm and narrow oval cigar shaped nuclei. Immunohistochemistry studies demonstrated a strong positivity for actin and desmin, and weak positivity for caldesmon.

Introduction

Leiomyosarcoma is one of the more frequent malignant mesenchymal tumors arising in soft tissues, the skin, the gastrointestinal tract, the uterus and rarely in the bone.1-4 It is characterized by atypical spindle cells. The diagnosis of leiomyosarcoma is based essentially on histopathologic and immune-histochemical evidence.

Case Report

A 67-year-old man was admitted to our hospital because of a 5-month history of pain in his left ankle. Physical examination revealed partial limitation of motion of the left ankle joint. On palpation, a tender, subcutaneous swelling on the anterolateral lower third of the patient’s left leg, just proximal to the ankle joint was noted. There was no palpable lymphadenopathy in the draining regional lymph nodes. The serum alkaline phosphatase, phosphorus, calcium, and uric acids levels were within normal limits. X-rays of the left leg with ankle revealed a poorly defined permeative osteolytic lesion in the distal third of the fibula. The tumor had mainly a metaphyseal location and extended into the epiphysis. This neoplasm occupied the medullary canal, breaking through the cortex and extending to surrounding soft tissue with slight periosteal new bone formation (Figure 1).

Computed tomography (CT) and Magnetic Resonance (MRI) confirmed the presence of an osteolytic fibular mass, which was expanding the medullary canal, destroying the lateral as well as the medial cortex and involving the surrounding soft tissue (Figure 1). A periosteal bone reaction was clearly seen in CT. Magnetic resonance imaging of the lesion showed it to be hypointense on T1-weighted image and heterogeneous on T2-weighted image with iso- and hyper-intense areas. The histological diagnosis of leiomyosarcoma was made on the basis of an open incisional biopsy. The most direct approach to the distal fibula was selected, the skin incision was also planned to be included in the definitive resection. A 2-cm longitudinal incision was made under fluoroscopy from the tip of the lateral malleolus extending proximally over the posterolateral aspect of the fibula. The incision was then deepened through the subcutaneous tissue down to the perios- teum, which was then incised. With the use of 2.5 mm drill bit, multiple cortical holes were performed in the form of a square. With the use of small osteotome, a cortical window was opened and bone curettage was done. Adequate specimen was taken followed by hemostasis to prevent the contamination of the surgical field with tumor cells. This was followed by closure of the different layers and Inserting a drain with the exit tract through the wound margin. A protective-weight bearing for was applied postoperatively. The routine oncological work-up revealed that the patient had no history of previous tumors. He denied any abdominal or pelvic pain. Abdominal and pelvic ultrasound revealed no evidence of tumors in gastrointestinal tract. Endoscopy demonstrated a completely normal oesophago-gastric and duodenal mucosa. Thorax CT excluded pulmonary metastases. Since no primary tumor could be demonstrated at any other localization, an en bloc resection of the distal left fibula was performed. After presenting the results of the resection in the second tumor conference, neither radiotherapy nor chemotherapy were indicated. The surgical margins were free of tumor. The ankle was stabilized in a Vacuum Shoe. The patient was put on a program of physiotherapy. The patient is still on regular follow-up to check for recurrence or metastasis.

Discussion

Our patient sought in the summer of 2013 medical advice because of persistent pain and swelling in the left lateral malleo-
lus. The initial workup showed an osteolytic lesion in the distal fibula. At first we have done the necessary imaging work-up. A biopsy procedure was then carried out on 12/07/2013, which confirmed the diagnosis of primary leiomyosarcoma of the bone.

After the usual preoperative preparation and patient consent, we carried out an en bloc resection of the left distal fibula on 16/08/2013. Here, a 15 cm piece en bloc has been resected at the distal fibula. With the marker pen the skin access was planned so as to include the old scar of the biopsy. Then followed under fluoroscopic control the determination of the safe zone about 4 cm cranial to the old biopsy scar. The skin incision was elliptical around the old scar. The tissues were then prepared to expose the lateral leg compartment. The fibula was sawed with the oscillating saw 6 cm above the tumor and then enucleated after that the attaching distal ligaments have been discontinued (syndesmosis and lateral collateral ligaments). After resection of the distal fibula appeared a bony-erosion in the tibia in the incisural fossa just above the joint line. It was unclear to the naked eye whether if that was tumor infiltration or not. The preoperative magnetic resonance imaging and CT showed no evidence of tumor extension into the tibia. It was then decided to remove this eroded bone island with the oscillating saw. Postoperatively the patient was mobilized with landscaped Vacoped boots (Figure 4). The postoperatively performed radiographs showed an orthograde position of the tibia in the mortise. Now and after almost 80 months after the index surgery, the patient does well, has good ankle mobility, and had no recurrence (Figures 5 and 6).

Primary leiomyosarcoma of the bone is an extremely uncommon malignant condition first described by Evans and Sanerkin. In the literature, there are only about 97 cases of reported primary bony leiomyosarcomas. On the other hand, these lesions are well documented in the gastrointestinal and female genital tracts.

According to their location, leiomyosarcomas can be subdivided into three groups with different clinical behaviors. The most common and aggressive group of leiomyosarcomas arises in deep soft tissues (e.g., the retroperitoneum and abdominal cavity) and female genital tract. The second group is represented by cutaneous and subcutaneous tumors. The third group consists of rare cases of vascular and primary bony leiomyosarcomas. Prognosis is generally poor for the retroperitoneal and subcutaneous tumors, variable for the bony type, and best for the cutaneous leiomyosarcomas.

Seventy-three of the 97 primary leiomyosarcomas of bone reported in the literature were located in the long bones of the extremities and involved mainly the metaphyseal area. The femur is the long bone most frequently involved (42%), followed by the tibia (38%) and the humerus (15%).

A leiomyosarcoma of the bone is a rare occurrence. Adelani et al. reviewed 107 skeletal leiomyosarcomas that had been previously reported in the English literature. According to their review, the patients’ age widely ranged from 9- to 87-year-old with a median age of 47 years. Twenty-nine percent of tumors arose in the distal femur, followed by proximal tibia (26%). The locations of skeletal lesions (Figure 7) were femur in 46 patients (distal 27, proximal 8, diaphysis 7, unknown 4), tibia in 27 (proximal 16, distal 5, diaphysis 2, unknown 4), pelvis in 14, humerus in 8 (proximal 7, diaphysis 1), mandible in 8, fibula in 4 (distal 4), maxilla.
in 3, rib in 3, clavicle in 2, scapula in 1, sternum in 1, distal phalanx in 1, thoracic vertebrae in 1, sacrum in 1, talus in 1. Most of the leiomyosarcomas arising in long bones involved the metaphyses.\(^1\)

The present case was located in the meta-epiphyseal region of the left distal fibula. There have been a few isolated cases in the literature where the tumor has involved the bones of the foot and ankle. The primary leiomyosarcoma involving the fibula has been, to our knowledge, four times previously reported in the literature. Radiologically, this tumor and most of the reported primary leiomyosarcoma of long bones show similar findings: they are usually osteolytic and may exhibit aggressive characteristics, such as permeation of the cortical bone and extension to surrounding soft tissue. However, generally speaking, Primary leiomyosarcoma of the bone does not have a typical radiographic appearance and can mimic any other primary or secondary malignant tumor. High-grade leiomyosarcomas show an ill-defined, irregular osteolytic appearance with a moth-eaten or permeative pattern. On the other hand, low-grade tumors exhibit a geographic pattern of bone destruction with a sclerotic rim, a thing that can simulate a benign process.\(^8,30\)

The diagnosis of primary leiomyosarcoma of bone was established by its characteristic histological appearance and supported by the positive immunohistochemical staining. So far, all the leiomyosarcomas described in bone have shown the same features, consisting of a sheet-like proliferation of spindle cells arranged in intersecting fascicles with focal malignant fibrous histiocytoma-like areas.\(^8,31,22\)

In any case of leiomyosarcoma involving bone, a metastatic lesion must be ruled out before the lesion can be designated as a primary tumor. The differential diagnosis includes malignant haemangiopericytoma, epithelioid angiosarcoma and epithelioid haemangioendothelioma.\(^32,33\) Malignant haemangiopericytoma of bone, although rare,\(^34\) may be difficult to differentiate from leiomyosarcomas. However, hemangiopericytoma does not show immunoreactivity for actin antibodies\(^2,35\) and does not display a complete ultrastructural smooth muscle differentiation. The most common misdiagnosis of leiomyosarcomas across the literature was the malignant fibrous histiocytoma. Other differential diagnoses include lymphoma, malignant fibrous histiocytoma, plasmacytoma, fibrosarcoma, Ewing’s sarcoma, osteolytic osteogenic sarcoma and metastatic carcinoma. Sundaram et al. reported two characteristics of primary bone leiomyosarcoma that may be helpful

**Figure 2. The resected part with the safe-zone.**

**Figure 3. Microscopic view of the lesion H&E: 1. Spindle shaped tumor cells with fascicular muster, tumor cells with eosinophilic cytoplasm and cigar shaped nuclei with atypia. 2. Nuclear atypia with hyperchromatosis. 3. Positive cytoplasmic actin expression in the tumor cells.**

**Figure 4. clinical follow-up photos one year postoperatively and rehabilitation with vacoped Boots.**

**Figure 5. Clinical follow-up 3 years after the index operation.**
in differentiating these from other aggressive osteolytic lesions. First, lesions had a considerable length, extending along the longitudinal axis of the bone, and second, the signal intensity of these lesions on T2-weighted MR images is intermediate to low (decreased signal intensity with respect to normal bone marrow), whereas most osteolytic lesions are hyperintense on T2-weighted images.36

The pathogenesis of the primary leiomyosarcoma of bone is unclear. Most opinions consider that it arises from the smooth muscle cells of blood vessels, although an origin in perivascular myofibroblasts or mesenchymal fibroblasts cannot be ruled out.6,5,13,23 Potential risk factors were identified in 10% of the cases across the literature and included chemotherapy, Paget disease of the bone, and orthopedic implants, previous bone infarction and

Figure 6. Radiological findings: A, immediately postoperative. B, one year postoperative. C, three years after the index operation.

Figure 7. Distribution of the primary leiomyosarcoma of the bone following the review of Adelani et al. (2009).
Case Report

Primary leiomyosarcoma of the bone is rare and should be kept in the differential diagnosis of primary malignant osteolytic neoplasms. Histopathological evaluation with immunohistochemistry analysis is the mainstay in reaching the accurate diagnosis. Treatment is primarily surgical with limited benefit from neoadjuvant and adjuvant therapies.

References


