

Macroscopic appearances and microscopic pathology of benign and malignant soft tissue tumours

Reily Ann Ivan^{1*}, Kuruvilla P Chacko², Viswanathan P³, Sarada V¹

¹Department of Pathology, ²Department of Obstetrics and Gynaecology, Chennai Medical College Hospital and Research Centre (SRM Group), Tiruchirapalli – 621 105, INDIA.

³Department of Pathology, Rajah Muthiah Medical College, Annamalai University, Annamalai Nagar – 608 002, INDIA.

Email: kuruvilla_chacko@yahoo.com

Abstract

The incidence of soft tissue tumours, especially the frequency of benign tumours relative to malignant ones, is nearly impossible to determine accurately. Benign soft tissue tumours outnumber malignant tumours by a wide margin. The main objective of this study is to describe the macroscopic and microscopic pathological features of benign and malignant soft tissue tumours. A total of 155 cases of soft tissue tumours over a period of two years were included. Soft tissue tumours accounted for 11.2% of all tumours. The benign tumours accounted 89.7% while malignant tumours constituted 10.3% (8.7:1). Benign soft tissue tumours showed predilection for head and neck region and malignant determined for lower extremities. The early diagnosis and prompt treatment may reduce the severity of morbidity and lessening mortality.

Keywords: Benign tumours, malignant tumours, macroscopic description, microscopic observation.

*Address for Correspondence:

Dr. Reily Ann Ivan, Department of Pathology, Chennai Medical College Hospital and Research Centre (SRM Group), Tiruchirapalli – 621 105, INDIA.

Email: kuruvilla_chacko@yahoo.com

Received Date: 10/08/2015 Revised Date: 28/09/2015 Accepted Date: 20/10/2015

Access this article online	
Quick Response Code:	Website: www.statperson.com
	DOI: 22 October 2015

INTRODUCTION

Among various type of tumours, Soft tissue tumours are considered as mesenchymal multiplication, that happen in extra skeletal nonepithelial tissue of the body, not including the viscera, covering of brain and lymphoreticular system¹. Soft tissue tumours can take place at any age. Both benign and malignant soft tissue tumours commonly present as painless mass. They occur everywhere in the body, the most widespread locations being the extremities, trunk, abdominal cavity and head and neck region^{2,3}. Soft tissue tumours have spellbound

among pathologists for many years because of the wide variety of tumours and histopathological similarities between some tumours with only subtle difference which is discernable on careful microscopic examination thus posing a diagnostic challenge to the histopathologist³. Soft tissues are mainly composed of connective tissue, adipose tissue, skeletal muscle, smooth muscle, blood vessels, lymphatics and peripheral nervous system⁴. Soft tissue tumours are unusual and comprised of 2% or less of surgical pathology cases. A diagnosis previously reached or suspected by light microscopy is supported by help of electron microscopy, immune-histochemistry and tissue cultures. The functions of special stains in soft tissue tumour pathology may be uneven, questionable or may validate the light microscopic diagnosis⁴. Tumours and tumour like lesions of soft tissue continues to be a challenge to both the surgeons and pathologists due to their biological behaviour and histogenesis. Soft tissue sarcoma (STS) is a kind of unusual tumours that can transpire anywhere in the soft tissues of the body including fat, muscle, connective tissue, nerves etc. Sarcomas can initiate anywhere in the body; typically, it develop in the soft tissues that encircle, attach or bear the

body's structure and organs⁵. The extensive disparity that many of the soft tissue tumours demonstrate in their histological patterns extends the pathologists diagnostic capability to an edge^{6,7,8}. Conceivably in no other field of diagnostic pathology has there been such a proliferation of newly described entities as in the areas of soft tissue pathology in the last 10-20 years⁹⁻¹⁶. This infrequency, inconsistency and multiplicity have interested us to take up the study on soft tissue tumours. The main objective of this study is to find out the macroscopic and microscopic pathology of soft tissues of both benign and malignant. The data of this type of investigation is limited in our Country (INDIA). The incidence of the various soft tissue tumours with special emphasis to macroscopic and microscopic determination was included in this study.

MATERIALS AND METHODS

A battery of 155 biopsy specimens of both incisional and excision were included which was received in the Department of Pathology, Rajah Muthiah Medical College and Hospital, Annamalai University, Chidambaram, INDIA. The detailed clinical data comprising of clinical diagnosis, relevant investigations including macroscopic (size, shape, color and macroscopic extension) and microscopic pathology (haematoxylin and eosin staining) were included. The specimens were maintained in the 10% neutral formalin for 24 hours and processed; 4mm thick sections were made from representative areas and submitted further for routine processing. The paraffin sections were placed in xylol for 2 minutes and transferred to absolute alcohol for 1 minute. Then it was transferred to haematoxylin for 10-40 minutes and then the slides were placed in the washing

tray for blueing. Sections were dipped in acid alcohol for few seconds and transferred to 1% eosin as counter stain for 3 to 4 minutes. Finally the slides were transferred to xylol I and II; then mounted using DPX. The microscopy depicted nucleus as blue and cytoplasm as shades of pink. For the photomicrograph, the equipment used in Olympus BX 51 model manufactured by Olympus America Inc powered by new UIS-2 (Universal infinity system) and DIC (differential interference contrast) optical system and enhanced y shaped frame. The halogen illumination of 12V/100W halogen illumination, two neutral density filters large 22mm field of view and widefield binocular was used. The numbers 10X and 20X indicated the patterns of objectives. Further, the classification of tumours was done according to the Histologic classification of soft tumours proposed by collective effort by pathologists.

OBSERVATION AND RESULTS

Out of four thousand and forty five surgical biopsies, neoplastic lesions were found among 454 (11.2%) specimens. A total of 155 soft tissue tumours were also identified. Out of soft tissue tumours, benign and malignant tumours were interpreted among 139 (89.7%) and 16 (10.3%) specimens respectively. The anatomical distribution of soft tissue tumours were well analyzed where vascular tissue (69.7%) dominated among head and neck site. Among upper limb and lower limb, it was found that adipose tissue depicted as 22.3% and 26.3% respectively. Even in the trunk region also, adipose tissue was found dominated (23.7%). In all cases, benign type of tumour dominated (Table 1).

Table 1: Anatomical distribution of soft tissue tumours

Site	Adipose tissue (n=76)		Fibrous tissue (n=12)		Neural tissue (n=28)		Skeletal tissue (n=1)		Smooth muscles (n=4)		Synovial tissue (n=1)		Vascular tissue (n=33)		
	B	M	B	M	B	M	B	M	B	M	B	M	B	M	
Head & Neck (n=49)	17 (22.3)	-	2 (16.7)	-	7 (25)	-	-	-	-	-	-	-	23 (69.7)	-	
Upper Limb (n=30)	17 (22.3)	-	-	-	7 (25)	2 (7.1)	-	-	3 (75)	-	-	-	1 (3.03)	-	
Lower Limb (n=43)	20 (26.3)	3 (3.9)	2 (16.7)	3 (25)	5 (17.8)	2 (7.1)	-	1 (100)	1 (25)	-	-	-	4 (12.1)	2 (6.06)	
Trunk (n=33)	18 (23.7)	1 (1.3)	5 (41.7)	-	5 (7.8)	-	-	-	-	-	-	-	1 (100)	2 (6.06)	
Total (n=155)	72 (94.7)	4 (5.3)	9 (75)	3 (25)	24 (85.7)	4 (14.3)	-	1 (100)	4 (100)	-	-	-	1 (100)	30 (90.9)	3 (9.1)

(B = Benign; M = Malignant) [Figure in parenthesis denoted percentages]

Majority of benign tumours like lipomas, fibromas, schwannomas and hemangiomas presented as painless tumour of less than 5 cms with more than 6 months

duration. Liposarcomas presented as painless swelling of ≥ 5 cms and ≥ 6 months. Neurofibromas presented as painful tumours of less than 5 cms with more than 6

months. The detailed descriptions of the clinical presentation of soft tissue tumours are depicted in table 2.

Table 2: Clinical presentation of soft tissue tumours among subjected included

Tumour	No. of cases	Duration		Site		Size		Pain
		≤6M	≥6M	UL	LL	TRU	H&N	
Angiosarcoma	3	2	1	0	2	1	0	0
BFH	2	1	1	0	2	0	0	1
Fibroma	7	3	4	0	0	5	2	4
Fibrosarcoma	2	0	2	0	2	0	0	0
Hemangioma	30	5	25	1	4	2	23	30
Leomyoma	4	3	1	3	1	0	0	4
Lipoma	72	10	62	17	20	18	17	63
Liposarcoma	4	0	4	0	4	0	0	0
MFH	1	0	1	0	1	0	0	1
MPNST	4	0	4	2	2	0	0	4
NF	14	0	14	5	4	2	3	14
Pleo-RMS	1	1	0	0	0	1	0	1
Schwanomma	10	7	3	2	1	3	4	6
Syn Sarc	1	0	1	0	1	0	0	1

[M – Minutes; UL – Upper Limb; LL – Lower Limb; TRU – Trunk; H&N – Head and Neck; BFH – Benign fibrous histiocytoma; MFH – Malignant fibrous histiocytoma; MPNST – Malignant peripheral nerve sheath tumour; NF – Neurofibroma; Pleo RMS – Pleomorphic rhabdomyosarcoma; Syn Sarc – Synovial sarcoma]

The incidences of various soft tissue tumours were determined and analyzed in this investigation. Among them, the maximum incidence was observed in lipomatous tumours (51.8%), followed by vascular tumours (21.6%), neural tissue tumours (17.3%), fibrous tumours (6.5%) and smooth muscle tumours (2.8%). The pictorial description of the incidences of soft tissue

tumours was depicted in figure 1. Among the malignant type of soft tissue tumours, the lipomatous and neural tissue tumours are observed in equal incidences (25%) whereas vascular and fibrous tumours showed equal incidences (18.7%). Lesser incidence was detected in synovial and skeletal muscle tumours of 6.25% (Figure 2).

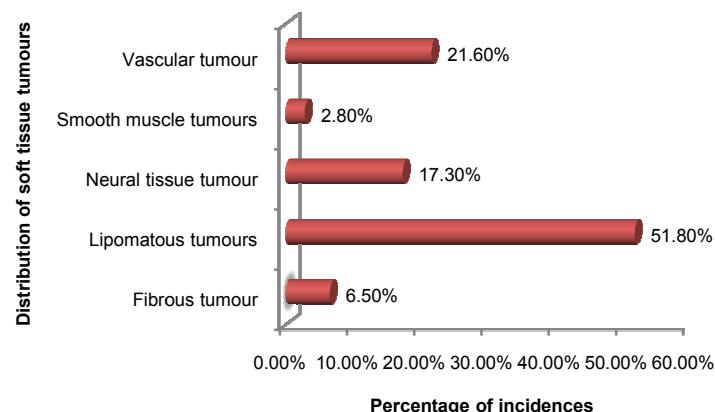


Figure 1: Incidences of various benign soft tissue tumours

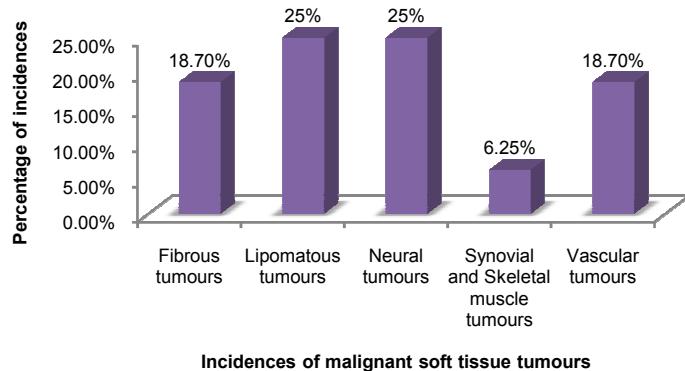


Figure 2: Incidences of various malignant soft tissue tumours

Among the soft tissue tumours, Lipoma (46.5%) dominated followed by Hemangioma (19.5%), neurofibroma (9%), schwannoma (6.5%) and others showed trace and less. The microscopic descriptions of lipoma, haemangioma, neurofibroma and schwannoma were depicted in figure 3A, 3B, 3C and 3D respectively. In the microscopic and macroscopic analysis, the tumour

lipoma showed distinct multilobular pattern and uniform yellow colour and microscopic description showed mature adipose tissue composed of adipocytes with univacuolated cytoplasm, eccentrically placed nuclei and thin walled blood vessels. The detailed description regarding the microscopic and macroscopic observations was interpreted in table 3.

Table 3: Macroscopic and Microscopic analysis of soft tissue tumours interpreted

Tumour	No. of cases analyzed	Macroscopic analysis	Microscopic analysis
Angiosarcoma ¹⁰	3	Well capsulated nodule that appeared to be cystic and hemorrhagic on the cut surface	Central area of haemorrhaging, lined by the neoplastic endothelium with prominent nucleoli
BFH ¹¹	2	Well demarcated nodule of 22mm in diameter; dark brown and yellow components	Unencapsulated dermal nodule with epidermal hyperplasia; predominant histiocyte like and fibroblast like spindle cells in storiform pattern
Fibroma ¹²	7	Smooth greyish external surface; multilocated cavities, solid, whitish fibroelastic features.	Hypercellular with nonatypical spindle cells arranged in storiform pattern, compatible with fibroma
Fibrosarcoma ¹³	2	Distinct border, firm consistency and broad bean like shape; yellowish white and whorl formation	Spindle shaped neoplastic cells; non blunt fusiform nuclei; typical hemangiopericytomatous pattern and contain collagen fibers
Hemangioma ¹⁴	30	Blood tinged multilocular cystic tumour contained in the periosteum	Masses of closely packed small vessels of capillary filled with blood
Leomyoma ¹⁵	4	The mass was grayish white with whorling pattern in cut surface; no hemorrhage or necrosis observed	Interlacing bundles of spindle cells; intersecting fascicles of smooth muscle without atypia, mitotic activity
Lipoma ¹⁶	72	Distinct, greezy, multilobular patterns and uniform yellow colour	Mature adipose tissue composed of adipocytes with univacuolated cytoplasm, eccentrically placed nuclei and thin walled blood vessels
Liposarcoma ¹⁷	4	large, solid, whitish, cerebroid, and myxoid mass, with variable hemorrhage and cystic degeneration, a heterogeneous cut surface	Matured fat cells along with lipoblast like atypical rounded cells with hyperchromatic nuclei.
MFH ¹⁸	1	Gross multilobulated soft tissue mass; solid grey white with minute areas of hemorrhage	Well differentiated fibroblast arrange in a myxoid matrix. Nuclear pleomorphism and mitotic activity
MPNST ¹⁹	4	Yellowish white tumour; no necrosis and haemorrhage; spindle shaped cells with elongated or pleomorphic nuclei and mild atypia	Arrangement in palisading fashion; marked contrast deeply hyperchromatic nuclei and pale cytoplasm
NF ²⁰	14	Solid homogenously grey white soft tissue	Proliferation of axon, Schwann cells, marked

		mass	
Pleo-RMS ²¹	1	Fleshy with focal areas of hemorrhage	elongated nuclei with wavy serpentine configuration and pointed ends Predominantly spindle shaped cells with scattered large cells containing deeply eosinophilic cytoplasm
Schwanomma ²²	10	Homogenous, firm, yellow-white and no true fibrous capsule	Composed of Antoni A and B areas; Spindle cell arranged in palisading fashion along with less cellular
Syn Sarc ²³	1	Well-circumscribed, lobulated tumour with a gray white cut surface, necrotic and cystic changes	Cellular biphasic tumour composed of pleomorphic cells arranged in a fascicular pattern

[BFH – Benign fibrous histiocytoma; MFH – Malignant fibrous histiocytoma; MPNST – Malignant peripheral nerve sheath tumour; NF – Neurofibroma; Pleo RMS – Pleomorphic rhabdomyosarcoma; Syn Sarc – Synovial sarcoma]

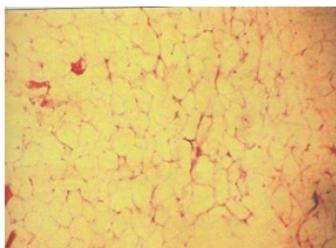


Figure 3A: Mature adipose tissue composed of adipocytes (Lipoma)

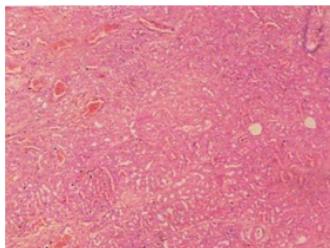


Figure 3B: Masses of packed vessels of capillary calibre filled with blood

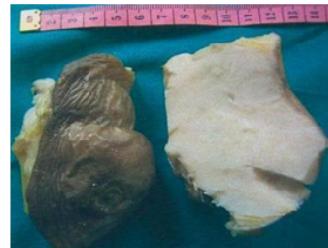


Figure 3C: Solid tissue mass and homogenously Grey white

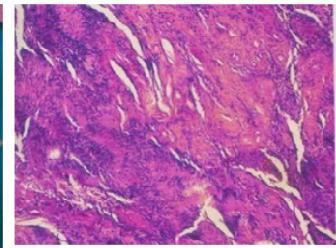


Figure 3D: Spindle cell arrangement – palisading (Verocay bodies)

DISCUSSION

Benign soft tissue tumours are fairly common and are treated with surgery alone. Prior to the 1970s, surgery was the primary therapy for malignant soft tissue tumours, and most patients with high-grade tumours had a poor prognosis and a significant mortality^{10,17-19}. Since the mid-1970s, radiation therapy, chemotherapy, and advanced surgical techniques have helped increase long-term survival and decrease the need for ablative surgery²⁰. There are several studies covering individual tumour types but collective studies covering all tumours are relatively less, but some studies have been conducted in the past so as to know the incidence, age, sex and site distribution of soft tissue tumours^{14,20-22}. Though follow up data provides important information on the ultimate biological behaviour of the tumours, due to various reasons, in our study, this could not be obtained⁴. Majority of patients presenting to our institution in advanced stage of the disease, indicating ignorance, fear and reluctance for surgery; as well as economic constraints, that delay early detection and initiation of proper treatment^{2,9}. The incidence appears to be increasing, targeting the younger population. This signifies the lack of awareness among the people and health care workers about cancers^{5,7,23}. It is also disturbing to know that although literate, patients do not understand the disease process and the need to come early

in case of illness. Limited availability of diagnostic aids and its high cost are other reasons for delay in diagnosis^{5,24,25}. Overall there is 50% mortality for patients with soft tissue sarcomas, and the vast majority of patients die from metastatic disease^{15,25}. Factors shown to be of importance in predicting survival on multivariate analysis include the grade of the tumour, the size of the tumour, the adequacy of resection, local recurrence and the depth of the tumour^{17,20}. These factors are, in general, related more to the biology of the tumour itself. Local recurrence will occur in up to 25% of patients, and factors associated with this on multivariate analysis include the adequacy of surgery and the resection margins, previous local recurrence, grade of the tumour and whether or not radiotherapy has been administered. With this detailed macroscopic and microscopic investigation, we were able to reassess the clinical profile of soft tissue tumours and their different types with site distribution and clinical pathological determination.

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Source of Support: None Declared

Conflict of Interest: None Declared