

A Case of Glomangiopericytoma of the Nasal Septum

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The Editor,

Sir,

A 78-year-old female patient presented to our clinic with congestion in the right nasal cavity and recurrent epistaxis for a month period. The medical history was not significant except hypertension, hyperlipidemia and rheumatoid arthritis. On physical examination, there was a 15 mm diameter, painless and bleeding tumour at the right side of the nasal cavity (Fig. 1A).

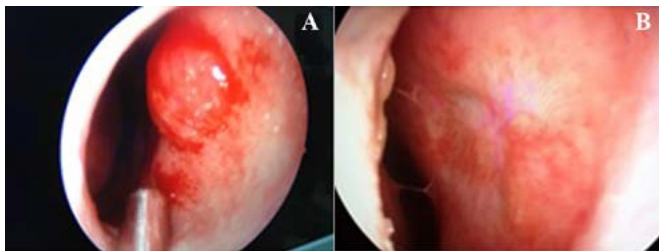


Fig. 1 (A) Right nasal endoscopy showing a haemorrhagic mass. (B) The 15 months of patient follow-up, no signs of recurrence were observed.

Endoscopic examination revealed a haemorrhagic mass in the right nasal septum. At laboratory evaluation there were no abnormal results. The haemorrhagic mass of the septum was widely excised endoscopically including the septum mucosa and the perichondrium. In immunohistochemical assessment, Vimentin was (+), SMA (+) and CD31 (+); CD34 focal positive; Desmin (–), S-100 (–), HMB-45 (–) and CK (–) and Ki-67 index was under 1% (Fig. 2A–E).

The tumour was histopathologically diagnosed as glomangiopericytoma. During the 15 months of patient follow-up, no signs of recurrence were observed (Fig. 1B).

Glomangiopericytoma, which is a type of sinonasal hemangiopericytoma, arises from the pericytes surrounding capillaries. Glomangiopericytoma is a very rare type of nasal cavity tumour, which shows a very slight rise in the female sex, and incidence age peak is during the seventh decade of life and varies in malignancy potential (1, 2). This tumour was classified as glomangiopericytoma by the World Health Organization (WHO) in 2005 (3). Glomangiopericytoma is described

in WHO classification as a borderline low malignancy tumour. The local recurrence rate is 16.8%. However, recurrence can occur as a result of incomplete excision. Thus recurrence is better considered as residual disease in such cases (4). Differential diagnosis includes similar pattern soft tissue tumours such as a solitary fibrous tumour, sinovial sarcoma, hemangioendothelioma, glomus tumour and conventional haemangiopericytomas (5).

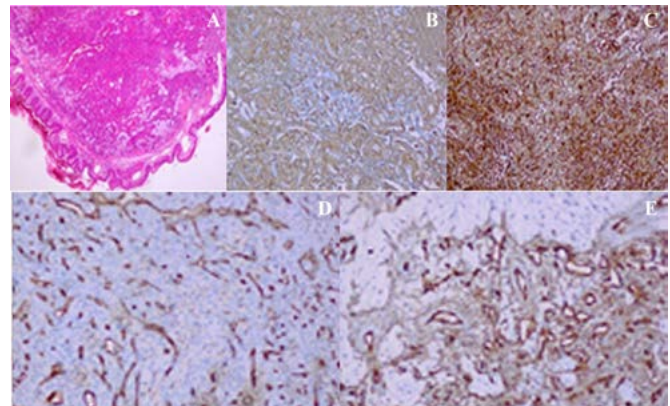


Fig. 2: (A) Hematoxylin-eosin staining reveals nodular lesion which is separated from the squamous metaplastic epithelium of the respiratory tract with a clear neat zone. (original magnification $\times 10$). (B) The results of immunohistochemical staining SMA (+) in the lining cells of the lesion (original magnification $\times 40$). (C) The results of immunohistochemical staining Vimentin (+) in the cells that make up the lesion. (original magnification $\times 40$). (D) The results of immunohistochemical staining CD 31 (+) in the vessel walls of the lesion (original magnification $\times 40$). (E) The results of immunohistochemical staining CD 34 (+) in the vessel walls and peripheral cells of the lesion (original magnification $\times 40$).

Malignancy in glomangiopericytomas is uncommon and malignant tumours display nuclear pleomorphism, high mitotic activity and necrosis (4). In our immunohistochemical assessment, Vimentin was (+), SMA (+) and CD31 (+); CD34 focal positive; Desmin (–), S-100 (–), HMB-45 (–) and CK (–) and Ki-67 index was under 1%. These results diagnosed the tumour as glomangiopericytoma. The gold standard treatment is usually accepted as resection with tumour-free margins (5). In our case, the tumour was widely excised including the septum mucosa and perichondrium. In our case, during the 15 months of patient follow-up, no signs of recurrence were observed.

Glomangiopericytoma is rarely detected at the nasal septum. Definitive diagnosis should be supported with clinical examination and histopathologic and immunohistochemical features. This rarely seen tumour should be kept in mind when evaluating nasal masses. Wide local excision is almost always sufficient for treatment but close follow-up is extremely important.

Keywords: Glomangiopericytoma, epistaxis, nasal mass, nasal septum.

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