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Elastofibroma Dorsi: An Uncommon and Under-Diagnosed Tumour. The Authors' Response[☆]

Fibroelastoma dorsi: un tumor infrecuente e infradiagnosticado. Réplica de los autores

We would like to thank the authors for their interest in and comments regarding our contribution about elastofibroma dorsi (ED).¹ We find interesting the use of new techniques or complementary explorations that can aid in the differential diagnosis of these lesions. Magnetic resonance (MR) is the ideal technique with the best diagnostic accuracy for ED.²

As we postulate in our study, we believe that MR should be done if the physical examination and the ultrasound study do not

clearly direct the diagnosis; nevertheless, more specific studies will provide greater functional and morphological information than the rest of complementary explorations.

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Bilateral Elastofibroma dorsi: a Very Rare Presentation for a Rare Pathology[☆]

Elastofibroma dorsi bilateral: una muy rara presentación para una rara patología

To the Editor:

Elastofibroma dorsi (ED) is an uncommon, non-encapsulated, non-benign tumor characterized by the proliferation of elastin fibers in a stroma of collagen and fatty connective tissue.¹ It is typically seen in people over the age of 60² and in women, with a male to female ratio of 13:1.³ We report two cases of a rare presentation for this type of pathology.

The first case is a 57-year-old symptomatic woman, with right elastofibroma measuring 5 cm × 4 cm that was satisfactorily removed surgically. Two years later, the patient presented a new mass measuring 2.3 cm × 2.3 cm, although without symptoms,

which was extirpated. The second case is that of a 51-year-old man presenting bilateral subscapular masses. They were resected sequentially. Both in the first as well as in the second case, the anatomopathologic results were elastofibroma.

Although the estimated prevalence of ED is 2%² in asymptomatic patients, in series of autopsies individuals over the age of 50 seem to present a prevalence of subclinical ED (<3 cm) reaching 24% in women and 11% in men.¹ In practice, within the exceptional nature of this type of tumors, a bilateral occurrence is extremely rare, and in the literature there are only 11 preceding clinical reports (Table 1), although in the series of autopsies there is also an observed prevalence of bilaterality that is greater than expected (7%).⁴

Diagnosis by imaging studies is usually begun with radiography, which can detect either a soft tissue mass or an elevation of the scapula. On ultrasound, a sub- and pre-scapular mass with a fibrillar, fasciculated appearance is usually observed. On CT, it is seen as a non-encapsulated mass that is lenticular in shape, isodense with the surrounding musculature, and with hypodense striations that correspond with dense fat. Lastly, MRI, which is considered the main imaging technique for its diagnosis, shows the ED as a fatty and fibrous lesion, as seen in a heterogeneous image with areas of intensity similar to muscle tissue (the fibrous part),

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Table 1
Management of Bilateral ED According to Different Authors.

	Biopsy	Unilateral Treatment	Synchronic Bilateral Treatment	Sequential Bilateral Treatment
Bennett (1988)				✓
Machens (1992)			✓	
Hoffman (1996)				✓
Hsieh (1999) [2 cases]	✓		✓	
Müller (1999)			✓	
Turna (2002)				✓
Kara (2002)			✓	
Fibla (2007)		✓		
Benhima (2008)	✓	✓		
Kourda (2009)		✓		
Martínez (2011)				✓

together with others that are hyperintense in strata alternating with the fibrous layers.¹

Classically, there was an indication for the need to carry out biopsy.^{1,2,5} Today, due to the greater specificity of the imaging tests in making the diagnosis, this need has been relegated to the exceptional atypical presentation that can make more difficult the differential diagnosis with pathologies such as sarcoma, desmoid tumors, lipoma, fibroma, schwannoma or hemangioma.^{2,6}

Surgical treatment is usually reserved for symptomatic cases larger than 5 cm.^{1,2,6} In our cases, surgery was indicated sequentially due to the metachronic presentation in the first case and in order to avoid greater patient morbidity in the second. In the literature, synchronic as well as sequential or unilateral approaches (not contralateral) have been used (Table 1), each with favorable evolution and with no relapses. We may therefore conclude that

the method of choice is that which best fits the characteristics and needs of the patient.

In conclusion, it is suffice to state that bilaterality in ED, although rare, is possible and should be contemplated at the time of diagnosis.

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Tuberculous Pseudotumor of the Rhinopharynx*

Pseudotumor de rinofaringe tuberculoso

To the Editor:

Tuberculosis is a predominantly pulmonary disease, although practically all organs and systems can be affected given the hematogenous dissemination of the bacillus. Isolated tuberculosis of the upper aerodigestive tract is rare and is normally associated with primary pulmonary disease.¹ This is an underestimated location due to the oligosymptomatic presentation and to the difficulty for exploring this anatomical region.² We present the case of rhinopharyngeal tuberculosis secondary to pulmonary tuberculosis that was diagnosed by the histopathologic analysis of the nasopharyngeal pseudotumor that was presented.

The patient is a 25-year-old woman with a history of smoking and weekend alcohol consumption. She consulted with her primary care physician due to symptoms of odynophagia with asthenia and weight loss that had been evolving over several weeks. Initially, she was diagnosed with infectious mononucleosis and was prescribed antibiotics. Days later, she was seen by an otorhinolaryngologist due to persistence of the symptoms, now in addition to suppuration and otalgia of the left ear. She began corticosteroid treatment after being diagnosed with chronic pharyngitis. After losing 8 kg in 3 months, the appearance of nighttime sweating and hemoptoic sputum, she was once again seen in otorhinolaryngology in order

to rule out the otorhinolaryngological origin of the hemoptysis. On exploration, a vegetative mass was observed in the nasopharyngeal region, or cavum (Fig. 1A). Upon cervical palpation, several inflammatory laterocervical lymphadenopathies were detected. A biopsy was taken from the lesion observed in the nasopharynx, and the results demonstrated granulomatous disease with tuberculous necrosis in exudative phase. Chest radiography showed bronchogenic dissemination lesions on both upper lobes, coexisting with miliary dissemination (Fig. 1B). Mantoux came back negative twice, as did the sputum sample. In the Ziehl-Neelsen culture of the biopsied tissue, *Mycobacterium complex* sensitive to major tuberculostatics was isolated. The rest of the exploration was normal. The patient was treated with rifampicin, isoniazid and pyrazinamide for 4 months and rifampicin and isoniazid for 2 more months, with complete remission of the disease.

Tuberculosis of the upper aerodigestive tract almost always represents an evolution of advanced pulmonary tuberculosis and can affect the larynx, pharynx and epiglottis.³ These locations are generally resistant to the infection due to the cleansing and inhibitory action of saliva on the tuberculous bacillus,⁴ in addition to other influential factors (saprophyte flora, striated pharyngeal musculature). Symptoms include dysphonia and odynophagia, in addition to chronic expectoration. The clinical signs are varied, from ulcers to pseudotumors and secretory otitis.¹ Some authors describe the lesions that are observed in the pharynx as a group of granulations (miliary tuberculosis) that are similar to "grains of semolina" or "fish eggs".⁵ The base diagnosis should be based on the demonstration of tuberculous mycobacteria using cultures in special mediums (Lowenstein-Jensen, Middlebrook). The presence of acid-fast bacilli with auramine or Ziehl-Neelsen staining is suggestive of

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