The patient had also been diagnosed with multiple lung metastases. At that time, the patient was treated with chemotherapy at our Oncology department. Although first-line, third-generation cyclophosphamide, vincristine, doxorubicin and dacarbazine chemotherapy and second-line, third-generation mesna, adriamycin, ifosfamide and dacarbazine chemotherapy were done, there was no interval change of size of the lung metastases.

About 1 year ago, the patient developed a metastatic tumor in the skull and the brain despite systemic chemotherapy, and received radiotherapy (30 cGy/10 fractions) to the involved skull and frontal lesion. However the skull mass continued to outgrow.

Computed tomography showed a mass lesion with bony erosion on the midline of the frontal area. Magnetic resonance imaging revealed a hyperintense ovoid mass on the T2-weighted image, an isointense on the T1-weighted image, and a homogeneous enhanced mass with gadolinium. Another small-sized enhanced mass with mild peritumoral swelling was found at the deep white matter of the left frontal lobe. A gross total resection of the skull lesion with cranioplasty was performed for the surgical defect. A histologic examination of the specimens revealed metastatic ASPS involving the skull. Surgery with a total removal of the lesions may be effective for improving a patient's symptoms especially from neurological dysfunction.

Key Words : Alveolar soft part sarcoma · Brain metastasis · Sarcoma · Surgery.

INTRODUCTION

Alveolar soft part sarcoma (ASPS), a rare tumor accounting for less than 1% of the sarcoma subtypes, usually develops in the soft tissues of the extremities. The histopathogenesis of ASPS is unclear, but it has specific cellular characteristics. It is also characterized by unusual patterns of metastatic spread. For example, brain metastases have been described as a common feature of metastatic ASPS, whereas those metastases are reported to be relatively rare in other high grade sarcomas. However, ASPS metastasized to both skull and brain metastases are unusual and only several cases have been reported. The present report discusses such a rare case of ASPS with metastases to both the skull and the brain.

CASE REPORT

A 53-year-old woman had a growing hard mass on the frontal part of her head for 8 months and complained of cosmetic problems. Four years ago, the patient had undergone surgery at the Orthopedic Surgery department of our hospital due to a palpable mass on the left thigh, and had been diagnosed with ASPS. The patient had also been diagnosed with multiple lung metastases. At that time, the patient was treated with chemotherapy at our Oncology department. Although first-line, third-generation cyclophosphamide, vincristine, doxorubicin and dacarbazine chemotherapy and second-line, third-generation mesna, adriamycin, ifosfamide and dacarbazine chemotherapy were done, there was no interval change of size of the lung metastases. About 1 year ago, the patient developed a metastatic tumor in the skull and the brain despite systemic chemotherapy, and received radiotherapy (30 cGy/10 fractions) to the involved skull and frontal lesion. However the skull mass continued to outgrow.

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primary site is in the head and the neck. Ronald et al. hypothesized that ASPSs arise from displaced paranganglionic mesoderm and have a close homology with parangliomas of the carotid body type. A muscle origin is indicated. The most common metastases reported are those affecting the lungs (42%), bones (19%), brain (15%), and lymph nodes (7%)19. In another series, the incidence rate of brain metastases was reported to be 19%, and it was always cited in association with metastases to other sites.

Histologically, the ASPS tumor should be distinguished from renal cell carcinoma, granular cell tumor, and paranglioma. Histological features show alveolar clusters separated by thin-walled vascular channels. The cells are polygonal with vesicular nuclei containing a nucleolus and eosinophilic granulated cytoplasm, which exhibit a positive periodic acid-Schiff (PAS) reaction and crystalline-to-granular material. ASPS is characterized by a tumor-specific ASPL-TFE3 fusion protein, der(17)(X;17) (p11;q25), that fuses the transcription factor 3 (TFE3) gene at Xp11 to the ASPL gene at 17q25, creating an ASPL-TFE3 fusion protein. Recently, an antibody directed against the C-terminus of the TFE3 has emerged as a highly sensitive and specific marker of ASPS.

The treatment of metastatic sarcoma to the brain is complicated by the relative radioresistance and chemoresistance of sarcoma cells. Thus, surgery is considered an important part of the management of this disease, and an appropriate plan of care should take into account the status of the patient’s systemic disease, the overall neurological and clinical status of the patient, and the number, size, location, and histological and radiographic features of the patient’s sarcomas.

Fox et al. reported a statistically significant increase in the survival rate of patients with ASPS histology (median survival of 27 months) when compared with all other sarcoma histologies (6.1 months). Previous case reports showed that surgically treated cases have a favorable outcome31,12. Bindal et al. recommended surgical excision of the intracranial metastases in patients who were not terminally ill and did not consider the involvement of the lungs as a contra-indication for surgery. They found that the five-year survival in these patients was better than the case with metastases from other sarcoma histologies. Radiotherapy is recommended after surgical excision because metastatic ASPS is resistant to conventional doxorubicin-based chemotherapy. However, in our case, adjuvant radiotherapy was not applicable due to preoperative radiation.

CONCLUSION

We report the very unusual case of ASPS metastatic to both...
the skull and the brain. The ideal management and the effective therapeutic strategy to adopt are still unclear. Total surgical resection may be effective in improving a patient’s survival and in treating neurological conditions.

References