A diagnostic challenge: Nodular fasciitis as a great mimicker of soft tissue sarcoma

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SUMMARY

Nodular fasciitis, also known as "pseudosarcomatous fasciitis" is a benign soft tissue tumour. Its diagnosis remains a challenge as it is clinically indistinguishable from soft tissue malignancy. We present a case of a 12-year-old boy with the complaint of 1 year history of painless swelling over the left zygomatic region. It was insidious, rapidly enlarging for 2 weeks, with no prior trauma. Clinically, there is an immobile subcutaneous mass over the left zygoma measuring 2x2cm, non-tender, well circumscribed, with firm-to-hard consistency. There is no cervical lymphadenopathy and his-skull x-ray was normal. Ultrasound shows superficial ill-defined hypoechoic lesion with vascularity changes. Fine needle aspiration cytology (FNAC) of the lesion shows atypical cells suspicious for malignancy. We proceeded with complete excision of the left zygomatic mass. Its histopathological examination finding is nodular non-capsulated mass, with spindle proliferation arranged in collagenous stroma, in favour of nodular fasciitis. Patient recovered well post operatively and there is no recurrence. Although truly benign, nodular fasciitis can present as painless and rapidly growing subcutaneous mass from underlying muscular fascia mimicking soft tissue malignancy. Generally, histopathological diagnosis is more superior than imaging. Histologically, nodular fasciitis is a spindle cell lesion marked by fibro-myoproliferation within a myxoid stroma. Benign spindle cell proliferations is difficult to interpret using fine needle aspiration (FNA)-smears alone, especially in pseudosarcomatous lesion. Commonly, aspirates are only reported as "atypical cells". Immunohistochemical stain in a larger tissue sample has more value histologically to exclude sarcomatous lesions. Cellular component of nodular fasciitis demonstrates reactivity towards vimentin (a fibroblast marker), and muscle specific actin. There is limitation of clinical and radiological diagnosis for nodular fasciitis as it mimics the malignant sarcomatous lesion. Interpretation based on fine needle aspiration smears alone is inadequate to confirm benign feature. Hence, immunohistopathological diagnosis by an experienced pathologist greatly help to confirm the diagnosis of nodular fasciitis, differentiating it from a sarcoma.

Surgical approach for a congenital midline cervical cleft: A case report of a rare congenital anomaly

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SUMMARY

Congenital midline cervical cleft (CMCC) is a rare congenital anomaly in neonate with limited cases reported worldwide. It is characterized by a defect in the anterior neck with subcutaneous fibrous cord, a skin tag superiorly, and a sinus tract inferiorly. Treatment is by complete excision and closure of the defect with Z plasty in order to create a tension-free closure and restore contour of the anterior neck. It is recommended from previous literature to perform the surgery as early as possible upon diagnosis for excellent results. We hereby report a Malay boy with CMCC since birth. MRI neck was done at day 19 of life, showing a percutaneous sinus tract extending to the bony surface of the manubrium. Surgery was planned at 2 months of life to prevent contracture formation over the neck. However, it was postponed in view of COVID 19 outbreak. During 4-month follow up, contracture did not set in, however, the serous discharge from the sinus has reduced. He then underwent excision of the midline cervical cleft and Z plasty at the age of 4-months. Postoperative course was uneventful and the patient was discharged well. Follow up at 1 and 3 months postoperatively, showed good wound healing and no evidence of contracture observed. This case highlights that the operation for CMCC can be delayed up to 4 to 6 months of age and the result is similar to early operation.