PostScript

LETTERS TO THE EDITOR

Glomus tumour of the ascending colon

Primary colonic glomus tumours are exceptionally rare and little is known about their natural history. Glomus tumours are mesenchymal tumours of pericytic origin, derived from the glomus body. They occur most commonly as benign subcutaneous lesions of peripheral soft tissue; however, they can infrequently arise at visceral sites including the stomach, pancreas, liver, lung, intestines and genitourinary tract.

We report the case of a previously well 37-year-old man who presented with a 3-year history of intermittent abdominal pain and altered bowel habit. At colonoscopy a ''cobblestoned'' area in the ascending colon was encountered; biopsy showed a tumour of uncertain pathology but with no clear evidence of malignancy. A CT scan revealed no abnormality in this area and there was no radiological evidence of metastatic disease. After discussion, an extended right hemicolectomy was performed and the patient made an uncomplicated recovery.

On gross examination, the tumour appeared flat and indurated; it was sited on the posterior wall of the ascending colon, measuring 30×20 mm. Microscopic examination of the tumour showed densely cellular lobules of varying size. The cells were small and round or cuboidal and intimately related to small vascular spaces within the lobules (fig 1A). No significant mitotic activity or necrosis was seen. The tumour involved the submucosa (fig 1B), muscularis propria and extended transmurally into the paracolic fat with prominent vascular invasion. Local lymph nodes in the resected specimen showed no evidence of tumour involvement.

Stains for mucin and neuroendocrine granules were negative. Immunohistochemistry was positive for vimentin and smooth muscle actin (SMA), but was negative for Cam5.2, CK7, CK20, LCA, chromogranin, synaptophysin, CD56, S100, desmin, CD117 and CD34. The histological and immunohistochemical profile confirmed the diagnosis of a primary colonic glomus tumour.

The immunohistochemical pattern and histological description are common to the three previously reported cases of colonic glomus tumours where data were presented,[1–3] and share similar immunohistochemical profiles to both extra-colonic gastrointestinal (GI) and peripheral glomus tumours.[1] However, in previous reports, the colonic glomus tumours were intramural[1] or confined to the adventitia[2] or submucosa.[3] Our case is unique in describing a tumour showing transmural growth extending into paracolic fat.

Regardless of the site of lesion in the GI tract, glomus tumours have many features which are usually associated with malignancy such as vascular invasion and focal atypia.[1] However, this apparent malignant potential is not supported by the known natural history of colonic glomus tumours as the previously reported cases have always exhibited benign behaviour and metastatic disease has never been reported.[1–3] By contrast, extra-colonic GI glomus tumours have been seen to metastasise,[1 4] and the best criteria to predict their malignant potential are those of Folpe *et al*, which are based on size (>2 cm), atypical mitotic activity, nuclear atypia and deep location.[5] Miettinen *et al* found that GI and peripheral glomus tumours are histologically and immunohistochemically comparable, but recommended that prognostic comparison between these two groups was inadvisable.[1]

As so few colonic glomus tumours have been reported, therefore, the metastatic potential of these tumours remains uncertain but is probably very low.

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Informed consent was obtained for publication of the patient's details in this report

doi: 10.1136/jcp.2006.041590

Accepted 27 July 2006

Competing interests: None.

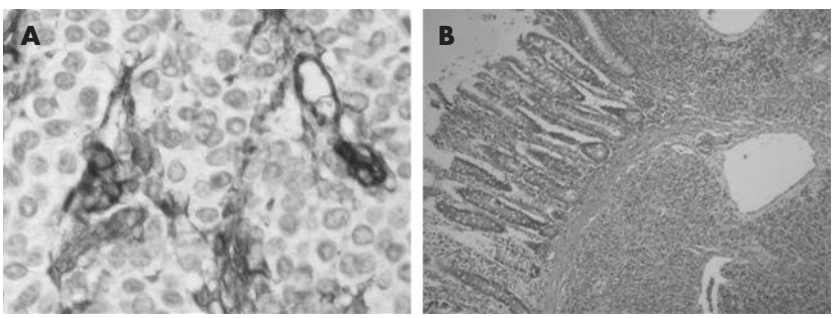

Figure 1 (A) Immunostaining for CD34 shows regular cuboidal tumour cells surrounding prominent vascular channels. (B) Glomus tumour shown below the colonic mucosa.

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The importance of placental examination in all fetal biopsy and postmortem examinations

The object of our study is to reflect on our experience and to examine the findings of fetal biopsy specimens and postmortem examinations in cases referred for clinically unexpected fetal death in utero (FDIU). Clinically unexpected FDIU indicates absence of known fetal, maternal or placental risk factors, that may have caused the death.[1 2]

This is a network-based cohort study of fetal biopsy specimens and postmortems carried out at Southern Health (which incorporates Monash Medical Centre, Moorabbin, Bentleigh; Monash Medical Centre, Clayton; Dandenong Hospital, Dandenong and Casey Hospital, Berwick, all in Victoria, Australia) from January 2002 to December 2005.

During this period, there were 314 fetal deaths among the 27 085 total births; 181 fetal deaths were unexpected[i]—these data include only fetuses of gestational age >20 weeks; unfortunately, the data for fetuses that died at <20 weeks of gestation are not recorded.

A total of 88 cases from 86 pregnancies were referred to as unexpected FDIU. Of these, 78 deaths were of singletons and 10 were of twins (two sets and six single twins). The mean (SD) gestation was 27 (6) (±17 weeks, 2SD), range 14 to 41 weeks (fig 1). The mean (SD) was 30 (2) weeks for twin pregnancies. The proportion of the sexes was roughly equal with 53% males (47 cases) and 47% females (41 cases). In terms of previous deliveries, 29 were multigravid, 27 were primigravid and 30 were not stated by the clinicians. The mean (SD) maternal age was 30.1 (11) years (fig 2). Two of the cases (2.3%) were subjected only to external examination.

In our data, 55 cases were of >20 weeks' gestation, so fewer than one-third of clinically unexpected FDIU had undergone postmortem