SOLITARY RETROPERITONEAL NEUROFIBROMA: A CASE REPORT

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A solitary neurofibroma arising in the retroperitoneal space without any other stigma of von Recklinghausen’s disease is reported. Confusion with another nerve sheath tumor, a schwannoma is a diagnostic pitfall. Histochemical and immunohistochemical stainings of the tumor are useful for the diagnosis of solitary neurofibroma.

Key words: Solitary neurofibroma, Retroperitoneal space, Alcian blue staining, S-100, NSE

INTRODUCTION

A neurofibroma is a benign nerve sheath tumor that occurs as a solitary tumor or as a partial manifestation of von Recklinghausen’s disease: an inheritant disease characterized by multiple cutaneous pigmented lesions (cafe-au-lait spots) and subcutaneous neurofibromas. Although genitourinary involvement of neurofibromas is rare, such cases have been reported in the bladder, kidney, ureter, penis, and retroperitoneal space. Previous literature shows confusion relating to the terminology of the peripheral nerve tumors. We report a case of a solitary retroperitoneal neurofibroma diagnosed by histochemical and immunohistochemical stainings as well as light microscopic appearance of the tumor.

CASE REPORT

A 56-year-old Japanese woman presented with a 2-year history of dysuria which fluctuated with periods of exacerbations and remissions. Significant medical history included total abdominal hysterectomy for leiomyomas 22 years earlier. Family history was negative for von Recklinghausen’s disease. Physical examination revealed traction pain in the left lower limb. Cutaneous examination revealed no cafe-au-lait spots or neurofibromas. All the hematological and serum biochemical data, and urinalysis revealed no abnormality. Drip infusion pyelogram (DIP) demonstrated the medially dislocated bladder and the left ureter, suggesting the existence of the extravesical mass (Fig. 1). On cystoscopy, the bladder mucosa was intact. Computerized tomography (CT) demonstrated a well encapsulated homogeneous mass in the retrovesical space (Fig. 2). Exploratory laparotomy, performed on May 2 1987, revealed an elastic soft tumor in the retrovesical space. The 8 x 8.5 x 8 cm tumor, weighing 326 g was completely excised. Cut surface of the tumor was yellowish-gray in color, and gelatinous. Microscopic examination of the excised tumor revealed fusiform tumor cells in numerous collagen fibrils and a non-organized matrix (Fig. 3). The cell arrangement of Antoni type A and type B was not observed. No cellular atypism and mitotic figures were observed. Alcain blue staining showed positive findings in the matrix. Immunohistostaining for S-100 protein and neuron specific enolase (NSE) showed positive in the tumor cells.
Fig. 1. DIP shows the displacement of the bladder and left ureter medially, suggesting a large extravesical mass.

Fig. 2. CT demonstrates a retrovesical mass.

Fig. 3. Histologic appearance of the tumor shows fusiform tumor cells in a matrix (H & E stain).

(Fig. 4, A and B). Thus, the tumor was diagnosed as a solitary neurofibroma. The patient remains well without any signs of tumor recurrence.

DISCUSSION

A neurofibroma and a schwannoma (neurilemoma) are benign nerve sheath tumors, originating from the Schwann cells. Although there is confusion relating to differentiation between a neurofibroma and a schwannoma, a neurofibroma is distinct from a schwannoma in the following points. (i) The former lacks the compact arrangement of cells in the Antoni type A tissue and delicate single cell thick fascicles of the Antoni type B tissue of a schwannoma. (ii) Alcian blue stains for acid mucopolysaccharides are negative in a schwannoma but positive in a neurofibroma. (iii) A neurofibroma contains fewer S-100 protein positive cells than a schwannoma.

S-100, a dimeric calcium binding protein, composed of different combination of $\alpha$ and $\beta$ subunits, mainly locates in glial and Schwann cells. NSE, a glycolytic dimeric enzyme, locates in neurons and neuroendocrine cells. Immunohistochemical demonstration of S-100 and NSE is valuable in the diagnosis of
a nerve sheath tumor. Unbalanced expression of S-100 subunits is observed in malignant nerve sheath tumors. Hayashi et al. observed an increased expression of the S-100 a subunit in the malignant part of neurofibromas. They concluded that the S-100 subunit immunoreactivity is a good marker for malignant schwannomas.

As described above, we could not distinguish between a neurofibroma and a schwannoma in the previous literature. Das Gupta et al. considered solitary neurofibromas and schwannomas (neurilemmomas) as the same entity, and they reviewed 303 such cases. In that report, most tumors occurred in the head and neck, and extremities. On the other hand, only two of these cases (0.66%) were retroperitoneal origin. Surgical excision of the tumor is the choice of treatment. Careful search for the coexistence of a malignant tumor is necessary, because 16% of the patients with a solitary neurofibroma were reported to have an associated malignant tumor.

It remains to be elucidated whether the clinical course of a solitary neurofibroma differs from that of a schwannoma.

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和文抄録

孤立性後腹膜神経線維腫の1例

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後腹膜に原発し，von Recklinghausen氏病の徴候のない孤立性神経線維腫の1例を報告する。診断上，もう一つの神経鞘由来の神経鞘腫との鑑別が問題で，腫瘍の組織化学染色および免疫組織化学染色が孤立性神経線維腫の診断に有用であった。（泌尿紀要 35: 1157-1160, 1989）