Diagnostic Pathology: Open Access

Case Report Open Access

Alveolar Soft Part Sarcoma of Nasal Cavity Showing Unusual Histologic Feature: A Rare Case Report

Kyungbin Kim[1], Suji Lee[1], Soon Wook Kwon[1], Yury Lee[1], Seoyoung Park[1], Chang Hun Lee[1,2], Ahrong Kim[1,2], Gi Young Huh[1,3], Kyu Sup Cho[4] and Kyung Un Choi[1,2*]

[1]Department of Pathology and Biomedical Research Institute, Pusan National University Hospital, Busan, Republic of Korea
[2]Department of Pathology, Pusan National University, Yangsan-si, Republic of Korea
[3]Department of Forensic Medicine, Pusan National University, Yangsan-si, Republic of Korea
[4]Department of Otorhinolaryngology and Biomedical Research Institute, Pusan National University Hospital, Busan, Republic of Korea

Abstract

Alveolar Soft Part Sarcoma (ASPS) is a rare mesenchymal neoplasm. It affects young adults more and occurs more frequently in the extremities. ASPS is exceedingly rare in the nasal cavity. We report a case of ASPS in the nasal cavity of a 17-year-old female. Its most striking features included organoid and pseudoalveolar arrangement of tumor cells, which were large and polygonal, with vesicular nuclei and abundant eosinophilic cytoplasm rich in granules. There were PAS-positive, diastase-resistant crystalline rods within the cytoplasm. Our case displayed inapparent pseudoalveolar growth pattern and frank pleomorphism. The diagnosis of ASPS, which presents uncommon morphologic findings in unusual sites, is challenging. Recognition of ASPS is greatly assisted by attention to its characteristic cytological features, including intracytoplasmic crystals and immunohistochemistry showing absence of skeletal muscle, epithelial, and neuroendocrine markers.

Keywords: Alveolar soft part sarcoma; Nasal cavity; Pathology; *TFE3*

Abbreviations

TFE3: Transcription Factor Binding to IGHM Enhancer 3; ASPS: Alveolar Soft Part Sarcoma; PAS: Periodic Acid-Schiff; ADHD: Attention Deficit Hyperactivity Disorder; PNS MRI: Paranasal Sinus Magnetic Resonance Imaging; PAS: Periodic Acid-Schiff; HMB: Human Melanoma Black; EMA: Epithelial Membrane Antigen; GFAP: Glial Fibrillary Acidic Protein

Introduction

Alveolar soft part sarcoma is a rare malignant tumor of uncertain lineage. It has characteristic histological and genetic features [1,2]. ASPS mainly affects adolescents and young adults (15-35 years of age, median age 25 years), with a female predominance. ASPS predominantly occurs in extremities and trunk [3,4]. Although it is also known to occur in the head and neck [5-11], especially in children, sinonasal ASPS is exceedingly rare [5-10]. Only five cases in nasal cavity have been reported to date [6-10].

ASPS typically shows a nesting and pseudoalveolar growth pattern. Its epithelioid tumor cells have a large eosinophilic cytoplasm with PAS-positive, diastase-resistant crystals. In some cases, the peudoalveolar pattern as a result of loss of cell cohesion within tumor nests may be lost and the tumor is composed of sheets of epithelioid cells, which can result in diagnostic confusion, especially for tumors at unusual sites [5,10]. A portion of the tumor demonstrates histologic features atypical for ASPS [3,5]. It is characterized by nuclear pleomorphism, increased nuclear hyperchromatism, increased nuclear-cytoplasmic ratio, and decreased cytoplasmic eosinophilia.

We describe an extremely rare case of ASPS of nasal cavity lacking pseudoalveolar growth pattern and showing atypical cytomorphologic features in a 17-year-old female. It is important to perform an accurate diagnosis of ASPS based on its typical cytologic findings described above *ASPSCR1-TFE3* gene fusion is highly specific for ASPS. An anti-TFE3 antibody has proven to be of great value in confirming the diagnosis of ASPS. It was also positive in our case.

Case history

A 17-year-old female patient presented with a 2-year history of right nasal obstruction. She was currently taking medication for ADHD and depression. She had been treated for precocious puberty seven years ago. She had a history of traumatic cerebral hemorrhage 14 years ago. In addition, she had a family history of pharyngeal cancer in her grandfather. Nasopharyngoscopy revealed a polypoid mass in the right posterior nasal cavity. Paranasal Sinus Magnetic Resonance Imaging (PNS MRI) demonstrated a well-defined enhancing mass at the right nasal cavity, involving middle and inferior meatus, measuring 3 x 3 x 1.6 cm in dimensions. The mass exhibited medium signal intensity on T2 weighted image. These images were interpreted as juvenile nasopharyngeal angiofibroma (Figures 1 and 2).

The patient underwent embolization and mass removal. On gross examination, the mass was 2.6 cm in maximum diameter. The cut surface was rubbery in yellow to white tan color. A significant portion of the mass showed a sheet-like growth pattern consisting of pleomorphic tumor cells with hyperchromatic nuclei. Nest formation surrounded by vascular channels of fine capillary size was focally observed. However, pseudoalveolar growth pattern as a result of loss of cell cohesion

***Corresponding author:** Kyung Un Choi, Department of Pathology, Pusan National University, Yangsan-si, Republic of Korea, Email: kuchoi@pusan.ac.kr

Received: 17-Jul-2024, Manuscript No. DPO-24-142151; **Editor assigned:** 19-Jul-2024, PreQC No. DPO-24-142151 (PQ); **Reviewed:** 02-Aug-2024, QC No. DPO-24-142151; **Revised:** 09-Aug-2024, Manuscript No. DPO-24-142151 (R); **Published:** 16-Aug-2024, DOI: 10.4172/2476-2024.1000235

Citation: Kim K, Lee S, Kwon SW, Lee Y, Park S, et al. (2024) Alveolar Soft Part Sarcoma of Nasal Cavity Showing Unusual Histologic Feature: A Rare Case Report. Diagnos Pathol Open 9:235

within tumor nests was not evident. Epithelioid, polygonal tumor cells contained large, vesicular nuclei with prominent nucleoli and abundant, clear to eosinophilic cytoplasm. Mitoses were 0 to 1 per 10 high-power fields (Figures 3, 4A and 4B).

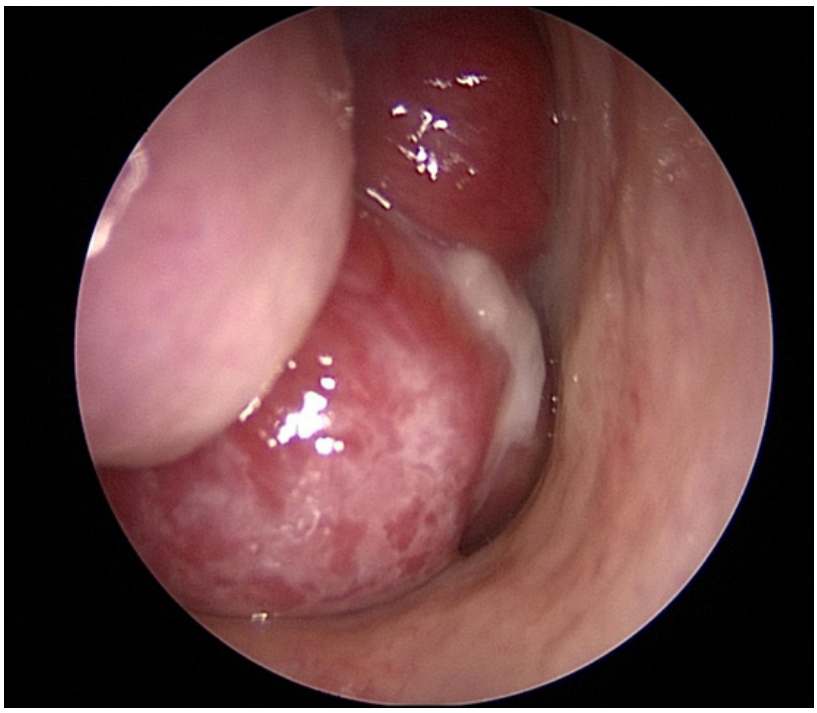

Figure 1: Nasopharyngoscopy showing a protruding polypoid mass lesion in the nasal cavity.

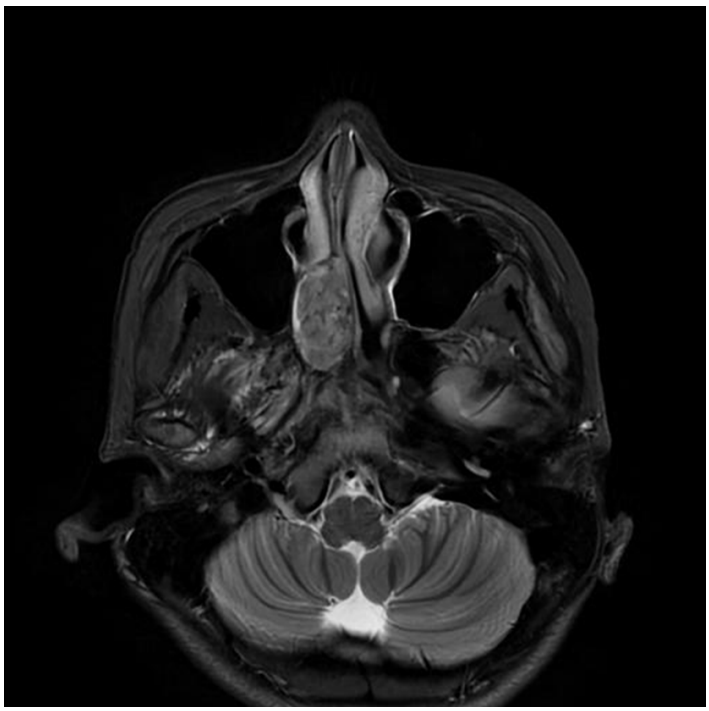

Figure 2: PNS MRI showing a nasal cavity mass approximately 3 cm in size, well-circumscribed, and with medium signal intensity on the T2-weighted image axial view.

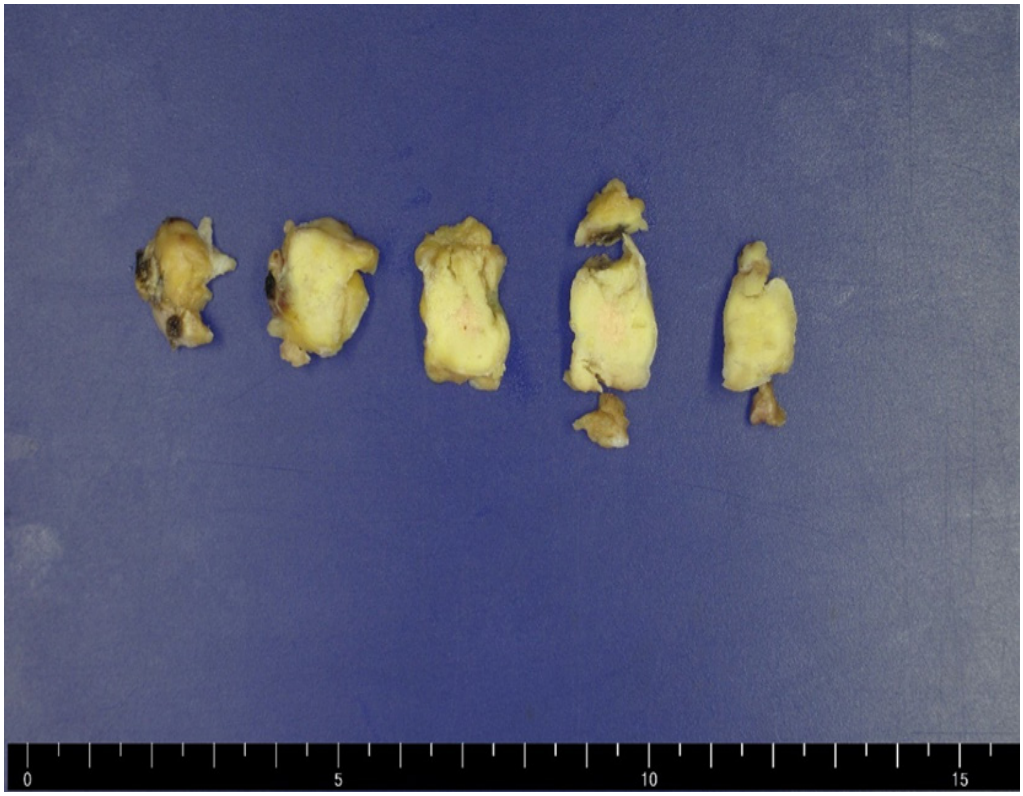

Figure 3: Gross findings of a resected specimen showing the mass, measuring 2.6 cm in maximum diameter, solid and yellowish-white on the cross section.

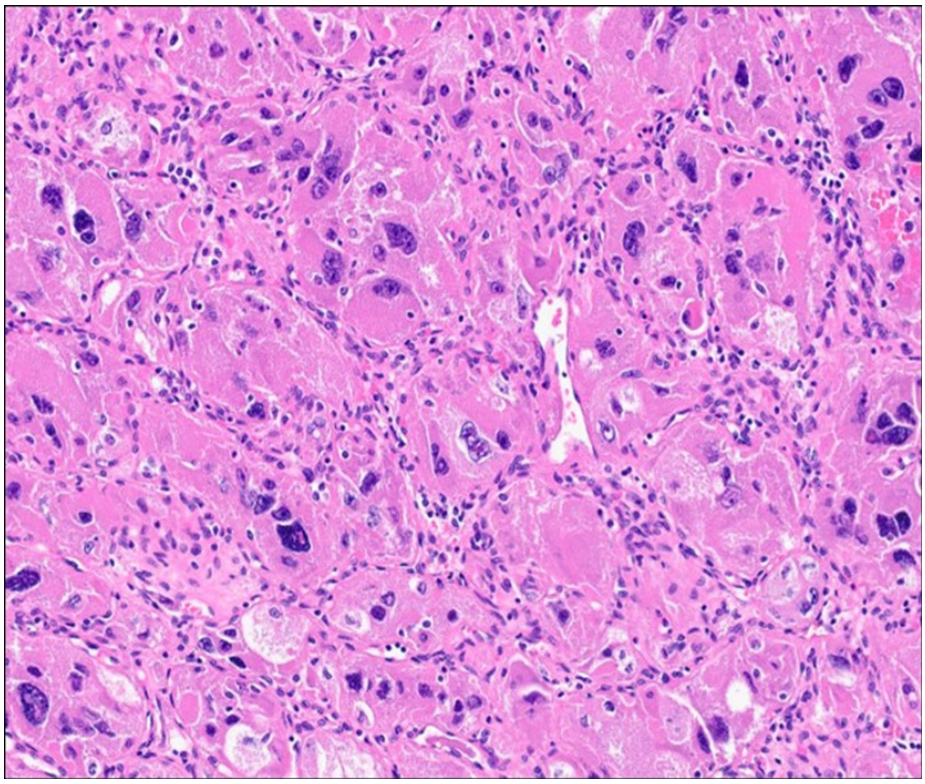

Figure 4A: Microscopic findings showing sheet-like pattern of frankly pleomorphic tumor cells.

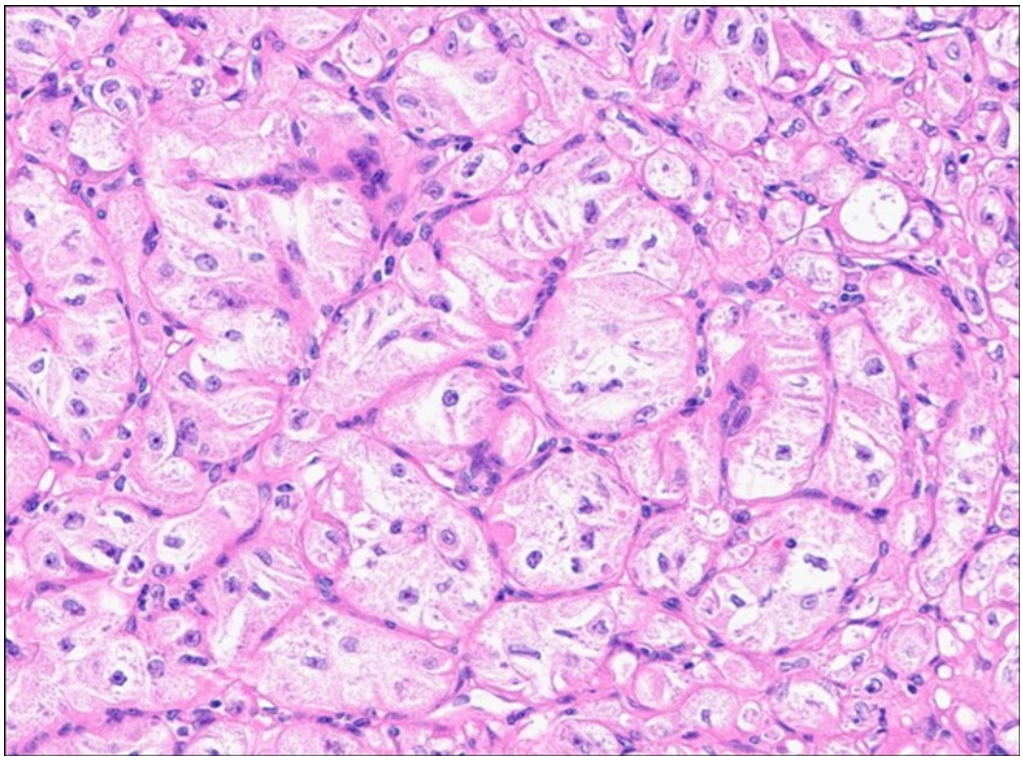

Figure 4B: Focal nest formation of relatively uniform tumor cells.

Methods

Differential diagnosis of tumors with large cells organized in nests with eosinophilic cytoplasm comprise malignant melanoma, renal cell carcinoma, adrenal cortical carcinoma, paragangioma, granular cell tumor, rhabdomyosarcoma, extrarenal rhabdoid tumor and perivascular epithelioid cell tumor (PEComa). Intracytoplasmic granules were frequently seen and PAS-positive, diastase-resistant. Immunohistochemically, tumor cells were negative for panCK, EMA, SMA, desmin, S100 protein, *CD56, CD31, CD34, HMB45*, melan A, chromogranin A, synaptophysin, GFAP, and *CD68*. The tumor cells showed nuclear reactivity for *TFE3* immunostaining. The MIB-1 labeling index was approximately 5% in the highest proliferating areas. Based on these findings, the lesion was diagnosed as solid variant of ASPS (Figures 5A and 5B).

At the last follow-up, which was 6 months after the last surgery, the patient was clinically well without evidence of recurrence or metastasis.

Discussion

ASPS is a relatively rare soft tissue tumor of uncertain lineage with a characteristic morphology. ASPS usually presents as a deep-seated mass, located predominantly in the extremities preferentially in adolescents and young adults [1-4]. ASPS occurring in the sinonasal region was first reported in 1988. Since its first report, it has been very rarely reported [5-10]. Since there were only five cases of ASPS in the nasal cavity prior to the present case [6-10], it is not easy to perform it's the differential diagnosis. In the case of sinonasal ASPS, it appears as a hypervascular polypoid mass at a young age. It is sometimes mistaken as a benign tumor in clinical practice. Our case was also clinically evaluated as a juvenile angiofibroma preoperatively.

Histologically, ASPS shows monotonous organoid and nest-like growth pattern consisting of large, round to polygonal cells usually displaying little variation in individual tumor cell size. Tumor cells have round, vesicular nuclei, prominent nucleoli, and abundant eosinophilic granular cytoplasm. Central discohesion within tumor nests results in characteristic pseudoalveolar-like structures. A portion of the tumor demonstrates histologic features atypical for ASPS [3,5], including nuclear hyperchromatism and pleomorphism, increased nuclear-cytoplasmic ratio, decreased cytoplasmic eosinophilia and granularity, mitotic figures necrosis, a less distinct nesting pattern and xantholomatous change. Diagnostic difficulties are encountered when the classical alveolar or pseudoalveolar pattern is absent and atypical cytologic features are seen. Our case displayed sheet-like to organoid growth pattern without typical discohesion, distinct areas of pleomorphic tumor cells with hyperchromatic nuclei and multinucleated giant cells. Our case has important diagnostic value as ASPS showing unusual histologic features can occur in the nasal cavity, an extremely rare area.

Tumor cells frequently show intracytoplasmic crystalline structures, which are PAS-positive and diastase-resistant [11,12]. Diagnosis through ancillary testing used to confirm rhomboid crystals using an electron microscope in the past. However, gene fusion is now mainly confirmed through *TFE3* immunostaining or molecular pathology techniques. ASPS has a characteristic der(17)t(X;17)(p11.2;q25) translocation, which fuses the *TFE3* transcription factor gene at Xp11 to a gene at 17q25, designated APSL [13,14]. Our case showed PAS-positive, diastase-resistant granules in the cytoplasm and *TFE3* nuclear immunoreactivity even in areas with atypical histologic features.

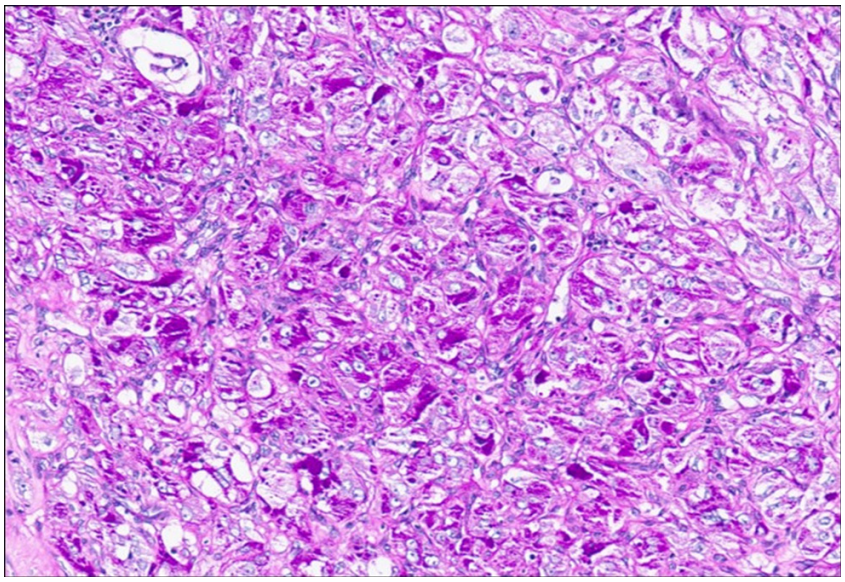

Figure 5A: Special and immunohistochemical stainings showing PAS-positive, diastase-resistant cytoplasmic crystals.

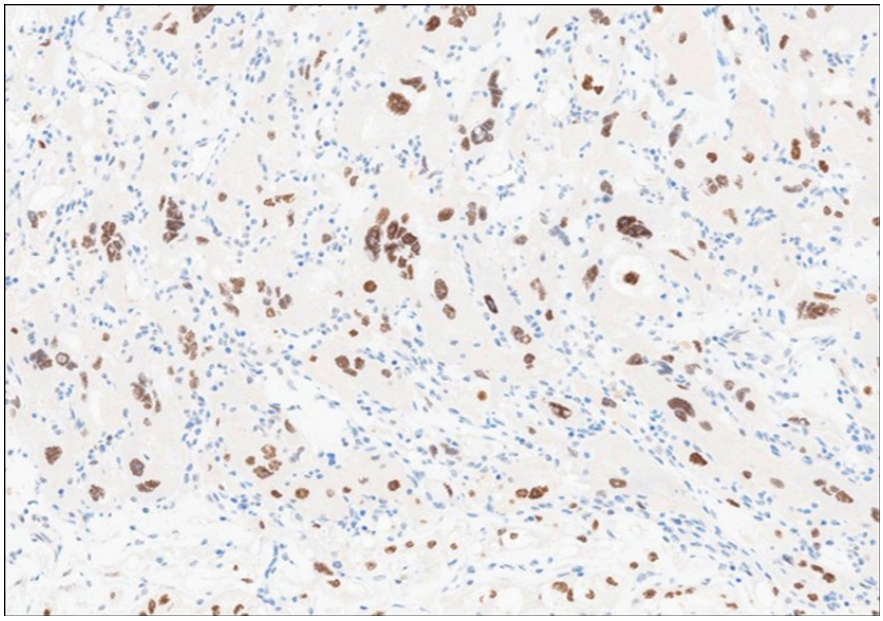

Figure 5B: Positive nuclear *TFE3* staining.

Differential diagnosis of ASPS comprise tumors with large cells organized in nests with eosinophilic cytoplasm, such as malignant melanoma, renal cell carcinoma, adrenal cortical carcinoma, paragangioma, granular cell tumor, rhabdomyosarcoma, extrarenal rhabdoid tumor and perivascular epithelioid cell tumor (PEComa) [4,5]. All these differential diagnoses can be excluded with clinical correlation, adequate PAS and immunohistochemical analysis. ASPS typically lacks expression of S100 protein, chromogranin A, synaptophysin, *myogenin*, MyoD1, smooth muscle actin, HMB45, melan A, keratin, and EMA, allowing its distinction from the above-mentioned differential diagnosis.

Treatment of choice is surgical resection with sufficient margins. In the case of positive margins, adjuvant radiotherapy or chemotherapy is performed. However, the role of chemotherapy in ASPS is not proven [4,12]. ASPS behaves as a relatively indolent sarcoma, characterized by late metastases. A 5-year survival rate of 59%~62% and a 10-year survival rate of 42%~47% have been reported [1,4]. The prognosis is better when patients are younger, the size is less than 5 cm, and the stage is low [11]. Lingual and orbital tumors also have very high survival rates [12]. No specific survival data exist for tumor in the sinonasal region. In our case, at six months after surgery, there was no evidence of recurrence or metastasis.

Conclusion

Conclusively, this report highlights the difficulty in diagnosing ASPS when it lacks the classical pseudoalveolar pattern and shows atypical cytologic features, such as pleomorphism. When it occurs in the nasal cavity, a very unusual location, characteristic cytomorphology should be recognized and PAS, DPAS staining and *TFE3* immunohistochemistry should be performed to accurately identify this tumor. We present an extremely rare case of ASPS lacking pseudoalveolar growth pattern and showing atypical cytomorphologic features in nasal cavity. This case could help clinicians and pathologists to avoid missing a diagnosis and taking an appropriate therapeutic approach.

Acknowledgements

This work was supported by a 2-Year research grant from Pusan National University.

Authors' contributions

Kyungbin Kim and Kyung Un Choi-Conceptualization; investigation; writing-original draft; writing-review and editing; project administration

Suji Lee, Soon Wook Kwon, Yury Lee, Seoyoung Park-Data curation; formal analysis; metholdogy; writing-original draft

Chang Hun Lee, Ahrong Kim, Gi Young Huh, Kyu Sup Cho-Conceptualization; investigation; writing-review and editing.

Data Availability

Data available on request from the authors.

Consent

Written informed consent was obtained from the patient to publish this report in accordance with the journal's patient consent policy.

References

1. Enzinger FM and Weiss SW (2013) Alveolar Soft Part Sarcoma. In: Soft Tissue Tumors. (6th edn). Collingwood: Saunders, Canada.
2. WHO Classification of Tumours (2020) Soft Tissue and Bone Tumours. (5th edn). Lyon: International Agency for Research on Cancer, France. 2020. 297-299.
3. Evans HL (1985) Alveolar soft part sarcoma. A study of 13 typical examples and one with a histologically atypical component. Cancer 10:912-917.
4. Shelke P, Sarode GS, Sarode SC, Anand R, Prajapati G, et al. (2018) Alveolar soft-part sarcoma of the oral cavity: A review of literature. Rare Tumors 17;10:2036361318810907.
5. Fanburg-Smith JC, Miettinen M, Folpe AL, Weiss SW, Childers EL. (2004) Lingual alveolar soft part sarcoma; 14 cases: Novel clinical and morphological observations. Histopathology 45:526-537.
6. Chatterji P, Purohit GN, Ramdev IN, Soni NK. (1977) Alveolar soft part sarcoma of the nasal cavity and paranasal sinuses. J Laryngol Otol 91:1003-1008.
7. Barbareschi M, Ferrero S, Ottaviani F (1988) Alveolar soft part sarcoma of the nasal cavity. Pathologica 80:363-370.
8. Rebinstein MI, Krake AF, McClatchey KD. (1988) Alveolar soft part sarcoma of the nasal cavity: Report of a case and a review of literature. Laryngoscope 98:1246-1250.
9. Singh G, Sharma MC, Suri V, Sarkar C, Garg A, et al. (2013) Alveolar soft part sarcoma of the paranasal sinuses masquerading as a giant invasive pituitary adenoma. Ann Diagn Pathol 17:276-280.
10. Dutta R, Kakkar A, Sakthivel P, Kumar R, Seth R, et al. (2021) Alveolar soft part sarcoma of the oro-maxillofacial region in the pediatric age group: Immunohistochemical and ultrastructural diagnosis of two cases. Head Neck Pathol 15:1303-1307
11. Casanova M, Ferrari A, Bisogno G, Cecchetto G, Basso E, et al. (2000) Alveolar soft part sarcoma in children and adolescents: A report from the soft-tissue sarcoma Italian cooperative group. Ann Oncol 11:1445-1449.
12. Akinyamoju AO, Gbolahan OO, Adeyemi BF (2020) Characterization of alveolar soft part sarcoma of the tongue: A clinico-pathologic study and scoping review. Ann Ib Postgrad Med18:122-134.
13. Ladanyi M, Lui MY, Antonescu CR, Krause-Boehm A, Meindl A, et al. (2001) The der(17)t(X;17)(p11;q25) of human alveolar soft part sarcoma fuses the *TFE3* transcription factor gene to ASPL, a novel gene at 17q25. Oncogene 20:48-57.
14. Argani P, La P, Hutchinson B, Lui MY, Reuter VE, et al. (2003) Aberrant nuclear immunoreactivity for *TFE3* in neoplasms with *TFE3* gene fusions: A sensitive and specific immunohistochemical assay. Am J Surg Pathol 27:750-761.