Letters to the Editor

Is \(^{18}\text{FDG PET/CT} \) evaluation really useful in the diagnosis of elastofibroma dorsi?

¿Es útil realizar una \(^{18}\text{FDG-PET/TAC} \) en la sospecha diagnóstica de elastofibroma dorsi?

Dear Sirs,

Blumenkrantz and co-workers\(^1\) have reported an interesting retrospective analysis on a relative large series of elastofibroma dorsi (ED) incidentally imaged with \(^{18}\text{FDG PET/CT} \) that prompted us a series of reflections, discussed herein.

As correctly remarked by the Authors\(^1\), “although it is not necessary to perform a PET study to diagnose such lesions, it is important to identify them in order to avoid misdiagnosis”. In fact, this entity being identified more and more frequently during \(^{18}\text{FDG PET/CT} \) scans performed for other purposes, the exact characterization of \(^{18}\text{FDG PET/CT} \) findings could be helpful for the physicians.

In this setting, there is a body of evidence\(^2,3\) supporting that \(^{18}\text{FDG PET/CT} \) could actually help in discriminating among benign and eventually malignant tumor. However, the answer concerning if the \(^{18}\text{FDG PET/CT} \) is really useful in the diagnosis and treatment planning of patients with ED is still unanswered and, in this context, the results reported by Blumenkrantz and coll.\(^1\) are very interesting and stimulate such debate.

As already reported\(^4\), in such patients we deem the diagnostic use of \(^{18}\text{FDG PET/CT} \) not yet fully supported by evidences strong enough to include it in the routine clinical practice.

In fact, the metabolic findings of such neoplasms may be variable (SUVmax ranging from 1.4 to 3.2 in the study of Blumenkrantz) and sometimes a moderate up to intense uptake (SUVmax up to 5)\(^5\) have been reported in few studies\(^6,7\); this could potentially mislead the final diagnosis. Indeed, Onishi and co-workers\(^1\) reported a 40% of ED with a \(^{18}\text{FDG uptake comparable or greater than the liver and confirmed their study remarking as these findings “should not be misinterpreted as abnormal accumulation observed in malignant lesions.”.}

In this regard, we have recently observed a patient with a right subscapular lesion with radiological features not clearly consistent with the diagnosis of ED; with the aim of discriminating from ED and a malignant tumor (sarcoma or other more rare malignant chest wall tumors) we have planned and performed a \(^{18}\text{FDG PET/CT} \) scan that revealed a moderate uptake of the radio-tracer (SUVmax up to 3.5) at the level of subcapsular lesion, this theoretically suggesting its malignant nature. The tumor was surgically removed and the definitive pathology was indicative for ED (with no peculiar pathological findings).

Therefore, we completely agree with the Authors\(^1\) concerning the inadequacy of \(^{18}\text{FDG PET/CT} \) evaluation when planning the best strategy of care. Furthermore, we would like to emphasize that the diagnosis of ED is substantially based on clinical even more than radiological findings. In fact, the localization in the infra-scapular region is substantially a pathognomonic sign in the diagnosis of ED. Even in case of \(^{18}\text{FDG PET/CT} \) “incidental positivity” in correspondence of a subcapsular soft tissue lesion, the diagnostic hypothesis of ED is more plausible than a soft tissue metastasis and a biopctic confirmation mandatory.

We would greatly appreciate the Authors’ reflections and reactions of the points raised.

References


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