Bilateral elastofibroma dorsi: a case report and review of the literature

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Introduction

Elastofibroma was first described by Jarvi and Saxen in 1961. It is a benign soft tissue tumor, slow growing of the characterized by an unclear etiology and is a source of ongoing debate. It is mainly located on the posterior wall of the thorax in a sub-scapular region, hence its name of elastofibroma dorsi. Relatively rare tumor with a prevalence of 2%, predominant in women over the age of 55. The diagnosis is more often evoked by the clinical symptoms as: pain, scapular snapping and discovered of a ill-mass. MRI is the more effective radiological examination and finally, the confirmed diagnosis belong to the pathological findings.

Patient and Methods

We report the case of a 71-year-old right-handed man without past surgical history who has a periscapular ill-mass on the left periscapular side for 3 years, initially considered as a lipoma. On MRI, the diagnosis finally retained is a bilateral elastofibroma dorsi. The evolution is reflected in the appearance of pain with limitation of the mobility of the left shoulder. The physical examination finds a firm tumefaction, adherent to the chest wall that interferes with the movements of the scapula with pain. MRI shows a fibrilar tumor mass with a T1 and T2 hyposignal with the length of 89 x 44 mm on the costal surface of the scapula, without modification for 3 years (figure 1 & 2). Surgical indication was based on the symptomatology with pain and the size of the tumor. The right tumor had no clinical relevance and was surgically neglected. Surgery have been performed on prone position with parascapular incision (figure 3). Marginal excision was necessary for the lesion (figure 4) followed by an histologic analysis of the all specimen.

Discussion

Elastofibroma is a benign, rare, slow-growing tumor. The location is more often in the sub and periscapular region, and almost exclusively adjacent to the lower angle of the scapula. Bilateral asynchronous localization is present in ± 60% of cases. The treatment of symptomatic forms is marginal surgical excision. For some authors, even in the absence of clinical findings when the diameter is greater than 5 cm, surgical resection should be performed. For others, because of the absence of malignant transformation, only biopsy confirming the diagnosis is required in the absence of symptomatology.

References