Fibrous Dysplasia with Aneurysmal Bone Cyst Presenting as Painful Solitary Skull lesion

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We report a rare case of fibrous dysplasia with the development of a secondary aneurysmal bone cyst presenting as solitary tumor of calvarium. Although fibrous dysplasia with aneurysmal bone cyst is rare, it should be taken into account in differential diagnosis of the osteolytic solitary skull lesion.

KEY WORDS: Aneurysmal bone cyst · Fibrous dysplasia · Skull.

INTRODUCTION

Fibrous dysplasia (FD) is a benign skeletal disorder, first described by Lichtenstein, in which abnormal development of fibroblast replaces medullary bone with fibrocellular tissue6,9,14). Among them, craniofacial FD represents approximately 7% of benign bone tumors7). The three most common radiological features of FD are pagetoid, sclerotic, and cystic patterns8). Computed tomographic (CT) scans show widening of diploic spaces, osseous expansion, and ground glass opacity12). Magnetic resonance image (MRI) reveals typically low signal intensity on T1- and T2-weighted images with contrast enhancement2).

Aneurysmal bone cyst (ABC) is an expanding osteolytic lesion superimposed on an existing pathological process of the bone11). ABC appears on plain X-rays as an ovoid lesion with varying degrees of diploic expansion or cortical thinning11). CT scan reveals an expansile bony cyst and MRI demonstrates high signal intensity on T1-weighted images, indicating hemorrhagic transformation5,11). On histopathology, ABC appears as blood-filled cavernous spaces with a paucity of endothelial cells. The cysts are separated by septa composed of fibrous tissue, which contain multinucleated giant cells and osteoid tissue9). ABC involves most commonly in the vertebrae and long bone. However, only a few cases of ABC affecting the calvarium have been reported. Moreover, the occurrence of a concomitant FD and ABC in calvarium is exceedingly rare. In the search of literature using Medline, only 10 cases including our report were retrieved1,10,13,16,18,20) (Table 1). Although the mechanism of the occurrence of FD with ABC is unknown, there is a report that a secondary form of ABC may arise from a disruption in the osseous circulation caused by primary lesion9).

Here, we report a rare case of FD in combination with ABC on the frontoparietal bone presenting as rapidly growing solitary scalp mass with review of literature.

CASE REPORT

This 18-year-old girl presented with painful scalp mass on the right frontoparietal region, 3 cm in diameter. She had no specific medical history and her general condition was good. She experienced severe headache of abrupt-onset 10 days ago and noticed a newly developed scalp mass on the right frontoparietal region. Physical examination was normal except for a bulging, tender scalp mass on the right frontoparietal region. She was neurologically intact. Routine laboratory data, including serum calcium, phosphorus, and alkaline phosphatase, were within normal limits.

A plain skull X-ray revealed an irregular osteolytic lesion...
involving skull vault (Fig. 1). Brain computed tomography scans showed approximately 2.5 cm sized, lobulated, osteolytic lesion over the right frontoparietal bone (Fig. 2). The center of the lesion was eccentric to the calvaria. As a consideration of her age and radiographic findings, it was initially regarded to be an eosinophilic granuloma involving skull. Plain X-rays and radionuclide bone scan were taken for other long bones and vertebrae for seeking evidence of histiocytosis, but there were no osteolytic bone lesions other than calvarial one.

During operation, a dark hemorrhagic cystic lesion was attached to the subcutaneous tissue and had completely eroded the inner and outer tables of skull, but there was no evidence of invasion of the dura. At the margins of the lesion, the skull was thickened and gritty in an area 1 to 1.5 cm around the lesion. En-bloc resection of the bony lesion including surrounding healthy bone enough to clear resection margin and curettage of the soft tissue involvement were performed. The cranial defect was repaired with the molded methyl methacrylate plate. After operation, no neurological deficit was found and a good cosmetic result was achieved.

On histopathological examination, the two different components were noted. The tissue removed from the solid component was composed of overgrowth of fibrous matrix and haphazardly scattered bony trabeculae characteristic of FD (Fig. 3). And, tissue removed from the cystic component showed cystic spaces containing red blood cells separated by septa containing spindle cell and multinucleated giant cells characteristic of ABC (Fig. 4). The final pathologic findings were consistent with FD in combination with ABC.

DISCUSSION

FD with ABC presenting with solitary calvarial lesion is an extremely rare entity. This lesion is first reported by Branch1) in 1986. The primary diseases known to be associated with ABC are osteoclastoma, osteosarcoma, osteoblastoma and hemangioma1). The report of ABC associated with FD is very rare, and moreover, the occurrence in skull vault is even rarer. Martinez et al.15) found only one case (2.4%) of ABC
in the 42 patients with FD. All the cases of calvarial FD with ABC retrieved by Medline search in literature have been reviewed and are summarized in Table 1.

On the analysis of the reported 9 cases, the most common clinical feature is expanding mass on the scalp with or without pain during a short period. The nature of rapid growth may come from the malignant change of FD. However, FD is a benign disease, even though malignant transformation has been reported in 0.5% of patients with monostotic FD and in 4% of polyostotic FD18. Therefore, the possibility of ABC transformation or abrupt cystic hemorrhage should be considered especially in patients who are younger than 20 years old. The most common radiological appearance of ABC transformation is the osteolytic lesion involving the inner and outer table of skull and expansion of the diploic space. The fluid-fluid level may suggest intracystic hemorrhage13.

On histopathology, FD with ABC has two components. FD component is irregular bony trabeculae with varying number of fibroblasts. ABC component is blood-filled cavernous space surrounded by multinucleated giant cells10.

The differential diagnosis of solitary osteolytic skull lesion includes hemangioma, epidermoid cyst, and eosinophilic granuloma17. Skull hemangioma is usually solitary lytic diploic space lesions. Hemorrhagic transformation can be seen on magnetic resonance images. Epidermoid cyst involves both the inner and outer tables and is well-defined lesions that lack central trabeculae and have a sclerotic rim. On the other hand, eosinophilic granulomas are round or oval non-sclerotic skull lesion with sharply defined margins. However, the differential diagnosis of these lesions is difficult on the radiological findings, confirmation by histopathologic findings is essential.

In review of the literature, the treatment of choice for FD with ABC is en-bloc resection and cranioplasty. Also, close follow-up to the resected lesion is recommended. In selected cases, preoperative embolization can be helpful to perform the excision with minimal blood loss16.

**CONCLUSION**

We report a rare case of FD with secondary hemorrhage from ABC. Although this disease entity is very rare, we should take it consideration in differential diagnosis of osteolytic calvarial lesions when the characteristic fluid-fluid level on CT scans and rapidly growing scalp mass is presented.

**References**

10. Itshayek E, Spector S, Gomori M, Segal R : Fibrous dysplasia in

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**Table 1. Summary of published cases of fibrous dysplasia in combination with aneurysmal bone cyst presenting with solitary lesion of calvarium**

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Sex/age</th>
<th>Symptom</th>
<th>Duration of symptom</th>
<th>Location</th>
<th>CT findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Branch CL, 1986</td>
<td>F/9</td>
<td>Expanding painful mass / Painless mass</td>
<td>1 month / 2 years</td>
<td>Parietal / Frontotemporal</td>
<td>Large area of bone lysis with erosion of the inner and outer tables and expansion of the diploic space with an abnormal rim of contrast enhancement</td>
</tr>
<tr>
<td>Branch CL, 1986</td>
<td>M/19</td>
<td>Painless mass</td>
<td>4 weeks</td>
<td>Parietal</td>
<td>Cystic expansion of the skull and soft tissue mass</td>
</tr>
<tr>
<td>Rappaport ZH, 1989</td>
<td>M/25</td>
<td>Painless mass</td>
<td>Unknown</td>
<td>Occipital</td>
<td>Intradiploic hypodense lesion</td>
</tr>
<tr>
<td>Wojno KJ, 1994</td>
<td>F/14</td>
<td>Painless mass</td>
<td>Unknown</td>
<td>Temporal</td>
<td>Heterogeneous cystic lesion</td>
</tr>
<tr>
<td>Wojno KJ, 1994</td>
<td>M/40</td>
<td>Expanding mass</td>
<td>Unknown</td>
<td>Frontal</td>
<td>Diffuse thickening of the calvarium and cystic lesion with septation</td>
</tr>
<tr>
<td>Ishayek E, 2002</td>
<td>M/19</td>
<td>Expanding painless mass</td>
<td>Unknown</td>
<td>Occipital</td>
<td>Expanded diploic space with ground glass appearance</td>
</tr>
<tr>
<td>Lin WC, 2004</td>
<td>M/18</td>
<td>Expanding painful mass</td>
<td>2 weeks</td>
<td>Frontal</td>
<td>Cystic degeneration and multiple cavities with internal fluid-fluid level</td>
</tr>
<tr>
<td>Mattei TA, 2005</td>
<td>F/19</td>
<td>Headache, nuchal rigidity, Painless mass</td>
<td>Unknown</td>
<td>Occipital</td>
<td>Subarachnoid hemorrhage and diploic cyst with fluid-fluid level</td>
</tr>
<tr>
<td>Lee JW, 2010</td>
<td>F/18</td>
<td>Expanding painful mass</td>
<td>10 days</td>
<td>Frontoparietal</td>
<td>Osteolytic lesion and expansion of the diploic space</td>
</tr>
</tbody>
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