Liposclerosing myxofibrous tumour

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DESCRIPTION
A 63-year-old man who was known to have chronic liver disease underwent a CT of the abdomen for evaluation of liver morphology. In the CT abdomen, he was coincidentally found to have an osteolytic lesion of the left proximal femur. He did not have any problems involving his left hip or thigh. On examination, no significant abnormalities could be detected clinically. Radiograph of the hip (figure 1) showed a solitary osteolytic lesion in the proximal femur involving the neck, intertrochanteric and subtrochanteric regions. The lesion had well-defined sclerotic margins, a narrow zone of transition and multiple septations within the matrix of the lesion. No cortical breach or periosteal reaction were present. MRI (figure 2) showed T2 and short tau inversion recovery hyperintense, T1 predominantly hypointense non-expansile intramedullary lesion with hypointense sclerotic rim. Thin septations, few hypointense foci and peripheral areas of fat were seen within the lesion. The patient was diagnosed to have liposclerosing myxofibrous tumour of the proximal femur. Owing to the predominantly benign nature of the condition and the absence of symptoms, the patient was managed conservatively. The patient was followed up for 6 months, was found to remain asymptomatic and the size of the lesion was found to remain constant.

Liposclerosing myxofibrous tumour is a rare tumour of the bone, which was first described in 1986.1 It is a benign fibro-osseous lesion, which has myxoid areas, osteoclastic activity, bone trabeculae similar to fibrous dysplasia, fat necrosis, ischaemic ossification and rarely cartilage components.2 It is found to occur most commonly in the fourth decade of life and proximal femur has been reported as the most common location.3 A few cases of malignant transformation of the lesion have been documented, and hence, it warrants close observation and follow-up.4

Learning points
► Liposclerosing myxofibrous tumour is a rare, benign fibro-osseous tumour of bone occurring most commonly in the proximal femur.
► It should be a differential when encountering a T2 hyperintense and T1 hypointense lesion with sclerotic rim.
► It can rarely transform into malignancy, and hence requires close observation and follow-up.

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