Hepatic angiosarcoma with an associated focal nodular hyperplasia-like nodule

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Introduction
Hepatic angiosarcoma (AS) is a rare malignant tumor exhibiting proliferation of the malignant endothelial cells and the formation of irregular vascular channels. We present a case in which a hepatic AS was accompanied by a nearby focal nodular hyperplasia (FNH)-like nodule within a fibrotic alcoholic liver. A hypervascular hepatic mass was found and a biopsy specimen taken from the mass was suspected to be a hyperplastic nodule. However, the follow-up ultrasonography, which was performed a half-year later, detected a large, hypervascular tumor at that site, and histology revealed an AS. In the resected liver specimen, which displayed moderate fibrosis, a small mass was found close to the AS. That small mass was composed of hyperplastic hepatocytes with fibrotic septa and abnormal vessels. No normal portal areas were evident, and so it was considered to be an FNH-like nodule. Possibly, an abnormal vasculature may have provided these lesions with a common pathogenic background, and secreted growth factors might have synergic effects on the growth of the lesions.

Hepatic angiosarcoma (AS) is a rare malignant mesenchymal tumor with an extremely poor prognosis [1,2]. It is characterized histologically by the presence of malignant cells forming anastomosing, irregular vascular channels [1,2]. Focal nodular hyperplasia (FNH), on the other hand, is a benign hepatic lesion displaying hepatocytic hyperplasia with fibrous center containing an abnormal vasculature [3-5]. FNH and FNH-like nodule, the latter a histologic mimic of FNH within a fibrotic liver [6], have been considered to be caused by an abnormal intrahepatic vascular supply [4,7]. However, to our knowledge there has been no report concerning a hepatic AS accompanied by FNH or FNH-like nodule. Here, we present a Japanese case with a ruptured hepatic AS accompanied by an FNH-like nodule within a fibrotic alcoholic liver, and we describe the lesions’ features, and discuss their association.

Case report
A 67-year-old Japanese man with alcoholic liver disease had been followed at the National Defense Medical College Hospital (Saitama, Japan), after his first referral because of elevations in liver enzyme values found in a medical check-up. He had been a habitual drinker (intake, more than 65 g of alcohol/day for 40 years). He had a previous history of operations for hemorrhoids and for intervertebral disc herniation, although he had not been exposed to Throtorast, arsenic, or vinyl chloride compound. His laboratory data revealed no hepatitis B or C viral antigen or antibody. After five-year-follow-up, abdominal ultrasonography revealed a roughly one cm-sized nodule within the lateral liver segment, and contrast computed tomography revealed early enhancement of the nodule. Specimens from repeatedly performed needle biopsies exhibited hepatocytic hyperplasia with mild structural atypia and sinusoidal dilatation, leading to suspicion of a hyperplastic nodule. Focal fatty change with ballooning degeneration was observed within the background liver parenchyma. However, the follow-up imaging studies performed a half-year later found, unexpectedly, a hypervascular mass sized 70 mm at the almost same site (Figure 1A). A hepatocellular carcinoma was suspected because of the results of the previous liver biopsy, although serum tumor markers (alpha fetoprotein and protein-induced by vitamin K absence or antagonist-II) were within their normal ranges. However, histologic examination of a needle biopsy specimen taken from the tumor led us to suspect an AS. Lateral liver segmentectomy was scheduled.

After receiving a preoperative enema on the morning of the operation day, he complained of feeling vaguely ill. During induction of anesthesia in the operation room, his systolic blood pressure suddenly fell to the 50 mmHg level. An urgent laparotomy revealed that the tumor had ruptured, causing a massive intraabdominal hemorrhage. The tumor was resected by lateral segmentectomy, and he recovered from the shock state. His post-operative course was uneventful. He underwent transcatheter arterial chemoembolization (lipiodol + adriamycin + mitomycin) and radiofrequency ablation, and was given systemic docetaxel and interleukin-2 because he was found to have a metastatic deposit within the right liver lobe. Despite this, the recurrent tumor grew and he was accompanied by chronic disseminated intravascular coagulation. Finally, he died following rupture of a metastatic lung tumor 11 months after the operation. Unfortunately, an autopsy was not performed.

Within the segmentectomy specimen, we found two distinct tumorous lesions (Figure 1B, C). One was a well-demarcated, 7 cm-sized, hemorrhagic tumor located in the subcapsular region and rupturing into the abdominal cavity, where it was responsible for the massive intraabdominal hemorrhage. Histology revealed that this...
features of the hepatic angiosarcoma (AS)

A. Abdominal computed tomography revealed a low-density tumor (indicated by yellow arrows) within the lateral liver segment

B, C. Within the resected (B) and histologic (C) specimens, in addition to the rupturing main tumor, a small nodule (white arrowheads) was found in the vicinity of the AS. HV in B and C indicates a hepatic vein, and the black bar in B indicates 1 cm

D. Histology revealed vasofomation by anaplastic tumor cells, consistent with AS

E, F. AS cells were immunoreactive for CD34 (E) and angiopoietin-1 (F) (C, D, hematoxylin-eosin; E, F, diaminobenzidine)

Discussion

Although a few cases of hepatic AS within a fibrotic alcoholic liver have been reported, the pathogenicity of AS in alcoholic liver fibrosis remains unclear [8-10]. We present here AS accompanied by an FNH-like nodule. We found the AS during the period of follow-up for the FNH-like nodule, and it had evidently grown rapidly to 70 mm in size during the preceding half-year. In the segmentectomy specimens, AS and the FNH-like nodule were located in intimate association, and abnormal blood vessels were also found, even outside the FNH-like nodule. In general, hypervascular hyperplastic nodules including FNH-like nodules are known to occur in alcoholic liver fibrosis, and FNH and FNH-like nodules have been considered to be localized lesions resulting from reactions to an abnormal circulatory change [3,4,6,7,11,12]. In fact, FNH is frequently associated with hepatic hemangioma, a benign counterpart of AS [2,13]. On the other hand, there is no published report of an association between abnormal vasculature and the pathogenesis of AS. However, in some cases AS has been reported to be in association with hepatic nodular regenerative hyperplasia, which exhibits diffuse hepatocytic hyperplasia due to abnormal circulatory disturbance throughout the whole liver [2,4,7]. On the basis of the above findings, we suspected that in the present case the AS and the FNH-like nodule may each have induced a positive response in the other, and that the increased blood-burden to the endothelium might have been partly responsible for the rapid development of the AS.

In the present case, sinusoidal capillarization was distributed throughout the FNH-like lesion, and both this capillarization and the AS cells expressed Ang-1. Recently, FNH was found to overexpress Ang-1, and transgenic mice with overexpression of an Ang-1 in their hepatocytes exhibited abnormal hepatic vasculature and hepatocytic nodular proliferation [14,15]. Further, AS has been reported to overexpress the receptor for Ang-1 [16,17]. The expressions of angiogenic growth factors in the present case might suggest a pathogenic
linkage between the lesion and the AS: possibly, Ang-1 secreted from the lesion and from the AS itself may have stimulated the growth of the AS. Our findings are consistent with this notion.

In conclusion, we have presented a case with a hepatic AS accompanied by a nearby FNH-like nodule. Although this is a rare association, it may result from the presence of abnormal vasculature and a local secretion of growth factors.

References


