

Mucinous (So-Called Colloid) Carcinoma of the Lung

I read with interest the report of mucinous (so-called colloid) carcinoma of the lung by Dr. Rossi and colleagues (*Am J Surg Pathol* Vol. 28, April 2004). They attribute the first reported case of what was probably a mucinous cystadenoma of lung to Gowar in 1978, and note subsequent reports of mucinous or colloid carcinomas of lung. In fact, I believe the first report of primary mucinous (gelatinous) carcinoma of lung was in a chapter on the pathology of lung cancer that I wrote for the book "Lung Cancer" edited by William L. Watson, then Chief of the Thoracic Surgical Service of Memorial Hospital for Cancer in New York City. The exact reference is in Chapter 3, "Pathology," pp. 70–72, and the gelatinous lung cancer is illustrated in a gross photograph and histology in Figures 3–24A, B, C. The book was published by C.V. Mosby Company in 1968, 10 years before the publication by Gowar.

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Authors' Reply:

We appreciate the interest of Prof. Melamed in our article on mucinous (colloid) carcinomas of the lung, and we apologize that our review of the literature missed his original description of this entity (which, unfortunately, does not appear on PUBMED or on more recent books of lung pathology).

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Fibroblastic Polyp of the Colon Shares Features With Vanek Tumor

To the Editor:

We read with interest the paper of Eslami-Varzaneh et al on colonic fibroblastic polyp (FP) that represents a new clinicopathologic entity.¹ Having read this article, we collected 3 cases of FP among 206 polyps (1.46%) in our routine practice and 1 case from files of one of us (A.C.). The main clinical features and sizes of polyps are shown in Table 1. All lesions were composed of fibroblastic proliferation (Figs. 1 and 2). Three polyps were associated with hyperplastic polyps (HPs), two with a tubular adenoma, and one with small mucosal prolapsing polyp. One polyp was of a mixed fibroblastic/hyperplastic type, containing hyperplastic crypts admixed with fibroblastic proliferation, and one was immediately adjacent to HP. The polyps measured from 2 to 3 mm. Thus, our results confirm the Eslami-Varzaneh et al observations¹ in respect to the low incidence, small size, predilection for the sigmoid and the rectum, and frequent HP association of FP.

The authors suppose that FP can represent an initial stage of Vanek tumor (VT) (inflammatory fibroid polyp),⁵ as some lesions in their study showed focally CD34 expression that is otherwise typical of VT.² Therefore, in our cases we have searched for features that would

be shared by both VT and FP. From this point of view, 1 case showed prominent vasculature (Fig. 3), 1 contained scattered eosinophils, and in 3 cases a vague but still visible onion skin-like arrangement of fibroblasts around some glands was seen (Fig. 2). It seems to us that such pattern was present also in some polyps in the series of Eslami-Varzaneh et al,¹ as it is recognizable in their Figure 2B. Immunohistochemically, two lesions showed CD34+ cells focally (Qbend10, DAKO), one contained scattered calponin+ cells (CALP, DAKO), and all four polyps showed reactivity for fascin (55K-2, DAKO) that is a marker for follicular dendritic cells (FDC) and that was recently reported by Pantanowitz et al⁴ to be positive in VTs (Fig. 4). Other FDC markers, such as CD21, CD23, CD35 (Ber-MAC-DRC, DAKO), EMA, and cyclin D1 (DCS-6, DAKO), were negative in our FPs. This result contrasts with positivity for CD35 and cyclin D1 described in VTs by Pantanowitz et al.⁴ Regarding supposed FDC differentiation in VTs, we were recently unable to confirm expression of CD21, CD23, CD35, and cyclin D1 in 14 cases of VT (manuscript in preparation). Also, Makhlof and Sobin did not find expression of FDC marker CD21 in their cases of VT.³ Thus, in our opinion, FDC differentiation in VT still remains to be confirmed by further studies, and this applies also for fascin-positive FPs presented here. In sum, in our cases of FP, we have seen the following features common with VT (al-

TABLE 1. Main Clinical Features of Fibroblastic Polyps

Age(yr)/Sex	Clinical Diagnosis	Location/Size	Associated Colonic Findings
73/M	Dyspepsia, colonic polyps	Rectosigma/3 mm	Hyperplastic polyp, tubular adenoma
52/F	Colonic polyps	Colon sigmoideum/3 mm	2 hyperplastic polyps
77/F	Suspected colitis, colonic polyps	Colon sigmoideum/2 mm	Mucosal prolapsing polyp
59/F	Colonic polyps	Rectosigma/3 mm	3 hyperplastic polyps, 3 tubular adenomas

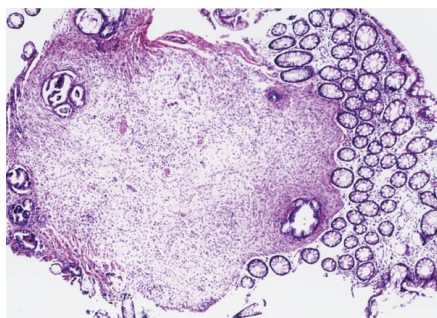


FIGURE 1. Low power view of FP.

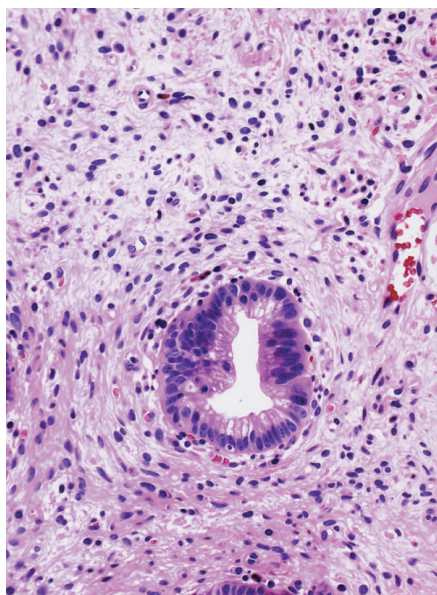


FIGURE 2. Typical monomorphic fibroblast proliferation of FP. A recognizable concentric periglandular cell arrangement and some eosinophils are seen.

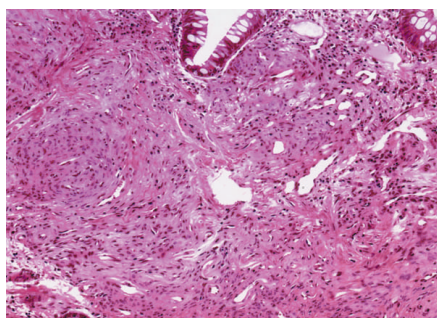


FIGURE 3. One lesion contained numerous vessels.

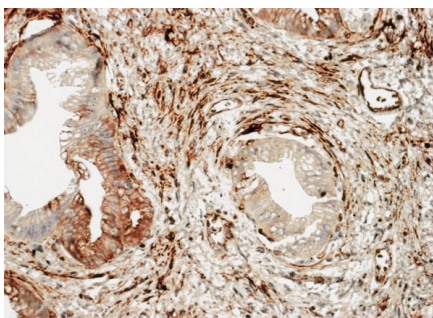


FIGURE 4. Fascin positivity in many stromal cells of FP.

though they were quantitatively less apparent): onion skin-like arrangement around the glands, rich vasculature, scattered eosinophils, and reactivity for fascin, CD34, and calponin. These observations indicate that the hypothesis of Eslami-Varzaneh et al¹ on the relationship between FP and VT can be correct.

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Fibroblastic Polyp of the Colon Shares Features With Vanek Tumor

Authors' Reply:

We would like to thank Drs. Zamecnik and Chlumska for their study, which supports our observations. However, we still feel the relationship of fibroblastic polyps to inflammatory fibroid polyp of the gastrointestinal tract (Vanek tumor) remains a speculation. Our own observations as well as theirs fail to establish a link between these two entities. The concentric arrangement of cells around bases of crypts and blood vessels can be a nonspecific histologic finding. Lack of follicular dendritic cell markers, frequent association with hyperplastic polyps, distal localization in the colon, and a distinct relationship with the muscularis mucosae all argue for fibroblastic polyps representing a distinct entity. However, clearly further studies are needed to clarify the nature of fibroblastic polyps as well as inflammatory fibroid polyps.

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