A 14-year-old healthy male child presented with a slowly growing painless mass in the abdomen since few months. There was no history of trauma or surgery. On examination, there was fullness in the lower part of the abdomen and the mass seemed to be arising from the pelvis. Routine investigations were unremarkable. An exploratory laparotomy was done. The mass was adherent to the urinary bladder and was found to be arising from the covering peritoneum.

Grossly, it was 6.0x8.5cm in size, grey-white, well-circumscribed, with a smooth outer surface. Cut surface was grey-white with a whorled appearance [Figure 1]. Microscopy revealed a well-circumscribed, unencapsulated hypocellular lesion. There was abundant hyalinized collagen [Figure 2], psammomatous [Figure 3] and dystrophic calcifications [Figure 4] with scarce lymphoplasmacytic infiltrate; consistent with a diagnosis of CFPT of the peritoneum.

Discussion

CFPT is a rare, benign fibrous lesion with an unknown pathogenesis. It usually affects children and young adults without gender predilection and clinically they present as painless masses.[1] Thick, band-like or punctuate calcifications are seen on CT.[2] Since its original description by Rosenthal and Abdul-Karim,[3] cases have been reported all over the body. Subcutaneous and deep tissues of the trunk, axilla, head and neck, inguinal and scrotal regions are commonly involved. Cases have also been reported in the mesentry, peritoneum, pleura (sometimes multiple), mediastinum and adrenal gland.[1] Till date no difference has been observed between the various sites of occurrence, although occasional case reports of multifocal lesions have been observed in the peritoneum and pleura. A case of multifocal peritoneal CFPT has been described involving two sisters, suggesting that there may be a genetic susceptibility to CFPT.[4]

Grossly, they are well marginated but unencapsulated, with a size range reported from 0.6 to 25 cm;[5] a gritty texture and firm whitish surface on sectioning. Microscopically, these lesions are paucicellular, hyalinized and fibrosclerotic with a variable inflammatory infiltrate consisting of lymphocytes and plasma cells. Calcifications, both psammomatous and dystrophic, are scattered throughout.[1]

Originally they were thought to represent sclerosing end stage inflammatory myofibroblastic tumor (IMT),[6] but recently distinct features between IMT and CFPT have been demonstrated. Inflammatory myofibroblastic tumors rarely contain calcifications and have a myofibroblastic proliferation varying from hyalinized acellular collagen to florid fibroblastic proliferation simulating sarcoma. All CFPT cases are diffusely positive for Factor XIIIa, vimentin and negative for smooth muscle actin, ALK-1 and CD34, although cases with CD34 positivity have also been reported by some authors.[7] On the contrary, all IMTs demonstrate positivity for actin and ALK-1, variable positivity for CD34 and focal positivity for Factor XIIIa.[1]

CFPT should also be distinguished from desmoid, solitary fibrous tumor, hyalinizing granuloma, elastofibroma or fibrous plaques of peritoneum.
Electron microscopy reveals fibroblasts accompanied by collagen fibrils; along with the calcifications which appear as electron dense amorphous masses and lamellated bodies.\(^1\)

Till date, they have behaved as benign tumors with simple local excision as curative treatment. Only one case of local recurrence has been reported so far.\(^1\)

**References**


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