hippocampus may be responsible for the TGA. This may be caused by direct toxic effect of the contrast medium or by sluggish flow in the cerebral circulation. The sluggish flow may be caused by platelet dysfunction owing to emotional stress of angiography and the contrast agent. The emotional stress of coronary angiography releases epinephrine which causes activation of platelets which slows the cerebral circulation. Thus, some TGA attacks may involve emotional reaction as an underlying pathophysiological mechanism.

It is also known that omnipaque, which was used, has less inherent anticoagulant property than the ionic agents. This may be responsible for the sluggish flow in the cerebral circulation and dysfunction of the medial temporal lobe causing TGA.

TGA is a dramatic event which occurs without warning. It is necessary for the cardiologist to recognize TGA as a dramatic complication of coronary angiography, but one which is transient and completely reversible.

Udyavar AR, D’souza RC, Gadkar N, Rajani RM
Department of Cardiology, P. D. Hinduja National Hospital & Medical Research Centre, Veer Savarkar Marg, Mahim, Mumbai-400016, India.

Correspondence: Rajesh Rajani, E-mail: rrajani20@hotmail.com

References

An unusual lipomatous hemangiopericytoma

Sir,

Lipomatous hemangiopericytoma is a very rare variant of hemangiopericytoma, which behaves in a benign fashion. It occurs in the lower extremity, thigh, pelvic fossa, and retroperitoneum. Histologically, these are characterized by an admixture of benign hemangiopericytomatosus areas with mature adipose tissue. To date, very few cases have been reported in literature. We report a case of this unusual, rare tumor in this paper.

A 39-year-old man came with a history of breathlessness since 1 year. A CT scan revealed a well-circumscribed heterogeneous mass containing fat located in the anterior mediastinum. The mass was surgically excised. On examination, it was well-circumscribed, measuring 6.5 \times 4.5 \times 4 \text{ cm}^3; the cut section was solid and whitish with intermixed yellowish fatty areas. On histology, the tumor showed diffuse sheets of cells with distinct pericytic vascular pattern (Figure 1). There were multiple branching anastomosing small and large vascular channels, giving a stag-horn appearance. Large areas of mature adipose tissue were seen interspersed in between (Figure 2). Tumor cells were plump polygonal with bland nuclear features. No spindle cells were seen. On immunohistochemistry (IHC) CD34 (monoclonal, Dako) was negative. Considering the histomorphological features, a diagnosis of lipomatous hemangiopericytoma was made. The patient has been free of any recurrences or metastasis for over a year.

Stout and Murray in 1942 introduced the term “hemangiopericytoma” for tumors that were composed mainly of pericytes. The diagnosis of hemangiopericytoma is based on the branching architectural pattern of small and large vessels. They occur during adult life, the common sites being thigh, pelvic fossa, and retroperitoneum. There are histomorphological similarities between hemangiopericytoma and solitary fibrous tumor (SFT). SFT occurs in the pleura.
and other body cavities. They show focal pericytic pattern with spindling of cells, broad zones of hyalinization, and on IHC virtually all cases are CD34-positive.[1,2]

A lipomatous hemangiopericytoma was first described in the German literature by Theunissen et al. in 1990.[2] In 1995, Nielson et al gave a detailed account of this tumor. Subsequently, more cases have been reported and few even at unusual sites such as head and neck.[3] Few authors even favor a unifying concept of lipomatous hemangiopericytoma and SFT.[1]

Our case had many unusual features. The site of occurrence of this tumor in the mediastinum is exceedingly rare.[1-3] To the best of our knowledge, only one more case has been described in the mediastinum.[3] CD34 negativity on IHC is also uncommon.[1-3] The closest differential diagnosis in our case is the SFT. But in our case, the architectural pattern was typical of lipomatous hemangiopericytoma and was present throughout the tumor. Spindling of the cells was not present.

Lipomatous hemangiopericytoma is an extremely unusual tumor. In some cases it may be mistaken for a well-differentiated liposarcoma.[4] Hence it is important to keep this entity in mind especially when only a small biopsy is available. Clinico-radiological features of a well-circumscribed mass and typical histology with lack of lipoblasts favor a diagnosis of lipomatous hemangiopericytoma.[1,4]

Amonkar GP, Deshpande JR, Kandalkar BM
Department of Pathology, T. N. Medical College and B. Y. L. Nair Hospital, Dr. A. L. Nair Road, Mumbai Central, Mumbai-400008, India

Correspondence:
G. P. Amonkar, E-mail: ppamonkar@hotmail.com

References