Clear cell chondrosarcoma of bone

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Abstract

Purpose. Clear cell chondrosarcoma is a rare variant of chondrosarcoma. Six cases are herein reported.

Subjects. We have treated six patients with clear cell chondrosarcoma in the past 28 years, representing 1.6% of all chondrosarcomas seen in this time period.

Results and Discussion. Half the patients had been initially underdiagnosed and inappropriately treated.

Conclusions. Our results and our review of the literature highlight the fact that inadequate initial treatment leads to a high rate of both local recurrence and metastasis whilst wide initial excision is usually curative.

Key words: clear cell chondrosarcoma, bone tumour, diagnostic imaging, limb-salvage surgical technique.

Introduction

Clear cell chondrosarcoma is a very rare malignant bone tumour. It was initially described by Unni et al. in 1976, and was called 'Clear-cell Variant of Chondrosarcoma'. Up to that time, the tumour had usually been mistaken for a benign tumour. Because of its rarity this lesion is still being confused with benign or more malignant bone tumours, both radiologically and histologically. We have reviewed our experience in treating clear cell chondrosarcoma at the Royal Orthopaedic Hospital, Birmingham, with the advantage of modern methods of diagnostic imaging and limb-salvage surgical techniques.

Patients and methods

We have undertaken a retrospective review of all patients with clear cell chondrosarcoma treated by the Royal Orthopaedic Hospital Oncology Service, Birmingham, UK. Data has been retrieved from the departmental computerised database supplemented by reviews of the case notes, and histological and radiological studies. Since 1970, six such cases have been treated, representing 1.6% of the 370 cases of chondrosarcoma registered at our centre in the last 28 years.

Five patients were male, and one was female. Their age ranged from 15 to 45 years. The predominant clinical presentation of the tumour was local pain in the affected bone of variable duration. Further clinical details are mentioned in Table 1.

Radiographic features

Initial radiographs were available for review in four of the six patients (Table 1). All the tumours were situated in the epiphysio-metaphyseal area of the long bones. The most common radiographic features were; an expansile radiolucent bony lesion, absence of any periosteal reaction and absence of soft tissue mass (Fig. 1). Magnetic resonance imaging (MRI) was obtained for two patients. On T1-weighted images, the lesion showed relatively homogeneous low to intermediate signal intensity, and heterogeneous high signal intensity on T2-weighted images (Fig. 2).

Pathological features

On gross histological examination, the tumours showed a lobulated mixed soft and solid lesion, composed of glassy tissue. On microscopic examination, faint microlobular and osteoblastoma-like features predominated on low-power examination (Fig. 3). The constant feature was the presence of large tumour cells, round-to-oval in shape with distinct borders, abundant clear cytoplasm and a centrally located round nucleus (Clear Cell Chondrocytes). Mitotic features were rare, and occasionally these cells showed eosinophilia. The other predominant feature was woven bone trabeculae within the microlobules or scattered between sheets of tumour cells. Multinucleated giant cells were seen in all tumours. There was variable cartilage matrix production.
| Case | Age/Sex (years) | Clinical presentation | Site | Plain radiographic features | Initial working diagnosis | Treatment | Further treatment | Follow-up | Outcome                  |
|------|----------------|----------------------|------|-----------------------------|--------------------------|-----------|------------------|-----------|-------------------------|
| 1    | 43/M           | Pain for 12 months   | Proximal femur | Radiolucent lesion, Thinned cortex | Chondrosarcoma          | Wide resection and endoprosthesis replacement | Resection and reconstruction of hemi-pelvis (for local recurrence after 19 years) | 20 years | Alive and free of disease |
| 2    | 27/F           | Pain                 | Ilium | Not available               | Chondroblastoma         | Curettage | Curettage (for local recurrence after 34 months) - Curettage (for local recurrence after 4 months) - Hindquarter amputation (for local recurrence after 5 years) | 13 years | Alive and free of disease |
| 3    | 26/M           | Pain for 30 months   | Expansile radiolucent lesion, Thinned cortex, Distal femur | Clear cell chondrosarcoma | Wide resection and endoprosthesis replacement Chondromyxoid fibroma | Curettage | Above knee amputation (for local recurrence after 5 years) | 2 years | Alive and free of disease |
| 4    | 15/M           | Pain                 | Distal femur | Not available | Clear cell chondrosarcoma | En-bloc resection |                    | 6 years | Died of lung metastasis |
| 5    | 45/M           | Asymptomatic, accidental X-ray finding | Distal femur | Expansile radiolucent lesion, Thinned cortex | Clear cell chondrosarcoma |                    |                   | 2.5 years | Alive and free of disease |
| 6    | 35/M           | Pathological fracture | Proximal femur | Expansile radiolucent lesion, Thinned cortex | Benign tumour/ chondroblastoma | Total hip replacement (Intra-lesional excision) |                    | 12 months | Alive with disease       |
Immunohistochemical analysis revealed the tumour cells were strongly positive to S-100.

**Treatment and results**

The clinical follow-up ranged from 12 months to 20 years (Table 1). Three patients in our study were given ‘inappropriate’ treatment at the referring institutions due to a mistaken provisional diagnosis of a benign cartilaginous tumour. One of these three patients had curettage of a tumour in her ilium for what was thought a chondroblastoma. She developed local recurrence after 34 months which was treated by further curettage. Within 4 months, she developed a rapid-growing local recurrence of the tumour spreading to the whole hemi-pelvis. Further biopsies then revealed the diagnosis of clear cell chondrosarcoma. The patient was offered radical surgical treatment (amputation) which she declined in order to keep her leg. She underwent a further two-stage curettage of her tumour and bone cement implanted in the defect. Five years later, another recurrence was treated by hindquarter amputation. Eight years after the amputation, she is still alive and free of disease.

The second patient was diagnosed initially as a case of chondromyxoid fibroma of the distal femur which was treated by curettage. After 63 months he developed a local recurrence treated by above-knee amputation following revision of the diagnosis to clear cell chondrosarcoma. Six months following the amputation he developed lung metastases and died shortly after that.
The third patient presented to another hospital with a pathological fracture of the neck of femur with a provisional diagnosis of osteomyelitis of the femur. This was confirmed at laparotomy and the patient was treated with antibiotic therapy. However, the patient did not improve and eventually died of sepsis.

In this study, all patients had correct diagnosis and appropriate treatment initially for the tumour resulting in good outcomes.

Discussion

Clear cell chondrosarcoma was described by Unni et al. in 1976 when they published a series on 16 patients. It is a very rare malignant bone tumour, comprising 1.6–5.4% of all chondrosarcoma, and 0.2% of biopsy-analysed primary bone tumours. Various suppositions have been made regarding the source of this tumour. Some considered that the most likely source of this rare chondrosarcoma variant is the same group of cells that give rise to chondroblastoma. Others suggested that it may represent the malignant counterpart of chondroblastoma.

The age at initial presentation ranges from 13 to 85, although most patients will be in their third to fifth decades. There is a male predominance of 1.6–2.6:1. Clear cell chondrosarcoma involves the proximal end of the long bone in 75% of the cases (60% femur, 15% humerus), 15% in the distal end of the long bone (60% femur, 15% humerus), 15% around the knee (distal femur and proximal tibia). In about 10%, the lesion has been noted in the skull, spine, ribs, pelvis, ulna or phalanges. Some of the others were asymptomatic and the lesion discovered as an incidental finding on plain x-ray.

Radiographically, when the tumour affects the long bone, the lesion is almost always located in the proximal end of the long bone (60% femur, 15% humerus), 15% in the distal end of the long bone (60% femur, 15% humerus), 15% around the knee (distal femur and proximal tibia). In about 10%, the lesion has been noted in the skull, spine, ribs, pelvis, ulna or phalanges. Some of the others were asymptomatic and the lesion discovered as an incidental finding on plain x-ray.
epiphyseal area with or without extension to the metaphysis. Very few cases are reported with tumour extending to or located entirely in the diaphysis. The most common radiographic features on plain X-ray, as described in this study and the previous literature, are: radiolucency (83%), expansion of the bone (75%), densification/calcification (45%), a border between tumour and host bone with or without sclerotic rim (49%), cortical involvement, often in the form of thinning (71%), the cortex was intact in the majority of cases and periosteal reaction (3%). Soft tissue masses are very rare (less than 10%). On computed tomography (CT), the appearances are similar to those seen on plain X-ray but CT is more sensitive at detecting calcification and cortical involvement. The magnetic resonance imaging (MRI) of this tumour tends to show a well demarcated geographic lesion with intermediate signal intensity on T1-weighted images, and a higher signal intensity on T2-weighted images. All these features are non specific. Differential diagnoses frequently reported include chondroblastoma, giant cell tumour, chondroma, chondromyxoid fibroma and cysts. If the tumour showed any malignant features, the differential diagnoses include osteosarcoma, malignant fibrous histiocytoma and fibrosarcoma.

The slow-growing nature of clear cell chondrosarcoma and the apparently benign radiographic and histological appearances in the majority of cases often results in difficulty in diagnosing the tumour at an early stage, with subsequent provision of conservative treatment. Various treatment modalities were used with fairly consistent outcomes throughout many published series. Intralesional surgical removal of the tumour (e.g. curettage, incomplete excision) yields an unacceptably high local recurrence of approximately 83\(^1\) to 86\(^3\), and death rate from 29\(^1\) to 50\%.\(^3\) In contrast, complete surgical removal of the tumour with a wide margin of disease-free tissue (e.g. en-bloc resection, primary amputation) has given a lower local recurrence rate of less than 15\(^3\), and much lower death rate.\(^1,3,5\) Radiotherapy was employed as an initial treatment with some claimed local control but poor outcome.\(^1,3\) Amputation was used in a few patients, usually when the initial diagnosis was incorrect and hence amputation was a salvage procedure.\(^1,3\) From our experience in this study and from the larger published studies,\(^1,3,5\) we confirm that inadequate treatment (e.g. curettage, incomplete excision, radiotherapy and chemotherapy as a primary treatment) certainly yields a poorer result compared with the adequate treatment (en-block excision of the tumour as a primary treatment) summarised in Table 2. Only patients with adequate follow-up information are considered in this table for comparison.

**Conclusion**

Clear cell chondrosarcoma is a low-grade and slow-growing tumour. Cure can be achieved by wide local excision in the majority of cases. Awareness of the condition and the diagnostic pitfalls will help improve both detection and survival.

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