Figure 1 Photomicrograph of ganglion cell-rich area. Arrows point to ganglion cells (→) and spindle cells (→→)

scrotal exploration was undertaken. Five small masses were identified and removed. All were paratesticular; the testicle, epididymis and vas deferens were entirely normal.

On histological examination the lesions proved to be composed of spindle cells resembling those of a nerve sheath tumour, as well as large round cells with abundant amphophilic cytoplasm and a large slightly eccentrically placed nucleus with a prominent nucleolus (Figure 1). There were no immature elements. They were judged to represent benign ganglioneuromata. MRI scanning excluded the presence of any synchronous retroperitoneal tumour.

COMMENT

Ganglioneuromas are the most benign of the neuroblastic group of tumours, which include neuroblastoma and ganglioneuroblastoma.¹ They consist of ganglion cells, Schwann cells and connective tissue.^{1,2} The most common locations are the posterior mediastinum, retroperitoneum, adrenal gland and neck.¹ To our knowledge there have only been three previously reported cases of paratesticular ganglioneuromas,^{3–5} of which one was actually a composite tumour consisting of a ganglioneuroma and a malignant peripheral nerve sheath tumour.³ Two of these cases were in children, one⁵ in an adult.

The paratesticular region consists of many cell types and neoplasms arising therefrom are histologically heterogeneous.⁶ Tumours in this region present as discrete scrotal masses and may cause diagnostic confusion with testicular tumours. The commonest benign tumours are lipomata, adenomatoid tumours and leiomyomata; the more common malignant neoplasms are sarcomas, mesotheliomas, lymphomas and epididymal adenocarcinomas.⁶ This region may on rare occasions be the site of metastatic spread of other primary tumours, including lung, pleura, stomach, colon, prostate and kidney.⁶ Scrotal involvement by a tumour that commonly affects the retroperitoneum is not surprising in

view of their common embryological origin. For this reason a patient with paratesticular ganglioneuromas should undergo imaging of the retroperitoneum and posterior mediastinum.

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A bloody mess: scalp lump misidentified

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Angiolymphoid hyperplasia with eosinophilia is seldom diagnosed preoperatively. When excising what seems to be a sebaceous cyst, the surgeon can be caught out by unexpected haemorrhage.

CASE HISTORY

An Asian man of 29 sought advice about an occipital lump that had been present for 5 years. It was occasionally itchy but painless. There were no other lumps and he gave no history of trauma to the site. On examination the lump was

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Figure 1 High-power view showing a proliferation of small vascular spaces lined by plump epithelioid endothelial cells

spherical (2 cm in diameter), soft and smooth; it was attached to the skin, which was hair-bearing; there was no regional lymphadenopathy. The preoperative clinical diagnosis was a sebaceous cyst.

The lump was excised with an ellipse of skin. Underlying the skin was a solid multilobated yellowish white mass measuring 1.0 × 1.5 × 1.3 cm. The surgical field was bloody, and about 100 mL of blood was lost before haemostasis was achieved. Microscopy showed a multinodular but ill-defined proliferation of vascular structures associated with lymphoid aggregates and numerous eosinophils (Figure 1). The features were consistent with angiolymphoid hyperplasia with eosinophilia. The patient was followed up for 2 years without evidence of recurrence.

COMMENT

In a patient with what seems to be a sebaceous cyst in the head and neck region, other diagnoses to be considered are metastases from tumours elsewhere, low-grade angiosarcoma, lymphocytoma, Kaposi's sarcoma, angiofollicular hyperplasia and tuberculosis. Angiolymphoid hyperplasia with eosinophilia (ALHE) is a benign condition of unknown cause usually diagnosed in the third to fifth decades of life.¹ The lesions may be single or multiple,² and patients may report pruritus (as did ours) or haemorrhage.³ Clinically the condition resembles Kimura's disease, though the lesions tend to be more superficial and lymph node involvement is less common.³ Microscopically they are clearly different: Kimura's disease is characterized by the presence of numerous lymphoid follicles with distinct germinal centres and an abundance of dendritic cells. IgE has been identified in the germinal centres of Kimura's disease but not ALHE.⁴

Local medical treatments have been used in ALHE but most patients have the lesion excised surgically. Recurrence is unusual. For surgeons who believe they are operating on a simple sebaceous cyst a hazard, as illustrated here, is that they will find themselves suddenly having to deal with a very bloody operating field.

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A mediastinal mass in end-stage liver disease

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The differential diagnosis of mediastinal masses visible on plain chest radiography does not usually include oesophageal varices.

CASE HISTORY

A man aged 28 with congenital hepatic fibrosis and secondary biliary cirrhosis was on the waiting list for liver transplantation. In the past, oesophageal varices had been treated endoscopically on many occasions by band ligation. On the present occasion he was admitted from the emergency department having become short of breath and nauseated, with abdominal pain and increasing confusion. He was deeply jaundiced (bilirubin 594 µmol/L) and had gross ascites; Glasgow Coma Scale score was 8. A chest radiograph showed a left pleural effusion with atelectasis of the basal segments of the underlying left lower lobe; but in addition there was a

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