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LETTER TO THE EDITOR

Commentary to: Giant cell reparative granuloma of the scapula: report of a case and literature review

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Sir,

I wish to draw your attention to a recent case report "Giant cell reparative granuloma of the scapula: report of the case and literature review" by Angelini a et al. Skeletal Rradiology (2019) 48: 1293–1298.

The authors have done an in depth review of the literature of this lesion in terms of its occurrence in the scapula. They have stated in their introduction: "The lesion is also known as a solid variant of aneurysmal bone cyst. Two definitions have been used in the pathology literature in recent years." Despite this statement, throughout the paper, they have omitted reference to the possibility that this is in fact a solid form of aneurysmal bone cyst which would explain the markedly expansile nature of the lesion which they note is "remarkable".

They have completely omitted to address the fact that it has long been known that lesions with classical histological features of aneurysmal bone cyst are seen in association with solid areas composed of tissue with the appearance of "giant cell reparative granuloma" [1, 2].

More significantly, they have not alluded to any of the recent molecular data which has clearly identified the presence of USP 6 mutations in aneurysmal bone cysts, in giant cell reparative granuloma of the small bones and hands and feet (not those in the jaws), in a subset of myositis ossificans, and in most cases of nodular fasciitis. (More recently these have also been identified in fibro-osseous pseudotumour of the digits).

The authors state that "the pathogenesis is unknown." These recent molecular findings support the concept that such lesions are neoplastic albeit with limited growth potential and, more importantly, that these entities form part of a spectrum of morphological change [3, 4].

These molecular findings increasingly garnered in recent years support the concept that entities with a solid appearance and histological features which in the past would have been termed giant cell reparative granuloma, all represent solid variants of aneurysmal bone cyst which is now the preferred terminology for such lesions. Ignoring this finding and continuing to imply that they are separate entities make interpretation of the paper confusing.

I would suggest that they test their case for USP6 mutations (this can be done by FISH testing on undecalcified sections) and if positive, the diagnosis of a primary solid aneurysmal bone cyst will be proven.

Yours sincerely,
S. Fiona Bonar

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