Corrigenda

WHO Classification of Tumours, 5th edition: Soft Tissue and Bone Tumours
Corrections made since the first print run

Summary of corrections:

Front matter p. iv

The WHO Classification of Tumours Editorial Board > Expert members: Soft tissue and bone tumours

Drs Gronchi and Messiou have been added to the list of WHO Classification of Tumours Editorial Board expert members:

Gronchi, Alessandro
Fondazione IRCCS Istituto Nazionale dei Tumori
Milan

Messiou, Christina
Royal Marsden Hospital
London

Chapter 1: Soft tissue tumours p. 54
Myositis ossificans and fibro-osseous pseudotumour of digits

Text that had accidentally been deleted from this page during the layout process has been added back to this section.

An updated, printable version of page 54 is included at the end of this document.

<table>
<thead>
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<th>Original text</th>
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| is extraskeletal osteosarcoma, which lacks zonation and shows malignant cytology. | **Etiology**
Unknown

**Pathogenesis**
Most cases of myositis ossificans and FP harbour the fusion COL1A1-USP6 (2980, 3008, 1036, 260, 1504). USP6 fusion genes are also encountered in aneurysmal bone cyst and nodular fasciitis, tumours with overlapping morphology.

**Macroscopic appearance**
Myositis ossificans is well delineated and ovoid, has a glistening soft-tan haemorrhagic centre and a firm greyish-white gritty periphery, and is 2–12 cm (average: 5 cm). FP is tan/grey/pink, smaller, and less well demarcated.

**Histopathology**
Myositis ossificans is characterized by zonal architecture. Initially, it is densely cellular, composed of spindle cells oriented randomly or in short intersecting fascicles. The spindle cells have eosinophilic cytoplasm and plump vesicular nuclei with nucleoli. Normal mitoses are often numerous. The stroma is vascular and myxoid and contains fibrin, extravasated erythrocytes, scattered lymphocytes, and osteoclast-like giant cells. Blood-filled cysts may be present. Peripherally, the spindle cells merge with osteoblasts that rim and populate ill-defined trabeculae and sheets of unmineralized woven bone, which is surrounded by well-formed trabecular and cortical-type bone that remodels into lamellar bone. Occasionally, the matrix contains cellular hyaline cartilage or the zonal architecture is not well developed (12, 802, 2116, 2335, 2658, 2987). The bone is randomly distributed in FP. An important differential diagnosis is extraskeletal osteosarcoma, which lacks zonation and shows malignant cytology.

**Cytology**
Cytology features …
Arteriovenous malformation/haemangioma (AVM/H) is a fast-flow, mostly congenital vascular anomaly characterized by the presence of arteriovenous shunts. There are two distinctive forms: deep-seated and cutaneous (cirsoid aneurysm or acral arteriovenous tumour). Most cases of extracranial AVM/H harbour MAP2K1 mutations, resulting in upregulated MAP2K1 (MEK1) activity. When these lesions involve multiple tissue planes, they are termed angiomatosis.

Subtype(s)
- Deep-seated AVM/H; cutaneous AVM/H (also called cirsoid aneurysm or acral arteriovenous tumour); angiomatosis (involving multiple tissue planes)

Etiology
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Etiology
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Cytology
Cytology features a dual cell population of spindle cells and large ganglion-like cells set in a myxoid stroma [1649].

Diagnostic molecular pathology
Molecular studies for USP6 rearrangement may be useful in the appropriate clinicopathological context.

Essential and desirable diagnostic criteria
Essential: hypercellular fascicles of uniform spindle cells; admixed woven bone with zonation, being most mature at the periphery.

Staging
Not clinically relevant

Prognosis and prediction
Treatment of myositis ossificans and FP is usually simple excision. Prognosis is excellent; recurrence is uncommon.