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LETTER TO THE EDITOR

Oral endovascular papillary angioendothelioma (Dabska tumor)

I was intrigued by the recent case report by Takaoka et al. (1). The authors observed an encapsulated small submucosal mass of the tongue in a 67-year-old man that they regarded as a form of endovascular papillary angioendothelioma (EPA). After reviewing the figures presented, I believe their diagnosis should have been given greater consideration. Although the difficulty in defining and diagnosing EPA has been repeatedly discussed, possibly because the previously reported examples may not be homogeneous (2), the clinical findings as well as the histologic features of the Takaoka et al. case are very different from that of EPA, also known as Dabska tumor (2–4). Most importantly, to the best of my knowledge, encapsulation thus far has not been documented in EPA and even in EPA-like tumors. Cutaneous EPA develops exclusively in a younger population, and the unifying feature of all cases is an ill-defined mass or a diffuse growth that replaces the dermis and extends into the subcutaneous tissues. It is composed of numerous ectactic vascular spaces, which interconnect, giving a cavernous appearance. In multiple areas, intravascular papillations of hobnail endothelium plug the lumina of the dilated vessels. Although EPA is characterized by this peculiar change, there is an underlying well-defined vascular lesion, usually cavernous lymphangioma (3, 4). Their tongue lesion lacked such a pathognomonic lymphangiomatous background; consequently, a characteristic lymphocytic infiltrate intermingling with the intraluminal papillary tufts was not evident. Closer inspection of the proliferating endothelial cells revealed that a hobnail appearance, with basally oriented cytoplasm and apically placed nuclei projecting off of the hyaline cores was vague. Moreover, there were no typical rosette-like clusters of distinctive small hobnailed cells floating freely in the lumina. Overall, acceptable criteria for a diagnosis of EPA were not met, both clinically and histologically.

So-called 'dabskoid intravascular papillary tufts', as illustrated by Takaoka et al. (1), have been found in a variety of reactive and neoplastic vascular lesions (5–8). As both the blood vessel nature and intravascular origin are admittedly evident by the prominent intraluminal content of erythrocytes and the surrounding thin vascular wall, as stated by the authors, it seems likely in my opinion that their case has more features of a mature form of intravascular papillary endothelial hyperplasia rather than of any kind of EPA or EPA-like tumors. Presumably, an exuberant endothelial proliferation has persisted after the thrombus has disappeared or was evoked in response to chronic obstruction of blood vessels without thrombosis. Although there remains considerable controversy as to the nosologic situation of EPA, the term *hemangioendothelioma* should at least be restricted to low-grade malignant or borderline vascular tumors (3, 4).

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