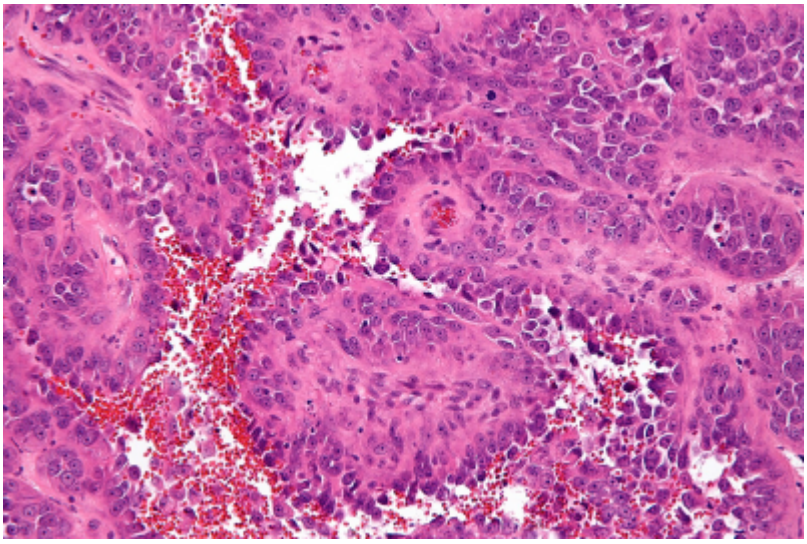
Epithelioid angiosarcoma



Epithelioid angiosarcoma is a rare, highly aggressive malignant tumor arising from vascular endothelial cells, characterized by epithelioid morphology—i.e., tumor cells that resemble epithelial cells in appearance but are of endothelial origin.

Key Features:

Histology: Large, pleomorphic epithelioid cells with abundant eosinophilic cytoplasm, prominent nucleoli, and frequent mitoses. Often displays areas of necrosis and hemorrhage.

Immunohistochemistry: Positive for CD31, ERG, FLI-1, and CD34; often negative for epithelial markers like cytokeratin (though focal positivity can occur, contributing to misdiagnosis).

Clinical Behavior: Extremely high rate of local recurrence and distant metastasis (lungs, liver, bone), with poor prognosis—median survival often less than 12 months.

Common Sites: Deep soft tissues (e.g., pelvis, limbs), skin, breast, pleura, bone, and rarely the spine or CNS.

Etiology: Sometimes associated with chronic lymphedema, prior radiation exposure, or foreign material (e.g., vascular grafts), though most cases are idiopathic.

Case reports

Nan et al. [1)] describe a rare case of epithelioid angiosarcoma (EA) involving the cervical spine, presenting with pathological fracture and kyphotic deformity, and document the surgical and adjuvant management as well as the clinical outcome in the World Journal of Clinical Cases.

1. Predictable Yet Pointless

The authors claim novelty by describing a rare anatomical presentation of EA. However, this

degenerates into a predictable narrative with **no new pathophysiological insights, no hypothesis generated**, and **no clinical paradigm challenged**. It is the kind of “rare case” that proliferates in low-barrier journals precisely *because* it demands no intellectual risk.

2. Zero Diagnostic Value

The authors bypass the opportunity to deepen our understanding of the **radiological-morphological signature** of EA in the spine. No comparative imaging, no differential diagnostic flowchart, no histopathological discussion beyond standard CD31/CD34 immunostaining. If this case had been published in 1995, it would be equally uninformative.

3. Therapeutic Confusion Disguised as Aggressiveness

Two major spine surgeries (posterior decompression + anterior corpectomy) followed by **immediate radiotherapy** in a moribund patient demonstrate **therapeutic overreach without oncological strategy**. There is no discussion on multidisciplinary planning, palliative thresholds, or whether delaying surgery or avoiding the second procedure might have prevented ARDS. The reader is left with the impression of a **surgical reflex**, not an evidence-based decision.

4. No Discussion of Differential Diagnosis or Biomarkers

In a tumor type notorious for being misdiagnosed as metastasis, chordoma, or sarcoma NOS, the absence of a **differential diagnostic framework** or advanced markers (ERG, FLI1, HHV-8, etc.) is alarming. **Histological laziness** cloaked in “rare disease” rhetoric.

5. Outcome Reporting: Conveniently Truncated

The patient dies 3 weeks after surgery, yet the discussion **fails to draw any causal or cautionary link** between the interventions and the fatal ARDS. No autopsy data, no postmortem imaging, no pulmonary workup. This **omission sterilizes the clinical narrative**, reducing it to anecdote.

6. Ethically Murky

The case implicitly raises an ethical dilemma—should maximal surgery be performed in aggressive, terminal tumors without demonstrated systemic control? Yet the authors shy away from even mentioning this, let alone framing it for academic discussion.

7. Journal Choice Reflects the Paper’s Weakness

Published in a journal known for **minimal peer review stringency**, the article offers **no citations of recent molecular or targeted therapy advances**, no engagement with broader oncological guidelines, and no rationale for the treatment decisions beyond procedural listing.

Definitions (for Teaching Purposes)

- **Histological laziness:** Failing to provide in-depth pathology discussion beyond CD31/CD34 and H&E staining in vascular tumors.
- **Surgical reflex:** The tendency to operate based on mechanical findings (compression, fracture) without integrating prognosis or systemic disease behavior.
- **Ethical sterilization:** Avoiding uncomfortable questions about futility, risk-benefit tradeoffs, and overtreatment in end-stage patients.
- **Postmortem evasion:** Reporting a perioperative death without diagnostic closure (autopsy, imaging, or medical reflection).

Conclusion

This case report is **an example of procedural reporting devoid of scientific merit**, clinical reflection, or ethical introspection. It contributes **nothing to the understanding of EA**, its diagnosis, biology, or management—beyond reiterating its rarity. In its current form, it is **neither hypothesis-generating nor practice-changing**, and serves as a **cautionary tale on how not to write a case report**.

Suggested Revisions

- Include comparative radiology with metastatic disease and primary bone tumors.
- Provide autopsy findings or detailed explanation of respiratory decline.
- Discuss therapeutic alternatives (e.g., single-stage surgery, biopsy + RT, palliative care).
- Frame the case within an oncological decision-making algorithm.

[1)]

Nan YH, Chiu CD, Chen WL, Chen LC, Chen CC, Cho DY, Guo JH. Epithelioid angiosarcoma of the cervical spine: A case report. World J Clin Cases. 2025 Jun 16;13(17):101593. doi: 10.12998/wjcc.v13.i17.101593. PMID: 40524767; PMCID: PMC11866273.