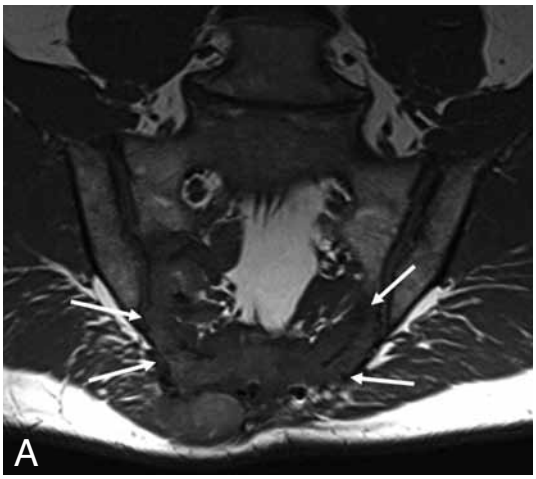
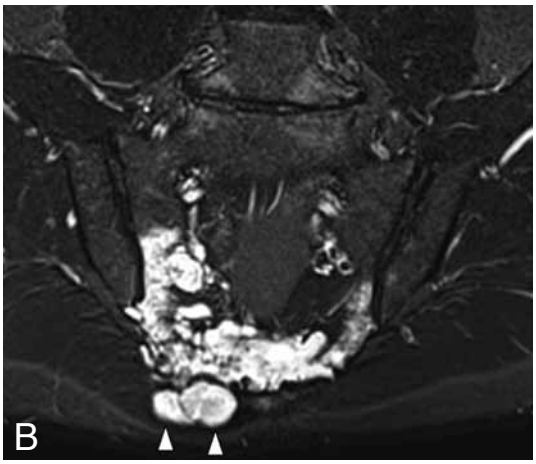
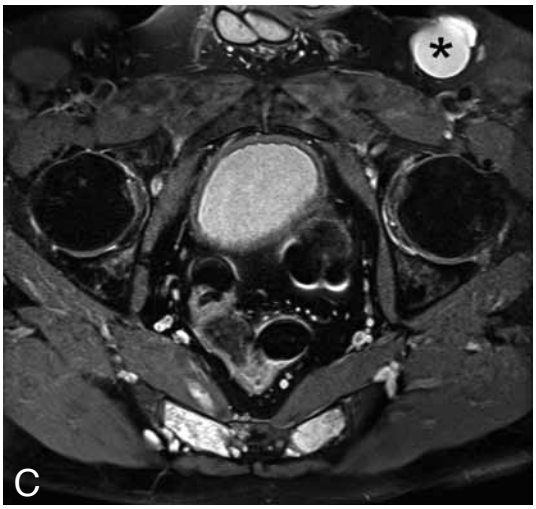
JBR–BTR, 2013, 96: 51.

IMAGES IN CLINICAL RADIOLOGY







Sacral chordoma

M. Behaeghe, A. Denis, L. Jans, K. Verstraete[1]

A 38-year-old man was admitted to our hospital for deep sacral pain. There was no significant medical history. Physical examination revealed pressure pain of the right sacroiliac joint. MRI showed a midline mass in the sacrum (arrows), isointense on T1-weighted MR images and hyperintense on T2-weighted MR images (Fig. A-B), enhancing with gadolinium. Cortical destruction was present with an extraosseous soft tissue mass (arrowheads). A well-defined lesion with similar MRI signal was seen in the left groin (asterisk) (Fig. C). Diagnosis of sacral chordoma with distant metastasis was made.

Comment

Chordoma is rare tumor, accounting for 1-4% of all primary bone malignancies, and has a poor prognosis. Chordomas arise from transformed remnants of notochord and are typically encountered in the axial skeleton, with most common sites being the sacrum, the skull base and the spine. Histologically chordomas are considered to be a low-grade neoplasm, but the high rate of local recurrence and potential for distant metastasis makes their clinical progression similar to that of malignant tumors.

Chordomas are indolent and slow growing and often clinically silent until late-stage disease. Imaging-related diagnostic delay may arise from overlooking lytic sacral lesions on conventional radiographs, or from CT or MRI studies of the spine not extending below S2 level.

Treatment of sacral chordomas is en bloc excision with wide margins and postoperative external- beam radiation therapy.

Reference

1. Walcott B.P., Nahed B.V., Mohyeldin A., et al.: Chordoma: current concepts, management and future directions. *Lancet Oncol*, 2012, 13: 69-75.

1. Department of Radiology, Ghent University Hospital, Gent, Belgium.