Patellar Capillary Hemangioma in a Child – Is Patellectomy Necessary?

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Abstract

Patellar capillary hemangioma is a very rare tumor with only a few reported cases in the medical literature. Previously, this tumor was treated by means of partial patellectomy. We treated a skeletally immature 13 years old boy with a painful capillary hemangioma by curettage, bone grafting and internal stabilization. Clinical and radiographic healing was noted with full recovery and return to normal activity. In two years follow-up the patient was pain-free, regained full motion, and participated in daily and physical demanding activities. No radiographic recurrence was noted. Curettage, bone grafting and internal stabilization may provide adequate solution and enable return to normal, pain free activity, obviating the need for patellectomy in cases of a patellar hemangioma.

Introduction

Tumors of the patella are very rare in the general population, comprising 0.1% of all skeletal tumors [1], and even more so in the pediatric age group. Within this population, benign tumors of the patella are more frequent than malignant tumors (73% of all tumors). The most common benign neoplasms are giant cell tumor and chondroblastoma [2,3].

Hemangioma of the patella is an extremely rare condition. The literature has described only ten histopathologically pediatric confirmed cases [2] which were treated mainly by patellectomy or semi-patellectomy, which might change knee function including mal tracking and quadriceps weakness [4]. We deemed this procedure as unacceptable in the pediatric patients. Therefore, we present our encounter with patellar capillary hemangioma and treatment by resection and local bone grafting.

Case Report

A 13 year old boy presented to the orthopedic outpatient clinic with left knee pain for several months. The patient’s personal medical history was unremarkable. Although he was active in kickboxing, there was no history of a specific injury, fever, local swelling or erythema of the knee.

On physical examination the patient exhibited normal gait, full knee range of motion, intact extensor mechanism, adequate stability of the knee and normal patellar tracking. There was tenderness to palpation over the patellar superior pole anteriorly.

Laboratory results including complete blood count, erythrocyte sedimentation rate and C-reactive protein were within normal range.

X-rays of the knee revealed a radiolucent lesion of the patella with well-defined borders, just superior to the middle of the patella occupying almost its entire sagittal diameter (Figure 1). Further imaging, including CT, MRI and Ultrasound, showed a transverse lesion with sclerotic borders and no soft tissue mass (Figures 2 and 3). The hardware was removed uneventfully 6 months after the initial surgery (Figure 6). In a two year follow up the patient was doing well.

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He regained full knee range of motion and is pain free. Complete radiographic healing of the lesion with incorporation of the bone graft was noted.

Discussion

Anterior knee pain is a common complaint in adolescents with a broad differential diagnosis. Acute pain may follow an injury resulting in fractures, dislocations or injury to ligaments, tendons or menisci. Chronic, long standing anterior knee pain may develop due to limb mal alignment, patellar mal tracking, overuse injuries and Osgood-Schlatter apophysitis [5]. Other causes include bipartite patella, which occurs in approximately 2% to 3% of the population, and is a developmental variation of ossification. This condition is usually asymptomatic but in young active patients may also cause anterior knee pain, usually following trauma, overuse or strenuous athletic activity [6]. Other pathologies, such as idiopathic chondromalacia and osteochondritis of the patella, might cause anterior knee pain in the adolescent population. Hip pathologies, such as Perthes disease or Slipped capital femoral epiphysis, must be excluded as they can present as anterior referred knee pain.

Tumors of the patella are very rare in the pediatric population, with hemangioma of the patella being an extremely rare condition. Literature search revealed only ten histopathologically confirmed cases [2] with minimal data regarding treatment and follow up (Table 1) [7,8]. Linscheid et al. [9] were the first to report of an adult suffering from a hemangioma of the patella which was treated by hemi patellectomy. Later on, Bansal et al. [10] reported two adult patients that underwent total patellectomy and whose pathology reports showed patellar hemangioma with multiple cysts. Kransdorf et al. [11] were the first...
To report of three pediatric hemangiomas of the patella, but no clinical descriptions or outcome were noted.

To the best of our knowledge this is the first report of a skeletally immature patient with a single cystic lesion, occupying a relatively large part of the patella. Non-surgical treatment was attempted but in light of persistence of pain and concerns regarding destabilization and possible pathologic fracture surgical intervention was favored. Due to the patient’s age, location of the lesion, lack of intra operative confirmed diagnosis and the intact articular cartilage, a decision was made to avoid patellectomy. The hemangioma responded well to curettage, bone grafting and temporary internal stabilization. Contrary to previous reports of hemangiomas in adults no patellectomy was necessary and the child regained full activity without pain.

**Conflict of Interest**

The authors declare that they have no conflict of interest.

**Informed Consent**

Informed consent was obtained from all individual participants included in the study.

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**Table 1: Literature review of published of patellar hemangiomas.**

<table>
<thead>
<tr>
<th>Publication Year</th>
<th>Initial Presentation</th>
<th>Age</th>
<th>Gender</th>
<th>Imaging site</th>
<th>Size</th>
<th>Treatment</th>
<th>FU</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linscheid et al.</td>
<td>1966</td>
<td>28 F</td>
<td>F</td>
<td>X-ray Upper pole</td>
<td>7 mm</td>
<td>Hemi-patellectomy</td>
<td>9 years</td>
<td>Mild discomfort</td>
</tr>
<tr>
<td>Bansal et al.</td>
<td>1974</td>
<td>30 F</td>
<td>F</td>
<td>X-ray Medullary</td>
<td>20*15 mm</td>
<td>Patellectomy</td>
<td>2 years</td>
<td>Full movement</td>
</tr>
<tr>
<td>Pandey et al.</td>
<td>1981</td>
<td>32 M</td>
<td>M</td>
<td>X-ray Medullary</td>
<td>20*15 mm</td>
<td>Patellectomy</td>
<td>1 year</td>
<td>Full movement</td>
</tr>
<tr>
<td>Kransdorf et al.</td>
<td>1989</td>
<td>15 M</td>
<td>M</td>
<td>X-ray NA</td>
<td>NA</td>
<td>Patellectomy</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Navarro et al.</td>
<td>2002</td>
<td>18 M</td>
<td>M</td>
<td>X-ray CT Upper pole</td>
<td>NA</td>
<td>Resection</td>
<td>3 years</td>
<td>Painless return to sport</td>
</tr>
</tbody>
</table>

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**Figure 6:** Recent radiograph demonstrating complete healing on AP (a), Lateral (b) and skyline (c) views.
References