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Other possibilities to consider before a diagnosis of intracranial hibernoma

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To the Editor—I read with interest the article by Zhang et al[1] entitled *Frontal lobe epilepsy and hibernoma: a case report* published in the *Hong Kong Medical Journal*. I agree that based on the gross appearance, a lipomatous tumour should be added to the list of differential diagnoses. Nonetheless hibernoma would not be my first consideration based on the haematoxylin and eosin–stained microscopic image. The quality of cytoplasmic vacuolation, thick vasculature and abundance of spindle cells are not explained by a diagnosis of hibernoma. Based on morphology, there are at least two entities, namely angiomyolipoma and metaplastic meningioma, that should receive attention first and worked up appropriately. Both contain cells with vacuolated cytoplasm, which may or may not be frankly adipocytic, are rich in spindle cells, and are highly vascular. The immunohistochemical results mentioned in the article [CK (-), S100 (-), MDM2 (-), CDK4 (-), P53 (-), CD34 (vascular +), and CD117 (-)][1] neither support nor exclude these entities, and the complete absence of S100 staining is unusual for hibernoma. Angiomyolipoma is usually positive for melanocytic markers (most consistently HMB45) and myoid markers (eg, smooth muscle actin and calponin). Meningioma is usually positive for epithelial membrane antigen, somatostatin receptor 2A, and progesterone receptor. These are the stains that should help confirm or exclude my interpretation.

Author contributions

The author is solely responsible for the concept, design, acquisition of data, analysis or interpretation of data, drafting of the manuscript, and critical revision of the manuscript for important intellectual content. The author had full access to the data, contributed to the study, approved the final version for publication, and takes responsibility for its accuracy and integrity.

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