

formed. This is because enchondroma and low-grade central chondrosarcoma are distinguished by how they behave, and histological features do not always predict behavior. Therefore, a pathologist attempting to analyze a cartilage lesion by histological features alone may be forced to render a diagnosis of "borderline cartilage neoplasm" or "cartilage lesion of uncertain malignant potential". These terms are of no use to the surgeon who must treat the patient. The behavior of a cartilage lesion is learned by clinical and radiographic features before a biopsy is done. The histological features are then interpreted in the light of this information. In adults, solitary enchondromas of long bone do not grow, whereas low-grade chondrosarcomas grow slowly. Therefore, the behavior of a cartilage neoplasm is best predicted by asking the question: "Is the lesion growing?" Clinical and radiographic features should be interpreted in the light of this question. It is best answered by serial radiographs and close clinical follow-up for a few months, a time-delay which does not compromise treatment results. This approach to diagnosis does not apply in the cartilage lesion of Ollier's disease, of the hand, or in children. In these lesions, slow growth does not always indicate malignancy.

The pathologist does have a role, however. Certain histological features, if present, indicate whether or not a lesion is growing. These features are primarily found on low-power study.

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Immunosuppression. Rare and not so rare osteoarticular infections

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Germans Trias i Pujol Hospital is a 600-bed university hospital that covers an area of 800,000 inhabitants and is a state referral center for the treatment of patients with AIDS.

We reviewed all cases of osteoarticular infection over a period of 15 years (1983-1998) associated with immunosuppressed patients.

From June 1983 to December 1998 the hospital has treated 8,420 cancer patients, 1,350 AIDS patients, 802 lymphoma-leukemia patients and 260 renal transplant patients.

Of the above 10,832 patients with some form of immunosuppression, 39 had osteoarticular infection, distributed as follows: 26 AIDS patients; six kidney-transplanted patients; five lymphoma-leukemia patients and two cancer patients.

The most common agent was *Staphylococcus aureus* and sporadic cases of *Salmonella*, *Escherichia coli*, *Candida albicans* and *Mycobacterium tuberculosis* were found.

Among the most unusual cases, we present two cases of *Rochalimaea* (*Bartonella*) infection (bacillary angiomatosis) and one case of *Scedosporium inflatum* (*S. prolificans*) infection.

Since 1983 when the first clinical and histopathological description of bacillary angiomatosis was reported, we have learned that the Gram-negative *Bartonella* rods cause a variety of cutaneous and extracutaneous clinical syndromes. In extracutaneous disease, most organ systems have been reported to be involved, including the head, liver, spleen, bone marrow and lymph nodes, central nervous system, muscles, soft tissues and bone.

Scedosporium prolificans (previously known as *Scedosporium inflatum*) is a dematiaceous fungus first described as a human pathogen in 1984. It has been involved in penetrating trauma, in intravenous drug use and in disseminated infections in immunocompromised patients.

The overall prevalence of osteoarticular infections in patients with an immunosuppressed status is low (0.3%). In AIDS patients the incidence is higher (1.9%).

Since the onset of the HIV pandemic, few cases of osteoarticular infections have been reported. As AIDS patients survive longer, it is now clear that HIV infection predisposes to infection by common pathogens as well as by opportunistic microorganisms.

It seems that the practice that leads to HIV infection determines the appearance of osteoarticular infection.

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