SHORT ACCOUNTS OF INTERESTING CASES, SOME MEDICAL DISASTERS, INVOLVING PATHOLOGY AND CLINICAL PRACTICE, FROM THE RECOLLECTION OF PROF. ALBERT CILIA-VINCENTI.

WE'RE PLANNING TO AMPUTATE THIS CHILD'S TOE

This is still the mid-1980s and the medical scene in Malta is still "under duress", with the MAM strike still on and with many specialist procedures requiring visiting consultants from the UK.

A clinician from my year at medical school, practicing in Malta, has two infant daughters, the younger of whom has had a recurrent nodule in one of her toes. I was sent the recurrent nodule for opinion – the first nodule was probably not referred to pathology. Local recurrence raised a suspicion of possible malignancy.

As luck would have it, I had just come across a scientific paper describing *recurrent digital fibroma of infancy*, a lesion that had also been called *digital neurofibrosarcoma*. The paper described a small fibrous lesion involving skin and subcutaneous tissue in fingers and toes of infants not older than three years, with high recurrence rate after excision, but no tendency to malignant transformation and, interestingly, spontaneous regression after age three. It also described characteristic intracytoplasmic inclusions within the fibroblasts, which could be mistaken for red blood cells, and which consist of actin filaments.

This lesion is derived from the myofibroblast, the cell with a principal role in granulation and reparative tissue, scar tissue, keloidal scars and the various superficial and deep fibromatoses. The digital lesion in question has therefore also been called *infantile digital myofibroblastoma*. It is now most commonly referred to as *infantile digital fibromatosis*. Some authors have also claimed this lesion can be made to regress by injecting with corticosteroid.

I transmitted the information of its benign nature in spite of local recurrence tendency to the Maltese surgeon that had referred me the case, together with a recommendation for conservative management. The parents were understandably anxious and consulted both another Maltese surgeon and a visiting British surgeon from Oxford's Nuffield Orthopaedic Hospital. They discussed amputating the toe but, before doing so, Oxford asked me to send them the histological sections for their pathologist to review.

Their pathologist was an author of an orthopaedic pathology book but, when he phoned me on receipt of the slides, it was obvious that he was unaware of this peculiar digital lesion of infants and said he couldn't see the inclusions I had claimed as characteristic. I therefore had to take micrographs, with arrows pin-pointing the inclusions, and posted them to him. I heard no further from Oxford. The parents eventually told me that the toe had been preserved and the girl had no further problems at the site. I understand she is now an established lawyer.

Her older sister read medicine in Malta and, close to her last medical school year, her father asked me whether I could recommend her to a clinician in UK for a summer clerkship. It so happened that because surgical senior registrars from London's St George's Hospital rotated with our surgical department in Winchester, I had become well-acquainted with the likes of Merion Thomas, subsequently oncological surgeon at The Royal Marsden, hepatic surgeon Melvin Rees at Basingstoke, and our own Winchester surgeon Dick Rainsbury who has gone on to become principal tutor at London's Royal College and the subject of a Daily Mail article detailing him as the top breast surgeon in the UK.

I asked Merion Thomas whether he would accept this Maltese female medical student to join his firm for a month or so. He did and reported back how bright she was. I understand she's now a consultant gynaecologist in London. Happy endings all round, for a change.