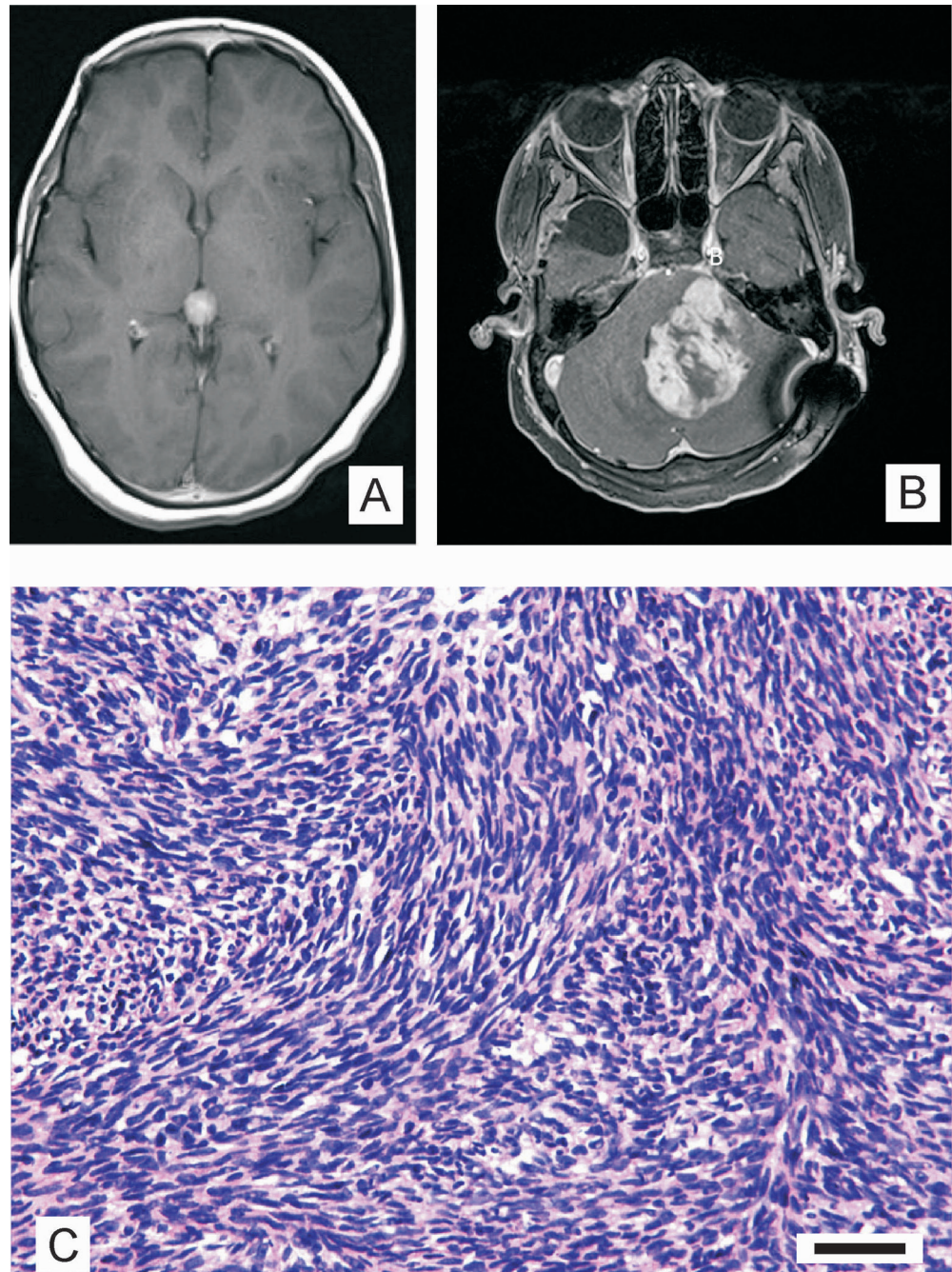


Microglioma in a child – a further case in support of the microglioma entity and distinction from histiocytic sarcoma

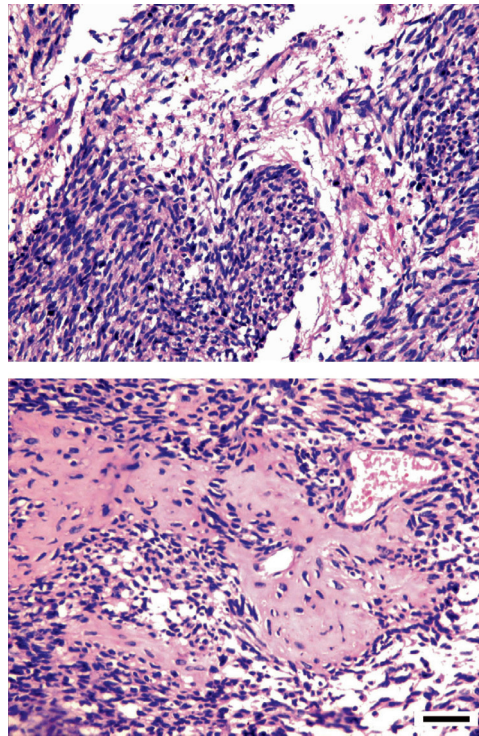
Anitha Mathews¹, Keiko Ohsawa², Michael E. Buckland^{3,4},
Chandrasekharan Kesavadas⁵, Kuttan Ratheesan⁶, Parukuttyamma Kusumakumary⁷,
Peter C. Burger⁸, Shinichi Kohsaka², and Manuel B. Graeber^{9,10,11,12}



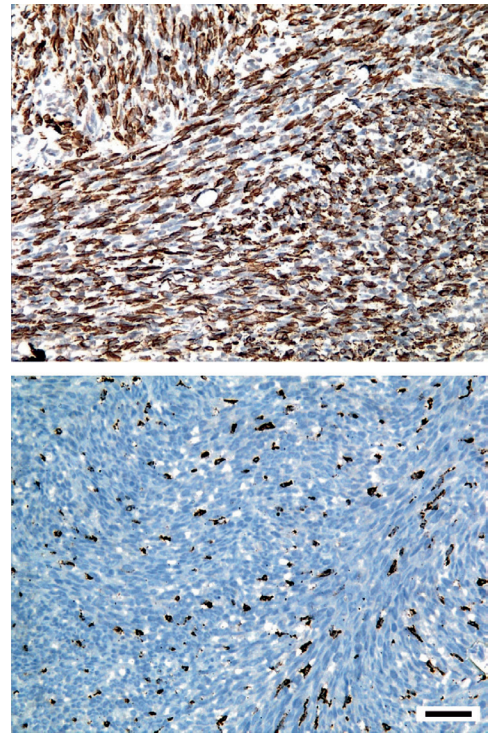
Received
December 28, 2015;
accepted in revised form
April 9, 2016

Correspondence to
Professor Manuel B.
Graeber, MD, PhD
FRCPath, Barnet-
Cropper Chair of Brain
Tumor Research
The University of
Sydney Brain and
Mind Center, Brain
Tumor Research
Laboratories,
94 Mallett Street,
Camperdown, NSW
2050, Australia
manuel@graeber.net

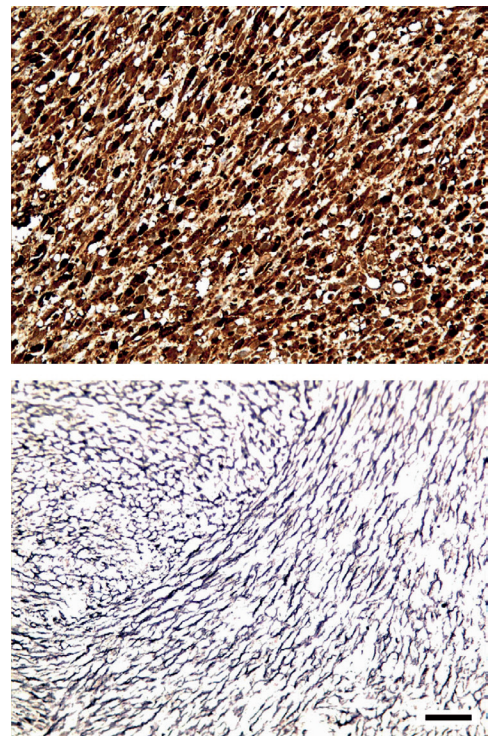
Supplemental Figure 1. A: Postcontrast MRI axial T1-weighted image obtained in April 2015 revealing a well-defined enhancing lesion in the pineal region. B: Postoperative follow-up scan performed in December 2015 showing the cerebellar lesion. C: Histology of the tumor in the pineal region representing gliosarcoma. Scale bar: 50 μm.



Supplemental Figure 2. Histology of the tumor in the pineal region. Typical biphasic tissue pattern of gliosarcoma (upper panel). Osseous metaplasia (lower panel). Scale bar: 50 μ m.



Supplemental Figure 3. Same tumour as in 2. Strong GFAP immunoreactivity (upper panel) but only few CD163-positive cells (lower panel) can be seen. Scale bar: 50 μ m.



Supplemental Figure 4. Same tumour as in 2. The upper panel shows very strong S100 positivity in glial areas, whereas reticulin-positive sarcoma-like patterns encroaching and surrounding glial tumor tissue (lower panel) are also found. Scale bar: 50 μ m.