Calcifying fibrous tumours of the diaphragm: A case report and literature review

SIJIA GUO[1,2], WENYA HAN[1,2], LINGLING YUAN[3], HANSHENG WANG[1,2], GE CHENG[1,2], YAXIN TUO[4], CHUANYONG XIAO[1,2], JIALONG GUO[5] and MEIFANG WANG[1,2]

[1]Department of Pulmonary and Critical Care Medicine, Taihe Hospital, Hubei University of Medicine, Shiyan, Hubei 442000, P.R. China; [2]Shiyan Key Laboratory of Major Chronic Respiratory Disease, Taihe Hospital, Hubei University of Medicine, Shiyan, Hubei 442000, P.R. China; [3]Department of Pathology, Taihe Hospital, Hubei University of Medicine, Shiyan, Hubei 442000, P.R. China; [4]Medical Imaging Centre, Taihe Hospital, Hubei University of Medicine, Shiyan, Hubei 442000, P.R. China; [5]Department of Cardiothoracic Surgery, Taihe Hospital, Hubei University of Medicine, Shiyan, Hubei 442000, P.R. China

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Abstract. Calcifying fibrous tumour (CFT), also known as calcifying fibrous pseudotumor, is a rare benign tumour that accounts for ~0.5% of all diaphragmatic tumours. It affects predominantly children and young adults, with a slight female predilection. Owing to its non-specific clinical presentations and imaging features along with its indolent growth pattern, CFT is frequently misdiagnosed. Histopathological examination remains the diagnostic gold standard, while complete surgical excision constitutes the mainstay of treatment. The present study reported a rare case of diaphragmatic CFT. Furthermore, all the case reports of CFT published in English in the PubMed database from 1946 to 2024 and detailed its diagnostic workup and therapeutic management were reviewed to enhance the recognition of CFT. The present study aims to reduce the number of missed diagnoses and misdiagnoses of CFT and the number of unnecessary high-risk surgeries, thereby improving the quality of life of patients with CFT.

Correspondence to: Professor Meifang Wang, Department of Pulmonary and Critical Care Medicine, Taihe Hospital, Hubei University of Medicine, 32 Renmin South Road, Maojian, Shiyan, Hubei 442000, P.R. China
E-mail: wmfpps02@hotmail.com

Dr Jialong Guo, Department of Cardiothoracic Surgery, Taihe Hospital, Hubei University of Medicine, 32 Renmin South Road, Maojian, Shiyan, Hubei 442000, P.R. China
E-mail: gjl88@126.com

Abbreviations: CFT, calcifying fibrous tumour; SpO_2, pulse oxygen saturation; PCT, procalcitonin; cTnI, cardiac troponin I; NT-proBNP, N-terminal pro-brain natriuretic peptide; CT, computed tomography; T1W, T1-weighted; 3D, three-dimensional; BID, twice a day; ALK, anaplastic lymphoma kinase; IHC, immunohistochemistry; SFT, solitary fibrous tumour; IMT, inflammatory myofibroblastic tumour; NA, not available; M, male; F, female; NED, no evidence of disease

Key words: CFT, diaphragm, diagnosis, differential diagnosis

Introduction

Calcifying fibrous tumour (CFT) is a very rare, non-cancerous lesion that can develop in various body parts (1). Its key microscopic features are spindle-shaped cells, collagen, chronic inflammation and distinctive dystrophic calcification (2). Despite its benign nature, CFT can grow in an invasive manner and appear as a poorly defined mass on scans. This makes it difficult to tell apart from other tumours, often leading to misdiagnosis and unnecessary treatment.

Diagnosing CFT is challenging for two main reasons. First, on imaging like CT scans, it typically shows a mass with coarse calcifications. On MRI, it often appears dark on both T1- and T2-weighted images due to its fibrous content (3,4). However, these features are not unique and overlap with other conditions, including cancers. Second, even a tissue biopsy can be misleading if it doesn't sample the characteristic calcified areas, potentially leading to a misdiagnosis of a more aggressive tumour.

Due to its rarity, reported cases of CFT are limited worldwide. While they have been found in numerous locations, this report presents, to the best of our knowledge, the first documented case of a CFT located in the diaphragm of a living patient. Previous reports of diaphragmatic involvement have been exceptionally scarce and just identified post-mortem (5).

This unique case describes the patient's journey, from clinical presentation and imaging to pathological findings, treatment and outcome. By detailing this process and comparing it with existing literature, we aim to improve the recognition of this rare tumour and help guide its diagnosis and management, ultimately preventing overtreatment.

Case report

A 45-year-old immunocompetent female patient presented with a pulmonary nodule that was incidentally detected

during routine health screening 2 months prior to admission (the examination was conducted in an external hospital and no report could be retrieved). The asymptomatic patient denied any respiratory symptoms, including cough, sputum production, haemoptysis, dyspnoea or systemic manifestations, such as fever, night sweats or weight loss. Initial surveillance over a two-month period at a referring institution demonstrated that the left lower lobe nodule slightly increased in size from 1.6 to 1.7 cm in maximal diameter on serial computed tomography (CT) imaging (baseline images unavailable for comparison). No therapeutic interventions were initiated during the observation period. For further evaluation, contrast-enhanced chest CT was performed in July 2024, at the outpatient clinic of Taihe Hospital (Shiyan, China) and revealed a well-circumscribed solid pulmonary nodule (1.7x1.3 cm) in the anteromedial basal segment of the left lower lobe with focal pleural thickening and retraction (Fig. 1A and B). Physical examination was within normal ranges. It revealed a body temperature of 36.6˚C (normal range, 36.0-37.2˚C), a pulse of 90 bpm (normal range, 60-100 bpm), a respiratory rate of 20 bpm (normal range, 12-20 breaths/min), a blood pressure of 122/87 mmHg (normal range, systolic 120-129 mmHg and diastolic 80-84 mmHg), a pulse oxygen saturation of 98% (normal range, ≥95%, without oxygen supplementation), clear breath sounds in both lungs, no dry or wet rales and no positive physical signs of other systems such as heart, abdomen, etc. Laboratory tests after admission revealed a white blood cell count of $5.66x10^9$/l (normal range, $4\text{-}10x10^9$/l), a red blood cell count of $5.54x10^{12}$/l (normal range, $4.3\text{-}5.8x10^{12}$/l), a haemoglobin concentration of 109 g/l (normal range, 130-175 g/l) and a platelet count of $209x10^9$/l (normal range, $125\text{-}350x10^9$/l). The erythrocyte sedimentation rate, IL-6 level, procalcitonin level, cardiac troponin I level, N-terminal pro-brain natriuretic peptide level, coagulation profile, liver function, renal function, electrolytes and thyroid function were all within normal ranges, and respiratory tumour markers and tuberculosis IgG antibodies were negative. Pulmonary function tests, electrocardiogram, cardiac ultrasound and lower limb venous ultrasound showed no abnormalities. Fiberoptic bronchoscopy revealed inflammatory changes in the bronchi without neoplastic lesions. Bronchoalveolar lavage fluid smears revealed no acid-fast bacilli but a small number of Gram-positive cocci. A CT-guided lung biopsy planned for two days after admission was cancelled due to the high risk associated with the lesion's proximity to the heart. A multidisciplinary consultation on four days after admission concluded that compared to two months ago, the pulmonary nodule had increased in size and exhibited imaging features such as lobulation, fine spiculation and pleural retraction (Fig. 1A and B). Three-dimensional (3D) reconstruction (Fig. 1C and D) demonstrated extensive connectivity between the lesion base and the diaphragm, raising suspicion of malignancy. Owing to the high risk of CT-guided percutaneous fine-needle aspiration biopsy, surgical biopsy was recommended. Preoperative evaluations, including non-contrast brain CT, adrenal ultrasound, carotid ultrasound and coronary CT angiography, revealed no abnormalities; abdominal ultrasound showed gallbladder wall thickening. On the eighth day after admission, the patient was administered a prophylactic antibiotic regimen of intravenous cefradine (1 g, BID) at a rate of 40 drops per minute for two days to prevent postoperative infection. On the subsequent day, video-assisted thoracoscopic surgery was performed. Intraoperative findings included multiple white, firm, coral-like nodules observed on the diaphragmatic pleural surface without pleural effusion or adhesions. The largest nodule was approximately 2 cm (Fig. 2A). Biopsy samples were fixed in 10% neutral buffered formalin at room temperature for 4-6 h, dehydrated using an increasing alcohol series, embedded in paraffin and sectioned into 3-μm slices. Haematoxylin and eosin staining was performed at room temperature for 40 min and sections imaged using a CX31 light microscope (Olympus Corp.). Pathological examination (Fig. 2B) of the diaphragmatic nodule revealed fibrous tissue hyperplasia with hyaline degeneration. Biopsy samples were fixed in 10% neutral buffered formalin at room temperature for 4-6 h, dehydrated using an increasing alcohol series, embedded in paraffin and sectioned into 3-μm slices. Hematoxylin and eosin staining was performed at room temperature for 40 min and sections were imaged using a CX31 light microscope (Olympus Corp.).

Postoperative chest CT performed one day postoperatively revealed postresection changes in the left diaphragm (Fig. 1E and F). Attempted supplemental immunohistochemistry (IHC) studies on the specimen from the first surgery were non-diagnostic due to tissue detachment artefacts. The patient was discharged on the second day after surgery, and the patient underwent two serial follow-up CT scans of the chest performed at six-month intervals, both of which demonstrated no evidence of recurrence. Subsequent follow-up with annual CT surveillance is planned.

Literature review

Only PubMed (https://pubmed.ncbi.nlm.nih.gov/) was used for the literature search and 200 case reports (199 in English and 1 in French) published between 1946 and 2024 were manually searched, using ‘calcifying fibrous tumour’ and ‘calcifying fibrous pseudotumour’ as search terms. Multiple reports have reported more than one patient, resulting in a total of 215 cases being included. In the search process, review articles that only conducted retrospective analyses and duplicate reports were excluded, and only the first published cases with sufficient case descriptions were included for analysis (Fig. 3). CFT can arise in multiple anatomical sites, most frequently the gastrointestinal tract and pleura, and less commonly the liver or reproductive tract. According to statistical data, only one case of a solitary CFT localized to the diaphragm has been documented, highlighting its exceptional rarity in clinical practice. For statistical purposes, only the most characteristic disease location was recorded in instances of multifocal involvement (excluding the current case). To better characterize chest calcifying fibrous tumour (CFT), seven published cases with the closest clinical association were analysed to enable comparison (Table I) (6-9). Regarding chest CFT, most patients present with ipsilateral chest pain or are incidentally diagnosed. Chest CT typically shows nodules with punctate enhancement at the margins, and the nodules generally appear as milky-white, lobulated solid masses. These features are highly consistent with those observed in the present case. However, unlike most chest

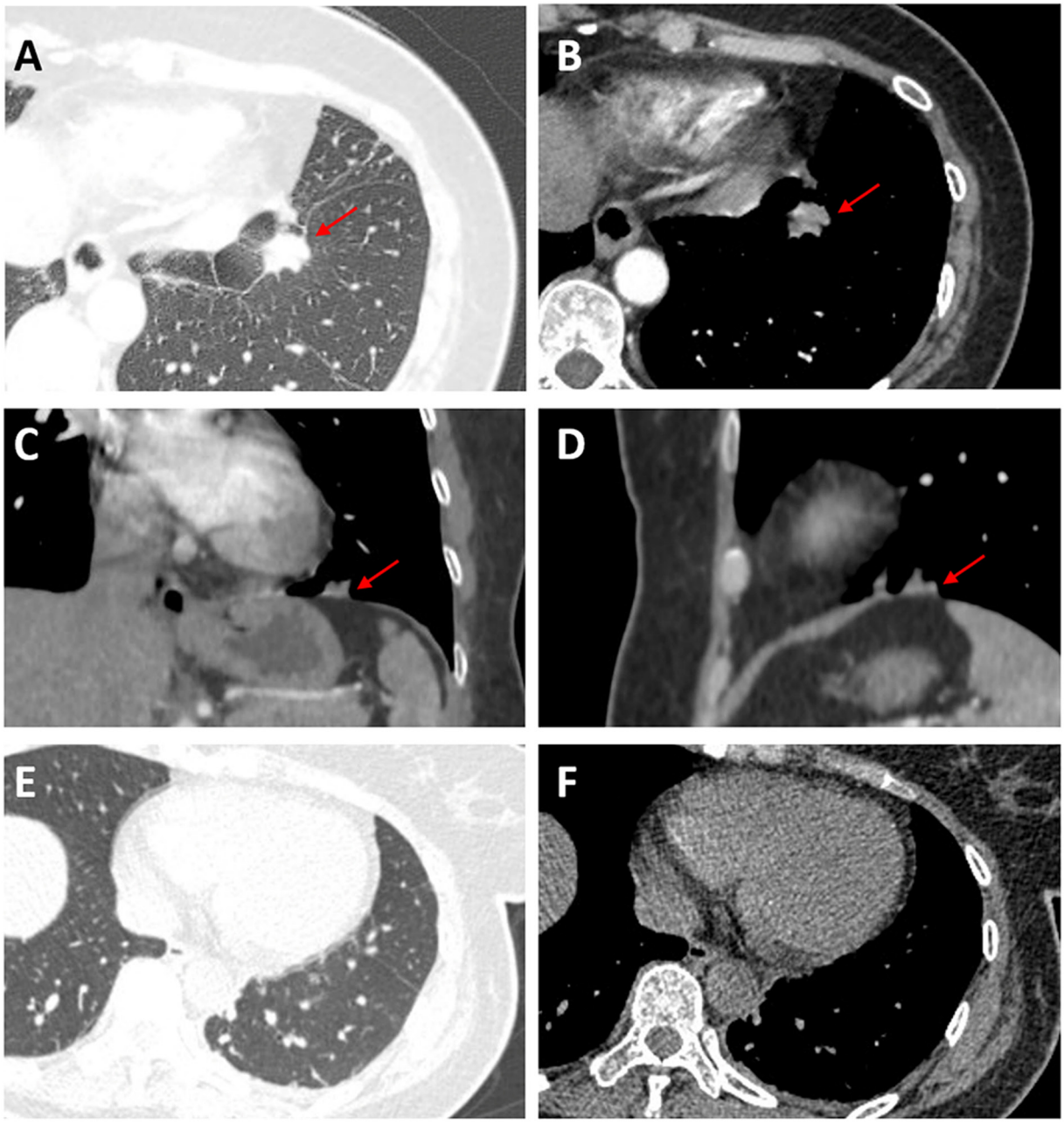

Figure 1. Chest images. (A) Chest contrast-enhanced CT scan demonstrating a lobulated solid nodule (1.7x1.3 cm) in the left lower lobe anteromedial basal segment (S8) (red arrows), which on the lung window (width 1,500 HU/level-600 HU) showed marginal spiculation, and also exhibited pleural retraction and diaphragmatic contact. (B) Mediastinal window of chest contrast-enhanced CT scan (width 350 HU/level 40 HU) revealing mild punctate enhancement (red arrows). Three-dimensional volume-rendered (C) coronal and (D) sagittal reconstructions illustrate the anatomic. The tumour (red arrows) demonstrates extensive adhesion to the diaphragm. Chest CT on the (E) lung window and (F) mediastinal window shows findings consistent with postoperative resection of a left lower lobe nodule, with associated bibasilar atelectasis.

CFTs, pathological examination in this case revealed fibrous tissue and inflammatory cell infiltration but no typical calcified bodies. Literature review revealed only one previously reported case of primary diaphragmatic CFT, which was incidentally discovered during autopsy following traumatic death (5). To the best of our knowledge, the current study presents the first documented case of primary diaphragmatic CFT successfully managed with complete surgical resection (R0). Notably, the morphological characteristics of the gross specimen of the present case are highly consistent with those of CFT reported by Mylapalli *et al* (5) and Kashizaki *et al* (10,11), suggesting that the appearance of this characteristic gross specimen may become an important basis for the diagnosis of CFT.

Discussion

CFT represents a rare benign fibroblastic proliferation (12,13); it was initially described by Rosenthal and Abdul-Karim (13) 1988 as a 'calcifying fibrous tumour of childhood' on the basis of paediatric cases. A subsequent clinicopathological analysis of 10 cases by Fetsch *et al* (14) in 1993 led to the revised nomenclature 'calcifying fibrous pseudotumor'. In 2013, the World Health Organization Classification of Tumours of

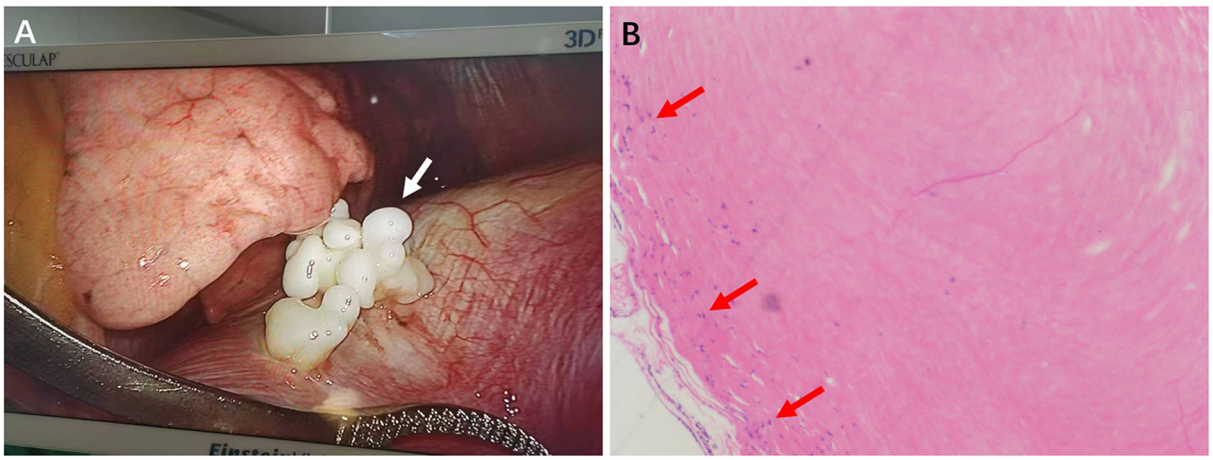

Figure 2. Thoracoscopic and histopathological features of diaphragmatic calcifying fibrous tumour. (A) Gross specimen showing a pearl-white, lobulated mass with coral-like nodularity on the diaphragmatic surface (white arrow). (B) Photomicrograph demonstrating hyalinized collagen bundles with sparse lymphocytic infiltration (red arrows) (H&E stain; magnification, x200).

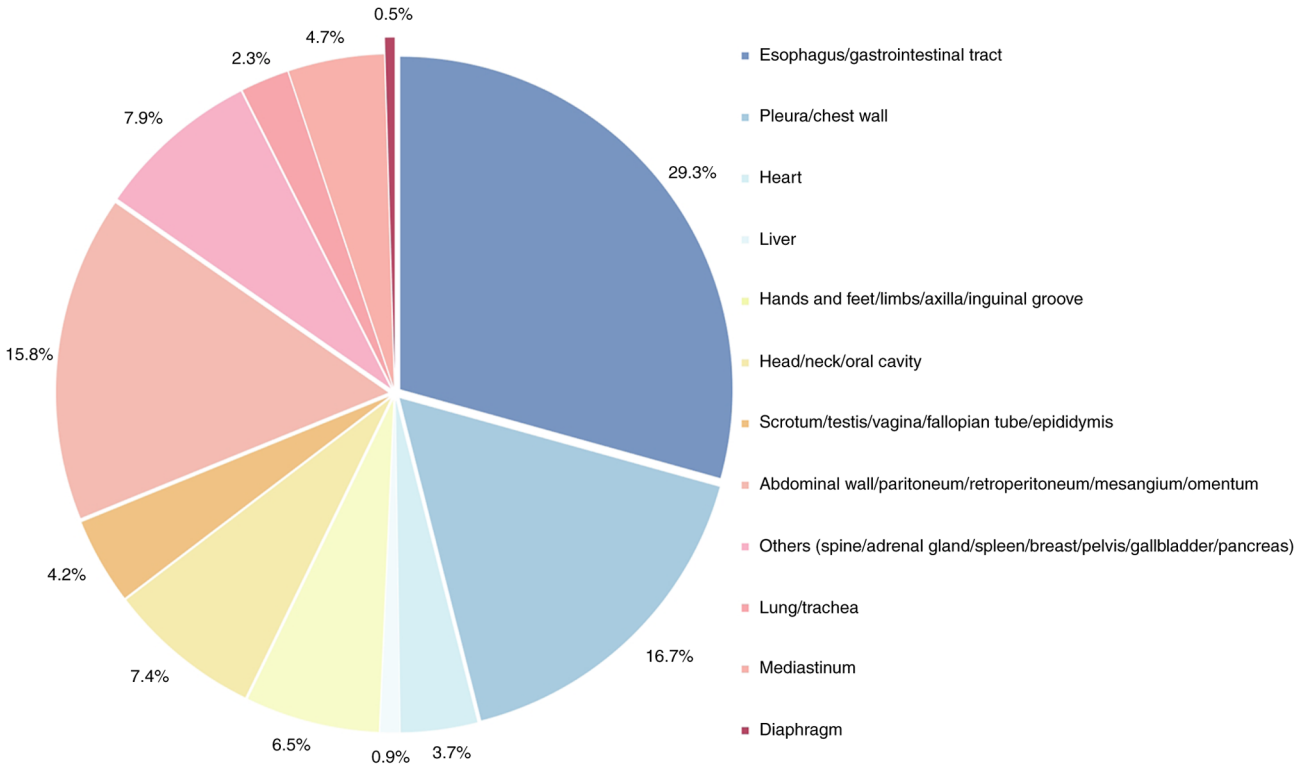

Figure 3. Anatomic distribution of calcifying fibrous tumours based on 215 published cases (current case excluded).

Soft Tissue and Bone formally defined CFT as a rare benign fibroblastic disorder (15).

According to earlier literature, the predilection sites of CFT were predominantly concentrated in soft tissues of the extremities, trunk and head/neck regions. However, with an increasing number of case reports, it is now evident that CFT can arise in virtually any anatomical location (12). The most frequent sites include the gastrointestinal tract, pleura, peritoneum and mesentery, which aligns with the trends summarized in the present study. A literature review by Chorti *et al* (1) reported a broad age range for CFT onset (1-85 years), with a slight female predominance.

CFT typically lacks distinctive clinical symptoms. However, when critical organs such as the lungs, spleen or pancreas are involved, it may not only induce compressive symptoms but also lead to functional impairments of the affected organs (16).

On CT images, thoracic CFT typically manifests as well-circumscribed solitary masses or multiple solid soft-tissue lesions. The lesions demonstrate either broad-based sessile attachment or pedunculated growth to the chest wall, exhibiting characteristic punctate to amorphous calcifications with a predominantly peripheral distribution (3,4). Enhanced CT revealed mild heterogeneous enhancement with preserved

Table I. Summary of the characteristics of seven previously reported cases of calcifying fibrous tumours that are most similar to the present case.

Author/year	Age, years/sex	Symptoms	Location	Chest CT/X-ray	Gross appearance	Pathological features	Therapy	Prognosis	(Refs.)
Pinkard *et al*, 1996	23, F	Chest pain	Pleural	Multiple pleural-based masses with central areas of increased attenuation	Well-demarcated, unencapsulated, lobulated masses; 1.5-12.5 cm	The calcifications had a laminated appearance typical of psammoma bodies	Surgical excision	NED	(9)
Pinkard *et al*, 1996	28, F	Incidental finding	Pleural	Heterogeneous extra-parenchymal pleural-based mass; central area of increased attenuation	Smooth, lobulated firm, whorled mass; 6.5 and 1.2 cm in maximum diameter	The calcifications had a laminated appearance typical of psammoma bodies	Surgical excision	NED	(9)
Pinkard *et al*, 1996	34, M	Chest pain	Pleural	Heterogeneous extra-parenchymal pleural-based mass in left anteroinferior cardiophrenic angle; central area of increased attenuation	Attached by a short pedicle to parietal pleura; 4.0 cm	The calcifications had a laminated appearance typical of psammoma bodies	Surgical excision	NA	(9)
Mylapalli *et al*, 2024	48, M	Incidental finding	Diaphragm	NA	Nodule-papillary pearly white coral-like outgrowth; 2.0 cm in maximum diameter	Dense hyalinized fibrocollagenous bundles with perivascular foci of scanty lymphoplasmacytic infiltration	NA	NA	(5)
Mito *et al*, 2005	54, M	Incidental finding	Pleural	Several nodular lesions, no calcifications were detected	Solid, white, fibrous matrix; 1.0x1.5x0.8 cm, 0.5x0.5x0.5 cm	Bland spindle cells, scant lymphoplasmacytic infiltrate and small calcification	Surgical excision	NED	(8)
Jang *et al*, 2004	31, F	Incidental finding	Pleural	Well demarcated calcifying mass	Smooth and lobulated; 8x7x5 cm	Psammomatous calcifications and areas of inflammatory infiltrate	Surgical excision	NED	(7)
Jia *et al*, 2021	38, M	Chest pain	Pleural	Subpleural mass with dystrophic calcification	Firm, pearly white masses; 5.0 cm in maximum diameter	Inflammatory lymphocytic infiltration, minute psammomatous calcifications	Incomplete resection	NA	(6)

Table I. Continued.

Author/year	Age, years/sex	Symptoms	Location	Chest CT/X-ray	Gross appearance	Pathological features	Therapy	Prognosis	(Refs.)
Guo *et al*, 2025	45, F	Incidental finding	Diaphragm	Lobulated solid nodule	Pearl-white, lobulated mass with coral-like nodularity	Hyalinized collagen bundles with sparse lymphocytic infiltration	Surgical excision	NED	Present case

NA, not available; CT, computed tomography; M, male; F, female; NED, no evidence of disease.

homogeneity of the non-enhancing tumour parenchyma and no radiologic evidence of peritumoral infiltration (3,17).

Magnetic resonance imaging findings of CFT lack specificity, generally presenting as masses with isointensity on T1-weighted (T1W) sequences and hypointensity on T2W sequences, with calcified regions showing marked signal voids. However, few reports describe CFT cases lacking detectable calcifications, suggesting potential heterogeneity in imaging manifestations (18). When CFT involves the diaphragm or pleura, tumour margins are frequently obscured by adhesions and traction to adjacent pleural tissues, posing challenges for radiological diagnosis and surgical planning. In the present case, 3D reconstruction was utilized to improve the anatomical assessment of tumour-adjacent tissue relationships. 3D imaging demonstrated extensive connectivity between the tumour base and the diaphragm, offering vital anatomical guidance for precise intraoperative resection. However, since this technology increases costs without proven prognostic benefits, it should remain a selective rather than standard preoperative tool.

CFT demonstrates distinct histopathological features: Solid, firm, lobulated masses with well-defined margins; smooth surfaces lacking encapsulation; and homogeneous grey-white fibrous cut surfaces devoid of haemorrhage or necrosis (17,19). Microscopically, spindle cells embedded in abundant collagenous stroma are characteristic and accompanied by dystrophic calcifications or psammoma bodies, with scattered lymphoplasmacytic infiltrates in the interstitium (1,2). IHC aids in differential diagnosis. Reported IHC profiles show diffuse positivity for vimentin and focal CD34 expression in spindle cells, whereas desmin, S-100 protein, STAT6 and anaplastic lymphoma kinase (ALK) are typically negative (7,20). In the current case, the gross specimen presented as white, hard, coral-like nodules. Microscopic examination revealed prominent fibrosis and scattered lymphocytes, although typical calcified nodules were absent, which is potentially attributable to sampling limitations in pathological sectioning or indication of early disease progression. Despite technical challenges (such as the tissue detachment in paraffin sections compromising IHC interpretability), the diagnosis of CFT was confirmed through an integrative analysis of morphological, pathological and radiological features, consistent with the diagnostic frameworks established by Mylapalli *et al* (5) and Kashizaki *et al* (5,10).

CFT generally has a favourable prognosis and the literature seldom emphasizes the necessity of differentiating it from malignant neoplasms. However, in the present case, the thoracic CFT presented on axial CT as a solid nodule with spiculated margins, lobulation and suspected pleural retraction. Compared with prior imaging, the lesion demonstrated slight interval growth, sharing overlapping radiological features with those of primary pulmonary malignancies. Thus, distinguishing thoracic CFT, particularly subpleural lesions, from primary lung malignancies is imperative in imaging interpretation.

Beyond primary lung cancer, CFT must be differentiated from the following thoracic fibrous tumours: i) Solitary fibrous tumour (SFT), typically arising from the pleura, appears on CT as a solitary, well-demarcated, hypervascular soft-tissue mass with homogeneous density. Larger SFTs may exhibit

hypodense or heterogeneous areas because of necrosis or haemorrhage, facilitating differentiation from CFT. On IHC, STAT6 expression serves as the most specific and sensitive diagnostic marker for SFT (21), whereas CFT is STAT6-negative. ii) Inflammatory myofibroblastic tumour (IMT): IMT often manifests on thoracic CT as a solitary, well-defined lobulated mass, predominantly in the lower lung lobes, mimicking CFT. However, IMT typically displays heterogeneous attenuation and enhancement, with frequent ALK positivity on IHC, a feature rarely observed in CFT (22,23). iii) Desmoid tumours: Desmoid tumours on CT usually present as round or oval dense shadows with minimal enhancement. Key discriminators include their infiltrative growth pattern, ill-defined margins and high postoperative recurrence rates. Definitive diagnosis relies on β-catenin positivity via IHC (24).

With respect to management, individualized treatment decisions are made on the basis of clinical evaluation. Given the indolent growth of CFT and its potential for local compressive effects, surgical resection is recommended for surgically eligible young patients (clinical judgment) (25). Upon review of prior cases, CFT demonstrates an unequivocally benign biological behaviour, with low recurrence rates after complete excision, no evidence of malignant transformation during long-term follow-up and a 100% survival rate (1). For asymptomatic patients with CFT with a high surgical risk (such as advanced age or severe cardiopulmonary dysfunction), active surveillance rather than intervention is advised. As reported in the present study, a 45-year-old female patient underwent thoracoscopic resection for a solitary thoracic mass and was ultimately diagnosed with CFT. Surveillance over one year has demonstrated no evidence of recurrence. The present case underscores the clinical importance of recognizing CFT to avoid misdiagnosis, inappropriate management and related complications.

The precise aetiology and pathogenesis of CFT remain elusive. It has been hypothesized that CFT may represent a late sclerotic phase of IMT (23). Another study has suggested associations with pathogenic mutations in the ZN717, FRG1 and CDC27 genes, leading to copy number variations in chromosomes 6 and 8 and altered coding regions. However, the underlying mechanisms require further investigation (6).

In summary, CFT is a benign tumour characterized by a slow growth tendency and easy misdiagnosis as other pulmonary nodules. Macroscopically, it typically presents as a white, firm, coral-like nodule. Radiological findings reveal a well-circumscribed, homogeneous mass with punctate calcifications. The identification of characteristic calcified nodules through IHC analysis serves as the gold standard for definitive diagnosis. Surgical resection represents the primary intervention and is associated with a favourable prognosis and a low rate of recurrence. Despite its rarity, CFT warrants consideration in the routine evaluation of pulmonary nodules because of its distinct clinical implications. As a benign neoplasm with indolent progression, CFT is frequently misclassified as granulomatous inflammation or malignancy on initial assessment, a diagnostic pitfall that may lead to overtreatment and substantial patient distress. Therefore, more evidence from accumulating case reports could aid in refining diagnostic and treatment approaches. When thoracic CT reveals homogeneous nodules with peripheral punctate or amorphous calcifications, CFT should be suspected. Through comprehensive case analyses and a literature review, the present study aimed to enhance the understanding of CFT and promote diagnostic and therapeutic progress, thereby facilitating accurate identification and more appropriate clinical management for these patients. Since the present literature search only used PubMed, it is expected that future studies will provide reviews with more complete evidence in this area.

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Availability of data and materials

The data generated in the present study may be requested from the corresponding author.

Authors' contributions

SG conceptualized the study and wrote the original manuscript. LY, GC and YT searched the literature and obtained case-related data. CX and WH analysed the data and relevant literature. MW and HW edited the final draft and assisted with language translation. JG provided surgical specimens. JG and MW confirm the authenticity of all the raw data. All authors read and approved the final version of the manuscript.

Ethics approval and consent to participate

This study was approved by the ethics committee of Taihe Hospital (Shiyan, China; approval no. 2025KS127) and was performed in accordance with the principles of good clinical practice following the Tri-Council guidelines. Informed consent for both the study and publication was obtained from the patient.

Patient consent for publication

The patient provided written informed consent for the publication of case information and images.

Competing interests

The authors declare that they have no competing interests.

References

1. Chorti A, Papavramidis TS and Michalopoulos A: Calcifying fibrous tumor: Review of 157 patients reported in international literature. Medicine (Baltimore) 95: e3690, 2016.
2. Zhang L, Wei JG, Fang SG, Luo RK, Xu ZG, Li DJ and Kong LF: Calcifying fibrous tumor: A clinicopathological analysis of 32 cases. Zhonghua Bing Li Xue Za Zhi 49: 129-133, 2020 (In Chinese).
3. Yu C, Wen X and Sun M: CT and MRI features of calcified fibrous tumor: A case report. Asian J Surg 48: 872-873, 2025.

4. Miyashita S, Ryu Y, Takata H, Asaumi Y, Sakatoku M, Seike T, Okamura T, Inamura K, Kawai H, Okuno N and Terahata S: Imaging findings of gastric calcifying fibrous tumour. Bjr Case Rep 2: 20160064, 2016.
5. Mylapalli JL, Jangir H, Sharma M, Prabhakar V, Sandhu PR, Subramanian A, Barwad A and Lalwani S: Post-mortem detection of a calcifying fibrous pseudotumor at a rare site-a case report. Indian J Pathol Microbiol 67: 669-671, 2024.
6. Jia B, Zhao G, Zhang ZF and Sun BS: Multiple calcifying fibrous tumor of the pleura: A case report. Thoracic Cancer 12: 2271-2274, 2021.
7. Jang KS, Oh YH, Han HX, Chon SH, Chung WS, Park CK and Paik SS: Calcifying fibrous pseudotumor of the pleura. Ann Thorac Surg 78: e87-e88, 2004.
8. Mito K, Kashima K, Daa T, Kondoh Y, Miura T, Kawahara K, Nakayama I and Yokoyama S: Multiple calcifying fibrous tumors of the pleura. Virchows Arch 446: 78-81, 2005.
9. Pinkard NB, Wilson RW, Lawless N, Dodd LG, McAdams HP, Koss MN and Travis WD: Calcifying fibrous pseudotumor of pleura. A report of three cases of a newly described entity involving the pleura. Am J Clin Pathol 105: 189-194, 1996.
10. Kashizaki F, Kano T, Kameda Y and Osawa H: Calcifying fibrous tumors resembling coral. Intern Med 63: 3111-3112, 2024.
11. Takabatake K, Arita T, Kuriu Y, Shimizu H, Kiuchi J, Takaki W, Konishi H, Yamamoto Y, Morimura R, Shiozaki A, *et al*: Calcifying fibrous tumor of the ileum resected by single-port laparoscopic surgery: A case report. Surg Case Rep 8: 64, 2022.
12. Larson BK and Dhall D: Calcifying fibrous tumor of the gastrointestinal tract. Arch Pathol Lab Med 139: 943-947, 2015.
13. Rosenthal NS and Abdul-Karim FW: Childhood fibrous tumor with psammoma bodies. Clinicopathologic features in two cases. Arch Pathol Lab Med 112: 798-800, 1988.
14. Fetsch JF, Montgomery EA and Meis JM: Calcifying fibrous pseudotumor. Am J Surg Pathol 17: 502-508, 1993.
15. Travis WD, Brambilla E, Müller-Hermelink HK and Harris C: Pathology and Genetics of Tumours of the Lung, Pleura, Thymus and Heart. In: International Agency for Research on Cancer. IARC Press, Lyon, 2007.
16. Abd Kahar NN and Al-Mukhtar A: Calcifying fibrous tumour-a rare cause of anaemia. J Surg Case Rep 2021: rjaa573, 2021.
17. Shibata K, Yuki D and Sakata K: Multiple calcifying fibrous pseudotumors disseminated in the pleura. Ann Thorac Surg 85: e3-e5, 2008.
18. Lee HJ, Jeong JS and Lee YC: Calcifying fibrous tumour of the pleura without gross calcification. Respirol Case Rep 12: e01365, 2024.
19. Suh JH, Shin OR and Kim YH: Multiple calcifying fibrous pseudotumor of the pleura. J Thorac Oncol 3: 1356-1358, 2008.
20. Lisowska H, Marciniak M, Cianciara J and Pawełczyk K: A rare case of calcifying fibrous pseudotumor of the pleura with an accompanying vascular anomaly in the pulmonary ligament. Kardiochir Torakochirurgia Pol 15: 59-61, 2018.
21. Kazazian K, Demicco EG, de Perrot M, Strauss D and Swallow CJ: Toward better understanding and management of solitary fibrous tumor. Surg Oncol Clin N Am 31: 459-483, 2022.
22. Narla LD, Newman B, Spottswood SS, Narla S and Kolli R: Inflammatory pseudotumor. Radiographics 23: 719-729, 2003.
23. Sigel JE, Smith TA, Reith JD and Goldblum JR: Immunohistochemical analysis of anaplastic lymphoma kinase expression in deep soft tissue calcifying fibrous pseudotumor: Evidence of a late sclerosing stage of inflammatory myofibroblastic tumor? Ann Diagn Pathol 5: 10-14, 2001.
24. Prendergast K, Kryeziu S and Crago AM: The evolving management of desmoid fibromatosis. Surg Clin N Am 102: 667-677, 2002.
25. Azam F, Chatterjee M, Kelly S, Pinto M, Aurangabadkar A, Latif MF and Marshall E: Multifocal calcifying fibrous tumor at six sites in one patient: A case report. World J Surg Oncol 12: 235, 2014.