Case report: A 3-year-old boy presented with a 6 week history of a lump in the posterolateral thigh. A clinical diagnosis of fat necrosis or fibrous tumour was made and surgical excision performed. Histological sections revealed a linear lesion in the dermis and subcutis consisting of hyperplastic lymphoid tissue and a mixed inflammatory infiltrate with eosinophils, similar to that seen in angiolymphoid hyperplasia with eosinophilia but associated with macrophages containing cytoplasmic basophilic material. Subsequent clinical history confirmed a vaccination injection at the site 2 years previously.

Conclusion: Injection site reactions can present many months after the injection and may show many histological patterns that may mimic other conditions. A high index of suspicion is required to avoid misdiagnosis.

METAPLASTIC PAPILLARY TUMOUR OF FALLOPIAN TUBE (MPTFT) PRESENTING AS AN ADNEXAL CYST DURING CAESAREAN SECTION: A CASE REPORT AND LITERATURE REVIEW

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An incidental adnexal cyst found during a caesarean section procedure in a 25-year-old primigravida was sent in fragments for histology. The lesion was suspected to be an ovarian dermoid cyst clinically.

Histologically, there was a distended fimbrial region of fallopian tube containing progressively branching mucosal papillae. These papillae were lined by plump columnar cells, a few of which were pseudostratified, with abundant eosinophilic granular cytoplasm. Scattered cells contained subnuclear intracytoplasmic mucin vacuoles and some ciliated cells were also present. No significant nuclear atypia or mitotic activity was seen. Luminal extracellular mucin was noted. This epithelial lining strongly expressed PAX8, oestrogen receptor and progesterone receptor. The Ki-67 proliferative index was up to 4%. A diagnosis of MPTFT was made. MPTFT is an exceedingly rare finding, usually associated with pregnancy. Each of the eleven previously reported cases were incidental histological findings, and all except one were found in tubal ligation specimens post-delivery. To our knowledge, this is the first surgically detected case of MPTFT presenting as an adnexal cyst.

The true nature of this entity (reactive versus neoplastic) remains uncertain. It must be recognised as a benign lesion and distinguished from serous borderline tumour.

AN UNUSUAL CASE OF BILATERAL BUMPY ARMS

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We present a diagnostically challenging case of a 36-year-old male with a prolonged history of bilateral upper limb nodular lumps associated with pain and paraesthesia.

Histologically, the nodules were seen in the deep dermis and subcutis, composed centrally of necrobiotic collagen surrounded peripherally by lymphoid aggregates, focally palisaded histiocytes and dispersed eosinophils. There is patchy stromal mucin

and few foci of karyorrhectic debris. There are accompanying intervening myofibroblasts and prominent aggregates of plasma cells. The deep dermal nodule contained aggregates of blood vessels lined by prominent endothelial cells surrounded by lymphocytes, eosinophils and less collagenisation.

The composite features suggest diagnostic possibilities of angiolymphoid hyperplasia with eosinophilia (ALHE), IgG4-related sclerosing disease, inflammatory pseudotumour and subcutaneous granuloma annulare (SGA). Although necrobiotic collagen and stromal mucin suggested SGA; the presence of plasma cells and eosinophils is unusual. We investigated the nature of the plasma cells by performing IgG and IgG4 immunohistochemical stains. Immunohistochemical negativity for ALK did not support the diagnosis of inflammatory pseudotumour. ALHE may rarely be associated with a fibro-granulomatous reaction, including the presence of multinucleate giant cells and may be located in the limbs.

We discuss these close differential diagnoses and consider the possibility of hybrid lesions.

IgG4-RELATED PROSTATITIS CLINICALLY MIMICKING PROSTATIC CARCINOMA: A CASE REPORT

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A wide range of extra-pancreatic manifestations of IgG4-related disease has been described, with prostatitis remaining one of the least studied. We report a first Australian case of IgG4-related prostatitis.

A 76-year-old man with a history of IgG4-related disease underwent investigations for renal impairment which revealed an obstructive uropathy on ultrasound scan. An MRI showed a prostatic peripheral zone tumour which was intensely FDG PET positive. In addition, an elevated prostate-specific antigen level of 26 ng/ml was detected and prostate cancer needed to be excluded.

Trans-perineal prostate biopsies were performed. The prostatic parenchyma showed a florid inflammatory cell infiltrate composed of plasma cells, lymphocytes and some eosinophils. There was also variable sclerosis of prostatic stroma and areas of phlebitis, sparing the adjacent arterioles. Immunohistochemical stains for IgG and IgG4 were positive, in keeping with changes of IgG4-related autoimmune prostatitis.

Albeit a rare manifestation, IgG4-related prostatitis needs to be recognised as a cause of lower urinary tract symptoms in patients with IgG4-related disease, and considered as a possible clinical and radiological mimic of prostatic carcinoma in these patients.

CASE REPORT OF A FOREARM LIPOBLASTOMA

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Case presentation: A 4-year-old boy presented with a soft slowly enlarging left forearm lesion. Imaging showed a 53×56×132 mm lesion expanding the entire dorsal extensor compartment of the forearm. This had previously been imaged