Aim/Introduction: The progression from microglandular adenosis (MGA) to atypical microglandular adenosis (AMGA) then to ductal carcinoma has been documented in case reports and series.^{1–6} We report here the first case of AMGA and residual invasive ductal carcinoma in the context of post-neoadjuvant chemotherapy.

Case/Methods/Results: A 57-year-old female presented with a 70×55 mm left breast lump. Her medical history included hysterectomy and bilateral oophorectomy for dysfunctional uterine bleeding and fibroid uterus. A breast needle core biopsy showed invasive carcinoma of no special type with areas of high grade ductal carcinoma *in situ*. Focal areas of MGA were noted. The tumour was ER–, HER2– and PR+(30%). A left axillary lymph node fine needle aspirate showed cohesive fragments of malignant epithelial cells consistent with metastatic carcinoma. The patient was initially treated with neoadjuvant chemotherapy (adriamycin, cyclophosphamide and docetaxel). The breast lump reduced in size to 10 mm in maximum dimension. Following review with a breast surgeon she underwent a left total mastectomy and axillary clearance.

Macroscopic examination of the breast specimen revealed an ill-defined nodular area measuring 80 mm in maximum dimension. Microscopically there was an atypical glandular proliferation with glands arranged haphazardly in fibrous stroma and fat. The glands showed a range of proliferative changes with areas of solid and cribriform architecture. These changes were consistent with a spectrum ranging from MGA to AMGA and ductal carcinoma *in situ*. The glands were devoid of a myoepithelial layer on immunoperoxidase stains. A 12 mm foci of invasive carcinoma in the form of nests and cords without tubule formation was also present which was similar to the initial core biopsy. All seventeen lymph nodes were negative for malignancy.

Discussion: Microglandular adenosis is an uncommon benign proliferative glandular lesion. Case studies have shown that carcinoma arises in cases of MGA^{1,3–6} and there is molecular evidence of its progression to malignancy.⁷ What is unclear are the effects of chemotherapy on MGA. We report here the first case of atypical MGA in the context of post-neoadjuvant chemotherapy.

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CUTANEOUS ROSAI DORFMAN DISEASE: A CASE REPORT AND LITERATURE REVIEW

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Purpose: Rosai-Dorfman disease (RDD) is a benign, multi-organ, non-Langerhans cell histiocytosis that was described as a distinct entity by Rosai and Dorfman¹ in 1969. Purely cutaneous RDD (C-RDD) has been described, but is considered a rare occurrence.² The aim of this study was to present a case of C-RDD and perform a literature review on the subject.

Material: A 62-year-old female presented with a single 7 mm nodule on her mid back. The lesion was completely excised.

Result and conclusion: The sections show a dermal based tumour composed of histiocytes admixed with a prominent mixed inflammatory infiltrate. Some of the histiocytes engulf inflammatory cells (emperipolesis). The lesional cells express S100 and CD68 and are negative for CD1a, consistent with C-RDD. Only a single cutaneous lesion has been detected and there is no systemic involvement.

In the literature, C-RDD is a histiocytosis of uncertain histogenesis, a distinct entity with no systemic involvement.³ Usually cutaneous lesions do not require any treatment besides excision as they show a self-limiting course and tend to regress spontaneously.

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SOLITARY FIBROUS TUMOUR OF THE PROSTATE: ASSESSMENT OF MALIGNANCY POST TREATMENT

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Aim: We present a case of solitary fibrous tumour (SFT) in an unusual site (prostate) in a patient who has undergone neoadjuvant radiotherapy.

Case summary: A 54-year-old man presented with renal colic symptoms and was incidentally found to have a 6 cm mass posterior to his prostate. Core biopsy revealed a mixed spindle cell lesion raising the possibility of a sarcomatoid tumour. The patient was treated with neo-adjuvant radiotherapy and subsequently a pelvic exenteration was performed. The histopathology of the resection specimen confirmed SFT.

Discussion: Solitary fibrous tumour is an uncommon fibroblastic mesenchymal tumour that was initially described in pleura, but can occur in any site. Due to the relative rarity of SFT in the prostate, there is still a limited understanding of the clinical course of this tumour. Several general criteria have been