medical literature lines up accordingly with these produced scores.

Discussion: The study displays the developing a numeric framework for developing 'critical values' in anatomic pathology is possible, and that this correlates well with contemporary consensus.

References

1. Renshaw S, Gould EW, Renshaw AA. Unexpected expectations in critical values in anatomic pathology. *Arch Pathol Lab Med* 2011; 135: 1391–3.
2. The College of American Pathologists' Laboratory Accreditation Program Laboratory general checklist item GEN.20365. Cited 29 Sep 2008. <http://www.cap.org/apps/docs/laboratoryaccreditation/checklists/laboratorygeneralsep07.doc>.
3. Pereira TC, Liu Y, Silverman JF. Critical values in surgical pathology. *Am J Clin Pathol* 2004; 122: 201–5.

ANALYSIS OF QUALITY IMPROVEMENT FORMS IN ANATOMICAL PATHOLOGY IN SRI LANKAN TERTIARY CARE REFERENCE LABORATORY

Harsha Samarasekara, Mangala Bapagoda,
Sandeepani Gunawardena, Susantha Liyanage,
Nihal Meedeniya, Ayesh Ruwan
Lanka Hospital Diagnostics, Colombo, Sri Lanka

Lanka Hospital Diagnostics (LHD) is ISO 15189 Accreditation tertiary care laboratory, offering general and specialised tests in anatomical pathology. The test menu of this laboratory was upgraded from July 2014 by provision of state of the art equipment and continuous supervision by a fulltime specialist anatomical pathologist. The quality management system of LHD has also been upgraded in line with higher level of international accreditation standards such as JCIA and CAP.

Aims of this study:

1. To identify basic process or workflow deficiencies in department of Anatomical Pathology.
2. To educate all stake holders involved in laboratory workflow to take necessary corrective and preventive actions.
3. To create a database where regular data analysis is performed and required interventions are being taken.

Method: Forty-one quality improvement forms were received under department of Anatomical Pathology (24.8% of all QI forms received). The root cause analysis performed for each item and immediate corrective actions taken, preventive action identified and implemented, whenever possible.

Results: Pre-analytical errors 23 (56.1%), analytical errors 6 (14.6%), post-analytical errors 5 (12.2%) and administrative/safety issues 7 (17.1%) were identified.

Common errors included incorrect identification of samples, mislabelling of samples, using wrong fixatives, delay of transport of specimens, wrong specimen type or size selection, wrong selection of specialised tests such as IHC markers, delay in reports and laboratory safety issues. Error rate in histopathology is approximately 0.039 %.

Discussion: Immediate corrective actions were taken for identified specific issues whenever possible. Analytical problems are resolved by having validated and quality controlled methods and regular in-house education for technical staff. Preventive action will be optimised by educating operation theatre staff, billing

staff and technical staff in the laboratory. Safety issues will be addressed by the safety and quality team by enhancing the regular educational program.

AN INTERESTING SKIN NODULE – EXTRANODAL, CUTANEOUS ROSAI-DORFMAN DISEASE

Sathiyamoorthy Selvarajan, Lee Ming

Anatomic Pathologist, Department of Pathology, Singapore General Hospital, Singapore

A 49-year-old Indian male presented to the dermatology outpatient clinic with a tender, pruritic and erythematous lump over the right chest. The nodule had been gradually enlarging over 2 months. No significant past medical history was noted. Clinical inspection revealed a localised papulo-nodular lesion measuring 3×3×2 cm, with several smaller satellite papules around it. No other abnormality was detected during the clinical examination.

Blood tests revealed a normal full blood count and biochemistry. A punch biopsy was performed. The histology revealed unremarkable epidermis, separated from a dense dermal infiltrate by a thin Grenz zone. The dermal infiltrate comprised large numbers of neutrophils, lymphocytes and plasma cells, interspersed with single and small groups of foamy histiocytes with multiple bland, ovoid nuclei. Many histiocytes showed emperipolesis of intact neutrophils and lymphocytes.

There was no involvement of underlying subcutaneous fat. Special stains for acid-fast bacilli and fungi were negative.

Immunohistochemistry was performed. The histiocytes within the specimen showed the following staining characteristics: S100 and CD68 positive; CD1a negative.

The final diagnosis was that of cutaneous Rosai-Dorfman disease. No further treatment was required other than topical emollients and topical steroids. The patient underwent computed tomographic scans of the upper body and head, which did not detect any lymphadenopathy.

SPORADIC CASE OF RETINAL VASCULOPATHY WITH CEREBRAL LEUKODYSTROPHY/HEREDITARY ENDOTHELIOPATHY RETINOPATHY NEPHROPATHY STROKE WITH NOVEL TREX1 MUTATION

Bonnie Scurry¹, Thomas Wellings², Himanshu Goel³,
Anja Pluschke¹

¹Pathology North, Anatomical Pathology, Pathology North Hunter New England, ²John Hunter Hospital, New Lambton, and ³Hunter Genetics, Waratah, NSW, Australia

The prevalence of cerebral microangiopathies is under reported.¹ We present a case of a 39-year-old male with a presenting complaint of increasing confusion and speech disturbance of some months duration. MRI revealed a 3.1×2.3 cm lesion with low T2 signal, located in the left corona radiata, suspicious for a malignancy. Contrast could not be given due to chronic kidney disease. Brain biopsy showed white matter necrosis with a small vessel vasculopathy comprising patchy foci of fibrinoid necrosis and associated lymphoplasmacytic inflammation. PAS and Beta