GLANDULAR DIFFERENTIATION IN EPSTEIN-BARR VIRUS RNA-EXPRESSING NASOPHARYNGEAL CARCINOMA

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Nasopharyngeal carcinoma (NPC) is described in the 2005 WHO Classification of Head and Neck Tumours as a carcinoma arising in the nasopharynx having light microscopic or ultra-structural evidence of squamous differentiation. In the current definition, adenocarcinoma is excluded. Rare adenocarcinomas of the nasopharynx show papillary growth or are of salivary gland-type, and are not associated with Epstein-Barr virus (EBV).

We report the case of a 37-year-old Southeast Asian Chinese male with a non-keratinising carcinoma, undifferentiated sub-type arising in the nasopharynx. Within the tumour, there were glandular structures with distinct lumens which were highlighted with mucicarmine. Cytokeratin AE1/3 and epithelial membrane antigen were diffusely positive in the tumour. Like typical non-keratinising NPC, the tumour demonstrated EBV encoded early RNA (EBER) by in-situ hybridisation. Biopsy from recurrent tumour 2 years later, after radiotherapy and chemotherapy, showed no evidence of glandular differentiation.

Glandular differentiation in NPC is exceptional. To our knowledge only 2 previous cases have been reported in white males in the United States where nasopharyngeal carcinoma is rare. We report the first case of NPC with glandular differentiation in Southeast Asia where the tumour is prevalent among ethnic Chinese and Southeast Asians.

A CASE OF CUTANEOUS METASTASIS OF THE SCALP FROM COLORECTAL ADENOCARCINOMA

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Background: Cutaneous metastases from internal malignancies occur in 0.6–10.4% of all patients with cancer¹ and account for 2% of all skin tumours.² Presented is a rare case of cutaneous metastases of the scalp from primary colorectal adenocarcinoma.

Clinical record: A 55-year-old woman with known colorectal adenocarcinoma presented with two scalp lesions. One resolved with systemic chemotherapy. The remaining 25×22 mm ulcerated, brown nodule in the left parietal region was excised. Histopathology demonstrated a dermal lesion composed of atypical glandular structures with central necrosis and overlying ulceration. Immunohistochemistry was negative for cytokeratin 7 and positive for cytokeratin 20 and carcinoembryonic antigen. Oestrogen and progesterone receptors and thyroid transcription factor-1 were negative. This pattern of staining is consistent with metastatic colorectal adenocarcinoma.

Discussion: Up to 4.4% of metastatic colorectal adenocarcinoma is manifest as cutaneous metastases.³ Presentation on the scalp, far removed from the primary site of cancer, is rare. Between 29 to 45% of cutaneous lesions are not initially suspected of being metastases.⁴ Early biopsy of any new or suggestive lesion in patients with known malignancy, with confirmation of origin through histopathology, is critical for patient care.

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A CASE OF PERIVASCULAR EPITHELIOID CELL TUMOUR (PECOMA)-NOS

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A 30-year-female presented with an incidental left adnexal mass. Macroscopically, the mass was a well circumscribed fleshy nodule with no recognisable adnexal tissue. Microscopically, the mass was encapsulated, composed of closely packed nests of polygonal cells with prominent nucleoli and abundant granular eosinophilic to clear cytoplasm. There is occasional whorl formation. Mitosis or necrosis are not seen. Immunohistochemically, neuroendocrine markers and muscle markers are negative. It is HMB45 and TFE3 positive. The features are of PECOMA NOS type which is associated with TFE3 gene rearrangement. It is a rare mesenchymal tumour with no normal counterpart. Most cases are benign, but a minority are unpredictably malignant. The histological and immunohistochemical features of this rare tumour will be discussed followed by review of the literature.

WELL DIFFERENTIATED LIPOSARCOMA OF THE PARATESTIS: AN UNUSUAL AND VARIABLE MORPHOLOGY

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Case presentation: A 60-year-old gentleman presented with a 45 mm solid right paratesticular mass. On cut sectioning, the mass was a well circumscribed, lobulated, yellow tumour with prominent fibrous bands and haemorrhage. The mass did not involve the testis. It was associated intimately with the spermatic cord which was surrounded by macroscopically normal appearing fat.

Microscopically the tumour was a well differentiated liposarcoma which showed three distinct different morphologies, including areas of inflammatory liposarcoma, sclerosing liposarcoma and lipoma-like liposarcoma. The tumour extended much further than was anticipated at macroscopy with the lipoma like component extending to the spermatic cord margin, up to 150 mm in maximum extent. The lipoma-like areas were positive for MDM2.

Discussion: Liposarcomas of the paratesticular tissue are rare and areas of inflammatory liposarcoma are exceedingly rare and usually occur in the retroperitoneum. However, this case highlights that liposarcoma needs to be considered in the differential diagnosis of inflammatory lesions and tumours of the paratestis. The subtle lipoma-like component involved the surrounding macroscopically normal fat. The implications of this and need for