to other parathyroid adenomas and can be distinguished by their weight and appearance at frozen section. However, no case associated with brown fat rich features has been previously reported. Although thought to be virtually absent in adults, nuclear medicine studies have shown areas of remnant brown fat exist, mostly in the neck and supraclavicular region.³ The topographical co-existence of parathyroid adenoma in regions where brown fat remnants are known to persist in adults may be of aetiopathogenic significance for this rare, hitherto undescribed variant of lipoadenoma of the parathyroid gland.

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A CASE OF DISSEMINATED STRONGYLOIDIASIS IN ADELAIDE DIAGNOSED ON PERITONEAL BIOPSY

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Aims: A case report presentation with associated literature review to discuss a case of disseminated *Strongyloides stercoralis* infection in Adelaide diagnosed on peritoneal biopsy and identified on subsequent tracheal aspirate cytology.

Methods: Photographic and descriptive presentation of a case received by the Department of Anatomical Pathology (SA Pathology) at The Queen Elizabeth and Royal Adelaide Hospitals. A subsequent literature review of ‘*Strongyloides stercoralis* and peritoneal biopsy’ was undertaken through electronic database searches of PubMed, MEDLINE and Google Scholar.

Results: The light microscopy of the peritoneal biopsy showed scattered *Strongyloides stercoralis* larval forms, while the tracheal aspirate cytology revealed rounded nematode larvae with oesophago-intestinal junctions discernible. By the time the patient was diagnosed with disseminated strongyloidiasis he had rapidly deteriorated, and died following multi-organ failure.

Discussion: Disseminated strongyloides is uncommonly encountered in Australian urban hospitals. It is predominantly observed in immunocompromised patients who have previously acquired chronic *Strongyloides stercoralis* infection from living in or travelling to Aboriginal communities, Southeast Asia, Africa and South America. Once hyperinfection is established, widespread parasitic dissemination occurs aggressively, with the patient often succumbing to the infection within days. These combined factors may cause diagnostic confusion, with the patient’s clinical course mimicking other diseases such as bacterial sepsis and vasculitides.

RETROPERITONEAL LIPOSARCOMA WITH DIFFERENT MIMICS: 2 CASE REPORTS HIGHLIGHTING DIAGNOSTIC CHALLENGES

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Liposarcomas are the most frequent soft tissue sarcoma in the retroperitoneum. There are different recognised subtypes of liposarcoma. We outline 2 cases of histology mimicking the morphology of liposarcoma and highlight the diagnostic challenges in interpretation of the final diagnosis.

The first case of retroperitoneal tumour microscopically showed a distinct paraganglioma-like growth pattern characterised by well-defined nests and whorls of cells arranged in zellballen pattern, separated by highly vascularised fibrous septa. Immunohistochemistry showed diffuse/strong positive staining with CD56 and focal staining with S100. This tumour mimicked a malignant paraganglioma. However, on close examination the adjoining fat appeared abnormal, which showed amplification of MDM2 gene. Thus this was finally diagnosed as a dedifferentiated liposarcoma.

The second case mimicked a Hodgkin’s lymphoma which showed dense mixed inflammatory infiltrate admixed with Reed-Sternberg-like cells. However, in the adjoining area sclerosing liposarcoma was identified. In addition, the patient had previous history of multiple recurrent liposarcoma.

The recognition of an atypical adipocytic component is very crucial to reach a diagnosis of liposarcoma. However, in many instances, awareness of these rare morphologies, knowledge of its pathological features, and careful clinicopathological correlation will enable accurate diagnosis.

CARCINOSARCOMA OF THE GASTRO-OESOPHAGEAL JUNCTION WITH A NEUROENDOCRINE COMPONENT: REPORT OF A RARE PATHOLOGICAL ENTITY AND POTENTIAL FOR DIAGNOSTIC ERROR ON BIOPSY

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A 65-year-old man presented with gastrointestinal bleeding and melaena and was diagnosed on endoscopic biopsy with a gastro-oesophageal junction (GOJ)-located large cell neuroendocrine carcinoma. A radical gastrectomy was performed. Macroscopically, a lobulated, ulcerated brown tumour 60×48×13 mm was identified at the GOJ. An intraluminal tumour fragment 20×10×16 mm was submitted separately.

Light microscopy of the tumour showed biphasic differentiation, with a carcinomatous component predominantly showing neuroendocrine differentiation with smaller areas of adenocarcinoma and basaloid squamous carcinoma, and an admixed spindle cell sarcomatous component in the intraluminal tumour fragment. Three lymph node metastases were identified, one with neuroendocrine carcinoma, the second with adenocarcinoma, and the third with a mixed pattern. On immunohistochemistry, the sarcomatous component was positive for vimentin and SMA, while the neuroendocrine carcinomatous component was positive for CD56, synaptophysin and cytokeratin, with focal positive staining for CK5/6 and chromogranin. These features were consistent with GOJ carcinosarcoma.

Carcinosarcoma is a biphasic neoplasm with both epithelial and mesenchymal malignant components. Gastro-oesophageal junction carcinosarcoma has only rarely been described in the literature. Carcinosarcoma can cause diagnostic problems, as only one element may be present in biopsies, as seen in this case, and metastases can resemble either element.