uncertainty of their origin, possible diagnostic pitfalls and lack of management guidelines.

41. THE MASSIVE OEDEMA OF THE OVARY: A CASE REPORT

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Background: The massive oedema of the ovary is a rare entity affecting mainly young women in their 20s and 30s. The oedema can involve either one or both ovaries. Its aetiology is thought to be due to either partial or intermittent torsion of the ovarian pedicle that interferes with lymphatic drainage.

Case: We present the case of a 27-year-old woman who presented to her local doctor, 7 months post-natal, with increasing abdominal distension, worsening acne and irregular menstrual bleeding. The antenatal ultrasound scans showed normal ovaries. A CT scan done at this current presentation showed a 25.6 cm multiloculated left ovarian cyst. She underwent open left cystectomy with salpingoophorectomy. Histological examination of the specimen showed the findings of massive left ovarian oedema with no malignancy.

Conclusion: It is important to recognise this condition as it can be mistaken for a malignancy, putting the younger patient at risk of overtreatment with the resultant loss of hormonal function which can lead to infertility.

42. MIXED ADENONEUROENDOCRINE CARCINOMA OF THE APPENDIX: A CASE REPORT

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Background: A gastrointestinal (GI) tumour with an exocrine and a neuroendocrine component is an unusual phenomenon that has been reported in the oesophagus, stomach, small intestine, appendix, liver, colon, rectum, and anal canal. It was first described in a publication by Cordier in 1924. Since then, different case reports, using different terms have been published, and this lead to a lot of confusion among both pathologists and clinicians. In 2000, WHO classified GI tumour with an exocrine and a neuroendocrine as mixed exocrine-endocrine tumours if each component represents at least 30% of the lesion. In the most recent (2010) WHO classification of neoplasms of the GI tract, such neoplasms are called 'mixed adenoneuroendocrine carcinomas' (MANECs).

Case: Here, we report a case of a 75 year man who presented with clinical features consistent with acute appendicitis. The patient underwent laparoscopic appendicectomy. Histopathological examination of the appendix showed acute appendicitis as well as MANEC of the appendix. The patient has since undergone right hemicolectomy and has been referred for chemotherapy.

Conclusion: These tumours seem to be derived from a multipotential stem cell capable of bidirectional differentiation and have a much worse prognosis than ordinary carcinoma.

43. A SPONTANEOUSLY RESOLVING BREAST LESION: CYTOLOGICAL FINDINGS OF NODULAR FASCIITIS OF THE BREAST

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Nodular fasciitis is a benign self-limiting mass forming fibroblastic/myofibroblastic proliferation that is clonal. It is usually subcutaneous in location and most commonly involves the upper extremities, trunk, head and neck. It can very rarely occur in the breast. It is not uncommon for nodular fasciitis to present as a rapidly growing tumor, which may lead to a false impression of malignancy both on clinical and cytological examination.

We report a case of nodular fasciitis of the breast in a young woman who presented with a tender rapidly growing breast lump. On radiology, it was difficult to determine whether the lesion was originating from breast tissue or pectoralis muscle. Ultrasound guided fine needle aspiration cytology was reported as atypical spindle cell neoplasm and the patient was referred to a breast surgeon for further management and definite diagnosis. Repeat imaging after 2-3 weeks showed that the lesion had disappeared. Follow up MRI, mammogram and ultrasound confirmed spontaneous resolution of the lesion.

Nodular fasciitis of the breast is rarely diagnosed on cytology alone and a histological diagnosis is usually required for a definite diagnosis. However, in this case, the lesion had spontaneously resolved. The cytological features, in conjunction with immunohistochemistry and clinical history, strongly suggest nodular fasciitis, which is further supported by a USP6 FISH probe. Awareness of this entity is important and nodular fasciitis should be considered in the differential diagnosis of rapidly growing spindle cell lesions of the breast.

44. A CASE OF MULTIPLE GASTROINTESTINAL ENDOCRINE AND NON-ENDOCRINE NEOPLASMS

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A 61-year-old man without significant medical history was clinically diagnosed to have marked hypergastrinemia and multiple lesions in the lower stomach and duodenum at the time of routine medical checkup. Endoscopic biopsy was subsequently performed in the stomach and was diagnosed as neuroendocrine tumor (NET). The patient then received pancreaticoduodenectomy with lymph node dissection. The lesion in the lower stomach was histologically diagnosed as NET G2 with gastrin production (gastrinoma). In the duodenum, three different lesions including somatostatin producing NET G1, a low grade gastrointestinal stromal tumor (GIST) and neurofibroma were detected. In addition, diffuse neurofibromatosis was also identified in the intestinal wall and the metastases of paraganglioma and NET in peripancreatic lymph nodes. This peculiar presentation of multiple endocrine and non-endocrine tumors in the gastrointestinal tract above indicated the presence