characteristic. As patients with TDT-negative T-ALL/LBL tend to show worse outcome, it is important to remember that lack of TDT expression is expected in subsets of T-ALL/LBL. This pitfall should not preclude a correct diagnosis.

71. INTESTINAL GANGLIONEUROMATOSIS WITH PERI-INTESTINAL NEUROFIBROMA LIMITED TO THE GASTROINTESTINAL TRACT MIMICKING CROHN'S DISEASE

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Introduction: Ganglioneuroma is a benign neurogenic tumor composed of ganglion cells, nerve fibers and Schwann cells. Intestinal ganglioneuromas are rare tumors more often identified in the adults as solitary polypoid ganglioneuromas, ganglioneuromatous polyposis and diffuse ganglioneuromatosis, presenting with abdominal pain, diarrhoea, thickening of the bowel wall and stricture formation. Diffuse ganglioneuromatosis is typically associated with multiple endocrine neoplasia, neurofibromatosis type 1 and Cowden syndrome. In this case report, we describe a case of diffuse and polypoid ganglioneuromatosis along with peri-intestinal neurofibroma in a 30 year old female with no syndromic afflictions.

Case report: 30 year old female was investigated for recurrent alternating episodes of constipation and diarrhoea since 15 days associated with abdominal distension and palpable mass per abdomen. On CECT abdomen and pelvis, multifocal strictures with subacute intestinal obstruction was noted with possibilities of Crohn's disease or tuberculosis. Surgically resected terminal ileum and ascending colon showed multiple linear ulcers, pseudopolyps and cobblestone appearance. On histopathological examination of the resected specimen, diagnosis of intestinal ganglioneuromatosis (polypoid and diffuse) with suture granuloma and peri-intestinal neurofibroma was given. History elicited for similar prior complaints showed nonspecific ileocolitis on biopsy 2 years earlier. She also gave history of surgery for resection and anastomosis 6 years back.

Conclusion: We report a patient with intestinal ganglioneuromatosis in whom clinical and radiological findings mimicked those of Crohn's disease/tuberculosis. Despite its rarity, intestinal ganglioneuromatosis should be considered in patients with findings of Crohn's disease/tuberculosis on radiological investigations who have intractable symptoms despite medical treatment.

72. HISTOPATHOLOGICAL STUDY OF UPPER GASTROINTESTINAL ENDOSCOPIC BIOPSY IN PATIENTS WITH DYSPHAGIA AND DYSPEPSIA IN SOUTH WESTERN COAST OF INDIA

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Background: Patients with non-neoplastic and neoplastic lesions of upper gastrointestinal tract (GIT) exhibit important alarming symptoms like dysphagia and dyspepsia. Upper gastrointestinal endoscopic biopsy is an effective and appropriate investigation to assess these patients.

Aims: The aim of this study is to identify various lesions of the upper GIT in patients presenting with dysphagia and dyspepsia along with endoscopic and clinical correlation. For early identification of malignant lesions, screening of premalignant lesions and to differentiate non neoplastic lesions from neoplastic lesions and thus help in its appropriate management.

Method: 200 consecutive endoscopic biopsy samples received in histopathology laboratory in and around Mangalore, India for a period of two years was subjected for histopathological examination. All the samples received in the histopathology laboratory sent in 10% formalin was processed, haematoxylin and eosin staining was done. Special stains were done wherever necessary.

Results: 80% of the patients presented with dyspepsia. The most common lesion encountered in the oesophagus was malignant lesions followed by premalignant lesions, benign neoplasms and non-neoplastic lesions. The most commonly encountered gastric lesion were non neoplastic lesions followed by malignancy, premalignant lesions and benign neoplasm. Among the duodenal biopsies, non-neoplastic lesions were most common followed by malignancy.

Conclusion: The fibreoptic diagnostic upper GI endoscopic biopsy is relatively less invasive, simple, safe, well tolerated procedure, cost effective and provides good diagnostic yield in confirming various upper GIT lesions. There is concordance of endoscopic biopsy findings with post biopsy resected specimens. In routine clinical practice, histopathology is the 'gold standard' for the definitive diagnosis of various lesions.

73. INTRAVASCULAR HISTIOCYTOSIS (IVH): A CASE REPORT

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Intravascular histiocytosis is a rare reactive cutaneous lesion of unknown pathogenesis. It is characterised by dilated vessels in the dermis containing aggregates of mononuclear histiocytes within the lumina. Most cases are reported in association with rheumatoid arthritis and cutaneous eruption typically occurs near swollen joints. The skin changes have included erythematous and violaceous macules, papules, plaques and indurated patches. We report a case of 80 years old female presented with a large erythematous patch around the right anterior shoulder joint where surgery was performed about 2 months previously. The erythematous patch was clinically thought to be erysipelas or cellulitis and treated with antibiotics without response.

We received a punch biopsy of skin measuring 4×6 mm. Microscopic examination of routine H&E stains revealed ectatic thin walled vessels in the dermis, the lumina of which are filled with histiocytes (macrophages). The vessels are lined by flattened single layer of endothelial cells. CD 68 and CD 31 immunostains demonstrate the macrophages within thin walled vessels. Morphological features and immunostains are consistent with intravascular histiocytosis.