challenge to both clinicians and pathologists. The classic symptoms are those of diarrhoea, malabsorption, and weight loss, reflecting infection of the small intestine. Involvement of the colon is uncommon. A range of systemic symptoms, many non-specific, such as arthralgia, fatigue, weakness, fever and anaemia may also occur. Presentation with systemic symptoms without intestinal manifestation may be far more common than previously appreciated, and the diagnosis may be missed, resulting in a protracted and life threatening course. We report a case of Whipple disease in a 47-year-old man with a prolonged extra-GIT presentation, resulting in misdiagnosis and mistreatment with immunosuppression. The diagnosis was finally reached after he developed mild diarrhoea, prompting colonoscopy and endoscopy. We discuss the biopsy findings in both colonic and duodenal biopsies, and highlight the diagnostic difficulties and recent advances in our understanding of this disease.

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UNUSUAL SPINDLE CELL LESION IN THE GASTROINTESTINAL TRACT: WHEN ALL ELSE FAILS

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Follicular dendritic cell sarcoma (FDCS) is a rare neoplasm affecting patients of a wide age range, typically in the young to middle-aged adult years. The primary lesion may be nodal or extra-nodal in more than half of cases. We present a case of FDCS in a 31-year-old male with a caecal mass and adjacent lymphadenopathy. Endoscopic biopsy of the caecum showed an atypical spindle cell lesion, formed by plump cells with indistinct cell borders, showing a vaguely nodular and whorled architecture. A scattering of lymphocytes were seen in amongst the neoplastic cells. Multiple entities from various cell lineages were considered in the wider differential diagnosis. Based on the morphologic features, the immunohistochemical work-up included CD21 and CD23 which confirmed the lesion to be FDCS. This case highlights the importance of awareness of this rare entity when considering the broader differential diagnosis of unusual spindle cell neoplasms in the GI tract. When recognised, it has a characteristic morphology and immunophenotype which allows for correct diagnosis.

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SEEING RED: TWO CASES OF CONGOPHILIC FIBRILLARY GLOMERULONEPHRITIS

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The presence of glomerular fibril deposition poses a diagnostic challenge for the pathologist as it may be seen in multiple disorders, in particular fibrillary glomerulonephritis (FGN) and renal amyloidosis. Traditional teaching dictates that these two entities can be differentiated using Congo red staining, with FGN not demonstrating positivity. However, a number of cases of congophilic FGN have been reported in the literature, suggesting that Congo red positivity can no longer be considered a robust differentiating marker. This case study outlines two separate cases at our institution in which FGN and amyloidosis could not be differentiated using Congo red staining alone. In these cases, other defining characteristics such as the immunoglobulin pattern on immunofluorescence and electron microscopic appearance were necessary to arrive at the final diagnosis. Recent studies have demonstrated that novel immunohistochemical stains such as DNAJB9 can be utilised as an alternative to Congo red staining to aid in differentiating between FGN and amyloidosis.

PULMONARY ADENOFIBROMA: A RARE INCIDENTAL FINDING MIMICKING MALIGNANCY

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Introduction: Pulmonary adenofibroma is a rare soft-tissue tumour, composed of epithelial and stromal components, both of which are histologically benign. The diagnosis is based on histopathological examination.

Case description: We present a 60-year-old ex-smoker male patient with a 21 mm nodule in the right lower lobe of his lung, which was an incidental finding in chest CT-scan. He underwent wedge resection of the right lung for frozen section examination, which was reported as low-grade neoplasm, with epithelial and stromal components.

Pathological findings: Permanent sections showed a reasonably well-defined neoplasm, characterised by cup-shaped papillary structures, surrounded by collagenised bland spindle-cell stroma. The papillary structures were lined by a layer of simple uniform cuboidal epithelium. No mitotic activity or significant nuclear pleomorphism was seen, neither in epithelial nor in stromal component. The epithelial cells were positive for CK7, EMA and TTF1, and negative for CK20 and CD10, whereas the stromal cells were positive for vimentin and Bcl2, and negative for SMA and CD34. The histological and immunohistochemical findings favoured pulmonary adenofibroma.

Discussion: The rarity of this tumour makes it a challenging clinical-radiologic diagnosis. The pathological importance is to distinguish it from other benign lesions, such as hamartoma and

solitary fibrous tumour (SFT), plus malignant tumours. A definitive diagnosis is required to plan appropriate management, while avoiding inappropriate and unnecessary surgical intervention.

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CASE REPORT: PRIMARY SPLENIC ANGIOSARCOMA – A RARE ENTITY

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Primary splenic angiosarcoma (PSA) is a rare, highly aggressive malignant neoplasm arising from splenic vascular endothelium, most commonly presenting in adults over the age of 50. Incidence is estimated 0.14–0.25 annual cases per million people. Patients present with splenic rupture and acute haemoperitoneum in up to 30% of cases. PSA is associated with a very poor prognosis, median survival is 5 months and historically shows no significant survival benefit with therapy.

We describe a case of a PSA to expand the literature of this rare entity. Given significant variability of histological features, even within a singular case, diagnosis between benign vascular tumours, malignant nonvascular tumours and malignant vascular splenic tumours can be challenging.

An 85-year-old woman presented with spontaneous splenic rupture. Emergent splenectomy was performed and macroscopic review of the spleen confirmed focal capsular rupture and diffuse areas of intraparenchymal haemorrhage. Microscopically, we found a highly vascular lesion featuring anastomosing vascular channels lined by variably atypical cells. The atypical cells showed enlarged nuclei, moderate eosinophilic cytoplasm, inconspicuous nucleoli, with frequent mitotic figures. Lesional growth pattern was inhomogenous, with areas of papillary, solid and spindle cell growth. Immunohistochemistry showed strong positivity for vascular markers CD31, CD34, Factor VIII and ERG. Ki-67 index was 20%.

KNOW YOUR ANATOMY: CASE REPORT OF A RECTAL GIST PRESENTING AS A PROSTATIC MASS

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Gastrointestinal stromal tumour (GIST) most commonly occurs in the stomach, followed by the small bowel and uncommonly the colorectum. GISTs can be composed of spindle or epithelioid cells, with most cases characterised by a gain of function mutation of the KIT gene. This case study reports a patient presenting with urinary retention due to a prostatic mass which

was biopsied. The histology was of a mitotically active spindle cell lesion with necrosis. Positive staining for CD117 and DOG1 confirmed the diagnosis of GIST. Subsequent imaging demonstrated a rectal origin of the tumour.

A MISSING TOOTH: CASE REPORT OF AN AMELOBLASTIC FIBROSARCOMA OF THE MAXILLA

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Ameloblastic fibrosarcoma is a rare malignant odontogenic tumour with slightly less than 100 published cases in the literature. It is characterised by benign ameloblastic epithelial cells admixed within a malignant mesenchymal component. It occurs more commonly in the mandible and is a locally aggressive tumour with a small potential for distant metastasis. This case study reports a patient with ameloblastic fibrosarcoma of the maxilla, including both the initial diagnostic biopsy and the subsequent surgical resection. In the initial biopsy both the epithelial and mesenchymal components were well represented, however in the surgical resection the malignant mesenchymal component dominated.

OLIGOSARCOMA, AN UNUSUAL BIPHASIC TUMOUR

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Gliosarcomas are a rare variant of IDH-wildtype glioblastoma, WHO grade IV that exhibit biphasic glial and mesenchymal differentiation. The described glial component is usually astrocytic in nature, however fewer than fifteen cases with an oligodendroglial component, so called 'oligosarcoma', are described in the literature. With the advent of modern molecular phenotyping and classification, only a subset of these tumours have been subjected to investigation by molecular modalities. We describe a case of a 65-year-old man who presented with headaches, right visual impairment and left sided weakness. His past medical history includes a low-grade glioma arising in the right temporal lobe twenty-one years prior. The glioma was diagnosed as a 'well-differentiated astrocytoma' and was treated with surgical resection and radiotherapy. Imaging studies showed a new peripherally enhancing, right temporal lobe lesion causing mass effect and midline shift. Histopathology showed a biphasic tumour exhibiting anaplastic oligodendroglioma admixed with sarcomatous areas. Isocitrate dehydrogenase-1 (IDH1 R132H) immunohistochemistry was strongly positive in the oligodendroglial component and weakly positive in the sarcomatous component. Fluorescent *in situ* hybridisation demonstrated a 1p19q co-deletion in the oligodendroglial component only. Next Generation Sequencing of the sarcomatous component confirmed an IDH1 mutation, TERT promotor mutation and 1p19q co-deletion confirming oligodendrogliomatous derivation.