who presented with anaemia and melena. He proceeded to have an endoscopy which identified an ulcer suspicious for carcinoma. Histological examination showed sheets of lymphoid cells along with abundant *Helicobacter* organisms. The case was initially worked up as a case of lymphoma with an immunohistochemical panel of lymphoid markers being completed. The dense lymphoid infiltrate was distracting from the inconspicuous epithelioid cells camouflaged in the dense inflammatory infiltrate. The tumour cells were found to be EBER-ISH and cyto-keratin positive, supporting the clinical impression of gastric carcinoma. Gastric carcinoma with lymphoid stroma is critically important to recognise and communicate to the treating clinicians as it provides prognostic information that may affect surgical management.^{1,2} This rare variant should always be considered in cases with dense inflammation, even when a presumed cause such as *Helicobacter* infection is found.

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DIFFUSE LARGE B-CELL LYMPHOMA MASQUERADING AS A PROSTHETIC JOINT INFECTION

Alexandra Walton, Lakshmy Nandakumar

Pathology Queensland, Royal Brisbane and Women's Hospital, Brisbane, Australia

Diffuse large B-cell lymphoma (DLBCL) is a well-reported form of non-Hodgkin's lymphoma (NHL) which arises in extranodal sites in up to 40% of cases, producing an array of non-specific signs and symptoms.¹ Although the cause of DLBCL is unknown, many of the described risk factors ultimately cause immunodeficiency.¹ Metallic joint prosthetics are of common use in Australia, however some studies have suggested metallic prosthetics may be associated with malignancy due to the theorised carcinogenic properties of metallic ions and the chronic inflammation related to both joint disease and replacement.² Herein we report a rare case of DLBCL in a woman who presented three years post-total knee replacement for rheumatoid arthritis related joint disease. She presented with vague symptoms that were in keeping with prosthetic joint loosening or infection, however light microscopy and immunohistochemical analysis of bone biopsies identified DLBCL as the cause. Some studies have suggested there may be a cohort of metallic-joint prosthetic related lymphomas which could be likened to the well-recognised breast-implant associated anaplastic large cell lymphoma (ALCL).³ This case discussion highlights the need for further international cohort studies that include a broad analysis of potential patient and prosthetic specific risk factors for malignancy.

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A RARE CASE OF METASTATIC BALLOON CELL MELANOMA

A. Walton, E. Tan

Department of Anatomical Pathology, Pathology Queensland, The Townsville Hospital, Townsville, Australia

The balloon cell melanoma is one of the rarest variants of malignant melanoma with a distinctive but non-specific morphology.¹ Balloon cells are typically large cells with abundant amphophilic to eosinophilic granular cytoplasm. The diagnosis of this variant is made when more than fifty percent of tumour cells are ballooned.¹ This is a case of metastatic balloon cell melanoma in a 42-year-old male with a known history of melanoma who self-detected an enlarging axillary lymph node. The primary cutaneous lesion was described as having both spindled and ballooned cells, in contrast to the nodal disease which was almost entirely composed of melanocytes with balloon cell morphology. The exact mechanism and trigger that results in this morphology is still unclear, however electron microscopy analysis has identified the granular-appearing cytoplasm to be composed of dilated and merging melanosomes.² This case highlights the importance of considering this rare variant, even in cases where the primary melanoma has more classical features and does not meet the criteria for balloon cell melanoma.

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INVASIVE STRATIFIED MUCIN-PRODUCING CARCINOMA. A CASE SERIES WITH ASSOCIATED PATHOLOGICAL FINDINGS

Joseph Whitfield, Ann Whitehouse, James Duhig

Anatomical Pathology, Sullivan Nicolaides Pathology, Brisbane, Australia

Background: Stratified mucin producing intraepithelial lesion (SMILE) is associated with high risk HPV carcinogenesis and morphologically overlaps with cervical intraepithelial neoplasia (CIN) and adenocarcinoma in situ (AIS). In 2016, Schoolmeester *et al.*¹ described a case series of SMILE in which they observed unambiguous invasive adenocarcinomas resembling SMILE and proposed the term 'invasive SMILE' for such lesions.

Aims: To describe a case series of a recently named group of endocervical adenocarcinomas.

Methods: A retrospective search of the practice records was performed using the last year of records. Eight cases were identified, 3 of which had a component of invasive carcinoma resembling SMILE.

Results: We identified 3 cases of invasive SMILE and described their pathological features.

Discussion: All cases showed cytologically bland nuclear features and distinct palisading. Mitotic figures and apoptosis were easily identified in all 3 cases. 2 out of 3 cases were mucin rich and showed a neutrophilic infiltrate. One case was mucin poor and lacked a neutrophilic infiltrate. We found co-existent CIN in 66% of cases and ACIS in 33% of cases. There are clear morphological and immunohistochemical features supporting the designation of invasive SMILE as a distinct entity in the spectrum of cervical neoplasias.

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OSTEOCHONDROMA OF HOFFA'S FAT PAD

Joseph Whitfield¹, Peter Steadman², Scott Somerville², Thomas Lloyd³, Geoffrey Strutton¹

¹Department of Anatomical Pathology, Princess Alexandra Hospital, Qld, Australia; ²Department of Orthopaedic Surgery, Princess Alexandra Hospital; and ³Department of Radiology, Princess Alexandra Hospital, Qld, Australia

Infrapatellar osteochondroma is a rare benign osteochondromatous proliferation involving the infrapatellar fat pad. The pathogenesis of these lesions is unclear, but is thought to result from metaplasia of mesenchymal cells as a consequence of chronic infra-patella fat pad infringement or end stage of Hoffa's disease¹. Given its uncommon occurrence, it can be mistaken for more common conditions about the knee. The extra-articular location is distinct from cartilaginous loose bodies and synovial chondromatosis, which involve the joint space. Despite the name, this condition is not related to osteochondroma of bone. We report a case of infrapatellar fat pad osteochondroma and discuss features to distinguish this condition from morphologically similar lesions.

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TACTILE CORPUSCLE-LIKE BODIES IN LARGE BOWEL MUCOSA – AN UNUSUAL BUT HARMLESS INCIDENTALOMA

Laura Wise¹, Dakshesh Vakil², Marjorie Walker¹, Ella Sugo¹

¹NSW Health Pathology, John Hunter Hospital, Newcastle, Australia;; and ²Maitland specialist centre, Maitland Private Hospital, Maitland, Australia

Tactile corpuscle-like bodies (TCLB) are lesions that morphologically resemble Wagner-Meissner corpuscles occurring in sites where these mechanoreceptors are normally absent.¹ They are rare, but have been described in multiple sites, either in isolation or as a component of other neurally-derived lesions.¹ It has been suggested that they may represent a reactive neural proliferation.¹ It is important to distinguish TCLB from granulomata, amyloid or other lesions of neural origin, such as

ganglioneuroma, as they have no known syndromic associations or clinical sequelae.¹ We present a case of TCLB occurring in the sigmoid colon.

A 57-year-old female with ulcerative colitis of twelve years duration was found to have a long-standing scarred-looking area of the sigmoid colon with a slightly undulant architecture. Biopsies from this area showed multiple lesions in the lamina propria and one submucosal lesion. The lesional cells had bland, eccentric, spindled nuclei partly encircling lamellated and fibrillary-looking eosinophilic cytoplasm. Immunohistochemistry showed strong, diffuse staining with S100 and SOX-10, weak non-specific staining with CD56, and no staining with EMA, CD163, synaptophysin, Claudin 1, NeuN, NFP, ERG, SMA, CD117 and Glut 1. The morphological and immunohistochemical features were of tactile corpuscle-like bodies.

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A RARE CAUSE OF AN ADRENAL INCIDENTALOMA

Anders S. Wong, Showan Balta, Mark Pilbeam
Australian Clinical Labs, Ballarat, Australia

Case summary: A 65-year-old gentleman was referred for consideration of adrenalectomy for an adrenal mass. This mass was initially incidentally discovered 13 years prior. The most recent CT scan reported the enlarging large adrenal mass of soft tissue density with areas of calcification and irregular peripheral enhancement with possible necrosis, measuring 58x45x41 mm (TRxAPxCC).

A laparoscopic adrenalectomy was performed, given the enlarging nature of the mass and subclinical hypercortisolism. Histopathological examination showed adrenal cortex surrounding a central area of haemorrhage and necrosis. Surrounding the area of haemorrhage were some atypical ectatic vessels, extending into the cortex. The findings were consistent with an adrenal haemangioma.

Discussion: Adrenal incidentalomas are an increasingly common finding with the rising availability and quality in medical imaging. Less than 100 case reports of adrenal haemangiomas have been reported in the English literature. In the majority of cases, adrenal haemangiomas are detected incidentally.

Conclusion: With the increasing detection of adrenal incidentalomas, it is important to consider the differential diagnoses of such masses. Although rare, adrenal haemangiomas are a well-documented cause, and may be associated with non-specific symptoms, and electrolyte and endocrinological abnormalities. Once resected, they can be diagnosed by their characteristic histological features.

WARTHIN-FINKELDEY GIANT CELLS IN AN AXILLARY LYMPH NODE DISSECTION SPECIMEN FOR BREAST CARCINOMA – A CASE REPORT

Zhi Yuen Yap¹, Tracy Tan²

¹Anatomical Pathology Department, LabPlus, Auckland City Hospital, Auckland, New Zealand; and ²Histopathology Department, Middlemore Hospital, Auckland, New Zealand