THROMBOSPONDIN TYPE-1 DOMAIN-CONTAINING 7A AND MEMBRANOUS NEPHROPATHY – THE FIRST RETROSPECTIVE ANALYSIS OF PODOCYTE ANTIGEN PREVALENCE AND PROGNOSIS IN AN AUSTRALIAN COHORT

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Background: Membranous nephropathy (MN) is the most common cause of nephrotic syndrome in adults. Antibodies to M-type phospholipase A2 receptor 1 (PLA2R) define primary MN and those to thrombospondin type 1 domain-containing 7A (THSD7A) are of growing interest. THSD7A is present in 10% of PLA2R negative MN¹ and 20% of cases are associated with malignancy.² THSD7A immunohistochemistry (IHC) has identified positive cases.³

Method: We performed retrospective THSD7A IHC on renal biopsies collected 01/01/2014 to 31/12/2018 at a single centre. PLA2R status was determined. We assessed for clinical concern of primary MN and malignancy.

Results: Tissue was available for 77 of 81 identified cases. IHC showed positivity for PLA2R in 35 cases (45%) and THSD7A in 1 case (1%). The positive case had no known malignancy but died of pneumonia within 5 months. Following interpretation of IHC, a separate study using mass spectrometry confirmed a relative abundance of THSD7A protein.

Conclusion: IHC for THSD7A was positive in 1% but interpretation of the IHC was challenging and lacked a gold standard for validation of results. This study was unable to provide meaningful interpretations about the significance of THSD7A IHC reactivity in the Queensland population and further study is needed.

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ROUND LIGAMENT POLYPOID ENDOMETRIOSIS PRESENTED WITH SHOULDER TIP PAIN, A CASE REPORT

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Endometriosis is a disease characterised by the presence of endometrial glands and stroma out of the endometrial cavity. The lesions are usually brown and nodular and often seen on the peritoneal surfaces of the intra-abdominal and pelvic organs. The disease affects about 15% of women of reproductive age with associated symptoms starting as early as puberty. The main symptoms are usually unexplained cyclical pelvic pain. Polypoid endometriosis is considered an uncommon variant of the disease with a limited number of reported cases. We hereby present a case of polypoid endometriosis of the round ligament with diaphragmatic nodules.

The patient presented with cyclical pelvic and shoulder pain. On surgery the ovaries and tubes were entrapped with fibrosis and the diaphragm was adherent to the liver surface. Microscopically, the round ligament nodule was a polypoid nodule lined by columnar cells and contained secretory endometrial-like glands with mucinous metaplasia supported by endometrial-like pseudodecidualised stroma. The same features were seen in the diaphragmatic lesion.

For this patient, the polypoid morphology and the type of pain were considered as an unusual presentation of the disease.

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INTRAPLACENTAL CHORIOCARCINOMA: A CASE REPORT

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Choriocarcinoma is an aggressive trophoblastic malignancy. Gestational choriocarcinoma occurs in 1 in 40,000 pregnancies. Most of cases follow the diagnosis of complete hydatidiform mole. Of all forms of gestational choriocarcinoma, asymptomatic intraplacental choriocarcinoma after non-molar pregnancies is the rarest.

We hereby present a case of incidental choriocarcinoma confined to the placenta with no evidence of dissemination to the mother or infant.

A 31-year-old female delivered a viable infant at 37 weeks gestation. Macroscopically, placenta disc demonstrated a 28 mm intraparenchymal firm fairly defined lesion with necrotic centre. Microscopically, the lesion showed extensive necrosis surrounded by solid aggregates of atypical syncytiotrophoblasts,

cytotrophoblasts and intermediate trophoblasts, percolating into intervillous spaces with no invasion of villous stromal vessels. Immunohistochemistry showed diffuse positivity for hCG and AE1/AE3 with focal p63, P40, GATA3 and hPL staining. AFP was weakly positive, while CD30 and ER were negative. Ki67 was 80–90%.

Mother and baby serial serum hCG has been consistently <1 IU/L. Imaging ruled out metastasis, so no chemotherapy has been initiated. To date, both mother and baby are disease-free.

In conclusion, intraplacental choriocarcinoma can present as a subtle gross lesion which can be mistaken for placental infarct. Hence, the incidence of placental choriocarcinoma may be higher than documented.

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CALCIFYING PSEUDONEOPLASM OF THE NEURAXIS: ACKNOWLEDGING AN UNUSUAL LESION IN THE SPINE

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Calcifying pseudoneoplasms of the neuraxis (CAPNONS) are unusual, non-neoplastic lesions that occur in varying locations across the central nervous system, intra-axially or extra-axially. They are classically discrete, calcified lesions, a feature which aids in surgical resection. Most commonly an incidental autopsy finding, the majority are observed intracranially, with spinal involvement occurring infrequently. Of the seventy CAPNON cases in the literature, only 37% occurred within the spine or at the level of the craniocervical junction.¹ We report a unique case of an intra-dural, extra-axial CAPNON in a patient with simultaneous central canal stenosis and a more caudal disc protrusion. As exemplified by this case, CAPNONS have a distinct set of histopathologic features. The lesion demonstrated hypocellular and fibrillary areas with a chondromyxoid matrix and epithelioid cell rimming. There were prominent psammomatous calcifications present. Furthermore, our case stained positive with antibodies against epithelial membrane antigen (EMA). Our report aims to expand the spectrum of differential diagnoses for intradural, extra-axial lesions, and raise awareness of this entity's unusual yet distinctive histopathologic features.

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USE OF A COLORECTAL CANCER-SPECIFIC PRO-FORMA TO IMPROVE JUNIOR DOCTORS' REQUEST FORM COMPLETION USING RCPA STRUCTURED REPORTING GUIDELINES

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Background and aim: Cancer reporting checklists improve completeness and quality of cancer reporting thus improving patient outcomes. This study aims to compare adequacy of pre-analytical information provided to pathologists using a colorectal cancer (CRC) specific pro-forma compared to a standard request form.

Methods: Standard pathology request forms were collected from junior doctors provided with a written mock clinical case of a low anterior resection ($n=15$). Data collected included specific parameters relevant to CRC reporting. The same data were collected after implementation of the colorectal-specific pro-forma.

Results and discussion: Other than patient details (100% vs 100%) and requesting doctor details (87% vs 87%), data collection was improved with use of a pro-forma compared to the standard form. Medical history was documented in 87% vs 20%; clinical obstruction 86% vs 0%; neoadjuvant therapy 93% vs 40%; operative procedure 100% vs 67%; specimen type 53% vs 33%; perforation 80% vs 7%; distance of rectal cancer from anal verge 80% vs 13%; involvement of adjacent organs 73% vs 0%; and existence of local residual cancer post surgery 60% vs 0%. These findings suggest use of a pro-forma request form for CRC could greatly improve quality and completeness of pre-analytical information provided.

COMPOSITE ANGIOIMMUNOBLASTIC T CELL LYMPHOMA AND EBV-POSITIVE DIFFUSE LARGE B CELL LYMPHOMA – AN UNCOMMON DIAGNOSIS

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Composite lymphoma (CL) is an uncommon entity in which two or more morphologically and immunophenotypically distinct lymphoid neoplasms occur synchronously within the same anatomical site. CLs containing both T and B cell neoplasms are particularly rare. We present a case of composite angioimmunoblastic T cell lymphoma (AITL) and EBV-positive diffuse large B cell lymphoma (DLBCL) in a 62-year-old male who initially presented with widespread pruritic macular rash followed by B symptoms, generalised lymphadenopathy and hepatosplenomegaly. Histological examination of an excised lymph node revealed the presence of a neoplastic T lymphocyte population associated high endothelial venule proliferation and