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.

References

1. Ngan HYS, Seckl MJ, Berkowitz RS, *et al.* Update on the diagnosis and management of gestational trophoblastic disease. *Int J Gynaecol Obstet* 2018; 143 (Suppl 2): 79–85.
2. Jiao L, Ghorani E, Sebire NJ, *et al.* Intraplacental choriocarcinoma: systematic review and management guidance. *Gynecol Oncol* 2016; 141: 624–31.

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.

References

1. Abdaljeel M, Mazumder R, Patel CB, *et al.* Multiple calcifying pseudoneoplasms of the neuraxis (MCAPNON): distinct entity, CAPNON variant, or old neurocysticercosis? *Neuropathology* 2017; 37: 233–40.

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