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

reactive polymorphous inflammatory background – features characteristic of AITL. Careful assessment also identified a second neoplastic population of large centroblast-like B lymphocytes. The neoplastic T cells were immunopositive for pan-T-cell antigens CD43, CD2, CD3 and CD5; and for markers of T follicular helper cell immunophenotype PD1 and CXCL13. The large centroblast-like B cells showed immunoreactivity to pan-B-cell antigens CD20, CD79a, PAX5 and OCT2, and to EBER signifying EBV-infection. CLs are unusual diagnoses but should be considered when there are clinical, morphological or immunophenotypical inconsistencies. In addition, the particular combination of lymphomas present impacts treatment decisions.

AN UNUSUAL BIPHASIC PULMONARY LESION: LATE METASTASIS FROM A MANDIBULAR AMELOBLASTOMA

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Ameloblastoma is mostly a benign odontogenic tumour most frequently arising within the mandible and maxilla. Although ameloblastoma can be locally aggressive and prone to local recurrence, metastasis is a rare (and usually late) complication. We report a case of a metastatic ameloblastoma to the lung following an original presentation with a traumatic jaw fracture through what was thought to be a mandibular odontogenic cyst in 1988. The definitive diagnosis of ameloblastoma was not reached until a local recurrence occurred ten years later; this was managed with hemimandibulectomy and post-operative radiotherapy. A single lung lesion was identified incidentally 33 years after the original presentation: it demonstrated typical morphological features of ameloblastoma and FOXP1 immunostaining was confirmatory. Recent advances in understanding the genetic pathogenesis of ameloblastoma demonstrate frequent *BRAF*^{V600E} mutations as well as mutations in other MAP kinase pathway genes such as *KRAS*, *NRAS*, *HRAS* and *FGFR2*.¹ Several case reports have indicated promising results with *BRAF* inhibitor therapy in metastatic ameloblastoma.²

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NEPHROPATHY IN FABRY DISEASE

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Fabry disease (FD) is a rare, progressive, X-linked multisystem lysosomal storage disorder caused by the partial or total deficiency of the lysosomal enzyme α -galactosidase A.

Herein, we report a case of a 24-year-old man with genetically proven Fabry disease who presented with angiokeratoma, lymphadenoma, feet paraesthesia and non-specific gastrointestinal symptoms including abdominal bloating and irregular bowel motions.

He had a family history of FD in his mother (carrier) and older brother who was receiving Enzyme Replacement Therapy (ERT). The renal biopsy was organised to assess the extent of renal involvement and eligibility for (ERT).

On light microscopy, the glomeruli showed characteristic podocytes with foamy vacuolated cytoplasm. There were mild background chronic changes and mild arteriosclerosis.

The electron microscopic examination revealed characteristic myeloid bodies in podocytes, interstitium, tubular epithelial cells, endothelial cells of peritubular capillaries and the arterioles. These myeloid bodies showed concentrically arranged lamellae of electron dense material.

The diagnosis of FD is often delayed due to its non-specific symptoms in the initial stage. It is recommended that ERT should be initiated as early as possible, and this underlies the importance of early detection of Fabry disease.

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PRIMARY OVARIAN DIFFUSE LARGE B-CELL LYMPHOMA

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The ovary is a common site for lymphoma in disseminated disease, but primary ovarian lymphoma is exceedingly rare.¹ Primary non-Hodgkin's lymphomas constitute 1.5% of ovarian malignancies.¹ The diagnosis carries a poor prognosis with a 5-year survival of 0 to 36%.² This case study reports a 27-year-old female with presenting with abdominal pain and urinary symptoms. Investigations found a large right adnexal mass which was removed laparoscopically. Microscopy showed replacement of the ovary by discohesive cells with high N:C ratio and scant cytoplasm. The cells had enlarged angular nuclei, clumped chromatin and small nucleoli. Immunohistochemistry for CD45, CD20, bcl-2, bcl-6, MUM-1 and PAX5 was positive. Flow cytometry showed a large clonal CD5- CD10- B cell population. These findings were consistent with a diffuse large B-cell lymphoma. Although rare the diagnosis primary ovarian lymphoma should be considered as a differential in round blue cell malignancies of the ovary. Significant mortality means early diagnosis is key for a favourable outcome.

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