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PRIMARY DIFFUSE LARGE B-CELL LYMPHOMA OF THE UTERUS – A CASE REPORT

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Extranodal non-Hodgkin's lymphoma (NHL) constitutes one fifth to one third of all cases of NHL. Secondary lymphomatous involvement of the female genital tract (FGT) is not rare and is often seen in disseminated disease; however, primary NHL of the FGT is extremely rare. The uterine corpus is only third to the ovaries and uterine cervix as a site for primary NHL of the FGT. Differentiation between primary and secondary involvement of FGT organ by a haematolymphoid neoplasm relies upon the localisation versus dissemination of the disease at time of diagnosis.

We report a case of a 71-years-old lady with primary diffuse large B-cell lymphoma (DLBCL) of the uterine corpus. The histology showed a diffuse infiltrate of large atypical discohesive cells associated with multinucleated tumour cells and brisk mitosis. A panel of immunohistochemical stains showed results consistent with the diagnosis of DLBCL made on routine stains. There was only one involved sentinel node, and radiologically there was no evidence of other involved sites by lymphoma.

Designation of the lymphoma as primary to the FGT is clinical and having appropriate imaging studies of the patient is vital for this purpose.

FIBROMUSCULAR DYSPLASIA OF SPLENIC ARTERY – A CASE REPORT OF UNUSUAL CLINICAL PRESENTATION

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Fibromuscular dysplasia (FMD) is an idiopathic, segmental, non-atherosclerotic and non-inflammatory disease of the musculature of arterial walls, leading to stenosis of small and medium-sized arteries. The disease typically affects the renal and extracranial carotid arteries, but it has been noted in most medium-sized arteries throughout the body, most commonly the mesenteric, external iliac and brachial arteries. Splenic artery aneurysms are uncommon, and their rupture is rare. Aneurysm of splenic artery associated with FMD is even rarer and only four cases of rupture of such aneurysms are identified in the literature, two of which were diagnosed postmortem, while all the cases presented acutely with haemodynamic shock.

We report a case of a 50-year-old gentleman with splenic arterial dissection aneurysm and underlying FMD of intimal type. The clinical presentation of recurrent upper abdominal pain preceding the acute deterioration with internal bleeding and shock is an unusual way for FMD to present clinically. The intimal type is not classically associated with the 'string of beads' radiological

appearance of FMD which is more associated with the medial type. This can lead to missing these highly potentially fatal cases. Increasing the awareness of the medical community about this condition can save lives.

PRIMARY OVARIAN CARCINOID WITHIN A MATURE CYSTIC TERATOMA – A CASE REPORT

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Primary ovarian neuroendocrine tumours are rare, the most common of which is the well differentiated carcinoid which represents 0.1% of ovarian tumours. Secondary ovarian neuroendocrine tumours are more common. The majority of the cases are perimenopausal or postmenopausal with young patients represent the even rarer instances.

We report a case of a 28-year-old lady who was being followed for a right adnexal cystic mass with radiological features of a teratoma, which was excised after increase in tumour size on repeat ultrasound scan. Histologically, the tumour is a mature cystic teratoma. A mixed insular and trabecular carcinoid was identified in continuity of one focus of thyroid follicular tissue. This carcinoid showed Ki-67 proliferation index of 6%.

The median Ki-67 index in primary ovarian carcinoid is 2.3% with a range of 0.6% to 8.4% (25th and 75th percentiles of 2.2% and 5.5%, respectively). Our patient represents one of the extremely rare cases of young age (<30 years) with a primary ovarian carcinoid developing within a mature cystic teratoma demonstrating a Ki-67 index of >5.5%.

HISTOLOGICAL FEATURES OF CHILBLAIN LIKE LESIONS IN SETTING OF COVID19 AND THEIR DIFFERENTIAL DIAGNOSES

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Aim: To present histological features of chilblain like lesion (CLLs) in Covid19 thereby to help identify it in Covid19 and differentiate it from various other clinical conditions that cause chilblain like lesion. The poster presents nine cases of CLLs caused by various clinical conditions including Covid19.

Method: H&E and special stains of skin punch biopsies.

Result: Although salient histological features are superficial and deep perivascular lymphocytic infiltration and perieccrine lymphocytic infiltration with or without thrombus, other features are spongiosis, dyskeratosis and vacuolation of basal cell layer, epidermal split, superficial dermal oedema and extravasation of red blood cells.

Discussion: Different aetiologies of CLLs include idiopathic, lupus erythematosus and Covid19. Mimics are erythema multiforme and fungal infections. Although CLLs in various clinical

conditions share some histological features, special stains like periodic acid-Schiff test (PAS) and Alcian blue help to differentiate them. PAS helps to diagnose fungal infection. Alcian blue helps to identify interstitial and periadnexal mucin in case of chilblain lupus erythematosus. PAS with C3 and IgM help to diagnose erythema multiforme. It is critical to classify CLLs to ensure proper management and limit conflation. Thus, history with histopathology and special stains help to differentiate CLLs in various clinical settings including Covid19.

EOSINOPHILIC VACUOLATED TUMOUR OF THE KIDNEY

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Eosinophilic vacuolated tumour (EVT) is one of the emerging entities of renal cell carcinoma. We present a case which we believe is second ever reported case of eosinophilic and vacuolated renal tumour (EVT) arising in setting of tuberous sclerosis syndrome. A 44-year-old male patient with past history (2017) of unclassified renal cell carcinoma of left kidney and known tuberous sclerosis syndrome receiving ongoing tyrosine kinase inhibitor therapy and undergoing radiological surveillance was found to have a 3 cm right renal mass. Macroscopic examination showed a well-defined unencapsulated variegated and haemorrhagic lesion. On microscopic examination, there was a solid growth pattern with focal papillary architecture comprised of cells with predominantly eosinophilic, but also vacuolated cytoplasm and at least focal high grade nuclear features. Immunohistochemical stains showed focal staining for CK7 and no staining for CD117, AMACR, 34BetaE12, HMB45, CA IX and ALK (D5F3). SDH was retained.

The importance of recognising this entity relates to association with somatic mutations of TSC/mTOR gene which are amenable to target therapy. EVT has a high grade histological appearance but displays indolent clinical behaviour bringing into question the validity of nucleolar grading in this setting.

UTILITY OF C-FOS IMMUNOHISTOCHEMISTRY AS AN ANCILLARY TOOL IN THE DIAGNOSIS OF PROLIFERATIVE FASCIITIS AND PROLIFERATIVE MYOSITIS

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Introduction: Proliferative fasciitis (PF) and proliferative myositis (PM) are benign soft tissue neoplasms occurring in the subcutaneous tissue (PF) or skeletal muscle (PM).¹ Gene FOS rearrangements and immunohistochemical (IHC) expression have been recently identified in PF/PM in a single study.²

Aim: To explore the performance of the c-FOS antibody in PF/MF and in a range of soft tissue sarcomas.

Material and methods: IHC for c-FOS using the polyclonal antibody ABE457 was performed on full sections of PF (n=5), PM (n=2), florid scars (n=6) and on a cohort of 275 samples from various sarcoma types derived from tissue microarrays (TMAs).

Result: All cases of PF/PM (100%) demonstrated ganglion-like cells and/or myofibroblastic cells positive for c-FOS IHC. From the sarcoma cohort, only 3 (1%) of 275 cases displayed c-FOS expression while none of the scars displayed immunoreactivity with the antibody.

Conclusion: Our study indicates that c-FOS positive stain can support the diagnosis of PF/PM in the appropriate clinical and morphological context. Negative c-FOS stain was identified in florid scars and in 99% of the sarcoma samples. Nonetheless, caution is warranted as our cohort is limited and further validation is required. In addition, 1% of soft tissue sarcomas also expressed C-FOS IHC.

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FOETAL ACARDIUS AMORPHUS – A RARE FINDING IN PLACENTA

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We present the case of a placental nodule from a 34-year-old female with an *in vitro* fertilisation pregnancy. Early ultrasound showed a dichorionic diamniotic pregnancy. A later ultrasound noted one foetus demised. Macroscopically, a nodule was on the foetal surface of the placenta. Microscopic examination showed mature intestinal epithelium, neural elements including ganglion cells and glial tissue. The nodule demonstrated squamous epithelium with adnexal structures, smooth muscle, vessels, lymphatics, bone and lymphoid aggregates. No immature component was seen.

The differential diagnosis is between a placental teratoma and foetus acardius amorphus, a rare foetal malformation. Differential diagnosis from placental teratoma is problematic and depends on the degree of skeletal organisation and umbilical cord formation.¹ Placental teratomas do not have an umbilical cord attachment to the placenta; while foetus acardius amorphus usually has some degree of axial organisation.² Antenatal diagnosis of an acardic twin is challenging. On ultrasound, they look like an amorphous lump of tissue that is easily mistaken for a hydropic dead foetus.³

Awareness of this entity may aid in future diagnoses of placental nodules in the context of a dichorionic diamniotic pregnancy.

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