College of Pathologists of Sri Lanka

Celebrating 50 years of excellence: Golden Jubilee 2025

50TH ANNIVERSARY INTERNATIONAL CONFERENCE

Commemorating the past, Excelling in the present, Aspiring for the future

CONFERENCE PROCEEDINGS

22-25 October, 2025

UCFM Tower,
Faculty of Medicine,
University of Colombo

in collaboration with the
British Division of International Academy of Pathology &
Faculty of Medicine, University of Colombo

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50th Anniversary International Conference 2025

Organized by the College of Pathologists of Sri Lanka

in collaboration with the

British Division of International Academy of Pathology

and the

Faculty of Medicine, University of Colombo

A Scientific Forum on Histopathology and Cytopathology

22nd – 25th October 2025

UCFM Tower, Faculty of Medicine,
University of Colombo, Sri Lanka

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MESSAGE FROM THE PRESIDENT

It is with immense honour and delight that I write this message as the President of the College of Pathologists of Sri Lanka and the Chairperson of the Organizing Committee for this momentous 50th Anniversary International Conference.

With great enthusiasm, I extend a heartfelt welcome to delegates from over 10 countries who have joined us for this landmark event. Your presence, alongside our fellow Sri Lankan pathologists from across the globe, underscores the international significance of this gathering.

This year's conference, held under the theme "Commemorating the Past, Excelling in the Present, and Aspiring for the Future," is more than just a scientific meeting—it is a commemoration. We take this opportunity to honour the past presidents and founder members of the College whose pioneering efforts laid our foundation.

The vibrancy of our field is reflected in the conference statistics: we are thrilled to welcome over 220 delegates and to review over 200 abstracts. The rich programme features diverse topics covering most aspects of histopathology and cytopathology, ensuring relevance and intellectual stimulation for all attendees.

This milestone event has been significantly enriched through vital collaborations with the Faculty of Medicine, University of Colombo and the British Division of the International Academy of Pathology (BDIAP). Our sincere thanks go to the Dean of the Faculty of Medicine, University of Colombo, and the President of the BDIAP for their invaluable partnership. We also acknowledge the involvement of all stakeholders, including our technical officers and medical students.

Running parallel to the scientific sessions, we are proud to have a book launch: The Final Diagnosis: a 50-year Odyssey, a comprehensive narration on history of the College of Pathologists and Laboratory Medicine in Sri Lanka and to host the innovative "Panoramic Pathovision" Pathology Art Exhibition, offering unique perspectives on our profession.

We are deeply grateful to Professor Indika Karunathilake, the Vice-Chancellor of the University of Colombo for gracing our inauguration ceremony as the Chief Guest, and to Professor Dilani Lokuhetti, the Head of the WHO Classification Tumours for delivering the thought-provoking keynote address.

Finally, my sincere appreciation goes to the dedicated Organizing Committee, our esteemed resource persons, and our generous sponsors. Their unwavering commitment has been crucial to the success of this anniversary event.

I wish all participants a memorable and inspiring conference. To our overseas delegates, I extend my best wishes for a pleasant journey and stay in beautiful Sri Lanka

Professor Priyani Amarathunga
President, College of Pathologists of Sri Lanka

MESSAGE FROM THE CHIEF GUEST

It is a profound honour to participate as the Chief Guest in the 50th Anniversary International Conference of the College of Pathologists of Sri Lanka (CPSL).This Golden Jubilee is far more than a celebration of five decades for the College; it is a recognition of more than a century of dedication to diagnostic services, especially for cancer patients, a commitment that has its historical roots firmly planted within the University of Colombo.

We are immensely proud that this prestigious conference is being held on the premises of the Faculty of Medicine, University of Colombo. With its establishment dating back to 1870, the Faculty is recognized as the second oldest medical school in South Asia, and it continues to be a vibrant beacon of medical education and research.

The 50th Anniversary International Conference brings together many eminent overseas resource persons and our own local experts to deliver an impressive academic program for sharing knowledge and expertise. With a significant number of scientific papers being presented in parallel sessions, this gathering provides crucial opportunities for young researchers to disseminate their scientific work. Furthermore, this international event, graced by over 50 overseas delegates from prestigious universities across the world, presents exceptional opportunities for international collaborations in cutting-edge research. This is also a wonderful platform to reconnect with our own alumni, many of whom are shining lights in pathology across the globe, allowing us to foster new friendships and look for powerful collaborative ventures.

On a personal note, it is a particular source of pride for me to see many familiar faces from the College, including your distinguished President, who is a cherished batchmate. These professional and personal relationships are the living embodiment of the strong community we have collectively built.

On behalf of the University of Colombo, I extend my deepest felicitations to the College of Pathologists of Sri Lanka. I wish this 50th Anniversary International Conference every success, and I look forward to witnessing the continued growth of this crucial field.

Professor Indika Mahesh Karunathilake
Vice Chancellor
University of Colombo, Sri Lanka

MESSAGE FROM THE KEYNOTE SPEAKER

It is a great honour to deliver this keynote message at this momentous occasion—the 50th anniversary celebration of the College of Pathologists of Sri Lanka (CPSL). On a personal note, this milestone holds deep significance for me, as I have had the privilege of serving as a past president of this prestigious college and am proud to be a life member.

The history of pathology in Sri Lanka spans five remarkable decades. CPSL was established half a century ago by a small group of visionary pathologists to represent all Sri Lankan pathologists: histopathologists, haematologists, and chemical pathologists. It holds the distinction of being one of the oldest professional colleges in Sri Lanka.

The journey of CPSL over these 50 years has been captured in the historical book launched to commemorate this golden anniversary. While there have been periods of dormancy, the college's activities have largely endured, even during challenges such as the recent COVID-19 pandemic, when the annual academic session was successfully held online. CPSL has consistently served as the backbone of professional and academic activity in Sri Lankan pathology, with annual academic sessions being the highlight. For over a decade, the college has also hosted biennial international conferences in collaboration with the British Division of the International Academy of Pathology (BDIAP).

CPSL members contribute actively to advancing pathology in Sri Lanka. They collaborate with the Postgraduate Institute of Medicine at the University of Colombo to train and evaluate postgraduate trainees, nurturing a new generation of pathologists on par with international standards. They also play a leading role in national cancer control initiatives, supporting screening programs and developing guidelines for the diagnosis of common cancers in close collaboration with the Ministry of Health and the National Cancer Control Programme.

CPSL's life members are also making their mark globally, holding prominent positions, delivering professional care, and contributing to the advancement of pathology internationally. Many have joined us today to celebrate CPSL's 50 years of achievement and to reaffirm their commitment to the college.

Over the past five decades, CPSL has grown into a leading pathology professional organization in the region. Today, it continues to navigate new challenges with the support of a dedicated and talented membership. As CPSL enters the next decade, I extend my heartfelt wishes to the college and its members—for continued success, strength, and the courage to keep the light of the CPSL torch burning brightly, as it has done so admirably over the past fifty years.

Professor Dilani Lokuhetty
Head, WHO Classification of Tumours, Lyon, France
Emeritus Professor, Consultant Histo/Cytopathologist
Faculty of Medicine, University of Colombo, Sri Lanka

MESSAGE FROM THE DEAN, FACULTY OF MEDICINE, UNIVERSITY OF COLOMBO

It is with great pleasure that I extend my warmest congratulations to the College of Pathologists of Sri Lanka (CPSL) as it celebrates its Golden Jubilee with the 50th Anniversary International Conference. This milestone is a fitting occasion to reflect on the remarkable contributions of the College and its members to the advancement of medical education, research, and patient care in Sri Lanka.

The Faculty of Medicine, University of Colombo, has been closely linked with the College since its very beginnings. Even before its establishment in 1975, pathologists from our Faculty such as Prof. W.A.E. Karunaratne and Prof. G.H. Cooray served the country with distinction from as early as 1936. Several Faculty members were among the founders of the College, most notably Prof. Daphne Atigalle, who went on to become its fourth President.

Over the years, no fewer than seven Presidents of the CPSL have hailed from our Department of Pathology. The Faculty also provided the early infrastructure for the College, with lecture halls in Pathology and Anatomy hosting meetings, academic sessions, and other activities. Faculty members have also played a pivotal role in academic publishing, with Prof. Chandu de Silva and Prof. Priyanthi Kumarasinghe serving as founding editors of the Journal of Diagnostic Pathology.

Beyond academia, our Department has pioneered services of national significance. These include the cervical cytology screening programme, perinatal pathology services, and the establishment of the Centre for Diagnosis and Research in Cancer (CeDARC) as a national referral centre. Today, this tradition of leadership continues, with the current President of the College, the Joint Secretary, and the Chief Editor of its journal all serving within our Faculty.

As we celebrate this golden milestone, the Faculty of Medicine remains committed to its enduring partnership with the CPSL. Looking ahead, we are determined to collaborate with the College in strengthening pathology services, advancing research, and building capacity in areas such as genomics, digital health, and precision medicine.

On behalf of the Faculty of Medicine, University of Colombo, I convey my heartfelt felicitations to the College of Pathologists of Sri Lanka and wish the 50th Anniversary International Conference every success.

Vidya Jyothi Professor Vajira Dissanayake
Chair and Senior Professor of Anatomy, Genetics and Biomedical Informatics
Dean, Faculty of Medicine, University of Colombo

MESSAGE FROM THE BDIAP PRESIDENT

I am honoured to have been invited to represent the British Division of the International Academy of Pathology (BDIAP) and, together with my colleague Dr. Michail Doukas, to speak at the 50th Anniversary International Conference of the College of Pathologists of Sri Lanka. I am certain that you will experience an excellent meeting, with a carefully developed scientific programme including many highlights in diagnostic pathology, as well as customary exciting social events, networking opportunities and heartwarming hospitality. I would like to congratulate the organising committee, and Professor Priyani Amarathunga in particular, for the smooth, meticulous and efficient way in which this meeting has been prepared. This meeting is evidence of the high professional standard of pathology in Sri Lanka, a true testament to everything that has already been achieved since the inception of your College, and an auspicious sign for the future.

As incumbent President of the BDIAP I am of course aware of, and grateful for, the very friendly and productive collaboration between our two societies which we have enjoyed over the years. The foremost example of this is "The Sri Lankan British School of Pathology". This is a biennial event which arose through contacts initially with the late Professor Bryan Warren in Oxford. The topic areas are selected by the local pathologists in the Sri Lankan College of Pathologists, and the British Division provides pathologists willing to travel to deliver intensive courses in the chosen areas. In 2024, the 9th Sri Lankan British School of Pathology took place in Colombo, for which topics were Breast, Thyroid and Lymphoma pathology, with participation of the visiting BDIAP speakers Professor Stefan Dojcinov, Professor Ian Ellis and Dr. David Poller. The next BDIAP Sri Lankan School of Pathology is planned to take place in 2026.

I would like to wish everyone a fantastic meeting, during which I hope to meet many of you personally. Congratulations on your 50th Anniversary!

සිතුනි, நன்றி,

Dr Jan von der Thüsen
President, British Division of the International Academy of Pathology

MESSAGE FROM JOINT SECRETARIES

It is with great honour and privilege that we, as Joint Secretaries of the College of Pathologists of Sri Lanka, extend our warm greetings to all participants of the 50th Anniversary International Conference 2025. This Golden Jubilee year marks a proud milestone in the history of our College, which since its inception in 1975, has worked tirelessly to advance the field of pathology through education, research, and service to the nation.

This year's conference is historic in many respects. For the very first time, we have been able to bring together world-renowned Sri Lankan pathologists working across the globe onto one forum, creating a unique opportunity to share knowledge and celebrate their remarkable contributions. The scientific programme is further enriched by over 15 distinguished international resource persons representing the USA, UK, the Netherlands, France, Australia, New Zealand, India, and Pakistan, together with a large number of eminent local experts. Their collective expertise ensures a truly diverse and intellectually stimulating academic programme. We are also delighted to note that, for the first time, our conference has been accredited by the Royal College of Pathologists (UK), giving this milestone event international recognition.

We are equally honoured to host a dedicated SAARC Symposium within the conference, strengthening regional collaboration in the field of pathology. With over 200 participants, including colleagues from Sri Lanka and a significant number of overseas delegates, this gathering reflects the global and regional spirit of unity, learning, and professional fellowship.

We take this opportunity to express our heartfelt gratitude to our respected President, council members, anniversary conference coordinators, and the organizing committee for their tireless dedication. We remain deeply thankful to our international and local speakers, abstract reviewers, editors, judges, and all members of the College who have contributed in countless ways. We also extend our sincere appreciation to our sponsors, whose generous support has made it possible to host an event of this magnitude.

We sincerely hope that this Golden Jubilee International Conference will prove to be academically rewarding and personally enriching for all participants. May this landmark celebration inspire us to build on the proud legacy of the College of Pathologists of Sri Lanka and continue to strengthen the discipline of pathology both regionally and globally.

Dr Lalani J De Silva and Dr Priya Amaraweera
Joint Secretaries- 2025

MESSAGE FROM CONFERENCE COORDINATORS




It gives us immense pleasure and pride to extend a heartfelt welcome to each one of you to the 50th Anniversary International Conference of the College of Pathology of Sri Lanka.

This milestone event is more than just a celebration—it is a tribute to the remarkable journey we have collectively travelled over the past five decades. Our theme, "Commemorating the Past, excelling in the Present, aspiring for the Future," reflects the essence of this occasion. We honour the pioneers whose vision laid the foundation of our college, recognize the current excellence in research, education, and diagnostic innovation, and look ahead with optimism to the advances and collaborations that will shape the future of pathology in Sri Lanka.

This year's conference brings together an excellent assembly of national and international experts, researchers, and trainees. Through keynote lectures, scientific symposia, interactive quizzes and workshops, we aim to foster meaningful dialogue and showcase new developments of diagnostic histopathology, cytopathology and molecular pathology. Whether you are a seasoned professional or an emerging pathologist, this event offers valuable opportunities to learn, network, and contribute to the advancement of our field.

As we celebrate this golden jubilee, let us also reaffirm our commitment to the highest standards of diagnostic pathology and patient care. Together, let us continue to push the boundaries of knowledge and innovation.

On behalf of the organizing committee, we thank you for your participation and support. Your presence enriches this event and helps us uphold the legacy of excellence that defines the College of Pathology.

With warm regards and best wishes for a successful and memorable conference,

Dr R C U Priyadarshika, Dr Champika Ratnayake, Dr Mathivathani Umashankar and Dr Samalai Kanagasabapathy
Conference Coordinators - College of Pathologist of Sri Lanka

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THE COUNCIL 2025

Seated from left to right

Dr Lalani J. de Silva (Joint Secretary), Dr Harshima Wijesinghe (Chief Editor), Dr R C U Priyadarshika (Conference Coordinator), Professor Chandu de Silva, Dr Priyanka Abeygunasekara (Immediate Past President), Professor Priyani Amarathunga (President), Dr Mangala Bopagoda (President Elect), Dr Cherine Sosai (Vice President), Professor Dulani Beneragama, Dr Ramani Punchihewa (Treasurer), Dr Priya Amaraweera (Joint Secretary)

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Absent Dr Modini Jayawickrama

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Co-Chairpersons : Professor Priyani Amarathunga
Dr Mangala Bopagoda

Coordinators : Dr R C U Priyadarshika (Chief Coordinator)
Dr Champika Ratnayake
Dr Mathivathani Umashankar
Dr Samalai Kanagasabapathy

Joint Secretaries : Dr Lalani J De Silva
Dr Priya Amaraweera

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Dr Gayani Ranaweera
Dr Charishma Fernando
Dr Saumya Liyanage

Abstract review coordinators
: Dr R C U Priyadarshika (Chief Coordinator)
Dr Deshani Walisinghe
Dr Saundika Udugampola
Dr Menaka Weerasinghe

Members : Professor Chandu de Silva
Professor Janaki Hewavisenthi
Professor Isha Prematilleke
Dr Priyanka Abeygunasekara
Dr Cherine Sosai
Dr Jayanjana Asanthi
Dr Lakmalie Kariyawasam
Dr Carmalita Senarath
Dr Avanthi Rajapakse
Dr Prabodha Samararathna
Dr Dayal Gamlaksha
Dr Chandika Epitakaduwa
Dr Ineesha Jayasinghe
Dr Niluka Ranathunga
Dr G H Pradeepa Gayani
Dr Amal Jayathilake
Dr Bhadramali Ransinghe
Dr Janakie Fernando
Dr Nayana Ratnayake
Professor Sulochana Wijetunge

Volunteers Dr Shashiprabha Amaratunga
Ms Yasassri Alvitigala
Ms Nuzha Nuha
Ms Buddhini Hettiarachchi
Dr Nethmini Wickramaarachchi
Dr Samudra Hetttige
Dr Jinali Rathnayake
Dr Kumudu Kumari
Dr Sithumini Rassagala
Dr Kaumadi Udeshika

Comperes Dr Rangana Karunaratne
Dr Sachinthana Sumanasekera

50TH ANNIVERSARY INTERNATIONAL CONFERENCE
ORGANIZING COMMITTEE 2025

Seated from left to right

Dr Lalani J. de Silva (Joint Secretary), Dr. Samalai Kanagasabpathy (Conference Coordinator), Professor Chandu de Silva, Dr Priyanka Abeygunasekara, Professor Priyani Amarathunga (Co-chairperson), Dr Mangala Bopagoda (Co-chairperson), Dr Cherine Sosai, Dr Ramani Punchihewa (Treasurer), Dr R C U Priyadarshika (Conference Coordinator), Dr Champika Ratnayake (Conference Coordinator), Dr Priya Amaraweera (Joint Secretary)

Standing left to right

Dr Jayanjana Asanthi, Dr Lakamlie Kariyawasam, Dr Camalita Senerath, Professor Isha Premathilake, Dr Harshima Wijesinghe (Chief Editor), Dr Avanthi Rajapakse, Dr Prabodha Samararathne, Dr Dayal Gamlaksha, Dr Chandika Epitakaduwa, Dr Deshani Walisinghe, Dr Saundika Udugampola, Dr Ineesha Jayasinghe, Dr Niluka Ranathunga

Absent

Dr G H Pradeepa Gayani, Dr Amal Jayathilake, Dr Bhadramali Ranasinghe, Dr Janaki Fernando, Dr Nayana Rathnayake, Professor Sulochana Wijetunge, Dr Gayani Ranaweera, Professor Janaki Hewavisenthi, Dr Charishma Fernando, Dr Saumya Liyanage, Dr Menaka Weerasinghe

50TH ANNIVERSARY CELEBRATION: MAIN HIGHLIGHTS
13th MARCH 2025

Chief Guest
Professor Neelakanthi Ratnatunga,
Professor Emeritus, University of Peradeniya

50th Anniversary Lecture
"The Final Diagnosis: A 50-year Odyssey,"
Professor Chandu de Silva,
Professor Emeritus,
University of Colombo

THE COLLEGE OF PATHOLOGISTS OF SRI LANKA
FELLOWSHIP AWARDS 2025

Professor Roshitha Waduge
Professor in Pathology
Department in Pathology
Faculty of Medicine, University of Peradeniya

Dr Shanika Fernandopulle
Consultant Histopathologist
Colombo North Teaching Hospital

Professor Dulani H Beneragama
Associate Professor
Faculty of Medical Sciences
University of Sri Jayewardenepura

INTERNATIONAL FACULTY

KEYNOTE SPEAKER
Professor Dilani Lokuhetty
Emeritus Professor, University of Colombo.
Head, WHO Classification of Tumours,
International Agency for Research on Cancer, Lyon.
France

Dr Jan von der Thüsen
President, British Division of International Academy of Pathology.
Consultant Histopathologist,
Department of Pathology and Clinical Bioinformatics,
Erasmus MC, Rotterdam.
Netherlands

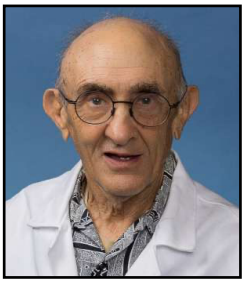
Dr Michail Doukas
Consultant Histopathologist,
Department of Pathology and Clinical Bioinformatics,
Erasmus MC, Rotterdam,
Netherlands

Professor Hemamali Samaratunga
Professor of Pathology,
Aquesta Specialised Uropathology,
University of Queensland, Brisbane, Queensland.
Australia

Dr Malee Fernando
Consultant Histopathologist,
Sheffield Laboratory Medicine,
Sheffield Teaching Hospitals NHS Foundation Trust.
United Kingdom

Professor Yasodha Natkunam
Professor in Haematopathology, Department of Pathology,
Stanford University School of Medicine, Stanford,
California.
USA

Dr M. Priyanthi Kumarasinghe
Chief Pathologist, Consultant Anatomical Pathologist,
Clinical Professor, School of Pathology and Laboratory Medicine,
University of Western Australia.
Australia



Professor Jonathan Said
Consultant Pathologist, David Geffen School of Medicine,
UCLA Medical Center, Los Angeles, California.
USA

Dr Anna Saparamadu
Consultant Cellular Pathologist,
Department of Histopathology,
Northampton General Hospital NHS Trust,
University Hospitals of Northamptonshire.
United Kingdom

Professor Bharat Rekhi
Professor and Pathologist, Department of Pathology,
Tata Memorial Hospital, Parel, Mumbai.
India

FACULTY OF SAARC SYMPOSIUM

Professor Nuzhat Husain
President, Indian Division of International Academy of Pathology.
Professor and Head of Pathology, State Referral Centre for Lab Investigations.
Former Dean, Dr Ram Manohar Lohia Institute of Medical Sciences, Lucknow.
India

Professor Shahid Pervez
Professor and Consultant Histopathologist,
Department of Pathology and Laboratory Medicine,
Aga Khan University Hospital, Karachi.
Pakistan

Professor Wiseman Pinto
Professor of Pathology and Former Dean, Goa University.
Former HOD, Department of Pathology,
Goa Medical College.
President, Asian Society of Cytopathology.
Chairman, International Affairs Committee IAC.

Dr Priyangi Amarabandu
Consultant Histopathologist,
Apeksha Hospital, Maharagama.
Sri Lanka

LOCAL FACULTY

Professor Chandu de Silva
Consultant Histopathologist, Emeritus Professor,
University of Colombo.
Sri Lanka

Dr Harshima Wijesinghe
Professor and Consultant Histopathologist,
Department of Pathology, Faculty of Medicine,
University of Colombo.
Sri Lanka

Professor Dulani Beneragama
Associate Professor and Consultant Histopathologist,
Faculty of Medical Sciences,
University of Sri Jayewardenepura.
Sri Lanka

Professor Primali Jayasooriya
Professor in Oral Pathology,
Department of Oral Pathology,
Faculty of Dental Sciences, University of Peradeniya.
Sri Lanka

Professor Isha Prematilleke
Professor and Consultant Histopathologist,
Faculty of Medical Sciences,
University of Sri Jayewardenepura.
Sri Lanka

Dr Niluka Ranathunga
Consultant Histopathologist,
District General Hospital, Chilaw.
Sri Lanka

RESOURCE PERSONS - WORKSHOPS

Lymphoma workshop	Professor Jonathan Said, Professor Yasodha Natkunam, Dr Priyanka Abeygunasekara*
Respiratory and mediastinal pathology workshop	Dr Jan von der Thüsen, Dr Ramani Punchihewa, Dr Roshana Constantine, Dr Jayanjana Asanthi*
Cytology workshop	Dr Dushyanti Samarasinghe, Dr Thushari Liyanage, Dr Cherine Sosai*, Dr Lalani J de Silva
Male and female genital pathology workshop	Professor Hemamali Samaratunga, Professor Bimalka Seneviratne, Professor Isha Prematilleke, Dr Gayani Ranaweera*
Dermatopathology workshop	Dr Anna Saparamadu, Dr Prabodha Samararathne, Dr Palitha Rathnayake, Dr Avanthi Rajapaksha*
Renal pathology workshop	Professor Sulochana Wijetunge*, Dr Harshima Wijesinghe, Dr Sonali Rodrigo
Liver pathology workshop	Dr Michail Doukas, Dr Mangala Bopagoda*, Dr Nishani Jayathunga
Soft tissue and bone pathology workshop	Professor Bharat Rekhi, Dr Malee Fernando, Professor Gayana Mahendra*, Dr Samalai Kanagasabapathy
	*Team coordinator

RESOURCE PERSONS – PRE-CONGRESS WORKSHOP

Dr Bharati Jhaveri
Pathologist,
State of Illinois, Springfield, Illinois,
USA

Professor Chandana Wickremaratne
Consultant Haematologist,
Faculty of Medicine, University of Ruhuna
Sri Lanka

Dr Gaya Katulanda
Consultant Chemical Pathologist,
National Hospital of Sri Lanka
Sri Lanka

Dr Nayana Ratnayake
Consultant Histopathologist
National Hospital, Kandy
Sri Lanka

Dr Kushlani Jayathilake
Consultant Microbiologist,
Sri Jayewardenepura General Hospital
Sri Lanka

Dr Chandanamali Punchihewa
CEO & Chief Scientist
Gene Labs Private Ltd, Nawala
Sri Lanka

Dr Geethika Jayaweera
Consultant Histopathologist,
Army Hospital, Colombo
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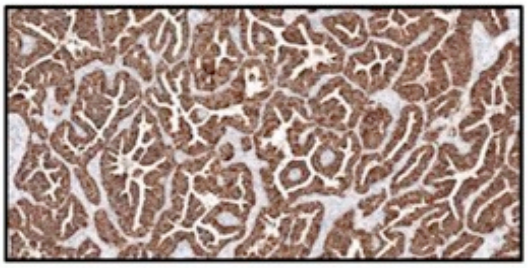
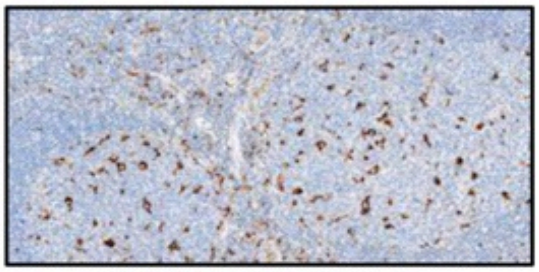
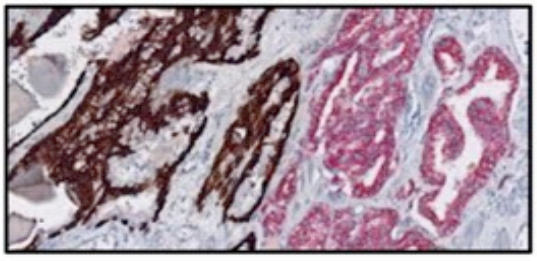


Breast Panel Assays



Lung Panel Assays



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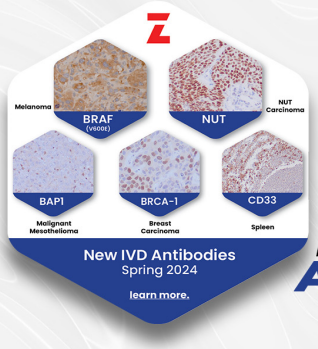

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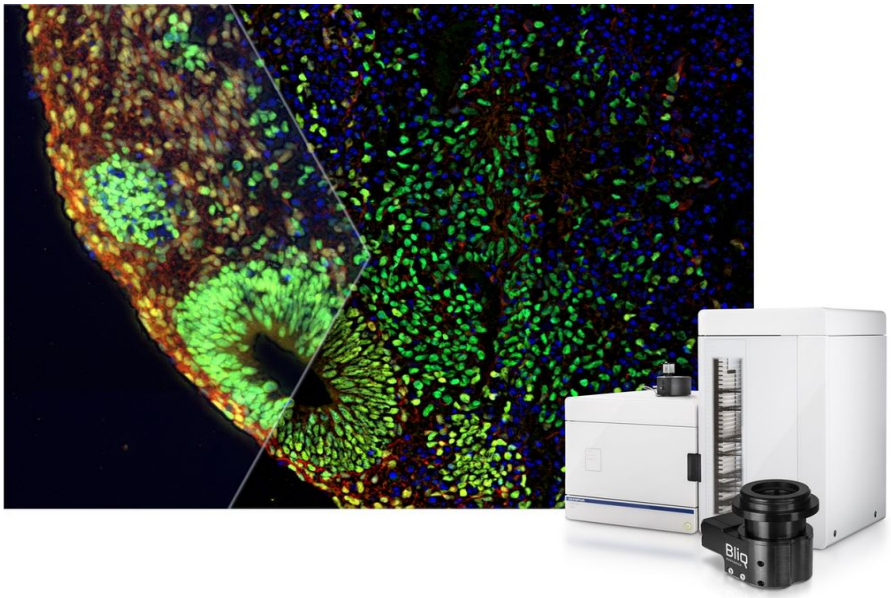

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PRE-CONGRESS WORKSHOP
PROGRAMME SCHEDULE

22nd October 2025: Mini Auditorium 2, Second Floor, UCFM Tower	
8.00 AM – 8.40 AM	Registration of participants
8.40 AM – 8.45 AM	Welcome address – *Professor Priyani Amarathunga*
8.45 AM – 9.15 AM	Patient implications of quality assurance of analytical phase with reference to accreditation based on EQUiP 7 & ISO 15189 *Professor Chandana Wickremaratne*
9.15 AM – 9.45 AM	Quality assurance in analytical phase of chemical pathology testing *Dr Gaya Katulanda*
9.45 AM – 10.15 AM	Quality assurance in analytical phase of haematology testing *Professor Chandana Wickremaratne*
10.15 AM – 10.45 AM	**Tea**
10.45 AM – 11.15 AM	Quality assurance in analytical phase of histopathology testing *Dr Nayana Ratnayake*
11.15 AM – 11.45 AM	Quality assurance in analytical phase of microbiology testing *Dr Kushlani Jayathilake*
11.45 AM – 12.15 PM	Quality assurance in analytical phase of molecular testing *Dr Chandanamali Punchihewa*
12.15 PM – 1.00 PM	Quality assurance in laboratory testing – How quality programs improve patient care *Dr Bharati Jhaveri (online)*
1.00 PM – 1.15 PM	**Question and Answer Session**
1.15 PM – 1.45 PM	Discussion of case scenarios *Dr Geethika Jayaweera and Dr Sandini Gunaratne*
1.45 PM	Closing remarks followed by lunch *Dr Carmalita Senarath*

PRE-CONGRESS WEBINAR FOR PATHOLOGISTS
PROGRAMME SCHEDULE

11.45 AM – 12.15 PM	Quality in anatomic pathology – back to basics *Dr Bharati Jhaveri (online)*
12.15 PM – 1.00 PM	Quality assurance in laboratory testing – How quality programs improve patient care *Dr Bharati Jhaveri (online)*

50TH ANNIVERSARY INTERNATIONAL CONFERENCE -2025
SCIENTIFIC PROGRAMME

Day 1 (23.10.2025): Main Auditorium	
8.30 AM - 9.00 AM	Registration
Chairpersons: Professor Janaki Hewavisenthi & Dr Mangala Bopagoda	
9.00 AM - 9.25 AM	Well differentiated hepatocellular lesions: diagnostic approach *Dr Michail Doukas*
9.25 AM – 9.50 AM	Medical liver biopsy: patterns of injury *Dr Michail Doukas*
9.50 AM - 10.15 AM	Microscopic clues and diagnostic challenges in salivary gland tumours *Professor Primali Jayasooriya*
10.15 AM – 10.30 AM	*Q and A session*
10.30 AM – 11.00 AM	**Opening Ceremony of "Panoramic Patho Vision" art exhibition**
11.00 AM - 11.15 AM	**Morning tea**
Chairpersons: Dr Roshana Constantine & Dr Jayanjana Asanthi	
11.15 AM- 11.40 AM	An update on grading of non-small cell lung carcinoma *Dr Jan von der Thüsen*
11.40 AM - 12.05 PM	Thymoma classification: laying the puzzle *Dr Jan von der Thüsen*
12.05 PM - 12.30 PM	Approach to diagnosis of melanocytic tumours *Dr Anna Saparamadu*
12.30 AM – 12.45 PM	*Q and A session*

Day 2 (24.10.2025): Main Auditorium				
8.30 AM - 8.45 AM	Registration			
8.45 AM - 10.05 AM	**Symposium on Recent Developments in Diagnostic Pathology in honour of Dr Ranee N Perera & Dr Ranga Wickramasinghe** Chairpersons: *Professor Bimalka Seneviratne & Dr Priyanka Abeygunasekara*			
8.50 AM - 9.10 AM	Recent developments in breast pathology *Dr Harshima Wijesinghe*			
9.10 AM - 9.30 AM	Diagnostic challenges in large B cell lymphomas *Professor Jonathan Said*			
9.30 AM – 9.50 AM	Recent developments in renal tumours *Professor Hemamali Samaratunga*			
9.50 AM - 10.05 AM	*Q & A session*			
10.05 AM – 10.30 AM	**Morning tea**			
10.30 AM – 11.50 AM	**Dr W D Ratnavale & Professor G E Tennakoon Memorial Symposium on Diagnostic Cytopathology** Chairpersons: *Dr Cherine Sosai & Dr Lakmalie Kariyawasam*			
10.35 AM - 10.55 AM	Pancreatic cytology *Professor Priyanthi Kumarasinghe*			
10.55 AM - 11.15 AM	Respiratory cytology *Dr Jan von der Thüsen*			
11.15 AM - 11.35 AM	Salivary gland cytology *Dr Niluka Ranathunga*			
11.35 AM - 11.50 AM	*Q & A session*			
11.50 AM – 12. 50 PM	**SAARC Symposium on Practicing Diagnostic Pathology in the Era of Molecular Genetics** Chairpersons: *Dr Nayana Ratnayake & Professor Priyani Amarathunga*			
11.50 AM - 12.05 PM	Molecular diagnosis of gliomas: implementing WHO CNS 5 in resource restrained settings *Professor Nuzhat Husain*			
12.05 PM - 12.20 PM	Molecular genetics vs IHC surrogate markers: preference in various common malignancies *Professor Shahid Pervez*			
12.20 PM - 12.30 PM	The role of pathologists and clinicians in optimum use of molecular diagnostics in Sri Lanka *Dr Priyangi Amarabandu*			
12.30 PM - 12.40 PM	Molecular genetics in cytology *Professor Wiseman Pinto*			
12.40 PM - 12.50 PM	*Discussion session*			
12.50 PM - 1.00 PM	*Commercial break*			
1.00 PM – 1.45 PM	**Lunch**			
	Workshop 1 Room 1	**Workshop 2 Room 2**	**Workshop 3 Room 3**	**Workshop 4 Room 4**
1.45 PM – 4.00 PM	Dr Bede Jayaweera & Professor Preethika Angunawela Memorial Workshop on Lymphoma	Dr Chithrika de Silva & Dr Phyllis Ganegoda Memorial Workshop on Lung and Mediastinal Pathology	Professor S B Ellepola Memorial Workshop on Cytology	Professor L R Amarasekera Honorary Workshop on Male and Female Genital Pathology
1.45 PM – 2.45 PM	Round 1	Round 1	Round 1	Round 1
3.00 PM – 4.00 PM	Round 2	Round 2	Round 2	Round 2
4.00 PM – 4.15 PM	**Afternoon tea**			
4.15 PM - 5.05 PM	Free papers Session 1	Free papers Session 2	Free papers Session 3	Free papers Sessions 4

Day 3 (25.10.2025): Main Auditorium				
8.30 AM - 8.45 AM	Registration			
8.45 AM -10.05 AM	**Dr Doris Peiris and Professor Daphne Attygalle Memorial Symposium on Approaches to Diagnosis** Chairpersons: *Professor Chandu de Silva and Professor Sulochana Wijetunge*			
8.50 AM - 9.10 AM	Approach to the diagnosis of small undifferentiated sarcomas *Dr Malee Fernando*			
9.10 AM - 9.30 AM	Approach to the diagnosis of epithelioid sarcoma *Professor Bharat Rekhi*			
9.30 AM - 9.50 AM	Diagnosis of GI biopsies: a systematic approach *Professor Dulani Beneragama*			
9.50 AM - 10.05 AM	*Q & A session*			
10.05 AM – 10.30 AM	**Morning tea**			
10.30 AM – 11.50 AM	**Professor R G Panabokke and Dr M A Nanda Prematilleke Memorial Symposium on Pitfalls/mimics in Diagnostic Pathology** Chairpersons: *Dr Modini Jayawickrama and Dr Sonali Rodrigo*			
10.35 AM – 10.55 AM	Non neoplastic lymph node lesions: pitfalls and mimics *Professor Yasodha Natkunam*			
10.55 AM - 11.15 AM	Prostate and bladder pathology: diagnostic pitfalls *Professor Isha Prematilleke*			
11.15 AM - 11.35 AM	Pitfalls and mimics in diagnostic liver pathology *Dr Michail Doukas*			
11.35 AM – 11.50 AM	*Q & A session*			
11.50 AM – 12.50 PM	**Online Interactive Quiz** *Professor Chandu de Silva* Chairpersons: *Professor Gayana Mahendra & Dr Avanthi Rajapaksa*			
12.50 PM - 1.00 PM	*Commercial break*			
1.00 PM – 1.45 PM	**Lunch**			
	Workshop 5 Room 1	**Workshop 6 Room 2**	**Workshop 7 Room 3**	**Workshop 8 Room 4**
1.45 PM – 4.00 PM	Dr S D Atukorala Memorial Workshop on Dermatopathology	Dr Saroja Siriwardene Honorary Workshop on Renal Pathology	Dr D H Cooray Memorial Workshop on Liver Pathology	Professor W E Karunaratne Memorial Workshop on Soft Tissue and Bone Pathology
1.45 PM - 2.45 PM	Round 1	Round 1	Round 1	Round 1
3.00 PM - 4.00 PM	Round 2	Round 2	Round 2	Round 2
4.00 PM – 4.15 PM	**Afternoon tea**			
4.15 PM - 5.00 PM	**Closing ceremony**			

ABSTRACTS OF THE CONFERENCE PROGRAMME

KEYNOTE ADDRESS

The shifting of sands: Evidence based pathology and the WHO Classification of Tumours

Professor Dilani Lokuhetty
Emeritus Professor, University of Colombo.
Head, WHO Classification of Tumours, International Agency for Research on Cancer, Lyon.
France

The World Health Organization Classification of Tumours (WCT) serves as the global reference standard for tumour diagnosis, first established in 1957 following a World Health Assembly resolution. Over the decades, five editions have been published, with the sixth edition (WCT-6) in preparation, advancing on the scientific and clinical foundation of earlier versions. While evidence-based medicine has long been central to broader healthcare, its integration into pathology has been slower. Recent updates to the WCT have embraced evidence-based pathology, embedding the latest research findings. However, the rapidly evolving scientific landscape (shifting of sands) continues to pose challenges in ensuring the classification reflects robust, up-to-date evidence.

To address this, the Evidence Map (Evi-Map) project, funded by the European Union, has been launched as an initial step to support WCT-6 and future editions. Evi-Map systematically compiles and organizes available research, creating evidence gap maps (EGMs) by tumour type. These EGMs not only highlight existing knowledge but also expose research gaps. By integrating individual EGMs into large-scale "mega maps," the initiative will underpin a dynamic software platform designed to provide live updates. This tool will allow continuous incorporation of emerging research and serve as a decision-making aid for WCT revisions. At present, EGMs are manually developed with the assistance of machine learning, while further exploration of artificial intelligence, including large language models, offers the potential to accelerate and refine the process.

Through these innovations and many others, the WCT seeks to maintain its position as the global gold standard in tumour diagnosis, ensuring future classifications remain evidence-based, clinically relevant, and aligned with advances in cancer research.

ABSTRACTS OF THE ACADEMIC PROGRAMME
DAY 1 (23.10.2025)

Well-differentiated hepatocellular lesions: diagnostic approach

Dr Michail Doukas
Consultant Histopathologist, Department of Pathology and Clinical Bioinformatics, Erasmus MC, Rotterdam, Netherlands

Well-differentiated hepatocellular mass-lesions are commonly encountered in daily practice and despite advancements in their characterization, they represent a diagnostic challenge, especially in needle biopsy specimens. The spectrum of these lesions includes benign, premalignant, and malignant entities with overlapping morphology. The differential diagnosis of these lesions in non-cirrhotic liver includes regenerative hepatic pseudotumor (RHP), focal nodular hyperplasia (FNH), hepatocellular adenoma (HCA) and (well differentiated) hepatocellular carcinoma (HCC). The diagnostic approach includes the interpretation of the architectural pattern(s)/changes and the cytological and nuclear features. The often-overlapping histomorphological features dictate the routine use of additional immunohistochemical stains and in selected cases molecular study. Relevant clinical information and radiological findings are also taken into consideration.
Histomorphologically, RHP represents a recently described pseudotumor characterised by the presence of portal tracts often with abnormalities in vascular structures (portal veins, hepatic arteries) and the presence of focal vascular thrombi and sinusoidal dilatation/congestion. FNH, at low power, typically looks like a cirrhotic liver (‘’focal cirrhosis”), with radiating fibrous bands originating from a central fibrous scar. Dystrophic vessels, ductular reaction and mild non-specific lymphocytic inflammation are the most common features. The distinctive ‘map-like’ immunohistochemical pattern of Glutamine Synthetase is useful for confirmation of the diagnosis. HCA represents a group of well-defined subtypes, based on a pathomolecular classification. Distinctive immunophenotype allows for characterization in most of the cases in HNF1a-inactivated HCA, inflammatory HCA, b-catenin activated HCA and sonic hedgehog HCA. A mixed inflammatory and ß-catenin activated HCA is also encountered. A small subset of HCA lacks a specific immunohistochemical profile or known genetic changes and is therefore categorised as ‘’unclassified’’. Finally, distinguishing well-differentiated HCC requires attention to trabecular thickness (>3 cell plates), loss of reticulin framework, stromal invasion, and cytological atypia.
The diagnosis or a prioritized differential diagnosis of well-differentiated hepatocellular lesions plays an important role in guiding clinical management.

Medical liver biopsy: patterns of injury

Dr Michail Doukas
Consultant Histopathologist, Department of Pathology and Clinical Bioinformatics, Erasmus MC, Rotterdam, Netherlands

Medical liver biopsy has a longstanding role in daily practice, and although it has been questioned in the era of new non-invasive modalities, it remains a cornerstone in diagnosing diffuse liver diseases when the realisation of an extensive workup provides unclear aetiology, guiding both classification and management. Assessment of individual histological findings such as inflammation, cellular changes, abnormal accumulation of various substances, and the extent of liver injury and/or fibrosis clusters into recognizable histological patterns of injury. Basic patterns of injury include hepatitic, cholestatic, fatty liver (steatotic), vascular, granulomatous, abnormal deposition, and mixed injury. The hepatitic pattern, seen in viral, drug-induced, or autoimmune hepatitis, shows interface activity, portal inflammation, and lobular necrosis. Cholestatic injury, typical of biliary obstruction or drug-induced liver injury, presents with bile plugs, ductular reaction, and canalicular bilirubinostasis. Steatotic injury reflects metabolic dysfunction, alcoholic liver disease, or drug effects, and is characterized by steatosis, ballooning,

inflammation, and often Mallory-Denk bodies. Vascular lesions such as sinusoidal obstruction syndrome or the recently described portosinusoidal vascular disease (PSVD) demonstrate disturbances of the microcirculation. Importantly, mixed patterns often occur, particularly in drug-induced liver injury, underscoring the need for clinicopathological correlation. Additional special stains (e.g., Reticulin, Trichrome/Sirius Red, PAS-D, Iron) and immunohistochemistry (e.g., keratin 7) may be used to highlight or identify features not easily seen on a haematoxylin and eosin stain. Accurate interpretation requires adequate biopsy length, especially in the era of detailed evaluation of fibrotic hepatic tissue.
Ultimately, recognition of patterns allows the pathologist to generate a clinically relevant differential diagnosis, which must then be refined through integration with laboratory results, imaging features, and clinical data.

Microscopic clues and diagnostic challenges in salivary gland tumours

Professor Primali Jayasooriya
Professor of Pathology, Aquesta Specialised Uropathology, University of Queensland, Brisbane, Queensland, Australia

Salivary gland tumours are diagnostically challenging due to their morphological diversity, with the current WHO 2022 classification recognizing fifteen benign and twenty-one malignant neoplasms. These challenges are further amplified when small incisional biopsies with limited tumour tissues are available for diagnosis, particularly in minor salivary gland neoplasms. This presentation outlines a practical approach that integrates clinicopathological correlation with a histopathological pattern–based framework to narrow the differential diagnoses, together with the cost-effective use of immunohistochemistry (IHC) to achieve a definitive diagnosis.
Microscopic clues considered within this framework include tubular and cribriform patterns, squamous differentiation, high-grade cytology, mucous cells, clear cells, lymphoid elements, and oncocytic features. Tumours with a tubular–cribriform pattern are particularly challenging, with one of the most frequent diagnostic dilemmas in routine practice being the distinction between adenoid cystic carcinoma, polymorphous adenocarcinoma, epithelial–myoepithelial carcinoma, and basal cell adenocarcinoma. While nuclear features and stromal elements provide important diagnostic clues, the judicious use of IHC can further aid differentiation, and these aspects and will be illustrated through case examples.
Focusing on minor salivary gland tumours of the palate, two additional cases will emphasize the significance of clinicopathological correlation in differentiating mucoepidermoid carcinoma from glandular odontogenic cyst, and clear cell carcinoma from clear cell odontogenic carcinoma.
In summary, this presentation highlights a pragmatic, resource-conscious diagnostic strategy that combines clinicopathological correlation including histopathological patterns, and selective IHC to overcome the challenges of diagnosing salivary gland tumours.

An update on grading of non-small cell lung carcinoma

Dr Jan von der Thüsen
President, British Division of International Academy of Pathology.
Consultant Histopathologist, Department of Pathology and Clinical Bioinformatics, Erasmus MC, Rotterdam, Netherlands

Recent advances in technology and treatment strategies have led to a shift of the diagnosis and treatment of non-small cell lung cancer (NSCLC) to earlier stages. While the selection of systemic treatment in advanced NSCLC has been greatly aided by the advent of molecular tumour profiling and this is now also applied to earlier stages in case of neo-adjuvant and adjuvant systemic therapy, the need for, and extent of curative treatment in earlier stages could also be guided by more detailed tumour assessment. This can be achieved by applying morphological (and potentially immunohistochemical) criteria to assign tumour grades which hold prognostic significance. In this lecture, established paradigms and

recent advances in the grading of common NSCLC subtypes will be discussed. These include the use of the IASLC classification for adenocarcinoma, new morphological ideas in squamous cell carcinoma, and more accurate prognostication by immunohistochemistry in neuroendocrine tumours. The potential use of artificial intelligence as an adjunct will also be touched upon.

Thymoma classification: laying the puzzle

Dr Jan von der Thüsen
President, British Division of International Academy of Pathology.
Consultant Histopathologist, Department of Pathology and Clinical Bioinformatics, Erasmus MC, Rotterdam, Netherlands

Thymic epithelial tumours (TETs) are classified according to the WHO classification. This has provided a strong basis for routine diagnosis and research, but inconsistences, areas of overlap and limited reproducibility between pathologists remain. Morphology is still central to this classification, but increasingly, other techniques, such as immunohistochemistry, molecular methods, and artificial intelligence are proving their value. This applies to clearer delineation and refinement of known subtypes, as well as uncovering new relationships and possibly novel disease entities. This presentation will provide an update of the whole spectrum of methods and technologies currently at the disposal of the practicing histopathologist to make a confident TET diagnosis, as well as exploring exciting future possibilities and developments.

Approach to the morphological diagnosis of melanocytic tumours

Dr Anna Saparamadu
Consultant Cellular Pathologist, Department of Histopathology, Northampton General Hospital NHS Trust, University Hospitals of Northamptonshire, United Kingdom

Melanocytic tumours encompass a wide range of morphological spectrum with varying clinical behaviour and outcome. The clinical presentation and dermoscopy examination could predict the diagnosis to a certain extent. However, tissue diagnosis is essential for establishing the accurate diagnosis, subtyping and providing staging parameters which guide management plans in malignant melanoma. Malignant melanoma is a common skin cancer in Caucasian population and the name itself alarms patients. There are benign melanocytic lesions which share some histological features of malignant melanoma. Spitz nevus, naevi of special sites, dysplastic naevi are some such tumours. No one morphological feature defines any tumour and awareness of the defining morphological features is essential for the correct management of patients and to avoid litigation. This presentation will focus on imparting some skills in recognising basic morphological features that define benign naevi and malignant melanomas. More importantly it will focus on the morphological features that would help to deal with challenging cases of benign naevi which mimic malignant melanoma. Appropriate use and interpretation of immuno-histochemical markers, especially a panel consisting of Sox10, HMB45 and P16 will be presented. Situations when Ki 67 and PRAME can be of help will also be discussed. Documentation of staging and prognostic parameters in malignant melanoma is essential in a histopathology report and those parameters will be highlighted. The accurate diagnosis of melanocytic tumours depends heavily on clinico-pathological correlation. Therefore, what pathologists need from clinicians to achieve this goal will also be highlighted.

ABSTRACTS OF THE ACADEMIC PROGRAMME

DAY 2 (24.10.2025)

SYMPOSIUM 1
Symposium on Recent Developments in Diagnostic Pathology in honour of Dr Ranee N Perera and Dr Ranga Wickramasinghe

Dr Ranee N Perera

Dr Ranee N. Perera, MBBS (Cey), DCP (Lond), DPath (Eng), PhD (Lond), FRCPath, was a pioneering pathologist whose career was dedicated to ophthalmic pathology and postgraduate training in Sri Lanka. Following her medical education in Colombo, she trained at the Institute of Ophthalmic Pathology, University of London, under the guidance of Professor Norman Ashton from 1967 to 1971. She then returned to Sri Lanka, where she served as Pathologist at the Eye Hospital, Colombo, from 1971 until her retirement in 1989.

Dr Perera made invaluable contributions to the College of Pathologists of Sri Lanka (CPSL). As a Category A founder member, she was present at the inaugural meeting in 1975, later serving as Council Member, Honorary Joint Secretary, and becoming a Life Member in 1985. She was also the founding Editor of the *Sri Lanka Journal of Pathology*, launching its first volume in 1985, and continued to serve as Editor through several terms between 1975 and 1992. Her editorial leadership ensured the establishment of the journal as a platform for scientific communication in pathology.

She played a pivotal role in postgraduate education. As Coordinator of the Diploma in Clinical Pathology (DCP) programme at the Postgraduate Institute of Medicine, she organized and led its sessions from its inception in 1984 until her retirement. This annual programme provided structured lectures and practical training across all major disciplines of pathology, supplementing in-service training and engaging a large faculty of visiting lecturers. She also served as a trainer in histopathology, contributing to the development of many postgraduate trainees.

Dr Perera's academic work included a PhD thesis on the structure and ultrastructure of the corneal epithelium, completed under Professor Ashton. She contributed to international scholarship as a reviewer of the *WHO Histological Typing of Tumours of the Eye and its Adnexa* (1980) and published widely in the *Sri Lanka Journal of Pathology*. Her research covered intraocular melanomas, corneal pathology, and broader reflections on the profession, and she also represented Sri Lanka at international conferences, including the XII World Congress of Pathology in Tokyo in 1983.

Dr Ranee N. Perera combined her expertise in ophthalmic pathology with leadership in education, research, and professional development. Her vision and dedication helped shape the foundations of postgraduate training and scientific publication in pathology in Sri Lanka, leaving a lasting legacy for the discipline.

Dr Himanshu Ranga Wickramasinghe

Dr Himanshu Ranga Wickramasinghe, MBBS, DCP, PhD (Manchester), served as Neuropathologist and Head of the Department of Pathology at the National Hospital of Sri Lanka. Together with Dr Doris Peiris (General Hospital, Colombo) and Dr Ranee Perera (Eye Hospital, Colombo), he convened the meeting that founded the College of Pathologists on 15 March 1975 at the General Hospital, Colombo. Their foresight laid the foundation for the College, to which every subsequent generation of pathologists in Sri Lanka owes a debt of gratitude. He was also pioneering figure in postgraduate pathology training and an inspiring teacher and mentor to many generations of Sri Lankan pathologists.

In 1981, he initiated the Pathology Training Programme at the Postgraduate Institute of Medicine

(PGIM), encompassing histopathology, haematology, microbiology, and clinical chemistry. As the first Director of the programme, he collaborated with senior colleagues, including Dr Chithrika de Silva and Dr Bede Jayaweera, to revise the curriculum in 1983 in line with standards of the Royal College of Pathologists (UK). The first taught course was launched in 1984 at the National Hospital of Sri Lanka, establishing a structured training pathway. He was also instrumental in starting the Annual Academic Sessions of the College of Pathologists of Sri Lanka, helping integrate newly qualified specialists into the professional community.

Following his retirement from government service, Dr Wickramasinghe continued as Director of the PGIM Pathology Programme. He introduced the cluster system of rotational training and initiated the Pathology Accreditation Programme to ensure consistent standards across training centres. He also encouraged newly qualified pathologists returning from overseas training to serve as trainers and examiners, safeguarding continuity as senior teachers retired.

A researcher with a doctorate in neuropathology, Dr Wickramasinghe studied aortitis in patients with atherosclerotic vascular disease. He expanded laboratory services in Sri Lanka by establishing serum thyroxine testing using radioisotope methods through the International Atomic Energy Agency, at a time when such testing was limited to Peradeniya. As Sri Lanka's only formally qualified neuropathologist of his era, he was highly skilled in neurocytology. Importantly, he introduced Fine Needle Aspiration (FNA) cytology to the country in 1986, applying expertise gained during a sabbatical in Australia.

Dr Wickramasinghe will be remembered not only for his many contributions to pathology but also for his humility, integrity, and dedication to service, leaving a lasting legacy for the profession in Sri Lanka.

Recent developments in breast pathology

Dr Harshima Wijesinghe
Professor and Consultant Histopathologist, Department of Pathology, Faculty of Medicine, University of Colombo. Sri Lanka

Recent developments in breast pathology are enhancing diagnostic accuracy, therapeutic stratification, and insights into tumour biology. Wider adoption of synoptic templates and standardized reporting, particularly in low- and middle-income settings, is improving data completeness and supporting treatment planning. Accurate pathological assessment after neoadjuvant therapy has gained prominence, with emphasis on the use of consistent criteria. Recent research has led to improved recognition of histological tumour types, including invasive lobular carcinoma and phyllodes tumours, refinement of the interpretation of immunohistochemical markers, and recognition of the clinical importance of "HER2-low" and "ultra-low" breast cancers. In parallel, liquid biopsy is emerging as a complementary tool, offering minimally invasive detection of circulating tumour DNA and facilitating real-time monitoring of therapeutic response. Digital pathology and artificial intelligence are increasingly being integrated into breast pathology practice, with the aim of enhancing workflows and interobserver consistency. Collectively, these developments strengthen precision oncology and patient-tailored breast cancer care.

Diagnostic challenges in aggressive B-cell lymphomas: emphasis on WHO 5th Edition and International Consensus Classification

Professor Jonathan Said
Consultant Pathologist, David Geffen School of Medicine, UCLA Medical Centre, Los Angeles, California, USA

Objective: Articulate new knowledge regarding aggressive B-cell lymphomas provided by histologic, immunohistochemical, and genomic profiling, recognize unresolved issues including the nature of high-grade unclassifiable lymphomas, and identify features most helpful in diagnosing problematic subtypes of aggressive B-cell lymphoma

Subgroups of DLBCL NOS
DLBCL can be characterized in two main groups, Germinal Centre B-cell (GCB) with signature of germinal centre B-cells (50% cases), Activated B-cell (ABC). The ABC group has gene profiles like those induced by in-vitro activation of peripheral group has been associated with an adverse prognosis.

Burkitt lymphoma
Translocation involving *MYC* are almost always found but are not specific for Burkitt lymphoma and in rare cases cannot be detected. No single parameter is the gold standard for diagnosis; morphology, cytogenetics, immunophenotype, and expression profiles all may contribute to the diagnosis. Burkitt lymphomas are 'MYC simple' and lack other translocations including *BCL2*.

High grade BCL with *MYC* and *BCL2* rearrangements (Double Hit lymphoma)
Per WHO cases with *MYC* and *BCL6* rearrangements and no *BCL2* translocation are classified either as a subtype of DLCL NOS, or HGBCL NOS according to cytomorphological features.

High grade BCL NOS is a poorly defined category for cases with high grade morphology which lack *MYC* and *BCL2* rearrangements. In practice many of these cases are intermediate between Burkitt lymphoma and DLBCL and therefore hard to classify.

Recent developments in renal tumours

Professor Hemamali Samaratunga
Professor of Pathology, Aquesta Specialised Uropathology, University of Queensland, Brisbane, Queensland. Australia

Since the publication of the first World Health Organisation (WHO) classification in 1981 there have been major advances in our understanding of the pathology of renal cell carcinoma (RCC). The Mainz classification in 1986 established clear cell RCC, papillary RCC, chromophobe RCC and collecting duct carcinoma as distinct tumour morphotypes. Renal medullary carcinoma was added later as a subtype of collecting duct carcinoma. Mucinous tubular and spindle cell carcinoma and translocation carcinoma were added to the classification in 2004. The Vancouver classification in 2012 included tubulocystic RCC, acquired cystic disease-associated RCC, clear cell (tubulo) papillary RCC and hereditary leiomyomatosis RCC syndrome-associated RCC (HLRCC). At this time, hybrid oncocytic chromophobe tumour (HOCT) & t (6:11) translocation carcinoma was added to the classification. Thyroid-like follicular RCC, succinate dehydrogenase (SDH) B deficiency-associated RCC and ALK-translocation RCC were classified as emerging entities. Over time, eosinophilic solid and cystic RCC and biphasic papillary RCC have been recognised as distinct tumours. The 2023 WHO classification established a novel category of molecularly defined cancers which included translocation carcinomas, FH deficient HLRCC tumours and SDH deficient tumours to which *ALK*-rearranged tumours were added at a specific tumour type. While some of these entities are clearly specific RCC morphotypes, the widening morphologic spectrum of some raises questions as to the relevance of this diagnostic category. Another problematic category in this classification is other oncocytic tumours which is a collection of poorly characterised or uncharacterised oncocytic neoplasms which are benign and would be more appropriately classified as oncocytoma.

SYMPOSIUM 2
Dr W D Ratnavale and Professor G E Tennakoon
Memorial Symposium on Diagnostic Cytopathology

Dr William Dharmaraja Ratnavale

Dr William Dharmaraja Ratnavale, born on 10 March 1913 in Kandy, was one of the most dynamic medical personalities of his time, remembered for his leadership in pathology, postgraduate training, and institution building. He received his early education at Trinity College, Kandy, where he excelled in both studies and sports. He entered the Ceylon Medical College and qualified LMS in 1936, later pursuing postgraduate studies in London at St. Bartholomew's and University College Medical Schools. His academic career was remarkable — MBBS in 1949, Diploma in Clinical Pathology in 1950, MRCP in 1951, MD and DPH in 1952, followed by FRCPath in 1968 and FRCP in 1971.

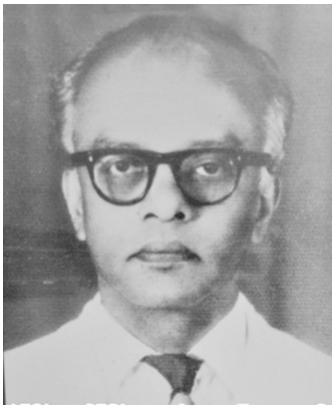
During the Second World War, he served as a graded specialist in pathology in the Army and subsequently worked as Assistant Pathologist at Colombo General Hospital. On his return from postgraduate training in the UK in 1952, he was appointed Chief Pathologist at the Colombo General Hospital, a position he held until 1964. A man with vision and organizational skill, he combined discipline and creativity in all his work. His private "Glass House Laboratory" set high professional standards and won international recognition. Later, as Director of the North Colombo Medical College, he transformed it into a respected medical school and oversaw the establishment of new wards and facilities at the Colombo North General Hospital, Ragama.

Dr Ratnavale was also active in postgraduate education. Known for his innovative approaches, he introduced informal "smoking discussions" that enlivened academic meetings and made the Ceylon Academy of Postgraduate Medicine — the forerunner of today's PGIM — a popular forum. His lectures in clinical pathology and his ability to stimulate debate left a strong impression on generations of doctors.

Beyond pathology, he served as President of several professional bodies, including the Ceylon Medical Association, the Ceylon Public Health Association, and the Ceylon Association of Social and Preventive Medicine. He was honorary physician to the Governor-General in 1962 and had a distinguished military career, rising to Lieutenant Colonel and commanding the Ceylon Army Medical Corps. A talented sportsman, he captained the national rugby team and later served as President of the Ceylon Rugby Football Union.

Soft-spoken, disciplined, and versatile, Dr Ratnavale passed away on 26 October 1995, leaving behind a legacy as a pathologist, teacher, leader, and gentleman of rare distinction.

Professor George Edmund Tennekoon



Professor George Edmund Tennekoon was a founder member of the College of Pathologists of Sri Lanka and played a key role in its early activities. He served as Vice President between 1975 and 1978, and as President from 1978 to 1979, later remaining on the council until 1983. During this formative period, he contributed significantly to strengthening the College's academic and professional work, laying the foundation for its continued development.

Educated at St. Anthony's College, Kandy, he excelled academically, obtaining a First Class at the London Matriculation examination. Entering the Ceylon Medical College, he graduated with First Class Honours as Licentiate of Medicine and Surgery, and later joined the Colombo Medical Faculty. After serving in several government hospitals, he joined

its Department of Pathology as a junior lecturer under the guidance of Professor W.A.E. Karunaratne. Awarded a scholarship for postgraduate studies, he proceeded to London where he was conferred a PhD for his seminal research on pulmonary oedema under Professor Roy Cameron at University College Hospital.

On his return to Sri Lanka, he was appointed Senior Lecturer in Pathology and was soon transferred to the newly established Faculty of Medicine at Peradeniya. There, as Head of Department, he set up the undergraduate teaching programme in pathology and initiated biopsy pathology services. These services not only supported the Kandy and Peradeniya hospitals, but extended to many outstation hospitals including Anuradhapura, Kegalle, Nawalapitiya, Nuwara Eliya, and Matale, greatly expanding access to modern diagnostic facilities.

Professor Tennekoon was a renowned teacher whose lectures on general pathological processes were legendary for their clarity. With just chalk and a blackboard, he conveyed complex concepts with simplicity and depth, leaving a lasting impression on generations of students. His research spanned a wide range of areas including lymphoma, the effects of betel chewing on the oral mucosa, and numerous collaborative experimental studies, all of which were published in prestigious journals.

He served as Dean of the Faculty of Medicine, Peradeniya, and was later conferred the Honorary Doctor of Science degree by the University of Peradeniya in recognition of his outstanding contributions. Soft-spoken, unassuming, and brilliant, Professor Tennekoon combined academic distinction with visionary leadership, leaving an enduring legacy in both the College of Pathologists and the wider medical community of Sri Lanka.

An uncommon intraductal neoplasm, cytology in the core biopsy era

Dr Priyanthi Kumarasinghe
Chief Pathologist, Consultant Anatomical Pathologist, Clinical Professor, School of Pathology and Laboratory Medicine, University of Western Australia, Australia

Current classifications of intraductal papillary neoplasms of the pancreas include three entities:

- Intraductal papillary mucinous neoplasms (IPMNs)
- Intraductal tubulopapillary neoplasms (ITPNs)
- Intraductal papillary oncocytic neoplasms (IOPNs)

Smears from IOPNs are typically highly cellular, composed of oncocytic cells with abundant granular cytoplasm, and notably minimal or absent mucin in the background. The cells are arranged in complex sheets and papillae, often with branching fibrovascular cores. On Pap and Giemsa stains, the cytoplasm appears granular bluish-green or magenta respectively, with well-defined cell borders, a relatively low nuclear-to-cytoplasmic ratio, round to oval nuclei, and prominent eccentric nucleoli.

The absence of mucin production with distinctive cytological features is a key feature that helps differentiate cystic IOPNs from IPMNs. At the molecular level, IOPNs are characterized by *PRKACA* or *PRKACB* gene fusions, in contrast to the *KRAS* and *GNAS* mutations commonly seen in IPMNs.

Despite invasive behaviour being observed in approximately 50% of IOPN cases, the 5-year disease-specific survival following surgical resection remains high, distinguishing IOPNs from more aggressive mimics and emphasizing the importance of accurate pretreatment diagnosis.

Diagnostic challenges arise due to mimics such as acinar cell carcinoma, neuroendocrine neoplasms, pancreatic ductal adenocarcinoma, and other primary or metastatic tumours with oncocytic features. Unlike IPMNs, a significant proportion of IOPNs present as solid or mixed solid-cystic masses, which may be misclassified as pancreatic ductal adenocarcinoma on imaging. Increasingly, EUS-guided core biopsies are being utilised to sample these complex and solid pancreatic masses posing different challenges.

Malignant pulmonary cytopathology

Dr Jan von der Thüsen
President, British Division of International Academy of Pathology.
Consultant Histopathologist, Department of Pathology and Clinical Bioinformatics, Erasmus MC, Rotterdam. Netherlands

While histological specimens of lung abnormalities are the gold standard in many pulmonary diseases, the use of cytology for the initial diagnosis and cancer staging remains an important cornerstone in the diagnostic armamentarium of most clinical practices around the world. This applies to both oncological and non-oncological (e.g. interstitial lung disease (ILD) and infection) settings and requires continued attention to the acquisition and advancement of expertise of diagnosticians involved in pulmonary cytopathology, as well as the adaptation of existing technologies (such as immunohistochemistry and molecular diagnostics) to the specific setting of cytology. In this lecture, examples of real-world cases of cytology-diagnosed thoracic malignancy will be discussed, including lung cancer and mesothelioma specimens, including useful ancillary techniques.

Salivary cytology: case-based discussion

Dr Niluka Ranathunga
Consultant Histopathologist, District General Hospital, Chilaw. Sri Lanka

Salivary cytology is one of the commonest cytology work up in day today practice. Even though the salivary gland is small in size, the pathologist should always consider it as a complex organ with different tissue components. In addition to the specific salivary epithelial and myoepithelial tissue, any other soft tissue component or inflammatory cell component can give rise to a neoplastic /inflammatory lesion within the salivary gland.
Salivary gland specific neoplasms have a wide phenotypical and genotypical diversity. A wide spectrum of morphological patterns is common within the same neoplasm.
Introduction of Milan classification for salivary cytology has produced significant accurate guidance for the managing clinicians providing the percentage of risk of malignancy. In common with the cytology of the other organs, available amount of diagnostic material plays a major role in final diagnostic category.
In my brief presentation, I will discuss a few cases and illustrate how the application of Milan category changed for a single category of a neoplasm, depending on the amount of available material,
Finally, even though Sri Lanka does not have the facility, the importance of cytogenetics in difficult cases of salivary cytology will be emphasised.

SYMPOSIUM 3
SAARC Symposium
on Practicing Diagnostic Pathology in the Era of Molecular Genetics

Molecular diagnosis of gliomas: implementing WHO CNS 5 in resource restrained settings

Professor Nuzhat Husain
President, Indian Division of International Academy of Pathology.
Professor and Head of Pathology, State referral centre for lab investigations.
Former Dean, Dr Ram Manohar Lohia Institute of Medical Sciences, Lucknow, India

Molecular genetics vs IHC surrogate markers: preference in various common malignancies

Professor Shahid Pervez
Professor and Consultant Histopathologist, Department of Pathology and Laboratory Medicine, Aga Khan University Hospital, Karachi, Pakistan

As we are quickly moving to 'Molecular Classification' of cancers rather than organ-based classification, based on the driver mutations or carcinogenic pathways, it is rapidly becoming irrelevant if the cancer is originating from the breast or colon or brain, what is more important is the prime carcinogenic pathway. In addition to many primary tumours, in about 50-60% advanced malignancies, systemic chemotherapy may be the only option, and it may be a futile exercise to make all efforts to pinpoint origin. Instead, what is important is if a tumour is ER/PR positive, HER2 positive, *EGFR* mutated, shows microsatellite instability (identified by mismatch repair (MMR) genes testing), *BRAF* or *RAS* mutated or shows one of many other such genomic possibilities. Here comes the dilemma, is relatively easier, cheaper and accessible IHC testing a good enough surrogate marker of the underlying genetic alteration or is molecular testing such as polymerase chain reaction (PCR), fluorescent in sit hybridisation (FISH) or next generation sequencing (NGS) necessary. We know that some predictive markers like ER/PR, MMR testing is highly reliable on IHC while driver mutations like *EGFR* do require PCR based testing and IHC staining is of no or little value. HER2 testing is one example where both IHC and FISH testing go hand in hand. This presentation will take up this challenge to deliberate the most practical solutions as the future has arrived earlier than expected.

The role of pathologists and clinicians in optimum use of molecular diagnostics in Sri Lanka

Dr *Priyangi Amarabandu*
Consultant Histopathologist, Apeksha Hospital, Maharagama. Sri Lanka

Sri Lanka is slowly reaching towards the advancement of diagnostic pathology services by expanding the capacity for molecular and cytogenetic diagnostics in the government sector. Currently the facilities available range from the Polymerase Chain Reaction (PCR) testing to the limited availability of Next Generation Sequencing (NGS) for molecular diagnostics and limited availability of Fluorescent In Situ Hybridization (FISH) for cytogenetic.
Pathologists and the clinicians working in Sri Lanka have a responsibility in using these limited facilities optimally and rationally so as to get the maximum benefit to the pathologists, clinicians as well as to the patients with minimal economic burden to the country.
Choosing the right sample type for the right application is the first step to the discovery of the complex message behind the double helix. If the specimen spoils before reaching the molecular laboratory, no recipe can fix it. So that from the point of removal of the specimen from the body it should meet the acceptance criteria in which the pathologists play as the physician of the specimen. This includes every step of transport, fixation, processing and storage of the specimen till it reaches the bench top of the molecular laboratory.

The clinicians need to focus on availability of target drugs, and the changes that will affect the management of the patients out of the molecular report when requesting the molecular testing. Having regular tumour board meetings that include medical and surgical Oncologists, Pathologists, Radiologists and Geneticists is a mandatory requirement for the maximal utilization of the molecular diagnostic services which ultimately results in quality personalized treatment and care.

Molecular genetics in cytopathology

Professor Wiseman Pinto
President, Asian Society of Cytopathology.; Chairman, International Affairs Committee IAC.
Professor of Pathology and Former Dean, Goa University; Former HOD, Department of Pathology, Goa Medical College, India

Molecular pathology is fundamentally transforming the field of cytopathology, moving it beyond traditional morphologic diagnosis into a sophisticated, multidisciplinary diagnostic arena. Cytopathology remains a cornerstone of rapid, cost-effective, and minimally invasive diagnosis, sometimes demonstrating superiority to histopathology in select clinical scenarios. However, for precise patient management, cytopathology findings must be interpreted holistically, integrating data from clinical history, imaging, biochemistry, and ancillary studies, including histopathology, special stains, and immunohistochemistry (IHC).
The modern practice leverages advanced molecular, genetic, and epigenetic analyses to refine diagnoses, identify new risk factors, and characterize novel disease entities. This integration is crucial for accurate classification of neoplasms, such as sarcomas, carcinomas, and haematolymphoid malignancies, by identifying specific biomarkers and genetic rearrangements. Finally, the importance of modern infrastructure, collaborative research, and understanding the logistics—indications, methods, and costs—of performing comprehensive genetic testing to ensure personalized therapeutic strategies is emphasised.

WORKSHOP 1
Dr Bede Jayaweera and Professor Preethika Angunawela Memorial Workshop on Lymphoma

Dr Bede Jayaweera

Dr Bede Jayaweera received his early education at St. Benedict's College, Kotahena, and graduated from the Colombo Medical Faculty before serving in several outstation hospitals. Following postgraduate studies in Britain, he was appointed Consultant Pathologist at the Maharagama Cancer Hospital in 1962, where he went on to become one of the most respected and sought-after specialists in the field. His diagnostic accuracy was recognized both locally and internationally, with second opinions from abroad consistently affirming his findings. Despite his eminence, Dr Jayaweera remained a humble and approachable figure who never lost touch with his roots.

As a leader and mentor, he was deeply respected by laboratory technologists for his guidance and collegiality. He valued their experience, sought their advice, and extended personal support to their families, earning their unwavering loyalty in return. During his tenure as Acting Director of the Cancer Hospital, he was noted for his integrity and effectiveness in addressing inefficiency, corruption, and complacency, while maintaining the respect of the entire staff as a strict yet fair disciplinarian.

A devout Catholic and man of great compassion, Dr Jayaweera devoted himself after retirement in 1995 to managing *Shantha Sevena*, a free home for terminally ill cancer patients, providing comfort and dignity during their final days. Simplicity and modesty marked his character throughout his life.

Dr Jayaweera's professional legacy includes pioneering the establishment of the College of Pathologists in 1975, where he served as Secretary and Treasurer, and actively shaping postgraduate histopathology curricula and in-service training. He also chaired the Board of Study in Pathology at the Postgraduate Institute of Medicine and contributed to numerous publications and conference presentations at both national and international levels. His life exemplified professional excellence, humility, and service to humanity.

Professor Preethika Angunawela

Professor Preethika Angunawela began her distinguished career in pathology in 1983 as a Lecturer in the Department of Pathology, Faculty of Medicine, University of Colombo. She obtained her MD in 1989, as part of the second cohort of postgraduate trainees in histopathology in Sri Lanka, and later received further training at Charing Cross Hospital, UK, under a Commonwealth Scholarship. She went on to earn fellowships from both the Royal College of Pathologists in the UK and in Australia, marking her as one of the country's most highly recognized specialists.

She rose steadily through the academic ranks, being appointed Senior Lecturer in 1990, Associate Professor in 1995, Professor in 1999, and Senior Professor in 2007. A pioneer in renal pathology in Sri Lanka, she also contributed significantly to the growth of oral pathology at a time when specialists in the field were scarce. Her research achievements were recognized with several prestigious fellowships and Presidential Awards for scientific contributions.

Professor Angunawela was a deeply committed teacher whose influence extended across undergraduate and postgraduate education. She supported undergraduate programmes at several medical faculties during staff shortages and was dedicated to postgraduate training, mentoring more than thirty consultant pathologists, contributing to postgraduate teaching in multiple specialties, and supervising numerous MPhil and PhD candidates. She served on the Board of Study in Pathology for many years, guiding academic standards and examinations with distinction.

An active and respected member of the College of Pathologists of Sri Lanka, Professor Angunawela served as its President in 2000, during which time she contributed significantly to strengthening the College's academic and professional role. She is remembered with deep respect for her academic excellence, her compassion, and her enduring contributions to the advancement of pathology and postgraduate education in Sri Lanka.

List of cases

1. NLPHL overlap with T-cell lymphoma by *Professor Yasodha Natkunam*
2. EBV+ mucocutaneous ulcer by *Professor Yasodha Natkunam*
3. Grey zone lymphoma with differential between DLBCL and CHL by *Professor Jonathan Said*
4. Cutaneous lymphoma by *Professor Jonathan Said*
5. Follicular dendritic cell sarcoma by *Dr Priyanka Abeygunasekara*

WORKSHOP 2
Dr Chithrika De Silva and Dr Phyllis Ganegoda
Memorial Workshop on Lung and Mediastinal Pathology

Dr Chithrika de Silva

Dr Chithrika de Silva, born in 1932 in Tangalle, hailed from a respected Buddhist family whose father moved the children to Colombo with the vision of providing them the best education. Among her siblings, all of whom became professionals, Dr de Silva and her brother, Professor Sanath Lamabadusooriya, chose careers in medicine. She received her early education at Ladies' College and later at Visakha Vidyalaya, excelling both academically and in extracurricular activities. In 1954, she graduated from the Colombo Medical Faculty with a Second Class in the final MBBS.

She pursued postgraduate training in histopathology in the United Kingdom, working at Charing Cross Hospital and the prestigious Hammersmith Hospital under the guidance of eminent pathologists. On returning to Sri Lanka, she served as Consultant Pathologist at the Base Hospitals in Kegalle and Gampaha. In 1984 she joined the National Hospital of Sri Lanka as Consultant Histopathologist, a position she held until her retirement in 1992. She was known as a professional of the highest integrity and a strict disciplinarian who led by example, instilling responsibility and discipline in her trainees and staff. Yet, her compassion emerged readily in times of need, earning her the loyalty and respect of all who worked with her.

A committed teacher, Dr de Silva maintained a close rapport with the Postgraduate Institute of Medicine, particularly during Prof. Panabokke's tenure as Director. She was an active member of the Board of Study in Pathology, serving as examiner for numerous diploma and MD examinations, frequently as chair of the examiner panel. Her expertise was also sought in postgraduate examinations in surgery, obstetrics, and gynaecology.

Following her retirement from government service, Dr de Silva joined the private sector, where she played a leading role in upgrading the histopathology laboratory at Nawaloka Hospital, raising it to its present standard. She remains remembered as a teacher, mentor, and pathologist of distinction, whose legacy continues through generations of medical professionals.

Dr Phyllis Ganegoda

Dr Phyllis Ganegoda was a distinguished Sri Lankan pathologist, holding the degrees MBBS (Ceylon), MD (Colombo), and D. Path. She served as the first haematologist at the National Hospital of Sri Lanka and served there until her retirement in 1996. Her career was marked by pioneering contributions to haematology and postgraduate medical education in pathology.

In 1985, Dr Ganegoda was successful in the MD Pathology examination (category A), the first candidate to do so in that category, and was formally board certified as a consultant pathologist. Through this achievement she established herself as a leader in the field. Her work has had lasting influence: through her teaching, mentorship, and administrative leadership she helped strengthen pathology and related fields as disciplines in Sri Lanka.

She was the very first haematologist to serve on the Board of Study in Pathology at the Postgraduate Institute of Medicine (PGIM), University of Colombo. In that capacity, she was instrumental in shaping training programmes for future pathologists. Additionally, she was the coordinator for the newly

established transfusion medicine curriculum and served in that capacity for three years at PGIM.
Her enduring legacy rests on her scholarship, mentorship, and service, which left an indelible mark on haematology, clinical transfusion, and academic pathology in Sri Lanka.

List of cases

1. NUT carcinoma and SMARCA4-deficient carcinoma and a couple of rare but morphologically recognisable TETs, micronodular thymoma and metaplastic thymoma by *Dr Jan von der Thusen*
2. A Solitary hilar mass: challenges in diagnosis and WHO classification: related to neuriendocrine tumours on biopsy by *Dr Roshana Constantine*
3. Mediastinal mass in a young male presented with SVC obstruction by *Dr.Ramani Punchihewa*
4. A case of interstitial pneumonia (NSIP): challenges in diagnosis by *Dr Jayanjana Asanthi*

WORKSHOP 3
Professor S B Ellepola Memorial Workshop on Cytology

Dr Sirinama Bandara Ellepola

Dr Sirinama Bandara Ellepola, fondly known as Cyril Ellepola, was a pioneering haematologist, teacher, and administrator whose career combined academic excellence with dedicated service to the College of Pathologists of Sri Lanka (CPSL). A proud alumnus of Trinity College, Kandy, he excelled in both studies and sports before entering the Colombo Medical Faculty. Following graduation, he trained in pathology in the United Kingdom, obtaining the Diploma in Pathology, but was recalled to Sri Lanka by the Ministry of Health due to the urgent shortage of specialists. His chosen field was haematology, where he made significant contributions both in practice and teaching.
Dr Ellepola was a founder member of CPSL and served as co-secretary from 1975 to 1979 under the presidencies of Dr W.D. Ratnavale and Professor G.E. Tennekoon. In this capacity, he played an active role in shaping the early direction of the College, strengthening its administrative framework, and supporting its academic activities. His involvement during the formative years helped establish CPSL as the leading professional body for pathologists in the country.
At the national level, he served as pathologist at the General Hospital, Badulla, where he developed the laboratory into a well-functioning diagnostic centre. Later, at the Faculty of Medicine, University of Peradeniya, he advanced to Professor of Pathology, where his vision extended beyond the university to national capacity-building. He was instrumental in founding the Medical Laboratory Technology School at the Teaching Hospital, Peradeniya, in collaboration with Professor Ingmar Jungner of Sweden. This initiative, later adopted by the Ministry of Health, provided systematic training for technologists, with guaranteed opportunities for university staff. Dr Ellepola also pioneered automation in hospital laboratories, securing the donation of a Hitachi autoanalyzer for the Peradeniya hospital through international collaborations. As a teacher, he was deeply committed to the professional growth of laboratory technologists, arranging DANIDA scholarships for overseas training. His research in population genetics led to a landmark publication, *A Genetic Study of the Veddas and the Sinhalese*, in the *Ceylon Journal of Medical Science* in 1986, which was later submitted for his M.Med.Path degree.
Colleagues and students alike remember Dr Ellepola as a firm yet kind administrator, a generous and unselfish professional who willingly shared resources, and a sportsman with an affable personality. His legacy endures through his pioneering role in CPSL, his leadership in haematology and education, and his vision in strengthening pathology services in Sri Lanka.

List of cases

1. Thyroid and lymph node cytology *by Dr Thushari Liyanage*
2. Pleural fluid cytology by *Dr Lalani J De Silva*
3. EBUS cytology by *Dr Dushyanti Samarasinghe*
4. Ascitic fluid cytology by *Dr Dushyanti Samarasinghe*
5. Jaw/neck lump by *Dr Cherine Sosai*

WORKSHOP 4
Professor LR Amarasekera Honorary Workshop on Male and Female Genital Pathology

Professor Lakshman Ranjit Amarasekera

Professor Lakshman Ranjit Amarasekara, is a distinguished teacher and academic who dedicated his life to the advancement of pathology in Sri Lanka. He received his early education at St. Thomas' College, Mount Lavinia, where he excelled in both studies and sports, representing his school in cricket and taking part in the legendary Royal–Thomian encounters. Entering the Faculty of Medicine, University of Ceylon, in 1960, he continued his sporting achievements as a member of the university cricket team. He graduated MBBS in 1965 with a Second Class, obtaining distinctions in pathology, microbiology, forensic medicine, and winning the prestigious Mathew Gold Medal in forensic medicine in 1963.

He joined the Faculty of Medicine, Colombo, as a lecturer in pathology in 1971, soon after, proceeding to the United Kingdom for postgraduate studies, completing a PhD in hepatocyte hyperplasia in chronic liver disease at the Royal Postgraduate Medical School, Hammersmith, under Professor Ken Vibren in 1976. On his return, he was promoted Senior Lecturer in 1979, became Head of the Department of Pathology in 1982, and was appointed to the Chair of Pathology in 1989, serving the faculty with distinction until his retirement in 2003. In recognition of his decades of service, he was conferred the title of Emeritus Professor in 2010.

Professor Amarasekara played a central role in postgraduate training at the Postgraduate Institute of Medicine, where he supervised and examined generations of trainees, serving as Chief Examiner for the MD Pathology and as Chairman of the Board of Study in Pathology. Many of his students went on to serve as leading pathologists both in Sri Lanka and abroad. He was also an active member of the College of Pathologists of Sri Lanka from its early years and served as its President in 1999, contributing significantly to its growth and academic mission.

Known affectionately as "LR," he combined academic excellence with warmth, modesty, and humour. A mentor who encouraged individuality and growth in his students and colleagues, he is remembered with gratitude for his dedication to teaching, his commitment to pathology, and his lasting legacy in shaping the discipline in Sri Lanka.

List of cases

1. Intraductal carcinoma of the prostate by *Professor Hemamali Samaratunga*
2. Micropapillary urothelial carcinoma of the urinary bladder by *Professor Hemamali Samaratunga*
3. Poorly differentiated renal cell carcinoma by *Professor Isha Prematilleke*
4. Bilateral Krukenberg tumours by *Professor Bimalka Seneviratne*
5. Extrauterine adenosarcoma *Dr Gayani Ranaweera*

ABSTRACTS OF THE ACADEMIC PROGRAMME

DAY 3 (25.10.2025)

SYMPOSIUM 1:
Dr Doris Peiris and Professor Daphne Attygalle
Memorial Symposium on Approaches to Diagnosis

Dr Doris Peiris

Dr Doris Christobelle Peiris (1920–2012) was a pioneering pathologist whose career spanned over five decades of service to Sri Lanka. Born in Lunawa, Moratuwa in February 1920, she received her early education at Bishop's College, Colombo, before entering the Colombo Medical Faculty in the late 1930s. Excelling in pathology under the guidance of Professor W. A. E. Karunaratne, she dedicated herself to the discipline immediately after graduation. She practiced across all four branches of pathology, with particular interest in histopathology and haematology.

Following service in several hospitals and the Medical Research Institute, Dr Peiris proceeded to the United Kingdom for postgraduate training. She was among a select group of sixteen students admitted to the prestigious Royal Postgraduate Medical School of the University of London, where she successfully completed the Diploma in Pathology and later obtained the MRCP. On returning to Sri Lanka, she served at the General Hospitals in Galle and Kandy, spending eight years in Kandy before her appointment in 1964 as Consultant Pathologist at the General Hospital, Colombo. She continued in this role until her retirement from government service in 1980. Thereafter, she contributed her expertise to the Sri Jayawardenepura Hospital until 1992, finally retiring at the age of 72. She lived a long and fulfilling life, passing away at the age of 92 in 2012.

Dr Peiris was a founder member of the College of Pathologists of Sri Lanka and served as its President from 1979 to 1983. In recognition of her invaluable contributions, the College established the *Dr Doris Peiris Memorial Gold Medal for Histopathology* in 2013, awarded to the most outstanding postgraduate trainee at the MD Histopathology examination. The medal continues to honour her legacy, inspiring excellence among future generations of histopathologists.

Professor Daphne Attygalle

Professor Daphne Attygalle (née Kanagaratne, 1922–1989) was a distinguished pathologist who played a pioneering role in medical academia. Educated at St. Bridget's Convent, Colombo, she remained closely connected to her alma mater, later serving as President of the Past Pupils' Association from 1975 to 1977. After completing her medical studies, she pursued postgraduate training in England and was elected a Fellow of the Royal College of Physicians.

In 1970, she was appointed Professor of Pathology at the Faculty of Medicine, University of Colombo, where she went on to leave a lasting legacy. She was elevated to Emeritus Professor in 1987, reflecting her decades of service to the institution. From 1982 to 1986 she served as Dean of the Faculty of Medicine, becoming the first woman to hold such a position at a Sri Lankan university. Though she declined an offer to serve as Vice-Chancellor, she later assumed duties as Acting Vice-Chancellor of the University of Colombo, a role she held until her passing in 1989.

Professor Daphne Attygalle was deeply involved in postgraduate medical education and was the first Chair of the Board of Study in Pathology at the Postgraduate Institute of Medicine, later re-elected after her initial term. She also served as an external examiner for the Faculty of Dentistry at the University

of Malaya. Her academic leadership extended beyond teaching and administration, as she was one of the fifty-three founding fellows of the National Academy of Sciences of Sri Lanka. In recognition of her service, she was awarded the national honour *Deshabandu* in 1986.
She was married to Dr Don Jinadasa Attygalle, Senior Physician of the National Hospital of Sri Lanka. To honour her legacy, the Sri Lanka Medical Association, annually awards the Professor Daphne Attygalle Medal for best research paper in cancer. Her career remains an enduring inspiration for future generations of pathologists and medical educators.

Approach to the diagnosis of small undifferentiated sarcomas

Dr Malee Fernando
Consultant Histopathologist, Sheffield Laboratory Medicine, Sheffield Teaching Hospitals NHS Foundation Trust,
United Kingdom

Mesenchymal tumours are one of the more challenging areas of diagnostic pathology and refinement of classification schemes plays a key role in improving the quality of data collection, trial findings and therapeutic options. The recent WHO classification of Soft Tissue Tumours and Bone has made a major step toward improved standardization of diagnosis. The refinement in diagnosis is specially evidenced in the group termed 'Small round cell sarcomas (SRCSs)' – a clinically aggressive, heterogenous group of entities that are particularly diagnostically challenging because of the clinical and radiological overlap and shared histomorphologic and sometimes immunophenotypic similarities but warranting different clinical management due to the diverse prognostic outcomes. The need to use immunopanels and molecular analysis, including methylation array testing, on ever shrinking tissue samples to differentiate between these entities adds to the diagnostic complexity. Whilst imprecise, the term SRCS provides a useful framework for conceptualizing this group that includes new entities defined by specific genetic abnormalities. I will focus on *CIC*-rearranged sarcoma, *BCOR*-altered sarcomas, and *EWSR1*:non-ETS sarcomas to include recent developments in desmoplastic small round cell tumour as well as sarcomas with *EWSR1/FUS*: *NFATc2* and *EWSR1:PATZ1* gene fusions, and highlight the clinical, morphologic, and immunophenotypic clues to the diagnosis with recognition of each molecular diagnostic hallmark. While each of these entities is less common than Ewing sarcoma, it is important to distinguish between them (and a few mimics) to enable correct diagnosis, prognostication, and potential therapeutic options. We pathologists play the key role in integrating morphologic, immunohistochemical and molecular characteristics to recognise these entities.

Approach to sarcomas with epithelioid morphology

Professor Bharat Rekhi
Professor and Pathologist, Department of Pathology, Tata Memorial Hospital, Parel, Mumbai, India

Cytomorphologically, mesenchymal tumours are characterised by a predominant cell pattern, namely round, epithelioid, spindle, pleomorphic, and vacuolated. Epithelioid cells are composed of moderate to abundant cytoplasm. An exaggerated version of epithelioid cells is "rhabdoid" morphology, composed of cells with an abundant cytoplasm, including intracytoplasmic inclusion pushing the nucleus to one side, the latter invariably showing pleomorphism, with or without intranuclear inclusions. It is important to note that "rhabdoid" morphology is not equational to a rhabdomyoblastic differentiation, the latter characterised by skeletal muscle differentiation with immunostains, such as desmin, myogenin and MyoD1. A "rhabdoid" cytomorphology can be seen in carcinomas, sarcomas, including proximal-type epithelioid sarcomas, melanomas and also in certain lymphomas. The pre-requisites for dealing with mesenchymal tumours, especially sarcomas with an epithelioid morphology include the clinical context, presentation, history and imaging. The morphological clues are tumour cell patterns, cytoplasmic and nuclear features, stromal changes; support of immunohistochemical

(IHC) stains; serum tumor marker levels, in suspected cases of germ cell tumours and carcinomas, and molecular testing to some extent.
It is noteworthy that, carcinomas occur more often is older patients, germ cell tumor in younger patients (mediastinum), and sarcomas across all age (mostly young adults). In terms of site, mucosa-based lesions have more chances to be carcinomas, while soft tissue-based lesions have more chances to be sarcoma. Primarily soft tissue masses have more chances to be sarcomas, while in cutaneous malignancies, carcinomas and adnexal tumours, including malignant types are relatively more frequent than sarcomas, except epithelioid sarcoma. The epidermis is more often involved in melanoma, while soft tissues are more often involved in an epithelioid MPNST and a melanoma of soft tissues. In cases of multiple bones and lymph node involvement, especially in paediatric patients, a haematolymphoid tumour, including anaplastic large cell lymphoma, showing epithelioid cytomorphology and differentiation is worth considering.
This presentation will include four classic examples of malignant tumours, including sarcomas with an epithelioid morphology; their differential diagnosis, in the form of a "case-based" approach with personal experiences.

Diagnosis of gastrointestinal biopsies: a systematic approach

Professor Dulani Beneragama
Associate Professor and Consultant Histopathologist, Faculty of Medical Sciences, University of Sri Jayewardenepura,
Sri Lanka

Gastrointestinal (GI) biopsies are among the most frequently encountered specimens in diagnostic pathology and play a pivotal role in patient management. Despite their importance, interpretation can be challenging due to small sample size, variable orientation, and overlapping histological features across different disease entities. A structured, systematic approach is therefore essential to achieve accuracy and consistency. A practical framework for evaluating GI biopsies begins with assessment of specimen adequacy and orientation, followed by careful correlation with clinical history and endoscopic findings. Histological analysis should be guided by recognition of reproducible patterns, such as inflammatory, infectious, and neoplastic processes that serve as entry points to differential diagnosis. Particular attention should be given to site-specific considerations, for example in oesophageal, gastric, small intestinal, and colonic biopsies. The use of ancillary techniques will be helpful in the context of their diagnostic yield.
Awareness on common pitfalls, such as misinterpretation of therapy-related changes or mimics of dysplasia is important to avoid diagnostic errors. By applying a systematic, pattern-based approach and integrating clinical information with morphologic findings, pathologists can enhance diagnostic precision and reproducibility. This method not only streamlines daily reporting but also fosters effective clinicopathological correlation, ultimately improving patient outcomes.

SYMPOSIUM 2
Professor RG Panabokke and Dr MA Nanda Prematilleke Memorial Symposium on Pitfalls/Mimics in Diagnostic Pathology

Professor Ralph Gemunu Panabokke

Professor Ralph Gemunu Panabokke, born in 1927, was one of the most eminent figures in Sri Lankan pathology, distinguished for his academic achievements, leadership in postgraduate medical training, and long-standing service to the College of Pathologists of Sri Lanka (CPSL). Born into a Kandyan family from Gampola, he was educated at Trinity College, Kandy, where he excelled in both studies and the arts, achieving first divisions in all public examinations and showing equal talent in drawing and painting.

He pursued medicine at the Faculty of Medicine, University of Colombo, and received training under two of Sri Lanka's foremost pathologists, Professors W.A.E. Karunaratne and G.H. Cooray. He later continued postgraduate studies in London under Professors Sir Roy Cameron and Everson Pearse, earning a PhD in experimental pathology, followed by the MD (Ceylon) and Fellowship of the Royal College of Pathologists.

Professor Panabokke was a founder member of CPSL, serving as council member from 1975 to 1983, Vice President in 1983–1984, and later President. His leadership helped shape the College during its formative years, strengthening postgraduate training and professional development.

He began his academic career at the University of Ceylon before moving to the newly established Faculty of Medicine, Peradeniya, where he rose through the ranks to Professor of Pathology. There he introduced modern technologies to the laboratory and trained a cadre of dedicated technologists. Alongside Professor George Tennekoon, he established biopsy pathology services that extended beyond Kandy and Peradeniya to hospitals in Anuradhapura, Kegalle, Nuwara Eliya, Matale, and other regions, significantly improving diagnostic services across the country.

At the Postgraduate Institute of Medicine (PGIM), he first represented the Faculty of Medicine and later chaired the Board of Study in Pathology. In 1989, he was appointed Director of PGIM, a post he held until 1996. During this period, he streamlined training programmes, expanded regional training centres, enhanced library facilities, and introduced workshops and seminars across specialties. His administrative leadership instilled discipline, professionalism, and meticulous record-keeping in the institute, leaving a strong foundation for its future growth.

Professor Panabokke was a prolific researcher in experimental pathology and published widely, earning recognition through many awards and scholarships. He was conferred Honorary Doctor of Science degrees by the Universities of Ruhuna and Peradeniya and also served as Visiting Associate Professor at the National University of Singapore. His administrative career was unparalleled, holding every major leadership position at the University of Peradeniya — Head of Department, Dean, Vice-Chancellor, Chairman of the Council, and finally Chancellor.

Renowned as a teacher and mentor, Professor Panabokke inspired generations of students and postgraduate trainees with his passion for science and his encouragement of research. His life's work, marked by academic excellence, administrative vision, and devotion to CPSL, continues to influence the field of pathology and medical education in Sri Lanka.

Dr M A Nanda Prematilleke

Dr Mapatunage Nanda Prematilleke, born on 21 January 1927 in Padukka, was a pioneering haematologist who played a central role in shaping laboratory medicine and postgraduate training in Sri Lanka. The eldest of seven siblings, she entered the Colombo Medical Faculty and graduated MBBS in 1954, completing her internship at the Lady Ridgeway Hospital, Colombo. Her early hospital service included posts in Colombo, Kandy, and Kurunegala, but it was during her appointment as Senior House Officer in Pathology at Kandy Hospital in 1960 that her love for pathology — and haematology in particular — took root.

At a time when structured postgraduate training was not available locally, she pursued further studies in the United Kingdom. By 1971 she had completed the DCP (London), the Diploma in Pathology, and the MRCPath in Haematology, and in 1983 was conferred the Fellowship of the Royal College of Pathologists. On her return, she served in Kurunegala and later at Kandy, where she became the first haematologist to be posted to the General Hospital. There she established the country's first dedicated haematology unit, comprising a laboratory, clinic, and ward, and single-handedly performed and reported hundreds of bone marrow biopsies each year. Her clinics in general haematology and anticoagulation served large patient populations, and her work is remembered by many as lifesaving.

Dr Prematilleke was equally committed to teaching. From 1964 she taught haematology to undergraduates of the Faculty of Medicine, Peradeniya, and later examined in clinical haematology for the final MBBS. She drafted the first MD Haematology curriculum for the Postgraduate Institute of Medicine, Colombo, paving the way for structured training in Sri Lanka. As the first postgraduate trainer in haematology in Kandy, she supervised numerous trainees who went on to become leaders in the field, many of whom continue to acknowledge her as their inspiration.

A prolific researcher, she published more than 30 articles, including pioneering work on haemoglobin ranges in Sri Lankans and hereditary haemolytic diseases. She also authored books and translated key medical texts into Sinhala. Even in retirement, she remained active, establishing the haematology laboratory at Asiri Hospital, Colombo, with her characteristic insistence on quality.

Her crowning achievement was serving as the Founder President of the Sri Lanka College of Haematologists from 1997 to 1999, establishing a lasting professional home for the specialty. Dr Nanda Prematilleke's determination, resilience, and scholarship left an indelible mark on haematology in Sri Lanka.

Non-neoplastic lymph node lesions: pitfalls and mimics

Professor Yasodha Natkunam
Professor in Haematopathology, Department of Pathology, Stanford University School of Medicine, Stanford, California, USA

Non-neoplastic lymph node lesions represent a broad spectrum of lymphoproliferations that are considered in the differential diagnosis of various lymphomas due to overlapping clinicopathologic features but do not represent malignant lymphomas. Awareness of these entities is important to avoid pitfalls, exclude mimics, and establish accurate diagnoses for appropriate patient management. These considerations have led to the inclusion of non- neoplastic lymphoid lesions that mimic lymphomas in the 5th edition of the World Health Organization classification of hematolymphoid tumors. Non-neoplastic proliferations that mimic lymphomas include those that expand or distort normal lymph node architecture by altering one or more of follicular, interfollicular, paracortical and sinus compartments of the lymph node. They can exhibit proliferations of atypical cells and be associated with inflammation, necrosis, or sclerosis. The aetiopathogenetic factors leading to these proliferations are broad and include infection, inflammation, and immune and/or genetic dysregulation that alter normal homeostasis. Select examples of B-cell and plasma cell-rich entities such as IgG4- related disease, Castleman disease and immunoblastic proliferations will be presented. Non- neoplastic T-cell and NK-cell proliferations include exuberant proliferations of T-follicular helper cells, cytotoxic T-cells and indolent TdT proliferations that can mimic highly aggressive T-cell and NK-cell lymphomas and select examples of these entities will also be covered. A systematic and multidisciplinary approach is essential to ensure the integration of clinical, pathologic, radiologic and genetic data and together help guide the final diagnosis.

Prostate and bladder pathology: diagnostic pitfalls

Professor Isha Prematilleke
Professor and Consultant Histopathologist, Faculty of Medical Sciences, University of Sri Jayewardenepura, Sri Lanka

Accurate histopathological interpretation of prostate and bladder specimens is essential to ensure appropriate patient management, yet both organs present a wide range of diagnostic challenges. In the prostate, benign mimics such as atrophy, adenosis, basal cell hyperplasia, and therapy-related changes can be misinterpreted as malignancy. Small atypical acinar proliferations (ASAP) and prominent nucleoli may further complicate assessment, while errors in Gleason grading carry significant prognostic implications. Immunohistochemistry and molecular markers can assist but must be interpreted cautiously in context.
In the bladder, differentiating reactive atypia from low-grade papillary urothelial carcinoma, and recognizing therapy-related changes, remain common pitfalls. Undergrading of high-grade carcinoma and understaging due to inadequate muscle sampling are frequent errors with direct therapeutic consequences. Histological variants can mimic benign or less aggressive lesions, leading to misdiagnosis if unrecognized. The role of immunohistochemistry and molecular markers in diagnosis and in guiding therapy (e.g. HER2 in advanced bladder cancer) will be outlined.
Across both organs, diagnostic accuracy depends on adequate sampling, meticulous morphological evaluation, and interpretation of clinical and radiological findings. Awareness of common pitfalls, judicious use of ancillary techniques, and multidisciplinary discussion are critical safeguards. This presentation will highlight illustrative cases and practical strategies to avoid errors.

Pitfalls and mimics in diagnostic liver pathology

Dr Michail Doukas
Consultant Histopathologist, Department of Pathology and Clinical Bioinformatics, Erasmus MC, Rotterdam, Netherlands

In diagnostic liver pathology, various pitfalls and caveats of histomorphologic evaluation are relatively frequently encountered, as many diseases share overlapping histological features or equivocal ancillary staining. Awareness of common mimics prevents misinterpretation and guides accurate diagnosis, both in the evaluation of biopsies and surgical specimens. For example, well-differentiated hepatocellular lesions may mimic both non-neoplastic entities and well-differentiated hepatocellular carcinoma. Mass-forming FNH may be confused with malignant neoplasms on limited biopsy samples. Conversely, bland-appearing hepatocellular adenomas may harbour malignant potential or a high risk of bleeding and be underestimated. Technical artifacts also contribute to pitfalls, such as crush artifacts, poor fixation, or fragmented biopsies that may mimic cellular atypia or fibrosis. Sampling error is also a major concern, particularly in heterogeneous diseases. Immunohistochemistry and special stains provide valuable adjuncts but must be interpreted cautiously, as markers like glypican-3 can be focally positive in benign conditions, or glutamine synthetase can show a patchy pattern (and not the classic map-like pattern) in steatotic FNHs. Moreover, portal tracts that contain significant inflammation can cause overinterpretation of the trichrome stain. Effective avoidance of pitfalls requires a systematic approach. First of all, specimen adequacy must be ensured with interpretation of the findings in a broader context, followed by the integration of clinical data and radiological features for a confident diagnosis.
Regular multidisciplinary discussion and awareness of diagnostic traps are essential to maintain accuracy and avoid over- or underdiagnosis in liver pathology.

WORKSHOP 5
Dr S D Atukorala Memorial Workshop on Dermatopathology

Dr Srilal Dharmadasa Atukorala

Dr Srilal Dharmadasa Atukorala, born in 1945, was a distinguished microbiologist and clinical bacteriologist who played a pivotal role in the early activities of the College of Pathologists of Sri Lanka (CPSL). As a founder member, he contributed actively to the College's growth and academic mission, strengthening postgraduate training and advancing the role of laboratory medicine in the country. He also served as a council member of the Sri Lanka Medical Association and the College of Microbiologists, linking the College's work with wider professional networks.

Educated at Royal College, Colombo, he excelled in both studies and sports, winning school colours in athletics, cricket, and rowing, and later representing the University of Colombo in cricket and rowing. He graduated MBBS in 1972 and completed his internship at the General Hospital, Colombo, and Castle Street Hospital before joining the Anti-Venereal Disease Campaign. Awarded a WHO fellowship, he trained in the United Kingdom, obtaining a Diploma in Microbiology and Membership of the Royal College of Pathologists (UK). On returning to Sri Lanka, he was appointed Clinical Bacteriologist at the National Hospital, a position he held until retirement in 2005, and from 1992 also served as Head of the Department of Pathology. After retirement, he continued as National Adviser to the Ministry of Health on Laboratory Medicine, where he compiled and published the *National Laboratory Manual*.

Dr Atukorala was a dedicated trainer and examiner who supervised pathology and microbiology trainees, served as Secretary to the Boards of Study in Pathology and Microbiology at the Postgraduate Institute of Medicine, and examined widely for postgraduate and undergraduate programmes. Internationally, he served as a WHO adviser on hospital infection control and SARS in South Asia, presented at conferences, and published over thirty scientific papers in peer-reviewed journals. His career, marked by professional excellence, service to CPSL, and commitment to teaching and research, left an enduring legacy for pathology and laboratory medicine in Sri Lanka.

List of cases

1. Atypical fibroxanthoma by *Dr Anna Saparamadu*
2. Inflammatory dermatoses by *Dr Palitha Rathnayake*
3. Approach to cutaneous lymphoid infiltrate by *Dr Avanthi Rajapakse*
4. Diagnostic approach to Sebaceous neoplasms by *Dr Prabodha Samararathne*

WORKSHOP 6
Dr Saroja Siriwardene Honorary Workshop on Renal Pathology

Dr Saroja Chandramukee Siriwardene

Dr Saroja Chandramukee Siriwardene, MBBS, DPath, MD (Chemical Pathology), is a pioneering figure in postgraduate pathology training and a trailblazer in the development of chemical pathology in Sri Lanka. She became the first to qualify in the specialty from the Postgraduate Institute of Medicine (PGIM) in 1991, marking a milestone in the recognition and establishment of this discipline.

As Consultant Chemical Pathologist at the National Hospital of Sri Lanka, Dr Siriwardene transformed laboratory services by introducing innovative and cost-effective practices that were soon adopted as models by other institutions. Her leadership and vision ensured that chemical pathology became an integral component of diagnostic medicine in the country.

Her contributions to postgraduate education have been equally significant. Joining the Board of Study in Pathology in 1995, she pioneered training in chemical pathology, supervising over 250 candidates for the Diploma in Pathology and more than 40 for the MD, ultimately building a cadre of 13 consultant chemical pathologists. She also contributed extensively to multiple postgraduate courses and to

undergraduate teaching across several universities, establishing a strong academic base for the specialty. Within the College of Pathologists of Sri Lanka (CPSL), Dr Siriwardene played a central role in advancing its mission. Serving as President in 2002, she guided the College during a period of expansion in training and academic activities. She remained an active council member and was a strong advocate for enhancing diagnostic services, postgraduate training, and academic standards.

Dr Siriwardene's influence on postgraduate pathology in Sri Lanka is both profound and enduring. Through her leadership at PGIM and CPSL, she shaped policies, supervised examinations, published scholarly contributions, and helped institutionalize high standards of specialist training. Her legacy is reflected in the strengthened College of Pathologists and the many pathologists she trained, who continue to uphold excellence in modern diagnostic practice.

The list of cases

1. Crescentic glomerulonephrtis and RPGN by *Dr Harshima Wijesinghe*
2. Vascular diseases of the kidney by *Dr Sonali Rodrigo*
3. Secondary glomerular diseases associated with nephrotic syndrome by *Professor Sulochana Wijetunge*
4. Glomerulonephritis in the transplanted kidney by *Dr Sonali Rodrigo*

WORKSHOP 7
Professor G H Cooray Memorial Workshop on Liver Pathology

Professor Gerald Henry Cooray

Professor Gerald Henry Cooray was one of the most distinguished medical figures of his generation, remembered for his pioneering contributions to pathology and his influence on medical education in Sri Lanka. Born in Panadura, he was the son of Henry Cooray, a government medical officer, and Pusethi Sudhira Jayawickrema. After excelling in his studies at Royal College, Colombo, he proceeded to King's College Hospital, London, qualifying with the Conjoint in 1932 and completing his MBBS the following year. On his return to Ceylon, he began his career in the Department of Health before joining the University of Ceylon as Lecturer in Pathology in 1946. In 1949 he obtained the MD (London) by thesis, winning the coveted Gold Medal in Pathology — the first and only Ceylonese to achieve this honour. He was appointed Professor of Pathology in 1953, awarded the MRCP in 1960, elected FRCP in 1966, and conferred the OBE in 1956.

Professor Cooray's career combined academic excellence with national and international leadership. He held the highest offices in several professional bodies, serving as President of the Ceylon Medical Association, President of the Ceylon Association for the Advancement of Science, and President of the Ceylon Cancer Society. His work extended beyond Sri Lanka, as he contributed to international committees and served on WHO Expert Advisory Panels on Cancer Diagnosis and Control. A prolific researcher, he published widely on diverse medical topics, with a special focus on oncology, and continued research until the final stages of his life. He was renowned as a teacher *par excellence*. His lectures were celebrated for their clarity and depth, inspiring both undergraduates and junior staff. Colleagues and students remembered him as a man of integrity — serious, truthful, honourable, and deeply religious.

Professor Cooray passed away at the age of 62, leaving behind words that reflected the strength of his character: "I have lived a good and useful life and do not intend ending it on a machine." His legacy endures not only in the development of the Colombo Medical School and the advancement of cancer pathology in Sri Lanka, but also in the professional standards and teaching traditions that continue to inspire the College of Pathologists of Sri Lanka.

List of cases

1. Liver biopsy (T25-15174): A 69-year-old man diagnosed with colorectal carcinoma in 2017 presented with distorted liver functions and quick progressive ascites. Clinical query: cirrhosis? Lymphoma? Malignancy? by *Dr Michail Doukas*
2. Liver biopsy (T24-18298): Liver biopsy of a 50-year-old man with a clinical history of Crohn's disease, presenting with heterogeneous areas in the liver on imaging (CT and MRI), as these abnormalities could not be further classified, a biopsy was performed from segment 7 by *Dr Michail Doukas*
3. Liver biopsy of a 38mm focal liver lesion? fat replete HCC by *Dr Nishani Jayatung*e
4. Liver biopsy Spindle cell lesion in a liver biopsy by *Dr Nishani Jayatunge*
5. Liver biopsy of a 12-year-old boy presented with decompensated cirrhosis or Liver biopsy of 7-year-old boy presented with pancytopenia, hepatosplenomegaly and increased transaminase by *Dr Mangala Bopagoda*

WORKSHOP 8
Professor WAE Karunaratne Memorial Workshop on Soft Tissue and Bone Pathology

Professor William Arthur Edward Karunaratne

Professor William Arthur Edward Karunaratne, born in 1887 in Negombo, was one of the most distinguished figures in Sri Lankan medicine and the first Professor of Pathology of the Ceylon Medical College. He was the son of Minneripitige Don Miguel Karunaratne, a public notary, and Leanage Dona Maria. Educated at St. Joseph's College, Colombo, he excelled both in academics and sport, representing the school in cricket. He went on to study medicine at University College, London, where he won the Bucknill Scholarship, the Filitter Exhibition, and numerous prizes, establishing himself as one of the most brilliant students of his time.

He graduated MBBS in 1917, obtained the MD in Medicine in 1921, and later the MD in Pathology by thesis. After returning to Ceylon, he served as Pathologist at the General Hospital, Colombo, and later as Lecturer in Pathology. In 1936, he was appointed the first Professor of Pathology at the Ceylon Medical College. His career advanced rapidly, and in 1942 he was unanimously elected Dean of the Faculty of Medicine, University of Ceylon. International recognition followed, with the University of London awarding him a DSc for his monograph on rhinosporidiosis, still considered a seminal work. He also received an honorary DSc from the University of Ceylon.

Professor Karunaratne's contributions to science and medicine were recognized with some of the highest honours: the OBE in 1948, the CMG in 1952, and the Papal Knighthood of St. Gregory in 1947. He was awarded MRCP in 1950 and FRCP in 1955. His research interests spanned liver disease and infectious pathology, but it was rhinosporidiosis that earned him global recognition. Beyond academia, he held leadership roles as President of the Ceylon Medical Association and General President of the Ceylon Association for the Advancement of Science. Known for his gentle manner, humility, and kindness, he was deeply respected by colleagues and beloved by students.

Professor Karunaratne passed away on 14 October 1966. His pioneering contributions to pathology, his leadership in medical education, and his personal warmth made him a legend in Sri Lankan medicine, remembered with the words: *"To have known him was to have loved him."*

List of cases

1. When cytokeratin expression is no longer a carcinoma Two cases by *Dr Malee Fernando*
2. Another differential for multiple bone and soft tissue lesions by *Professor Bharat Rekhi*
3. Rapidly enlarging calf mass in a newborn By *Dr Samalai Kanagasabapathy*
4. A phantom limb by *Prof Gayana Mahendra*

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**RP 02, RP 03, RP 19, RP 32, RP 37, RP 42, RP 43 have been withdrawn by the authors.*

RP 1

Distinguishing the tall cell from other subtypes of papillary thyroid carcinoma on fine needle aspiration: a morphometric and cytological study

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Introduction and objective: Tall cell subtype of papillary thyroid carcinoma (T-PTC) is defined by the presence of tumour cells with a height: breadth ratio of >3. We aimed to determine if the cytomorphological features are sufficiently characteristic to enable its distinction from classic and other aggressive subtypes of PTC on fine needle aspiration cytology (FNAC).
Methodology: The cytological features of 20 cases of histologically proven T-PTC were compared with 20 cases of classic PTC (C-PTC). Three cases of columnar PTC (CC-PTC) and hobnail PTC (H-PTC) were also included. The presence of tall cells (height: breadth ratio>3) was confirmed by morphometry. Thirty-seven parameters were analysed using a semi-quantitative scoring system, including background, architecture, cellular, and nuclear features. Fisher's probability test and Chi-square test were used in the statistical analysis.
Results: Isolated tumour cells, spindle cells, tall cells, and tail-like cells were seen in a significantly higher number of cases of T-PTC than C-PTC ($p < 0.05$). The sensitivity, specificity, positive predictive value and negative predictive value of these features in identifying T-PTC ranged from 90-100% and approached 100% when all four features were present in a given case.
Discussion: The cytomorphological characteristics of T-PTC, H-PTC, and CC-PTC are distinctly different. Key features distinguishing T-PTC from C-PTC include tall cells, spindle-shaped cells, and tail-like cells with irregular nuclear contours. CC-PTC is characterized by columnar cells with elongated, pseudostratified nuclei. H-PTC is defined by clusters of cells with knobby contours and large, round cells exhibiting abundant cytoplasm.
Conclusions: These distinctive cytomorphological attributes can aid cytopathologists in differentiating these aggressive PTC subtypes from the classic subtype during preoperative FNAC.
Keywords: papillary carcinoma thyroid, tall cell, FNAC, cytomorphology, morphometry

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RP 4

Incidence and temporal trends of lymphoma in Sri Lanka, 2005–2021: an analysis of National Cancer Registry data

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Introduction and objectives: Globally, the incidence of lymphoma has been increasing, with regional and gender-specific variations. Understanding these patterns in a developing country like Sri Lanka is critical to guide cancer prevention and control strategies. This study aims to describe the incidence and temporal trends of lymphoma in Sri Lanka from 2005 to 2021.
Methodology: A retrospective analysis was conducted using population-based cancer incidence and mortality data from the National Cancer Control Programme (NCCP) registries. Age-standardized rates (ASR) were calculated, and temporal trends were assessed using join point regression to estimate annual percent change (APC) and average annual percent change (AAPC).
Results: A total of 15,577 lymphoma cases were reported, with a male predominance (60%: 9,346 males; 6,231 females). The overall incidence increased significantly over 16 years (AAPC: 4.1%; $p<0.05$), with a 1.4-fold rise in both sexes and a marked rise among 0–19-year-olds, exclusively post-2019 (females: 2.5-fold, males: 4.5-fold; $p<0.05$). Non-Hodgkin lymphoma (NHL) accounted for 79% and showed the most significant and consistent increase (AAPC: 3.2%; $p<0.05$), with a two-fold rise in both genders. Hodgkin lymphoma (HL) comprised 21%, with a three-fold rise in females but an overall non-significant trend. NHL mortality rose significantly in males ($p<0.05$), while female mortality remained stable.
Discussion: The increasing lymphoma burden, particularly among males and older adults, may reflect both genuine rises in disease and improvements in diagnostics and reporting.
Conclusion: Lymphoma incidence in Sri Lanka is rising, underscoring the need for strengthened surveillance, early detection, and tailored cancer control strategies.
Keywords: incidence, lymphoma, mortality, Sri Lanka

RP 5

Complete audit cycle on completeness of documentation and concordance of diagnosis of frozen sections

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Introduction: Frozen section (FS) is a vital diagnostic procedure for immediate clinical decision making. Accuracy of diagnosis and proper documentation are essential for ensuring continuity of care, quality assurance and medicolegal purposes.
Objective: To evaluate the completeness of documentation and concordance of diagnosis of FS in a tertiary care centre.
Methodology: Completeness of FS reporting was assessed using five parameters. Pathology reports of FS performed during January to September 2024 were audited. Types of FS included in the audit and re-audit were sentinel lymph nodes, resection margins, brain smears, and ganglion assessment in bowel. Components of a complete FS report including the patient identification number (PIN), imaging findings, specimen receipt time (RT), time of informing diagnosis (informed time - IT) and diagnostic concordance between the FS and final histological diagnosis were documented. Re-audit was performed from October 2024 to May 2025, after introducing a rubber stamp on the request form containing all the components to be filled by a doctor.
Results: A total of fifty-seven FS were evaluated in the first audit cycle. All request forms contained PIN (100%). The rates of documenting imaging findings, RT, IT, concordance, were 80% (46/57), 14% (8/57), 36% (21/57) and (96% (55/57) respectively. PIN, RT, and IT were present in all forty-six reports (100%) included in the re-audit. Imaging findings and concordance were documented in forty-one (89%) and forty-five (97%) respectively.
Conclusion: Documentation of FS details improved significantly after introducing a rubber stamp. However, 100% concordance could not be achieved due to the requirement of immunohistochemistry in some cases. Documentation of imaging findings was the least improved component owing to lack of information provided from wards/theatres. Proper advising of clinical staff will minimise information gaps in the future.
Keywords: documentation, frozen sections

RP 6

Audit on completeness of reporting core data items of thyroid malignancies

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Introduction and objective: The Royal College of Pathologists (RCPath) provides a core dataset for histopathological reporting of thyroid malignancies to ensure diagnostic accuracy and consistency. This audit evaluated the completeness of thyroid cancer histology reports at National Hospital Kandy, focusing on adherence to RCPath's core data elements.
Methodology: Eighty-nine thyroid cancer reports, issued from January 1 to December 31, 2024, were included in the audit. Each report was evaluated against RCPath core dataset criteria, including operative procedure, intraoperative findings, specimen submitted, tumour site, histologic type, tumour size, focality, histological grade, tumour circumscription, capsular invasion, extrathyroidal extension, lymphovascular invasion, margin status, lymph node status, mitotic activity, necrosis, coexisting pathology, and parathyroid status. Reports with confirmed distant metastasis were excluded. Completeness of reporting core data items was analysed.
Results: Specimen details, operative procedure, specimen submitted, tumour site, focality, tumour size, histologic type, capsular invasion, margin status, and lymph node status were documented in all reports. Tumor circumscription (98.87%), coexisting pathology (97.75%), lymphovascular invasion (95.50%), and extrathyroidal extension (89.88%) were well-reported. Presence of mitotic activity and necrosis was mentioned in 79.97% of reports. However, histological grade and parathyroid status were missing in 88.70% and 42.69% of reports, respectively. Intraoperative findings were inconsistently documented. Only 42.69% of reports included all required core elements.
Discussion: While most RCPath elements were documented, significant gaps in reporting of histological grade and parathyroid status suggest a need for standardized reporting and improved availability of clinical data.
Conclusion: Although compliance was high, report completeness remains suboptimal. Structured templates and targeted training are recommended to improve adherence to guidelines and report quality.
Keywords: thyroid malignancies, core data, audit

RP 7

A descriptive cross-sectional study on clinicopathological features of osteosarcoma diagnosed at a tertiary care centre

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Introduction and objective: Osteosarcoma (OS) is the commonest primary malignant bone tumour worldwide.
Method: Clinicopathological features of all OS cases diagnosed at Departments of Histopathology, Faculty of Medicine, Colombo, National Hospital of Sri Lanka and Lady Ridgeway Hospital from January 2021- December 2023 were reviewed.
Results: Sixty-five cases were included (34 biopsies; 21 post-neoadjuvant chemotherapy (PNAC) enbloc excisions; 10 PNAC amputations). Male: female ratio was 1.5:1. 72.3% (47/65) patients were between 10-19 years (mean age-17.32). Majority (97%,63/65) affected long bones (femur-32/65, tibia-23/65, humerus-5/65; fibula-2/65; radius-1/65). Meta-diaphysis was commonly affected (47/63;74.6%) followed by metaphysis (14/63;22.2%) and meta-epiphysis (2/63; 3.1%). Clinical presentations included lump/swelling (51/65;78.4%) and pain (14/65;21.5%). The majority were identified as OS on radiology (94%,61/65) and others as Ewing sarcoma (1/65), giant cell tumour (1/65) and malignant without a definite diagnosis (2/65). All 65 cases were conventional OS comprising osteoblastic (33/63;), chondroblastic (27/63), fibroblastic (1/63), telangiectatic OS(2/63), chondromyxoid fibroma-like (1/63) and chondroblastoma-like (1/63) patterns. Malignant osteoid (MO) was mostly lace-like (60/65;92.3%), followed by trabecular (26/65;30.7%), filigree (18/65;27.6%), nodular (17/65;26.1%), and broad sheet-like (3/65;4.6%). MO was extensive in 53 (53/65;81.5%) and focal in 12 (12/65;18.4%). Predominant cell types were spindled (43/65;66.1%) and epithelioid (22/65;33.8%) followed by small (3/65;4.6%), plasmacytoid (3/65;4.6%) and giant cells (GC) (9/65;13.8%). Additional features included tumour scaffolding (27/65;41.5%), normalization of atypia (15/65;23%), haemangiopericytomatous vessels (8/65;12.3%) and non-neoplastic GC (14/65;21.5%). Tumour necrosis following NAC ranged from 7-100% (mean 44%). Huvos grading was I (1/31), II (9/31), III (11/31) and IV (10/31%).
Discussion and conclusion: The clinical characteristics are similar to international data. Uncommon morphological features observed were haemangiopericytomatous vessels, broad sheet-like malignant osteoid and non-neoplastic giant cells. Nearly 1/3 of cases showed >90% response to neo-adjuvant chemotherapy.
Keywords: osteosarcoma

RP 8

Uncommon histological features of giant cell tumours of bone which may lead to misdiagnosis: a review of clinicopathological features of 59 cases

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Introduction and objectives: Giant cell tumour of bone (GCTB) is a locally aggressive, rarely metastasizing neoplasm. This study highlights the clinicopathological features of GCTB, with emphasis on uncommon histological features.
Methodology: All GCTB cases diagnosed at Departments of Histopathology, Faculty of Medicine, Colombo and National Hospital of Sri Lanka from January 2021- December 2023 were reviewed.
Result: The 59 cases included seven biopsies, 33 curettings and 19 en-bloc excisions (one post-denosunab excision). Male: female ratio was 1.2:1. The 20-39 age group was most commonly affected (29/59; 49.1%; mean age - 36.2). 76.2% (45/59) involved long bones (femur-21/59, tibia-12/59, radius-7/59, humerus-5/59). Meta-epiphysis (32/45;71.1%) was most commonly affected. 55(93.2%) cases were called GCT on imaging. Four (6.7%) were called aneurysmal bone cysts. The denosumab-treated case showed abundant reactive osteoid (RO) without viable tumour (1/59). Irregular GC distribution (24/58; 41.3%) and spindled tumour cells (42/58;72.4%) were not uncommon. Uncommon histological features included; storiform growth (16/58;27.5%), stromal overgrowth (5/58;8.6%), irregular nuclear contours (2/58; 3.4%), haemangiopericytomatous vessels (25/58;43.1%), clear cells (5/58;8.6%), chondroid metaplasia (3/58;5.1%), variably sized GC (2/58;3.4%) and vascular spaces around tumour cells (9/58;15.5%). Forty-two (72.4%) cases showed focal RO (nodular-25/42, trabecular-15/42). Lace-like osteoid was rare (2/42). Mitoses ranged from 1-36 per 2mm2 (mean-6.1). Four showed vascular invasion (4/58;6.8%). All 18 untreated excisions showed soft tissue extension. Permeative growth and malignant transformation were absent.
Discussion and conclusion: Clinical characteristics align with international data. Awareness of the uncommon histological features will help to avoid misdiagnosis of GCTB especially in scanty specimens.
Keywords: Giant cell tumour of bone, pathology

RP 9

An audit of diagnostic adequacy in renal biopsies based on international standards

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Introduction and objectives: Renal biopsy is a critical diagnostic procedure in nephrology. The adequacy of biopsy samples, measured by the glomerular yield, directly impacts diagnostic accuracy and patient management. This audit aimed to evaluate the adequacy of renal biopsy specimens received at a tertiary care histopathology unit over a one-year period.
Methodology: A retrospective audit was conducted on all renal biopsies received between 1st January to 31st December 2023. Adequacy was assessed based on international/Banff criteria: a minimum of 10 glomeruli for native renal biopsies and at least 10 glomeruli plus two arteries for transplant biopsies. Data were extracted from histopathology reports and analysed using descriptive statistics.
Results: A total of 188 biopsies were evaluated, including 158 native (84.0%) and 30 transplant (16.0%) biopsies. The mean age was 43.57 years (SD14.36), and 55.3% (n=104) were male. The mean total core length was 11.20mm (SD6.67) and greater in transplant (12.67 mm, SD6.64) than native (10.92 mm, SD6.64) biopsies. The mean glomerular count was 8.69 (SD7.43), with transplant biopsies yielding slightly more glomeruli ($\bar{x}$9.17) than native ($\bar{x}$8.60). Only 39.2% (n=62) of native biopsies and 30% (n=9) of transplant biopsies met adequacy criteria. Approximately half of the native biopsies (53.1%, n=84) contained at least seven glomeruli, while 46.7% (n=14) of transplant biopsies had at least seven glomeruli plus one artery.
Discussion and conclusion: A substantial proportion of renal biopsies did not meet adequacy criteria, potentially limiting diagnostic accuracy. Enhancing biopsy technique, standardizing protocols, and providing targeted training are recommended to improve glomerular yield and reduce repeat procedures. Regular audits can help drive continuous quality improvement in renal biopsy services.
Keywords: renal biopsy, adequacy, transplant, audit

RP 10

Defining the optimal core length for renal biopsy adequacy: a data-driven threshold from a Sri Lankan perspective

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Introduction and objectives: Adequate tissue sampling is essential for accurate histopathological diagnosis in renal biopsies. Insufficient samples may compromise diagnostic accuracy and necessitate repeat procedures. This study aimed to evaluate the relationship between biopsy core length and diagnostic adequacy and to determine an optimal cut-off length that maximizes diagnostic yield.
Methodology: A retrospective analysis was conducted on all renal biopsy samples obtained between January 2023 and December 2024 at a tertiary care centre. Biopsy adequacy was recorded as a binary outcome, and core lengths were measured in millimetres. Adequacy was assessed based on international /Banff criteria: a minimum of 10 glomeruli for native renal biopsies and at least 10 glomeruli plus 2 arteries for transplant biopsies. Receiver operating characteristic (ROC) curve analysis was used to evaluate the predictive ability of core length, and the optimal cut-off was determined using the Youden Index (sensitivity+specificity-1).
Results: Of the total 351 specimens, 284 (80.91%) were native and 67 (19.09%) were transplant biopsies. Majority was male (n=183, 52.14%). Approximately a third (n=128, 36.5%) was deemed adequate and 223 (63.5%) inadequate. The mean core length was 11.67mm (SD=6.56 mm). ROC analysis demonstrated fair discriminative ability, with an area under the curve of 0.71 (95% CI:0.65-0.76). The optimal cut-off length was 11.5mm, corresponding to a sensitivity of 60.9%, specificity of 70.9%, and a maximum Youden Index of 0.318.
Discussion and conclusion: A renal biopsy core length of ≥11.5 mm is associated with improved diagnostic adequacy for both native and transplant biopsies. This cut-off serves as a practical benchmark for clinicians performing biopsies, particularly in settings where on-site adequacy assessment is not available.
Keywords: renal biopsy, core length, diagnostic adequacy, ROC analysis, Youden Index

RP 11

Diagnostic role of Bmi1 in oesophageal squamous cell carcinoma

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Introduction and objectives: Oesophageal squamous cell carcinoma (OSCC) is one of the most common malignancies worldwide. Despite being an aggressive malignancy, a reliable minimally or non-invasive serological marker for diagnosis is still elusive. In the present study, we intend to study the diagnostic role of Bmi1 in OSCC.
Methodology: Fifty-one (51) consecutive biopsy-proven cases of OSCC and age and sex matched symptomatic, endoscopy/biopsy-negative controls were included. Serum levels of autoantibodies against Bmi1 were measured by reverse capture enzyme-linked immunosorbent assay (ELISA). Serum levels were correlated with age, gender, site, differentiation, stage, and overall survival.
Results: Patients (aged 28-81 years) showed a male predominance. Serum autoantibody levels against Bmi1 were significantly higher in OSCC patients than controls (median 220.8 vs 98.0, $p < 0.05$). A Bmi1 level $\geq$ 220.8 yielded an area under the curve (AUC) of 0.85, with 85.0% sensitivity and 84.0% specificity. Elevated Bmi1 was significantly associated with nodal metastasis ($p = 0.014$), advanced stage ($p = 0.035$) and reduced mean survival (27.14 months). On univariate analysis, poor differentiation ($p = 0.002$) and advanced stage ($p = 0.013$) were significant risk factors.
Discussion and conclusion: High Bmi1 expression correlates with poor differentiation, advanced stage, and reduced survival, highlighting its potential as a diagnostic and prognostic biomarker. It offers a non-invasive method for the early detection of oesophageal squamous cell carcinoma. Its role in cancer stem cell regulation and therapy resistance further supports its use in targeted screening and diagnostic panels.
Keywords: Bmi1, oesophageal squamous cell carcinoma, ELISA

RP 12

Solitary plasmacytoma: journey through bone and beyond, a retrospective clinicopathological study from a tertiary care cancer centre in India

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Introduction and objective: Solitary plasmacytoma (SP), a rare plasma cell neoplasm, is characterised by localised clonal plasma cell proliferation without systemic involvement. It manifests as solitary plasmacytoma of bone (SPB) or extramedullary plasmacytoma (EMP). Limited data exist on SP from Indian cohorts. The objective of this study was to describe the clinicopathological features of solitary plasmacytoma at a tertiary care centre.
Methods: This was a retrospective study of 24 cases of SP identified from a cohort of 799 plasma cell neoplasms. Clinical records, histopathological and immunohistochemical profiles, and laboratory investigations were reviewed. Treatment strategies included radiotherapy, surgical excision, and/or systemic chemotherapy depending on anatomical location and disease burden. Patient outcomes were assessed in terms of overall survival (OS) and disease-free survival (DFS). Ethical approval was obtained from the Institutional Ethics Committee (IEC no. 11000801).
Results: Of the 24 cases of SP 15 (62.5%) were SPB and 9 (37.5%) were EMP. The median age at presentation was 62.5 years, with a male predominance (male: female ratio 8:1). The vertebrae and pelvic bones were the most frequently involved sites in SPB, while EMP predominantly involved the upper aerodigestive tract. Pain was the most common presentation. Serum M protein was detected in 17 (70.8%) patients. Radiotherapy, particularly with volumetric modulated arc therapy (VMAT), was the primary treatment modality in 75%(n=18) of patients. At six months, OS and DFS were 87.7% and 61.7%, respectively. Disease progression occurred in nine (37.5%) patients, with four (16.7%) progressing to multiple myeloma.
Conclusion: SP constitutes a distinct clinicopathologic entity within plasma cell neoplasms, with heterogeneous anatomical presentations and potential for progression to multiple myeloma. Timely diagnosis, site-specific radiotherapy, and rigorous long-term surveillance are essential. This study augments limited Indian data and highlights the need for standardized therapeutic protocols.
Keywords: solitary plasmacytoma, multiple myeloma, radiotherapy

RP 13

An audit of reporting of thyroid cytology specimens and their correlation with thyroid histology

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Introduction and objectives: The Royal College of Pathologists recommends assigning Thy categories in thyroid cytology for consistent reporting and audit. This audit aimed to assess (1) the proportion of reports with a Thy category, (2) distribution across Thy categories, (3) correlation with histology, and (4) referral patterns to multidisciplinary team (MDT) or specialist centres.
Methodology: A retrospective review of 100 thyroid cytology cases (2024) at Cumberland Infirmary was performed. Distribution by Thy category was assessed against national data. Where available, histology was used to calculate positive predictive value (PPV). Referrals to thyroid cancer MDT and for specialist opinions were reviewed.
Results: Thy categories were assigned in 98% of reports. Distribution aligned 50% with national data. Higher-than-expected Thy1/1c (34%) and Thy3a (26%) rates were noted. Histological correlation was available in 24 cases. PPVs were 100% for Thy4 and Thy5, 60% for Thy3f, and 23% for Thy3a. All Thy5 and most Thy4 cases were referred to MDT. Despite tertiary advice, 32% of Thy3 cases were referred.
Discussion: Good compliance with RCPath guidance was observed. Overrepresentation of Thy1 and Thy3a categories may reflect local sampling or interpretive practices. PPVs were within or above national ranges. Referral of Thy3 cases varied from tertiary expectations.
Conclusion: This audit supports high standards in cytology reporting but highlights the need for a local protocol on Thy3 referrals. A re-audit is recommended in 12 months.
Keywords: thyroid cytology, audit

RP 14

Clinical, endoscopic and histomorphological spectrum of immune checkpoint inhibitor - associated colitis

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Introduction and objectives: Immune checkpoint inhibitors (ICPI) significantly improve clinical outcomes in various cancers. However, colitis is one of the most important adverse reactions caused by ICPIs, which are known to elicit variable injury patterns in the gastrointestinal mucosa with corresponding endoscopic abnormalities. In this retrospective study, we tried to analyse and classify the clinical, endoscopic, and histomorphological spectrum of ICPI-associated colitis.
Methodology: The institutional database was retrospectively searched for cases of ICPI-associated colitis over a four-year period. Colonic biopsies were reviewed, and histologic patterns of injury were recorded. Relevant clinical and imaging details were gathered.
Results: Forty-six patients with ICPI-colitis were identified, following colonoscopy (41/46, 89%) or flexible sigmoidoscopy (5/46, 11%) with biopsy. The most common cause for ICPI-colitis was seen to be pembrolizumab (22/46, 48%) with the predominant presenting symptom being diarrhoea (41/46, 89%) of intermediate grade (CTCAE G2, 17/46, 13.9%). In ICPI colitis attributed to pembrolizumab, most of the cases showed apoptotic colopathy (8/15, 53%) followed by mixed histologic injury patterns (7/17, 41%) comprising apoptotic colopathy and focal or diffuse active colitis. Apoptotic colopathy on biopsy was associated mostly with normal appearing colonic mucosa on colonoscopy. On the other hand, severe ulcerative lesions and pseudomembranous colitis features on colonoscopy corresponded to mostly mixed histologic patterns of injury on biopsies. Refractory ICPI colitis resulting in intestinal rupture led to surgical resection in one case.
Discussion and conclusion: ICPI colitis represents a varied spectrum of histologic injury patterns, of which apoptotic colopathy and mixed injury patterns comprising apoptosis and focal/diffuse active colitis, or lymphocytic colitis were the most prevalent in our study cohort.
Keywords: immune checkpoint inhibitors, ICPI- associated colitis

RP 15

Seropositive versus seronegative autoimmune hepatitis: comparative analyses of histomorphological characteristics in liver biopsies of autoimmune hepatitis patients

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Introduction and objectives: Lack of diagnostic biomarkers in conjunction with the wide spectrum of clinical presentations, make the diagnosis of autoimmune hepatitis (AIH) challenging, specifically in seronegative patients. In this regard, apart from clinical features, histological evaluation of liver biopsies is of paramount significance in arriving at the diagnosis. In this study, we tried to compare and evaluate any plausible difference in histomorphological parameters between seropositive and seronegative cases of AIH.
Methodology: Cases of AIH were shortlisted by retrospectively searching our computerized database. Stained slides of available cases were then retrieved, reviewed and morphologically graded, based on several histological parameters which included architecture, density of portal tract inflammation (PTI) and composition of inflammatory infiltrate, interface hepatitis, confluent necrosis, lobular inflammation, presence of emperipolesis, acinar transformation, bile ductular proliferation, lymphocytic cholangitis, cholestasis, feathery degeneration, Mallory Denke(MD) bodies, macro-or-microvesicular steatosis, plasma cell or lymphoid clusters, Russell body, endotheliitis, Kupffer-cell hyperplasia, hyaline globules, nuclear glycogenisation, P-I-R score of liver fibrosis, nodule size and septal thickness. Pertinent clinical information was collected. The parameters were compared between the seropositive and seronegative cohorts.
Results: Out of 65 AIH-cases, 44(67.6%) were found to be seropositive, while the rest were seronegative. Severity of PTI, lymphocytic cholangitis and endotheleiitis were found to be greater in the seropositive group. MD bodies though occasional were also found only in this group.
Discussion and conclusion: Seronegative and seropositive AIH showed similar morphological features. Sample size was a limitation. Studies with a larger cohort of seronegative AIH cases may be needed to highlight smaller differences.
Keywords: autoimmune hepatitis, seropositive AIH, seronegative AIH, treatment responsive AIH, incomplete response/treatment failure AIH

RP 16

Comprehensive histopathological audit of appendectomy specimens: analysis of diagnostic patterns and clinical correlations

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Introduction and objectives: Appendectomy is one of the most common surgical procedures worldwide, and histological examination plays a crucial role in diagnostic evaluation and detecting incidental findings that need clinical attention. This audit aims to analyse the spectrum of histopathological findings in appendectomy specimens over a period of 16 months from 2024 to 2025, to evaluate common diagnostic trends, assess the incidence of negative appendectomies and identify rare and clinically significant cases.
Methodology: A retrospective audit was conducted on 182 appendectomy cases, categorizing diagnoses into acute appendicitis (AA), lymphoid follicular hyperplasia (LFH), neoplasms (neuroendocrine tumours, sessile serrated lesion, low-grade appendiceal mucinous neoplasms (LAMNs), adenocarcinoma), fibrous obliteration and nonspecific changes. Demographic data (age, gender), diagnostic subcategories (e.g. suppurative, serositis), and unusual findings (parasitic infestations, granulomatous inflammation) were analysed. Statistical evaluation included frequency distribution and age/gender associations.
Results: The majority of cases (68%; n=118) were diagnosed as AA with serositis being noted in 55% (n=65) of these. LFH (18%; n=33); was prevalent in paediatric patients (mean age: 12 years). 4% (n=7) of Neoplasms were identified comprising neuroendocrine tumours (n=3), sessile serrated lesions (n=2), LAMN (n=1) and adenocarcinoma (n=1). 10% (n=18) of appendectomies showed nonspecific findings, which was predominant in females (65%, n=12). Rare findings included granulomatous appendicitis (n=2), *Enterobius vermicularis* infestation (n=2), and Crohn-like features(n=1).
Discussion: The high rate of serositis-associated appendicitis suggests advanced inflammation at presentation. The predominance of LFH in children correlates with physiological immune responses. The negative appendectomy rate was 10%, which falls within the commonly accepted limit of 10–20% in surgical literature, but it still underscores the ongoing diagnostic challenges in clinically equivocal cases.
Conclusion: This audit confirms the critical role of histopathological assessment in appendectomy specimens, particularly in guiding clinical management and detecting unexpected neoplasms. Continued emphasis on thorough pathological examination remains warranted.
Keywords: appendicectomy, acute appendicitis

RP 17

A retrospective analysis of tumour-infiltrating lymphocytes and their association with tumour budding and lymphovascular invasion in colorectal carcinoma

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Introduction and objectives: Colorectal carcinoma (CRC) remains a major cause of cancer morbidity and mortality worldwide. Stromal tumour-infiltrating lymphocytes (TILs) play a critical role in the immune response against CRC, influencing potential tumour behaviour. Tumour budding and lymphovascular invasion (LVI) are also key histological features associated with tumour spread. This study aimed to determine the association between TIL grade and the presence of tumour budding and LVI in resected CRC specimens.
Methodology: A retrospective analysis of consecutive 100 CRC specimens (2020-2023) was conducted. Exclusion criteria include specimens with prior chemoradiation and multiple tumours. Data included TIL grade [low (0-10%), intermediate (10-50%), high (50-100%)], tumor budding (present/absent), and LVI status. Statistical analysis was performed to determine associations using chi-square tests and logistic regression.
Results: Of the 100 cases, 32% exhibited low TILs, 52% intermediate, and 16% high TILs. Tumor budding was present in 62% of cases, while LVI was observed in 34%. A significant inverse correlation was noted between higher TIL grades (intermediate/high) and tumor budding ($p < 0.05$). Conversely, LVI was more frequent in cases with low TILs (45%) compared to intermediate/high TILs (25%, $p < 0.01$).
Discussion and conclusion: This study demonstrates that higher TIL levels are associated with decreased tumour budding suggesting that higher lymphocytic infiltration may suppress tumour budding. Similarly, lymphovascular invasion was less frequent with higher TIL. Thus, these findings may be a good indication that TIL may help suppress tumor aggressiveness through immune surveillance. While limited by its retrospective nature and variable follow-up, these results support the use of TIL grading as a biomarker, but prospective studies would be necessary to explore their clinical applications.
Keywords: tumour-infiltrating lymphocytes, tumour budding, lymphovascular invasion

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RP 18

Association between stromal tumour-infiltrating lymphocytes and pathological stage in colorectal carcinoma: a retrospective study

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Introduction and objectives: Stromal tumour-infiltrating lymphocytes (TILs) are a critical component of the immune response against colorectal adenocarcinoma (CRC), influencing disease progression and prognosis. This study aimed to assess the correlation between stromal lymphocyte grade and tumour stage (both tumour T-stage and nodal N-stage) in CRC to determine the potential prognostic significance of TILs.
Methodology: The CRC histology reports and slides of 100 patients were analysed retrospectively, focusing on TIL grade (low: 1-10%, intermediate: 10-50%, high: 50-100% stromal TILs), tumour stage (pT1–pT4), and nodal stage (N0–N2). Descriptive statistics and the chi-square tests were used to determine associations between stromal TIL grade and T/N stages.
Results: The cohort comprised 56 women and 44 men, with a median age of 62 years. TIL grades were distributed as low (34%), intermediate (52%), and high (14%). Higher TIL grades (intermediate/high) were more frequent in early T-stages (pT1–pT2: 68%) compared to advanced T-stages (pT3–pT4: 45%). A similar trend was observed for N-stage, with higher TIL grades in N0 (65%) versus N1–N2 (48%). The chi-square test revealed a significant inverse correlation between TIL grade and T-stage ($p < 0.05$), but there was no significant association with N-stage ($p > 0.1$).
Discussion and conclusion: The findings suggest that higher TIL infiltration is associated with less advanced tumour stages, supporting the role of the immune response in limiting local tumour progression and highlighting its potential as a biomarker for favourable local disease control. The lack of correlation with nodal involvement may result from divergent mechanisms governing lymphatic spread.
Keywords: tumour infiltrating lymphocytes, colorectal carcinoma, tumour/nodal stage

RP 20

Clinicopathological profile of parotid gland neoplasms in a Sri Lankan oncology referral centre

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Introduction and objectives: Parotid gland tumours comprise a wide spectrum of benign and malignant tumours. This study aimed to evaluate the demographic and histological patterns of parotid tumours at a tertiary care cancer centre in Sri Lanka and compare findings with already existing local and international data.
Methodology: A retrospective analysis was performed on the data of patients who underwent surgery for parotid gland tumours at the National Cancer Institute (NCI) from 2021 onwards. Data on age, sex and histological type were analysed and compared with existing literature.
Results: Fifty-five cases with were included in the analysis. The mean age was 51.35 years (SD=16.892) and 51% of the patients were males. 63.6% (35/55) were malignant tumours, which is significantly higher than the global (15-32%) and previous local data (33-43%). Benign tumours accounted for 36.4% (20/55). Mucoepidermoid carcinoma was the most common malignancy (16/35; 29%), with 75% female predominance. Warthin tumour was the most frequent benign tumour (9/20; 45%).
Discussion and conclusion: The elevated malignancy rate may reflect referral bias to a national oncology centre. The higher frequency of Warthin tumours over pleomorphic adenomas contrasts with traditional patterns. Mucoepidermoid carcinoma is the most commonly found malignant tumour among the patients who underwent parotid surgery at NCI - Maharagama, Sri Lanka, whereas Warthin tumour had the highest frequency among benign cases. Establishing tumour registries in island-wide tertiary care institutes would help to better understand the shifting landscapes of parotid gland tumours.
Keywords: parotid gland tumours, Sri Lankan oncology referral centre

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RP 21

An appraisal of the utilization of the International Academy of Cytology Yokohama standardized reporting system for breast fine needle aspiration biopsy cytopathology: a study of diagnostic accuracy, risk of malignancy and histopathological correlation

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Introduction and objectives: Breast carcinoma is the most commonly encountered cancer among women globally. Triple assessment is an important approach in the pre-operative assessment of breast lesions. The International Academy of Cytology (IAC) Yokohama system for reporting breast fine needle aspiration biopsy cytopathology (FNAC) standardises reporting and allows the calculation of risk of malignancy (ROM). The objectives of the present study were to categorize all breast FNAC specimens according to the newly proposed IAC Yokohama reporting system and to determine diagnostic accuracy, ROM for each category, sensitivity, specificity, negative predictive value (NPV) and positive predictive value (PPV) along with cyto-histopathological correlation.
Methodology: Nine hundred and forty cases of breast FNAC were retrieved from December 2019 to December 2020, categorized from C1 to C5 according to the new IAC system and analysed to determine diagnostic accuracy, ROM, cyto-histopathological correlation, specificity, sensitivity, NPV, PPV and interobserver variability. Of the 940 cases, details for cyto-histopathological correlation were available in 358.
Results: Out of 940 cases, 57 (6%) were categorized as insufficient, 658 (70%) benign; 9 (1%) atypical, probably benign; 28 (3%) suspicious; and 188 (20%) malignant. ROM was calculated as 0% in C1 and 4%, 66%, 83% and 99% in the C2, C3, C4 and C5 categories respectively. Statistical analysis showed 94.5% sensitivity, 98.5% PPV, 95.8% NPV, 98.9% specificity and 97% diagnostic accuracy
Conclusion: The new IAC standardized reporting system of breast FNAC evokes the utilization of a rapid, accurate and low-cost diagnostic test and broadens the understanding and application of breast FNAC as a diagnostic tool.
Keywords: breast, cytology, International Academy of Cytology Yokohama system

RP 22

Audit of turnaround time for intraoperative touch imprint cytology of sentinel lymph nodes in a tertiary care histopathology laboratory with high caseload

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Introduction and objectives: Intraoperative touch imprint cytology of sentinel lymph nodes (SLNs) plays an essential role in real-time decision-making during breast cancer surgery. Timely communication of results is critical to avoid unnecessary intraoperative delays and ensure patient safety. This audit was conducted to evaluate turnaround time (TAT) and identify areas to be improved to enhance intraoperative efficiency in a busy tertiary care histopathology service.
Methodology: Twenty breast cancer surgeries with intraoperative SLN assessments were reviewed retrospectively over six months. The following time intervals were documented and analysed: specimen reception, slide preparation, staining, handover of stained slides to the pathologist, and result communication. TAT was measured from specimen arrival to result delivery, with standards of ≤30 minutes (optimal) and ≤40 minutes (acceptable). Rapid staining was compared with the ideal 4–6 minutes
Results: The mean TAT was 40.6 minutes (range: 20–97). Eight cases (40%) exceeded 40 minutes and were delayed. Twelve (60%) were within the acceptable limit, of which six (30%) achieved the optimal ≤30 minutes. The average staining time was 27.6 minutes, while slide preparation and reporting averaged 7 and 6 minutes, respectively. Staining was the main contributor to the delay.
Discussion and conclusion: Delays were most evident when the same staff member managed both staining and frozen sections, indicating workload contribution. Staining was the main cause of prolonged TAT. Strategies to improve efficiency include streamlining workflow, training staff on urgent procedures, and enforcing clear protocols. A dedicated workstation is recommended, as using the routine cut-up stations for urgent smears also reduced efficiency. A follow-up audit is planned after introducing corrective measures.
Keywords: sentinel lymph node, intraoperative cytology, turnaround time, histopathology, audit

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RP 23

Retrospective analysis of specialised immunohistochemical markers used at a referral centre for cancer diagnosis in Sri Lanka

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Introduction and objectives: Standard immunohistochemical (IHC) panels resolve most cases of cancer diagnosis. However, a subset of diagnostically challenging tumours requires more specialised IHC markers. This study aims to evaluate the utilization of specialised IHC markers at a referral centre in a resource limited setting.
Methodology: Of the 100 IHC markers available at the centre, 20 were categorized as specialised markers (IgG4, STAT6, INI1, PD1, CDK4, MDM2, AMACR, BER-EP4, P57, MUC4, C-MYC, beta HCG, Granzyme B, MPO, Glypican 3, SOX10, TLE1, SDHB, ERG, AR). All cases reported at the centre from January 2022 to May 2025 were reviewed for the usage of these markers.
Results: Of the 3343 cases reported at the centre, IHC testing of the selected markers was performed in 213 cases (6.37% of all cases; number tests=266). The most frequently utilized markers were SOX10 (n=43), ERG (n=33), IgG4 (n=35), TLE-1 (n=19), STAT6 (n=18), INI1 (n=21), Glypican 3 (n=16) and PD1 (n=16). C-Myc (n=5), MPO (n=4), SDHB (n=3), AR (n=5), beta HCG (n=1) were used less than six times over the three-year period. These markers were used mainly in the diagnosis of soft tissue tumours and lymphomas.
Discussion and conclusion: The frequent use of SOX10, ERG and IgG4 suggests that they may need to be more freely available as standard markers. The occasional use of the other 17 markers studied justifies their availability only at referral centres. Raising awareness among pathologists in the country about the availability of these markers in the centre may improve utilization.
Keywords: immunohistochemistry, cancer, diagnosis, resource limited setting

RP 24

Histological risk classification of Wilms tumor after chemotherapy: a tertiary care centre experience from India

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Introduction and objective: Wilms tumour (WT) is a malignant renal tumour occurring in childhood. Histologically they are triphasic, biphasic or monophasic incorporating an admixture of blastemal, epithelial and mesenchymal elements. Unfavourable histological features include nuclear enlargement >three times, obvious hyperchromasia and multipolar mitotic figures. The SIOP (International Society of Paediatric Oncology) recommends preoperative chemotherapy followed by surgery. Post chemotherapy induced changes and viable tumour components are assessed on histology. SIOP histological risk classification includes low risk with cystic partially differentiated nephroblastoma/completely necrotic WT, intermediate risk with epithelial, stromal, mixed, regressive/focal anaplasia and high risk with diffuse anaplasia blastemal type on histology. Our objective was to perform histological risk stratification of Wilms tumour (WT) based on the SIOP (International Society of Paediatric Oncology) classification.
Methods: Cases of WT reported at a tertiary care centre in India from January 2021 to April 2025 were reviewed and categorized according to histological risk stratification of WT based on SIOP classification.
Results: Histological specimens from 49 patients with WT comprising biopsy (11), nephrectomy (24), and biopsy followed by nephrectomy (14) were evaluated. The mean age was 40 months (range 6 to 228 months). The male: female ratio was 32:17. WT involved the right (19; 38.7%), left (19; 38.7%) and bilateral kidneys (11; 22.4%). Thirty-eight (77.6%) received chemotherapy before histological assessment. Unfavourable histology was seen in three patients (6.1%). Diffuse anaplasia was present in one (2.0%) and blastemal type histology in six (12.2%). On SIOP histological risk classification one was low risk (2.0%), 32 were intermediate risk (65.3%), and six were high risk (12.2%). The mean follow-up duration was 21.3 months. During this period two patients died, and one experienced a recurrence. One death and one recurrence were recorded among the high-risk SIOP group
Conclusion: This study summarizes SIOP histological risk classification in post chemotherapy WT patients.
Keywords: Wilms tumour, histological risk, classification

RP 25

A descriptive study of Gleason pattern 4 in prostatic acinar adenocarcinoma: experience from a tertiary care centre in Sri Lanka

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Introduction and objectives: Understanding the presence and extent of Gleason pattern 4 helps in risk stratification and treatment planning for prostate cancer. This study describes the prevalence and architectural heterogeneity of Gleason pattern 4 in prostatic carcinoma.
Methodology: The study analysed 226 consecutive transrectal ultrasound (TRUS) -guided prostate biopsies reported from January 2020 to January 2025 at the Colombo North Teaching Hospital. Gleason pattern 4 in all prostate cancers was subtyped as cribriform, fused glands, poorly formed glands, and glomeruloid based on WHO/ISUP guidelines. The frequency and distribution of these subtypes was analysed using descriptive statistics.
Results: The median age of the patients was 72 years (IQR: 67–75). The overall prevalence of Gleason pattern 4 was 79.20% (179/226) and was associated with the following patterns as the dominant or codominant pattern: 5 – 75/179 (41.89%), 3 - 72/179 (40.22%), and 4 - 31/179 (17.32%). Overall percentage of each subtype was as follows: cribriform 51.06%, fused glands 35.78%, poorly formed glands 11.66% and glomeruloid structures 1.5%. The cribriform subtype was most frequent, in grade group 4 (55.33%), the fused subtype in grade group 5 (39.79%) and the glomeruloid sub type in grade group 2 (2.29%)
Discussion and conclusion: Cribriform subtype of Gleason pattern 4 was the most common across all grade groups, differing from global trends that typically report a predominance of the fused glands sub type. The rarity of the glomeruloid pattern aligns with international data. The high prevalence of cribriform architecture, especially in grade 4, is clinically relevant due to its known association with poor prognosis and aggressive behaviour.
Keywords: prostate acinar adenocarcinoma, Gleason score, Gleason pattern 4

RP 26

Association between clinicopathological features and Gleason grade group with emphasis on Gleason pattern 4 in prostatic adenocarcinoma

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Introduction and objectives: Gleason grading is important for risk stratification and management of patients with prostatic carcinoma, and the significance of Gleason pattern 4 is now recognized. This study aims to determine the association of clinicopathological features with both the Gleason grade group (GGG) and architectural subtypes of Gleason pattern 4 in GGG2 and GGG3.
Methodology: A total of 226 TRUS-guided prostate biopsies was analysed. Those exhibiting Gleason pattern 4 were subtyped as cribriform, fused, poorly formed and glomeruloid based on WHO criteria. The association between clinicopathological parameters (perineural invasion (PNI), lymphovascular invasion (LVI), intraductal carcinoma, high-grade PIN, extra-prostatic invasion, total tumor burden, prostate specific antigen (PSA) level, and age) and both GGG and the architectural subtypes of Gleason pattern 4 (in GGG 2 and 3) was assessed using the chi square test.
Results: A statistically significant association was found between the GGG (1-5) ,PNI ($p < 0.001$), LVI ($p = 0.01$), and PSA levels ($p = 0.02$). In Gleason pattern 4 cancers [46/226 (20.35%) GGG2 and 30/226 (13.27%) GGG3] the architectural subtypes did not show a significant association with the clinicopathological parameters.
Discussion and conclusion: The overall GGG (1-5) was significantly associated with PSA levels and markers of tumor aggression, such as PNI and LVI, consistent with the existing literature. The architectural subtypes of Gleason pattern 4 in GGG2 and GGG3, however, did not show a significant association, suggesting that architectural subtypes of pattern 4, when considered in isolation, may have limited prognostic value. To better understand their clinical relevance, these subtypes should be evaluated against survival.
Keywords: prostate, acinar adenocarcinoma, Gleason, pattern 4

RP 27

An audit of placental histopathology referrals; are we following the 2022 RCPath guidelines?

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Introduction and objectives: Placental histopathology (PH) plays a crucial role in neonatal care and the management of future pregnancies. The Royal College of Pathologists (RCPath) guidelines 2022 have stated essential and non-essential criteria for placental specimen referral. This audit is designed to evaluate the adherence to RCPath 2022 guidelines in routine referrals of placentas for PH at a tertiary care centre.
Methodology: The request forms of placentas received within a year, starting from January 2024, were assessed for compliance with the RCPath 2022 referral criteria, including mandatory data and provision of additional clinical details. Data collected using a proforma was analysed using descriptive statistics.
Results: A total of 24 placentas were received. The indications for the referral were documented in 96% of cases (compliance > 90%). Only 75% were referred due to essential criteria, while the indications were non-essential in 25% (limit > 10%). Among the mandatory data, only the mother's name was fully compliant (100%). Patient age (91%), gestational age (70%) and obstetric history (25%) fell below standards. Key details such as the delivery date, birth weight, centile, and baby's sex were not stated in any of the cases (0%). Additional information, such as mode of delivery (79%), patient contact information (54%), and physician's contact information (62%), was reported variably.
Discussion: While most referrals included an indication, 25% of these were non-essential, overburdening the pathology services. Lack of clinical information in the majority makes meaningful assessment of PH difficult.
Conclusion: Poor adherence to essential referral criteria and limited clinical information in the request forms highlight the need for creating intradepartmental awareness on the referral criteria and the design of a standardised request form. A re-audit will be carried out after implementing the new request form, which is essential to ensure appropriate use of pathology services and to improve the quality of PH assessment.
Keywords: placental histopathology, referral, compliance, RCPath 2022 guidelines

RP 28

Audit of colorectal biopsy reporting for inflammatory bowel disease in a specialised gastroenterology centre

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Introduction and objectives: The reporting of colonic biopsies for the diagnosis of inflammatory bowel disease (IBD) was audited based on the audit standards and assessment criteria established by the Royal College of Pathologists (RCPath).
Methodology: Twenty-five consecutive cases of IBD reported in the Department of Pathology, Faculty of Medicine, Kelaniya, from January to November 2024 were retrieved. The information in these reports was audited against 24 criteria, under the categories of clinical details and processing (7), macroscopic (2), and microscopic descriptions (8), and the summary/conclusion (7).
Results: The reporting of the ten criteria concerning macroscopic and microscopic description showed full compliance. The main area of non-compliance was in the clinical details and processing category, where only the criteria on the site of origin reached the standard (100% compliance). 4/7 criteria in the summary/conclusion category were compliant. The non-compliant criteria in summary/conclusion included, summary of microscopic changes (64%), degree/grade of activity (84%) and turnaround time (TAT) of 18 days (IQR-10-25). Out of all 24 criteria, 15 reached 100% compliance (62.5%). This audit highlighted four good practices.
Discussion and conclusion: The audit identified two main weaknesses: the lack of clinical and endoscopic details, and delays in TAT. The possible reasons encountered for the latter were inadequate clinical details, delays in peer review at the departmental level and unexpected trade union action by non-academic staff during the audit period. It is envisaged that an urgent discussion with the clinical teams and the addition of these details to the web-based reporting system will address this issue to a large extent. A re-audit will be mandatory.
Keywords: inflammatory bowel disease reporting, RCPath audit standards

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RP 29

Histopathological evaluation of regressive features of liver fibrosis

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Introduction and objectives: Liver fibrosis is recognised as a potentially reversible condition. Histopathological evaluation of regression may aid in evaluating therapeutic outcomes. This study aimed to descriptively assess the regressive features of liver fibrosis in liver specimens received at the Department of Histopathology, Faculty of Medicine, Kelaniya.
Methodology: A retrospective descriptive cross-sectional study was carried out on liver specimens, which included liver biopsies, resections, and explants received at the centre over a period of five years. The specimens reported to have any degree of fibrosis were selected. Transplant biopsies and poor-quality slides/blocks were excluded. A total of 110 cases were examined by two pathologists. The eight components of the hepatic repair complex (HRC) were assessed using haematoxylin and eosin and Masson's trichrome stains.
Results: The male: female ratio was 40:70; median age was 51 years; 104 were biopsies, and six were liver resections. All eight components of the HRC were identified. The three most frequently observed regressive features were perforated delicate septa (90/110; 82%), hepatocytes within portal tracts/split septa (62/110; 56%), and minute regenerative nodules (60/110; 55%). Delicate periportal fibrous spikes were observed in 27/110 (34%) of cases. The other HRC components identified included: isolated thick collagen fibres (2/110; 2%), aberrant parenchymal veins (4/110; 4%), portal tract remnants (2/110; 2%), and hepatic vein remnants (1/110; 1%).
Discussion and conclusion: The frequent observation of perforated delicate septa and hepatocytes within portal tracts/split septa in this study aligned with results reported in the literature. However, minute regenerative nodules, rarely noted in previous studies, emerged as one of the three most common HRC features in our study. Isolated portal tracts were identified in only 2%, despite this being a more frequent feature in other studies.
Keywords: hepatic repair complex, liver fibrosis, haematoxylin and eosin, Masson's trichrome stain

RP 30

Evaluation of an innovative method for teaching drawing of histopathology diagrams to second year MBBS students

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Introduction and objectives: Drawing of factually accurate histopathology diagrams is a challenging task. Apart from being a requirement of the competency-based medical education curriculum, it helps in development of the psychomotor domain of learning. An innovative method to teach drawing of histopathology diagrams to second year MBBS students was introduced and evaluated, and the students' perception of this method was assessed.
Methodology: In this interventional study, students were provided with a validated hand-drawn pencil sketch of a histopathology diagram. They traced the outlines on the sketch, coloured it with haematoxylin and eosin pencils, then drew the same diagram independently (method C). Three diagrams were selected, and students drew all three diagrams once, each by a different method. The scores were compared with conventional methods, copying from standard histopathology atlas (method A) and from a hand-drawn colour chart (method B). Inter-group and pair-wise comparisons were done using Kruskal-Wallis test and Mann-Whitney U test respectively, followed by intra-class correlation. Student feedback was obtained using an online pre-validated questionnaire based on a Likert scale.
Results: 188 students completed the entire process. The mean score for method C (4.88 [0.16]) was higher than those for method A (3.63 [0.91]) and method B (4.76 [0.30]). There were statistically significant differences between method C and methods A and B ($p<0.01$). The innovative practice was well-received and contributed to better retention of the topics.
Discussion and conclusion: The process of drawing and colouring engages multiple sensory modalities. Creating accurate histopathological diagrams, while also offering a calming and engaging learning experience, aids in the development of spatial awareness. The innovative method resulted in improved diagram quality and greater ease of drawing compared to conventional techniques, highlighting its potential as a more effective educational tool.
Keywords: alternative teaching, innovative practice, medical education

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RP 31

A comparative study of bronchoscopy guided cytology specimens with bronchial biopsies in diagnosing lung malignancies

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Introduction and objectives: Bronchoscopy provides minimally invasive access to respiratory tract lesions, enabling the collection of cytological samples through bronchial wash and brush. This study evaluates the diagnostic efficacy of bronchial wash cytology (BWC), and bronchial brush cytology (BBC) compared to bronchial biopsy, which is considered the gold standard for diagnostic purposes.
Methodology: An observational, cross-sectional analytical study was conducted at the National Hospital of Respiratory Diseases, Welisara, from January 2020 to December 2024. A total of 237 consecutive patients with clinical, radiological, or bronchoscopic suspicion of lung cancer were enrolled based on predefined inclusion and exclusion criteria. BW and BB results were compared against biopsy findings, evaluating sensitivity, specificity, positive predictive value (PPV), negative predictive value (NPV), and overall diagnostic accuracy (ODA).
Results: BWC identified five true positive cases out of 115 biopsy-confirmed malignancies, resulting in a sensitivity of 4.35%. The specificity was 98.36%, with 120 true negatives and only two false positives. PPV was 71.43%, NPV 52.17%, and ODA 52.74%. In contrast, BBC showed a significantly improved diagnostic performance correctly identifying 60 true positives and 103 true negatives, yielding a sensitivity of 52.17% and specificity of 84.43%. The PPV and NPV were 75.95% and 65.19%, respectively, with an ODA of 68.35%.
Discussion and conclusion: In resource-limited settings, selecting the most effective technique is crucial, thereby saving time, effort, and cost while ensuring reliable diagnosis and optimal use of available medical resources. BBC demonstrated superior diagnostic sensitivity and accuracy compared to BWC in detecting lung malignancies. These findings support the use of bronchial brushing rather than bronchial washings as a diagnostically more effective cytological tool during bronchoscopy.
Keywords: bronchial wash cytology, bronchial brush cytology, sensitivity, specificity, overall diagnostic accuracy

RP 33

Evaluation of histopathology reporting practices in hepatoblastoma: a retrospective audit at Lady Ridgeway Hospital, Sri Lanka

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Introduction and objectives: Hepatoblastoma is the most common primary malignant liver tumour in children. Accurate histopathological diagnosis of hepatoblastoma is essential for effective management. This audit evaluated the completeness and timeliness of histopathology reports of hepatoblastoma against the College of American Pathologists (CAP) guidelines.
Methodology: A retrospective review of 23 histopathology reports (12 excision and 11 core biopsies) of hepatoblastoma issued from January 2021 to December 2024 at Lady Ridgeway Hospital for Children, Colombo, was conducted. Reports were assessed for compliance with CAP standards, and turnaround times.
Results: In excision biopsy specimens, procedure, tumour site, and resection margins were documented in 100% of reports. Over 80% of reports included details on tumour size, histologic type, lymphovascular invasion and lymph node status. Details on the macroscopic extent of the tumour at operation, histologic grade, distant metastasis, and staging were absent in all reports. In core biopsies, the procedure type was the only parameter reported in all reports. Tumour site and other pathological findings appeared in over 80%, tumour focality and serum alpha-fetoprotein levels were mentioned in 41.6%, and ancillary studies in 8.3% of reports. The mean turnaround time was three days for core-cut biopsies and 10 days for excision biopsies, with only 63% of excision biopsies reported within seven days.
Conclusion: The audit revealed underreporting of essential oncologic parameters, particularly in excision specimens. Delayed reporting may adversely affect multidisciplinary treatment planning. Standardized reporting templates will be implemented to enhance the completeness and efficiency of reporting, and a re-audit will be carried out in one year.
Keywords: hepatoblastoma, audit

RP 34

Validation of a novel artificial intelligence-based tool for Ki-67 quantification in breast cancer: enhanced accuracy, reproducibility and efficiency in resource limited setting

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Introduction and objectives: Ki-67 proliferation index is important in guiding breast cancer treatment. The International Ki-67 Working Group (IKWG) recommends hot-spot (HS), and the global scoring (GS) methods to quantify Ki-67, which is categorized as low (<5%), intermediate (6–29%), and high (>30%). The manual methods are time-consuming, prone to inter-observer variability and potential sampling bias based on selected microscopic fields. This study aimed to validate a novel artificial intelligence (AI)-based tool and evaluate its accuracy and efficiency compared to manual scoring.
Methodology: An AI model was developed using EfficientNetV2 architecture, incorporating distance transformation and watershed algorithms for precise cell segmentation. The AI tool captures high-power digital images of the entire Ki-67 immunohistochemically stained slide in real time as it is moved on the stage of the microscope and automatically computes the Ki-67 proliferation index. The model was trained on 350 digital images annotated by pathologists and validated with an additional 350 images. AI-derived Ki-67 indices of 20 cases were compared with blinded manual scores by two pathologists using HS and GS methods. Agreement was analysed using intraclass correlation coefficient (ICC) and Bland-Altman plots. Assessment efficiency was compared by measuring evaluation time.
Results: The AI model showed 94.3% accuracy in cell-to-cell identification against pathologist annotations. ICC analysis indicated excellent reproducibility between AI and manual methods for HS (ICC=0.946, 95% CI:0.672–0.984) and GS method (ICC=0.963, 95% CI:0.879–0.987). Bland-Altman analysis confirmed strong agreement without significant systematic bias. The AI method significantly reduced evaluation time compared to manual scoring by pathologists (HSt:AI mean=25.5s, pathologist mean=152.2s, $p<0.01$, t=-7.38; GS:AI mean=250.8s, pathologist mean=455.1s, $p<0.01$, t=-6.96).
Conclusion: The AI-based tool offers accurate, reproducible, and significantly more efficient Ki-67 quantification, representing a reliable, standardized alternative to manual methods. It eases workload and reduces diagnostic turnaround times in resource-limited settings. Limitations include dependence on digital microscopy and high-quality slide preparation.
Keywords: Ki 67 index, AI tool, breast cancer

RP 35

Correlation in benign uterine conditions: a retrospective study from a tertiary care centre in Sri Lanka

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Introduction and objectives: Benign uterine conditions (BUCs) are common causes of morbidity and infertility among women. Regular clinicopathological correlation provides valuable insights into diagnostic challenges, improving diagnostic accuracy and management. This study aimed to assess the concordance between clinical and histopathological diagnoses of BUCs and to evaluate symptom patterns in patients without a definitive clinical diagnosis.
Methodology: A retrospective, descriptive cross-sectional study was conducted from November 2023 to November 2024 at a tertiary care centre. Histologically confirmed BUCs were analysed using histopathology reports, requisition forms and bed head tickets. For cases with definitive clinical diagnoses, concordance, sensitivity, specificity, positive and negative predictive value were calculated. In cases without a clinical diagnosis, symptom patterns were cross tabulated with the final histopathological findings.
Results: A total of 366 patients were studied: 76.2% (n=279) had a definitive clinical diagnosis, while 23.8% (n=87) did not have a clinical diagnosis. Most patients were perimenopausal (54.09%; n=198). The overall clinicopathological concordance was 84.3%. Uterine fibroids were the most frequently diagnosed condition both clinically and histopathologically (concordance 77.7%, sensitivity 77.1%). Endometrial hyperplasia had the highest concordance (96.4%), while adenomyosis showed the lowest (68.4%). Heavy menstrual bleeding (36.7%; n=32) was the most common symptom among patients without a specific clinical diagnosis. Overlapping symptoms among fibroids, adenomyosis and polyps contributed to the clinical diagnostic uncertainty.
Discussion and conclusion: The findings underscore the limitations of symptom-based clinical diagnosis in BUCs. Conditions such as adenomyosis and polyps are often underdiagnosed due to overlapping presentations, highlighting the need for histopathological confirmation. Routine clinicopathological correlation is essential for enhancing diagnostic precision and ensuring optimal management of BUCs, particularly in cases with overlapping clinical symptoms.
Keywords: benign uterine conditions, clinical diagnosis, histopathological correlation

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RP 36

PD-L1 immunohistochemistry in gastric and gastro-oesophageal junction adenocarcinoma: comparison of combined positive score across 22C3 and SP263 assays

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Introduction and objectives: Programmed death-ligand-1 (PD-L1) is a potential target for immune checkpoint inhibitors in various cancers. The current study aimed to evaluate the concordance of combined positive score (CPS) across 22C3, and SP263 assays when interpreting PD-L1 immunohistochemistry on oesophageal and gastro-oesophageal junction (GOJ) adenocarcinoma.
Methodology: Twenty-two biopsies and eight resection specimens of oesophageal and GOJ adenocarcinoma were evaluated for PD-L1 SP263 expression at the Department of Pathology, Royal Surrey Hospital, over a period of four years (January 2021 to December 2024). These specimens were re-evaluated for PD-L1 22C3 assay at Poundbury Cancer Institute by an independent pathologist blindly to the PD-L1 SP263 assay results. The two results were compared for concordance.
Results: 93% (28/30) cases showed a significant concordance between the results of PD-L1 SP263 and 22C3 assay analysis. Two cases showed significant discordance. One case showed a high staining with SP263 compared to the 22C3 assay giving a high PD-L1 count for SP263. The other case showed depleted tumour tissue in the section that was recut for the 22C3 assay giving a low value.
Discussion and conclusion: There are three major commercially available immunohistochemistry assays to quantify PD-L1 expression in cancer cells; SP263, 22C3 and 28-8. A CPS $\geq$1 is currently used to classify a tumour as PD-L1 positive. According to NICE guidelines, oesophageal or GOJ adenocarcinomas with a PD-L1 CPS $\geq$5 is eligible for treatment with nivolumab, while a CPS $\geq$10 qualifies for pembrolizumab therapy. This study demonstrated analytical concordance between the SP263 and 22C3 assays when CPS scoring was applied, consistent with previously published data.
Keywords: PD-L1immunohistochemistry, gastric carcinoma, 22C3, SP263

RP 38

Morphological predictors of microsatellite instability in Gleason grade 4 and 5 prostate cancers

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Introduction and objectives: Prostate carcinoma (PCa) is the second commonest cancer in men globally and accounts for 6.3% of malignancies in men in Sri Lanka. Microsatellite instability (MSI) is an emerging prognostic and predictive factor in PCa. This study aimed to determine the prevalence of MSI in Gleason grade (GG) 4 and 5 PCa and describe its association with clinical and pathological features in cohort of Sri Lankan men with PCa.
Methodology: Fifty-six cases of high-grade (GG 4 and 5) PCa diagnosed at the Department of Pathology, Faculty of Medicine, Colombo were retrieved retrospectively from 30th March 2023. Age and serum PSA levels were obtained from request forms. Haematoxylin and eosin-stained slides were reviewed for GG, tumour morphology (e.g. tumour type, cribriform/fused/ill-formed glands, glomeruloid structures, sheets, singly infiltrating cells, cords), perineural invasion, and tumour burden. Immunohistochemistry for mismatch repair proteins (MMR) (MSH2, MSH6, MLH1, PMS2) was performed on selected blocks. Associations between MMR loss and clinicopathological features were assessed with chi-square test.
Results: MMR loss (MSH2 and MSH6) was observed in 5.4% (3/56), all of which were GG 5+5. There was no loss of MLH1 or PMS2. A significant association was found between MMR loss and GG(p=0.005). There was no association with other clinicopathological features.
Discussion and conclusion: MMR loss was found in 5.4% of high-grade PCa. A significant association with GG 5+5 tumours, compared to 4+4, 4+5 and 5+4 tumours was identified. Currently there are trials to determine efficacy of immunotherapy in high grade carcinomas. Therefore, testing MSI may have therapeutic impact in the future. Low prevalence of MMR loss, loss of MSH2 and MSH6 with preserved MLH1 and PMS2 and association of MMR loss with higher GG are similar to findings in studies done worldwide.
Key words: prostate cancer, Gleason grade, microsatellite instability
Acknowledgement: This study was funded by National Research Council grant SP 21-01 and the University of Colombo.

RP 39

A single centre experience on the utility of fine needle aspiration cytology and the Bethesda system in assessing thyroid nodules

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Introduction: Thyroid nodules are common in clinical practice. Fine Needle Aspiration Cytology (FNAC), guided by the Bethesda System for Reporting Thyroid Cytopathology (TBSRTC), is a standard approach to risk stratification. This study assesses the utility of FNAC and TBSRTC in assessing thyroid nodules in a single centre.
Methods: This retrospective study included 250 patients who underwent FNAC followed by histopathological assessment over two years. FNAC results were categorized (I–VI) per TBSRTC. Sensitivity, specificity, positive predictive value (PPV), negative predictive value (NPV), diagnostic accuracy, and risk of malignancy (ROM) were calculated. Histopathology was the gold standard; for Category III, ROM was reported due to its equivocal nature.
Results: Among 250 cases, Category I (4%) had 70% nondiagnostic histology. In Category II (51.8%), 96.1% were benign; ROM 3.8%. Category III (3%) showed ROM of 53.3%. In Category IV (8.5%), including both follicular adenomas and carcinomas, sensitivity and specificity were 42.9% and 57.1%, with ROM 38%. Category V (12.8%) showed sensitivity 84.4%, corrected specificity 72.2%, ROM 80.6%. Category VI (20%) showed sensitivity 94% and corrected specificity 82.6%, ROM 95%. Overall sensitivity, specificity, and diagnostic accuracy were 92.2%, 72.5%, and 83.5% respectively.
Conclusion: FNAC interpreted via TBSRTC offers high sensitivity and acceptable accuracy. Categories III–V remain diagnostic grey zones requiring cautious interpretation. Including ROM improves clinical risk assessment. We can conclude that FNAC continues to be vital in thyroid nodule management.
Keywords: thyroid cytology, Bethesda

RP 40

Comparison of non-diagnostic rates (Bethesda category I) in thyroid fine needle aspiration cytology between ultrasound-guided and direct techniques: an audit from a tertiary care centre

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Introduction and objective: As defined by Bethesda 2023, sample adequacy of thyroid cytology is determined by evaluating cellular quality, cellularity, and colloid content. Adequate samples must contain at least six clusters of ten well-preserved thyroid follicular epithelial cells, without significant obscuring by blood or air-drying artifacts. Samples that do not meet these standards are classified as non-diagnostic. This audit aims to compare the rate of non-diagnostic smears obtained via ultrasound (US)-guided aspiration versus those collected through direct fine needle aspiration cytology (FNAC).
Methodology: A retrospective cohort including all US guided FNAC and direct FNAC cases performed from March 2024 to March 2025 at National Hospital Kandy were analysed and the proportion of non-diagnostic samples was calculated.
Results: A total of 527 US-guided thyroid FNACs were performed, of which 134 (25.4%) were reported as non-diagnostic (Bethesda Category I). In comparison, 283 direct (non-ultrasound-guided) FNACs were conducted, with 75 (26.5%) yielding non-diagnostic results.
Discussion and conclusion: Both techniques resulted in a high proportion of non-diagnostic smears with ultrasound-guided FNAC demonstrating a slightly lower rate of non-diagnostic results compared to direct FNAC. Factors contributing to the high non-diagnostic rates in both methods may include operator experience, nodule characteristics such as size, depth, and cystic nature, as well as slide preparation techniques. The following recommendations are proposed to address these issues: training programs focused on The Bethesda System for Reporting Thyroid Cytopathology criteria, improving FNAC techniques through structured skill development, establishing standardized protocols for both ultrasound-guided and direct FNAC procedures, incorporating rapid on-site evaluation (ROSE) to assess sample adequacy during the procedure and conducting thorough pre-procedural assessment of nodule characteristics. A follow-up audit is recommended four to six months after implementing these measures to evaluate their effectiveness.
Keywords: non-diagnostic percentage, TBSRTC criteria, ultrasound guided FNAC, direct FNAC

RP 41

Nottingham grade distribution for breast carcinoma in National Hospital Kandy

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Introduction and objectives: Breast carcinoma (NST) is a common malignancy, and its prognosis is largely determined by tumour grade. The Nottingham grading system is widely used, and its distribution is known to follow an accepted ratio of 2:3:5 for Nottingham Grade 1, Grade 2, and Grade 3, respectively. This audit aims to determine the ratio of Nottingham grades given for the breast carcinoma cases reported in National Hospital Kandy and compare it with the accepted distribution of 2:3:5.
Methodology: We analysed the Nottingham grades given for all cases of breast carcinoma (NST) diagnosed on core biopsy (140) in 2025 at the National Hospital Kandy.
Results: 24 cases were reported as grade 1, 104 cases were reported as grades 2 and 12 were reported as Nottingham grade 3. The observed ratio for Nottingham grade 1, 2, 3 was 2:9:1. The mean absolute deviation was 0.3 which was significant. According to the chi- square formula there was a statistically significant deviation between the Nottingham ratio and the standard ratio at the 5% significance level.
Discussion and conclusion: There was a significant deviation of Nottingham grade ratio from the standard which could be due to subjective intra observer variability, fixation and processing artifacts or real biological or demographic variation. Regular training workshops, use of reference slides, peer review, ensuring strict adherence to protocols and improving tissue processing quality are suggested. The audit reveals the significant deviation from the standard ratio of Nottingham grading in the cases reported in National Hospital Kandy. The possible causes will be analysed and corrected. Reaudit will be done on core biopsies in three months.
Keywords: Nottingham grading system, tumour grade, breast carcinoma

RP 44

Fallopian tube precursor lesions in high-grade serous carcinoma : insights from a study in a tertiary care centre in Sri Lanka

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Introduction and objectives: High-grade serous carcinoma (HGSC) is the most common and lethal form of ovarian cancer. The p53 signature and serous tubal intraepithelial carcinoma (STIC) in the fallopian tube are identified as its precursor lesions. However, data from Sri Lanka on these precursor lesions are limited. This study assessed the prevalence of p53 signature and STIC in women with HGSC, and in those undergoing salpingectomy for benign indications, within a Sri Lankan cohort.
Methodology: This retrospective cross-sectional study analysed the fimbriae of fallopian tubes from three groups: Group 1; patients diagnosed with HGSC (n=48) and low-grade serous carcinoma (LGSC) (n = 2), Group 2; women under 55 years undergoing salpingectomy with or without hysterectomy for benign conditions (n = 180) and Group 3; women over 55 years undergoing similar procedures (n = 180). All specimens were evaluated histologically and with p53 immunohistochemistry.
Results: Among HGSC cases, 2.08% (n=1) showed p53 signature and 4.1% (n=2) showed STIC. None of the LGSC cases demonstrated either lesion. In Group 2, neither p53 signature nor STIC was detected. In Group 3, 1.1% (n=2) showed p53 signature, while no STIC lesions were observed. The differences in the prevalence of these lesions among HGSC, LGSC and the benign groups were not statistically significant ($p > 0.05$).
Discussion and conclusion: The prevalence of p53 signature and STIC in this study was markedly lower than internationally reported rates. These findings suggest the possibility of population-specific factors influencing HGSC carcinogenesis, warranting further large-scale studies incorporating molecular analysis. Nevertheless, our findings contribute to the ongoing discussion on the potential value of routine opportunistic salpingectomy in Sri Lanka as a preventive strategy.
Key words: serous carcinoma, serous tubal intraepithelial carcinoma, p53 signature
Acknowledgement: This study was funded by University Research Grant (URG/2022/47/M), University of Peradeniya.

RP 45

Expression of vitamin D metabolism and signalling markers in malignant thyroid tumours and benign thyroid lesions

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Introduction and objective: Vitamin D exists in several forms, with 1,25-dihydroxyvitamin D_3 [$1,25(OH)_2D_3$] being its biologically active form which exhibits antiproliferative and re-differentiating effects in various cancers, including thyroid cancer. Our objective was to determine the expression of Vitamin D receptor (VDR), CYP24A1, and Ki-67 in malignant and benign thyroid tumours and correlate these findings with histopathological parameters.
Methodology: Eighty-eight thyroidectomy specimens (46 benign, 42 malignant) were studied prospectively. Immunohistochemistry staining for VDR, CYP24A1, CYP27B1 was scored from 0-9 based on intensity and percentage of positive cells (score ≥4 - positive). The proportion of Ki67 positive cells was assessed. Associations between marker expression and tumour type were analysed using ANOVA and Pearson's correlation.
Results: Among the 88 cases, 32 were papillary thyroid carcinoma of which 81.25% showed high VDR expression (score ≥4), 65.65% showed low CYP24A1 expression (score 2) and 87.5% showed no CYP27B expression (score 0). Among 33 cases diagnosed as multinodular goitre/hyperplastic nodules, 54% exhibited low VDR expression (scores 0–1), 88% showed positive CYP24A1 expression, and 79% had low CYP27B1 expression (score 2). Ki-67 was elevated (30% or higher) in malignant thyroid tumours compared to benign lesions. VDR expression showed a moderate correlation with malignancy ($r=0.62$) but did not reach statistical significance.
Conclusion: The altered expression patterns of VDR, CYP24A1, and Ki-67 in malignant thyroid tumours suggest a possible involvement of vitamin D signalling in thyroid tumorigenesis. Despite lacking statistical significance, the trends indicate a potential role for vitamin D in modulating tumour behaviour, possibly through pathways related to immune regulation and cellular differentiation and warrants further investigation in larger patient cohorts.
Keywords: vitamin D receptor, thyroid malignancy
Acknowledgment: SDUAHER for funding

RP 46

Correlation between radiological and histological diagnosis of breast core needle biopsies in a tertiary care unit in Sri Lanka

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Introduction and objectives: Core needle biopsy (CNB) is critical in breast cancer diagnosis. This study evaluates the adequacy of CNB and its diagnostic concordance with the Breast Imaging Reporting and Data System (BIRADS) and the histological biopsy category (B category). In malignant cases, the Nottingham grade (NG) was also reviewed to explore tumour differentiation patterns.
Methodology: Data of all breast CNBs received from 01.01.2024 to 31.12.2024 were retrieved. The key variables extracted included the BIRADS category, histological (B) category, and the NG in the malignant biopsies.
Results: Of the 94 CNB included in this study, B1, B2, B3, B4 and B5 lesions were 17(18.09%), 24(25.53%), 0(0%), 3(3.14%) and 50 (53.19%), respectively. BIRADS 5 lesions (24/94) showed a strong correlation with B5 lesions, reflecting the effective radiological targeting of malignant lesions (83.3%; 20/24). Of the BIRADS 4 lesions (40/94), 45% (18/40) were B5, 5% (2/40) were B4 and 50% (20/40) were B1 and B2. 25 % of BIRADS 2 lesions (1/4) and 11% of BIRADS 3 lesions (1/9) were B5 lesions. NG in invasive malignancies (Category B5b) was 25.58%, 55.81%, and 18.60% for NG1, NG2 and NG3, respectively. A grading was not assigned in 8.51% (4/47) of B5b cases due to inadequate tumour tissue.
Discussion: This study shows a strong correlation between image-guided biopsies and histological diagnoses. Most radiologically suspicious/malignant lesions (BIRADS 4 and 5) were accurately targeted. This supports the effectiveness of imaging-based triage. In our study, NG2 was the most common histological grade. However, NG3 has been reported as the predominant grade in similar studies.
Conclusions: This study highlights the strengths of the diagnostic workflow of breast CNBs. However, areas requiring attention include improvement in specimen adequacy, provision of the BIRADS grade in all CNBs and review of the grading protocol.
Keywords: core needle biopsy, breast cancer, BIRADS, histological category (B category), Nottingham grade.

RP 47

An audit of fine needle aspiration cytology in a tertiary care centre in Sri Lanka

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Introduction and objectives: Fine needle aspiration cytology (FNAC) is a rapid, minimally invasive diagnostic technique used in detection of tumours. This audit aims to evaluate the distribution, diagnostic categories, and adequacy of FNAC at a single tertiary care unit in Sri Lanka.
Methodology: The audit included 127 FNAC samples received from 1.1.2024 to 31.12.2024 and reported using standard classification systems: Bethesda (thyroid), C-coding (breast), and Milan (salivary gland (SG)). Lymph nodes (LN) were categorized as non-diagnostic, benign, atypical and malignant. 76.4% (97/127) were ultrasound-guided (USG). 23.6% (30/127) were palpation-guided (PG).
Results: Anatomical distribution comprised thyroid 52.8% (67); LN 18.9% (24); breast 18.1% (23); and SG 7.9% (10). Diagnostic categories were Thyroid: non-diagnostic / Bethesda category (BC) I 32.8% (22), benign / BC II 58.2% (39), atypia of undetermined significance / BC III 7.5% (5), follicular neoplasms / BC IV 1.5% (1). LN: non-diagnostic 33.33% (8); benign 37.5% (9), malignant 29.2% (7). Breast: Non-diagnostic/C1 69.6% (16), C2 13.0% (3), C3 13.04% (3), C4 4.3% (1). SG: non-diagnostic/MC I 50% (5), benign neoplasms/MC IVA 30% (3), SG neoplasm of uncertain malignant potential/MC IV B 20% (2). Other sites included chest wall, scalp, and neck abscesses. Non-diagnostic category for USG FNAC was 48.45% (47/97); breast 34.04 % (16/47), thyroid 36.17% (17/47), LN 14.89% (7/47), SG 10.63% (5/47), chest wall 2.12% (1/47) and neck abscess 2.12% (1/47). Non-diagnostic category for PG was 20% (6/30); breast 0%, thyroid 83.33% (5/6), LN 16.66% (1/6) and SG 0%.
Discussion and conclusion: The thyroid was the most commonly sampled site, with a majority of benign diagnoses. A significant proportion of non-diagnostic smears, particularly from thyroid and breast, highlight the need for improved sampling techniques. LN FNACs showed a balanced distribution of benign, malignant, and non-diagnostic results. SG aspirates also had a high non-diagnostic rate, indicating sampling challenges. No C5 breast lesions were seen, as BIRADS 4/5 cases were typically referred for core needle biopsies. No Bethesda V or VI thyroid lesions were identified. These findings were reviewed and may be due to inadequate sampling of high-risk nodules, differences in clinicians' FNAC thresholds or selection bias (with suspicious cases referred elsewhere). USG FNAC showed a higher non-diagnostic rate than PG FNAC, especially in breast and thyroid lesions. These findings collectively emphasize the importance of technique refinement, adequate training, and site-specific considerations to enhance diagnostic yield and reduce non-diagnostic rates in FNAC practice.
Keywords: fine needle aspiration cytology, tertiary care unit

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Histo-morphological correlation of fine needle cytology diagnosis of thyroiditis in a cohort of patients from Sri Lanka

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Introduction and objective: In the Bethesda system for reporting thyroid cytopathology, thyroiditis falls under the TBSRTC II category and is a common diagnosis. Only a few Sri Lankan studies have explored the correlation between fine needle aspiration cytology (FNAC) and histological findings in thyroiditis. Our study aims to address that gap and enhance the diagnostic accuracy of thyroiditis in cytology.
Methodology: Descriptive cross-sectional study of samples received at the Department of Pathology, Faculty of Medicine, Peradeniya in 2018 and 2019. Thirty-eight patients with FNAC-diagnosed thyroiditis who later underwent surgery were analysed, with thirty-eight patients diagnosed with colloid nodules as a control group.
Results: Among cases diagnosed by FNAC exclusively as thyroiditis, 19 (50%) were confirmed histologically, while 16 (42.1%) had colloid nodules and three (7.9%) had incidental malignancies. In the control group, 32 (84.2%) had colloid nodules, nine (24%) showed evidence of thyroiditis, and two (5.26%) had exclusive thyroiditis. The sensitivity, specificity, positive predictive value, negative predictive value, and overall accuracy of FNAC for diagnosing thyroiditis were 67.9%, 60.4%, 50%, 76.3%, and 63.1%, respectively.
Discussion and conclusion: While the sensitivity observed aligns with international findings (65–98%), specificity was comparatively lower (72-100%). Over diagnoses may stem from inadequate clinical and imaging correlation, poor technique during FNA, and interpretative variability. Improving diagnostic accuracy requires a multidisciplinary approach incorporating clinical, radiological, and laboratory data. Techniques like radiology-guided aspiration, supervised FNAC, adherence to guidelines, regular internal audits, and ongoing professional training are recommended to enhance outcomes.
Keywords: fine needle aspiration cytology, thyroiditis

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CR 6	Deep (aggressive) angiomyxoma of the ischiorectal fossa: an uncommon mesenchymal tumour	*B. N. Adhikari** *R. Goonesinghe*
CR 7	Cribriform morular thyroid carcinoma: an uncommon thyroid malignancy of uncertain histogenesis	*B. N. Adhikari ** *P. Abeygunasekara*
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CR 142	Sertoliform endometrioid carcinoma of the ovary: a diagnostic mimic of sex cord-stromal tumours	*C.P. Weeraratne** *L.J. De Silva* *A.A.H. Priyani*
CR 143	Hybrid oncocytic/chromophobe tumor of the kidney: navigating the diagnostic grey zone	*C. P.Weeraratne** *L. J. De Silva* *A. A. H. Priyani*
CR 144	Atypical lipomatous tumour with a rare presentation	*L. D. Wickramasinghe** *A. S. Rodrigo* *S. Pathiraja*
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CR 147	A rare case of drug induced eosinophilic granulomatosis with polyangiitis	*K. K. Wijeyarathne** *S. Wijetunge* *R. Abeysekara*
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**CR 92, CR 101, CR 127, CR 136 and CR 145 have been withdrawn by the authors.*

CR 1 (Case series)

Clinical and immunomorphological diversity of peripheral T cell lymphoma, not otherwise specified: a case series

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Introduction: Peripheral T-cell lymphoma NOS (PTCL-NOS) represents a heterogeneous group of mature T-cell lymphomas with diverse morphology, variable immunophenotypes and involvement of nodal and extranodal sites. We present five cases illustrating their diagnostic complexity.
Case series: The patients (three females, two males, age range 49–78 years), presented with localized lymphadenopathy (cervical 2/5, inguinal 2/5) and paraaortic lymphadenopathy with iliac bone infiltration (1/5). Two had constitutional symptoms. Histopathology revealed a gradation of small to large atypical lymphoid cells showing diffuse (3/5) and sinusoidal (1/5) growth patterns. One case lacked intact architecture. Notable features included a background inflammatory infiltrate (3/5) and pale cytoplasm (2/5). Individual cases showed binucleation, necrosis, granulomata and prominent high-endothelial venules. Hallmark and Reed–Sternberg-like cells were absent. Immunohistochemistry consistently showed CD3 positivity and CD20 negativity. Loss of CD2 and a CD8-dominant phenotype were each observed once. Granzyme B was positive in two cases. Three contained CD30-positive large mononuclear atypical cells staining negatively with CD15, PAX5, and EBER. Cyclin D1 was focally expressed in one. CD79a, BCL2, MUM1, CD10, PD1, ALK1, EMA and TdT were negative, helping to exclude angioimmunoblastic T-cell lymphoma, Hodgkin lymphoma (HL), and B-cell lymphomas.
Discussion and conclusion: Unusual clinical and immunomorphological features identified included localized disease, bone involvement, lack of all the typically described morphologic and immunophenotypic features, granulomas and focal CyclinD1 expression. The presence of CD30 positive large, atypical cells could lead to confusion with HL. Awareness of unusual features of PTCL and use of a broad immunohistochemistry panel are crucial in accurate diagnosis, especially in settings lacking molecular diagnostics.
Keywords: peripheral T cell lymphoma, not otherwise specified, CD 30, Cyclin D1

CR 2

CNS embryonal tumour, not otherwise specified; a rare brain tumour in children

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Introduction: CNS embryonal tumour, not otherwise specified (NOS), is a high-grade malignant embryonal neoplasm that primarily affects young children, typically under three years of age. Histologically, it may exhibit a mixture of poorly differentiated small round blue cells, rhabdoid tumour cells, and foci of mesenchymal or epithelial differentiation. The diagnosis of atypical teratoid/rhabdoid tumour (AT/RT) is supported by the loss of nuclear expression of SMARCB1 (INI1) or SMARCA4 (BRG1).
Case report: A 4-year-old previously healthy boy presented to the paediatric ward with recent onset headache and drowsiness. Magnetic resonance imaging (MRI) showed a brain lesion in left frontal lobe. Crush smear and imprint cytology prepared from a biopsy of the lesion revealed poorly differentiated cells with a few scattered rhabdoid cells having eccentrically located nuclei and eosinophilic cytoplasm. Histology revealed an infiltrating tumour comprising solid sheets and trabeculae of poorly differentiated cells with high nuclear to cytoplasmic ratio. Scattered cells with rhabdoid features were identified. Focal areas of myxoid stroma and geographic necrosis were present. The tumour cells were positive for EMA, vimentin, GFAP and SMA. MyoD1 was negative. INI-1 studies were not available. A diagnosis of CNS embryonal tumour NOS was made.
Discussion and conclusion: Based on the histological findings and available immunohistochemical stains a diagnosis of CNS embryonal tumour, NOS was suggested, and the patient was referred to a tertiary care cancer hospital for further management. Although surgical resection is effective in reducing tumour mass, prognosis is very poor in these tumours. The patient succumbed to death within two months of diagnosis.
Keywords: CNS embryonal tumour, not otherwise specified (NOS), INI-1

CR 3

Prostate rhabdomyosarcoma: a rare mesenchymal tumour

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Introduction: Prostate rhabdomyosarcoma is a rare tumour entity in prostate, accounting for less than 0.1% of malignant prostate tumours. It is rare in adults and has a highly malignant potential. Several therapeutic approaches, such as radical surgery, radiotherapy and chemotherapy are used in the management.
Case report: A 42-year-old man presented to the genitourinary ward with symptoms of dysuria and perineal pain of one week duration. Ultrasound scan was suggestive of prostatitis, and he was treated with broad spectrum antibiotics. Prostate specific antigen (PSA) level was 1.1ng/ml. As his symptoms were worsening, prostate biopsy was done. Prostate biopsy revealed an infiltrating tumour, entirely composed of atypical spindle cells arranged in whorls and fascicles. These spindle cells had enlarged hyperchromatic nuclei. Focal areas showed cells with rhabdoid differentiation with eccentrically placed nuclei and eosinophilic cytoplasm. Large areas of necrosis and mitoses were identified. There were no foci of glandular differentiation. On immunohistochemical evaluation the atypical spindle cells showed diffuse desmin and MyoD1 positivity with negative staining for AE1/AE3 confirming the diagnosis of rhabdomyosarcoma of prostate.
Discussion and conclusion: Rhabdomyosarcoma is rare in adults. It occurs mainly in children during the first decade of life. Radiological investigations are helpful in characterizing the primary tumour and in detecting spread to the regional lymph nodes. A multidisciplinary team discussion was arranged for further management, and it was decided to proceed with chemotherapy.
Keywords: prostate rhabdomyosarcoma, mesenchymal tumour

CR 4

Endometriosis, an uncommon histological finding in the bladder

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Introduction: Bladder endometriosis is the presence of functional endometrial tissue in the bladder. This usually occurs in the posterior wall of the bladder above the trigone or at the dome. It is thought to be due to retrograde menstruation which seeds the surface of bladder serosa or may occur as a consequence of prior surgery. It does not occur due to metaplasia of Mullerian remnants or extension from anterior uterine adenomyosis. The bladder is the most common site (70%-80%) of endometriosis of the urinary tract. Endometriosis commonly occurs in women between the second and fifth decade and in post-menopausal women receiving exogenous oestrogen. Very rarely it can occur in men taking oestrogens for prostate cancer.
Case report: A 28-year-old previously healthy woman presented with non-specific lower abdominal pain. Computed tomography (CT) scan and cystoscopy revealed posterior bladder wall thickening. Transurethral resection of the bladder lesion showed bladder tissue lined by urothelium with a retained umbrella cell layer. The subepithelial tissue showed cystically dilated glands lined by endometrial-like cells surrounded by endometrial stroma. Collections of haemosiderin laden macrophages were also seen in the adjacent stroma. Immunostaining with ER and PR showed positive staining in endometrial like glands and stromal cells. Cytokeratin 7 positivity was seen in both the endometrial glands and urothelium. The histological and immunohistochemical findings confirmed the diagnosis of endometriosis of the bladder wall.
Conclusion: The management includes non-steroidal anti-inflammatory drugs for pain, hormonal contraceptives and GnRH analogues. Surgical resection of the lesion is the main mode of treatment.
Keywords: endometriosis, bladder

CR 5

Adenoid cystic carcinoma with high grade transformation: a case report of an uncommon phenomenon

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Introduction: Adenoid cystic carcinoma (AdCC) is a malignant salivary gland neoplasm characterized by frequent recurrences and late metastases. High-grade transformation (HGT) is an uncommon phenomenon which worsens prognosis and alters treatment approaches.
Case report: A 59-year-old woman presented with right facial swelling. Contrast enhanced computed tomography (CECT) showed an expansile mass with calcifications eroding the maxillary bone with no significant cervical lymphadenopathy. Histopathological examination of a partial maxillectomy specimen revealed a tumour with a cribriform and tubular architecture composed of monomorphic basaloid cells with abrupt transition to solid islands of pleomorphic cells containing prominent nucleoli, increased mitoses and central necrosis. p63 confirmed the presence of myoepithelial differentiation in conventional areas and absence in solid islands. CD117 was diffusely positive in both components. HER2 was negative. Ki67 was 47% in solid areas and 18% in conventional areas. P53 was not performed.
Discussion and conclusion: HGT represents dedifferentiation of AdCC into a poorly differentiated adenocarcinoma or anaplastic carcinoma. Loss of myoepithelial differentiation and conventional architecture, presence of squamoid and micropapillary areas, nuclear pleomorphism, and high proliferative index distinguish transformed areas. Evidence suggests a role of p53 mutations and HER2-neu over-expression in HGT. However, 70-80% AdCC with HGT are reported to be HER2 negative. The presence of a conventional AdCC component aids in distinction from tumours like salivary duct carcinoma. HGT shows a high propensity for lymph node metastasis. Thorough sampling is crucial to identify HGT as elective neck dissection will be considered. AdCC with HGT represents a distinct entity requiring recognition through histomorphological assessment. This enables risk stratification and implementation of aggressive treatment.
Keywords: adenoid cystic carcinoma, high grade transformation, aggressive clinical course, salivary gland malignancy

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CR 6

Deep (aggressive) angiomyxoma of the ischiorectal fossa: an uncommon mesenchymal tumour

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Introduction: Deep angiomyxoma (DAM) is a rare mesenchymal tumour with a predilection for the perineal region of women of reproductive age. Despite its benign nature, DAM is locally infiltrative with a high risk of recurrence. It is often misdiagnosed as a benign lipomatous lesion or Bartholin cyst. Histopathological evaluation is essential for accurate diagnosis.
Case report: A 28-year-old nulliparous woman presented with a gradually enlarging painless labial lump of five months duration. Ultrasound scan showed a hyperechoic lesion in the right labia majora. Surgical excision showed a lobulated, solid white tumour measuring 90x70x20mm. Histopathological examination revealed a focally infiltrative lesion composed of bland spindled cells in a myxoid stroma. Mitoses were inconspicuous. A prominent component of medium-sized thick walled and capillary-sized blood vessels was present. The spindled cells showed diffuse positivity for ER and focal positivity for SMA, CD34 and desmin. Ki67 proliferation index was 6%. Based on the above findings, a diagnosis of DAM was made.
Discussion: DAM is a rare tumour whose infiltrative nature and hormone receptor positivity make it prone to recurrence, especially if excision is incomplete. Histopathological and immunohistochemical evaluation are crucial to differentiate it from superficial angiomyxoma, angiomyofibroblastoma and myxoid lipomatous tumours. Wide local excision and hormonal therapy are the mainstays of treatment. Immunohistochemical positivity for HMGA2 and demonstration of *HMGA2* rearrangement by molecular studies can further confirm the diagnosis.
Conclusion: DAM, although benign, poses a diagnostic and therapeutic challenge due to its propensity for recurrence. Histopathological examination remains essential for definitive diagnosis.
Keywords: deep (aggressive) angiomyxoma, mesenchymal tumour, female genital tract

CR 7

Cribriform morular thyroid carcinoma: an uncommon thyroid malignancy of uncertain histogenesis

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Introduction: Cribriform morular thyroid carcinoma (CMTC) is an uncommon thyroid malignancy of uncertain histogenesis showing a strong association with familial adenomatous polyposis (FAP) syndrome. Predominantly affecting young females, it exhibits unique histological and immunohistochemical features.
Case report : A 16-year-old woman presented with a painless goitre. Ultrasound scan showed a solitary right thyroid nodule. Fine needle aspiration cytology was suspicious for a papillary thyroid carcinoma (PTC). Histopathological evaluation of a total thyroidectomy specimen revealed a solitary, partially encapsulated tumour composed of cribriform nests, follicles and papillae with focal capsular invasion. Most follicles lacked colloid. Focal nuclear features of PTC were seen. Squamoid morules were absent. With these features, a differential diagnosis of cribriform morular thyroid carcinoma and invasive encapsulated follicular variant of PTC was made. Immunohistochemistry showed diffuse nuclear positivity for beta-catenin, ER and TTF1 confirming the diagnosis of CMTC. Genetic testing for FAP was recommended.
Discussion: Cribriform morular thyroid carcinoma, once considered a variant of papillary thyroid carcinoma, is now regarded a distinct thyroid malignancy of uncertain histogenesis with unique genetic features and clinical significance. This is further supported by its immunohistochemical negativity for PAX8 and thyroglobulin, markers of follicular epithelial cell differentiation. CMTC can show overlapping features with other thyroid tumours. Its hallmark is the presence of cribriform structures and squamoid morules, which were absent in our case. While morulae are characteristic of CMTC, cases exhibiting exclusively cribriform architecture without morulae have been documented and can pose a diagnostic challenge. The presence of nuclear beta-catenin is a key diagnostic clue and is linked to *APC* gene mutation. CMTC in FAP are often multifocal, bilateral and small whereas sporadic tumours are solitary and larger. Recognizing CMTC is clinically significant to prompt surveillance and genetic testing for FAP as it is reported to precede colonic manifestations.
Conclusion: CMTC is an uncommon thyroid malignancy with distinctive histopathological characteristics. Accurate diagnosis is critical not only for management but due to its syndromic associations.
Keywords: cribriform morular thyroid carcinoma, thyroid malignancy of uncertain histogenesis, familial adenomatous polyposis

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CR 8

Balamuthia mandrillaris granulomatous amoebic encephalitis: a tale of two cases

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Introduction and objectives: Free living amoebae are opportunistic organisms which have the capability to infect humans. Pathogenic free-living amoebae can lead to infections of the central nervous system with very high mortality rates. We present two such cases.
Case report: Case 1: A 28-year-old man presented with two episodes of generalized tonic clonic seizures (GTCS) associated with headache. Magnetic resonance imaging showed a T2 hypointense left frontal lobe lesion with diffusion restriction, suggesting a broad differential diagnosis including tuberculosis (TB), sarcoidosis and lymphoma, among others. The lesion was biopsied. Case 2: A 47-year-old man presented with GTCS with radiology showing multiple intracranial lesions suggestive of TB. He was started on anti-TB treatment. However he continued to worsen rapidly, and a biopsy was done. Biopsies from both cases showed abscess formation with viable areas showing amoebic trophozoites that were periodic acid Schiff (PAS) positive and diastase resistant. The first patient also had skin lesions, biopsies from which revealed the same organisms. All biopsies were sent for polymerase chain reaction (PCR) testing targeting the 18S rDNA gene of *Balamuthia mandrillaris* and the presence of 210 band confirmed the presence of the organism in all.
Discussion and conclusion: Amoebic granulomatous encephalitis is rare and often is diagnosed only in postmortem specimens. These are unsuspected clinically and usually diagnosed on histopathology. PCR can help in confirmation and species identification which dictates management of these patients. A knowledge of this rare entity is helpful for pathologists as it can aid in timely diagnosis and appropriate management of these rare cases.
Keywords: amoebic encephalitis, *Balamuthia mandrillaris*, brain abscess, central nervous system tuberculosis

CR 9 (Case series)

Naevus lipomatosus superficialis: a case series

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Introduction: Naevus lipomatosus superficialis (NLS) is a rare benign cutaneous hamartoma characterized by mature adipose tissue in the dermis. Clinically, it appears as soft, skin-coloured or yellowish papules or nodules. It manifests in two forms: classical(multiple lesions) and solitary(single lesion).
Case series: Fifteen histopathologically confirmed cases of NLS were studied over two years. A strong female predominance was noted (M:F ratio 1:14), with a mean age of 39.5±13.6 years. The lesion duration ranged from 6 months to 30 years and sizes ranged from 1to10 cm. The thigh (n=5,33.3%) and buttocks (n=4,26.7%) were the most common sites, followed by the back (n=2,13.3%), nape, axilla, inguinal region, and shoulder (n=1, 6.7%). All lesions were solitary and nine (60%), were pedunculated and six (40%) presented as nodules. Histology showed epidermal atrophy and dermal lobules of mature adipocytes mixed with collagen. Clinically, eight cases (53.3%) were misdiagnosed as papillomas, five (33.3%) as acrochordons, and one case (6.7%) each as sebaceous cyst or soft tissue swelling.
Discussion: NLS likely arises from developmental anomalies such as adipocyte differentiation from pericytes or dermal connective tissue metaplasia. The classical form appears early in life, while the solitary form occurs at any age. Unlike previous reports of no gender bias, this series showed female predominance. Common differentials include lipofibroma, skin tags, and papillomas.
Conclusion: NLS is a rare cutaneous malformation. Findings from this limited case series suggest a female predominance and a tendency to present as a solitary lesion. However, larger studies are needed to confirm these patterns. Accurate clinical and histopathological recognition is crucial to avoid misdiagnosis with more common benign skin lesions.
Keywords: naevus lipomatosus superficialis, cutaneous hamartoma, dermal adipocytes

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CR 10

Pregnancy induced hypertension with microvascular damage leading to multiorgan failure and acute pancreatitis.

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Introduction: Acute pancreatitis is a rare complication in pregnancy and has been reported to be associated with pre-eclampsia
Case Report: We present a case of a 28-year-old primi mother diagnosed with monochorionic diamniotic twins and pregnancy-induced hypertension. She was admitted to the ward due to dribbling and upper abdominal pain at 33 weeks of period of amenorrhoea. On admission she had high blood pressure and proteinuria. She underwent an emergency caesarean section. The surgery was uneventful and there was no evidence of pancreatitis. Two live babies were delivered. Two hours later, she became haemodynamically unstable without internal haemorrhages. Laboratory findings revealed elevated liver enzymes, low albumin, high amylase, and acute renal dysfunction indicating multi-organ involvement. Imaging confirmed acute pancreatitis, and she required continuous renal replacement therapy for metabolic acidosis. She underwent splenectomy due to a retroperitoneal hematoma but ultimately succumbed to multi-organ failure 12 days later.
Autopsy findings revealed massive cerebral oedema, ischemic and necrotic changes in abdominal organs (pancreas, bowel and uterus). Extensive fat necrosis was observed in the thoracic cavity and omental tissue. Gall stones were not present. Histopathology confirmed necrosis in pancreas, bowel and uterus. Extensive thrombosis of larger vessels and features of thrombotic microangiopathy in the lungs and heart were identified. Submitted tissue of the lung did not show features of diffuse alveolar injury. Liver tissue was not received for microscopic assessment. Fat necrosis was present in intra-abdominal organs and the thoracic wall. A diagnosis of acute pancreatitis, disseminated intravascular coagulation and organ ischemia was made.
Discussion and conclusion: Although pancreatitis is rarely reported in association with preeclampsia/eclampsia, its occurrence can be attributed to microvascular changes in preeclampsia that may affect pancreatic vessels, leading to acute pancreatitis.
Keywords: pregnancy-induced hypertension, acute pancreatitis, disseminated intravascular coagulation, multi-organ failure

CR 11

Giant cell fibroblastoma of the post auricular region

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Introduction: Giant cell fibroblastoma (GCF) is a rare soft tissue tumour with a male predominance, primarily affecting children and adolescents. It is considered part of the spectrum of dermatofibrosarcoma protuberance (DFSP), often exhibiting a recurrent, locally aggressive behaviour but a low metastatic potential.
Case report: We received an excision biopsy of a post auricular region dermal lesion in an otherwise asymptomatic 36-year-old woman with no prior history of malignancy or trauma. Histology showed a well-demarcated, hypocellular dermal neoplasm composed predominantly of spindle cells and scattered multinucleated giant cells. Irregular, branching, pseudo-vascular spaces lined by spindle cells were seen. The stroma was collagenous. There was no evidence of necrosis, mitotic activity or infiltration into the surrounding tissue. Immunohistochemistry for CD34 was positive in the spindle and giant cells. Desmin, MyoD1, pan-cytokeratin, CD 68 and S100 were negative. The findings supported a fibroblastic origin and ruled out myogenic, epithelial, and histiocytic differentiation. A diagnosis of GCF was made.
Discussion and conclusion: GCF is a rare entity and should be considered in the differential diagnosis of CD34-positive spindle cell tumours of the dermis, especially in younger patients. It has a close relationship with DFSP both histologically and genetically, often harbouring the *COL1A1–PDGFB* fusion gene. Although GCF is considered to be of intermediate malignancy with a tendency for local recurrence, it rarely metastasizes. Complete surgical excision with clear margins is recommended to prevent recurrence.
Keywords: giant cell fibroblastoma, multinucleated giant cells, pseudo-vascular spaces, dermatofibrosarcoma protuberance

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CR 12

A challenging case of dual malignancy in liver and kidney with metastasis in ectopic adrenal tissue

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Introduction and objectives: Hepatocellular carcinoma (HCC) is the most common primary malignancy in the liver. The commonest malignancy in the kidney is clear cell renal cell carcinoma (CCRCC). Concurrent occurrence of these two tumours is rare. Liver hilum is a known but rare site for ectopic adrenal tissue. While most ectopic adrenal tissue is asymptomatic, rarely it can develop primary adrenal cortical neoplasms or even metastasis. We present a case of dual malignancy with HCC and CCRCC with HCC metastasis in ectopic adrenal tissue in the liver hilum.
Case report: A 74-year-old diabetic patient was admitted due to reduced glomerular filtration rate. An ultrasound scan followed by CT scan of the abdomen revealed a solitary liver lesion (56x54mm) and a right renal mass (42x40mm). Right partial hepatectomy and right partial nephrectomy were performed. Histology of the renal lesion revealed a CCRCC. The liver lesion showed a well differentiated HCC. Hilar fatty tissue revealed discrete round masses of adrenal tissue (calretinin showed moderate nuclear and cytoplasmic positivity, Hep-Par1 was negative). One such masses showed an HCC deposit (Hep-Par1 showed diffuse strong granular cytoplasmic positivity, calretinin was negative)
Discussion and conclusion: Concurrent occurrence of HCC with CCRCC is exceedingly rare and only a few cases are reported in the literature. This case is further complicated by presence of ectopic adrenal tissue in the liver hilum and finding HCC metastasis within them. While finding adrenal metastasis is a common occurrence, involvement of ectopic adrenal tissue is rare. This may be overlooked during standard pathological evaluations. However careful evaluation of gross pathology, histology, and thoughtful usage of immunohistochemistry aided the correct diagnosis.
Keywords: hepatocellular carcinoma, clear cell renal cell carcinoma

CR 13

ALK positive large B cell lymphoma: a diagnostic difficulty

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Introduction: ALK positive large B cell lymphoma (ALK+LBCL) is an extremely rare aggressive lymphoma that usually occurs in immuno-competent young men. Owing to its unusual morphology and immunophenotype, misdiagnoses are not uncommon. We present a case of ALK+LBCL that posed a diagnostic difficulty.
Case report: A biopsy of a right cervical lymph node from a 39-year-old immuno-competent man was referred from a local hospital. Histology revealed effaced nodal architecture due to a neoplasm composed of highly atypical lymphoid cells with plasmablastoid morphology with eccentrically placed pleomorphic nuclei, macronucleoli and abundant amphophilic cytoplasm. Apoptotic and mitotic activities were high. The tumour cells were negative for CD20, CD79a, PAX5, CD3 and CD30 and positive for LCA, CD138 and MUM1. ALK-1 showed granular cytoplasmic staining and Ki67 was 80%. We concluded the diagnosis as ALK+LBCL.
Discussion and conclusions: Pleomorphic lymphomas with plasmablastic morphology are a heterogenous group of terminally differentiated B cells which typically lack the expression of CD 20 and show variable expression of other B cell markers. The main entities included are plasmablastic myeloma, plasmablastic lymphoma, primary effusion lymphoma and ALK+LBCL. The main clue for finding B cell lineage in this group is MUM1 and CD 138 positivity. ALK+LBCL is more likely to express B cell transcription markers such as BOB1 and OCT2, expression rate of PAX5 is low. Younger age and immunocompetent status in this patient should prompt adding ALK staining. Diffuse large B cell lymphoma with plasmablastic morphology is a mimic that often shows CD20 positivity. Awareness of this group of lymphomas is essential to avoid misdiagnosis.
Keywords: ALK positive large B cell lymphoma, ALK stain

CR 14

Idiopathic scrotal calcinosis: a case report of a rare entity

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Introduction: Idiopathic scrotal calcinosis (ISC) is a rare, benign condition presenting with multiple calcified nodules within the dermis of the scrotal skin. It has no clear aetiology.
Case report: A 27-year-old man presented with progressively increasing multiple painless nodules in the scrotum. There was no history of discharge, ulcer or infection. Nodulectomy showed multiple, firm, subcutaneous nodules in the scrotal wall. Serum calcium, phosphate and parathyroid hormone levels were normal. There were basophilic calcified nodules without surrounding epithelium. Necrotic material was seen in the periphery with collections of foreign body type giant cells in a background of chronic inflammation. No granulomata were seen.
Discussion and conclusion: ISC is an example of dystrophic calcification which is usually asymptomatic but may produce vague pain or discharge. It can be complicated with secondary infection. It commonly occurs in young men 20-40 years of age. Surgery is the main stay of treatment with rare recurrence. Malignant transformation is not reported.
Keywords: idiopathic scrotal calcinosis

CR 15

An unusual presentation of low grade appendiceal mucinous neoplasm of appendix

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Introduction: Low grade appendiceal mucinous neoplasm (LAMN) of appendix is a low grade non-invasive epithelial proliferation without infiltrative growth. It is common in the elderly with equal gender distribution and usually presents as appendicitis.
Case report: A 50-year-old man presented with bilateral scrotal lumps clinically and radiologically diagnosed as bilateral inguinal hernias. Ultrasound scan showed no testicular masses. The abdomen was unremarkable. Bilateral herniotomy was performed and hernial sacs were sent for histology. Microscopy of both hernial sacs showed fibrous cyst walls with pools of extra cellular mucin containing small aggregates of epithelioid cells. The presence of mucin and bland cells necessitated the exclusion of a reactive process with mesothelial cell proliferation or a metastatic deposit of a mucinous tumor. Subsequent contrast enhanced computed tomography (CECT) showed an enlarged appendix suspicious for a mucinous neoplasm. He underwent appendicectomy. Histology of the appendix revealed an undulating, filiform mucinous epithelium with mild nuclear atypia, pseudostratification and pushing type invasion consistent with LAMN.
Discussion: The goal of management in LAMN includes prevention of rupture, seeding and development of pseudo myxoma peritonei. Prompt diagnosis and timely treatment of mucinous neoplasm of appendix is critical. This case is an example why LAMN should be within the differential diagnosis of bilateral hernia containing mucin. In LAMN, presence of mucin in the serosal surface would upstage the tumor. Timely treatment will improve the prognosis.
Keywords: low grade appendiceal mucinous neoplasm

CR 16

A rare occurrence of epidermoid cyst in the tongue

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Introduction: Dermoid and epidermoid cysts can occur in the head and neck region, with approximately 11.5% of head and neck dermoid cysts found in the floor of the mouth, making it the most common intraoral location. The cervical region is the second most frequent site, while occurrence in the tongue is rare. Overall, these cysts represent less than 0.01% of all oral cavity cysts.
Case report: A 49-year-old woman presented with a swelling on the ventral aspect of the tongue persisting for three months duration. On examination, there was a well circumscribed, mildly tender lesion with no discharge. Histology showed a subepithelial cyst lined by stratified squamous epithelium with a retained granular layer. The cavity contained lamellated keratinous material with foci of calcification. Skin adnexal structures are not seen There was no evidence of malignancy.
Discussion and conclusion: Epidermoid cysts are commonly located on the face, neck, chest and upper back; 7% of cysts involve the head and neck with fewer cases affecting the oral cavity, particularly the tongue. It has very minimal risk of malignancy and recurrence. Complete surgical excision is the treatment of choice. Accurate diagnosis and differentiation from dermoid cysts are essential optimal treatment and outcomes.
Keywords: epidermoid cyst, tongue

CR 17

Haemosiderotic variant of dermatofibroma: a rare variant of a common tumour

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Introduction: Dermatofibroma (DF) is a common benign fibrohistiocytic lesion. Haemosiderotic variant of DF(HVDF) is very rare with a reported incidence of 1.7% of all DF.
Case report: A 21-year-old man presented with a thigh lump of one year's duration, which had shown recent rapid enlargement. On clinical examination, the lesion was non-tender and tested negative for the pinch sign. Grossly, the excised specimen was a skin-covered, solid mass measuring 15 × 12 × 10 mm. The cut surface appeared tan with areas of hemorrhage. An unencapsulated, dermal lesion composed of spindle cells and histiocytic cell aggregates was seen on microscopy. The spindle cells had moderately pleomorphic nuclei with eosinophilic cytoplasm. Intracellular and extracellular hemosiderin was prominent in the vascular stroma. Foci of red cell extravasation were seen. Scattered Touton-type giant cells and zones of peripherally thickened collagen were present. Based on the histomorphological features, a diagnosis of HVDF was made.
Discussion: Although CD34 and desmin are negative in HVDF, FXIII is usually positive. Complete surgical excision remains the primary treatment; however, literature reports a relatively high recurrence rate of approximately 19–20% even after complete removal. Despite being a rare variant of a common tumour, awareness of HVDF is clinically and histologically important, as it can mimic melanoma, potentially leading to diagnostic confusion.
Keywords: haemosiderotic variant, dermatofibroma

CR 18

Mixed neuroendocrine non-neuroendocrine tumour in ascending colon

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Introduction: Mixed neuroendocrine non neuroendocrine neoplasms (MiNEN) are mixed epithelial neoplasms in which a neuroendocrine component is combined with a non-neuroendocrine component. Each component is morphologically and immunohistochemically recognizable as a discrete component and constitutes at least 30% of the neoplasm. MiNEN represents roughly 1-2% of all colorectal malignancies.
Case report: A 50-year-old man presented with anaemic symptoms, loss of appetite and loss of weight for three weeks. Colonoscopy showed a circumferential growth in the ascending colon. He underwent right-side hemicolectomy. There was a polypoidal mass in the ascending colon measuring 60x60x40mm. Histology showed an infiltrating malignant tumour with two distinct morphologies. There was a component of adenocarcinoma comprising malignant glands infiltrating a desmoplastic stroma, which showed strong immunoreactivity for CDX2 and CK20 and was negative for neuroendocrine markers and a neuroendocrine component composed of sheets of tightly packed cells with granular chromatin pattern with no necrosis or mitoses and showing positivity for synaptophysin and chromogranin with negativity for CK20 and CDX2.
Discussion: The heterogeneity and rarity of MiNENs make timely recognition and accurate diagnosis challenging. Morphological recognition of this entity and confirmation by immunohistochemistry is the mainstay of diagnosis. Identifying a neuroendocrine component comprising at least 30% of the tumor is crucial, as a proportion below this threshold leads to a diagnosis of adenocarcinoma with neuroendocrine differentiation—resulting in significantly different management strategies. The mainstay of treatment of MinNEN is surgery with or without chemoradiotherapy. Its biological behavior is mostly driven by the neuroendocrine component.
Keywords: mixed neuroendocrine non neuroendocrine neoplasm, colon

CR 19

A rare case of primary diffuse large cell lymphoma of central nervous system

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Introduction: Primary central nervous system lymphomas (PCNSL) are lymphomas confined to the central nervous system (CNS) at presentation with no evidence of systemic involvement. DLBCL is the commonest PCNSL. It is common in older people with a median age of 66 years. CNS-DLBCL has a worse prognosis compared to systemic DLBCL.
Case report: A 61-year-old woman presented with acute left leg and face weakness. Magnetic resonance imaging showed a space occupying lesion involving the right lentiform nucleus and internal capsule suggestive of a glioma. No lymphadenopathy, hepatosplenomegaly or mediastinal masses were detected. Excision of the lesion revealed sheets of medium to large discohesive cells with pleomorphic, hyperchromatic nuclei and scanty cytoplasm with brisk mitotic activity showing angiocentric invasion. The atypical cells were positive for the immunomarker CD20 and were negative for CD10 and CD3. Ki67 proliferative index was 70%.
Discussion: PCNSL can be misdiagnosed as a glioma both clinically and radiologically. High degree of suspicion should be maintained in elderly patients presenting with neurological symptoms. Methotrexate based polychemotherapy has shown prolonged survival. Immunoglobulin (Ig) gene clonal rearrangement is seen in DLBCL which is currently unavailable in Sri Lanka.
Keywords: diffuse large B cell lymphoma, central nervous system lymphoma

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CR 20

A rare case of myeloid sarcoma

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Introduction: Myeloid sarcoma (MS) is a tumoral mass composed of mature or immature myeloid blasts in an extramedullary anatomical location. MS occurs denovo or in in association with acute myeloid leukaemia (AML), myeloproliferative neoplasia or myelodysplastic syndrome. Although MS is common in paediatric AML, it is less frequently (0.25%) seen in adults.
Case report: A 37-year-old woman who was diagnosed with AML 15 months back and defaulted treatment presented with lymphadenopathy in mandibular region. Microscopic examination of the lymph node showed completely effaced architecture with sheets of monomorphic medium sized cells with vesicular nuclei, a dispersed chromatin pattern, conspicuous central, single nucleoli and moderate eosinophilic cytoplasm. Mitotic activity was brisk with many apoptotic bodies. Necrosis or extra nodal extension were not seen. Small lymphocytes and scattered histiocytes were present in the background. The neoplastic cells were strongly positive for MPO and CD68 and weakly positive for CD117. They were negative for CD3 and CD20.
Discussion: MS should be differentiated from lymphoma, particularly from diffuse large B cell lymphoma, lymphoblastic lymphoma and Burkitt lymphoma. Immunohistochemistry is essential for definitive diagnosis. Cytogenetic and molecular abnormalities in myeloid sarcoma are similar to those in AML. Since treatment is different in each category, it is mandatory to differentiate MS from other differential diagnoses. Studies concerning the prognosis and therapy response are limited, but generally MS is treated with induction chemotherapy. However, survival rates are very low with a five-year survival rate of 15%.
Keywords: myeloid sarcoma

CR 21

Composite lymphoma featuring classic Hodgkin lymphoma and follicular lymphoma: a rare entity

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Introduction: Composite lymphoma (CL) is defined as two or more morphologically and immunophenotypically distinct lymphomas or lymphoid neoplasms that occur in the same site. Among those CL composed of Hodgkin lymphoma with non-Hodgkin is extremely rare.
Case report: A 47-year-old woman presented with generalized lymphadenopathy without any constitutional symptoms. An axillary lymph node sent for histology showed completely effaced architecture with a predominant follicular pattern. The follicles were of the same size with attenuated marginal and mantle zones. Tingible body macrophages were not seen. In the parafollicular region large binucleate and mononucleate cells with prominent nucleoli and eosinophilic cytoplasm residing in lacunae were identified resembling Reed Sternberg cells. Mitoses or necrosis were not evident. The background showed scattered eosinophils. Immunohistochemically in the interfollicular area the large cells were positive for CD15, PAX5 and CD30. They were negative for CD 20, CD10 and BCL2. The neoplastic follicles were positive for BCL2, CD20 and CD10. Ki67 was 48%. Features were compatible with concurrent occurrence of follicular lymphoma and classic Hodgkin lymphoma.
Discussion and conclusion: The recognition of CL is important to determine the prognosis of the patient. Immunophenotyping, cytogenetics and gene rearrangement analysis are all important in determining the clonality of the tumour but are currently unavailable in government sector.
Keywords: composite lymphoma

CR 22

A rare case of primary ovarian lymphoma masquerading as a pedunculated fibroid

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Introduction: Primary ovarian lymphomas (POL) are rare, accounting for <1.5% of ovarian neoplasms. Most POLs are of B-cell origin, with diffuse large B-cell lymphoma being the most common. Due to their rarity and nonspecific clinical and radiological features, POLs can be mistaken for other more common ovarian malignancies, which may lead to unnecessary surgical interventions.
Case Report: A 59-year-old woman presented with a three-month history of pyrexia of unknown origin and markedly elevated serum lactate dehydrogenase (3717 U/L). Bone marrow biopsy showed granulocytic hyperplasia without evidence of malignancy. Contrast-enhanced computed tomography (CECT) of the abdomen and pelvis revealed a large pelvic mass (14.6x10.6x13.8cm) that was interpreted as a pedunculated subserosal uterine fibroid and a single enlarged paraaortic lymph node. A hysterectomy with bilateral salpingo-oophorectomy was performed. Intraoperatively, a large right ovarian mass was identified, while the uterus, cervix, left fallopian tube, and left ovary appeared normal. Gross examination showed a homogeneous, solid, tan ovarian tumor with focal haemorrhages and an intact capsule. Histology revealed sheets of discohesive, small to medium-sized malignant cells with hyperchromatic nuclei, prominent nucleoli and frequent mitoses. The initial differential diagnoses included a poorly differentiated sex cord stromal tumour and a lymphoma. Immunohistochemistry demonstrated strong, diffuse membranous positivity for LCA, CD20 and nuclear positivity for MUM1. WT1, CD10, CD3, CD5, Cyclin D1 and MYC were negative, confirming the diagnosis of diffuse large B cell lymphoma, activated B-cell subtype. The patient was started on systemic chemotherapy.
Discussion: POL poses a diagnostic challenge due to its overlapping imaging and clinical features with other ovarian neoplasms. Maintaining a high index of suspicion especially in cases where clinical features are suggestive of a haematological neoplasm can help avoid unnecessary radical surgery, as POL is primarily treated with systemic chemotherapy. Preoperative tissue diagnosis may be considered when feasible.
Keywords: primary ovarian lymphoma; B-cell lymphoma

CR 23 (Case series)

Primary orbital and ocular adnexal lymphoma: a retrospective analysis of eight cases

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Introduction: Orbital and ocular adnexal lymphomas (OOALs), comprising 1–2% of non-Hodgkin lymphomas, present diagnostic challenges due to their varied manifestations. Histopathology with immunohistochemistry is the key for accurate diagnosis. This case series describes the pathological features of OOAL at a single centre
Methodology: A retrospective analysis was conducted on eight consecutive cases of OOAL diagnosed between September 2023 and March 2025. Formalin-fixed, paraffin-embedded tissue sections and panel of immunohistochemical (IHC) markers which was applied in accordance with the World Health Organisation classification based on the diagnostic requirement of each case, including CD3, CD20, CD21, CD23, Ki-67, BCL-2, CD30, CD10, CD5, Cyclin D1, kappa and lambda light chains, CD15, CD43, EMA, BCL-6, CK, CD45, CD99, TdT, SOX11, ALK-1, perforin, and CD45RO were reviewed.
Results: Patients were aged 40–70 years (median age of 55 years) with 05 males (62.5%) and 03 females (37.5%). The lower eyelid was the most commonly affected site, and the predominant clinical presentation was an orbital mass. The majority of cases were interpreted as non-Hodgkin lymphoma, with extra nodal marginal zone lymphoma of mucosa-associated lymphoid tissue (MALT) type being the most frequent diagnosis (n=4). One case each was diagnosed as classic follicular lymphoma, diffuse large B-cell lymphoma, mantle cell lymphoma of blastoid variant, and ALK-negative anaplastic large cell lymphoma.
Discussion and conclusion: We report eight cases of primary OOAL, all in adult patients. MALT lymphoma represents the most common type which is consistent with similar studies reported worldwide. This case series underscores the spectrum of ocular lymphomas and the indispensable role of histopathology and IHC in diagnosis and classification, which directly influences management and outcomes.
Keywords: adnexal, orbital, lymphoma, conjunctiva, ocular adnexal lymphoma, immunohistochemistry

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CR 24

Pulmonary sclerosing pneumocytoma mimicking lung cancer: a diagnostic challenge

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Introduction: Pulmonary sclerosing pneumocytoma (SP) is a rare benign tumour of the lung, with unpredictable biological behaviour. SP can histologically resemble malignancy, making intraoperative and preoperative diagnosis challenging, particularly on frozen sections.
Case report: A 19-year-old woman was incidentally found to have a solitary pulmonary nodule on imaging. The intraoperative frozen section raised concern for a malignant tumour, prompting a lobectomy. Gross examination revealed a well-circumscribed mass. Histopathology showed surface cuboidal epithelial cells and stromal round to polygonal cells, arranged in papillary, sclerotic, and haemorrhagic patterns. On immunohistochemistry the surface cells and round stromal cells showed strong positivity for EMA and TTF-1. The surface cells showed strong positivity for napsin A and cytokeratin, and the round stromal cells showed weak nuclear positivity for ER with low Ki67 proliferative index. Synaptophysin was negative in both cell types.
Discussion: SP typically affects middle-aged women but can present in young adults. The papillary pattern observed in frozen sections raises the possibility of papillary adenocarcinoma, bronchioloalveolar carcinoma, epithelioid mesothelioma, and papillary adenoma. Presence of areas of solid growth and variable cytological atypia necessitates considering a potential malignancy. Moreover, hypercellularity, glandular formation, and calcification are recognized as significant diagnostic pitfalls, underscoring the importance of evaluation of the permanent sections and immunohistochemistry analysis.
Conclusion: This case highlights the diagnostic pitfalls of SP, particularly on frozen sections. Awareness of this entity, its histological features, and appropriate immunoprofiling are essential to avoid unnecessary surgery in benign lesions.
Keywords: sclerosing pneumocytoma, pulmonary nodule, frozen section, TTF-1, benign lung tumor

CR 25

Two cases of post infectious glomerulonephritis with pyelonephritis following skin sepsis

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Introduction: Post infectious glomerulonephritis (PIGN) is an immune mediated glomerular disease due to cross reacting antibodies. PIGN co-existing with acute pyelonephritis due to direct bacterial invasion of the renal parenchyma is rare.
Case report: Case 1: A 66-year-old, non-diabetic man with no evidence of immunosuppression was investigated for body swelling and increasing serum creatinine. He had chronic bilateral lower limb eczema. Case 2: A 51-year-old woman was evaluated for nephritic syndrome. She had bilateral lower limb swelling and psoriasis and was on long term methotrexate. In both cases, the patients had urine full report evidence of proteinuria and haematuria with no evidence of an increase in urinary leucocytes. Both patients had no other clinical symptoms. Histopathology of renal biopsies from both patients showed features of acute diffuse proliferative glomerulonephritis without crescents. The interstitium contained a moderately heavy infiltrate of lymphocytes and plasma cells admixed with neutrophils. There was tubulitis mediated by neutrophils and pus cell casts were also evident. Immunofluorescence studies of case 1 showed moderate granular C3 deposits only. Case 2 showed strong IgG deposits in the capillaries and mesangium. Both cases were diagnosed as PIGN with pyelonephritis.
Discussion and conclusion: In both cases ongoing secondary skin sepsis due to eczema and psoriasis may have resulted in bacteraemia along with cross reacting antibody formation leading to PIGN with pyelonephritis with immune suppression due to methotrexate being contributory in case 2 . Pyelonephritis can be clinically silent. Therefore, it is important to look for features of co-existing pyelonephritis in renal biopsies in susceptible patients, as pyelonephritis component needs separate treatment.
Keywords: glomerulonephritis, pyelonephritis, eczema

CR 26

Cellular neurothekeoma: a rare tumour posing a diagnostic challenge

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Introduction: Neurothekeoma is a rare benign superficial dermal soft tissue tumour predominantly occurring in young women in the head and neck region. It is considered to be of fibrohistiocytic origin with the ability to differentiate into myofibroblasts and recruit histiocytes.
Case report: A 24-year-old woman presented with a gradually enlarging painless skin coloured forearm lump. We received an ellipse of skin measuring 1.4 cm in maximum diameter. Microscopy showed a well-defined dermal lesion with lobular growth pattern. There were round to oval nests composed of epithelioid and spindle cells separated by dense collagen bands. The cells within the nests were arranged in a whirling pattern. The epithelioid cells had round to oval nuclei with coarse chromatin prominent nucleoli and abundant clear to pale eosinophilic cytoplasm with indistinct cell borders. Occasional bizarre nuclei were present. Mitotic activity and necrosis were not seen. The tumour cells were positive for SMA and NSE and negative for S100, HMB45 and desmin. Ki 67 was 2%.
Discussion and conclusion: The differential diagnosis for dermal based lesions comprising epithelioid cells with abundant cytoplasm are granular cell tumour, melanocytic naevus, melanoma and neurothekeoma. Granular cell tumours are S100 positive and HMB 45 negative. Melanomas are positive for both S100 and HMB 45. Naevi show positivity for S100 and HMB 45 in the superficial dermal component. In contrast, neurothekeomas are characteristically negative for S100 and HMB-45, but show positivity for markers such as NSE and SMA. A diagnosis of cellular neurothekeoma was made. Accurate diagnosis requires careful histopathological evaluation and a thorough immunohistochemical workup, particularly given the overlapping morphology with other dermal epithelioid lesions. Awareness of this rare entity is crucial to avoid misclassification and to guide appropriate clinical management.
Keywords: neurothekeoma, immunohistochemistry

CR 27

Appendicular non-mucinous adenocarcinoma presenting as appendicular intussusception: an extremely rare presentation

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Introduction: Appendiceal intussusception, in which the appendix invaginates into the caecum, is an extremely rare finding in about 0.01% of appendicectomies and presents with features of acute appendicitis or obstructive symptoms. Mucocele, endometriosis, parasites, lymphoid hyperplasia and tumours have been identified as precipitating causes. This is a case of appendiceal non-mucinous adenocarcinoma, a rare tumour at this site, presenting as an appendicular intussusception.
Case report: A 49-year-old man presented with sudden onset of right iliac fossa abdominal pain for two days. CT abdomen showed inflammatory changes in the ileocecal junction with intussusception of the appendix. He underwent a right hemicolectomy. This specimen was 30 cm in length and revealed an elongated polypoid protrusion in the caecum with an indentation on the serosal surface at the base, corresponding to the anatomical location of the appendix. The appendix was not separately identified. Microscopically, the intussusceptum showed extensive mucosal ulceration with a moderately differentiated adenocarcinoma underneath involving the muscularis propria and the subserosa of the mesoappendix. The core showed muscularis propria with adipose tissue lined by mesothelium at the centre, which demonstrated the inverted appendix with the mesoappendix. The appendiceal mucosal tissue was not identified due to extensive ulceration. The tumour was staged as pT3. The rest of the specimen showed no additional pathologies.
Discussion and conclusion: Due to its rarity, appendicular intussusception may not be suspected at the initial presentation. Correlation with the radiological features and macroscopic features is mandatory to diagnose this condition, while a careful histological assessment is vital to confirm the aetiology.
Keywords: appendiceal adenocarcinoma, appendiceal intussusception

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CR 28

Endometrial carcinoma presenting as an endometrial polyp

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Introduction: Endometrial polyp is a benign overgrowth of endometrial tissue that is common in perimenopausal and postmenopausal women. Concurrent hyperplasia occurs in 1-30% of polyps and subsequent carcinoma develops in 0.5 – 3%.
Case report: A 62-year-old woman presented with postmenopausal bleeding. An endometrial curetting showed a high-grade endometrial carcinoma. She underwent total abdominal hysterectomy and omentectomy with pelvic lymph node dissection. The uterus showed a polyp with an irregular surface in the fundus measuring 6x3x4.5cm. Microscopically, the polyp revealed two foci of an infiltrating tumour involving 1/3 of the periphery of the polyp. The tumour was composed of complex papillary and glandular structures lined by columnar cells with highly pleomorphic enlarged nuclei and prominent nucleoli. Mitotic activity was brisk. Squamous morules were present. Solid regions were not evident. The rest of the polyp showed typical features of a benign endometrial polyp. Invasion of the stalk was not seen. The non-polypoid endometrium was atrophic. The tumour cells showed scattered positivity for vimentin and ER and wild-type positivity for p53. A diagnosis of early endometroid-type endometrial carcinoma arising in a benign endometrial polyp was made.
Discussion and conclusion: In the absence of background endometrial hyperplasia this is likely to be a rare case of a de novo tumour arising from a benign endometrial polyp. Although benign endometrial polyps are common, particularly in postmenopausal women, careful histopathological evaluation is essential to avoid overlooking an underlying or emerging malignancy.
Keywords: endometrial polyp, endometrial carcinoma

CR 29

Exploring a new thyroid entity: a case of follicular adenoma with papillary architecture

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Introduction: The World Health Organisation 5th edition classification of thyroid tumours introduced the entity of follicular adenoma with papillary architecture (FAPA), thereby enhancing our understanding of thyroid neoplasms and reducing the potential for overdiagnosis of papillary thyroid carcinoma (PTC).
Case report: A 52-year-old man presented with a left solitary thyroid nodule. Ultrasound imaging revealed a TIRADS 4 lesion with mixed solid and cystic components. Fine needle aspiration cytology showed papillary clusters with oedematous, vascular cores lined by cells with mildly enlarged nuclei without classic nuclear features of PTC and was reported as suspicious of PTC. A total thyroidectomy specimen showed a 37×23×22mm sized encapsulated lesion involving the entire left lobe with a pale tan cut surface and focal cystic and haemorrhagic areas. Microscopy showed a tumour with a predominantly intrafollicular papillary architecture. The papillae showed oedematous vascular cores. The lining cells were cuboidal to low columnar with cytoplasm and round, basally located nuclei with fine chromatin. Focal nuclear crowding was present. The nuclei lacked clearing, overlapping, nuclear grooves and pseudo-inclusions. The neoplastic cells showed diffuse membrane positivity for CD56 and weak focal membrane positivity for CK19.
Discussion and conclusion: FAPA can mimic papillary carcinoma in cytology due to the presence of papillary structures. However, the lining cells may not exhibit the classic nuclear features typically observed in PTC. When papillary architecture with oedematous, vascular cores is present, it is important to exercise caution not to over diagnose PTC in the absence of classic nuclear features. This case emphasises the need to recognise follicular adenoma with papillary architecture as a distinct entity, since it has the potential for misdiagnosis as PTC in cytology.
Keywords: follicular adenoma, papillary architecture

CR 30

High-grade myxofibrosarcoma of the thigh

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Introduction: Myxofibrosarcoma (MFS) is a malignant fibroblastic neoplasm demonstrating a spectrum of histological grades with prominent pleomorphism, mitotic activity, and an infiltrative growth pattern, posing significant diagnostic challenges.
Case report: A 55-year-old woman presented with a painless, gradually enlarging swelling in the right thigh of eight months. Magnetic resonance imaging (MRI) showed an ill-defined, subcutaneous soft tissue mass with solid and cystic areas, skin involvement, and increased vascularity but no deep fascia or muscle invasion. Wide local excision revealed a multilobulated, gelatinous to firm nodule measuring 25×25×20 mm. Histology showed a multinodular tumour with alternating hypocellular myxoid areas and hypercellular regions of pleomorphic spindle cells, curvilinear vessels, frequent atypical mitoses, and infiltration into surrounding adipose tissue. No lipoblasts, chicken wire vasculature, necrosis, or vascular invasion were seen. The closest clearance from the deep margin was 1 mm. A diagnosis of high-grade myxofibrosarcoma was made based on the biphasic pattern, marked pleomorphism, mitotic activity, infiltration, and characteristic vasculature.
Discussion and conclusion: High-grade MFS has higher local recurrence and metastasis risks than low-grade tumours, requiring wide excision and close follow-up. Differential diagnoses include myxoid liposarcoma, low-grade fibromyxoid sarcoma, and myxoid dermatofibrosarcoma protuberans. In this case, classic morphology was diagnostic, and immunohistochemistry (IHC) was not performed. However, IHC is valuable when morphology is ambiguous, helping confirm MFS and exclude mimics. For example, myxoid liposarcoma shows lipoblasts and is S100 positive; low-grade fibromyxoid sarcoma is MUC4 positive; myxoid dermatofibrosarcoma protuberans shows CD34 positivity. This case highlights classic MFS features and emphasises the importance of comprehensive sampling, imaging, biopsy, and margin assessment for effective management.
Keywords: myxofibrosarcoma, soft tissue, tumour, curvilinear, myxoid

CR 31

Lymph node metastasis mimicking histiocytes in endometrioid carcinoma with microcystic elongated fragmented pattern of invasion: a potential diagnostic pitfall

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Introduction: Microcystic, elongated fragmented pattern (MELF-p) of myometrial invasion is a distinct histologic feature infrequently seen in low-grade endometrioid carcinomas (EC). This pattern is associated with deep myometrial invasion, lympho-vascular space invasion (LVSI) and lymph node metastasis (LNM).
Case report: A 65-year-old woman presented with a uterine mass detected incidentally on transvaginal ultrasound scan. Magnetic resonance imaging (MRI) revealed an endometrial tumour infiltrating the outer half of the myometrium. Biopsy confirmed EC. She underwent total hysterectomy, bilateral salpingo-oophorectomy, right/left external iliac sentinel lymph node (EISLN) excision. Gross-examination revealed a 35mm polypoid endometrial tumour with deep myometrial invasion. Histologically, the tumour was a grade-1-EC with prominent MELF-p of invasion at the invasive front. There was deep myometrial invasion with no cervical involvement or LVSI. Left EISLN showed micrometastatic carcinoma measuring 0.26 mm in maximum dimension. Additionally, both right and left EISLN showed singly scattered histiocyte-like tumour cells and tiny clusters expressing AE1/AE3 in the peripheral sinus, measuring <0.2mm; consistent with isolated tumour cells(ITC). The tumour was staged FIGO IIIC1.
Discussion and conclusion: LNM in the context of MELF-p poses a diagnostic challenge, as typical glandular or papillary morphology is not present. LNM contain single or small clusters of tumour cells mimicking histiocytes, resembling the discohesive cells observed in MELF-p invasion. This characteristic histomorphological feature of metastatic tumour cells may lead to a missed diagnosis of LNM. Therefore, when MELF-p infiltration is encountered in the uterine tumour, meticulous examination of the SLN and utilisation of pancytokeratin immunohistochemistry is recommended to accurately diagnose LNM and guide appropriate staging and clinical management.
Keywords: endometrioid carcinoma, microcystic, elongated fragmented pattern of invasion, sentinel lymph node, isolated tumour cells

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CR 32

Serous carcinoma component of uterine carcinosarcoma metastasizing to the fallopian tube and masquerading as serous tubal intraepithelial carcinoma: a rare diagnostic challenge

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Introduction: Uterine serous carcinoma(USC) is a high-grade malignancy associated with poor prognosis. Serous tubal intraepithelial carcinoma(STIC) is a precursor of tubo-ovarian high-grade serous carcinoma. Although USC frequently involves lymph-nodes and peritoneum, metastasis to fallopian tubes (FT) with STIC-like morphology is uncommon.
Case Report: A 60-year-old woman presented with postmenopausal bleeding. Imaging revealed a large polypoid tumour, confined to the endometrial cavity. Gross-examination of the excision specimen revealed a 70mm variegated polypoid mass, largely confined to the endometrial-cavity. Histologically, the tumour was a carcinosarcoma, with 60–70% comprising USC (WT1 negative, p53 mutant/overexpression) in a background of serous endometrial intraepithelial carcinoma (SEIC). There was no deep myometrial/cervical stromal invasion. The right FT exhibited segments of stratified, non-ciliated epithelial cells containing enlarged pleomorphic, hyperchromatic nuclei morphologically resembling STIC. Immunohistochemically, these foci showed mutant/overexpression of p53, and a high Ki-67 index, features typical of STIC. However, they were negative for WT1. Given the similar immunohistochemical-staining pattern to the USC, these tubal lesions were diagnosed as metastatic deposits. Additionally, both ovaries and the bladder peritoneum contained metastatic serous carcinoma; FIGO stage IIIB. The patient was referred for adjuvant therapy.
Discussion : STIC in the context of USC should be evaluated using an extended immunohistochemical panel including WT1. Negative WT1 and matching mutant p53 expression in both uterine and tubal lesions support metastatic disease rather than true STIC. In rare cases of WT1 positive USC, next-generation-sequencing to confirm identical *TP53* mutations in both lesions can aid in accurate diagnosis.
Conclusion: Awareness of this rare occurrence and the judicial use of immunohistochemistry is necessary to prevent under-staging of USC and ensure appropriate management.
Keywords: STIC, uterine serous carcinoma, fallopian tube metastasis, carcinosarcoma

CR 33

Rare occurrence of extramedullary haematopoiesis in a breast implant capsule: a diagnostic challenge

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Introduction: Extramedullary haematopoiesis (EMH) is defined as the formation of haematopoietic cells outside the bone-marrow (BM). While EMH is commonly observed in organs such as the spleen and liver, its occurrence within breast implant (BI) capsules is exceedingly rare and is not reported in the literature to the best of our knowledge.
Case report: An 80-year-old woman was treated for left breast cancer with a reconstruction textured BI in 2002. Ultrasound-scan demonstrated capsule contracture with significant peri-implant collection. The clinical concern was BI-associated anaplastic large cell lymphoma (ALCL), and the capsule was excised. The case was referred from a peripheral hospital due to the presence of atypical CD30-negative multinucleated cells, not diagnostic of ALCL. Histologically, the capsule displayed sclerotic-fibrosis, silicon associated foreign-body-type-giant-cell response, fibrin admixed with megakaryocytes (some large and hyperlobated), erythroid colonies and myeloid precursors, in keeping with EMH. The megakaryocytes were negative for CD30 and AE/AE3 and positive for CD31/CD61. No evidence of ALCL or carcinoma recurrence was identified, and haematology referral was advised. Later, following further inquiry, it was confirmed that the patient was already under haematology follow-up for essential thrombocythaemia (ET), information that was unavailable to the referring pathologist at the time of diagnosis.
Discussion and conclusion: Causes for EMH include myeloproliferative neoplasms (MPN) as in this patient, myelodysplastic syndrome, haemoglobinopathies and BM infiltration by metastases. Failure to recognise megakaryocytes in EMH, especially in unexpected sites, may result in clinically significant misdiagnoses. Awareness of a pre-existing underlying cause may prompt a general pathologist to consider EMH. In absence of a known aetiology, detecting EMH, should prompt haematological investigation for an underlying cause.
Keywords: extramedullary haematopoiesis, breast implant

CR 34

An uncommon initial manifestation of follicular lymphoma in the urinary bladder

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Introduction: Follicular lymphoma is an indolent B cell non-Hodgkin lymphoma which typically arises in lymph nodes. Extranodal involvement is reported in 10-20% of cases. The frequent sites of extranodal involvement are bone marrow, gastrointestinal tract, skin, lungs and central nervous system. Urinary bladder involvement is exceedingly rare.
Case report: A 69-year-old woman with early cirrhosis was found to have an incidental bladder lesion on ultrasound scan. CT scan confirmed a lesion in the posterior wall of the bladder measuring 3.7x3.3x3.1cm. She had no lower urinary tract symptoms. Transurethral resection of the bladder tumour was performed. Histopathological analysis revealed an atypical lymphoid infiltrate in the sub urothelial tissue. The lymphoid infiltrate showed a mixed nodular and diffuse pattern of growth. Small cleaved centrocytes and a few centroblasts were seen. No Reed Sternberg cells or lymphoepithelial lesions were identified. The neoplastic cells were positive for CD10, CD20 and BCL-2 and negative for CD3 and CD5 confirming the diagnosis of follicular lymphoma. Subsequent PET-CT scan revealed widespread lymphadenopathy and hypermetabolic lesions in the pancreas, right kidney and urinary bladder. Mesenteric, cervical, mediastinal, abdominal and left inguinal lymph node groups were involved. This fulfilled the criteria to classify it as stage IV disease (Lugano classification). In view of the generalized lymphadenopathy and multi-organ disease, she was diagnosed with systemic follicular lymphoma with extranodal involvement.
Discussion and conclusion: This case highlights the importance of considering lymphoma in the differential diagnosis of atypical bladder lesions. Bladder lymphomas can be primary or secondary. Therefore, accurate diagnosis relies on histopathology, immunohistochemistry and systemic workup to determine the extent of spread of the disease. A multidisciplinary team approach is mandatory for optimum management and outcomes.
Keywords: follicular lymphoma, nodal, extranodal.

CR 35

A rare case of nasopharyngeal carcinoma in an adolescent girl presenting as a clival lesion

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Introduction: Nasopharyngeal carcinoma is an uncommon malignancy in children and adolescents. It may present with advanced locoregional extension involving the parapharyngeal space, skull base and cervical lymph nodes. Clival invasion is rare but indicates a clinically advanced disease with aggressive behaviour.
Case report: A 12-year-old girl presented with a headache for one month. She had cervical lymphadenopathy, unilateral hearing loss and diplopia. Magnetic resonance imaging (MRI) revealed an ill-defined mass eroding the clivus, extending to nasopharynx, oropharynx and prevertebral space. The radiological and clinical diagnosis was clival chordoma. Imprint cytology smears made from a biopsy from the skull base were inconclusive as there were marked crush artefacts. Subsequent histological evaluation showed an infiltrating tumour composed of sheets, nests and cords of cells with nuclear pleomorphism, hyperchromasia and spotty necrosis. Given the patient's clinical presentation, imaging characteristics, and histopathological features, the differential diagnoses considered included Ewing sarcoma, poorly differentiated carcinoma, lymphoma and poorly differentiated chordoma. The initial immunohistochemistry panel demonstrated positivity for AE1/AE3 and EMA and negativity for LCA, S100 and CD99. These findings were supportive of carcinoma and suggested a non-keratinizing nasopharyngeal carcinoma. Subsequent immunohistochemistry revealed positivity for CK5/6 and P40 which confirmed the diagnosis of nasopharyngeal carcinoma. The patient underwent concurrent chemoradiotherapy and had a favourable response.
Discussion and conclusion: Nasopharyngeal carcinoma with clival involvement in a young girl represents a rare and atypical presentation. Early diagnosis is challenging due to the subtle and nonspecific presentation. Timely imaging and prompt histological diagnosis are essential for better outcomes. As nasopharyngeal carcinoma has a strong association with Epstein-Barr (EBV) virus and EBV testing may aid in its diagnosis.
Keywords: nasopharyngeal carcinoma, clivus, chordoma

CR 36

A rare case of giant dedifferentiated liposarcoma of the para-testis presenting as scrotal swelling

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Introduction: Dedifferentiated liposarcoma (DDL) is an aggressive tumour with a worse prognosis and a higher risk of metastasis than well differentiated liposarcoma. The local recurrence rate of DDL is 40%, and the metastatic rate ranges from 15% to 30%[1].
Case report: A 76-year-old man presented with right-sided scrotal swelling accompanied by mild pain for the past seven months. We received a right high inguinal orchidectomy specimen, a measuring 12.5x6x6 cm and weighing 190 grams. The cut surface showed a lobulated, yellowish to white, homogenous, bulging tumour. Microscopic examination of the tumour showed differentiated and dedifferentiated components. The well-differentiated components comprised mature adipocytes admixed with varying numbers of pleomorphic and often bizarre multinucleated tumour cells, atypical lipoblasts and floret cells. Classic lipoblasts with scalloped nuclei and signet ring lipoblasts showing cytoplasmic vacuolation were also seen scattered throughout the tumour admixed with the atypical cells. The dedifferentiated component was cellular and a non-lipogenic sarcoma with significant pleomorphism and mitotic rate of 5 mitoses/10 high-power fields, resembling a spindle cell sarcoma. A diagnosis of dedifferentiated liposarcoma was made. Immunohistochemistry with MDM2 and CDK4 further confirmed the diagnosis of dedifferentiated liposarcoma.
Discussion and conclusion: Giant paratesticular liposarcoma is a rare, slow growing tumour often misdiagnosed as a hernia or lipoma, leading to delays in treatment. It typically affects men aged 50–70 years. Radical orchidectomy with high inguinal cord excision is the treatment of choice. Dedifferentiated liposarcoma is rare and difficult to diagnose but can be reliably identified with histology and immunohistochemistry for MDM2 and CDK4.
Keywords: dedifferentiated liposarcoma, paratestis, immunohistochemistry MDM2, CDK4

CR 37

Undifferentiated carcinoma with osteoclast-like giant cells: a rare pancreatic carcinoma

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Introduction: Undifferentiated carcinoma with osteoclast-like giant cells (UC-OGC) is a rare, aggressive variant of pancreatic ductal adenocarcinoma (PDAC), comprising approximately 1% of pancreatic malignancies. Despite its rarity, UC-OGC displays a distinct morphological and immunohistochemical profile essential for accurate diagnosis and optimal management.
Case presentation: A 61-year-old man presented with haematemesis and melena. Upper gastrointestinal endoscopy and contrast-enhanced CT revealed a polypoidal ampullary mass. Endoscopic biopsy revealed a poorly differentiated carcinoma with positive epithelial markers. Whipple's pancreaticoduodenectomy, revealed an 8.5cm tumour in the pancreatic head, invading the ampulla and duodenum. Histology demonstrated an undifferentiated neoplasm composed of atypical mononuclear cells interspersed with numerous osteoclast-like multinucleated giant cells, without any conventional ductal adenocarcinoma components. Immunohistochemistry confirmed mononuclear cell positivity for CD68, EMA and AE1/AE3 and negativity for Cytokeratin-7, CD117, DOG1, and CD34 stains. The OGC and some mononuclear cells were strongly positive for CD68, supporting histiocytic lineage. The tumour exhibited mutant p53 expression. It was staged as pT3pN0 and was completely resected with negative margins. The patient remains on regular oncological follow up.
Discussion and Conclusion: UC-OGC may mimic high-grade sarcomas and epithelioid GISTs. Epithelial marker expression distinguishes it from mesenchymal tumours, while absent or focal DOG1/CD117 expression helps to exclude GISTs. Osteoclast-like giant cells are reactive, CD68-positive, and non-neoplastic, although some mononuclear cells may also be histiocytic. UC-OGC often harbours *KRAS* and *TP53* mutations, linking it to PDAC biology. Absence of glandular differentiation and conventional ductal elements is associated with poor prognosis. Careful histopathological and immunohistochemical evaluation is crucial for accurate diagnosis and appropriate treatment.
Keywords: pancreas, adenocarcinoma, giant cells

CR 38 (Case series)

Clinicopathological and immunomorphological profile of primary head and neck synovial sarcoma cases from a tertiary care cancer centre in India: a case series

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Introduction: Synovial sarcoma (SS) is a malignant mesenchymal neoplasm with variable epithelial differentiation, which has a propensity to occur in young adults. It occurs most frequently in extremities. Head and neck synovial sarcomas (HNSS) constitute less than 0.1% of all head and neck cancers and 5-7% of all SS. This case series describes the clinicopathological profile of primary head and neck synovial sarcoma.
Case series: The clinicopathological, immunohistochemical and molecular features of head and neck SS reported over a four-year period at a tertiary care centre were assessed. Ten patients diagnosed with SS in the head and neck region were studied. The median age was 24.5 years, and the mean tumour diameter was 5.6 cm. The affected sites were the temporal region, supraglottis, epiglottis, orbit, occipital region, preauricular region, tonsillar region, parapharynx and parotid gland. Six cases were reported as monophasic SS, three as biphasic and one as poorly differentiated SS. The most consistent immunohistochemical markers were TLE-1 (100%), SSX-SS18 (72%), CD56 (83%), BCL2 (83%), and CD99 (80%). FISH for *SS18: SSX* fusion was done in two cases, which were both positive. Two patients had surgery along with adjuvant chemoradiation and six patients received only chemoradiation. The median follow-up duration of the cohort was 20 months [Inter-quartile range (IQR): 2.2–22 months]. During follow-up, two patients developed local recurrence and four developed metastases.
Discussion and conclusion: Head and neck sarcomas are rare. Meticulous pathologic evaluation and awareness of the typical and atypical histology of SS, along with the apt application of immunohistochemical markers, such as TLE1 and SS18 and/or cytogenetics (*SYT* translocation), assist in precise recognition of this entity.
Keywords: synovial sarcoma, head and neck, chemotherapy, immunohistochemistry.

CR 39

HPV related multiphenotypic sinonasal carcinoma

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Introduction: HPV related multiphenotypic sinonasal carcinoma is a rare tumour associated with high-risk human papilloma virus(HPV) particularly genotype 33. The tumour exhibits a mixed histological phenotype, including adenoid cystic carcinoma(ACC), basaloid and squamous cell carcinomas(SCC). They are exclusively found in the sinonasal region, have a high frequency of local recurrence, and are indolent compared to sinonasal squamous cell carcinoma (SCC). Distant metastases are rare and regional lymph node involvement has not been reported.
Case history: A 68-year-old woman presented with a left nasal mass which was biopsied. Microscopy showed a polypoid respiratory and transitional type mucosa with an underlying basaloid tumour having tubular, cribriform and solid patterns. The neoplastic cells were moderately pleomorphic with hyperchromatic nuclei. Mitosis and apoptosis were frequent. On immunohistochemistry, the tumour showed positivity for AE1/3, CK7, P63, SMM and S100. P16 showed block positivity. Proliferation on Ki67 was 30%. CK5/6 and P40 staining were patchy. Desmin, MyoD1 and myogenin were negative. High risk HPV genotype 33 was detected. EBER(ISH) was negative. A fusion event involving *SMARCB1, NUTM1, MYB* and *MYBL1* were not seen.
Discussion: Differential diagnoses included sinonasal SCC, ACC, SMARCB1-deficient sinonasal carcinoma, sinonasal undifferentiated carcinoma (SNUC) and the remote possibilty of olfactory neuroblsatoma(ON). Positivity for HPV and absence of fusion events excluded ACC, SMARCB1-deficient sinonasal carcinoma and SNUC. Presence of myoepithelial differentiation ruled out a SCC while negativity for myogenic markers and neuroendocrine markers excluded myogenic tumours and ON. Recognising this rare tumour is important as despite the high-grade histological features, they have an indolent clinical course and a better prognosis.
Keywords: HPV related multiphenotypic sinonasal carcinoma, HPV genotype 33, sinonasal.

CR 40

A rare case of intraorbital pleomorphic adenoma

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Introduction: Pleomorphic adenoma is a benign tumour commonly occurring in the salivary glands. Those arising from ectopic lacrimal glands in the orbital cavity are rare, with only a few reported in the literature. It comprises 1-2% of orbital tumours and 12% of lacrimal gland tumours.
Case report: A 61-year-old woman presented with right-sided proptosis and blurred vision. Non-contrast CT brain demonstrated a hyperdense extraconal mass in the right orbit. Intraoperatively, there was a solid, rounded tumour. Macroscopically, the specimen was an enucleated solid mass measuring 25x24x20mm with a white, solid cut surface. Microscopy showed a well-circumscribed biphasic tumour composed of ducts and cords of epithelial cells with outer myoepithelial cells in a chondromyxoid stroma. Mitotic figures were not seen. Tumour necrosis was absent.
Discussion: Ectopic lacrimal glands can occur in the conjunctiva, the orbit and the eyelid. Pleomorphic adenomas developing from ectopic lacrimal glands usually present as a painless, gradual onset proptosis, rarely with diplopia or reduced vision. Generally, they develop in the 5th and 6th decades of life. Histopathological findings of pleomorphic adenomas of the lacrimal gland are similar to those that arise in the salivary glands. Although uncommon, the presence of morphological atypia, including enlarged, pleomorphic, or hyperchromatic nuclei, frequent/abnormal mitotic figures and capsular invasion, suggests a greater likelihood of carcinomatous transformation. Complete excision is curative.
Conclusion: The case described displays the characteristic clinical, radiological and histopathological features of pleomorphic adenomas. Pleomorphic adenoma needs to be considered as a differential diagnosis in intraorbital tumours.
Keywords: pleomorphic adenoma orbit

CR 41

Incidental renal angiomyolipoma in a patient with endometrioid type endometrial carcinoma

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Introduction: Renal angiomyolipoma (AML) is a benign mesenchymal tumour composed of blood vessels, smooth muscle, and fat. While often asymptomatic, AMLs can present diagnostic challenges due to their heterogeneous nature. This case highlights the incidental discovery of a renal AML in a patient with a history of endometrioid type endometrial carcinoma (EEC), emphasising the importance of comprehensive evaluation in patients with a history of malignancy.
Case report: A 55-year-old woman with a history of grade 2 EEC underwent total abdominal hysterectomy and bilateral salpingo-oophorectomy (TAH-BSO). Postoperative imaging revealed a Bosniak III/IV cystic lesion in the left kidney. Given the complex nature of the lesion, a left partial nephrectomy was performed. Histopathological examination revealed features consistent with classic renal AML, including a triphasic composition of predominant mature adipose tissue, thick-walled blood vessels, and smooth muscle cells. Immunohistochemical staining was positive for HMB-45 and smooth muscle actin, confirming the diagnosis.
Discussion and conclusion: Current literature and evidence do not support a shared genetic link between these two tumours. The concurrent occurrence of EEC and AML in a single patient is very rare and this presentation is likely coincidental. This case is presented for its rarity. The incidental finding of a renal AML in a patient with a history of EEC emphasizes the need for thorough evaluation of abdominal lesions in a patient with a history of malignancy.
Keywords: angiomyolipoma, endometrioid type endometrial carcinoma, renal cyst

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CR 42

An unusual presentation of primary lung adenocarcinoma in a young woman

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Introduction: Lung carcinoma is a leading cause of cancer related mortality. Pericardial effusion is a known complication of advanced lung cancer, but its occurrence as an initial presenting symptom in a young patient is rare. This case highlights the importance of considering malignancy in young patients presenting with pericardial effusion.
Case Report: A 39-year-old non-smoking previously healthy woman presented with progressive dyspnoea over two weeks. Physical examination revealed tachycardia, hypotension, and muffled heart sounds. Echocardiography confirmed a large pericardial effusion with signs of tamponade. Pericardial fluid cytology revealed malignant cells from an adenocarcinoma. Chest CT showed a right upper lobe lung mass and mediastinal lymphadenopathy. Biopsy of the lung lesion revealed an adenocarcinoma. Immunohistochemical studies with TTF1 and CK7 confirmed a primary lung adenocarcinoma.
Discussion and conclusion: Primary lung adenocarcinoma presenting with pericardial effusion is uncommon, especially in young, non-smoking women. Identifying malignant cells in pericardial effusion can be challenging, as reactive mesothelial cells may show morphological features such as binucleation, increased nuclear-to-cytoplasmic ratio, and prominent nucleoli which overlaps with those of neoplastic cells. Malignant pericardial effusion often indicates advanced disease and predicts a poor prognosis in lung carcinoma. This case highlights the importance of considering malignancy in young patients presenting with pericardial effusion.
Keywords: lung adenocarcinoma, pericardial effusion, cardiac tamponade,

CR 43

Colonic ganglioneuroma

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Introduction: Ganglioneuroma of the colon is a rare, benign mesenchymal neoplasm that is distinct from adrenal gland lesions of the same name.
Case report: A 41-year-old man underwent screening colonoscopy that revealed a descending colon polyp. The 10x10x5mm polyp with a 5 mm attachment base was excised and examined histologically. The specimen showed expansion of the lamina propria by bland spindled mesenchymal cells (Schwann cells) with scattered ganglion cells. No atypia was observed. Immunohistochemically, spindle cells were S100 positive, while ganglion cells exhibited synaptophysin positivity but were S100 negative, confirming the diagnosis of ganglioneuroma.
Discussion and conclusion: The differential diagnoses included ganglioneuromatosis (excluded due to the solitary nature of the polyp), perineurioma (S100 negative), and mucosal Schwann cell hamartoma (both Schwann cell hamartoma and ganglioneuroma show S100 positivity, but ganglioneuromas contain ganglion cells). Gastrointestinal ganglioneuromas are most common in the left colon and rectum, with occasional cases in the appendix. They can be solitary or multiple, the latter termed ganglioneuromatosis. Histologically, bland Schwann cells expand the lamina propria, with ganglion cells present in varying numbers. Immunohistochemically, ganglion cells express synaptophysin and neuron-specific enolase (NSE), while Schwann cells stain diffusely with S100. Most cases are sporadic and indolent, but multiple lesions may indicate syndromic associations, including MEN2B, Cowden syndrome, or, less commonly, neurofibromatosis type 1. Polypectomy is typically curative, though identifying individuals with potential germline mutations is crucial for early intervention in associated syndromes.
Keywords: colon, ganglioneuroma, ganglioneuromatosis

CR 44

Epithelial inclusion cyst in a cervical lymph node: a rare presentation

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Introduction: Epithelial inclusion cyst within a lymph node is a rare benign condition which can be mistaken for a metastatic deposit of a squamous cell carcinoma.
Case report: A 42-year-old woman presented with a right jaw lump. Radiology showed a well-defined lesion in the submandibular gland. Fine needle aspiration cytology was performed, and microscopy showed mature squamous cells consistent with an epithelial inclusion cyst/trichilemmal cyst. Surgical excision was done. Macroscopically, the cut surface of the salivary gland was unremarkable, and the lymph node showed a cystic defect with creamy material. On histology, the lymph node showed a stratified squamous epithelium lined cyst filled with keratinous debris which was compatible with the cytological diagnosis. There was no nuclear atypia which will be seen in a carcinoma.
Discussion: Epithelial inclusion cysts within lymph nodes are a rare finding most commonly occurring in cervical lymph nodes. Although incidental, typically benign epithelial inclusion cysts in lymph nodes can pose diagnostic challenges particularly in distinguishing them from metastatic squamous cell carcinoma.
Keywords: epithelial inclusion cyst, lymph node

CR 45

Histopathology at the crossroads: differentiating cutaneous thrombosis from haemorrhage in paroxysmal nocturnal haemoglobinuria

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Introduction: Paroxysmal nocturnal haemoglobinuria (PNH) is a rare clonal haematopoietic stem cell disorder characterized by complement-mediated intravascular haemolysis and a high risk of life-threatening thrombosis. Differentiating between thrombosis and bleeding complications in PNH can be clinically challenging, especially in patients on anticoagulation.
Case report: A 50-year-old man with a two-year history of PNH on long-term rivaroxaban presented with sudden-onset severe abdominal pain and extensive, irregular, non-blanching violaceous patches with focal blackish discoloration over the neck, chest, and upper back. Laboratory investigations showed stable haemoglobin, and platelet counts with normal coagulation parameters, effectively ruling out active bleeding. The clinical dilemma was whether the lesions reflected PNH-related thrombosis or rivaroxaban-induced bleeding, a key distinction for guiding anticoagulation management. A skin biopsy was performed, and histology revealed dermal blood vessels occluded by fibrin thrombi, confirming intravascular thrombosis without necrosis or vasculitis. There is no evidence of dermal haemorrhage or extravasation of red blood cells. This ruled out anticoagulant-related bleeding, and rivaroxaban was continued to prevent further thrombosis.
Discussion and conclusion: PNH is associated with a high risk of atypical thrombosis, often requiring long-term anticoagulation. However, distinguishing thrombotic lesions from anticoagulant-induced bleeding can be clinically challenging. In this case, skin biopsy revealed fibrin thrombi without vasculitis, confirming intravascular thrombosis rather than bleeding. This histological evidence guided the continuation of rivaroxaban therapy, preventing inappropriate discontinuation. The case highlights the importance of considering drug complications, as well as the decisive role of histopathology in managing diagnostic uncertainty. Early biopsy should be pursued in similar complex clinical scenarios to optimize patient outcomes.
Keywords: paroxysmal nocturnal haemoglobinuria, intravascular thrombosis, rivaroxaban, skin biopsy, fibrin thrombi, histopathology

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CR 46

Intravascular adenomyosis mimicking a low-grade endometrial stromal sarcoma: a diagnostic challenge

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Introduction: Intravascular adenomyosis is a rare benign variant of adenomyosis that can closely mimic low-grade endometrial stromal sarcoma (LG-ESS) due to the presence of benign endometrial stroma within vascular spaces. This case highlights the importance of awareness of this condition and thorough histopathological assessment to avoid misdiagnosis.
Case History: A 45-year-old woman underwent a hysterectomy for chronic pelvic pain. The specimen included the uterus with cervix, bilateral fallopian tubes, and ovaries. Grossly, the uterus measured 110×90×60 mm, with an extensively trabeculated myometrium with a thickness of 25 mm. No distinct lesion was identified. Microscopically, the endometrium was non-phasic, and the myometrium showed widespread adenomyosis. Endometrial stromal fragments were seen within vascular spaces, lined by bland endothelium, mimicking LG-ESS. These stromal cells were CD10 and ER positive, while CD34 highlighted the vascular endothelium. Despite extensive sampling, no evidence of stromal sarcoma was identified.
Discussion: Intravascular adenomyosis is a rare phenomenon that may be observed in the context of extensive adenomyosis, even in the absence of any underlying malignancy. The primary diagnostic challenge lies in its morphological and immunohistochemical overlap with low-grade endometrial stromal sarcoma (LG-ESS), as both entities can exhibit similar staining patterns for markers such as CD10 and ER. However, several distinguishing features support a benign diagnosis: the presence of typical adenomyotic foci, lack of cytological atypia, and a non-destructive, well-circumscribed growth pattern.
Conclusion: This case highlights the potential for misdiagnosis of intravascular adenomyosis as LG-ESS. Accurate diagnosis requires attention to macroscopic findings, adequate sampling, careful interpretation of immunohistochemistry, and familiarity with this rare but benign entity.
Keywords: intravascular adenomyosis, endometrial stromal sarcoma, diagnostic pitfall

CR 47

A rare case of pleomorphic dermal sarcoma of the scalp

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Introduction: Pleomorphic dermal sarcoma (PDS), previously considered an aggressive variant of atypical fibroxanthoma (AFX), is a rare, high-grade cutaneous mesenchymal tumour. It typically affects the sun-exposed skin of elderly individuals. Its morphological overlap with other malignancies and the lack of specific immunohistochemical markers poses a significant diagnostic challenge.
Case History: An 87-year-old woman presented with a rapidly enlarging, ulcerated scalp lesion. Excision revealed an ill-defined, firm, tan-brown mass measuring 50mm in maximum dimension with surface ulceration. Histology revealed an invasive tumour involving the entire dermis and infiltrating into the subcutaneous tissue, comprising pleomorphic spindle and polygonal cells arranged in sheets, trabeculae, and fascicles. The tumour exhibited marked nuclear pleomorphism, irregular nuclei, prominent nucleoli, brisk mitoses (including atypical forms), and extensive necrosis. Hyalinized collagen bundles, pale eosinophilic basement membrane-like material and pseudoangiomatous areas were also evident. The tumour cells were diffusely positive for vimentin and CD10, and negative for pan-cytokeratin, S100, CD34, CD31, desmin and SMA. Based on morphology and immunoprofile, the diagnosis of PDS was made.
Discussion and conclusion: PDS is a rare, high-grade cutaneous tumour diagnosed by exclusion due to its pleomorphic morphology and lack of specific immunomarkers. It closely resembles AFX but is distinguished by aggressive features such as necrosis, perineural and lymphovascular invasion, and deep tissue infiltration, as mentioned in this case. Accurate diagnosis requires careful histological evaluation, correlation with clinical findings, and a broad immunohistochemical panel. Complete surgical excision with clear margins is the mainstay of treatment, with close follow-up due to the risk of recurrence or metastasis.
Keywords: pleomorphic dermal sarcoma, spindle cell tumour, diagnostic challenge

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CR 48

Diverse morphological spectrum in a differentiated liposarcoma of the retroperitoneum

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Introduction: Dedifferentiated liposarcoma (DDLPS) is an aggressive liposarcoma, often found in the retroperitoneum and characterized by well-differentiated and non-lipogenic sarcomatous components. Its diverse morphological spectrum causes a diagnostic dilemma in the absence of well-differentiated areas. This case highlights the spectrum of morphological heterogeneity of a DDLPS and underscores the need for thorough histopathological evaluation to identify areas of well-differentiated liposarcoma.
Case Report: A 68-year-old man presented with chronic left loin pain. CT scan revealed a necrotic, retroperitoneal mass abutting the lower pole of the left kidney. The surgical resection specimen comprised the left kidney with an attached well-circumscribed, bossellated, firm tumour measuring 200x100x70 mm. The cut surface was firm, grey-white with focal whorled, yellow, and gelatinous areas. Microscopy revealed a malignant tumour comprising moderately pleomorphic, atypical spindle cells with heterogenous morphology including herringbone, storiform, meningothelial-like whorls, areas resembling dermatofibrosarcoma protuberans, fibrosarcoma-like fascicles, and neural-like storiform packets in a collagenous to myxoid stroma with a hemangiopericytomatous vascular pattern. Poorly differentiated pleomorphic sarcoma-like areas and areas with rhabdomyoblastic differentiation were also present. The periphery and a few intratumoral foci showed a well-differentiated liposarcoma comprising lobules of variably sized and shaped adipocytes separated by thick and thin fibrous septa containing atypical hyperchromatic spindle cells and rare lipoblasts. These areas showed an abrupt transition from well-differentiated components to dedifferentiated non-lipogenic components diagnostic of DDPLS.
Discussion and conclusion: This case highlights the wide spectrum of histological features in DDPLS that results in diagnostic complexity and emphasises the importance of thorough sampling to identify well-differentiated components that ensure an accurate diagnosis required for treatment decisions and prediction of clinical outcomes. Studies for MDM2 and CDK4 amplification will be helpful in cases lacking well-differentiated areas.
Keywords: dedifferentiated liposarcoma, morphological diversity.

CR 49

Metaplastic carcinoma of the breast masquerading as a giant cell tumour on core biopsy

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Introduction: Metaplastic carcinoma of breast is a rare, aggressive, triple-negative breast carcinoma characterized by the transformation of epithelial cells into mesenchymal or non-glandular elements, including spindle cells, squamous cells, and heterologous components such as chondroid or osseous tissue. A particularly rare subtype accounting for only 0.5–1.2% of all breast carcinomas, shows osteoclast-like giant cells (OGC).
Case report: A 44-year-old woman presented with an ulcero-proliferative breast mass in the central region of the left breast measuring 4 × 4 cm with no clinical evidence of axillary lymphadenopathy. An initial core needle biopsy was suggestive of a giant cell tumor of breast. Modified radical mastectomy was performed and histopathological examination showed a metaplastic carcinoma with heterologous mesenchymal differentiation.
Discussion: The exact origin and role of OGC in breast cancer remain unclear. Current research indicates that OGCs are not malignant but are reactive immune cells. Although their presence alone may not directly affect patient outcomes, they are often found in aggressive, fast-growing tumours, warranting careful evaluation. The biopsy in this case showed numerous uniformly distributed osteoclastic giant cells, admixed with mononuclear stromal cells. There was no evidence of glandular structures, atypical epithelial cells, or a malignant epithelial component and no cytological atypia, high mitotic activity, or necrosis, which would raise suspicion for a carcinoma or sarcomatous tumour. Surgery is the primary treatment, and the benefit of chemotherapy/radiotherapy is unclear. Since these tumours are typically triple-negative and tend to behave more aggressively, treatment plans should be individualized.
Conclusion: This case highlights the importance of obtaining a representative tissue sample to avoid diagnostic errors in core needle biopsies, especially in tumours with mixed histological patterns or heterologous elements.
Keywords: metaplastic carcinoma, giant cell tumour, immunohistochemistry, heterologous mesenchymal differentiation

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CR 50

SMARCA4-deficient undifferentiated tumour of the oesophagus: a diagnostic challenge

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Introduction: SMARCA4-deficient undifferentiated tumours (SMARCA4-UT) are rare, aggressive neoplasms characterised by loss of SMARCA4 protein, a key component of the SWI/SNF chromatin-remodelling complex. They have been reported in multiple anatomical sites and often pose a diagnostic challenge due to their undifferentiated morphology and absence of lineage-specific immunophenotypic markers.
Case report: An 85-year-old man presented with iron deficiency anaemia. Oesophagogastroduodenoscopy revealed an ulcerated lesion in the lower oesophagus. Histological examination demonstrated a poorly differentiated malignant tumour composed of large, pleomorphic cells with eosinophilic cytoplasm and prominent macronucleoli. The overlying squamous epithelium was ulcerated but non-dysplastic. Immunihistochemistry was negative for a broad panel of epithelial (AE1/3, CK8/18, MNF116, P63, CDX2, CK7, TTF1), lymphoid (CD45, CD3, CD2, CD20, CD79a, CD30, MUM1, CD138, EBV, EBER), melanocytic (SOX10), neural(S100), muscle (desmin), GIST (DOG1, CD117) and vascular markers (CD34, CD31). Additionally, there was complete loss of SMARCA4 expression, supporting the diagnosis of SMARCA4-deficient undifferentiated carcinoma of the oesophagus.
Conclusion: This case underscores the diagnostic difficulty associated with SMARCA4-UT, which often lack distinguishing histological or immunophenotypic features. These tumours may represent dedifferentiated transformation from conventional oesophageal adenocarcinomas and are typically associated with poor prognosis. Including SMARCA4 in the immunohistochemical work-up of undifferentiated malignancies is essential for accurate diagnosis. Although standardised treatment protocols are lacking, emerging data suggests potential sensitivity to novel therapies, including immune checkpoint inhibitors and targeted agents, warranting further clinical investigation.
Keywords: SMARCA4-deficient, undifferentiated carcinoma, oesophagus, immunohistochemistry

CR 51

Retroperitoneal myopericytoma mimicking liposarcoma on imaging: a rare histological diagnosis

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Introduction: Myopericytoma is a rare perivascular myoid neoplasm that typically exhibits indolent behaviour. It most commonly arises in the dermis or subcutis of distal extremities. Deep-seated forms, especially in the retroperitoneum, are exceedingly rare and may mimic high-grade sarcomas, such as liposarcoma, on imaging. Accurate histological identification is essential due to implications for management and prognosis.
Case report: A 37-year-old woman presented with progressive abdominal fullness for four months. CT imaging revealed a large, encapsulated retroperitoneal mass (32 × 10 × 17 cm) with solid and cystic areas, raising the suspicion of a liposarcoma. The mass was excised. Grossly, it was well-circumscribed, with a smooth surface. The cut surface showed solid whitish areas interspersed with gelatinous and cystic zones. Histology showed a spindle cell lesion composed of numerous staghorn-like vessels surrounded by concentrically arranged bland spindle cells. Myxoid and haemorrhagic changes were present in cystic zones. Pleomorphism and mitoses were minimal. The differential diagnosis on morphology included angioleiomyoma, solitary fibrous tumour (SFT), and myopericytoma. Immunohistochemistry showed diffuse SMA positivity, while desmin, CD34, and S100 were negative, confirming a diagnosis of myopericytoma.
Discussion: Retroperitoneal myopericytomas are diagnostically challenging due to their rarity and radiological overlap with aggressive tumours. Their concentric perivascular growth pattern, SMA positivity, and lack of CD34 and desmin help distinguish them from SFT and angioleiomyoma. Larger tumours may exhibit degenerative changes, adding to the diagnostic complexity.
Conclusion: This case highlights the critical role of histology and immunohistochemistry in diagnosing rare spindle cell neoplasms that radiologically mimic sarcomas.
Keywords: myopericytoma, retroperitoneal tumour, spindle cell neoplasm, immunohistochemistry

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CR 52

Two cases of rare variants of focal segmental glomerulosclerosis: cellular and collapsing subtypes

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Introduction: Focal segmental glomerulosclerosis (FSGS) is a kidney disease characterized by segmental sclerosis in <50% glomeruli. The cellular and collapsing variants are particularly rare subtypes of FSGS.
Case report: Case 1: A 35-year-old woman presented with hypertension and heavy proteinuria. Microscopic analysis of her renal tissue showed segmental sclerosis with hypercellularity and hypertrophic podocytes. There was moderate mesangial proliferation, and an interstitial infiltrate composed mainly of lymphocytes. Tubular atrophy and interstitial fibrosis were observed in 30% of the parenchyma. Immunofluorescence showed negativity for IgG, IgA IgM and C3. The microscopic features aligned with the diagnosis of FSGS cellular variant with background tubular atrophy with interstitial fibrosis. Case 2: A 25-year-old woman with a history of epilepsy presented with acute kidney injury. Her renal biopsy revealed multiple globally sclerosed glomeruli and glomeruli with segmental sclerosis. One glomerulus demonstrated podocyte hyperplasia with intracellular resorption globules. The underlying capillary tuft showed collapse. Endocapillary proliferation, karyorrhexis and crescents were not present. There was extensive tubular atrophy and interstitial fibrosis, with significant arteriolar sclerosis. Immunofluorescence was negative for IgG and IgA. There was IgM 2+ mesangial staining and C3 2-3+ coarse granular mesangial staining. The microscopic features aligned with the diagnosis of FSGS collapsing variant with background chronic interstitial nephritis and advanced hypertensive vasculopathy.
Discussion and conclusion: Identification of subtypes of FSGS is important as the prognosis of these subtypes is different with the worst prognosis associated with the collapsing variant. This abstract presents the pathological features of two of the rare subtypes of FSGS.
Keywords: focal segmental glomerulosclerosis, cellular and collapsing variant

CR 53

A rare case of epithelioid trophoblastic tumour

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Introduction: ETT is a rare gestational trophoblastic neoplasm derived from neoplastic chorionic-type intermediate trophoblasts.
Case report: A 31-year-old woman presented with abnormal vaginal bleeding. She was a mother of two children and had a history of complete hydatidiform mole after first pregnancy. Serum HCG was 10, 000 IU/L. Abdominal ultrasound scan was reported as a leiomyoma. Macroscopic examination of her uterus showed a 100x80x50 mm size solid expansile intrauterine mass with a whitish yellow cut surface. Microscopic examination showed a tumour composed of pleomorphic epithelioid-like cells with areas of hyalinization and necrosis. The individual cells had large vesicular nuclei and eosinophilic to clear cytoplasm. They were positive for p63, and negative for SALL4, beta hCG, HMB45, and SMA. The Ki 67 proliferation index was 30%. There was no infiltrative growth pattern or vascular invasion.
Discussion: ETT is a trophoblastic tumour with antecedent gestational events including full-term deliveries, spontaneous abortions, and hydatidiform moles. HCG levels are elevated, although lower than choriocarcinoma. p63 is useful for differentiating chorionic-type from implantation-type trophoblastic tumours. Metastasis and death occur in 25% and 10% of patients, respectively. It can metastasize to the lung and brain. Squamous cell carcinoma and placental type-trophoblastic tumour are the most important differential diagnoses. The hyaline matrix and necrosis can resemble keratin.
Conclusion: The diagnosis of ETT can usually be made on morphology. Accurate diagnosis would guide therapy and prognostication.
Keywords: epithelioid trophoblastic tumour, hydatidiform mole, choriocarcinoma

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CR 54

Dedifferentiated chondrosarcoma of the scapula with cervical lymph node metastasis: a rare occurrence

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Introduction: Dedifferentiated chondrosarcoma (DDCS) is a rare, high-grade malignant tumor that arises from pre-existing low-grade chondrosarcoma. It demonstrates an extremely aggressive course compared to conventional chondrosarcoma, with a high propensity for local recurrence and distant metastasis, commonly to the lungs and bones. Lymph node involvement is exceptionally rare.
Case report: A 54-year-old man with a prior diagnosis of grade-2 chondrosarcoma of the scapula treated with scooping, presented with local recurrence after four months. Magnetic resonance imaging (MRI) showed interval progression with an enhancing soft tissue component of known chondrosarcoma. Shoulder disarticulation, including sternocleidomastoid muscle and level III/IV nodal mass was performed. Gross examination revealed a white, firm, lobulated tumor with focal gritty and myxoid areas measuring 170x120x60 mm. Histological examination revealed a low-grade cartilaginous component that was abruptly juxtaposed with high-grade sarcomatous areas, including regions exhibiting rhabdomyoblastic differentiation. These findings are characteristic and confirmatory of DDCS. The lymph node mass revealed metastatic DDCS with a predominant rhabdomyomatous component. The patient is currently undergoing chemoradiotherapy following surgical resection.
Discussion and Conclusion: Bone sarcomas mainly metastasize through the haematogenous route. Lymph node metastasis is rare due to the paucity of lymphatic channels in the bone. This case highlights the rare occurrence of lymph node metastasis of DDCS. The presence of lymphatic spread in DDCS may indicate an unusually aggressive phenotype or suggest the involvement of a sarcomatous component with an inherent propensity for lymphatic dissemination. It is important to have a high index of suspicion for regional lymphatic involvement, particularly in cases of recurrent or histologically aggressive sarcomas.
Keywords: dedifferentiated chondrosarcoma, lymph node metastasis

CR 55

Osteofibrous dysplasia-like adamantinoma of the tibia in an adolescent girl

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Introduction: Adamantinoma is a rare, slow-growing tumour mainly affecting the tibia. Osteofibrous dysplasia (OFD) - like adamantinoma is an intermediate variant, difficult to distinguish from OFD and classical adamantinoma. This case report outlines the clinical, radiological, and histological features, along with the surgical management of OFD-like adamantinoma occurring in a young girl.
Case report: A 16-year-old girl presented to the orthopaedic clinic with a complaint of progressive swelling over her right leg for six months. Magnetic resonance imaging (MRI) of the right leg revealed a well-demarcated lesion in the mid-diaphysis of the tibia, exhibiting cortical destruction and intramedullary extension, raising the suspicion of a malignant bone tumour, most notably osteosarcoma. A core needle biopsy was performed, followed by a segmental resection of the mid-shaft of the right tibia. Gross pathological examination showed a solid, tan intramedullary tumour with a maximum diameter of 98 mm, breaching the cortex and extending into adjacent soft tissues. Microscopic evaluation revealed a lesion with bone trabeculae lying in a dominant spindle-cell stroma resembling osteofibrous dysplasia. Interspersed were small islands and nests of epithelial cells showing squamoid differentiation. Immunohistochemistry showed strong positivity for pancytokeratin in the epithelial components, confirming the epithelial nature of the squamoid islands. Based on the histological and immunohistochemical findings, a diagnosis of OFD-like adamantinoma was made.
Conclusion: This case highlights the importance of a thorough histopathological and immunohistochemical evaluation in the diagnosis of tibial bone lesions in adolescents. Early recognition and surgical intervention are essential for favourable outcomes.
Keywords: adamantinoma, OFD-like adamantinoma, tibia

CR 56

Coexistence of mucinous and Brenner tumour: a case report of a rare entity

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Introduction: Mixed epithelial tumours of the ovary are defined by the presence of more than one epithelial component accounting for at least 10% of the tumour. Coexistence of mucinous and Brenner tumours is a well-recognized combination that has been rarely reported. Here we report such a case that mimicked an ovarian malignancy clinically and on imaging.
Case Report: A 52-year-old woman presented with abdominal distension and right pelvic pain for several months. Ultrasonography and contrast enhanced computed tomography (CECT) revealed a 192×135×163 mm, multilocular, complex, cyst with solid areas and multiple septations, involving the pelvis and lower abdomen. Serum CA-125 was elevated up to 67.5 IU/mL. Total abdominal hysterectomy, bilateral salpingo-oophorectomy and omental biopsy were performed. Gross examination revealed a right ovarian cyst (160×130×100 mm) comprising multiple locules with gelatinous contents and a yellow solid area (70×30 ×20 mm). Histology of the cystic component revealed a mucinous cystadenoma comprising mucin-secreting columnar epithelium with no evidence of atypia or invasion. The solid area showed well-circumscribed nests of transitional-type epithelium in dense fibrous stroma, consistent with a benign Brenner tumour. The uterus, left ovary, and omentum showed no significant pathology. Peritoneal fluid cytology was negative for malignant cells.
Discussion and conclusion: 1.3% to 4% of mucinous neoplasms contain a component of a Brenner tumour and its possibility should be considered if the imaging finds a cystic component with a homogeneously hypointense solid component in T2-weighted images. These mixed tumours may arise from transitional cell metaplasia or common progenitor cells. Careful grossing is essential to detect components of a Brenner tumour and recognizing both components is crucial to avoid misdiagnosis and predict accurate prognosis.
Keywords: mixed epithelial tumour, mucinous cystadenoma, Brenner tumour, ovary, rare ovarian neoplasm

CR 57

Myxoid meningioma: a rare pattern of the metaplastic meningioma subtype

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Introduction: Meningiomas are the commonest diagnostic category of brain tumours. There are 15 different subtypes of meningioma. Myxoid meningioma (MM)is rare and belongs to metaplastic subtype of Central Nervous System World Health Organization (CNS WHO) grade 1 category. Only 17 cases have been reported in the English literature to date.
Case report: A 43-year-old woman presented with recent onset headache and left hemiparesis. Magnetic resonance imaging (MRI) brain revealed a right frontotemporal dura-based lesion. The tumour was excised, and macroscopy revealed a circumscribed unencapsulated tumour with a mucoid cut surface measuring 85x75x25mm. Microscopy showed a circumscribed lobulated lesion composed of haphazard and focal lobules of spindled and stellate cells with small nuclei, pseudoinclusions and scanty eosinophilic cytoplasm floating in abundant myxoid stroma. No mitoses or necrosis was seen. A diagnosis of myxoid meningioma was confirmed by immunohistochemical (IHC) tests. The tumour cells showed strong and diffuse positivity with EMA and vimentin and were negative for S100 excluding schwannoma.
Discussion: MM should be considered in the differential diagnoses of dural-based tumours with myxoid stroma. Other possibilities include schwannoma and myxoid solitary fibrous tumour (SFT). The presence of a lobulated pattern and nuclear pseudoinclusions in addition to the myxoid tumour morphology were the histological clues for MM which was confirmed by positivity with EMA and vimentin and negativity for S100.
Conclusion: Being an extremely rare, myxoid meningioma is always a diagnostic challenge. Although its behavior is not different from other CNS WHO grade 1 subtypes, accurate diagnosis by excluding other non-meningothelial neoplasms such as schwannoma and myxoid SFT is important as their therapeutic implications and prognosis are different.
Keywords: myxoid meningioma, metaplastic, CNS WHO grade 1

CR 58

Lymphocytic mastitis masquerading as breast carcinoma in two patients with diabetes mellitus

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Introduction: Lymphocytic mastitis is a rare fibroinflammatory disease in patients with longstanding diabetes mellitus (both type 1 and type 2, although more common in type 1 diabetes). It is a diagnostic challenge as clinicoradiological features mimic breast carcinoma.
Case report: Case 1: A 58-year-old woman with diabetes for 20 years, presented with a right breast lump of three months duration. Ultrasound scan (USS) and mammogram showed BIRADS 4C and 4A lesions in both breasts, suspicious for malignancy. Case 2: A 61-year-old woman with longstanding diabetes, had a gradually enlarging right breast lump. USS and mammogram showed a BIRADS 5 lesion, highly suggestive of malignancy. Core biopsies of lesions in both cases revealed breast tissue with dense sclerotic stroma. Wide local excisions (WLE) of breast lesions were performed, resulting in three WLEs from both breasts in case 1 and one WLE in case 2. All specimens showed ill-defined firm white areas macroscopically. The histopathological findings in all specimens were similar with dense stromal fibrosis, benign breast duct-lobular units surrounded by dense lymphocytic inflammation and scattered stromal cells showing mild nuclear atypia. Immunohistochemistry done on case 1 showed CD20-positive B-lymphocytes around duct-lobular units. SMA highlighted the stromal cells which were negative for MNF116 and P63. Immunohistochemistry was not performed on case 2. Lymphocytic mastitis was diagnosed in both cases.
Discussion: Lymphocytic mastitis is a clinicoradiological mimic of breast carcinoma, with a definite diagnoses commonly not made on core biopsies. Discordance between clinicoradiological and histopathological findings leads to unwarranted surgical excisions in these patients.
Conclusion: Awareness of this entity reduces unnecessary investigation and surgical treatment in patients with long standing diabetes.
Keywords : lymphocytic mastitis, diabetic mastopathy

CR 59

Neuroendocrine carcinoma of the breast presenting with metastasis

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Introduction: Primary neuroendocrine carcinoma (NEC) of the breast is extremely rare, amounting to 0.1% to 5% of breast cancers. It has an aggressive clinical course, with local and distant metastasis.
Case report: A 48-year-old woman presented with a severe headache. Contrast MRI scan revealed multiple extracranial and intracranial (supra and infratentorial) ring enhancing lesions favouring leptomeningeal metastasis. An enlarged occipital lymph node was excised and sent for histology which showed sheets, nests and trabeculae of cells with pleomorphic nuclei and stippled chromatin. Immunohistochemistry showed diffuse positivity for CD56 and focal positivity for pancytokeratin with a Ki67 index of 91%. CD99, CD5 and CD20 were negative. This was diagnosed as a metastatic deposit of a NEC. Extensive investigations revealed a mammographically detected right breast BIRADS 4B lesion, moderately suspicious for malignancy. Core biopsy revealed a tumour with similar morphology to the previously detected NEC. It showed strong, diffuse positivity for synaptophysin and was negative for ER, PR and HER2. Ki67 index was 70%. Thus, this case was concluded as a small cell NEC of the breast with lymph node metastasis and extra and intracranial metastasis. She was referred for further neoadjuvant treatment.
Discussion: Nodal and systemic metastasis of primary NEC of the breast are not uncommon at presentation. They are generally positive for ER and PR receptors, with triple negative tumours having poorer prognosis. The differential diagnosis of primary NEC includes metastatic small cell carcinoma of non-mammary origin (most commonly from the lung), Merkel cell carcinoma, lymphoma, melanoma and other primary breast tumours including metaplastic carcinoma, invasive breast carcinoma NST with basaloid cells and an increased N:C ratio and solid-basaloid adenoid cystic carcinoma.
Conclusion: Metastatic deposits of NEC warrants investigation of the breast.
Keywords : neuroendocrine carcinoma, breast, brain metastasis

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CR 60

Index case of visceral leishmaniasis caused by *Leishmania siamensis* in Sri Lanka

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Introduction: Visceral leishmaniasis (VL) is a life-threatening parasitic disease. Although Sri Lanka is endemic for cutaneous leishmaniasis, sporadic VL cases caused by *Leishmania donovani* are emerging. We report the first Sri Lankan case of VL caused by *Leishmania siamensis*, which was a diagnostic challenge.
Case report: A 66-year-old man presented with a one-month history of dry cough, anaemia, weight loss, and intermittent fever. Examination revealed hepatosplenomegaly and generalised lymphadenopathy.Blood tests revealed elevated erythrocyte sedimentation rate, pancytopenia, rouleaux formation, and raised β2-microglobulin. Bone marrow biopsy and aspiration showed rouleaux formation and marked streaming of cells with 40% plasma cells. Leukaemia/lymphoma was suspected. Tuberculosis (TB) and myeloproliferative neoplasm (MPN) were excluded by negative TB culture, GeneXpert, and MPN panel. Contrast-enhanced-CT chest/abdomen showed hepatosplenomegaly with bilateral axillary and para-aortic lymphadenopathy, suggesting a lymphoproliferative disorder. After five months of inconclusive workup and frequent blood transfusions, a left axillary lymph node (LN) biopsy measuring 20x10x5 mm and 15x10x5 mm was sent for histology. The LN showed follicular hyperplasia and microgranulomas of epithelioid histiocytes in the paracortex and sinuses, containing minute intracytoplasmic round bodies. Giemsa stain highlighted amphophilic leishmania amastigotes. PAS was negative. No giant cells, necrosis, or malignancy were seen. A histopathological diagnosis of reactive lymphoid hyperplasia with granulomatous inflammation, favouring leishmaniasis was made. Polymerase chain reaction (PCR) on repeat bone marrow aspirate confirmed *Leishmania siamensis*. He successfully recovered following a full course of conventional amphotericin.
Discussion and conclusion: This case highlights the diagnostic challenges of VL in non-endemic areas, where symptoms and blood investigations can resemble haematologic malignancies. The diagnosis was achieved only through histopathological examination of the LN, identifying Leishmania amastigotes. PCR confirmed the species as *Leishmania siamensis*, highlighting the role of molecular diagnostics in challenging cases of visceral leishmaniasis. This first Sri Lankan report of *Leishmania siamensis* calls for increased clinical vigilance, molecular diagnostics, and ongoing surveillance
Keywords: visceral leishmaniasis, *Leishmania siamensis*, Sri Lanka, granulomatous lymphadenitis

CR 61

Cytological diagnosis of hydatid cyst: the value of special stains

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Introduction: Hydatid cysts, caused by *Echinococcus granulosus,* primarily affect the liver and may cause diagnostic challenges. Although cytology is rarely used alone, it can provide a definitive diagnosis when aided by special stains.
Case report: A 48-year-old woman presented with fever and right hypochondrial pain of six weeks duration. She had lived in the Middle East 10 years ago. An incidental liver cyst (5.7×5.4×5 cm) was identified on radiology eight years ago, but she defaulted follow-up. The current contrast enhanced computed tomography (CECT) showed a 10×8.8×8.6 cm cystic hepatic lesion with detached membranes, suggestive of a hydatid cyst. Laboratory results revealed leucocytosis, eosinophilia, elevated c-reactive protein (CRP) (68 mg/L) and erythrocyte sedimentation rate (86 mm/1st hour). Differential diagnoses included a liver abscess and an infected hydatid cyst. A PAIR (puncture/aspiration/instillation/re-aspiration) procedure yielded 300 mL of milky fluid; 17 ml was submitted for cytological analysis. Haematoxylin and eosin-stained alcohol-fixed smears revealed numerous refractile, semitranslucent hooklets and degenerated protoscolices-like elements. Ziehl-Neelsen (ZN) stain on smears and Mason's trichrome stain (MT) on formalin-fixed paraffin-embedded cell block sections highlighted pink-red hooklets, confirming the diagnosis of a hydatid cyst. Periodic-acid-Schiff and Papanicolaou stains did not demonstrate any staining of the hooklets. The hooklets were non-polarizable under polarised light microscopy.
Discussion and conclusion: This case highlights the value of cytology and routinely used special stains in diagnosing hydatid disease, particularly when clinical and imaging findings are suggestive but not definitive. PAIR is a less invasive procedure with minimum morbidity. MT was more effective and reliable than ZN for diagnosing hooklets. Cytology, supported by special stains such as MT and ZN, provides a rapid and accurate diagnostic tool for hepatic hydatid cysts, especially when used alongside therapeutic procedures like PAIR.
Keywords: hydatid cyst, cytology, liver, special stains, echinococcus

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CR 62

A twin challenge: a viable foetus coexisting with a complete hydatidiform mole

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Introduction: Twin molar pregnancy with a coexisting live foetus and hydatidiform mole is a rare form of gestational trophoblastic disease, occurring in approximately 1 in 20,000 to 1 in 100,000 pregnancies. In a complete hydatidiform mole with a coexisting live foetus (CHMCF) a normal foetus with biparental inheritance coexists with a mole of purely paternal origin (46 chromosomes). In partial mole with coexisting foetus (PHMCF), a normal foetus is present alongside a triploid mole (69 chromosomes: 23 maternal, 46 paternal).
Case Report: A 24-year-old primigravida underwent routine antenatal ultrasound at 14 weeks, revealing a live foetus alongside a separate vesicular mass suggestive of a hydatidiform mole. She had persistently elevated serum β-hCG levels. She was monitored and referred to a tertiary care centre at 35+6 weeks following per vaginal bleeding. An emergency lower segment caesarean section was performed, resulting in the delivery of a healthy infant. Gross examination revealed a normal-appearing placenta weighing 357 g (75th percentile) and a distinct grape-like vesicular mass. The differential diagnosis included a partial mole with a viable foetus or a dichorionic, diamniotic twin pregnancy. Histopathology confirmed a complete hydatidiform mole characterized by diffuse villous enlargement, hydropic changes, cistern formation, and circumferential trophoblastic hyperplasia with cytologic atypia. The adjacent placenta was histologically normal apart from a few abnormal chorionic villi attached to its foetal surface. The infant delivered had an uneventful hospital stay and is well.
Discussion: Histological diagnosis of a complete mole which does not give rise to a foetus helped confirm this case as a twin pregnancy with a coexisting foetus. It also helps in risk stratification since 15-20% of complete moles progress to invasive mole or choriocarcinoma, whereas the risk is lower (~5%) in partial moles. Despite delivering a healthy infant, close surveillance will be required in this case to exclude these complications.
Keywords: complete hydatidiform mole with coexisting foetus, partial hydatidiform mole with coexisting foetus

CR 63

Focal thickening of the skull; a hidden sign of meningioma

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Introduction: Meningioma is the most common type of primary brain tumour. The incidence of hyperostosis associated with cranial meningioma varies widely, with some studies reporting it in up to 50% of cases.
Case report: A 48-year-old woman presented with a one-year history of complete loss of vision in the left eye. She had no history of trauma or prior ocular disease. Neurological examination confirmed left-sided visual impairment with no light perception. Contrast-enhanced computed tomography (CECT) of the head and face was reported as being suggestive of craniofacial fibrous dysplasia. Multiple fibrofatty and bony fragments were received. Histological examination revealed thickened, sclerotic bony trabeculae infiltrated by nests and lobules of meningothelial cells, demonstrating vague whorl formation. The tumour cells were positive for epithelial membrane antigen (EMA) and progesterone receptor (PR). The morphological and immunophenotypic features were consistent with a diagnosis of meningioma associated with hyperostosis of the adjacent bone. Her vision improved following surgical intervention.
Discussion: Meningiomas can invade the adjacent bone, leading to localized bone thickening known as hyperostosis. This hyperostosis is often detectable on CT scans using bone window settings. In cases where hyperostosis is present, complete surgical excision of the meningioma along with resection of the involved bone is recommended. This approach not only reduces the risk of tumour recurrence but also has the potential to significantly improve the patient's quality of life**.**
Keywords: hyperostosis, meningioma.

CR 64

Invasive breast carcinoma with sebaceous differentiation: a diagnostic rarity

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Introduction: Invasive ductal carcinoma of no special type (IDC-NST) may rarely exhibit a sebaceous pattern, a phenomenon first described by Van Bogaert and Maldague in 1977 as lipid-producing tumours of the breast. It is very rare with only nine cases reported in the literature.
Case report: A 37-year-old woman presented with a two-month history of a palpable lump in the left breast. Mammography revealed a BIRADS II lesion. Wide local excision of the left breast revealed a whitish, irregular mass measuring 20×20×15 mm. Histopathological analysis confirmed an invasive breast carcinoma of no special type (NST), predominantly exhibiting a sebaceous pattern (75%) with lobular architecture. The tumour comprised two distinct cell populations: centrally located cells with mildly pleomorphic, eccentrically placed nuclei, prominent nucleoli, and vacuolated cytoplasm; and a second component of smaller, ovoid to spindle-shaped cells with basophilic, non-vacuolated cytoplasm. Cytoplasmic vacuoles were PAS-positive and PASD-resistant. Immunohistochemistry showed negativity for p63. The tumour was classified as Nottingham Grade II. Hormone receptor analysis demonstrated positivity for estrogen (ER) and progesterone (PR) receptors, while HER2/neu was negative. There is no cutaneous involvement.
Discussion: Primary sebaceous carcinoma (SC) of the breast is a rare subtype of invasive breast carcinoma of no special type, recognized in the WHO 5th edition classification. It shows sebaceous differentiation within mammary tissue, without cutaneous origin. The exact histogenesis is unclear. Key differentials include lipid-rich carcinoma, glycogen-rich clear cell carcinoma, and cutaneous sebaceous carcinoma. These tumours typically exhibit strong ER/PR positivity and low HER2 expression. Prognosis remains uncertain due to the rarity of cases, underscoring the need for further studies.
Keywords: invasive breast carcinoma with sebaceous pattern.

CR 65

Twisted troubles: a rare case of small bowel obstruction caused by intestinal endometriosis

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Introduction: Gastrointestinal endometriosis occurs in 5%-15% of women with pelvic endometriosis, most commonly affecting the rectum and sigmoid colon. Involvement of the terminal ileum is rare, and bowel endometriosis is an uncommon cause of intestinal obstruction.
Case report: A 38-year-old woman was admitted with abdominal pain, nausea, and vomiting. She had a history of intermittent abdominal discomfort. Computed tomography (CT) scan of the abdomen and pelvis revealed small bowel dilatation with a transition point between the distal and proximal ileum, suggestive of small bowel obstruction. She underwent distal ileal resection. Total abdominal hysterectomy and bilateral salpingo-oophorectomy were also done simultaneously due to radiological suspicion of pelvic endometriosis. Macroscopic examination of the resected ileum revealed viable bowel with multiple brownish haemorrhagic areas on the serosal surface. There was no evidence of strictures, adhesions, or volvulus. Similar brownish lesions were observed on both fallopian tubes and ovaries. Histopathological analysis of the ileum confirmed multiple endometriotic foci on the serosal side. Endometriotic foci were also identified in both fallopian tubes and ovaries, confirming the diagnosis of endometriosis. The patient had an uneventful postoperative recovery.
Discussion and conclusion: Intestinal endometriosis is a rare and often overlooked cause of small bowel obstruction, especially in young women. Its nonspecific symptoms make preoperative diagnosis challenging. In this case, definitive diagnosis was made following surgical resection and histopathological examination, which confirmed the presence of endometrial tissue in the bowel wall. This case underscores the importance of considering endometriosis in women with unexplained gastrointestinal symptoms, as early recognition is key to appropriate management and prevention of life-threatening complications.
Keywords: endometriosis, intestinal obstruction

CR 66

Superficial CD34-positive fibroblastic tumour: a rare and challenging diagnostic entity

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Introduction: Superficial CD34-positive fibroblastic tumour (SCD34PFBT) is a recently recognized mesenchymal neoplasm, first described in 2014. As the name suggests, this tumour is located in the superficial soft tissues and demonstrates CD34 positivity on immunohistochemistry. To date, only a limited number of cases have been reported in the literature.
Case report: A 35-year-old woman presented with a four-year history of a painless, slowly growing lump in the upper thigh. Ultrasound imaging revealed a well-defined, oval lesion measuring 16.5 × 9.5 × 11.3 mm in the subcutaneous plane of the anterolateral thigh. Histological examination showed a tumour composed of short fascicles and sheets of spindle to epithelioid cells. The tumour cells were large, with pleomorphic and hyperchromatic nuclei; occasional cells exhibited bizarre nuclear morphology. The cytoplasm was abundant, eosinophilic, and displayed a glassy appearance. Immunohistochemically, the tumour cells showed strong and diffuse positivity for CD34. Pancytokeratin was negative. The Ki-67 proliferation index was approximately 8%. Based on the morphological and immunohistochemical findings, a diagnosis of SCD34PFBT was made.
Discussion: SCD34PFBT shows fascicles or sheets of epithelioid to spindle cells with abundant granular to glassy eosinophilic cytoplasm. The nuclei are pleomorphic and hyperchromatic, but mitotic activity is extremely low, consistent with its indolent nature. Immunohistochemically, up to 30% of cases may be negative for pancytokeratin. Recognition of this entity is crucial, as its marked nuclear pleomorphism may mimic a high-grade sarcoma such as epithelioid sarcoma, undifferentiated pleomorphic sarcoma, dermatofibrosarcoma protuberans, and malignant granular cell tumour, potentially leading to misdiagnosis. SCD34PFBT is considered locally aggressive, and complete surgical excision remains the treatment of choice.
Keywords: superficial CD34-positive fibroblastic tumour

CR 67

Rare case of light chain proximal tubulopathy

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Introduction: Light chain proximal tubulopathy (LCPT) occurs as a complication of monoclonal gammopathy in 0.5%-5% of cases. It is characterized by the accumulation of monoclonal light chains in proximal tubular cells resulting in tubular dysfunction. Either kappa or lambda light chains are deposited, but kappa restriction is typically seen in crystalline forms while non-crystalline forms are often lambda restricted.
Case report: A 73-year-old man presented with nephrotic-range proteinuria and rapidly progressing kidney disease. Biochemical findings revealed proteinuria (3033 mg/g), elevated serum creatinine (3.43 mg/dL), and reduced eGFR (18 mL/min/1.73 m²), with serum free light chain analysis showing lambda restriction. Renal biopsy showed histologically unremarkable glomeruli. A few proximal tubules contained hard, cracked casts with a granular and nodular appearance, which were weakly periodic acid Schiff (PAS) positive, silver negative, and polychromatic with Masson trichrome. There was diffuse acute tubular injury with bubbly granular cytoplasm in the proximal tubules, disproportionate to the damage caused by casts, suggesting possible LCPT. Immunofluorescence was inconclusive due to lack of glomeruli. Immunohistochemistry showed lambda light-chain restriction with diffuse granular deposits in proximal tubular epithelial cytoplasm confirming LCPT. No light chain deposits were seen in glomeruli.
Discussion: LCPT is a form of acute tubular injury with characteristic histological features which are easily overlooked when examining renal biopsies of patients with monoclonal gammopathy. Differential diagnoses include oxalosis, phosphate nephropathy and drug toxicity. Immunofluorescence and electron microscopy confirm the diagnosis.
Conclusion: Acute renal impairment in patients with monoclonal gammopathy can be due to LCPT. Awareness of this rare occurrence is crucial for early diagnosis and appropriate treatment to avoid further kidney damage.
Keywords: light chain proximal tubulopathy (LCPT)

CR 68

Plasmablastic lymphoma presenting as a renal mass in an immunodeficient person

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Introduction: Plasmablastic lymphoma (PBL) is a rare, aggressive large B-cell lymphoma with plasmablastic or immunoblastic morphology and a terminally differentiated B-cell immunophenotype. It is frequently linked to human immunodeficiency virus (HIV) infection and typically manifests in the oral cavity. We report a rare presentation of PBL as a unilateral renal mass in an HIV-positive man.
Case report: A 46-year-old man, who was HIV-positive, presented with lower abdominal pain and weight loss for four months. Contrast enhanced computed tomography (CECT) scan revealed a lobulated exophytic mass involving the right kidney. A nephrectomy specimen showed a 10x8 cm, greyish-white, lobulated, exophytic tumor involving the right kidney. Microscopically, the tumour comprised diffuse sheets and lobules of intermediate to large, atypical cells separated by fibrous septa. The tumour cells had plasmacytoid morphology with vesicular nuclei having conspicuous nucleoli, moderate eosinophilic cytoplasm, frequent mitoses and apoptotic bodies. The tumour cells were diffusely positive for immunohistochemical stains CD38, CD138 and MUM-1, and showed patchy positivity for EMA. MYC expression was present in >30% atypical cells. Pan B cell markers, CD20, CD79a, and PAX5 were negative. EBV-LMP-1 and HHV-8 marker were negative. Ki67 proliferation index was 80%. These features rendered the diagnosis of PBL.
Discussion and conclusion: The histomorphologic and immunophenotypic characteristics of PBL and plasmablastic myeloma are almost identical, therefore clinical, radiological and histological correlation is needed in the diagnosis. Diagnostic criteria favouring plasmablastic myeloma include renal impairment, a substantial paraprotein, osteolytic lesions, hypercalcemia and diffuse bone marrow involvement which were not seen in this patient. Epstein-Barr virus (EBV) positivity in the neoplastic cells, a relationship with HIV infection, and a high Ki-67 proliferation index support a diagnosis of PBL. Although rare, PBL should be considered as a differential diagnosis of a renal mass of immune-deficient patients.
Keywords: plasmablastic lymphoma, immune-deficient, myeloma

CR 69

Beyond the expected: anaplastic large cell lymphoma presenting in the pleura

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Introduction: Anaplastic large cell lymphoma (ALCL) is a rare mature T cell lymphoma which is clinically, pathologically and genetically heterogenous.
Case report: A 67-year-old man presented with unexplained costal pain of six months duration. Radiology showed right pleural thickening along with a pleural based mass measuring 6.7x6 cm. The clinico-radiolgical diagnosis was tuberculosis. A biopsy of the pleural mass showed features of a non-Hodgkin lymphoma. On immunohistochemistry the cells were positive for LCA, CD 5 and CD30, and negative for Pan CK, CD20, PAX 5, ALK and EBV LMP. Based on immunomorphological features a diagnosis of primary ALCL of the pleura was made.
Discussion: Extra-cavitary involvement of ALCL in the lung is uncommon, and its occurrence in the pleura is even more exceptional. Reports of ALCL manifesting as a pleural mass without associated pleural effusion are exceedingly limited. Both ALK-positive and ALK-negative ALCL are composed of large lymphoid cells with hallmark cells, and strong and uniform expression of CD30.
Conclusion: Rare cases of atypical lymphomas may present without the classical clinical features, making diagnosis challenging and often unexpected. In such instances, histomorphology and immunohistochemistry remain the gold standard for accurate diagnosis.
Keywords: Anaplastic large cell lymphoma, T cell lymphoma, CD30

CR 70

The quest for the source: determining the origins of a bladder tumour

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Introduction: Adenocarcinoma of the bladder may be primary or secondary to metastatic spread. Primary adenocarcinoma of the bladder (PACB) is a rare, aggressive malignancy with a worse prognosis than conventional urothelial carcinoma.
Case report: A 34-year-old woman presented with right loin pain. She had no other symptoms. She had a past history of a right borderline mucinous ovarian tumour (2022) and a rectal carcinoma with lung and liver metastasis (2023). She had surgery for the ovarian and rectal tumours and had completed chemotherapy with a good response seen in the lung and liver deposits on CT scan. Examination revealed only right flank tenderness. Ultrasound scan of the abdomen showed a right hydronephrosis with dilatation of the right ureter. Cystoscopy revealed a tumour in the wall of the bladder close to the right ureteric orifice. Biopsy of the tumour showed a moderately differentiated adenocarcinoma (enteric type). Immunohistochemistry for CK7 and CK20 showed strong positive staining. Beta catenin showed membranous staining and ER was negative. As such, a PACB was diagnosed. The hydronephrosis was relieved with a stent. She was discharged to be followed up at the surgical oncology clinic.
Discussion and conclusion: Immunohistochemistry for ER being negative and CK 7 and CK 20 showing strong positivity with membranous staining for beta-catenin favoured a PACB over a metastasis of ovarian or colorectal origin. PACB may be urachal (1/3) or non-urachal (2/3) in origin. Urachal adenocarcinomas arise in the midline of the dome of the bladder and have a worse prognosis than non-urachal tumours. The tumour was in the lateral wall of the bladder close to the right ureteric orifice favouring a non-urachal origin. Bladder adenocarcinomas are rare, aggressive tumours that are difficult to treat. Determining their origin requires a multi modal approach and is important for further management and prognostication.
Keywords: primary adenocarcinoma of bladder, origins, secondary deposits

CR 71

Large cell neuroendocrine carcinoma of the genitourinary tract: diagnostic challenges in determining the primary site

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Introduction: Large cell neuroendocrine carcinoma (LCNEC) of genitourinary tract is an extremelyrare high-grade neoplasm characterized by neuroendocrine morphology at microscopic level, high mitotic activity and immunohistochemical (IHC) evidence of neuroendocrine differentiation. It usually has a poor prognosis despite treatment.

Case report: A 79-year-old man was investigated for haematuria and lower urinary tractsymptoms. Ultrasound scan revealed prostatomegaly with a volume of 52ml. Prostate specific antigen (PSA) level was 1.14 ng/ml. Multiple transurethral biopsies were taken from the median lobe of prostate. Microscopy revealed an infiltrating tumor composed of cords, trabeculae, acinar and cribriform structures in a loose myxoid stroma. Large areas of necrosis were seen. The neoplastic cells were medium in size and showed round to polygonal hyperchromatic nuclei,high nuclear: cytoplasmic ratio, fine chromatin pattern, frequent nucleoli, moderate nuclear pleomorphism and brisk mitotic activity. Morphology was suggestive of a LCNEC, possibly a primary prostatic or bladder LCNEC or a metastatic deposit. Neuroendocrinedifferentiation was confirmed by positive staining with synaptophysin and CD56. The tumorwas negative for CK7, CK20, and PSA. Magnetic resonance imaging (MRI) scan was done later and revealed a tumourarising from the bladder and invading into the prostatic urethra. No other lesions were identified in the prostate gland.

Discussion and conclusion: Determining the primary site of LCNEC within the genitourinary tract poses a significant diagnostic challenge. When both the bladder and prostate are involved, immunohistochemical studies are inconclusive as tumours of prostatic origin are negative for PSA and prostatic acid phosphatase (PAP) while tumours of bladder origin are negative for high molecular weight keratins, p63 and uroplakin. Hence, imaging is crucial in identifying the primary and excluding metastatic deposits. Accurate diagnosis requires a multidisciplinary approach to guide appropriate treatment and to improve prognostic assessment.

Keywords: large cell neuroendocrine carcinoma, bladder, prostate

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CR 72

A rare case of hepatocellular carcinoma presenting as a gingival mass

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Introduction: Hepatocellular carcinoma (HCC) is the 6th most common cancer worldwide and accounts for 75-85% of primary liver cancers. Around 50% cases of hepatocellular carcinoma are associated with metastases. Metastasis of hepatocellular carcinoma to the oral cavity, particularly with the initial presentation as a gingival lump, is exceedingly rare.

Case report: A 70-year-old man presented with a painful progressive swelling on the left side of the face of four months duration. Examination of the region revealed an exophytic soft tissue mass in the retromolar region. Incision biopsy of the lesion showed a lesion composed of solid sheets and trabeculae with a sinusoidal pattern containing cells with enlarged, irregular, hyperchromatic round nuclei with abundant eosinophilic cytoplasm. Prominent eosinophilic nucleoli were present. Mitoses were present with abnormal forms. Foci of tumour necrosis and scattered hyaline globules were identified. The neoplastic cells showed strong and diffuse cytoplasmic positivity with AE1/AE3 and diffuse granular cytoplasmic positivity with HepPar1. The cells were negative for EMA, Melan A, CK5/6, CK7 and CK20. Subsequently the patient underwent contrast enhanced computed tomography (CECT) neck, chest and abdomen and was found to have a liver lesion with cervical metastasis. Since the oral lesion was symptomatic, surgical excision of the lesion followed by chemotherapy was planned.

Discussion and conclusion: Gingival metastasis arising from primary hepatocellular carcinoma is extremely rare, posing a diagnostic challenge. When the histological morphology of a biopsy is suggestive of HCC—particularly in the absence of positivity for other immunohistochemical markers—it is essential to consider metastatic HCC in the differential diagnosis. This is especially important in elderly patients, to prevent potential misdiagnosis..

Keywords: hepatocellular carcinoma, gingival lesion

CR 73

A rare case of extranodal marginal zone lymphoma of the thyroid

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Introduction: Extranodal marginal zone lymphoma (EMZL) of the thyroid is an indolent primary extranodal B cell lymphoma. About 5% of EMZLs occur in the thyroid and account for 2% of all thyroid malignancies. Presence of Hashimoto thyroiditis is a known risk factor for developing EMZL. Around 30-45% of lymphomas of the thyroid are EMZLs.
Case report: A 70-year-old man presented with a progressive lump in the anterior neck. Ultrasound scan showed a significantly enlarged thyroid gland with a markedly enlarged left lobe. Fine needle aspiration cytology (FNAC) was reported as Bethesda category II, lymphocytic thyroiditis. The total thyroidectomy contained a right unencapsulated nodule and a larger left lobe nodule measuring 30x23x22 mm and 125x85x75 mm respectively. Histology revealed an area devoid of follicles infiltrated by small lymphocytes, plasmacytoid cells, immunoblasts, centroblast-like cells and scattered plasma cells. Follicular colonization, follicular destruction and adjacent multiple lymphoepithelial lesions were present. The background thyroid tissue showed moderate thyroiditis. The neoplastic cells stained strongly with CD20 but negatively with CD5 and CD23. The background T cells were positive for CD3 and CD5. CD23 showed an expanded follicular dendritic cell meshwork due to follicular colonization.
Discussion and conclusion: EMZL of the thyroid exhibits an indolent course, developing as a response to autoimmune processes. Its diagnosis with FNAC alone may be challenging, as it mimics autoimmune thyroiditis. Therefore, histological assessment with immunohistochemistry is necessary to confirm the diagnosis. Key distinguishing features include expanded nodules without intervening normal thyroid tissue and background lymphoepithelial lesions.
Keywords: extranodal marginal zone lymphoma, thyroid

CR 74

Placental mesenchymal dysplasia: a rare placental pathology associated with adverse foetal outcome

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Introduction: Placental mesenchymal dysplasia (PMD) is a rare disorder characterized by vascular abnormalities and placentomegaly. It is often associated with malformations such as Beckwith-Wiedemann syndrome (BWS).
Case report: A 28-year-old woman in her first pregnancy delivered a baby girl at 39 weeks of gestation by an emergency caesarean section due to thick meconium. An anomaly scan was not performed. The baby did not cry at birth and passed away despite resuscitation. Autopsy showed a large baby (3370 g; > 95th centile for the gestational age) with dysmorphic features, having limb abnormalities, an enlarged globular heart, and multiple splenicules. Ovarian tissue showed gonadal dysgenesis. There was hepatomegaly with cholestasis and prominent extramedullary haematopoiesis. Evidence of BWS was not seen. The placenta weighed 1123 g (>95th centile for gestational age). Stem villi were cystically dilated, hydropic and showed cistern formation with abnormal, dilated, thick-walled vessels and increased stromal cellularity. Excess trophoblastic cell proliferation was absent. Some foetal vessels showed mural thrombi suggestive of foetal vascular malperfusion. Maternal vascular malperfusion, evident by placental infarctions and intervillous thrombi, was present.
Discussion: Ultrasonically, PMD is often misdiagnosed as a molar pregnancy due to the presence of vesicles caused by dilated placental vessels. The differential diagnoses for placentomegaly include CMV infection and hydrops. Malformed vessels, villous stromal changes and absent trophoblastic cell proliferation aid the differentiation. Stromal overgrowth and vascular abnormalities can result in secondary pathological changes such as maternal and foetal vascular malperfusion, leading to adverse foetal outcome.
Conclusion: Histological examination of the placenta is mandatory to distinguish PMD from other placental abnormalities. A definitive diagnosis is vital for clinical decision-making for the management of subsequent pregnancies, as the chances of recurrence are rare, unless associated with BWS.
Keywords: placental mesenchymal dysplasia, neonatal death

CR 75

Oxalate nephropathy induced by *Averrhoa bilimbi* ingestion in a previously healthy male

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Introduction: Oxalate nephropathy (ON) is a rare cause of acute kidney injury (AKI), often triggered by ingestion of oxalate-rich foods or underlying metabolic disorders. In Sri Lanka the commonest cause is consumption of starfruit, especially high amounts for medicinal purposes. This report discusses a 40-year-old man who developed AKI after consuming *Averrhoa bilimbi* (bilin), a fruit known for its high oxalate content. Two similar cases have been published in the Sri Lankan literature.
Case report: A previously healthy man presented with severe abdominal pain and vomiting of one day after consuming approximately 16 bilimbi (bilin) fruits (200g). His symptoms were accompanied by reduced intake of food and fluid due to gastrointestinal discomfort. Clinical examination revealed signs of dehydration. Initial investigations revealed a serum creatinine of 934 µmol/L, indicating AKI. Urinalysis showed 2+ albumin, and ultrasound excluded obstructive uropathy. The haematoxylin and eosin-stained section of the renal biopsy showed fan shaped lightly basophilic polarizable crystals in the tubular lumen, patchy tubulitis, partial tubular destruction, and a moderate interstitial infiltrate of lymphocytes admixed with eosinophils. The glomeruli were unremarkable. He made a full recovery with supportive treatment.
Discussion: ON results from deposition of calcium oxalate crystals in renal tubules, usually after intake of oxalate-rich food combined with dehydration. Extensive tubular damage leads to AKI. High bilimbi (bilin) consumption followed by dehydration likely led to AKI. Biopsy provided definitive evidence of ON and confirmed the absence of pre-existing renal disease.
Conclusion: ON can cause reversible AKI when recognized and treated promptly. This case highlights the potential risks associated with high consumption of oxalate-rich foods and emphasises the need for awareness among both healthcare providers and patients regarding dietary oxalate intake.
Keywords: oxalate nephropathy, bilimbi, calcium oxalate , dietary oxalate

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CR 76

Incidental finding of Sertoli-Leydig cell tumour in the background of an inflammatory tubo-ovarian mass

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Introduction: Sertoli-Leydig cell tumour (SLT) accounts for around 2% of all ovarian tumours.
Case report: A 49-year-old nulliparous woman presented with fever, vaginal bleeding and vaginal discharge for four days. The ultrasound scan (USS) revealed a cystic and solid mass in the left adnexa measuring 97x58 mm. C-reactive protein was high (166.1 ml/dL). The high vaginal swab was negative for organisms. She was treated with intravenous antibiotics followed by left side salpingo-oophorectomy. This specimen showed a tubo-ovarian mass, with surface irregularities, adhesions and defects, measuring 68x45x35 mm, with areas containing purulent material. There was a yellowish white circumscribed ovarian lesion measuring 12x9x7 mm, the microscopy of which revealed Sertoli cells forming hollow and solid tubules, irregular collections of cells, and closely admixed Leydig cells. Cellular atypia was minimal. Mitoses were 3/10 high power fields. No retiform architecture, poorly differentiated areas or heterologous elements were seen. Both cell types were positive for inhibin and the Sertoli cells were positive for pan cytokeratin. These features were compatible with a moderately differentiated SLCT. The background ovary and the fallopian tube showed mixed inflammatory cell infiltrates with areas of suppuration. This patient is currently well and the follow up USS was negative for residual tumour.
Comment: Around 10% of moderately differentiated SLCTs show malignant behaviour. As there were adhesions and a defect in the ovarian tissue, incomplete tumour excision and spillage of tumour cells were additional concerns as these increase the risk of recurrence and metastases. The incidentally found tumour in this patient highlights the pathologists' role in diagnosing unsuspected lesions with prognostic implications.
Keywords: Sertoli-Leydig cell tumour, ovarian stromal tumour

CR 77

A rare case of acardiac twin in twin reversed arterial perfusion sequence

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Introduction: Twin reversed arterial perfusion (TRAP) sequence is a rare anomaly affecting 1 in 35,000 to 70,000 pregnancies, exclusively seen in monochorionic twins. It is characterised by abnormal arterioarterial placental anastomoses, allowing retrograde perfusion of a malformed, nonviable acardiac twin by a structurally normal "pump" twin. The acardiac twin lacks a functioning heart and major organs, while the pump twin is at risk for high-output cardiac failure, polyhydramnios, and preterm labour.
Case report: A 31-year-old G2P1 woman with a monochorionic diamniotic pregnancy presented in preterm labour at 34 weeks. TRAP sequence had been diagnosed via anomaly scan, and serial ultrasounds showed increasing size of the acardiac twin and polyhydramnios. Caesarean section was performed following antenatal corticosteroid administration. A healthy pump twin and a stillborn acardiac twin were delivered. We received the acardiac twin with an abdominal cavity and attached umbilical cord. The placenta was not included. The skeleton was underdeveloped, with fragments of rib and pelvic bones, and rudimentary lower limbs. The head, thorax, upper limbs, and external genitalia were absent confirming acephalic subtype. Internal findings included generalized oedema, a single globoid kidney, and hypoplastic bowel loops. Histologically, the heart and bowel tissues were unremarkable.
Discussion: This case represents the acephalic variant of TRAP sequence, which is the most common morphological type. The presence of typical malformations supports the diagnosis.
Conclusion: Postmortem examination of the acardiac twin provides valuable insight into the anatomical spectrum and supports accurate diagnosis and clinical counselling.
Keywords: twin reversed arterial perfusion (TRAP), monochorionic twins, acardiac twin,

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CR 78

Endometrioid type endometrial carcinoma with adenoma malignum like myoinvasion extending into the cervix and mimicking endocervical adenocarcinoma

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Introduction: Endometrioid endometrial carcinoma is the most common gynaecologic malignancy. Rarely, it exhibits an adenoma malignum-like myoinvasive pattern, seen in only 0.2–1.33% of cases. This pattern consists of diffusely infiltrating, widely spaced, bland-appearing glands lacking a stromal or inflammatory response. When such tumours extend into the cervix, they may mimic gastric-type mucinous adenocarcinoma (adenoma malignum) of cervical origin, causing diagnostic confusion. Immunohistochemistry (IHC) is essential for accurate classification.
Case report: A 54-year-old woman presented with a one-year history of irregular, heavy menstrual bleeding. Endometrial curettage showed endometrial hyperplasia with atypia (EHA). Hysterectomy with bilateral salpingo-oophorectomy revealed a 6×3×2.5 cm endometrial polyp and diffusely thickened endometrium; cervix and adnexa appeared grossly unremarkable. Histology showed diffusely infiltrating well-formed, small glands lined by minimally pleomorphic columnar cells, extending from the endometrium through the full thickness of the lower uterine myometrium and into the cervical stroma, sparing the cervical mucosa. Stromal desmoplasia, mitotic activity and lymphovascular/ perineural invasion were not seen. IHC showed strong ER positivity, and multi-focal vimentin positivity in tumour cells, with negativity for CEA, confirming endometrial origin. The endometrial polyp and uterine corpus showed EHA.
Discussion: Deceptively bland morphology of this tumour with cervical involvement, mimicked cervical adenocarcinoma. However, IHC results and absence of cervical mucosal infiltration supported an endometrial origin. This underscores the importance of recognizing this rare invasive pattern.
Conclusion: Adenoma malignum-like myoinvasion in endometrial carcinoma is rare and diagnostically challenging. Awareness of this pattern and appropriate use of IHC are vital to prevent misdiagnosis and ensure optimal patient management.
Keywords: adenoma malignum-like myoinvasion, endometrioid endometrial carcinoma, endocervical adenocarcinoma

CR 79

Intrauterine foetal death due to cardiac haemangiomatosis

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Introduction: Cardiac haemangiomatosis is an extremely rare condition characterized by the extensive proliferation of thin walled, ectatic vascular channels within the myocardium. Although rarely reported, it can lead to intrauterine foetal death (IUFD), especially when it affects myocardial function or disrupts the cardiac conduction system. This report presents the histopathological findings of a case of IUFD caused by cardiac haemangiomatosis.
Case report: A 32-year-old gravida 2, para 1 woman presented at 30 weeks of gestation with decreased foetal movements. Her pregnancy had been otherwise uncomplicated. Ultrasound confirmed IUFD, with absent foetal cardiac activity and reduced amniotic fluid. A stillborn female foetus was delivered vaginally, with no visible external congenital anomalies. Internal organs including the heart were macroscopically normal. Histopathological examination of the foetal heart revealed widespread replacement of the myocardium by numerous thin walled, dilated vascular channels consistent with haemangiomatosis. These vascular lesions disrupted the normal myocardial architecture and extended into the conduction system, suggesting that either high-output heart failure or a fatal arrhythmia could have led to the IUFD. No evidence of hydrops fetalis was present, and other internal organs showed no significant histopathological abnormalities.
Discussion: Cardiac haemangiomatosis involves the diffuse infiltration of abnormal vascular structures into the myocardium, impairing cardiac function and potentially triggering arrhythmias. The absence of hydrops foetalis suggests an acute terminal event rather than progressive heart failure.
Conclusion: Though rare, cardiac haemangiomatosis should be considered in unexplained IUFD cases. Histopathological examination is crucial for diagnosis, and advancements in prenatal imaging could help in early detection of this uncommon condition.
Keywords: cardiac haemangiomatosis, intrauterine foetal death

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CR 80 (Case series)

Clinicopathological profile of leprosy in the post-elimination era: a case series

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Introduction: Despite national elimination targets, leprosy remains a public health concern in certain parts of India. This case series highlights the clinical and histopathological diversity in leprosy and the importance of clinicopathological correlation for accurate diagnosis.
Case series: Sixteen newly diagnosed leprosy cases were studied from May 2024 to April 2025. The patients were aged 14–67 years (mean: 36.4) with a male-to-female ratio of 2.2:1. Clinical features included thickened nerves (n=14), nodular lesions (n=8), hypoesthetic patches (n=7), a solitary flank lesion (n=1), and a neck abscess (n=1). Ridley-Jopling classification showed four cases each of borderline tuberculoid, borderline lepromatous, and lepromatous leprosy, and two each of tuberculoid and histoid types. Histological examination identified tuberculoid (n=6), lepromatous (n=5), borderline (n=2), indeterminate (n=2) and histoid (n=1) types. Clinicopathological concordance was 37.5%. Two clinically typical cases were reclassified as indeterminate. Fite-Faraco staining was negative in one histoid and one lepromatous case.
Discussion : This case series highlights marked clinical and histopathological variability in leprosy. While classic signs like thickened nerves were common, atypical features such as a solitary flank patch and neck abscess complicated diagnosis. Clinicopathological concordance was low (37.5%) with some clinically typical cases being reclassified as indeterminate. Fite-Faraco staining was negative in two multibacillary cases, revealing diagnostic challenges.
Conclusion: Leprosy remains endemic with varied and misleading presentations. This study underscores the need for clinicopathological correlation to ensure accurate diagnosis and timely treatment. In endemic regions, early biopsy, thorough histopathology and vigilance are vital for effective management, even post-elimination.
Keywords: leprosy, *Mycobacterium leprae*, Ridley-Jopling spectrum, tuberculoid leprosy, histopathology

CR 81

Cavernous haemangioma presenting as a large cystic mass of the pancreas

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Introduction: Pancreatic cavernous haemangioma (PCH) is extremely rare, accounting for 0.1% of pancreatic tumours. It is a benign tumour comprising dilated vascular spaces lined by an endothelium. Pre-operative diagnosis is challenging due to its rarity and lack of distinctive imaging features.
Case report: A 47-year man presented with features of obstructive jaundice. Imaging studies revealed a cystic neoplasm in the head of the pancreas. The pancreaticoduodenectomy specimen showed a large mass lesion measuring 15x10x10 cm. The cut surfaces were multicystic and filled with brownish material. Microscopic examination demonstrated a multilocular cystic neoplasm lined by flattened epithelium. The cystic spaces were filled with eosinophilic proteinaceous material. Atypical cellular features were not found despite extensive sampling. The cyst lining cells showed immunohistochemical positivity for CD31.
Discussion and conclusion: PCH is a rare benign tumour of the pancreas. It can mimic other cystic neoplasms in the pancreas as it lacks a distinctive imaging pattern. Although rare, a high degree of suspicion is required in surgical procedures due to bleeding. Extensive sampling and immunohistochemistry for vascular markers are recommended in evaluating cystic neoplasms in the pancreas with flattened lining epithelium.
Keywords: pancreatic cavernous haemangioma, cystic neoplasm, pancreaticoduodenectomy

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CR 82

Primary sclerosing cholangitis clinicoradiologically misdiagnosed as a cholangiocarcinoma in the liver

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Introduction: Primary sclerosing cholangitis (PSC) is an inflammatory disease that results in the progressive stricturing of the biliary tree, leading to cirrhosis. Patients with PSC have a significantly higher lifetime risk of developing cholangiocarcinoma (CCA), estimated to be around 20%.
Case report: A 62-year-old man presented with painless obstructive jaundice for four months and was found to have a stricture at the confluence in endoscopic retrograde cholangiopancreatography (ERCP). Imaging revealed a biliary stricture, suspicious of malignancy. He underwent a left hepatectomy, which showed multiple pale tan streaks radiating from the medium-sized ducts. Extensive sampling of these areas revealed medium to small-sized bile ducts with moderate to dense periductal inflammation, predominantly comprising plasma cells and lymphocytes, and concentrically laminated onion skin-like fibrosis around most of these ducts. There was no evidence of intraductal or invasive malignancy. The background liver showed steatosis and grade II fibrosis. These features were compatible with PSC, and there was no evidence of cholangiocarcinoma. The postoperative period was uneventful. He is being followed up at the clinic.
Discussion and conclusion: Differentiation of PSC and CCA is challenging due to overlapping clinicoradiological features, particularly in the early stages. Serum CA19-9 level, ERCP with bile duct brushing for cytology, and FISH to detect aneuploidy in CCA are the screening strategies currently available for detecting CCA in PSC. However, none of these reliably differentiate between PSC and CCA. Newer studies using DNA methylation markers on liquid biopsies have shown promising results in the early detection of CCA in PSC.
Keywords: primary sclerosing cholangitis, cholangiocarcinoma, onion skin-like fibrosis, DNA methylation markers

CR 83

Cutaneous lymphoid hyperplasia mimicking primary cutaneous follicle centre lymphoma

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Introduction: Cutaneous lymphoid hyperplasia (CLH) is an immune skin reaction to various stimuli. Sometimes exuberant CLH occurs mimicking a cutaneous lymphoma clinically and histologically. When follicular hyperplasia is prominent it can mimic a primary cutaneous follicle centre lymphoma (PCFCL).
Case report: A 76-year man presented with a firm skin nodule on the neck for three months. The biopsy showed a heavy infiltrate of small mature lymphocytes in the deep dermis and subcutis, predominantly arranged in follicles with pale centres. These centres contained centrocytes and a few centroblasts with some tingible body macrophages. Vague mantle zone rims were identified in follicles. On immunohistochemistry CD20 was positive predominantly in the follicles and CD 3 in the interfollicular regions. BCL2 was negative in the follicle centres and highlighted the intact mantle zones. CD23 highlighted the preserved follicular dendritic meshwork confined to follicle centres. Ki67 was high in the follicle centres, about 42%. Hence, a diagnosis of CLH was made.
Discussion and conclusion: Both CLH and PCFCL commonly present as a solitary nodule in the head and neck region of adults. Microscopy of both show a follicle pattern. Both show negative BCL2 stain and high Ki67 activity in the centres, making the diagnosis challenging. CD 10 is positive in follicle centre cells in CLH. CD 10 faint positivity may be present in PCFCL. In this case the presence of tingible body macrophages, preserved mantle zone and follicular dendritic cell meshwork confined to follicle centre were in favour of CLH over PCFCL. Flowcytometry and molecular studies may be helpful in confirmation. When diagnosis is indefinite in challenging cases close follow up is indicated. Clonal studies can be done in inconclusive cases. PCFCL has an indolent behaviour with excellent prognosis.
Keywords: cutaneous lymphoid hyperplasia, primary cutaneous follicle centre lymphoma, follicles, localized response, low grade B cell lymphoma.

CR 84

Columnar cell papillary thyroid carcinoma with unusual fine needle aspiration cytology appearance

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Introduction: Columnar cell papillary thyroid carcinoma (CC-PTC) is a rare entity with an incidence of 0.15-0.4% of all papillary thyroid carcinomas (PTC). The fine needle aspiration cytology (FNAC) of this subtype is more like PTC NOS. We report a case of CC-PTC with an unusual FNAC appearance.
Case report: A 23-year woman presented with a neck lump of five months duration. There was no evidence of sinister symptoms, suspicious lesions elsewhere in the body or a family history of malignancy. Ultrasound scan of the thyroid revealed a TIRADS IV nodule in the left lobe. FNAC revealed hypercellular smears with many 3D papillary structures; nuclear anisocytosis and occasional grooves were present in the constituent cells. The background showed numerous sheet-like discohesive cells with eccentric amphophilic cytoplasm and mild to moderately pleomorphic nuclei; typical nuclear features of PTC were not evident. Cytology was reported as a malignant smear with a differential diagnosis of PTC or medullary thyroid carcinoma (MTC) - papillary variant. Histology of the nodule revealed a tumour composed of branching papillae lined by columnar cells with elongated, hyperchromatic nuclei with pseudostratification. Nuclear features of classic PTC such as nuclear grooves, chromatin clearing, intranuclear inclusions or nuclear features of MTC such as fine stippled chromatin were not identified. Cytoplasm was eosinophilic. Mitoses were around 4/10hpf. Necrosis was not identified. Amyloid deposits were not identified. A histological diagnosis of CC-PTC was made.
Discussion: Cytology of CC-PTC is frequently reported as PTC NOS. Cytological diagnosis was challenging in this case due to the presence of numerous discohesive background cells with eccentric amphophilic cytoplasm, reminiscent of medullary carcinoma. The presence of discohesive cells in the background is rare in CC-PTC, however it has been reported.
Conclusion: Variants of PTC can have unusual FNAC appearance and are not well described in standard references due to their rarity. Histo-cyto correlation is the best way of recognising these patterns.
Keywords: columnar cell papillary thyroid carcinoma, fine needle aspiration cytology

CR 85

Sudden death of a young man following arrhythmogenic right ventricular cardiomyopathy with atrial fibrosis

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Introduction: Arrhythmogenic right ventricular cardiomyopathy (ARVC) is a rare genetic disease with autosomal dominant inheritance and variable penetrance, giving rise to a spectrum of cardiac symptoms. The characteristic feature is the fibro-fatty replacement of the free wall of the right ventricle (RV). Left ventricular (LV) and biventricular involvement are recognised, hence the recent terminology arrhythmogenic cardiomyopathy is preferred. Sudden cardiac death (SCD) occurs in 50% of cases.
Case report: A 25-year-old previously well, male undergraduate collapsed while resting and was found dead on admission. There was no history of sudden death at a young age in his family. Autopsy showed cardiomegaly, alveolar haemorrhage and oedema. The RV wall was soft and fatty, with thinning of the free wall. The LV showed concentric thickening. The left atrium (LA) showed fibrosis. Bilateral coronary trunks showed a narrowed lumen due to mural thickening. There was no atheroma or thrombi. Histology showed replacement of the RV myocytes with fat and interstitial fibrosis. The remaining myocytes showed fibre disarray. The LV wall showed hypertrophic muscle fibres with disarray. The endocardial surface of the LA showed fibrosis.
Discussion and conclusion: In ARVC, mutations occur in genes encoding proteins of the cardiac desmosome that provide mechanical connections between myocytes. Fibro-fatty replacement of the myocardium leads to ventricular arrhythmias and progressive cardiac dysfunction, causing SCD. Atrial fibrillation following atrial fibrosis is recently thought to be a cause for SCD in ARVC. The significance of non-atheromatous narrowing of the coronary trunks in this case is questionable and needs further study. The usefulness of genetic testing in ARVC is not only limited to confirmation of the diagnosis but is essential for targeted screening programs for the family members.
Keywords: arrhythmogenic right ventricular cardiomyopathy, sudden cardiac death, atrial fibrosis

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CR 86

Massive ovarian oedema: a cause of acute abdomen in young women

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Introduction: Massive ovarian oedema (MOE) is an unusual cause of ovarian enlargement in young women, and half of the cases present with an acute abdomen due to partial or complete torsion of the affected ovary. Clinically and radiologically, this may mimic other surgical and gynaecological causes of acute abdomen, which also include ovarian neoplasms
Case report: A 19-year-old woman known to have polycystic ovarian syndrome (PCOS) presented with severe right-sided colicky abdominal pain of one day. She had experienced a similar episode three weeks back that had resolved with analgesics. Ultrasound scan on admission showed a 9cm right adnexal mass and mild free fluid. The right ovary was not identifiable. The left ovary was normal. Laparoscopic resection of the mass with the fallopian tube was performed, and fragments of dark brown tissue (7x7 cm) were received. Microscopy showed partly viable ovarian tissue with massive diffuse stromal oedema, fragmented follicular structures and cortical fibrosis. Evidence of venous infarction was present.
Discussion and conclusion: MOE is thought to be caused by partial intermittent torsion of the ovarian pedicle, interfering with the venous and lymphatic drainage of the ovary, resulting in enlargement mimicking a solid adnexal mass. Androgenic manifestations and PCOS are seen in some. In contrast, benign tumours like lymphangiomas are solid and cystic masses. Acute torsion can clinically mimic appendicitis or ectopic pregnancy. Though most of the cases are managed with oophorectomy, intraoperative diagnosis can assist ovarian conservation in these young patients.
Keywords: massive ovarian oedema, polycystic ovarian disease

CR 87

Poorly differentiated component in an encapsulated angioinvasive follicular thyroid carcinoma: a diagnostic challenge

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Introduction: The Turin classification is the diagnostic algorithm currently used for the diagnosis of high-grade follicular cell-derived non-anaplastic thyroid carcinomas. However, this lacks clear criteria regarding the extent of necrosis required to differentiate differentiated thyroid carcinoma with poorly differentiated areas (DTC-PDA) from poorly differentiated thyroid carcinoma (PDTC), which has a poorer prognosis.
Case report: A 63-year-old man presented with a gradually enlarging thyroid mass over two years, accompanied by recent rapid growth, dyspnea and dysphagia for six months. Imaging revealed a suspicious, solitary, hypoechoic nodule in the isthmus with increased vascularity. A total thyroidectomy was performed. Macroscopically, there was a well-circumscribed, solid white tumour measuring 65x55x40 mm, involving the isthmus and extending into both lobes, with no evidence of gross extrathyroidal extension. The entire tumour periphery was sampled. Microscopically, the tumour showed a variably thick capsule and comprised closely packed microfollicles with round, hyperchromatic nuclei. No features of papillary thyroid carcinoma or anaplastic carcinoma were present. Multiple foci showed capsular and extensive vascular invasion. Less than 5% of the tumour demonstrated a trabecular growth pattern, focal necrosis, and a high Ki-67 proliferation index of 10%, indicative of poorly differentiated transformation.
Discussion: When there is focal solid growth with a mitotic count ≤ 3/10 HPF and equivocal nuclear features, necrosis becomes a critical determinant in distinguishing PDTC from DTC-PDA. Turin classification lacks definitive cutoff values for these key histological features, resulting in uncertainty in diagnosing borderline cases. Some studies suggest that even minimal necrosis supports a diagnosis of PDTC.
Keywords: follicular thyroid carcinoma, poorly differentiated components

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CR 88

A rare case of primary endometrial squamous cell carcinoma arising over a submucosal leiomyoma

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Introduction: Primary endometrial squamous cell carcinoma (PESCC) is an exceedingly rare malignancy, accounting for less than 1% of uterine corpus cancers. Its pathogenesis is not well understood. Here we report a case of PESCC confined to a submucosal leiomyoma.
Case report: A 64-year-old woman presented with a one-month history of per vaginal discharge. Examination revealed a fibroid-like polyp protruding through the cervical os. Hysterectomy, bilateral salpingo-oophorectomy and fibroid polypectomy were performed. A separate nodular mass (65x40x35mm) covered by mucosa was also received, and its fundal attachment was confirmed on gross examination. Histological examination showed a leiomyoma completely lined by squamous epithelium exhibiting full-thickness dysplasia. An invasive squamous cell carcinoma of the basaloid type was identified arising from this dysplastic epithelium and infiltrating into the submucosal leiomyoma. The tumour comprised atypical polygonal cells with hyperchromatic nuclei exhibiting peripheral palisading and high mitotic activity. No keratin pearls or tumour necrosis was seen. There was no evidence of myometrial, cervical, lymphovascular, or serosal invasion. The endometrium was sampled completely and showed cystic atrophy, except at the fundal attachment of the leiomyoma, which showed high-grade full-thickness dysplasia of the metaplastic squamous epithelium. The cervix showed no dysplasia or malignancy. Bilateral ovaries, fallopian tubes, and parametria were free of tumour.
Discussion and conclusion: The diagnosis of PESCC requires three criteria: absence of coexistent endometrioid adenocarcinoma, no continuity with cervical squamous epithelium, and exclusion of other primary squamous malignancies. Accurate diagnosis relies on the exclusion of more common neoplasms such as endometrioid adenocarcinoma and cervical SCC. This tumour showed the typical PESCC immunoprofile (p63+/CK7-). Its endometrial origin was confirmed by the absence of cervical dysplasia. This case highlights the importance of comprehensive histological and immunohistochemical evaluation, especially when lesions clinically mimic benign conditions, such as fibroids.
Keywords: primary endometrial squamous cell carcinoma.

CR 89

A rare case of gliomatosis peritonei associated with a mature cystic teratoma

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Introduction: Gliomatosis peritonei (GP) is a rare condition marked by the presence of mature glial tissue in the peritoneum. It is most commonly associated with immature ovarian teratomas and less frequently with mature teratomas. Proposed mechanisms include implantation during tumour rupture or differentiation of peritoneal pluripotent cells under tumour influence.
Case report: A 40-year-old woman presented with progressive abdominal distension. CT scan revealed a mixed echogenic right adnexal lesion with cystic and solid components, suggestive of a dermoid cyst with neoplastic changes. Serum CA-125 was elevated (93 U/mL), while LDH and beta-hCG were normal. Intraoperatively, multiple omental nodules suspicious of metastatic deposits were identified. Gross examination showed a cystic and solid mass with an intact capsule, measuring 160x170x70 mm, which comprised 70% solid and soft brain matter-like tissue. The cystic areas contained sebaceous material and hair. No necrosis or papillary structures were identified. The tumour was extensively sampled and revealed a mature cystic teratoma with predominant glial tissue. No immature or malignant components were seen. Omental tissue showed mature glial nodules confirmed by GFAP immunostaining, consistent with GP.
Discussion and conclusion: This case emphasizes the diagnostic challenge of gliomatosis peritonei associated with mature cystic teratoma, as it can closely mimic a malignant ovarian neoplasm with peritoneal metastases. Although GP can clinically and radiologically mimic malignancy, accurate diagnosis with comprehensive histology and immunohistochemistry is essential to avoid unnecessary aggressive treatment. Prognosis is favourable in the absence of malignant or immature elements.
Keywords: gliomatosis peritonei

CR 90

Oral mucosal melanoma; a rare entity

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Introduction: Oral mucosal melanoma is an extremely rare and highly aggressive malignant neoplasm that mostly arises from the maxillary gingiva and palate of the oral cavity. These represent <1% of all melanomas and 0.26% of all oral malignancies. These tumours affect older adults with a peak incidence in the seventh decade of life.
Case report: An 81-year-old otherwise healthy woman presented with a blackish growth on the anterior maxilla of two-months duration. Contrast-enhanced computed tomography (CECT) revealed a heterogeneously contrast-enhancing, bone destructive lesion suggestive of a malignant lesion. Total maxillectomy was done. Macroscopically, an exophytic, hyperpigmented mass measuring 28x28x25mm was in the anterior maxilla. Microscopy revealed a malignant melanoma composed of sheets, fascicles, and nests of pigmented atypical spindle cells containing marked pleomorphic, vesicular nuclei with prominent nucleoli. Junctional activity was seen, confirming that the lesion was arising from the maxillary mucosa. The tumor focally infiltrated into the maxillary bone (pT4a). Lymphovascular and perineural invasion were seen.
Discussion: Primary oral mucosal melanoma is a rare and aggressive malignant neoplasm with a poorer prognosis than cutaneous melanoma, due to the delay in presentation and diagnosis. The Clark and Breslow classifications are not used as prognostic predictors in mucosal melanoma due to architectural differences between oral mucosa and skin. The five-year survival for head and neck mucosal melanoma ranges from 20% to 50%. Surgery is the mainstay of therapy. Adjuvant radiotherapy may reduce local recurrence, and immunotherapy is beneficial.
Keywords: mucosal melanoma, maxilla

CR 91

Endometriosis of the terminal ileum and mesenteric lymph nodes presenting as a malignant tumour: an unusual presentation of a common entity

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Introduction: Endometriosis is a common condition in women of reproductive age, where functional endometrial tissue grows outside the uterus. It commonly affects the pelvic organs, such as the ovaries and uterine ligaments, and can occasionally involve the gastrointestinal tract with features of subacute bowel obstruction, as in this case.
Case report: A 37-year-old woman with one child presented with severe abdominal pain, progressively worsening constipation and intermittent vomiting for six months. The abdominal ultrasound and an erect abdominal X-ray revealed dilated small bowel loops in the right iliac fossa, suggestive of a subacute intestinal obstruction, suspicious of bowel malignancy. An urgent exploratory laparotomy with a right hemicolectomy was performed. Macroscopic examination of the resected specimen revealed a constricted segment proximal to the ileocecal junction, and the cut sections show a mass within the ileal wall and obstructing the bowel lumen, measuring 30x15x10 mm. Microscopy revealed endometrial glands and stroma in the mucosa, submucosa, muscularis propria and subserosa of the ileal lesion, appendix, mesenteric fat and mesenteric lymph nodes. Immunohistochemistry showed ER positivity in both glandular and stromal components, confirming the diagnosis of endometriosis. Postoperatively, the patient was managed with combined oral contraceptive pills.
Discussion and conclusion: Endometriosis of the gastrointestinal tract is less common, and the involvement of the terminal ileum, appendix and mesenteric lymph nodes is rare. Treatment of intestinal endometriosis consists of surgery and pharmacotherapy, including hormonal therapy with gonadotropin–releasing hormone analogs.
Keywords: endometriosis, terminal ileum

CR 93

Sinusoidal CD30 positive B cell lymphoma masquerading as metastatic carcinoma and anaplastic large cell lymphoma: a diagnostic challenge

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Introduction: Sinusoidal large B cell lymphoma is a rare diagnostically challenging entity due to its morphological pattern which mimics metastatic carcinoma and anaplastic large cell lymphoma. It exhibits a prominent sinusoidal pattern where neoplastic lymphoid cells fill the lymph node sinuses. The histological mimicry highlights the critical role of immunohistochemistry (IHC) in achieving an accurate diagnosis.
Case report: A 67-year-old woman presented with enlarged lymph nodes in para-aortic, left pelvic and left inguinal regions. Histology of the left inguinal lymph node showed effacement of the nodal architecture with expanded sinuses and surrounding residual follicles. The sinuses were filled with neoplastic cells with pleomorphic vesicular nuclei and moderate amphophilic cytoplasm. There were occasional mitoses. Pancytokeratin and HMB 45 were negative in the sinusoidal tumour cells excluding the possibilities of metastatic carcinoma and malignant melanoma. The neoplastic cells within sinuses were strongly positive for LCA and CD20 and negative for CD3, favouring a lymphoma with a B cell lineage. The neoplastic cells were strongly positive for CD 30 and a diagnosis of sinusoidal CD30 positive B cell lymphoma was made.
Discussion and conclusion: Sinusoidal CD30-positive large B-cell lymphoma is a rare entity that can be mistaken for metastatic carcinoma or anaplastic large cell lymphoma due to its distinctive sinusoidal histological pattern. This case highlights the critical role of IHC in achieving an accurate diagnosis and underscores the need for pathologists to recognise this rare variant of large B-cell lymphoma for timely and appropriate management.
Keywords: sinusoidal B cell lymphoma, metastatic carcinoma, anaplastic large cell lymphoma

CR 94

An unusual case of disseminated cutaneous histoplasmosis, clinically mimicking Kaposi sarcoma in a patient with HIV/AIDS

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Introduction: Histoplasmosis, caused by *Histoplasma capsulatum*, typically affects the lungs. Disseminated histoplasmosis is rare (<5%) and may present with cutaneous manifestations in immunocompromised individuals, sometimes mimicking Kaposi sarcoma.
Case report: A 36-year-old patient with HIV/AIDS presented with multiple violaceous skin lesions, generalized lymphadenopathy and prolonged fever of two weeks. The initial clinical suspicion was Kaposi sarcoma. Tuberculosis screening including Gene Xpert were negative. Skin biopsy showed sheets of histiocytes at the interface and periadenexal regions. Lymph node biopsy showed sheets of histiocytes. No granulomas or caseation were identified in both. The cytoplasm of the histiocytes contained small, uniform, oval, yeast-like organisms with clear halos, highlighted by PAS stain, confirming Histoplasma. Histoplasma antigen was detected in urine. Radiology revealed a right upper lobe lung mass. Lung biopsy showed collections of histocytes and foamy macrophages with mixed inflammatory cells. No fungal elements, necrosis or granulomas were identified. The patient was treated as Mycobacterium avium complex (MAC) infection of the lung following multidisciplinary discussion, based on the histology and radiology. The patient responded well to MAC regimen and antifungal therapy. Complete recovery was confirmed by clinical and radiological resolution.
Discussion and conclusion: Cutaneous histoplasmosis and Kaposi sarcoma share overlapping symptoms including constitutional symptoms, violaceous skin lesions and visceral organ (lung, lymph node) involvement often causing diagnostic confusion in HIV patients. The risk of misdiagnosis is high in immunocompromised settings where both conditions coexist. Therefore, Histoplasmosis should be considered in the differential diagnosis of atypical cutaneous lesions in HIV-infected patients, especially when resembling Kaposi sarcoma. Timely histopathological examination is essential for accurate diagnosis.
Keywords: histoplasmosis, Kaposi sarcoma, HIV/AIDS

CR 95

Tumefactive demyelinating lesion mimicking glioma: a diagnostic challenge

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Introduction: Tumefactive demyelinating lesion (TDL) is a rare inflammatory demyelinating disease of the central nervous system occurring predominantly in young and middle-aged females. Based on the clinical presentation and imaging findings, it is difficult to distinguish between brain tumours, abscesses and TDLs. Unlike brain tumours, TDLs respond well to steroids. Therefore, reliable distinction is important for proper management.
Case report: A 41-year-old woman who defaulted treatment for hypertension and arthritis presented with sudden onset slurring of speech and left sided mouth deviation. Magnetic resonance imaging (MRI) revealed a right frontal lesion with the differential diagnosis of either low grade glioma or TDL. The intraoperative neurosurgical impression was of an intermediate grade glioma, while crush smears showed a mixed population of reactive glial cells, many foamy macrophages, inflammatory cells and occasional normal neurons. No atypical cells were seen. Histology revealed brain parenchyma with pale areas of relatively less cellular density, containing numerous foamy macrophages. There was perivascular inflammation predominantly composed of lymphocytes. Haemorrhage, necrosis or evidence of malignancy was not seen.
Luxol fast blue stain confirmed the loss of myelin in pale areas and highlighted the myelin fragments engulfed within the macrophages. Neurofilament immunostaining confirmed the preservation of axons.
Discussion and conclusion: As per this case, TDLs often present with acute neurological deficits. MRI features may mimic a glioma, prompting surgical intervention. This misdiagnosis can lead to unnecessary oncological treatment. Therefore, a multidisciplinary approach including clinical, radiological, cytological and histopathological analysis is vital to avoid the diagnostic pitfalls.
Keywords: tumefactive degenerating lesion, glioma, Luxol fast blue, neurofilament

CR 96

Secretory carcinoma of the parotid masquerading as metastatic papillary thyroid cancer: role of cyto-histo correlation

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Introduction: Secretory carcinoma of the salivary gland is a rare (< 0.3 % of all salivary tumours), low grade malignancy, predominantly arising in the parotid gland. There is a slight male predominance and mean age of occurrence is 49 years. A hallmark is the presence of *ETV6-NTRK3* fusion. Cytological features of this tumour may mimic a metastatic carcinoma. Therefore, diagnosis can be challenging when it arises in patients with a history of previous carcinoma.
Case report: A 59-year-old man who had undergone total thyroidectomy for papillary thyroid carcinoma (PTC) presented with an enlarged right side parotid lump. Fine needle aspiration cytology (FNAC) showed features of a malignant neoplasm more in favour of metastatic deposit of a papillary thyroid carcinoma. The patient underwent surgical excision. Histopathological examination revealed a circumscribed but focally infiltrating tumor with cystic, solid and papilliform architecture. Microcysts contained eosinophilic colloid-like secretions which were stained by both periodic acid - Schiff (PAS) and alcian blue stains. Neoplastic cells were monomorphic with central round to oval vesicular nuclei, small distinctive nucleoli and moderate eosinophilic vacuolated cytoplasm. Immunohistochemistry was negative for TTF 1, DOG 1 and P63 and positive for S100 supporting the diagnosis of secretory carcinoma.
Discussion and conclusion: Secretory carcinoma can mimic metastatic PTC cytologically due to overlapping features including glandular architecture, cytoplasmic vacuolation and colloid-like secretory material. This highlights the limitations of FNAC and importance of a multidisciplinary diagnostic approach, incorporating histopathology, immunohistochemistry and molecular testing for accurate identification.
Keywords: thyroid, salivary gland, secretory carcinoma, papillary thyroid carcinoma

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CR 97

A rare giant: a case report of a large gastric glomus tumor

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Introduction: Gastric glomus tumours (GGT) are rare mesenchymal tumours composed of modified smooth muscle cells, mostly located in the gastric antrum. GGT shows a wide age distribution (18 years to 90 years). Kay et al. published the first case of GGT in 1951. Pre-operative diagnosis of GGT is challenging due to its clinical and imaging similarities with other common submucosal tumours, such as gastrointestinal stromal tumours (GIST).
Case report: A 41-year-old woman presented with pain in abdomen for 10 days. Imaging studies confirmed a large, sub-mucosal gastric tumor, favouring GIST. She underwent wedge resection of the stomach, and the macroscopy showed a well-circumscribed mass arising from the wall of the stomach, measuring 17 cm in its largest dimension. The cut surface was heterogeneous, grey-brown, soft, rubbery and with large areas of cystic change. Microscopy showed that the tumour originated from the smooth muscle layer of the stomach. It comprised monomorphic cells arranged in a solid pattern surrounded by blood vessels. Mitosis was infrequent, (2-3 mitosis/ 10 HPF) with no atypical mitoses or tumour necrosis. Multiple areas of cystic change and haemorrhage were seen. On immunohistochemistry , the tumour cells were positive for smooth muscle actin and vimentin, and negative for desmin, CD117 and DOG1. The post-operative course was uneventful. Following one year of post-surgical follow-up, the patient is doing well with no signs of recurrence or metastasis.
Discussion and conclusion: GGTs are usually benign, with a low risk of malignancy. Deep location like visceral organ or mediastinum, size of more than 2 cm, nuclear atypia and high mitotic activity are the features of malignancy. Tumour size in reported cases ranges from 0.8 cm to 17 cm with this case being one of the largest reported. Radiographically, GGT appears as a submucosal mass with contrast enhancement in the arterial phase. GISTs and neuroendocrine tumours are important differential diagnoses. Surgical wedge resection, as performed in this case, remains the treatment of choice. Close follow-up is crucial for large tumours for early detection of recurrence or metastasis.
Keywords: gastric glomus tumor, immunohistochemistry, wedge resection

CR 98

Multiple trichoepithelioma on face in 45-year-old woman with no family history

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Introduction: Trichoepitheliomas are rare benign skin adnexal tumors derived from hair follicles. Multiple trichoepitheliomas typically present as part of an autosomal dominant condition known as multiple familial trichoepithelioma (MFT). Sporadic cases without family history are exceedingly rare.
Case Report: A 45-year-old woman presented with multiple, flesh-colored, dome-shaped papules and nodules scattered across her face, particularly concentrated on the nasolabial folds, forehead, and cheeks. The lesions had gradually appeared over the past decade. She denied any family history of similar conditions. Clinical examination revealed firm, non-tender papules ranging from 2-8mm in diameter. Histopathological examination of the excisional biopsy specimen showed multiple well-circumscribed dermal nodules composed of basaloid cells arranged in nests and strands with peripheral palisading. Horn cysts and fibroblastic stroma were prominent features.
Discussion: The absence of family history in this case of multiple trichoepitheliomas suggests a sporadic mutation or incomplete penetrance of the *CYLD* gene. Differential diagnoses including basal cell carcinoma and syringoma were ruled out through histopathological examination. Treatment involved surgical excision of symptomatic lesions and CO2 laser therapy for cosmetic improvement.
Conclusion: This case highlights the importance of considering multiple trichoepithelioma in the differential diagnosis of facial papules even without family history. Further genetic studies may elucidate the pathogenesis of sporadic multiple trichoepitheliomas and guide targeted therapeutic approaches.
Keywords : trichoepithelioma, family history, basaloid tumour, skin

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CR 99

Acute oxalate nephropathy in a child due to *Averrhoa bilimbi* (bilin) ingestion

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Introduction: *Averrhoa bilimbi ('bilin')* and *Averrhoa carambola* (star fruit) are members of the Oxalidaceae family, both known to contain high concentrations of oxalic acid. While star fruit-induced nephropathy is relatively well documented, cases of bilimbi-associated acute kidney injury remain rare, especially in children. Oxalate-induced nephropathy occurs when excessive oxalate precipitates in renal tubules, leading to obstruction and acute tubular injury.
Case report: A previously healthy 7-year-old girl presented with abdominal pain, vomiting, and oliguria for three days following ingestion of a large quantity of bilimbi ('bilin') fruit. She exhibited facial puffiness, abdominal distension, and hypertension. Laboratory findings showed elevated serum creatinine (381 µmol/L) and blood urea (181 mg/dL), mild proteinuria, and haematuria. Urine microscopy revealed 15–20 pus cells and 10–15 red cells per HPF with no red cell casts. Renal ultrasound showed hypoechoic kidneys with prominent pyramids. Renal biopsy demonstrated normal histomorphology of glomeruli, with focal tubular deposition of translucent, fan-shaped polyhedral crystals that were birefringent under polarized light, along with focal tubulitis. The interstitium and immunofluorescence findings were unremarkable. The patient responded well to supportive care and was discharged in stable condition with planned nephrology follow-up.
Discussion and conclusion: The presence of intratubular oxalate crystals and tubular injury, combined with a clear temporal link to bilimbi ingestion and the absence of systemic or immune-mediated disease were consistent with diagnosis of acute oxalate nephropathy due to dietary hyperoxaluria. Prompt recognition and biopsy to exclude other pathologies are essential for favourable outcomes.
Keywords: oxalate nephropathy; Averrhoa bilimbi; dietary hyperoxaluria

CR 100

NTRK-rearranged spindle cell neoplasm of gastrointestinal tract

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Introduction: *NTRK*-rearranged spindle cell neoplasm (NTRK-RSCNS) is a rare heterogenous emerging group of soft tissue tumour with *NTRK* gene rearrangement, which occurs mostly in children and young adults. Genetic testing confirms *NTRK* -rearranged tumours. The presence of *NTRK* rearrangement is of therapeutic significance.
Case report: A 37-year-old woman presented with abdominal pain and was found to have an abdominal mass on CT scan. A pyloric biopsy showed a low-grade spindle cell tumour. It was negative for CD 117 and DOG 1, showed dual expression for CD34 and S100 and was positive for pan-NTRK immunohistochemistry (IHC). The distal gastrectomy performed two years after the initial diagnosis showed a 45 mm tumour, with solid and cystic appearance. Histology showed uniform bland appearing spindle cells arranged in haphazard fascicles, with prominent interstitial collagen fibres and perivascular ring-like hyalinisation. There was no necrosis. It had dual expression for CD34 and S100. It was negative for DOG-1 and CD117. Pan- NTRK IHC was positive. Next-generation-sequencing (NGS) showed a *LMNA-NTRK1* fusion. No *KIT* or *PGGFRA* alteration was detected. Final diagnosis was a *NTRK*-rearranged spindle cell neoplasm.
Discussion: These tumours show diverse morphology and usually co-expresses CD34 and S100 and are negative for CD 117, DOG 1 and SOX 10. They are characterised by specific *NTRK* gene fusions. Diagnosis of this tumour requires fish or NGS testing. The presence of *NTRK* rearrangements makes these tumours responsive to NTRK inhibitors, a class of targeted therapies.
Conclusion: In summary, NTRK- RSCNS are a growing area of interest in the study of gastrointestinal tumours, and their identification and treatment are evolving with advances in molecular diagnostics and targeted therapies.
Keywords: NTRK rearranged spindle cell neoplasm

CR 102

Eosinophil rich fine needle aspiration cytology as an initial clue to diagnosing angioimmunoblastic T cell lymphoma

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Introduction: Angioimmunoblastic T-cell lymphoma (AITL) is a subtype of peripheral T-cell lymphoma (PTCL) often associated with generalized lymphadenopathy and systemic symptoms. Cytological diagnosis is rarely conclusive especially when findings mimic reactive or eosinophilic lymphadenitis.
Case report: An 81-year-old woman presented with cervical lymphadenopathy of three months duration, which gradually increased in size. She showed systemic symptoms including low-grade fever and had raised levels of LDH. Initial fine needle aspiration cytology (FNAC) of the lymph node showed polymorphous lymphoid cells with scattered enlarged cells and numerous eosinophils. On histology, the lymph node showed a partially effaced architecture with a polymorphous population of small to medium-sized lymphocytes, scattered immunoblasts, histiocytes, plasma cells, and numerous eosinophils amid prominent arborizing high endothelial venules (HEVs). Follicles were regressed. CD3 and CD 10 showed an increased expression in T lymphocytes, while expression of CD20 was diminished, indicating a reduction in the number of B lymphocytes..
Discussion: AITL presents with nonspecific systemic symptoms and lymphadenopathy making clinical diagnosis difficult. It is usually not possible to make a diagnosis on FNAC due to the polymorphous cytology. In this case numerous eosinophils seen in the aspirate led to a suspicion of lymphoma but did not exclude entities such as parasitic infestation or Kimura disease. Histopathology and immunohistochemistry remain the gold standard for diagnosing AITL. Early recognition is crucial since prognosis is poor.
Conclusion: This case highlights the need for a high index of suspicion when FNAC reveals increased numbers of eosinophils. While Hodgkin lymphoma would be an important differential diagnosis when increased eosinophils are seen in a FNAC, AITL should also be considered particularly in elderly patients presenting with lymphadenopathy.
Keywords: angioimmunoblastic, peripheral T cell lymphoma, immunoblasts

CR 103

Submucosal variant of Whipple's disease: an unfamiliar presentation of a known entity

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Introduction: Whipple's disease is a rare, chronic infection with multisystemic involvement. The causative organism is *Tropheryma whipplei*, an actinobacterium, ubiquitously present in the environment. If the disease is not promptly recognized and treated, central nervous system involvement may develop, which can be fatal.
Case report: A 69-year-old previously healthy man developed fever, abdominal pain, loose stools and loss of 8kg over months. Imaging was suggestive of a neoplasm with oedema of small intestine, caecum and appendix and loco-regional lymphadenopathy. Right hemicolectomy with excision of a jejunal segment was done. Macroscopy showed extensive adhesions among the bowel loops. The jejunal lumen was yellowish and sticky. The jejunal wall was thickened with transmural patchy yellowish foci. Microscopy showed sheets of macrophages, containing numerous blackish-blue material within the cytoplasm with adjacent lymphocytes, plasma cells and neutrophils, within the submucosa of jejunum, caecum and appendix. Sheets of similar macrophages were also seen in subserosa of caecum and appendix. No villous blunting, intraepithelial lymphocytosis, granulomas, suppuration or necrosis were seen. Extensive sampling revealed no similar macrophages in lamina propria. Pericolic lymph nodes showed reactive changes only.
Discussion and conclusion: The differential diagnoses based on microscopy included were malakoplakia, histoplasmosis and Whipple's disease. Periodic acid Shiff (PAS), Gram and Perl stains were done. Although PAS positive organisms were seen within macrophages, positivity of Gram stain together with histomorphology, excluded histoplasmosis. Negativity of Perl and acid-fast stains excluded malakoplakia and tuberculosis. Diagnosis of submucosal Whipple's disease may be challenging with jejunal biopsy, unless the submucosa is adequately sampled.
Keywords: Whipple disease, submucosal, intracellular organisms

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CR 104

Basal cell carcinoma and syringocystadenoma papilliferum arising in a naevus sebaceous of Jadassohn: an uncommon presentation

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Introduction: Sebaceous nevi are congenital cutaneous hamartomas that can give rise to various benign and malignant tumours of epidermal, adnexal and mesenchymal origin during adulthood. It is postulated that sebaceous nevus cells arise from pluripotent epithelial germ cells, which can later differentiate into various cell types.
Case report: A 57-year-old man presented with recent rapid enlargement of a long-standing scalp lump. Excision of the lump showed two distinct nodules, one of which had an irregular papillary surface. Microscopy of the irregular nodule revealed epidermal verrucous hyperplasia, hyperkeratosis and parakeratosis. Gradual transition of stratified squamous epithelium at the epidermal surface into a bi-layered ductal epithelium was seen. Collections of lymphocytes and plasma cells were present within the papillary fronds. The other nodule comprised lobules of basaloid cells with peripheral palisading, cystic denegation and focal cleft formation. Nuclei were hyperchromatic with scattered mitoses. Focal pigmented melanocytes were seen, without any atypia. The dermis showed an increased number of sebaceous glands with abnormal distribution and configuration. Some were located higher than normal in the dermis, directly opening into the epidermal surface, with no connection to a hair follicle.
Discussion and conclusion: This case was concluded as basal cell carcinoma (nodulocystic subtype) and syringocystadenoma papilliferum arising in a naevus sebaceous of Jadassohn. Rapid enlargement, nodule formation or ulceration favours neoplastic transformation of naevus sebaceous. Early surgical excision with margin clearance is the suggested management for the sebaceous naevi.
Keywords: nevus sebaceus of Jadassohn, syringocystadenoma papilliferum, basal cell carcinoma

CR 105

Carcinoma ex pleomorphic adenoma, infiltrating a Warthin tumour: synchronous tumours posing a diagnostic challenge

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Introduction: Pleomorphic adenoma (PA) is a benign neoplasm seen in major salivary glands with a potential for malignant transformation. Warthin tumour (WT) is a monomorphic adenoma thought to arise from salivary ductal inclusions in intra-parotid lymph nodes. Synchronous occurrence of carcinoma ex pleomorphic adenoma (CA ex-PA) and WT is exceptional and yields diagnostic challenges, particularly in cytology.
Case report: A 62-year-old man presented with rapid enlargement of his right parotid gland. Fine-needle aspiration cytology revealed atypical epithelial cells with mitoses and necrosis in a lymphoid background, suggestive of malignancy. He had a history of excision of a PA in the same gland, ten years prior. An ultrasound scan identified only one parotid lesion. Parotidectomy revealed an infiltrating solid tumour. Microscopy showed a well-demarcated lesion with biphasic epithelial and myoepithelial elements in a chondromyxoid stroma. The invasive component, arising from PA, resembled salivary duct carcinoma and showed marked nuclear atypia, cribriform structures, necrosis, and frequent mitoses. Lymphovascular and perineural invasion were present. There was also a second separate tumour, composed of bi-layered oncocytic cells in lymphoid stroma, compatible with WT. It was focally infiltrated by the carcinoma. Chronic sialadenitis was seen in the background tissue.
Discussion and conclusion: Incomplete excision of PA increases recurrence risk due to residual tumour pseudopodia, potentially leading to malignant transformation. CA ex-PA and Warthin tumour have distinct pathogenesis and genetic backgrounds. Their synchronous occurrence is exceedingly rare with only one well-documented case report. Presence of synchronous tumours complicates cytological diagnosis, especially when features overlap. Awareness of this rare possibility is crucial for accurate diagnosis and management.
Keyword: carcinoma ex pleomorphic adenoma, Warthin tumour, synchronous

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CR 106 (Case series)

A case series of bone and soft tissue tumours with unusual presentations, challenging the diagnosis

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Introduction: The case series presents bone and soft tissue tumours with unusual location, presentation or histopathology leading to diagnostic difficulties.
Case series: Case 1: A 41-year-old man presented with a painful well-circumscribed swelling in ankle of two years. The clinical diagnosis was a ganglion cyst. The lesion was completely excised with clear surgical margins. Histopathology showed a perivascular proliferation of monomorphic round cells with round to oval nuclei and eosinophilic cytoplasm. SMA and vimentin were positive. A diagnosis of cystic glomus tumour was made. Case 2: A 40-year-old man presented with polyneuropathy, with sensory and motor loss of three months duration and was found to have vasculitis, and soft tissue mass of 3.5cm at T2 level. The peripheral blood smear, bone marrow aspirate, trephine biopsy and serum electrophoresis showed no significant findings. Histopathology of the T2 mass showed sheets of plasma cells leading to a morphological diagnosis of solitary plasmacytoma of bone. Case 3**:** A 12-year-old girl presented with a mass measuring 4x3.5x2 cm, in the right thigh, which was completely excised with wide surgical margins. Histopathology showed sheets of spindle cells in a fibromyxoid stroma with osteoid. Immunohistochemistry showed positivity of SMA and CD10, and negativity of S100 and desmin. Although the negativity for S100 and desmin was unusual a diagnosis of ossifying fibromyxoid tumour was made based on the morphology.
Discussion and conclusion: The presentation of glomus tumour as a cystic lesion in ankle and solitary plasmacytoma with polyneuropathy are rare. Ossifying fibromyxoid tumour is an extremely rare distinctive mesenchymal neoplasm of uncertain differentiation with potential for recurrence, and an atypical immunophenotype can be challenging in the diagnosis.
Keywords: glomus tumour, plasmacytoma, ossifying fibro myxoid tumour, bone tumours

CR 107

Two cases of granulomatosis with polyangiitis: histological features in small biopsy samples

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Introduction: Granulomatosis with polyangiitis (GPA) is an antineutrophil cytoplasmic autoantibody (ANCA) - associated vasculitis characterized by necrotising granulomatous inflammation in the lungs. The histological findings in the literature are typically described in resection specimens. Diagnosis can be challenging in small biopsy samples. We describe the histological features in small biopsy samples from two patients with GPA.
Case report: Both patients presented with a history of GPA and cavitating mass lesions on radiology. Case 1: A 56-year-old woman presented with cough, breathlessness, fatigue, loss of weight and loss of appetite with collapse at the bridge of the nose. A lung biopsy was performed with the clinical differentials of infection, vasculitis and cancer. The biopsy showed prominent neutrophilic abscesses and an area of basophilic necrotic debris with peripheral palisading suggestive of a poorly formed granuloma. Case 2: An endobronchial ultrasound (EBUS) sample was received from a 52-year-old man who presented with weight loss, constitutional symptoms, hearing loss, nasal involvement and previous ANCA-positive serology. The clinical differentials at the time of lung biopsy were infection, inflammatory lesion and cancer. The clot from the EBUS sample mainly showed micro-abscesses. Focal peripheral palisading histiocytes and fibrinoid necrosis were seen. EVG (Elastin van Gieson) stain revealed disruption of internal elastic lamina suggestive of vasculitis. Stains for acid-fast bacilli and fungi were negative in both cases which ruled out infective causes. In the multidisciplinary meeting, a diagnosis of GPA was confirmed in both cases by correlating clinical, radiological, serological and histological findings.
Discussion and conclusion: Diagnosis of GPA in a small biopsy is challenging as the characteristic features, such as the geographic pattern of necrosis and vasculitis are not as evident as in a resection specimen. In both cases, the presence of granuloma was not a prominent feature. The diagnosis was based on a strong clinical correlation. The clue for histological diagnoses was the presence of neutrophilic microabscesses, basophilic necrosis and disruption of internal elastic lamina in EVG stain. In a small biopsy with features of neutrophilic microabscesses, GPA should be considered as a differential diagnosis if the clinical history is suggestive and there should be a low threshold for performing EVG stain.
Keywords: granulomatosis with polyangiitis, ANCA vasculitis, endobronchial ultrasound biopsy

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CR 108

Female adnexal tumour of probable Wolffian origin: an extremely rare tumour

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Introduction: Female adnexal tumor of probable Wolffian origin (FATWO) is a rare epithelial neoplasm of low malignant potential. FATWO primarily originates within the broad ligament and less frequently within mesosalpinx, fallopian tube (FT), ovary, paravaginal region and retroperitoneum. Less than 100 cases have been reported in the literature.
Case report: A 38-year-old woman presented with abdominal pain. Serology for tumour markers was normal.. Magnetic resonance imaging (MRI) revealed a 110mm pelvic mass with an attachment to the broad ligament. Intraoperatively the mass was confined to the broad ligament with no attachment to the ovary, FT or uterus. Macroscopically the mass showed a solid and cystic appearance. On histology, the solid areas comprised nests and sheets of cells with fairly uniform oval nuclei with fine chromatin and occasional nuclear grooves. Sieve-like, well-defined cysts with no true cellular luminal border were present. The mitotic rate was 1/10 high power field and the proliferative index was 10%-15%. This morphology raised possibilities of both FATWO and granulosa cell tumour (GCT). On immunohistochemistry, AE 1/3, CAM5.2, caldesmon, inhibin, AR, ER, PR, vimentin, WT1 and CD56 were positive. CK7, CD10, desmin, myogenin, melan-A, S100, HMB45, CD117 and D2-40 were negative.
Discussion and conclusion: Differentiation of FATWO from endometrioid carcinoma, Sertoli-Leydig cell tumour and GCT is challenging due to its variability in immunohistochemical and molecular findings. FATWO is typically negative for EMA, PAX8 and shows focal staining for inhibin, CK7, AE1/AE3 and CD10. Large tumour size, capsular invasion with rupture, increased mitotic activity, hypercellularity and nuclear atypia indicate a possible aggressive clinical course and risk of recurrence and metastasis. Due to its malignant potential, regular long-term follow-up is recommended.
Keywords: female adnexal tumor of probable Wolffian origin, broad ligament

CR 109

A rare case of pancreatic carcinosarcoma with an osteosarcomatous component

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Introduction: Carcinosarcoma of the pancreas is an extremely rare malignancy. Twenty-nine cases have been reported in the literature and only two showed an osteosarcomatous component. This report presents a case of carcinosarcoma composed of pancreatic ductal adenocarcinoma and osteosarcoma.
Case report: A 48-year-old woman with stage IA squamous cell carcinoma of the cervix was found to have a 37 mm lesion in the pancreatic head on magnetic resonance imaging. She subsequently underwent a Whipple's procedure. Gross examination revealed a pancreatic head mass invading the duodenum. Histopathology demonstrated an admixture of moderately to poorly differentiated pancreatic ductal adenocarcinoma and osteosarcomatous components. The osteosarcomatous component contained osteoclast-type multinucleated giant cells showing malignant osteoid production**.** The adenocarcinoma component showed lymphovascular and perineural invasion. All 16 regional lymph nodes were free of tumour.
Discussion and conclusion : According to the World Health Organization classification, carcinosarcoma of the pancreas is classified together with anaplastic undifferentiated carcinoma and sarcomatoid undifferentiated carcinoma. Carcinosarcoma comprises two pathologically distinct components. The carcinoma component can be well-to-poorly differentiated, ductal-like adenocarcinoma, squamous cell carcinoma or basal cell carcinoma. The mesenchymal component can be a spindle-cell sarcoma or undifferentiated sarcoma and could contain heterologous elements of osteosarcoma, rhabdomyosarcoma or chondrosarcoma. Differential diagnosis for this case would include metastatic osteosarcomas and undifferentiated carcinoma with osteoclast-like giant cells (UCOGC). However, UCOGC lacks malignant osteoid production. Carcinosarcoma of the pancreas is a rare disease with high mortality for which there is no established systemic therapy.
Keywords: carcinosarcoma, pancreas, heterologous elements, osteosarcoma

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CR 110

Chondroid lipoma: a mimic of malignancy

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Introduction: Chondroid lipoma (CL) is an extremely rare benign adipocytic tumour which is easily mistaken for myxoid liposarcoma (ML), extraskeletal myxoid chondrosarcoma (EMC) or chordoma.
Case report: A 52-year-old woman, evaluated for a breast mass, was incidentally found to have a left paraspinal mass of 18 mm at the level of T8/T9 on MRI spine. An excision biopsy of the lesion showed a lobular, well-circumscribed, encapsulated, lesion within the skeletal muscle tissue composed of nests and cords of small univacuolated and multivacuolated lipoblasts embedded in a myxoid-chondroid matrix. There was no nuclear pleomorphism, mitotic activity or necrosis. Admixed mature adipose tissue was present. On immunohistochemistry, S100 stain showed strong positivity in the mature adipocytes and weak positivity in the lipoblasts. AE1/AE3 and CAM5.2 were negative. MIB-1 was very low. RNA-based next generation sequencing (NGS) panel detected a fusion of *C11orf95:MKL2* (MRTFB), confirming the diagnosis of CL.
Discussion: CL is a deep-seated tumour of skeletal muscle, fibrous connective tissue and subcutaneous fat seen commonly in the proximal extremities and less commonly in the distal extremities, trunk, and head and neck. The multivacuolated cells can resemble lipoblasts, chondroblasts, or physaliphorous cells, raising the possibility of ML, EMC and chordoma, respectively. However, ML lacks a chondroid matrix and CL lacks the delicate branching vasculature of ML. EMC lacks mature adipose tissue and lipoblasts. Chordoma does not contain mature fat and is positive for EMA and keratin.
Conclusion: A high level of suspicion and familiarity with the histomorphological features are of practical importance to avoid misdiagnosis and overtreatment of CL, as the tumour does not recur or metastasize, and complete excision is curative.
Keywords: chondroid lipoma, histopathology

CR 111

Tracheobronchopathia osteoplastica; a rare benign disease

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Introduction: Tracheobronchopathia osteoplastica (TO) is a rare benign disease, of unknown cause. It is characterized by bony submucosal nodules distributed throughout the anterolateral walls, projecting into the laryngotracheobronchial lumen. It is usually diagnosed incidentally during bronchoscopy or autopsy
Case report: A 73-year-old man presented with a chronic cough of three-months duration. Chest CT showed intra luminal nodular protrusions of 2-3mm size, in the trachea and main bronchus. Bronchoscopy revealed hard nodular lesions in the trachea, left main bronchus and right upper lobe. The specimen was received as multiple tiny nodules with a maximum size of 2-3mm each. Microscopy showed polypoidal fragments of bronchial mucosa, covered by histologically unremarkable respiratory epithelium. The sub-epithelium showed nodular metaplastic bone with focal fatty marrow spaces within some of them. Cartilage, granulomata, amyloid like material or evidence of dysplasia or malignancy were not seen.
Discussion and conclusion: The differential diagnosis of TO include papillomas, sarcoidosis, amyloidosis, tuberculosis and granulomatosis with polyangiitis which were excluded on morphology. Reported cases in the literature are referred to as tracheobronchopathia osteochondroplastica. In the absence of chondroid areas, this case was diagnosed as TO. To date, there is no definitive therapy to eradicate TO. Treatments are non-specific; antibiotics are used to treat respiratory tract infections and inhaled corticosteroids are used for chronic cough. The prognosis is favourable. Many cases in the literature have reported little progression over the years.
Keywords: nodules, tracheobronchopathia osteoplastica, cough

CR 112

Atypical teratoid/ rhabdoid tumour: a rare embryonal tumour.

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Introduction: Atypical teratoid/ rhabdoid tumour (AT/RT) is a rare, high grade central nervous system (CNS) embryonal tumour accounting for 1.6% of all paediatric CNS tumours. Mostly AT/RTs occur in children below two years.
Case report: A one year and six months old child presented with vomiting and unsteadiness. Magnetic resonance imaging of the brain revealed a space occupying lesion in the left posterior fossa. The intra-operative crush smear revealed singly scattered and sheets of embryonal cells, many rhabdoid cells and numerous mitotic figures. Histology showed a cellular tumour predominantly composed of rhabdoid cells with focal areas of primitive neuroectodermal differentiation and mesenchymal elements. The rhabdoid cells exhibited round, eccentric nuclei with vesicular chromatin, prominent nucleoli and abundant homogeneously eosinophilic cytoplasm with distinct cell membranes. The mesenchymal elements included spindle cells dispersed in a myxoid matrix with areas of immature cartilaginous differentiation. Areas of necrosis and haemorrhage were seen. The rhabdoid cells showed strong and diffuse cytoplasmic positivity for vimentin and SMA and were negative for synaptophysin.
Discussion: Germ cell tumours are important differential diagnosis of AT/RT. Germ cell markers and skeletal differentiation are not typically expressed in AT/RTs. In this case, as clinical and morphological diagnoses was more compatible with AT/RT, above markers of differentiation were not performed.
Conclusion: The immunomorphological features were compatible with an AT/RT (CNS WHO grade 4). Loss of SMARCB1 expression is the genetic hallmark of AT/RT. Therefore, genetic testing for confirmation is necessary in the ideal setting. Overall, patients with AT/RT have a poor prognosis.
Keywords: atypical teratoid/ rhabdoid tumour (AT/RT), central nervous system (CNS)

CR 113

Massive ovarian oedema mimicking a malignancy in a 17-year-old girl

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Introduction: Massive ovarian oedema is a rare condition affecting young women in their reproductive age. It clinically mimics malignancy and is characterized by enlargement of the ovary due to stromal accumulation of oedema fluid.
Case report: A 17-year-old girl who had irregular menstrual cycles and heavy menstrual bleeding since menarche presented with abdominal pain. On radiological evaluation she was found to have a solid right ovarian tumour. Serological evaluation, including alpha-fetoprotein, lactate dehydrogenase, and CA-125, were within normal limits. The resected ovary measured 85 × 75 × 35 mm. It had an intact capsule with a smooth, glistening white outer surface. The cut surface showed white gelatinous material with punched out cystic spaces. Microscopy showed ovarian tissue with diffuse and massive oedematous stroma. Ovarian follicles were seen entrapped within the stroma. The superficial cortex was fibrotic and seen at the periphery. The stroma stained negatively for mucin with Alcian blue. There is no evidence of associated fibromatosis or malignancy. The morphology was consistent with massive ovarian oedema.
Discussion and conclusion: The pathogenesis of massive oedema is thought to be intermittent torsion of the ovary on its pedicle, causing obstruction of venous and lymphatic drainage. This is a rare condition that mimics an ovarian malignancy in the clinical setting. Although most of the reported cases are successfully treated with oophorectomy, the condition should ideally be managed conservatively as it has a benign course. Pathologists should be aware of this rare condition in order to diagnose it in intra-operative frozen sections, thereby avoiding unnecessary surgery.
Keywords: massive ovarian oedema

CR 114

Toxoplasma lymphadenitis demonstrating a bradycyst on fine needle aspiration cytology: a rare finding

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Introduction: Toxoplasmosis is caused by *Toxoplasma gondii,* a protozoan. Lymph nodes are the most commonly affected site. It is diagnosed on tissue biopsy, fine needle aspiration cytology (FNAC) and serology.
Case report: A 63-year-old man presented with a 1cm submental lymph node of one month duration. FNAC smears from the lymph nodes revealed small collections of epithelioid histiocytes forming many microgranulomas. A single large round bradycyst containing numerous crescentic bradyzoites was seen. The background showed a polymorphous population of lymphocytes, numerous tingible body macrophages and crushed germinal centres containing large cells with mitotic figures. There was no evidence of caseous necrosis, suppuration, atypical lymphocytes or malignant epithelial cells. The cytomorphological features were consistent with toxoplasma lymphadenitis.
Discussion: The presence of microgranulomas in a background of reactive lymphoid hyperplasia points towards a diagnosis of toxoplasmosis. Bradycysts are a very rare finding on cytology smears. In the present case, we detected a bradycyst with intracytoplasmic organisms which confirmed the diagnosis.
Conclusion: Careful attention to cytological features in FNAC material is valuable in diagnosing toxoplasma lymphadenitis. Clinical correlation and serological tests for detecting toxoplasma-specific antibodies is useful in confirmation of the diagnosis.
Keywords: toxoplasma lymphadenitis, fine needle aspiration cytology, bradycyst

CR 115

Extramedullary myeloma with anaplastic morphology occurring in the peritoneum

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Introduction: Extramedullary haematogenous spread of myeloma can involve any systemic organ and is seen in about 10% of cases. Known metastatic sites include liver, lungs, lymph nodes, peritoneum and very rarely the central nervous system.
Case report: A 65-year-old man while being evaluated for pyrexia of unknown origin, was found to have thickening of the proximal small bowel and multiple pelvic peritoneal lesions on CT scan. Serum protein electrophoresis was normal. Urine Bence Jones protein was not detected, however urine protein electrophoresis showed an abnormal monoclonal band. Peritoneal biopsy showed a poorly differentiated malignancy with large highly pleomorphic, anaplastic cells showing multiple lobulated, embryo-like and horseshoe-like nuclei. Some cells showed rhabdoid morphology. Background showed a few plasmacytoid cells, lymphocytes and eosinophils. The initial morphological diagnosis was an anaplastic lymphoma, but LCA, CD3, CD20 and CD30 were negative. The second-line panel including PanCK, MPO, CD235a, desmin and S100 also showed negative staining while CD138 and CD 56 showed diffuse membrane staining in the neoplastic cells. Bone marrow showed moderate cellularity with 30% plasma cells of typical morphology. The case was concluded as a metastatic deposit of a myeloma.
Discussion: Extramedullary metastatic myeloma may consist of immature cells or plasmablasts as opposed to mature plasmacytic cells seen in marrow. These immature cells display marked nuclear variations with anaplastic morphology, making the diagnosis challenging when occurring at unusual sites.
Conclusion: Extramedullary metastatic myeloma should be considered in the differential diagnosis of poorly differentiated malignancies, when initial immunohistochemistry (IHC) panels are inconclusive. Clinical correlation with biochemical investigations and the use of appropriate IHC panels are important.
Keywords: extramedullary metastatic myeloma, peritoneum

CR 116

Solitary reticulohistiocytoma: an extremely rare histiocytic lesion of the skin

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Introduction: Solitary reticulohistiocytoma is a localized form of reticulohistiocytosis without systemic involvement. It is a non-Langerhans histiocytic lesion mainly affecting young adults. It clinically presents as a reddish brown single nodular skin lesion. Aetiology is unknown. It is a benign lesion and excision is curative.
Case report: A 20-year-old man presented with a solitary reddish brown nodular cutaneous lesion over the right forearm of eight months duration. Macroscopy of the excision specimen revealed a pale tan nodular lesion in the dermis measuring 9x7x2mm. Microscopic examination showed a nodular lesion in the dermis comprising mononuclear epithelioid histiocytes and multinucleated giant cells, admixed with lymphocytes. The mononuclear cells and giant cells had abundant eosinophilic ground glass cytoplasm. Focal collections of xanthomatous cells were present. A few giant cells showed engulfed neutrophils. Cells with atypical, grooved nuclei or eosinophils were not seen. The lesional cells were positive for CD 68 and vimentin and negative for S100. Based on the histomorphological and immunohistochemical features, a diagnosis of solitary reticulohistiocytoma was made.
Discussion and conclusion: Differential diagnoses of solitary reticulohistiocytoma include juvenile xanthogranuloma, and Langerhans cell histiocytosis. Langerhans cell histiocytosis shows cells with atypical nuclei with scattered mitoses that react strongly to S-100, CD1a and langerin in contrast to the cells of reticulohistiocytoma. Absence of Touton giant cells, the cytologic appearance of the mononuclear and multinucleated non-Langerhans histiocytes, and the abundant eosinophilic ground glass cytoplasm, along with the predominant lymphocytic infiltrate differentiates solitary reticulohistiocytoma from juvenile xanthogranuloma. Lesional cells usually show positivity for CD68, CD163 and vimentin. This case highlights that, while extremely rare, solitary reticulohistiocytoma should remain a differential diagnosis for cutaneous lesions with a histiocytic infiltrate.
Keywords: solitary reticulohistiocytoma, cutaneous histiocytic lesions

CR 117

A case of melioidosis: a disease with a limited histopathological understanding

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Introduction: Melioidosis is an infectious disease caused by a soil saprophytic bacterium, *Burkholderia pseudomallei*. Sri Lanka is considered non-endemic for melioidosis, but the disease incidence has shown an increasing trend over recent years. Melioidosis can be categorised as a localised infection, acute pulmonary infection or acute bloodstream infection leading to abscess formation in the visceral organs including the liver.
Case report: A 29-year-old man presented with an acute febrile illness of five days duration. All initial haematological investigations and inflammatory markers were suggestive of an acute bacterial infection. Despite antibiotic treatment his fever spikes persisted for two weeks duration. Subsequently he developed right hypochondrial pain. Abdominal imaging revealed a well-defined heterogenous lesion measuring 71x65x56 mm in the left lobe of the liver. Microscopy of the liver biopsy showed granulomatous inflammation with focal suppuration. There was no evidence of fungal hyphae, confluent granulomas, Langhan giant cells or caseous necrosis. Upon inquiry of further clinical details, it was revealed that *Burkholderia pseudomallei* was isolated from the liver aspirate and serum melioidosis antibodies were positive. The observation of suppurative granulomatous inflammation in the liver biopsy further supports this diagnosis, as melioidosis is known to cause this type of inflammatory response.
Discussion and conclusion: Common differential diagnoses for suppurative granulomatous inflammation in the liver include infections caused by fungi, atypical mycobacterial, *Bartonella henselae* and *Entamoeba histolytica.* Detailed and comprehensive descriptions of the histopathology of human melioidosis remain limited. Histopathological features described in literature include abscess formation, suppurative granulomatous inflammation, multinucleated giant cells, haemorrhage, and fibrin thrombi. Melioidosis should be diagnosed in the correct clinical setting together with serological evidence or isolation of the organism. Although tissue samples for histological evaluation in melioidosis are encountered infrequently, it is crucial to maintain awareness of its characteristic histopathological features in order to avoid underdiagnosis of the condition.
Keywords: melioidosis, suppurative granulomatous inflammation

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CR 118

The critical role of clinicopathological correlation in diagnosing Riedel thyroiditis

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Introduction: Riedel thyroiditis is a rare disorder characterized by a dense fibroinflammatory process involving the thyroid gland and adjacent structures. Extensive fibrosis leads to a "stony-hard" consistency of the thyroid and distressing symptoms such as dyspnoea, dysphagia, and hoarseness. It is the prototypical manifestation of IgG4 related disease in the thyroid gland.
Case report: A 25-year-old woman with a diagnosis of Hashimoto thyroiditis, following left thyroid lobectomy a few months ago, underwent right thyroid lobectomy due to diffuse enlargement of the gland. The right thyroid lobe measured 30x10x5 mm, had a homogeneously white cut surface and was rubbery in consistency. Microscopy showed atrophic thyroid tissue with dense and diffuse fibrosclerosis. The fibrosis extended to the adjacent structures, entrapping lymph nodes, vessels and the parathyroid gland. Obliterative phlebitis was present. The microscopic features raised the possibility of Riedel thyroiditis and since the fibrous variant of Hashimoto thyroiditis can share similar features, further clinicopathological correlation was sought to aid in accurate diagnosis. The patient reported experiencing progressive dyspnoea and dysphagia over the past few months prior to the surgery and intraoperative findings revealed that it was a challenging surgery as the gland was firmly adhered to the adjacent structures including the trachea and the oesophagus, which supported a diagnosis of Riedel thyroiditis.
Discussion and conclusion: Differentiating between Riedel thyroiditis and fibrosing variant of Hashimoto thyroiditis is challenging as there can be overlapping features. However, there are key differences in their aetiology, clinical presentation and histological features. In this case, the histological findings of dense fibrosis which extended beyond the thyroid capsule and obliterative phlebitis along with the history of progressive dyspnoea and dysphagia favoured the diagnosis of Riedel thyroiditis over Hashimoto thyroiditis. This case emphasizes the importance of careful clinicopathological correlation in the accurate diagnosis of the disease to help the clinician in the effective management which includes surveillance for other organ involvement by IgG4 related disorders.
Keywords: Riedel thyroiditis, IgG4 related diseases, Hashimoto thyroiditis

CR 119

A rare case of mucinous adenocarcinoma of the endometrium with intestinal type differentiation

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Introduction: Mucinous adenocarcinoma is a variant of endometrioid endometrial adenocarcinoma discovered rarely (1-9% of cases). Diagnosis requires more than 50% mucinous differentiation. Mucinous differentiation is typically of endocervical type and rarely intestinal type. Interestingly they are considered low-grade with a good prognosis.
Case report: A 79-year-old woman (para 2) presented with a two-month history of intermittent postmenopausal bleeding. Examination revealed a palpable pelvic mass. Ultrasound scan and contrast enhances computed tomography (CECT) identified a 9.8x9.1 cm solid and cystic uterine mass. CEA and CA-125 were not done. Total abdominal hysterectomy and bilateral salpingo-oophorectomy was performed. Grossly, a 6.5x6x4.5 cm gelatinous polypoidal tumour filling the endometrial cavity with more than 50% myometrial invasion was identified. The cervix, ovaries, and tubes were unremarkable. Microscopy revealed an adenocarcinoma with extensive mucinous differentiation. Small tumour cell clusters were suspended in pools of abundant extracellular mucin (confirmed with Alcian blue stain). The residual endometrium was atrophic with no features of hyperplasia or atypia. The tumour was limited to the uterine corpus. Endocervix and bilateral adnexa were unremarkable. On immunohistochemistry CK7, CDX2 and ER were positive. CK20 was negative. Ascitic fluid was negative for malignant cells.
Discussion: The tumour was limited to the uterine corpus. ER and CK7 positivity supported an endometrial origin. Positivity for CDX2 supported an intestinal-type mucinous adenocarcinoma. There were no gastrointestinal symptoms, prior history of cancer or radiological evidence of other malignancy, supporting a primary uterine origin.
Conclusion Clinical, radiological, and histological features supported a diagnosis of primary mucinous adenocarcinoma of the endometrium with intestinal-type differentiation. As the tumour is known to be low grade and is confined to the uterus, the prognosis is favourable. Awareness of such rare variants is crucial for accurate diagnosis, management and predicting prognosis.
Keywords: mucinous adenocarcinoma, endometrioid endometrial adenocarcinoma

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CR 120

IgG-4 related disease presenting as a pancreatic mass with liver involvement

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Introduction: Immunoglobulin G4 (IgG4) related disease is a relatively rare systemic fibroinflammatory condition that can involve multiple organs including the pancreas and liver. The pathogenesis involves an inflammatory and a fibrogenic process resulting in organ damage. Three characteristic histological findings include a dense lymphoplasmacytic infiltrate rich in IgG4-positive plasma cells, obliterative phlebitis and fibrosis with a storiform pattern, which aids in distinguishing IgG4 related diseases from other conditions that lead to fibrosis .
Case report: Contrast enhanced computed topography (CECT) of a 56-year-old man with abdominal pain for three months showed a solid and cystic neoplasm involving the head of the pancreas, suggestive of a intrapancreatic cystic neoplasm. Whipple's procedure and a liver biopsy were performed. Ill-defined, fibrotic areas involving the entire pancreatic parenchyma were seen macroscopically. Histology of the pancreas showed preserved lobular architecture of the parenchyma with a florid lymphoplasmacytic infiltrate. Extensive acinar atrophy and islet cell hyperplasia were present. Concentric periductal fibrosis of the stroma with a focal storiform pattern was seen. Immunohistochemistry revealed an IgG4-positive, plasma cell count of 250 per high power field(hpf) in the pancreas. Similarly, the liver biopsy showed a dense lymphoplasmacytic infiltrate associated with portal fibrosis and duct dilation with an IgG4 positive plasma cell count of 150 per hpf.
Discussion and conclusion: Correlation of clinical, serological, imaging and histopathological findings is required for a conclusive diagnosis. Organ-specific criteria for the diagnosis include an IgG4 positive plasma cell count greater than 50 per high power field in both pancreas and liver. As non-specific features may mimic pancreatic cancer and other medical conditions, early recognition and management is vital for complete recovery. Glucocorticoids are the preferred first-line of treatment
Keywords: IgG-4 related disease, pancreatitis, hepatitis

CR 121

Pancreatic gastrointestinal stromal tumour; a rare occurrence

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Introduction: Gastrointestinal stromal tumour (GIST) is the most common mesenchymal tumour of the gastrointestinal tract (GIT), with stomach being the commonest site. GIST occurring outside the GIT are termed as extra-gastrointestinal stromal tumour (EGIST). Most are sporadic with 5-10% of the cases occuring in association with a variety of syndromes.
Case report: A 49-year-old man presented with an abdominal mass. The contrast-enhanced computed tomography (CECT) revealed a large, cystic neoplasm within the head of the pancreas infiltrating into the right colonic mesentery. The clinical differentials were a solid pseudopapillary neoplasm or a mucinous cystic neoplasm. Subsequently a pancreatico-duodenectomy with right hemicolectomy was performed. Grossly, the tumour was extensively necrotic with a rim of solid, tan, viable tumour at the periphery. Microscopically, a highly cellular tumour, composed of nests and cords of spindled and epithelioid cells with moderately pleomorphic, vesicular nuclei and vacuolated cytoplasm was seen. Mitoses amounted to 2/5mm^2. Extensive necrosis was present. Lymphovascular invasion or lymph node deposits were not identified. Cells showed diffuse membranous positivity for CD 117 and negativity for PanCK, synaptophysin, chromogranin, CD 34 and S100. Ki67 proliferation index was 2%.
Discussion and conclusion: GISTs arise from the interstitial cells of Cajal within the myenteric plexus. EGISTs are rare, and pancreatic GISTs are even rarer, mostly arising in head of the pancreas. The majority are large, exceeding 5 cm. Diagnosis is based on histopathological, immunohistochemical, and molecular features. Common differentials include leiomyoma, schwannoma and solitary fibrous tumour. Complete surgical resection with clear margins is the primary choice of treatment.
Keywords: gastrointestinal stromal tumour, pancreatic gastrointestinal stromal tumour

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CR 122

Appendiceal schwannoma; an extremely rare entity

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Introduction: Schwannomas are benign, slow growing neurogenic tumours that arise from the Schwann cells. While they commonly occur in the head and neck, gastrointestinal schwannomas are uncommon and the appendix is a particularly rare location, with only a few cases reported in the literature.
Case report: A 72-year-old woman presented with intermittent right iliac fossa (RIF) pain for two months and fever for the past three days. Computed tomography (CT) revealed a well-defined mass in the RIF, with absent internal vascularity and mild perilesional inflammation. An appendectomy was performed. Gross examination showed a tan-yellow, solid tumour located in the body of the appendix, measuring 24 × 18 × 16 mm and situated 15 mm from the resection margin. Microscopically, the lesion was a well-circumscribed spindle cell tumour confined to the muscularis propria. The tumour was composed predominantly of hypercellular areas, with focal fibromyxoid hypocellular regions. The cells were spindly, exhibiting elongated vesicular nuclei, some with tapering ends. Occasional nuclear palisading and Verocay bodies were identified. No mitotic activity or necrosis was observed. Immunohistochemically, the tumour cells showed strong and diffuse positivity for S-100.
Discussion and conclusion: These tumours may be detected incidentally in asymptomatic patients or can clinically mimic acute appendicitis. Typically, radiology shows a well-demarcated, and homogeneously enhancing mass. The differential diagnosis includes leiomyoma, gastrointestinal stromal tumour, and neuroendocrine tumour. The diagnosis is based on characteristic histological features, confirmed by diffuse expression of immunohistochemical staining, of S100. Complete surgical resection with clear margins remains the primary mode of treatment. Malignant transformation and recurrence are rare.
Keywords: appendiceal schwannoma, gastrointestinal schwannoma, appendicitis, schwannoma

CR 123

Squamous metaplasia of lactiferous ducts of breast: a mimic of duct ectasia

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Introduction: Squamous metaplasia of lactiferous ducts (SMOLD) is an uncommon, benign inflammatory breast lesion which may mimic a breast abscess, duct ectasia or a cystic neoplasm clinically and radiologically.
Case report: A 40-year woman presented with a gradually enlarging breast lump and pain for four years. Radiology showed, a retro-areolar solid mass that was suspicious of malignancy. The lesion was excised and a cystic area, filled with thick, whitish material was seen on macroscopy. Histology showed a cystic cavity containing eosinophilic, keratin-like material showing positivity on the Papanicolaou stain. The cyst was lined by a dual layered epithelium exhibiting focal squamous metaplasia. Foreign body type multinucleated giant cells, histiocytes and a mixed inflammatory infiltrate were seen in the perilesional tissue, suggestive of cyst wall rupture. Cytoplasmic vacuolation of duct epithelial cells were present in the surrounding breast tissue, suggestive of lactational changes with periductal and perilobular inflammation. The patient provided a history of prolonged breast feeding of her four-year-old child.
Discussion and conclusion: SMOLD usually presents as a painful swelling near the nipple. Radiology shows a retro-areolar, ill-defined, hypoechoic lesion. SMOLD can occur secondary to lactation mastitis, as was seen in this patient. Ductal injury leads to replacement of the usual dual lining of a dilated duct by squamous epithelium and accumulation of compacted anucleate squames, obstructing the duct. Differential diagnoses include mammary duct ectasia, retro-areolar abscess and epidermal inclusion cysts. Complications include axillary lymphadenopathy, infection, abscess and fistula formation.
Keywords: breast abscess, SMOLD, squamous metaplasia of lactiferous ducts

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CR 124

Thoracic SMARCA4-deficient undifferentiated tumour

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Introduction: Thoracic SMARCA4-deficient undifferentiated tumour is an aggressive malignant neoplasm associated with smoking that occurs in the thorax of adults that presents with frequent metastases to lymph nodes, bones, adrenal glands, brain and abdominal cavity.
Case report: A 52-year-old man, who was an ex-smoker presented with dyspnoea, loss of weight and haemoptysis. There was an ill-defined, compressing mass in contrast enhanced CT. Endo-bronchial ultrasound guided aspirate revealed cells with highly pleomorphic nuclei and small amounts of cytoplasm. Clot preparation revealed diffuse sheets of variably discohesive, round to ovoid epithelioid cells with vesicular chromatin, prominent nucleoli and scattered rhabdoid cells. Mitoses and necrosis were seen. Initial differential diagnoses were a poorly differentiated carcinoma, melanoma, NUT carcinoma or a high-grade lymphoma. The tumour cells showed positive staining with synaptophysin. CD56 showed focal immunoreactivity. AE1/AE3, CAM5.2, CK7, P40, TTF1, S100, LCA and chromogranin were negative. Negative cytokeratin stain excluded a poorly differentiated carcinoma. S100 negativity excluded a melanoma. Negative P40 and LCA stains excluded NUT carcinoma and high-grade lymphoma respectively. Cellular features and background necrosis raised the possibility of a high-grade tumour other than a neuroendocrine carcinoma. A diagnosis of thoracic SMARCA4 deficient undifferentiated tumour was made based on complete loss of SMARCA4 in tumour cells with the presence of a positive internal control.
Discussion and conclusion: Thoracic involvement, radiological findings, cellular features (sheets of discohesive, epithelioid cells, prominent nucleoli) and loss of SMARCA4 on immunohistochemistry confirmed the diagnosis. A small number of NSCLCs can show SMARCA4 deficiency and cellular cohesion, gland formation, diffuse strong keratin expression will support this differential. Metastasis of similar SMARCA4-UT arising from uterus, ovary, stomach, kidney and pancreas were excluded in the MDT meeting. Prognosis is poor as this tumour shows aggressive behaviour.
Keywords: SMARCA4-deficient, undifferentiated, aggressive behaviour

CR 125

Tubulocystic renal cell carcinoma with poorly differentiated component

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Introduction: Tubulocystic carcinoma is a rare, indolent tumour with good prognosis. Associated poorly differentiated components are exceedingly rare and are associated with an aggressive clinical course with perinephric and sinus fat invasion, nodal involvement and distance metastasis.
Case report: A 49-year-old man presented with back pain, lower abdominal pain and painless gross haematuria. Cystoscopy examination was unremarkable. Ultrasound scan and contrast enhanced CT revealed a tumour confined to the left kidney with a cystic part in the upper pole and a solid high-grade component in the middle. The left radical nephrectomy specimen showed a typical spongy/bubble wrap-like appearance in the cystic area with a solid area arising from the lower edge. Microscopy showed well-formed tubules of various sizes. Some cystically dilated larger tubules were separated by thin fibrous septae. The cystic spaces were lined by cuboidal to columnar cells with abundant eosinophilic cytoplasm, hobnailing of nuclei, round enlarged and vesicular nuclei with prominent nucleoli. Papillary structures were identified. The solid areas revealed a high-grade carcinoma with sinus fat invasion. Based on the macroscopic and histological features, a diagnosis of tubulocystic renal cell carcinoma (TCRCC) with a poorly differentiated component was made (TC-PD). Immunohistochemistry showed vimentin-positivity and CD10 and CK7-negativity.
Discussion and conclusion: These tumours show cytomorphological features associated with fumarate-hydratase (FH) deficiency such as a tubulopapillary and papillary pattern with ISUP grade 3 nuclei. The differential diagnosis included medullary carcinoma and collecting duct carcinoma. There are a few reported cases of TCRCC with a poorly differentiated component having an infiltrative adenocarcinoma reminiscent of collecting duct carcinoma.
Keywords: tubulo-cystic renal cell carcinoma. high grade component

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CR 126

A rare case of gastric endometriosis presenting as a pre pyloric ulcer

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Introduction: Gastric endometriosis is a rare condition that occurs when endometrial glands and stroma are present in the stomach. Although rare it causes significant morbidity and is associated with malignant transformation.
Case report: A 56-year-old post-menopausal woman presented with severe epigastric pain, nausea, and regurgitation of one year duration. Upper gastrointestinal endoscopy showed a large pre-pyloric ulcer. Gastric biopsy showed an ulcer with an exudate at the base and endometrial glands surrounded by stroma in the floor of the ulcer. On immunohistochemistry the glands were positive for ER and the stroma was positive for CD10. Benign nonspecialised gastric mucosa was seen in the background. A diagnosis of gastric endometriosis was made.
Discussion and conclusion: Gastric endometriosis can present as an ulcer and can cause reflux symptoms. It can be complicated by malignant transformation if left untreated. Endoscopic evaluation and histological assessment supplemented with immunohistochemistry are helpful to reach diagnosis, as in this case. Accurate diagnosis aids in the management and prevention of complications. Gastric endometriosis is a rare condition and can mimic common conditions such as peptic ulcer disease. This case highlights the importance of considering endometriosis in the differential diagnosis of gastric reflux disease.
Keywords: gastric endometriosis, prepyloric ulcer

CR 128 (Case series)

Myositis ossificans in fracture site soft tissue following primary native treatment for bone fractures

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Introduction: In South Asian countries native medical practices such as Ayurveda and indigenous fracture-reduction techniques, tight splinting, bandaging and application of herbal poultices or oil are frequently utilized in the management of fractures. It has been observed that some of those patients who have undergone primary native treatment present with overgrown callus of bones, hardening of soft tissues at the fracture site and restricted movements at the nearest joints. The reason for this is not explained clearly in literature.
Methodology: We analyzed 11 biopsies received to Department of Pathology, Faculty of Medicine, Peradeniya over two years since 2023 from adult patients who had undergone native treatment for fractures and later presented for corrective surgeries due to above symptoms. Presence of excessive callous of the bones was a macroscopic observation in all patients. Two pathologists analyzed the slides independently, comparing observed changes with standard pathological features of fracture healing. Eight of the 11 patients (72.7%) showed Myositis Ossificans (MO). Among these 62.5% of patients had received native treatment for less than three weeks and rest (37.5%) for more than three weeks. All the biopsies showed varying degrees of granulation tissue formation and fibrosis of soft tissues corresponding to healing process.
Discussion and conclusion: MO is a complication following fracture healing where heterotrophic ossification occurs within muscle or soft tissue, in an inappropriate healing mechanism. With our observations, hardening of soft tissues following native treatment is most likely due to MO. A case control study with primary western medical treatment needs to be carried out for further evaluation.
Keywords: myositis ossificans, native treatment, fracture

CR 129

Intrahepatic mucinous cystic neoplasms in women: two cases with distinct clinical presentations

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Introduction: Mucinous cystic neoplasms (MCNs) of the liver are rare cyst-forming epithelial tumours, seen predominantly in women, characterised histologically by mucinous epithelium and ovarian-like stroma. We report two cases of hepatic MCNs.
Case report: Case 1: A 40-year-old woman presented with pruritus and dark - coloured urine, with no features of complaints of jaundice. Imaging revealed a polypoidal lesion at the hepatic hilum along with a stricture in the mid common bile duct. She was managed surgically with a left hemi-hepatectomy and caudate lobectomy. Case 2: A 61-year-old woman presented with a right upper abdominal mass and recurrent episodes of cholangitis, but no history of jaundice. Imaging suggested a Type IV choledochal cyst. She underwent a left lateral segmentectomy. Both cases revealed a multiloculated cystic lesion of the liver extending into the bile duct. Histology revealed a multilocular cystic lesion lined by mucinous epithelium overlying ovarian-like stroma. Periodic acid Schiff (PAS) staining confirmed the presence of mucin, while PR immunohistochemistry confirmed the ovarian-type stroma. No high-grade dysplasia or invasion was seen.
Discussion and conclusion: These two cases highlight the diagnostic challenges posed by MCNs due to their varied clinical and radiological presentations. Histological examination, supported by PAS and PR staining, is essential for accurate diagnosis and distinction from other biliary or cystic entities. Key diagnostic criteria include mucinous epithelium and ovarian-like stroma confirmed by mucin stains and immunohistochemistry. Complete surgical excision with clear margins is paramount to prevent malignant transformation and ensure favorable outcomes. Awareness of their varied presentation aids in early diagnosis and appropriate management.
Keywords: mucinous cystic neoplasm, liver, ovarian-like stroma.

CR 130

Adrenal pseudocyst in a young hypertensive patient: a benign mimic of adrenal cortical carcinoma

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Introduction: Adrenal cystic lesions are uncommon and often discovered incidentally during imaging for unrelated conditions. Among them, adrenal pseudocysts are rare, non-neoplastic lesions that may mimic adrenal cortical carcinoma (ACC) radiologically. Accurate histological diagnosis is critical for proper clinical management.
Case Report: A 41-year-old woman undergoing evaluation for early-onset hypertension was found to have a 3x2cm right adrenal mass on contrast-enhanced computed tomography (CECT), raising suspicion for ACC. Right adrenalectomy was performed. Gross examination revealed a well-circumscribed, unilocular cystic lesion in the adrenal cortex measuring 13x10x10mm and filled with a golden yellow homogeneous material. The remaining adrenal gland appeared unremarkable. Microscopically, the cyst wall was composed of dense fibrous tissue without an epithelial lining, consistent with an adrenal pseudocyst. The cyst lumen contained fibrinous material. The surrounding adrenal parenchyma showed normal histology, with no evidence of malignancy or cortical hyperplasia.
Discussion: Adrenal pseudocysts are uncommon lesions that can mimic neoplastic processes on imaging studies. They are thought to originate from prior haemorrhage, infarction, or degenerative changes within the adrenal gland. Histologically, the defining feature of pseudocysts is the absence of an epithelial or endothelial lining, which differentiates them from epithelial cysts, endothelial cysts, and true cystic neoplasms. Diagnosis is confirmed by excluding parasitic aetiologies, typically through morphological assessment. In younger patients, adrenal pseudocysts present a particular diagnostic challenge due to their atypical presentation and imaging features, often necessitating surgical excision for definitive diagnosis and management.
Conclusion: Adrenal pseudocyst is a rare, benign entity that may present as a radiologic mimic of malignancy. Histopathological examination remains essential for definitive diagnosis and appropriate patient management.
Keywords: adrenal pseudocyst, adrenalectomy, cystic adrenal lesion.

CR 131

Grade 1 neuroendocrine tumour of the common hepatic duct presenting as obstructive jaundice

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Introduction: Neuroendocrine tumours (NETs) of the biliary tract are extremely rare and can mimic more common biliary malignancies such as cholangiocarcinoma. Histological examination and immunohistochemistry are essential for definitive diagnosis.
Case report: A middle-aged woman presented with obstructive jaundice and recurrent cholangitis following endoscopic retrograde cholangiopancreatography. Imaging revealed a polypoidal lesion at the common hepatic duct. A radical bile duct excision was performed. Gross pathology identified an exophytic tumour measuring 27×24×10mm, located at the common hepatic duct and extending into the left hepatic duct. Microscopic examination showed a well-differentiated neuroendocrine tumour composed of nests, trabeculae, and cords of uniform cells. Mitotic activity was 6 per 2 mm². There was no necrosis, but perineural invasion was present. Immunohistochemistry revealed focal moderate cytoplasmic positivity for synaptophysin and chromogranin, and a Ki-67 index of 2.6%. All resection margins were clear (R0), with the closest margin being 5 mm.
Discussion: Biliary NETs are uncommon and often diagnosed incidentally. Surgical resection with negative margins is the treatment of choice. Despite the low grade and favourable Ki-67 index, perineural invasion may influence prognosis.
Conclusion: This case underscores the need to consider NETs in differential diagnoses of biliary obstruction and highlights the importance of complete surgical excision and histological evaluation.
Keywords: neuroendocrine tumour, bile duct, common hepatic duct, perineural invasion

CR 132

Synchronous adenocarcinoma of sigmoid colon and rectal neuroendocrine tumour

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Introduction: Colorectal carcinoma is among the most common cancers worldwide. However, its concurrent occurrence with rectal neuroendocrine tumours is rare.
Case Report: A 67-year-old man who presented with altered bowel habits of one-year duration was found to have a polypoidal growth in the distal sigmoid colon and a large polyp in the upper rectum. A CT scan showed a distal sigmoid colon malignancy with subtle serosal invasion, locoregional and solitary anterior mediastinal lymphadenopathy. A biopsy of the sigmoid colon lesion showed an invasive adenocarcinoma arising from a tubulo-villous adenoma with high-grade dysplasia. Subsequent sigmoid colectomy revealed a moderately differentiated invasive adenocarcinoma. Microscopy of the rectal lesion revealed neoplastic cells with uniform, round to oval nuclei, salt and pepper chromatin and eosinophilic granular cytoplasm with scanty mitoses. Its features were in keeping with a well-differentiated neuroendocrine tumour confined to the submucosa. The stalk margin was not involved by the tumour. Immunohistochemical assessment revealed strong positivity for synaptophysin and weak to moderate positivity for CD56 and Ki67 (4%).
Discussion and conclusion: While colorectal carcinoma is a common malignancy, its concurrent presentation with a neuroendocrine tumor in the rectum is exceedingly uncommon. This case highlights the diagnostic importance of understanding the potential underlying mechanisms or shared risk factors contributing to such synchronous presentations.
Keywords: synchronous, adenocarcinoma, neuroendocrine tumor, male

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CR 133

Acquired perforating collagenosis involving the upper back

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Introduction: Perforating dermatoses comprise a group of disorders in which dermal connective tissue components are eliminated through the epidermis. Acquired perforating collagenosis (APC) is a rare type of perforating dermatosis, characterized by transepidermal elimination of altered collagen. It typically occurs in association with systemic conditions such as diabetes mellitus, chronic kidney disease, and other chronic illnesses. The exact prevalence and incidence remain unclear, partly due to underreporting, overlapping clinical features, and diagnostic challenges. One study identified the lower limbs as the commonest site of involvement and followed by upper limbs and trunk.
Case report: A 59-year-old woman with a background of chronic liver cell disease, diabetes mellitus, and hypothyroidism presented with a six-month history of localised pruritic papular eruptions over the upper back. Clinical examination revealed multiple umbilicated, keratotic papules accompanied by post-inflammatory hyperpigmentation. Histopathological evaluation of the skin biopsy demonstrated a broadened, cup-shaped epidermal invagination filled with parakeratotic debris, degenerated basophilic collagen, and neutrophils. The overlying epidermis appeared atrophic and contained a thin layer of parakeratosis. Masson's trichrome stain highlighted vertically oriented collagen fibres traversing the epidermis, while elastin staining showed absence of elastic fibbers. No fungal elements were detected.
Discussion and conclusion: Most acquired perforating dermatosis are thought to arise from trauma-induced transepidermal elimination, commonly precipitated by chronic pruritus and scratching, thus the lesions are typically distributed over easily accessible extensor surfaces and back of the trunk. Differential diagnoses include folliculitis, prurigo nodularis, keratoacanthoma, insect bites and epidermal inclusion cysts. Histopathological confirmation is essential for definitive diagnosis. Management should focus on relieving pruritus and addressing associated systemic comorbidities to prevent recurrence.
Keywords: perforating dermatosis, perforating collagenosis, umbilicated keratotic papules.

CR 134

Secretory carcinoma of the parotid gland: a rare entity

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Introduction: Secretory carcinoma (SC) which was previously called mammary analogue secretory carcinoma of the salivary gland is a relatively new and rare type of salivary gland malignancy. This tumour displays a characteristic t (12;15) (p13; q25) translocation that results in the *ETV6-NTRK3* gene fusion.
Case report: A 58-year-old woman presented with right side parotid gland enlargement of one year duration. It was reported as a mixed parotid tumour on ultrasound scan. Fine-needle aspiration cytology was suggestive of a Warthin tumour. A haemorrhagic, cystic and solid white lesion was identified in the right side superficial parotidectomy. Microscopy revealed a partly circumscribed, infiltrative, unencapsulated and lobulated tumour interspersed by fine fibrous septa. The tumour was composed of microcystic and tubular structures filled with both periodic acid Schiff (PAS) and Alcian blue positive, colloid-like luminal secretions. The tumour cells contained low-grade round, vesicular nuclei with prominent nucleoli and pale-pink vacuolated cytoplasm. Mitoses were inconspicuous. Features of high-grade transformation and lympho-vascular or perineural invasion were not identified. Squamous cells or mucoid cells were not seen. The diagnosis of secretory carcinoma was confirmed by diffuse, strong cytoplasmic and nuclear positivity for S100 and cytoplasmic and membranous positivity for mammaglobin in the tumour.
Discussion and conclusion: Morphology and immunophenotype confirmed the diagnosis of secretory carcinoma. The close morphological mimic acinic cell carcinoma is unlikely due to the diffuse and strong positivity for the S100 and mammaglobin. Although secretory carcinoma has an indolent behaviour, accurate diagnosis will direct the usage of selective tropomyosin receptor kinase (TRK) inhibitors.
Keywords: secretory carcinoma, acinic cell carcinoma, S100, mammaglobin

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CR 135

Mixed germ cell tumor of testis with malignant transformation to chondrosarcoma

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Introduction: Testicular mixed germ cell tumours (TMGCTs) are a diverse group of neoplasms encompassing various histopathologies, clinical problems, and prognostic outcomes. Although it is a documented occurrence, somatic type malignant transformations (SMTs) in MGCTs are uncommon, occurring in about 3–6% cases.
Case Report: A man in his early third decade presented with a one-month history of right scrotal swelling and pain, which progressed to a size of 5 × 4 cm. Computed tomography scan revealed a large, well-defined, heterogeneously enhancing lesion in the right scrotal sac. The patient underwent bilateral high inguinal orchidectomy for right testicular tumour and left cryptorchid testis. Histopathological examination revealed components of seminoma, yolk sac tumour, embryonal carcinoma and teratoma. In one focus of immature cartilage exhibiting chondrosarcomatous (CS) transformation in the form of cytological atypia and mitotic activity was identified and confirmed by immunohistochemistry (IHC) for MGCT markers including S100 and SOX9.
Discussion: CS often arise from the malignant transformation of teratomatous mesenchyme although alternative mechanisms such as aberrant differentiation of primitive germ cells and de-differentiation of blastematous stroma within a yolk sac component may also contribute to its development.
Conclusion: Prognosis of testicular tumours depends mainly on the clinical stage, but emergence of a sarcomatous component presents a challenge in the treatment of germ cell tumours. Identification of the histological subtype of this component can be used as a guide to specific chemotherapeutic regimens.
Keywords: testicular mixed germ cell tumour, chondrosarcomatous transformation, orchidectomy

CR 137

High-grade differentiated papillary thyroid carcinoma arising from diffuse sclerosing papillary thyroid carcinoma: a rare occurrence

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Introduction: Diffuse sclerosing papillary thyroid carcinoma (DSPTC) is an uncommon and aggressive sub-type of papillary thyroid carcinoma, more frequently seen in younger patients. It is characterized by extensive lymphatic spread, prominent fibrosis, squamous metaplasia and dense lymphocytic infiltration. While DSPTC itself is aggressive, transformation into a high-grade differentiated carcinoma is exceedingly rare and is associated with a significantly poorer prognosis.
Case report: A 56-year-old woman was evaluated following the incidental detection of a thyroid mass. Imaging revealed bilateral thyroid masses with suspicious cervical lymphadenopathy. Fine-needle aspiration cytology (FNAC) was indicative of papillary thyroid carcinoma with high-grade features. The patient underwent a total thyroidectomy with central neck dissection. Histopathology confirmed DSPTC, exhibiting hallmark features such as dense stromal fibrosis, lymphocytic infiltration, psammoma bodies and squamous metaplasia. Notably, focal regions demonstrated high-grade transformation characterized by marked nuclear atypia, elevated mitotic figures, and areas of necrosis, consistent with high-grade differentiated carcinoma. Multiple lymph node metastases were identified. The patient is currently awaiting radioiodine therapy.
Discussion and conclusion: Unlike conventional papillary thyroid carcinoma, DSPTC demonstrates *RET/PTC* rearrangements in 60% of cases, with *BRAF* mutations being uncommon. This case highlights the potential for aggressive behaviour in DSPTC, particularly when high grade transformation occurs. Recognition of such transformation is critical, as it necessitates a more aggressive and individualized treatment approach. Comprehensive histopathological assessment and multimodal therapy, including surgery and adjuvant treatments, are vital for improving clinical outcomes.
Keywords: diffuse sclerosing papillary thyroid carcinoma, high grade

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CR 138

A rare case of encapsulated papillary carcinoma in the male breast: a diagnostic challenge

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Introduction: Encapsulated papillary carcinoma is a rare type of breast neoplasm that typically presents in females. It is rare in males accounting for 3% of breast cancers in men.
Case report : A 59-year-old man presented with a right-side breast lump. Ultrasound scan revealed a subareolar BIRADS V lesion. Tru-cut biopsies performed on two occasions were concluded as benign. However, based on the high clinico-radiological suspicion, a right mastectomy was performed. Macroscopy showed a blood-filled cyst with patchy whitish areas measuring 17x14x23mm in the subareolar region. Microscopy showed an encapsulated tumour with a thick fibrous capsule. The tumor showed a large central area of haemorrhage. The patchy whitish areas revealed cords of tumour cells and true papillae with low-grade nuclei and eosinophilic cytoplasm. Following extensive sampling, a focus of invasion measuring 2x2.5 mm with similar morphology was also identified. Immunohistochemically, both the encapsulated lesion and the invasive focus expressed ER and PR with no expression of HER-2. The papillary lesion did not express SMA.
Discussion and conclusion: Encapsulated papillary carcinoma is characterized by its distinct encapsulated structure and the presence of papillary formations. Due to the cystic nature of the tumour in this case, biopsies may have failed to yield adequate tissue for identifying the papillary architecture of the lesion. A high degree of suspicion helps in arriving at the correct diagnosis when the tumour is cystic/haemorrhagic masking the true nature of the breast lump. The rarity of encapsulated papillary carcinomas in males adds to the diagnostic difficulty.
Keywords: encapsulated papillary carcinoma, male breast

CR 139

A rare presentation of metastatic hepatocellular carcinoma as cutaneous lump

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Introduction: Hepatocellular carcinoma (HCC) is the most common malignant primary liver tumour. The usual sites of metastasis of HCC are the lungs, followed by lymph nodes, adrenal gland and bones. Cutaneous metastasis is extremely rare. Metastasis of HCC is associated with poor prognosis and is a defining factor in its staging and treatment..

Case report: A 65-years-old cirrhotic patient presented with a progressively enlarging lump measuring 4cm in maximum diameter over the lateral canthus of the right eye. Ultrasound scan (USS) denoted a mass with possible underlying superficial bone erosion. FNAC smears revealed a cluster and acinar arrangement of polygonal neoplastic cells with centrally located round nuclei and eosinophilic cytoplasm. Nuclear inclusions, binucleation and transgressing vessels were also seen. The cytological differential diagnoses included metastasis from HCC and a primary adnexal neoplasm. Computed tomography (CT) scan showed evidence of liver cirrhosis with heterogeneous enhancing lesions involving segments V and VI of the liver. A core biopsy of the liver confirmed the diagnosis of HCC.

Discussion and conclusion: Considering clinicopathological and radiological findings, this case was diagnosed as HCC with cutaneous metastasis over the lateral canthus of the eye. This is an extremely rare site of extrahepatic metastasis of HCC. This case highlights the importance of considering the possibility of cutaneous metastasis in cirrhotic patients presenting with unusual skin lesions. Recognition of such atypical presentations is crucial for accurate staging and management.

Keywords: hepatocellular carcinoma**,** extra hepatic metastasis, cutaneous metastasis

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CR 140

A rare case of myeloid sarcoma with monocytic differentiation presenting as multiple skin nodules in an elderly man

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Introduction: Myeloid sarcoma with monocytic differentiation is a rare subtype of myeloid sarcoma characterized by the extramedullary proliferation of immature myeloid cells exhibiting monocytic differentiation. It is frequently associated with acute monocytic leukaemia and may also present as isolated extramedullary disease.

Case report: A 91-year-old man presented with multiple skin nodules that had developed over a one-month period. Clinical evaluation revealed pancytopenia, generalized lymphadenopathy and splenomegaly. Biopsies from the skin nodules showed sheets of poorly cohesive mononuclear cells with enlarged vesicular nuclei, convoluted nuclear membranes, scant cytoplasm, and frequent mitoses infiltrating subepithelial tissue. Trephine biopsy revealed infiltration by atypical cells morphologically similar to those seen in the skin lesions. The differential diagnoses included high-grade lymphoma and myeloid sarcoma. Neoplastic cells of the skin biopsy showed diffuse membrane positivity for LCA and negativity for CD3 and CD20. Sudan black was positive in neoplastic cells favouring the diagnosis of myeloid sarcoma. Further immunohistochemistry showed diffuse granular cytoplasmic positivity for CD68 with negativity for MPO, CD34 and CD117 and Ki-67 proliferation index of 95%. Based on these findings, a diagnosis of myeloid sarcoma with monocytic differentiation was made. He was started on chemotherapy to provide supportive care and symptomatic management considering his age and health status.

Discussion and conclusion: Myeloid sarcoma with monocytic differentiation is rare. It is a diagnostically challenging entity which could be easily misdiagnosed. Therefore, a comprehensive panel of immunohistochemical markers and special stains are needed for accurate diagnosis. Immunophenotyping of myeloid sarcoma has prognostic and therapeutic implications.

Keywords: myeloid sarcoma, monocytic differentiation, immunophenotyping

CR 141

BAP1- inactivated melanocytoma

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Introduction: BAP1- inactivated melanocytoma is characterized histologically by epithelioid cell morphology and inactivation of the *BAP1* gene. Differentiation of this entity from a malignant melanoma is very important as this carries an indolent clinical course. Multiple such lesions raise the possibility of BAP1 tumour predisposition syndrome.
Case report: A 52-year woman presented with a 5mm papule on her left neck. The clinical impression was that of basal cell carcinoma. Histology revealed dermal melanocytic proliferation with no junctional activity. The melanocytes showed epithelioid morphology and moderate to abundant cytoplasm. There was no maturation toward the depth. The nucleoli were prominent, not eosinophilic. The periphery of the lesion showed circumscribed margins with a patchy lymphoid infiltrate. Immunohistochemistry showed S100, Melan A and p16 positivity, while HMB 45 and PRAME were negative. Ki-67 proliferation index was low. BAP1 was lost in the cells of concern with a positive internal control.
Discussion and conclusion: Biallelic inactivation of the *BAP1* gene sporadically or as a germline mutation causes this entity. Germline mutations of *BAP1* is associated with malignancies such as malignant mesothelioma, uveal melanoma, cutaneous melanoma, cholangiocarcinoma and renal cell carcinoma. Combined BAP1-inactivated melanocytomas can be confused with melanoma arising in a naevus. Helpful clues in the diagnosis are the recognition of the typical epithelioid melanocytes, and loss of BAP1 expression in the absence of malignant features. Awareness of this entity is the key to differentiate it from a malignant melanoma.
Keywords: BAP1-inactivated melanocytoma, malignant melanoma

CR 142

Sertoliform endometrioid carcinoma of the ovary: a diagnostic mimic of sex cord-stromal tumours

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Introduction: Ovarian endometrioid carcinomas are known for their diverse histologic appearances, occasionally mimicking sex cord–stromal tumours through tubular, nested or cord-like patterns. Recognizing these morphological variants is crucial to avoid diagnostic pitfalls.
Case report: A 38-year-old woman presented with lower abdominal pain. Ultrasound imaging revealed a cystic lesion arising from the left adnexa. She underwent oophorectomy. Macroscopically, a 140 x 110 x 90 mm, multilocular, cystic and solid ovarian mass was received. The capsule was breached focally. The tumour exhibited two distinct histological patterns. The predominant solid areas demonstrated a proliferation of back-to-back, simple tubules and cord-like structures embedded in an oedematous stroma, resembling Sertoli cell tumour morphology. These tubules were lined by cuboidal cells with round-oval nuclei showing minimal atypia and inconspicuous nucleoli. No areas of confluent solid growth were identified. In other regions, the tumour showed well-formed, well-differentiated glands lined by tall columnar epithelial cells with low-grade, stratified nuclei, consistent with endometrioid adenocarcinoma. Some of the glandular spaces and cystic areas contained eosinophilic secretions. No Leydig cells or squamous morules were seen. Adjacent cystic areas revealed endometriosis and a focus of borderline endometrioid tumour. Immunohistochemistry demonstrated strong, diffuse ER and EMA positivity in the neoplastic glands, focal vimentin positivity, and negative staining for calretinin and inhibin.
Discussion and conclusion: This case represents a sertoliform variant of endometrioid carcinoma, a recognized mimic of sex cord–stromal tumours. The tubular, nested, and cord-like patterns can resemble Sertoli cell tumours and Wolffian tumours, posing diagnostic challenges. Immunohistochemistry is essential: strong ER and EMA positivity, along with negative calretinin and inhibin staining, supports an epithelial origin. The presence of endometriosis further favours an endometrioid carcinoma. Awareness of this pattern is critical, as accurate classification directly impacts treatment and prognosis.
Keywords: endometrioid carcinoma, sertoliform, sex-cord stromal tumours, ovary

CR 143

Hybrid oncocytic/chromophobe tumor of the kidney: navigating the diagnostic grey zone

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Introduction: Renal tumours with oncocytic cytoplasm span a morphological spectrum, exhibiting overlapping features between oncocytoma, a benign neoplasm, and chromophobe renal cell carcinoma (ChRCC), a malignant tumour with relatively favourable outcomes. Distinguishing between these entities is clinically significant. Hybrid oncocytic/chromophobe tumours (HOCTs) are increasingly recognised and present diagnostic challenges due to their biphasic morphology and variable immunophenotype.
Case report: A 66-year-old man, without signs of Birt–Hogg–Dubé syndrome (BHDS), underwent left partial nephrectomy for a renal mass. Grossly, the tumour was well-circumscribed, tan-brown with yellowish solid areas. It measured 55×45×45 mm and showed no extension into the perinephric or sinus fat. Histologically, it exhibited two distinct morphologic patterns: one with chromophobe-like features, characterized by large polygonal cells with distinct cell borders, pale to clear cytoplasm, and occasional "raisinoid" nuclei; and another with oncocytoma-like features, composed of small nests and solid sheets of cells with abundant granular eosinophilic cytoplasm and round, central nuclei in an oedematous stroma. No tumour necrosis, sarcomatoid or rhabdoid differentiation was identified. Immunohistochemically, the chromophobe-like areas showed strong, diffuse positivity for CK7, CD117, and Hale colloidal iron, whereas the oncocytoma-like areas demonstrated patchy, faint CK7 positivity, diffuse but weaker CD117 expression, weak CD10 positivity and a faint Hale colloidal iron staining.
Discussion and conclusions: HOCTs are typically indolent, but careful distinction from ChRCC, oncocytoma and other eosinophilic renal tumours like epithelioid angiomyolipoma, *SDH* deficient-RCC, fumarate hydratase deficient- RCC, MiT family translocation-RCC, and eosinophilic solid and cystic RCC is essential. Recognizing their biphasic morphology is critical for accurate diagnosis and management, especially given potential association with BHDS.
Keywords: chromophobe, oncocytoma, renal tumour

CR 144

Atypical lipomatous tumour with a rare presentation

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Introduction: In the past pathologists relied mainly on morphology for diagnosis. In the modern era, however, the integration of advanced diagnostic techniques based on clinical context is essential for precision diagnosis.
Case Report : A 67-year-old man presented with a recurrent upper arm lump that had been reported as a lipoma 10 years back. The solid, homogeneously fatty mass measured 95x50x25 mm. Microscopy revealed an adipocyte proliferation with minimal size variation and bland nuclei. No lipoblasts were identified. Focal areas showed proliferation of bland spindle cells in a myxoid stroma. Overt nuclear pleomorphism, chicken-wire like vasculature, increased mitosis, necrosis or heterologous elements were not present. The tumour involved the resection margin. The tumour was sampled extensively (almost 90%), and deeper levels were examined, but the morphological features remained the same. Despite the benign morphology, the large size of the mass, recurrent nature and involvement of the margins were worrisome features and warranted molecular studies. Molecular analysis revealed CDK4 amplification. MDM2 was inconclusive. The case was diagnosed as an atypical lipomatous tumour, with margin involvement.
Discussion: Lipoma-like subtype of ALT/well differentiated liposarcoma can be challenging to differentiate from a lipoma. ALT carries a risk of dedifferentiation and metastasis if not completely excised; therefore, accurate differentiation between the two entities is crucial for determining prognosis.
Conclusion: In resource poor settings, selecting cases for molecular studies based on strong clinical suspicion and not being solely reliant on the morphology, benefits the patient in the long run. When there is no access to advanced testing, it's important to clearly state the diagnostic uncertainty and recommend complete excision and follow up.
Keywords: atypical lipomatous tumour, molecular test, CDK4, MDM2, resource poor setting

CR 146

Lymph node deposit of a cystic papillary thyroid carcinoma radiologically mimicking a cystic hygroma

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Introduction: Papillary thyroid carcinoma (PTC) is the most common thyroid malignancy, typically presenting as a solid thyroid nodule. Cystic variants of PTC can pose a diagnostic challenge, especially when they mimic benign cystic lesions such as cystic hygroma on imaging.
Case report: A 23-year-old man presented with a left-sided neck mass. Ultrasonography and magnetic resonance imaging (MRI) suggested a cystic hygroma. Fine needle aspiration cytology (FNAC) was reported as a benign cyst with focal haemorrhage, favouring a branchial cyst. Excision showed two cysts measuring 30x25x10mm and 23x20x10mm. The cut surface showed a cyst with brown fluid and solid areas. Histopathology was consistent with a PTC with cystic change. This was further confirmed by immunohistochemistry, demonstrating TTF-1 and CK19 positivity in tumour cells. He subsequently underwent total thyroidectomy and cervical block dissection which revealed a multifocal PTC, the largest tumour size being 3mm, and multiple lymph node deposits.
Discussion: PTC is known to become cystic and can mimic other benign cystic lesions radiologically and cytologically especially when it presents with lymph node deposits. Although this feature is a frequent finding in PTC, cystic PTC is not identified as a subtype in the World Health Organisation classification.
Conclusion: This case highlights the potential for cystic PTC to be misdiagnosed as a cystic hygroma based on imaging alone or misdiagnosis in cytology if only the cyst fluid is aspirated. Histopathological evaluation, supplemented by immunohistochemistry, plays a crucial role in establishing the correct diagnosis. Awareness of this rare presentation can aid in timely and accurate management.
Keywords: papillary thyroid carcinoma, cystic change, imaging

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CR 147

A rare case of drug induced eosinophilic granulomatosis with polyangiitis

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Introduction: Eosinophilic granulomatosis with polyangiitis (EGPA) is a rare chronic granulomatous vasculitic disease that causes multisystemic manifestations. It is a complex diagnosis made using a scoring system developed by the American College of Rheumatology in 2022 and includes clinical details, laboratory investigations and histological assessment for confirmation. A score of six or more is 85% sensitive and 99% specific for a final diagnosis.
Case report: A 65-year-old woman, with history of hyperthyroidism, dyslipidemia and resolved leg cellulitis, presented with an acute onset vasculitic rash on her lower limb. She had subnephrotic proteinuria, haematuria and peripheral eosinophilia of 12%. Chest x-ray showed hazy lung shadows. c-ANCA was negative and p-ANCA was not available. She had no known history of bronchial asthma, neuropathy or cardiac symptoms. Other than statins and carbimazole she had been on several medications including on and off antibiotics and non-steroidal anti-inflammatory drugs. Renal biopsy revealed crescentic glomerulonephritis with extensive necrotizing lesions containing eosinophils. An interstitial eosinophil infiltrate and moderate tubulitis mediated by eosinophils was also identified. Immunofluorescence studies were negative. Skin biopsy revealed eosinophil mediated small vessel vasculitis with fibrinoid necrosis. Neither of the biopsies showed chronic changes.
Discussion and conclusions: In this patient, the diagnostic criteria for EGPA were fulfilled. However, considering the acute onset of renal and skin lesions and detailed assessment of medication history, drug induced EGPA was favoured over primary onset of EGPA. Several medications act as triggers for EGPA in genetically susceptible patients. Therefore, reviewing and altering medications is needed. This case highlights the importance of close clinico-pathological correlation.
Keywords: eosinophilic granulomatosis with polyangiitis, drug-induced vasculitis

CR 148

A rare case of fungal cellulitis in an immunocompromised patient

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Introduction: Cellulitis is a common condition affecting the dermis and subcutaneous fat, frequently caused by bacteria like staphylococci and streptococci. The prognosis is usually good as successful treatment is available. However, in immunocompromised patients, infection with atypical organisms can lead to significant morbidity and mortality.

Case report: A 46-year-old man with diabetes mellitus who was also on chemotherapy for hairy cell leukaemia presented with one to two weeks history of right lower limb swelling, redness, and multiple surface blisters. The clinical diagnosis was cellulitis. Investigations revealed persistent neutropenia, elevated C-reactive protein (CRP) with negative blood and wound swab cultures. Despite conventional antibiotics, the cellulitis progressed, and a skin biopsy was performed. The biopsy showed suprabasal blisters, diffuse dermal inflammation and multiple invasive fungal hyphae in deep dermal and subcutaneous blood vessels. Grocott methenamine silver stain and periodic acid Schiff stains highlighted thin fungal hyphae with septations and acute branching resembling *Aspergillus*. Intravenous antifungal treatment was started, but the patient expired due to disseminated fungal infection, including fungal pneumonia.

Discussion and conclusion: In immunocompromised patients presenting with progressively worsening cellulitis despite conventional treatment, it is crucial to consider other unusual aetiologies such as fungal infections. Routine microbiological investigations like superficial wound swabs and cultures may not detect deep angioinvasive fungi, as seen in this case. Therefore, in such presentations, it is very important to consider skin biopsy and histological assessment for accurate diagnosis. Early and accurate diagnosis is very important to prevent morbidity and mortality.

Keywords: fungal cellulitis, immunocompromised patient

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WINNERS OF THE VIDEO COMPETITION FOR MEDICAL STUDENTS

Best video awards: Awarded at the 50th Anniversary Celebration on 13th March 2025

1st Place - Contestant No. 27
Topic: "Hope in Healing" - Awareness video on cervical cancer
Participants: Shankavy Shanthirasegaram, Sunthareswaran Subangan, Kavippiriyah Kanakeshwaran, Krishnavi Ratnaranjan, Amalathas Johan Jeevathas, Mithurshan Jayanathan
Supervised by Dr Lalani J De Silva, Faculty of Medicine, University of Colombo

2nd Place - Contestant No. 1
Topic: "The Invisible Heroes: Early Detection and the Role of Pathologists in Breast Cancer"
Participant: Q. Rahimaa Lamis
Supervised by Dr Lalani J De Silva, Faculty of Medicine, University of Colombo

3rd Place - Contestant No. 24
Topic: "A Second Chance"
Participants: Kanesamoorthy Kanoojan, Yogendran Mathushanan, Wijayanthy Wijayakumar, Jegatheswaran Janenthan
Supervised by Dr J M M Theepan, and Dr Balavally Thanenthiran, Faculty of Medicine, University of Jaffna

Most popular video awards: Awarded at the Inauguration Ceremony of the 50th Anniversary International Conference on 23rd October 2025

1st Place - Contestant No. 14
Topic:
Participant: R K Umedha Sewmini
Supervised by Dr Chamini Gamakaranage, Faculty of Medicine, University of Sabaragamuwa

2nd Place – Contestant No. 06
Topic:
Participants: W. Amindu Udesh, Kavindu Jayasekara, Monali Anushka, Ashraff Wafi, Surangi Udesha, Upuli Indrachapa
Supervised by Dr Wasanthi Wickremasinghe, Faculty of Medicine, University of Moratuwa

3rd Place - Contestant No. 24
Topic: "A Second Chance"
Participants: Kanesamoorthy Kanoojan, Yogendran Mathushanan, Wijayanthy Wijayakumar, Jegatheswaran Janenthan
Supervised by Dr J M M Theepan and Dr Balavally Thanenthiran, Faculty of Medicine, University of Jaffna

PATH MASTER QUIZ: INTER UNIVERSITY PATHOLOGY QUIZ PARTICIPATING TEAMS AND THE WINNERS

Participating teams:

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Faculty of Healthcare Sciences, Eastern University of Sri Lanka
Faculty of Medicine, University of Jaffna
Faculty of Medicine, General Sir John Kotelawala University
Faculty of Medicine, University of Kelaniya
Faculty of Medicine, University of Moratuwa
Faculty of Medicine, University of Peradeniya
Faculty of Medicine, University of Ruhuna
Faculty of Medicine and Allied Sciences, Rajarata University of Sri Lanka
Faculty of Medicine, Sabaragamuwa University of Sri Lanka
Faculty of Medical Sciences, University of Sri Jayewardenepura
Faculty of Medicine, Wayamba University of Sri Lanka

The winners of the Quiz

Champions – Faculty of Medicine, University of Colombo

Team members:
S T P Narangoda (Team leader), C A Jayalath, S Tharsikan, B Apiram, D M R D Nanayakkara

Academic Coordinators:
Dr Gayani Ranaweera, Dr Ahalyaa Sivashangar

1st Runners-up – Faculty of Medical Sciences, University of Sri Jayawardenepura

Team members:
D P A Gunarathna (Team leader), M W T Dinethra, I J C Fernando, D M C S Dissanayake, Sajith Bandara

Academic Coordinators:
Professor Bimalka Seneviratne, Professor Isha Prematilleke.

2nd Runners-up - Faculty of Medicine, University of Kelaniya

Team members:
M N M Akeel (Team leader), K D R Wishwajith, D M V S Dhanasekara, U K G S M Wickramasinghe, A K A Aathique

Academic Coordinator:
Dr Mangala Bopagoda

PARTICIPANTS OF THE PANORAMIC PATHOVISION ART COMPETITION AND EXHIBITION

Paintings

"The eyes with hidden scope"	L Logica
“Discovering the hidden secret”	K Kumari Wijeyarathne
“Beautiful world of histopathology”	W A J Dissanayaka
“Rescued by different arms of pathology”	L S M Sigera
“Colonic saree design”	J A Kaumadi Udeshika
“Embracing modern technology for a better future”	Dayal S Gamlaksha
“Dreamscape of a pathologist”	Lalani J De Silva
“Cytology: tracing the footprints of disease through the lens”	R M J B Rathnayake
“Under the sky - a land scape wall art”	N G C P Nanayakkara
“Immersed in beauty while safeguarding health”	M K L Manjula
“Smoking & betel —> cancer”	Vinothika Sivamayuran
“The GI 50”	M N Fathima Amra
"Mandela of bowel"	Sihani Pramoda
“Eyes of the pathologist”	Chandu de Silva

Photography

“The silent rings: signet shadow in the stomach”	B D B M Baduraliyage
“මා නිල් සයුරය - ඔබ රළු වෙරලය නැත කිසිදා අප හමුවන්නේ”	M Mandhodaree Rajapakse
“The deceptive tree”	Lalani J De Silva
“Love beneath the lens”	R M J B Rathnayake
"A volcano erupting with lava splashing from a green valley"	J A Kaumadi Udeshika
“Photography”	Vinothika Sivamayuran
“With love, SK”	M N Fathima Amra

Poetry

“නයිරොයිඩ් වතගොන”	B D B M Baduraliyage
“I see you”	Pavithra Samarakoon
"Tiny courage" (prose)	PM Madhusha Pilapitiya
“අම්මා නැති ලොවක ඔබ තනි වෙයිද දුවේ”	M Mandhodaree Rajapakse
“Silent heroes”	K D Rammuthupura
“Through the microscope lense”	W A J Dissanayaka
“Feeling blue”	Rangana Karunaratne
"නපුරු සෛලය"	J A Kaumadi Udeshika
“Poetry”	Arundathi Kurukulasuriya
“If for histopathologists”	Chandu de Silva
“The life under the microscope”	D P K Rathnayake
“A wonderful tumour”	L Dunya Wickramasinghe
“A cell's journey”	M N Fathima Amra
“Apoptosis “	Sihani Pramoda
“A gift (Apooru Thegga)”	N Jayanjana Asanthi
“Poem”	A Illeperuma

Other creative crafts

“A giant in pathology”	N G J C P Nanayakkara
“Artistic inspiration of Warthin tumour”	S P R S Kumari

WINNERS OF THE ART COMPETITION AND EXHIBITION

Painting Category

1st Place – Dr Lalani Jayamali De Silva
Senior Lecturer, Faculty of Medicine, University of Colombo
Topic: Dreamscape of a Pathologist

2nd Place – Dr Liyanage Shamithra Madhumali Sigera
Consultant Mycologist, Department of Mycology, National Hospital, Galle
Topic: Rescued by different arms of pathology

3rd place – Dr Mohamed Naseer Fathima Amra
Postgraduate trainee in histopathology, National Hospital of Sri Lanka
Topic: 'The GI 50'

Photography Category

1st Place – Dr Lalani Jayamali De Silva
Senior Lecturer, Faculty of Medicine, University of Colombo
Topic: The Deceptive Tree

2nd Place - Dr Mohamed Naseer Fathima Amra
Postgraduate trainee in histopathology, National Hospital of Sri Lanka
Topic: 'With Love, SK'

3rd Place – Dr Madhara Mandhodaree Rajapakse
Registrar in histopathology, National Hospital, Galle
Topic: මා නිල් සයුරය - ඔබ රළු වෙරලය, නැත කිසිදා අප හමුවන්නේ..

Poetry and Proses Category

1st Place – Dr Madhara Mandhodaree Rajapakse
Registrar in histopathology, National Hospital,Galle.
Topic: අම්මා නැති ලොවක ඔබ තනි වෙයිද දුවේ …

2nd Place – Dr Buddimani Madavi Baduraliyage
Lecturer, Department of Pathology, Faculty of Medicine, University of Ruhuna, Galle
Topic: තයිරොයිඩ් වතගොත

3rd place – Dr L. D. Wickramasinghe
Senior registrar in histopathology, Sri Jayewardenepura General Hospital
Topic: A wonderful tumour

Creative Craft Category (Only two entries)

1st Place – Dr Ruwani Sandamalika Kumari
Histopathology trainee, Faculty of Medicine, University of Peradeniya
Topic: Artistic inspiration of Warthin tumour

2nd Place – Dr NGJCP Nanayakkara
Medical officer, Medical Research Institute, Sri Lanka
Topic: A giant in pathology

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2. The British Division of International Academy of Pathology (BDIAP)
3. The Dean and the administrative staff of the Faculty of Medicine, University of Colombo
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12. Our Sponsors
13. The members of the subcommittees who dedicated their time and effort to the 50th Anniversary Celebration events
14. The medical students who participated in the 50th Anniversary Celebration events
15. Ms. Isuri Udara, Administrative Assistants, College of Pathologists of Sri Lanka
16. All others who contributed in various ways

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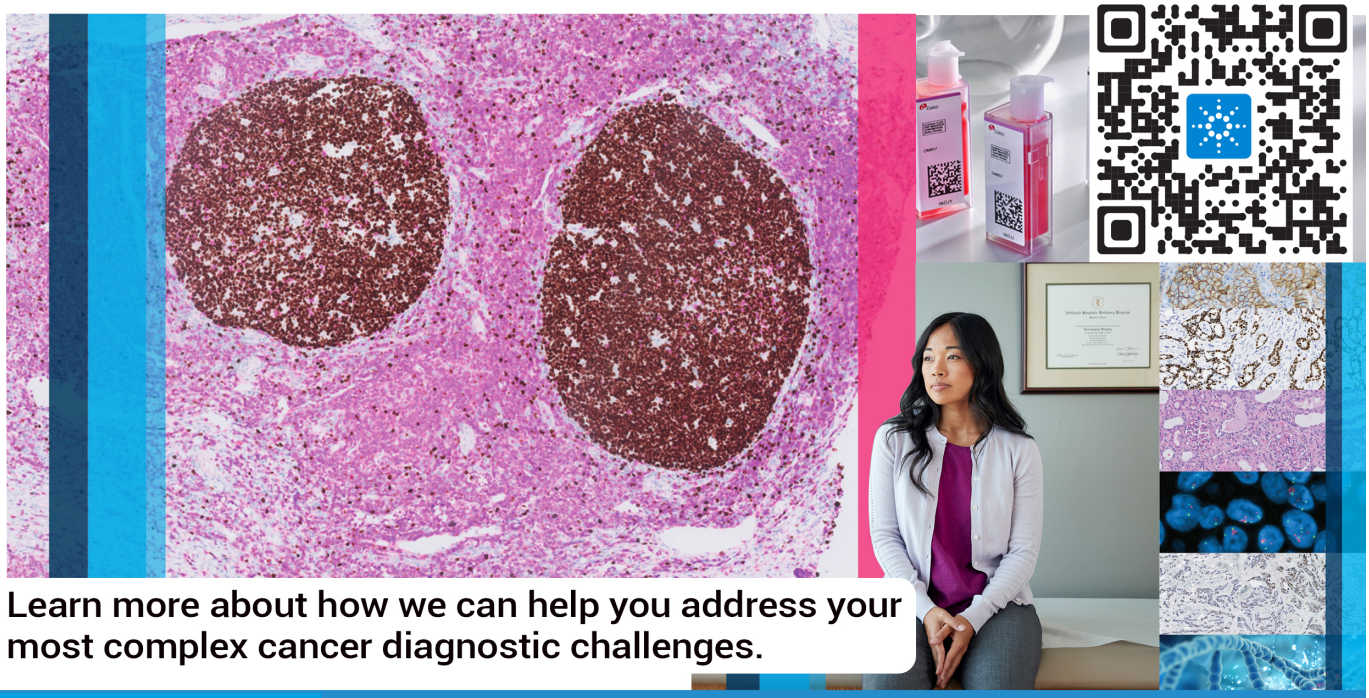

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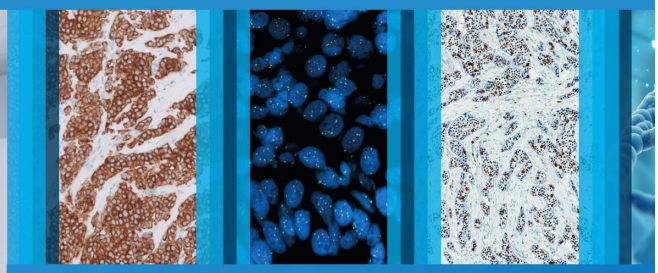

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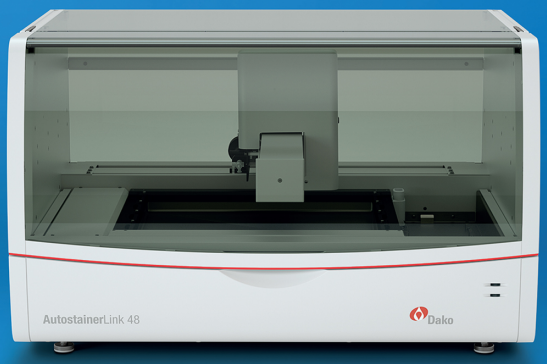

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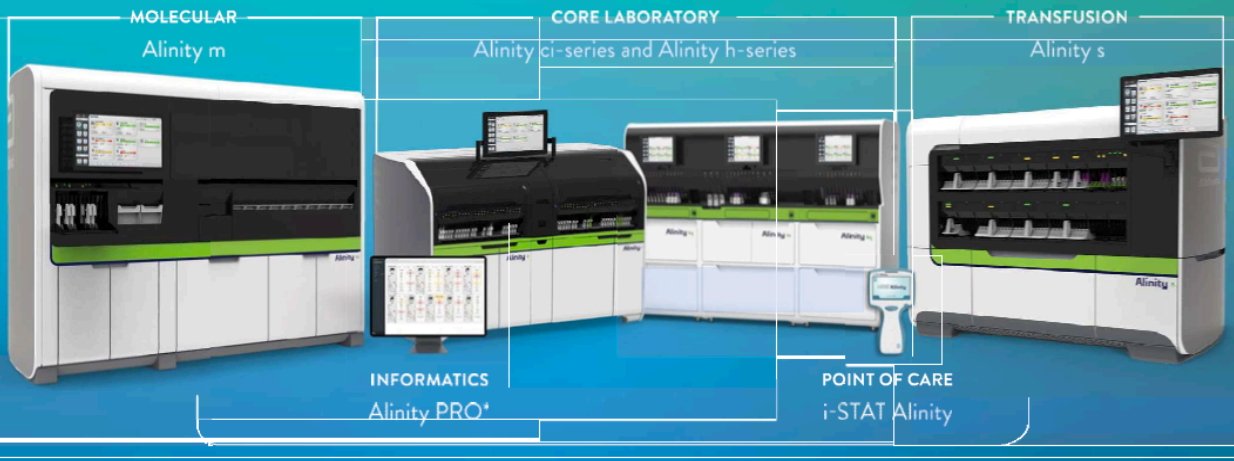

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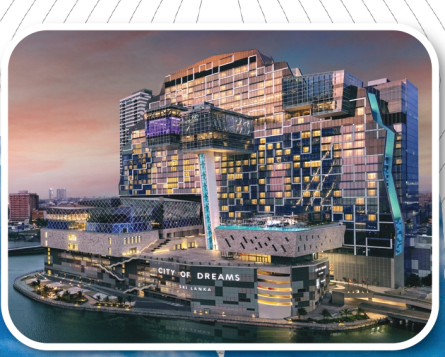

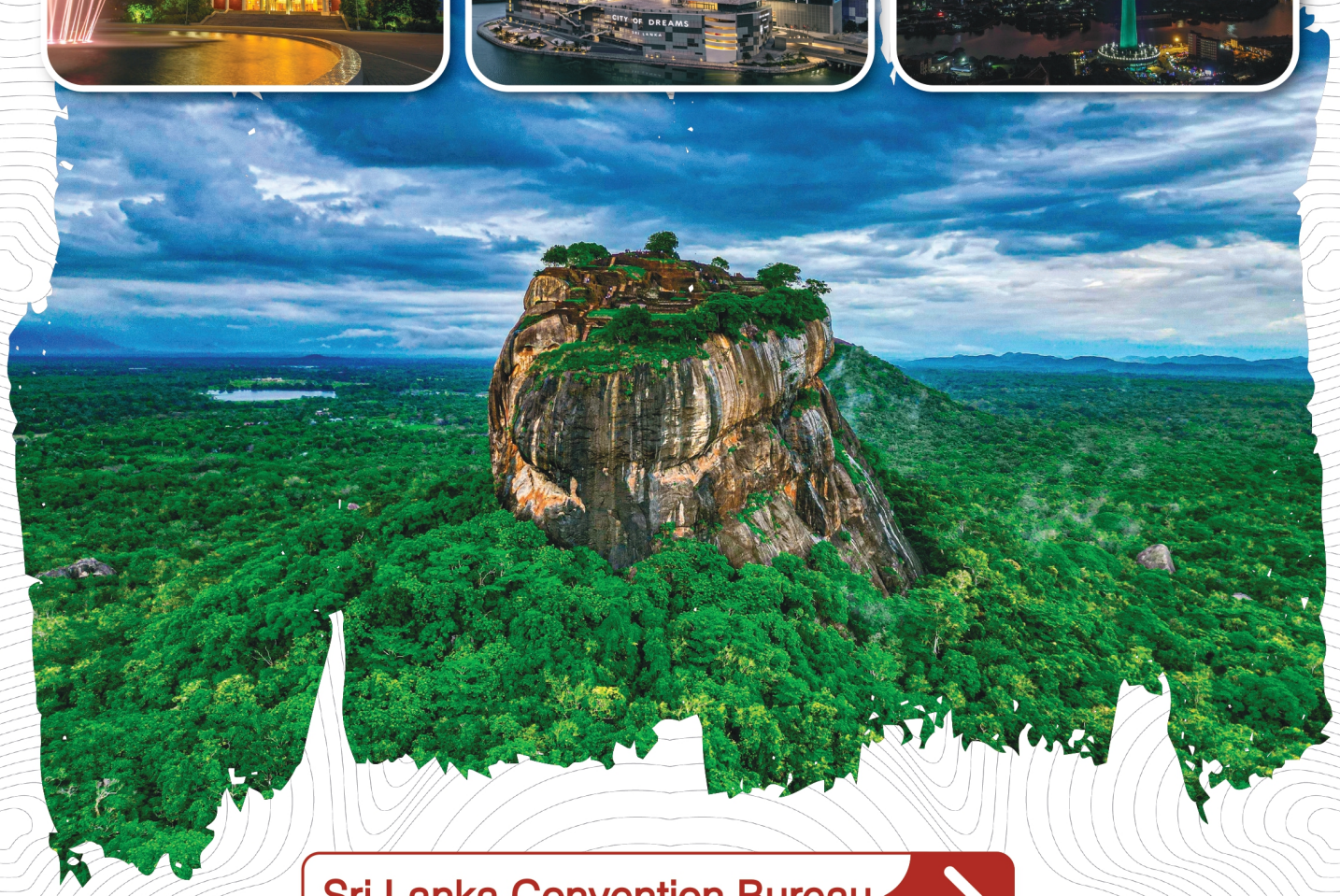

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