though a few long term remissions to etoposide–methotrexate–actinomycin-D or cisplatin–etoposide treatment have been reported.[5]

There are many lessons to be learnt from this unfortunate patient. Pathologists must always consider, especially in an unusual clinical setting, the possibility of a trophoblastic neoplasm, a potentially curable disease, before labelling a tumour as a high grade carcinoma or an incurable disease. For physicians, it underscores the fact that sound clinical judgement followed by good communication with the pathologist is the key to a correct diagnosis. Finally, it is a reminder that it is mandatory to take an obstetric history, even in apparently non-obstetric cases.

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CORRECTIONS

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Figure 4 of an article in the September issue should have been published in colour (Fukuzawa R, Heathcott RW, More HE, *et al*. Sequential *WT1* and *CTNNB1* mutations and alterations of ß-catenin localisation in intralobar nephrogenic rests and associated Wilms tumours: two case studies. *J Clin Pathol* 2007;60:1013–16). Figure 4 is published in colour on our website at http://jcp.bmj.com/supplemental.

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An article in the September issue was published with an incorrect title (Stój A, Rudzki Z, Stachura J, *et al*. The *JAK2* V617F mutation in Philadelphia-negative chronic myeloproliferative disorders. *J Clin Pathol* 2007;60:1070–1). The correct title should be: The JAK2 V617F mutation is frequently present in buccal swabs from patients suffering from Philadelphia-negative chronic myeloproliferative disorders, who carry the mutation detected in bone marrow or peripheral blood cells.