Sarcomatoid carcinoma is a rare malignant diagnostic problem in frozen carcinosarcoma: possible postScript.

Microscopically, most of the tumour was composed of moderately atypical spindle cells with pleomorphic nuclei and eosinophilic cytoplasm, in which cross striations were not readily observed. The carcinomatous component showed varying degrees of distinct gland formation, the dimensions of which ranged from large cystic spaces to small tubular structures. The tumour invaded the pleura. There were no positive lymph nodes.

Immunohistochemically, the carcinomatous cells were positive with antibodies to various cytokeratins, including AE1/AE3 (prediluted; Dako, Carpenteria, California, USA). They were negative for vimentin (prediluted; Dako). Sarcomatous cells were negative for cytokeratins and strongly positive for vimentin (prediluted; Nichirei, Tokyo, Japan). S-100 (prediluted; Nichirei) was positive in the foci with cartilaginous differentiation.

It is important to know just how small a carcinocarcinoma of the lung can be, because the existence of small carcinosarcomas suggests that the sarcomatoid transition could take place relatively early. In the literature, small carcinocarcinomas of the lung are encountered extremely rarely. Koss et al. reviewed the literature and found 34 cases that fit the WHO definition of pulmonary carcinocarcinoma, among which only two cases were 2 cm in size. Early lesions of carcinocarcinoma of the lung may necessitate intraoperative diagnosis. Care should be taken in the interpretation of a frozen section because insufficient sampling could lead to an erroneous diagnosis, such as reactive fibroplastic proliferation.

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References

Figure 1 Frozen section of the tumour, which was composed of moderately atypical spindle cells with an inflammatory infiltrate, resembling reactive fibroplastic proliferation. The carcinomatous element was not conspicuous (haematoxylin and eosin stain; original magnification, ×100).

Caution should be taken in using CD31 for distinguishing the vasculature of lymph nodes

When interpreting lymph node biopsies it is sometimes necessary to distinguish the different compartments of the lymph node. In normal lymph nodes the task may be easily accomplished, but it can be difficult for effaced lymph nodes. We compared the usefulness of routine use of endothelial markers for distinguishing sinuses from vascular channels in the lymph node.

Eighteen lymph nodes—seven normal lymph nodes from a patient with colonic cancer (patient 1), eight from a patient affected by diffuse large B cell lymphoma of the stomach (patient 2), and three from a patient with anaplastic large cell lymphoma (ALCL) (patient 3)—were selected from the archives of the department of pathology, Kariya General Hospital, Japan. The tissues were fixed in 10% formalin and embedded in paraffin wax. Standard tissue sections, 6 μm thick, were stained with haematoxylin and eosin. Immunohistochemical staining was performed by means of the Ventana marker reagent (Ventana, Tucson, Arizona, USA). The primary antibodies used were commercially available antibodies directed against factor VIII (prediluted; Dako), CD31 (prediluted; Dako, Carpenteria, California, USA), CD34 (prediluted; Dako), anti-CD31 (prediluted; Nichirei) and S-100 (prediluted; Nichirei). Anti-CD34 was applied to the sections of all lymph nodes from patients 1 and 2, but only decorated vascular channels. For anti-factor VIII, background staining was very intense in the sinuses. Anti-CD34, when pretreated with either trypsin or in the microwave, was positive not only for the endothelium of vascular channels but also for the lining cells of sinuses. When applied to the lymph nodes from patient 3, all the tumour cells were confined within spaces that were lined by CD31 positive cells (fig 1). The application of anti-CD34 suggested that these spaces were in fact sinuses (fig 2), leading to the conclusion that this case represented ALCL with a sinus pattern of involvement.

The sinuses of the lymph node are different from vascular channels in that they are not lined with endothelium. CD31 is believed to be a highly specific marker for endothelial cells. Recently, however, McKenney and associates showed that the expression of CD31 by macrophages could easily be detected on formalin fixed, paraffin wax embedded sections, causing misdiagnosis in surgical pathology practice. This characteristic of CD31 may also be important in distinguishing the compartments of the lymph node or spleen.

The presence of CD31 cannot be used to distinguish sinuses from capillaries or venules because specific dendritic cells that line the sinuses of lymph nodes are also positive for CD31. Apparent positivity for CD31 could lead to the misinterpretation of sinuses as vascular channels. CD31 is expressed by a variety of cells, and can be detected not only in endothelial cells, but also in reactive fibroblasts and some types of benign and malignant mesenchymal neoplasms. Applying
Cirrhosis with steatohepatitis following longterm stilboestrol treatment

Diethylstilboestrol, which is chemically related to the female hormone oestrogen, was the main form of androgen suppression in the treatment of advanced prostate cancer up until the late 1980s. Although luteinising hormone releasing hormone (LHHRH) analogues have superseded diethylstilboestrol, treatment of prostate cancer.

Although the effect of stilboestrol on the liver has been investigated, research has focused on animal models. One human study described parenchymal damage, in the form of non-alcoholic steatohepatitis, in six post-mortem cases with a history of diethylstilboestrol treatment for prostate cancer. In addition, two documented cases of hepatocellular carcinoma have been reported following longterm stilboestrol treatment. Interestingly, non-alcoholic steatohepatitis is seen not only with oestrogenic drugs such as stilboestrol, but also with the partial agonist drug tamoxifen. It is known that steatohepatitis inducing drugs such as stilboestrol accumulate within mitochondria, resulting in ATP depletion and lipid peroxidation of hepatocytes.

Diethylstilboestrol was once the main alternative to orchietomy in the treatment of prostate cancer. However, its potential side effects, which include breast enlargement and cardiotoxicity, mean that it has been largely superseded by LHHRH analogues with superior safety profiles. Although the use of stilboestrol has declined, its reintroduction to large scale clinical use has recently been proposed, particularly for early hormone refractory disease. This case report emphasises the need for regular monitoring of liver function tests in those receiving such treatment. It also serves as a further example of a steatohepatitis inducing drug.

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References

BOOK REVIEWS

Cytopathology of the Breast

McKee GT. (£130.00.) Oxford University Press, 2002. ISBN 0 19 514006 0.

Grace McKee’s recent publication provides an extremely comprehensive overview of breast entities. Although it is entitled “Cytopathology,” it encompasses much more, providing clinical and histopathological details, in addition to cytopathological features of a very wide range of breast entities.

The initial chapters provide detailed discussions of normal breast histology and cytology; methods of aspiration, smear preparation, and laboratory techniques, including sections on the reporting of cytopathological specimens and the limitations of cytology. Although concentrating on fine needle aspiration biopsy material, exfoliative cytology of nipple secretions and ductal lavage specimens are also included. Subsequent chapters are organised such that entities are introduced with clinicopathological descriptions followed by gross, histological, then cytopathological features. For many entities this is followed by a summary of cytopathological findings. There are numerous photomicrographs of both histological and cytopathological features, which are of excellent quality, the discussions are detailed, and references are extensive. The very comprehensive nature of the text is perhaps a slight disadvantage, then cytological specimens. For many entities this is followed by a summary of cytopathological findings. There are numerous photomicrographs of both histological and cytopathological features, which are of excellent quality, the discussions are detailed, and references are extensive. The very comprehensive nature of the text is perhaps a slight weakness, for even the numerous photomicrographs cannot fully illustrate the features of some of the lesions discussed, and although the limitations of cytopathological diagnoses are described, it is not always clear whether the diagnosis of some entities from the cytopathological specimen is practically feasible.

The book is splendidly written and beautifully illustrated. In the context of the recent changes in breast diagnosis and the increased complexity of breast lesions, an in-depth review of breast from the cytopathological and histological perspectives is timely. This book will be a useful reference text for those involved in diagnosing breast lesions by either cytology or histology, and may also be recommended to clinicians who take their own cytopathological breast specimens.

The Diagnosis of Lymphoproliferative Diseases: An atlas


The authors set out clearly in their preface how and why this atlas came into being. An atlas in pathology is usually a compendium or analecta of illustrations attended by short annotations. As a rule, atlases don’t make the “go for” book list when it comes to a diagnostic crunch. This book is more than an atlas. Condensed into a mere 262 (258 if one really wants to be pedantic) pages, crammed with excellent colour illustrations, this book is also full of facts, suggestions and guidelines. From the introduction (where one of the authors indulges himself with a military reference!), which contains very useful tables of antibodies used in haematopathology to the index at the back, I found the book extremely user friendly and written in an almost conversational style.

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R Chetty

CALENDAR OF EVENTS

Full details of events to be included should be sent to Maggie Butler, Technical Editor JCP, The Cedars, 36 Queen Street, Castle Hedingham, Essex CO9 3HA, UK; email: maggie.butter2@btopenworld.com

ACP Management Course for Pathologists, 2003

10–12 September 2003, Hardwick Hall Hotel, Sedgfield, County Durham, UK
Further details: Ms Valerie Wood, ACP Central Office, 189 Dyke Road, Hove, East Sussex, BN3 1TL, UK. (Tel: +44 01273 775700; Fax: +44 01273 773303; Email: valerie@pathologists.org.uk)

Dermatopathology Update

10–13 September 2003, Fairmont Copley Plaza Hotel, Boston, Massachusetts, USA
Further details: Tel: +1 617 384 8600; Email: hms-cme@hms.harvard.edu; website: wwww.cme.hms.harvard.edu

Predictive Oncology Meeting

15–16 September 2003, Solent Hotel, Fareham, Portsmouth, UK
Further details: Professor Ian A Cree, Translational Oncology Research Centre, Department of Histopathology, Michael Darmady Laboratory, Queen Alexandra Hospital, Cosham, Portsmouth PO6 3LY, UK. (Tel: +44 (0)23 92 286378; Fax: +44 (0) 23 92 286379; Email: ian.cree@porthosp.nhs.uk)

Medicare India

6–8 April 2004, Pragati Maidan, New Delhi, India
Further details: Rob Grant, Kinex Log, 5 New Quebec Street, London W1H 7BD, UK. (Tel: +44 (0) 207 723 8020; Fax: +44 (0) 207 723 8060; Email: rob.grant@kinexlog.com; Website: www.medicare-expo.com or www.kinexlog.com)