LETTER TO THE EDITOR

Author’s response

Our recent review1 on a cohort of fine needle aspiration of the breast reported an atypical rate of about 7%, and of these, about 2% had a histological follow-up. A further analysis was carried out on these cases with excision, yielding a benign rate of about 67%. Cases without histological excision were excluded from the calculation, as a significant number of cases were lost to follow-up, and while a proportion may not have been subjected to surgery because of radiological benignity, we cannot assume that these represent the majority. This figure was actually in concordance with that reported in the literature that ranges from 48% to 68%.7–9 Nevertheless, we concede that our reported benign rate of 67% taking into account only those with histological excision will represent a lower end of the range of benign outcomes of atypical aspirates.

The aim of our review was to evaluate cytological parameters predictive of excision outcome in a cohort of atypical aspirates. We did not set out to assess the accuracy of how an atypical diagnosis was made in cytology, and hence did not reclassify these atypical FNACs in this cohort. We agree that reclassification of specific criteria for diagnosis of atypia in breast aspirates will be a worthwhile exercise in further understanding and promoting precision in this category.

Phuong Viet The Tran,1 2 Philip C W Lui,1 Alex M C Yu,1 Pham The Vinh, 2 Helen H L Chau,3 Tony K F Ma,4 Puay-Hoon Tan,5 Gary M Tse1

1Department of Anatomical and Cellular Pathology, Prince of Wales Hospital, The Chinese University of Hong Kong, Hong Kong; 2Department of Breast Surgery, Ho Chi Minh City Oncology Hospital, Vietnam; 3Department of Diagnostic Radiology and Organ Imaging, Prince of Wales Hospital, The Chinese University of Hong Kong, Hong Kong; 4Department of Pathology, North District Hospital, Hong Kong; 5Department of Pathology, Singapore General Hospital, Singapore

Correspondence to Dr Gary Tse, Department of Anatomical and Cellular Pathology, Prince of Wales Hospital, Ngan Shing Street, Shatin, NT, Hong Kong; garytse@cuhk.edu.hk

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CORRESPONDENCE

Hyaline vascular Castleman disease relapsing as T cell rich B cell lymphoma with paraneoplastic pemphigus

A 32-year-old woman presented with mild fever and solitary discrete cervical lymph node (5 cm) for 2 years. The excision biopsy showed preserved lymph-node architecture with prominent onion skinning (figure 1) and hyalinised blood vessels in the germinal centres (figure 1, inset). The patient was investigated thoroughly for lymph nodes elsewhere but, no lymph nodes could be detected. The overall picture was suggestive of localised Castleman disease (LCD), hyaline vascular type. The HIV, HHV-8 and Epstein Barr Virus serology was negative.

The patient returned 5 years later with abdominal distension, weight loss, cervical and inguinal lymphadenopathy, hepatosplenomegaly and vescicobullous skin rashes for 3 months. CT and MRI revealed multiple lymph nodes. A further analysis was carried out on these cases with excision, yielding a benign rate of about 67%. Cases without histological excision were excluded from the calculation, as a significant number of cases were lost to follow-up, and while a proportion may not have been subjected to surgery because of radiological benignity, we cannot assume that these represent the majority. This figure was actually in concordance with that reported in the literature that ranges from 48% to 68%.7–9 Nevertheless, we concede that our reported benign rate of 67% taking into account only those with histological excision will represent a lower end of the range of benign outcomes of atypical aspirates.

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excision of affected lymph node may not be potential in the hyaline vascular type, simple obscure pathogenesis. With preneoplastic potential in the hyaline vascular type, simple owing to the preneoplastic potential in LCD.

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Atypia in fine needle aspirates of breast lesions

The paper by Tran et al on the histological correlates of atypia in fine needle aspirates (FNAs) of the breast was useful in suggesting which cytological features are likely to indicate malignancy. However, their conclusion that 67% of atypical FNAs are from benign lesions and 33% malignant tumours may be misleading.

In their review of 5340 cases, 363 (7%) of breast FNAs were diagnosed as atypical, but the authors include in their analysis only those 98 atypical aspirates that had a historical follow-up. The reason why the remaining 265 lesions were not biopsied was probably because, in most cases, they were clinically and radiologically benign; omitting these cases from analysis therefore constitutes a significant workup (verification) bias. The true proportion of atypical FNAs that were from benign lesions is therefore likely to be significantly higher than their figure of 67% suggests, and a review of these patient’s medical records would allow a fairly accurate estimate of the true figure. Including all 363 atypical FNAs in their analysis would also, by increasing the size of the cohort, address one of the criticisms of the study made by the authors themselves, thereby increasing the accuracy of the results by narrowing their CIs.

Furthermore, given that the assessment of cytological atypia is subjective, it is also rather surprising that none of the 98 aspirates originally reported as atypical was changed to either benign or malignant on review. This suggests that a further bias, namely review bias, may be present, as these FNAs were not subject to blinded review (by being mixed in with an unknown number of benign and malignant aspirates, for example). Knowing that all the FNAs reviewed had already been considered atypical might have unconsciously biased the reviewers in their interpretation of the cytological characteristics.

Paul Mansour, Martin W Shaw
Department of Cellular Pathology, Southport & Ormskirk Hospitals NHS Trust, Southport, UK
Correspondence to Dr Paul Mansour, Department of Cellular Pathology, Southport District General Hospital, Town Lane Kew, Southport PR8 6PN, UK; paul.mansour@nhs.net

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