ref	Code	Case	Diagnosis	Comment	Score
3006	109	AP260	Nodular sclerosis Hodgkin lymphoma (100%)	Immunostains for CD30, CD15 and PAX-5 to highlight the neoplastic cells.	100
2961	222	AP260	Nodular sclerosis Hodgkin lymphoma	nil	100
3013	246	AP260	Nodular sclerosis classical Hodgin's lymphoma	Need to perform CD3, CD20, CD15, CD30	100
3051	333	AP260	Classical Hodgkin lymphoma, nodular sclerosis subtype; 100%	Confrim by immunohistochemical studies for PAX5 (weak, focal), CD30(+), CD15(+), CD3(-), CD20(-).	100
3071	338	AP260	HODGKIN'S LYMPHOMA (NODULAR SCLEROSIS type)	CONFIRM BY POSITIVITY FOR CD15 AND CD30. CORRELATE WITH ANY NODAL DISEASE.	100
3035	369	AP260	Hodgkin lymphoma. 100%	nil	90
2944	448	AP260	Nodular sclerosis classical Hodgkin lymphoma 100%	nil	100
2980	515	AP260	Nodular sclerosis Hodgkin's lymphoma (100%)	nil	100
2970	517	AP260	nodular sclerosing Hodgkin's lymphoma	nil	100
3062	530	AP260	Hematolymphoid tumor, differential diagnosis: (1) Nodular sclerosing type, classical Hodgkin disease; (2) Langerhan cell histiocytosis.	IHC - CD1a, S-100, Langerin.	80
2953	663	AP260	Langerhans cell histiocytosis	nil	0
3020	763	AP260	Nodular sclerosis classical Hodgkin lymphoma	To be confirmed by immunohistochemistry	100
3080	794	AP260	Nodular sclerosing Hodgkin lymphoma (90%) Langerhans cell histiocytosis (10%)	Immunostaining for CD30, CD1a, S100 will help to establish the diagnosis.	100
2988	873	AP260	Malignant lymphoma, e.g. Hodgkin僮 lymphoma, perform CD30, CD3, CD20, and MPO for granulocytic sarcoma, S100 for Langerhan cell histiocytosis, and special stain to exclude infections (100% probability).	nil	60
3061	888	AP260	Epithelioid haemangioma (angiolymphoid hyperplasia with eosinophilia) 100%	nil	0
2997	911	AP260	Hodgkin lymphoma, nodular sclerosing.	nil	100
3007	109	AP261	Lipoprotein glomerulopathy (100%)	Frozen section for oil-red-O stain to highlight the intracapillary lipoprotein thrombi.	100
2962	222	AP261	Lipoprotein glomerulopathy	nil	100
3014	246	AP261	Lipoprotein glomerulopathy	PAS stain	100
3052	333	AP261	Lipoprotein glomerulopathy; 100%	nil	100
3072	338	AP261	LIPOPROTEIN GLOMERULOPATHY.	nil	100
3036	369	AP261	Lipoprotein glomerulopathy. 100%	Do electron microscopy.	100

2945	448	AP261	Lipoprotein glomerulopathy 100%	Clinical pictures, family history and histologic features fit the entity.	100
2981	515	AP261	Lipoprotein glomerulopathy (100%)	nil	100
2971	517	AP261	lipoprotein glomerulopathy	nil	100
3063	530	AP261	Lipoprotein glmoerulopathy	nil	100
2954	663	AP261	Lipoprotein glomerulopathy	nil	100
3021	763	AP261	Lipoprotein glomerulopathy	nil	100
3081	794	AP261	Lipoprotein glomerulopathy (100%)	nil	100
2989	873	AP261	Lipoprotein glomerulopathy (100% probability).	nil	100
3060	888	AP261	Lipoprotein glomerulopathy 100%	Correlate with the ultrastructural findings, lipoprotein profile of the patient and the renal pathology of the patient's younger brother.	100
2998	911	AP261	Lipoprotein glomerulopathy	nil	100
3010	109	AP262	Post-irradiation angiosarcoma (100%)	Confirm with immunostains for vascular markers including CD31, CD34, Factor VIII.	100
2963	222	AP262	Angiosarcoma	nil	100
3015	246	AP262	Radiation related angiosarcoma of small intestine	nil	100
3053	333	AP262	Angiosarcoma; 100%	Confrim by positive immunostainin for CD31 and CD34.	100
3073	338	AP262	ANGIOSARCOMA. Likely radiation induced.	nil	100
3037	369	AP262	Angiosarcoma, likely post-irradiation. 100%	nil	100
2946	448	AP262	Angiosarcoma, favor radiation associated 100%	nil	100
2982	515	AP262	Angiosarcoma, high grade (100%)	nil	100
2972	517	AP262	angiosarcoma	nil	100
3064	530	AP262	Post-radiation angiosarcoma.	nil	100
2955	663	AP262	Post-irradiation angiosarcoma	nil	100
3022	763	AP262	Angiosarcoma (high grade, radiation-induced)	nil	100
3082	794	AP262	Angiosarcoma, post-irradiation (100%)	nil	100
2990	873	AP262	Angiosarcoma 100%Probability).	nil	100
3044	888	AP262	Angiosarcoma 100%	nil	100
2999	911	AP262	Angiosarcoma	Probably irradiation induced	100
3011	109	AP263	Mucinous bronchiolo-alveolar carcinoma (100%)	The tumour is classified as Adenocarcinoma in situ, mucinous type, in the 2011 IASLC/ATS/ERS classification.	100
2964	222	AP263	Bronchioloalveolar carcinoma (Mucinous type)	nil	100

3016	246	AP263	Adenocarcinoma with bronchiolo-alveolar pattern	nil	95
3054	333	AP263	Mucinous bronchioloalveolar carcinoma (adenocarcinoma in situ); 100%	nil	100
3074	338	AP263	BRONCHIOLOALVEOLAR CARCINOMA, mucinous type.	nil	100
3038	369	AP263	Bronchioloalveolar carcinoma. 100%	nil	100
2947	448	AP263	Bronchiolo-alveolar carcinoma 100%	nil	95
2983	515	AP263	Bronchioloalveolar carcinoma, mucinous type (100%)	nil	100
2973	517	AP263	bronchioloalveolar carcinoma, mucinous type	nil	100
3065	530	AP263	Bronchioloalveolar carcinoma, mucinous type.	nil	100
2956	663	AP263	Bronchioloalveolar carcinoma, mucinous type	nil	100
3023	763	AP263	Mucinous adenocarcinoma in situ	1. Classification according to the latest IASLC/ATS/ERS Classification (Feb 2011) 2. Need to extensively sample the tumor to rule out invasive or minimally invasive component	100
3083	794	AP263	Mucinous adenocarcinoma with bronchiolo-alveolar carcinoma pattern (100%)	Adequate sampling is necessary to exclude other patterns.	95
2991	873	AP263	Bronchioloalveolar carcinoma, mucinous type (100 %Probability).	nil	100
3045	888	AP263	Bronchioloalveolar carcinoma of the mucinous type 100%	nil	100
3000	911	AP263	Bronchioloalveolar carcinoma, mucinous type	nil	100
3012	109	AP264	Well differentiated endocrine neoplasm (100%)	Confirm with immunostains for neuroendocrine markers, synaptophysin, chromogranin.	100
2965	222	AP264	Carcinoid	nil	100
3017	246	AP264	Neuroendocrine tumour of the stomach	Immunostaining with chromogranin and synaptophysin	70
3055	333	AP264	Carcinoid (neuroendocrine tumor) grade 1	Confirm by positive staining for neuroendocrine markers (e.g. synaptophysin, chromogranin)	100
3075	338	AP264	CARCINOID	SIZE 6 MM. INVOLVING SUBMUCOSA.	100
3043	369	AP264	Carcinoid tumor.(Well differentiated endocrine tumor) 100%	Do synaptophysin and chromogranin stains.	100
2948	448	AP264	Gastric carcinoid 100%	nil	100
2984	515	AP264	Carcinoid tumour (100%)	Extensive sampling for assessment of any coagulative tumour necrosis, vascular invasion and mitotic count	100
2974	517	AP264	carcinoid tumour	nil	100
3066	530	AP264	Well differentiated neuroendocrine tumor.	nil	100

2957	663	AP264	Well-differentiated neuroendocrine tumor (benign behavior) (WHO classification)	nil	100
3024	763	AP264	Well-differentiated neuroendocrine tumor (carcinoid tumor)	nil	100
3084	794	AP264	Neuroendocrine tumour, well differentiated (grade 1, WHO) (carcinoid tumour)	Immunostaining for synaptophysin and chromogranin to confirm neuroendocrine differentiation.	100
2992	873	AP264	Carcinoid tumour, type III (100% Probability).	nil	100
3046	888	AP264	Carcinoid tumor (well differentiated neuroendocrine tumor) 100%	nil	100
3001	911	AP264	Neuroendocrine tumour.	Confirmed with neuroendicrine markers (chromogrnin; synaptophysin).	70
3031	109	AP265	Opportunistic infection, differential diagnoses include toxoplasmosis, histoplasmosis and leishmaniasis. (100%)	Grocott and Giemsa stains for further assessment, correlate with culture result.	100
2966	222	AP265	Pneumocystic carinii	nil	80
3018	246	AP265	Necrotising inflamation and acute lung injury	Special stains with Grocott, PAS, mucicarmine, Warthin-Starry and Dieterle to exclude different fungal organisms, Legionella pneumonia, Rhodococcus Equi, cryptococcus and Pneumocystis jiroveci. Immunostains with CMV and herpes.	80
3056	333	AP265	Necrosis, favor toxoplasmosis (70%); Ddx Histoplasma (10%), Mycobacteria (10%), Fungus (10%).	Immunohistochemical studies for toxoplasma. Special stains for mycobacteria (acid-fast), fungus (grocott).	100
3076	338	AP265	NECROTIZING LESIONS SUGGESTIVE OF TOXOPLASMOSIS.	CONFIRM BY IMMUNOSTAIN. ALSO IMMUNOSTAINS AND GROCOTT STAIN TO EXCLUDE OTHER OPPURTUNISTIC INFECTION EG. ADENOVIRUS, CMV, ASPERGILLOSIS, PCP etc.	100
3039	369	AP265	Necrotic nodules, favor infective causes, e.g. pneumocystitis, toxoplasma, etc. 100%	Do infective stains, e.g. Grocott, Ziehl Neelsen, Gram, mucicarmine stains; also pneumocystis immunostain.	100
2949	448	AP265	Necrotizing pneumonia 100%	Pending special stains for identification of causative organisms: Toxoplasma (70%), Pneumocystis (20%), cryptococcus (9%), adenovirus (1%)	100
3009	515	AP265	Infective microorganism present, suggestive of toxoplasmosis	To perform Ziehl Neelsen, Gram and Warthin Starry to rule out other infectious causes	100
2976	517	AP265	necrotizing pneumonia, rule out infective agents: toxoplasmosis, cytomegalovirus	nil	100
3067	530	AP265	Presence of multifocal miliary small nodular area with sign of necrosis of alveolar wall surrounded by reactive pneumocytes, suggestive of viral infection in immunosuppressive patient. Also seen in superimposed with other infection.	nil	80

3008	663	AP265	Necrotizing inflammation	Infection especially opportunistic ones such as fungal infection due to Pneumocystis carinii and viral infection need to be excluded. Ancillary studies including special stains (Grocott, PAS and Ziehl Neelsen stains) and immunohistochemical studies for viral inclusion (such as CMV) are suggested. Correlation with microbiological and viral culture is also mandatory.	80
3026	763	AP265	Multiple pulmonary necrosis and infarct	Consistent with infection; need to consider toxoplasmosis	100
3085	794	AP265	Necrotising pneumonia and diffuse alveolar damage, to exclude infective organisms such as toxoplasmosis (100%).	Immunostaining for toxoplasma, and special stains to rule out acid fast bacilli, fungi and pneumocystis will be useful.	100
2993	873	AP265	265 necrotizing pneumonia, perform ZN, PASD, grocott to exclude TB, Nocardia, PCP and fungal infection (100% Probability)	nil	80
3047	888	AP265	Pneumocystis carinii pnenmonia 100%	Perform special stains to confirm the diagnosis, and to rule out other bacterial and fungal infections.	80
3002	911	AP265	Necrotizing pneumonia	Need to perform panel of infective stains (e.g. gram; fungal, ZN), especially look for nocardia, legionella infection.	80
3032	109	AP266	Endometrium with decidual change and Arias-Stella reaction (100%).	To exclude ectopic pregnancy.	100
2967	222	AP266	Abortion (Epithelial inclusion seen, favor Biotin inclusion(not herpes simplex), suggestive of gestational endometrium)	nil	100
3019	246	AP266	Haemorrhagic and necrotising decidua. No evidence of chorionic villi or placental site reaction.	1. Embed all the tissue. 2. Look for pregnancy outside the uterus. 3. Exclude endogenous and exogenous hormonal intake.	100
3057	333	AP266	Decidua and Arias-Stella reaction (100%)	nil	100
3077	338	AP266	ARIAS-STELLA REACTION	The possibility of vascular lesions of the decidua should be excluded by clinical correlation and more sampling.	100
3040	369	AP266	Decidua. 100%	Embed all the whole specimen.	100
2950	448	AP266	Decidua, focal Arias-Stella reaction. No chorionic villi 100%	nil	100
2985	515	AP266	Decidua and Arias Stella reaction	nil	100
2979	517	AP266	Decidua, Arias-Stella Reaction	nil	100
3068	530	AP266	Decidualized endometrium with focal Arias-Stella phenomenon, with hemorrhage, exudation and presence of few cells suggestive of intermediate trophoblastic cells suggestive of intrauterine pregnancy.	Need to do, betaHCG, hPL, cytokeratin for confirmation.	100
2958	663	AP266	Decidua	Please correlate with clinical history and pregnancy test result.	100

3027	763	AP266	Decidua, no products of gestation	May need to embed all tissue to look for products of gestation	100
3086	794	AP266	Decidua and gestational type endometrium, no products of gestation or placental site reaction detected (100%).	Correlate with clinical findings to exclude the possibility of extrauterine pregnancy.	100
2994	873	AP266	Decidua and Arias-Stella reaction, take more blocks to look for chorionic villi and need to exclude ectopic pregnancy (100%Probability).	nil	100
3048	888	AP266	Decidual tissue 100%	Correlate with clinical history to rule out ectopic pregnancy, or hormonal effect.	100
3003	911	AP266	Decidua with Arias-Stella reaction. No definite POG	Consider additional sampling for presence of POG	100
3033	109	AP267	Atypical teratoid/rhabdoid tumour (100%)	Immunohistochemically, tumour cells are positive for EMA, vimentin, SMA, sometimes express GFAP and neurofilament. Cytogenetic analysis will show monosomy or deletion of chromosome 22.	100
2968	222	AP267	AT/RT(Atypical teratoid/rhabdoid tumor)	nil	100
3025	246	AP267	Anaplastic ependymoma	Differential diagnosis: embryonal tumour including atypical teratoid rhabdoid tumour, supratentorial PNET and ependymoblastoma. Immunostains with GFAP, EMA and INI-1.	80
3058	333	AP267	Atypical Teratoid/rhabdoid tumor	Immunostaining for INI1 (loss of staining) Genomic study for INI1 gene delection	100
3078	338	AP267	EPENDYMOMA. 100%	CONFIRM BY GFAP positivity. The less likely differential is atypical teratoid/rhabdoid tumor which will show loss of nuclear staining for INI-1.	80
3041	369	AP267	Atypical teratoid/rhabdoid tumor. 100%	Do INI1 which will show loss of nuclear staining.	100
2951	448	AP267	DDx: Primitive neuroectodermal tumour (40%), Atypical teratoid rhabdoid tumour (40%), Malignant Ependymoma (20%)	Require ancillary studies (immunostaining, cytogenetics, molecular studies) for definitive tumour typing	80
2987	515	AP267	Malignant high grade tumour, favour anaplastic ependymoma (80%) with differential diagnosis include primitive neuroectodermal tumour (PNET) (20%)	nil	50
2977	517	AP267	atypical teratoid/rhabdoid tumour	nil	100
3069	530	AP267	Primary malignant tumor, differential diagnosis: (1) Anaplastic ependymoma; (2) Atypical teratoid/ rhabdoid tumor.	Immunohistochemistry: SMA, EMA, GFAP.	80
2959	663	AP267	Ependymoma	nil	50
3028	763	AP267	Anaplastic ependymoma (WHO grade 3)	nil	50
3088	794	AP267	Anaplastic ependymoma (90%), atypical teratoid/rhabdoid tumour (10%).	Immunostaining for GFAP, EMA will be helpful for tumour typing, and Ki67 to establish the proliferative index.	80

2995	873	AP267	Anaplastic ependymoma, DDX: Atyical teratoid/ Rhabdoid tumour, take more blocks for other component (100% Probability).	nil	80
3049	888	AP267	Malignant tumor (100%), differential diagnoses include atypical teratoid/rhabdoid tumor (50%) and primitive neuroectodermal tumor (50%).	Perform immunostains including vimentin, EMA, smooth muscle actin, GFAP, CD99, synaptophysin and INI1. There is loss of INI1 expression in atypical teratoid/rhabdoid tumor.	90
3004	911	AP267	Anaplastic ependymoma	nil	50
3034	109	AP268	Carcinoma arising from inverted papilloma (100%)	nil	100
2969	222	AP268	Papilloma with inverted pattern of growth and focal malignant change	nil	100
3030	246	AP268	Invasive tumour with lymphovascular permeation, in the background of inverted papilloma	nil	100
3059	333	AP268	Carcinoma arising from inverted papilloma; 100%	nil	100
3079	338	AP268	ADENOSQUAMOUS CARCINOMA ARISING FROM INVERTED PAPILLOMA.	nil	100
3042	369	AP268	Inverted papilloma with focal suggestion of early invasion. 100%	Cut deeper section and embed all the specimen.	95
2952	448	AP268	Nose - Squamous cell carcinoma arising in Schneiderian papilloma	nil	100
2986	515	AP268	Squamous cell carcinoma in a background of inverted papilloma (100%)	nil	100
2978	517	AP268	Squamous Cell Carcinoma in Schneiderian papilloma	nil	100
3070	530	AP268	Schneiderian papilloma, assoicated with Papillary carcinoma in situ.	nil	90
2960	663	AP268	Sinonasal (inverted) papilloma with foci of low grade dysplasia	The presence of oncocytic component could signify a more aggressive behavior with higher risk of local recurrence. With the presence of dysplasia, additional blocks, if any tissue left, should be sampled to safely exclude any carcinoma component.	80
3029	763	AP268	Sinonasal papilloma with dysplasia and squamous cell carcinoma	nil	100
3087	794	AP268	Squamous cell carcinoma (invasive and in-situ), arising in inverted papilloma (100%).	nil	100
2996	873	AP268	Squamous cell carcinoma arising from Schneiderian papilloma with dysplasia (100% Probability).	nil	100
3050	888	AP268	Squamous cell carcinoma arising from sinonasal papilloma 100%	Nil	100
3005	911	AP268	Sinonasal papilloma, with focal severe dysplasia	nil	90