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FP8
Clinicopathological characteristics of cutaneous melanoma in the European country with the highest incidence: a population based study, 1996–2011

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Background. Aim of the present study is to assess the incidence trend of cutaneous melanoma in Southern Switzerland, a region with the highest incidence rate and a pure opportunistic screening strategy reaching 35% of the population at risk.

Methods. All invasive and in-situ incident cases occurred in 1996–2011 were retrieved from the Ticino Cancer Registry. European age-standardized incidence rates were computed by period of diagnosis, Breslow thickness and histological types. Trends were measured as the annual percentage change (APC) and the corresponding confidence interval (95% CI).

Results. A total of 1464 patients had a diagnosis of cutaneous melanoma, 1230 invasive and 234 in-situ. Invasive cases were categorized as: superficial-spread-melanoma (55.7%), nodular-melanoma (10.0%), lentigo-maligna-melanoma (5.4%), melanoma-not-otherwise-specified (35.2%) and other-types (5.6%). Incidence rate of invasive melanoma rose from 17.4 per 100,000 inhabitants in 1996–2003 to 20.6 in 2004–2011, with an overall APC of +2.1% (95% CI: -0.8% to +5.1%; p=0.35). The increasing incidence trend was observed for superficial-spread-melanoma (APC=+2.9%; 95% CI: -1.1% to +7.0%; p=0.14) and thin melanomas (i.e. ≤1.00 mm; APC=+3.4%; 95% CI: +0.2% to +6.7%; p=0.04), whereas we detected a descriptive growing incidence for thick melanomas (APC=+2.1%; 95% CI: -1.4% to +5.8%; p=0.22).

Conclusions. The present study highlights first an increase of incidence trend of superficial-spread melanoma and thin melanoma, as possible consequence of secondary prevention measures; second a lack of decrease of nodular-melanoma and thick melanoma, phenomenon that could explain the lack of expected mortality reduction. These results suggest that in Southern Switzerland there is room for additional public health efforts; particularly, primary and secondary prevention campaigns targeted at specific populations could additionally reduce melanoma mortality.

FP9
Tumor budding in pancreatic cancer: are we missing important prognostic information?

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Background. Tumor budding is defined as single tumor cells or small cell clusters at the invasive front of gastrointestinal (including colorectal, gastric and ampullary) carcinomas and is linked to adverse prognosis. To date it has not been reported in pancreatic ductal adenocarcinomas (PDACs).

Methods. Whole-tissue sections of 120 PDACs with full clinicopathological and follow-up information were stained with pancytokeratin. Tumor budding was assessed in 10 high-power fields (HPFs) by two pathologists and considered high-grade (HG) when an average of ≥10 buds was counted. Measurements were correlated to the patient and tumor characteristics.

Results. Inter-observer agreement was strong (ICC=0.72). HG-budding was found in 70.3% of cases and was linked to advanced pT-stage (p=0.0469), lymphatic invasion (p=0.0192) and decreased disease-free and overall survival (p<0.0001 and p=0.0005). There was no association with pN, pM, R-stage or vascular invasion. In multivariate analysis the prognostic effect of HG-budding was independent of lymphatic invasion, pN and R-stage [p<0.0001, HR 95% CI 3.65 (2.1–6.4)].

Conclusions. Tumor budding occurs frequently in pancreatic cancer, is an indicator of worse outcome and adds independent prognostic information. Routine use of tumor budding would help to better stratify patients into prognostic subgroups.

FP10
Renal replacement lipomatosis mimicking tumor after renal transplantation

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Background. Renal tumors may occur after kidney transplantation. We present two patients who underwent nephrectomy due to suspicion of malignant renal tumors in native kidneys and in a transplant.

Methods. The nephrectomies were examined grossly, on conventional microscopy, by immunohistochemistry and fluorescence in-situ hybridization. The findings were correlated with clinical data, CT and MRI-findings.

Results. Case 1 was a 63-year-old man who was transplanted 28 and 16 years ago. A CT scan showed a growing mass in both native kidneys. The preoperative differential diagnosis included angiomylipomatous changes and uncertain malignant tumor. Grossly the kidneys were shrunken and perirenal fat was massively hypertrophic. Histology revealed renal replacement lipomatosis with end-stage kidneys and massively increased perirenal fatty tissue with focal inflammation. Case 2 was a 63-year-old man transplanted 28 and 35 years before nephrectomy of the first transplant due to changes interpreted as solid and cystic masses, suspicious for neoplasia, possibly cystic renal cell carcinoma. Grossly the kidney was shrunken and surrounded by myxoid tissue. Histology showed renal replacement lipomatosis with end-stage kidney and increased perirenal fatty tissue with extensive myxoid areas and fibrosis.

Conclusions. Renal replacement lipomatosis or replacement kidney lipomatosis after transplantation may clinically mimic benign and malignant tumors, such as angiomylipoma, renal cell carcinoma or sarcoma. It has been associated with kidney stones and recurring infection of the kidney, reported also in the non-transplant setting. Awareness of the entity allows a correct diagnosis, possibly avoiding nephrectomies and the associated risks of complications.