The Author’s Reply

We appreciate Dr Mubarak’s comments and are glad to note that his experience mirrors our findings. We concur that the spectrum of coauthors could differ between geographic regions, but how different or how significant these are is yet to be determined. We, however, believe that many of the secondary findings in our population are relevant in most populations, as Dr Mubarak also seems to indicate from his experience. To clarify the 2 questions raised, cholangiocarcinoma was included because it was an unknown finding only unearthed by biopsy. What was clinically suspected was hepatocellular carcinoma, given the patient’s underlying cirrhosis. Therefore, inclusion of this case is consistent with our Materials and Methods criteria.

The 7 cases of primary hemosiderosis were included because although they were known elsewhere in the patients’ records before liver biopsy, this information was not apparent from the stated indications for the biopsies, which were strictly for viral hepatitis workup. However, in the course of reporting the biopsy findings, the reporting pathologists investigated what was known about these patients and found independently that the patients had been worked up elsewhere or by other groups of physicians and confirmed to have the relevant HFE mutations, and/or they found prior biopsy specimens predating our study period for which this information was stated. These cases, therefore, were deemed consistent with our selection method and included in our study; also, they highlight our emphasis of the importance of the pathologist’s active efforts to ensure adequate clinicopathologic input in issuing a final report, even in cases in which the stated indication for liver biopsy was limited to viral hepatitis.

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Reference

Solid Cell Nests, Papillary Thyroid Microcarcinoma, and HBME1

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To the Editor

We read with great interest the article by Nasr et al1 in which the authors concluded that caution must be exercised in the interpretation of HBME1 immunohistochemical stains in chronic lymphocytic thyroiditis. We agree entirely that there are several potential morphologic and immunophenotypic pitfalls in the interpretation of small atypical foci in the setting of thyroiditis. In fact, based on the photomicrographs in Image 1A in the article,1 we would raise the possibility that at least a subset of the described “tiny foci of atypical epithelium with inconclusive nuclear features” is actually ultimobranchial body/solid cell nests (SCNs). The ability of ultimobranchial body/SCNs to mimic papillary thyroid microcarcinoma is well recognized, especially in thyroid glands with chronic lymphocytic thyroiditis.2,3

SCNs composed of epidermoid-like cells (type 2 SCNs; reviewed by Asioli et al3) are more readily distinguished from papillary thyroid microcarcinoma. It may be more difficult to differentiate type 1 SCNs from papillary thyroid microcarcinoma.3 The cells of type 1 SCNs have oval nuclei with cleared chromatin and occasional nuclear grooves (Image 1A) and (Image 1B). Type 1 SCNs are frequently surrounded by eosinophilic basement membrane. When the H&E appearance of SCNs is inconclusive, immunohistochemical markers may be of help. As previously reported, SCNs are strongly positive for p63.4

A less recognized feature of type 1 SCNs is positive staining by HBME1 (see Image 1C, with an inset showing a “floret-like” nest). Of note, an adjacent area of epidermoid-like SCNs (type 2) is negative for HBME1 and strongly positive for p63 (Image 1D).

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References


Image 1 A, Type 1 and 2 solid cell nests (H&E, ×200). B, Type 1 solid cell nest (H&E, ×400). C, Type 1 solid cell nest highlighted by HBME1 immunohistochemistry (×200). D, Solid cell nests are positive by p63 immunohistochemistry (×200).