

# National Liver Histopathology EQA Scheme

Circulation F1  
Spring/Summer 2012

Histories and photomicrographs

# EQA Business meeting – Brief!

- Circulations F1 and G1 discussed today
- Each has 81 responses (around 99 members)
- 38 members in audience today
- New since last year:
  - Virtual slides of connective tissue stains
  - ‘masterclass’ discussion of selected cases (2 per round)
  - Educational participation – MCQ format self-assessment
- Collated responses and suggested scoring sent to members
  - invited to comment:
    - 4 comments on F1
    - 1 comment on G1
- Steering committee met this morning
- Questionnaire to members next year

Suggested scoring shown in red box

Meeting discussion shown in blue box

## **Case F1/386**

**39 M**

Known hep B positive Chinese male.

HBs and e antigen positive. HBV DNA 9.7

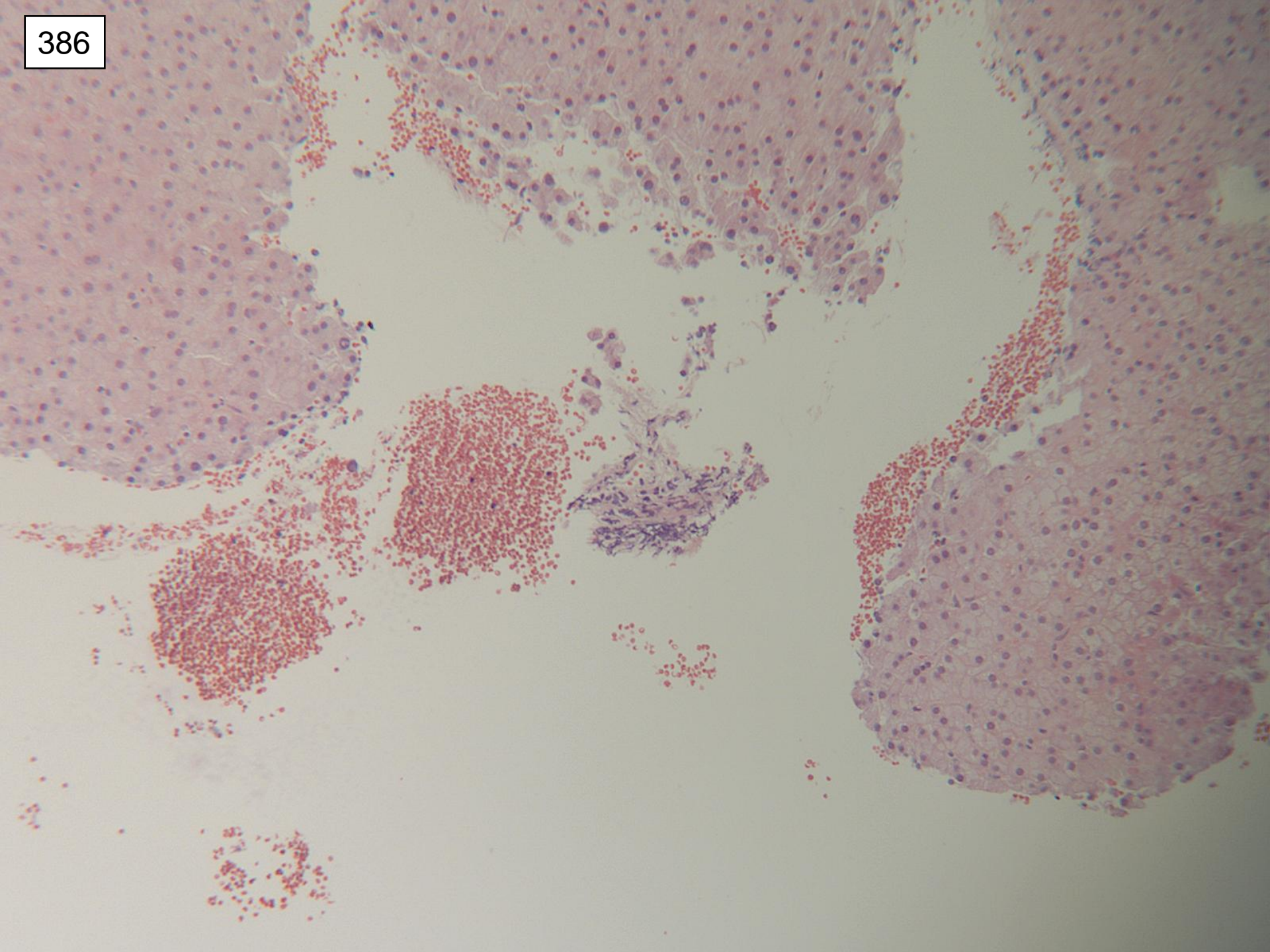
Not obese. AFP 3.

To assess inflammation and fibrosis

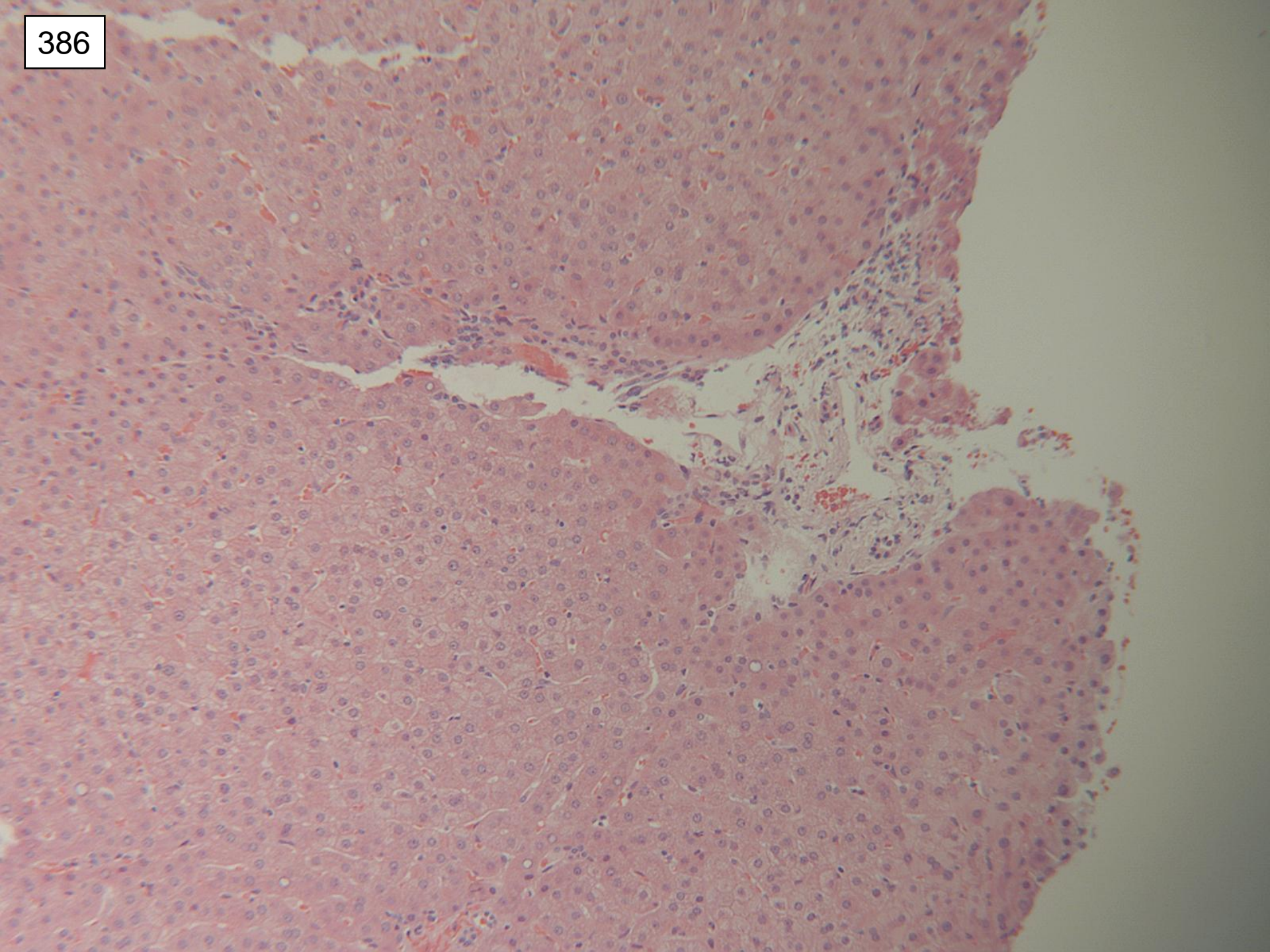
4 brown cores up to 7mm long (please also see  
connective tissue stain on website)



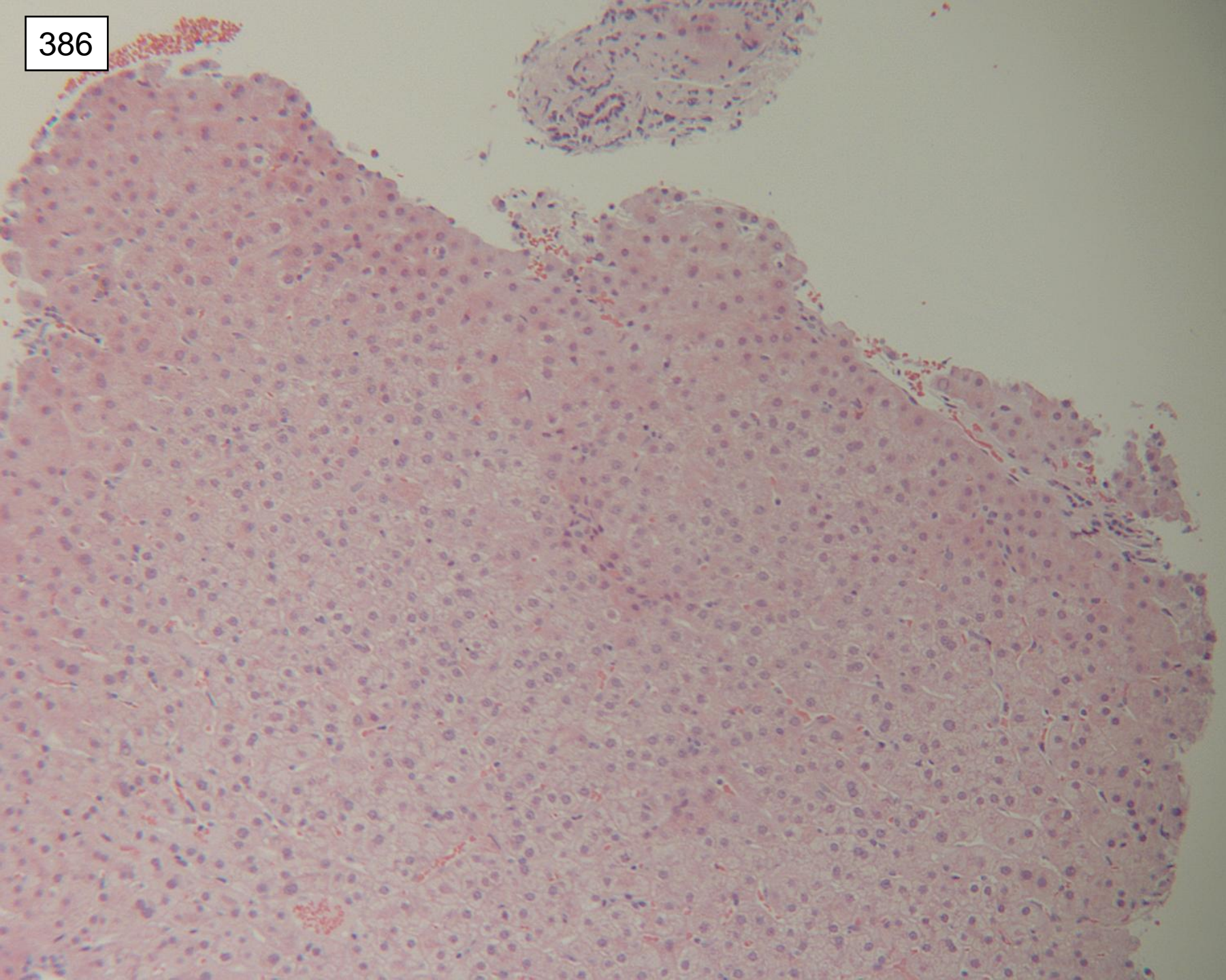
386

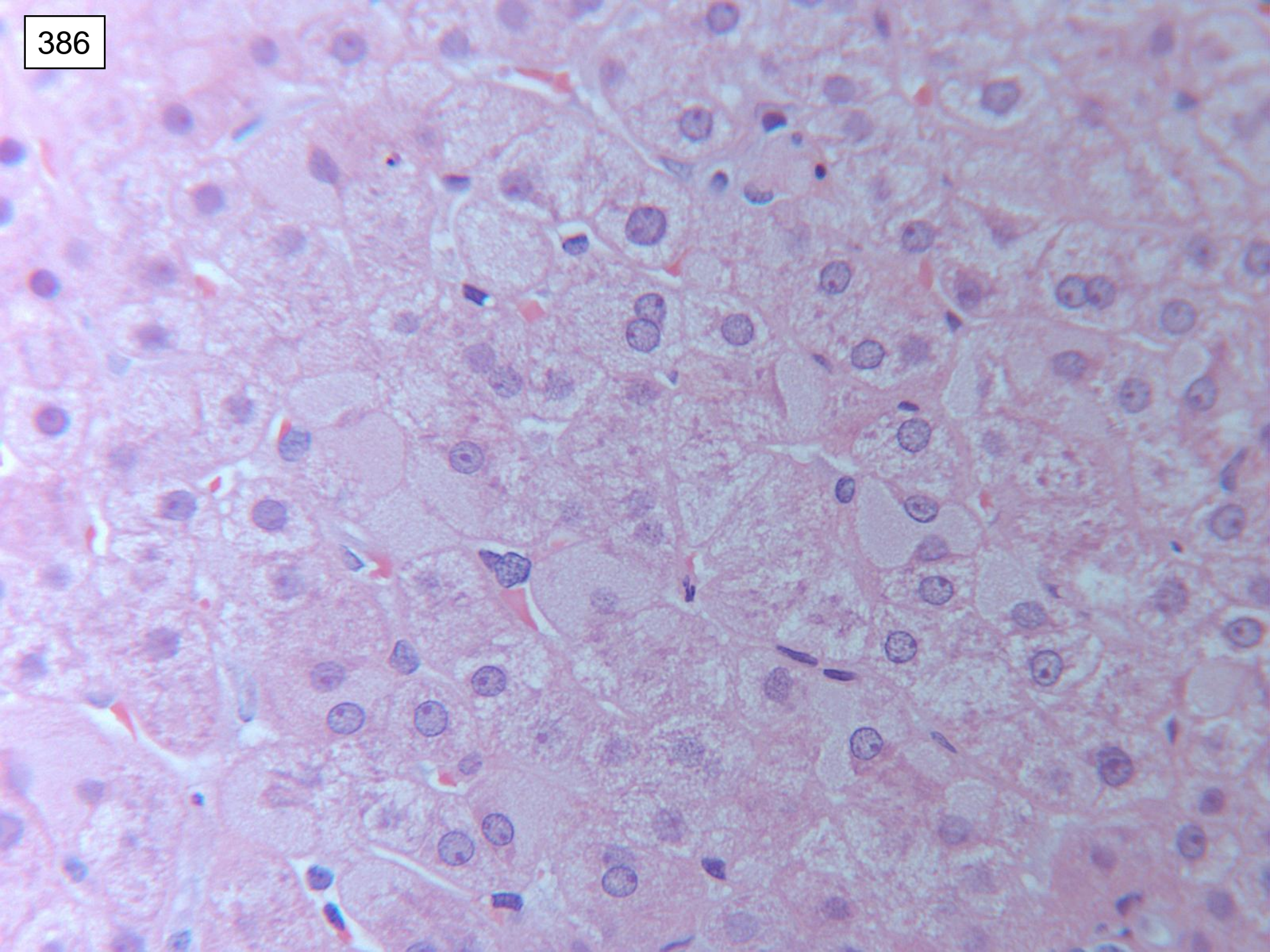


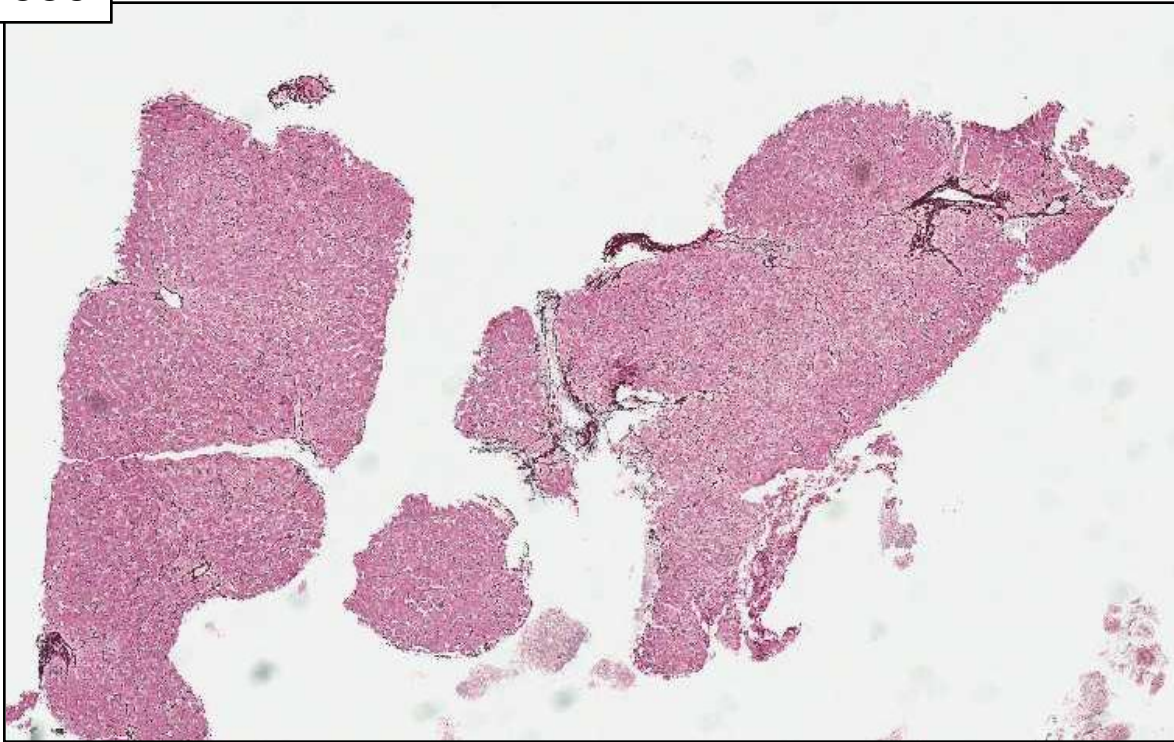
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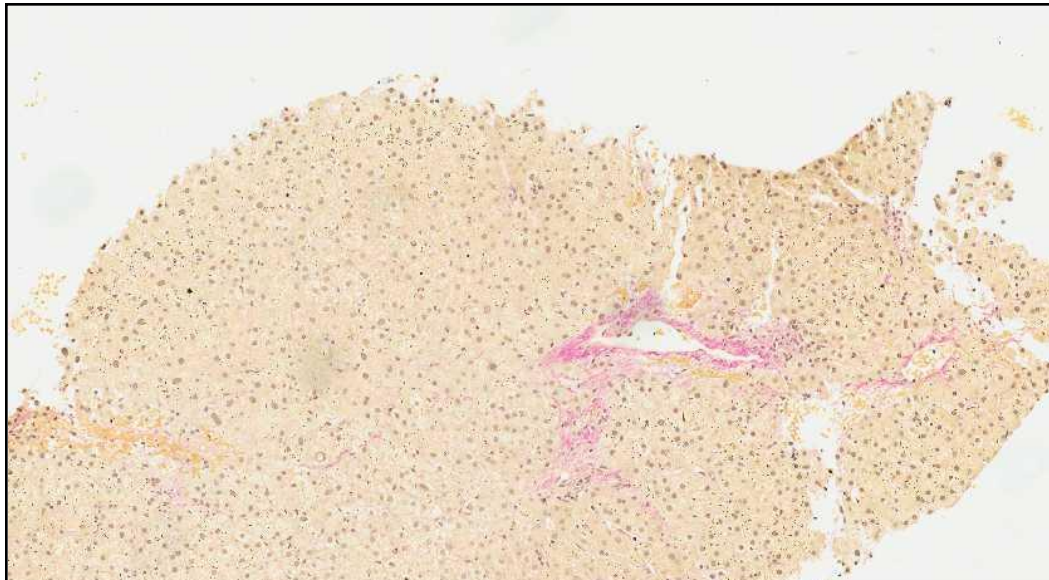
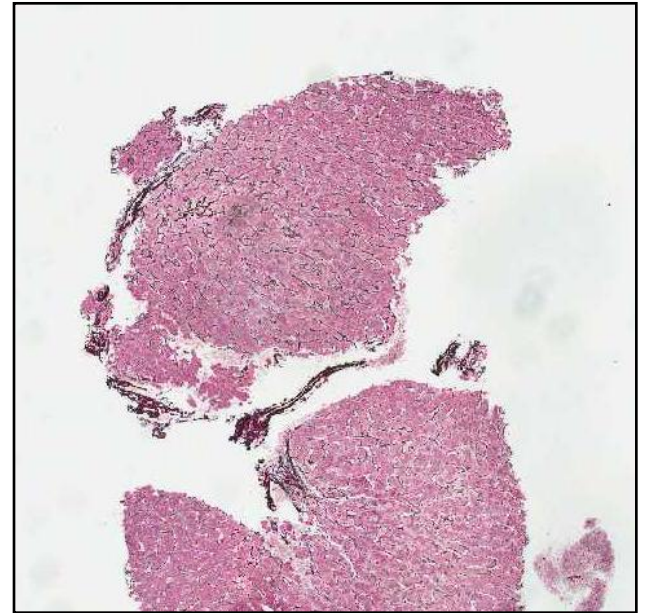
386







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VG

## Case 386; Aetiology:

Ground glass hepatocytes: 46. **Hepatitis B: 66**

No mention of either ground glass or hepatitis B: 10

**Hepatitis C: 2**

### Fibrosis stage:

Ishak stage: 43 responses - see histogram

### Stage as text:

no fibrosis: 5

No significant fibrosis: 6

Mild/early stage: 13

Bridging fibrosis: 2

Mod-severe fibrosis: 1

Possible/incomplete cirrhosis: 3

Cirrhosis: 3

Difficult/inadequate: 18

### Disease activity:

Ishak grade: 36 responses, see histogram

### Activity as text:

None/Inactive: 6

Minimal/very mild: 20

Mild/low 6

### Other scores:

Metavir: A0F2;

Scheuer Grade 2 Stage 2:

### Free text comments:

Possible higher stage: 6

'no hepatitis or fibrosis'

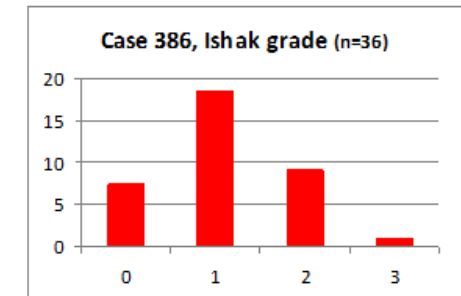
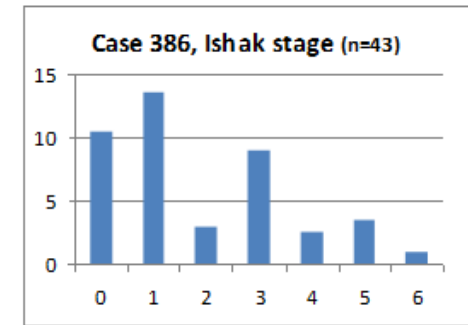
'there is no fibrosis and I cannot see cirrhosis or neoplasia. Carrier'

Immune tolerance phase: 3

Carrier/carriage: 2

'Highly replicative'

Needs immuno :1



JIW Comment: very fragmented biopsy – not suitable for staging disease

–responses giving advanced stage often base this on fragmentation of core.

### Suggested approach to scoring:

score 10 for any response including hepatitis B

score 5 if states ground glass hepatocytes, but does not include hepatitis B in response

score 0 if no mention of hepatitis B or ground glass hepatocytes, or gives hepatitis C as the cause.

Stage/grade not considered when scoring.

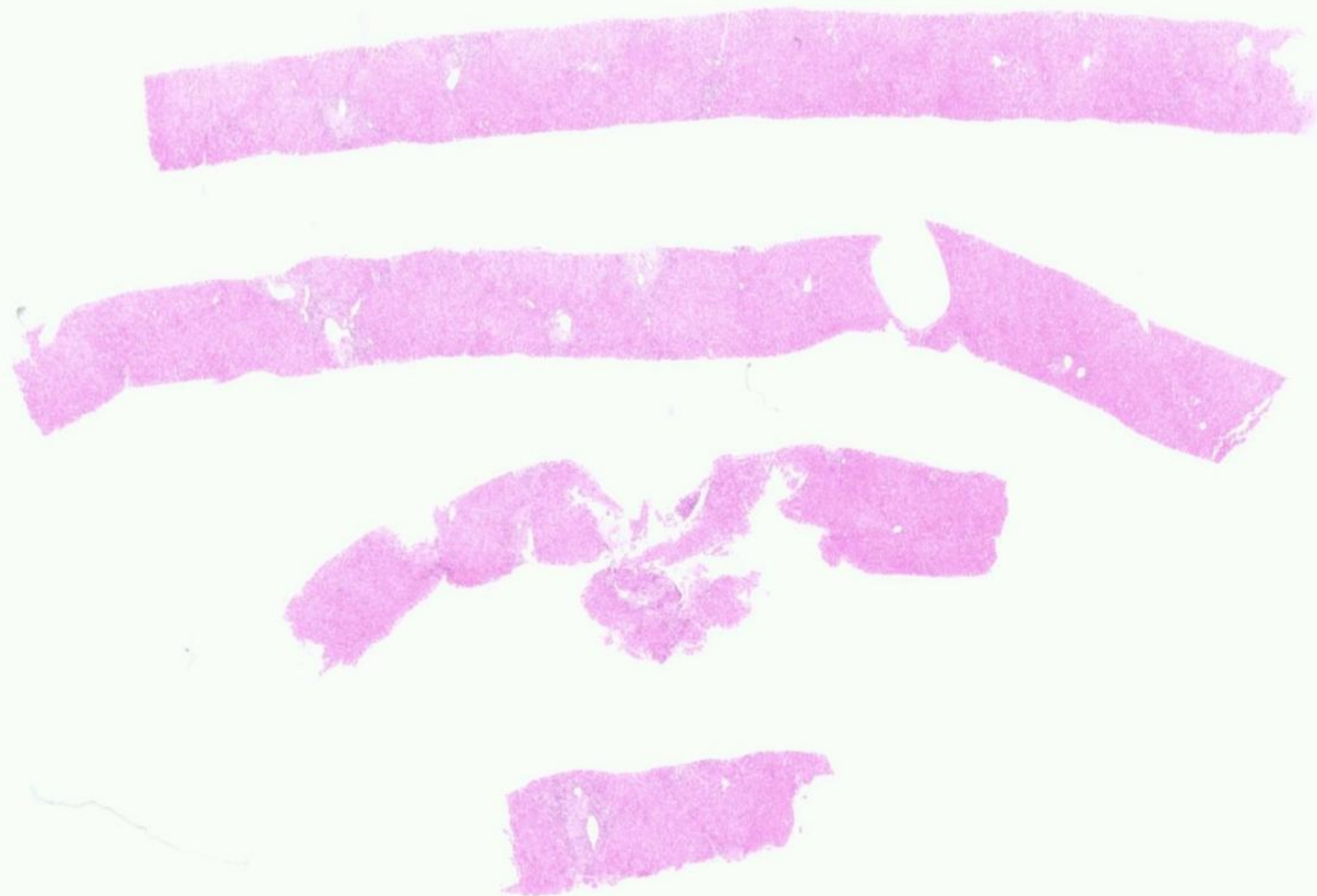
Suggestions agreed

**Case F1/387**

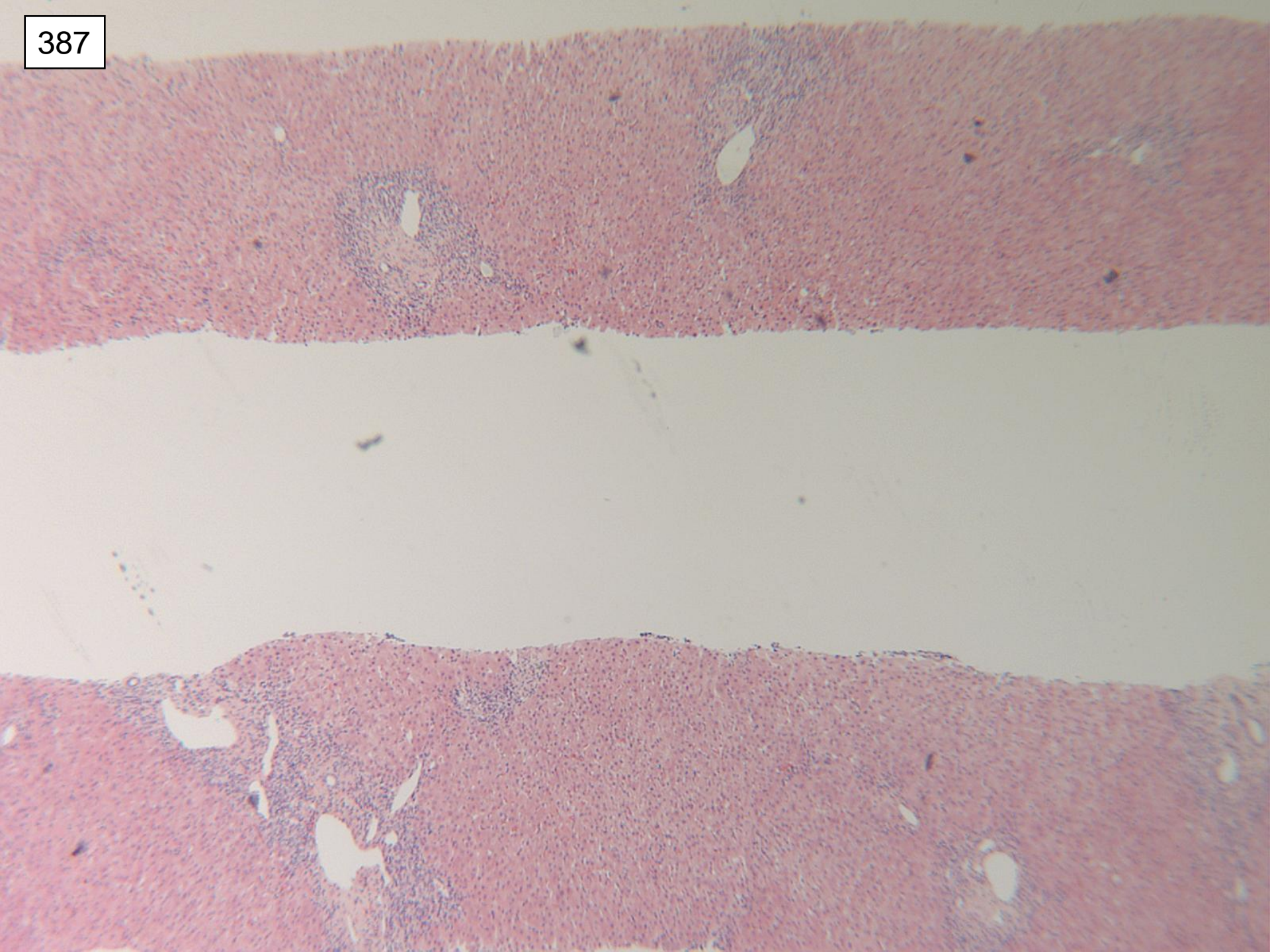
**78 F**

ALT – recent course of flucloxacillin and on  
aspirin. ANF +ve

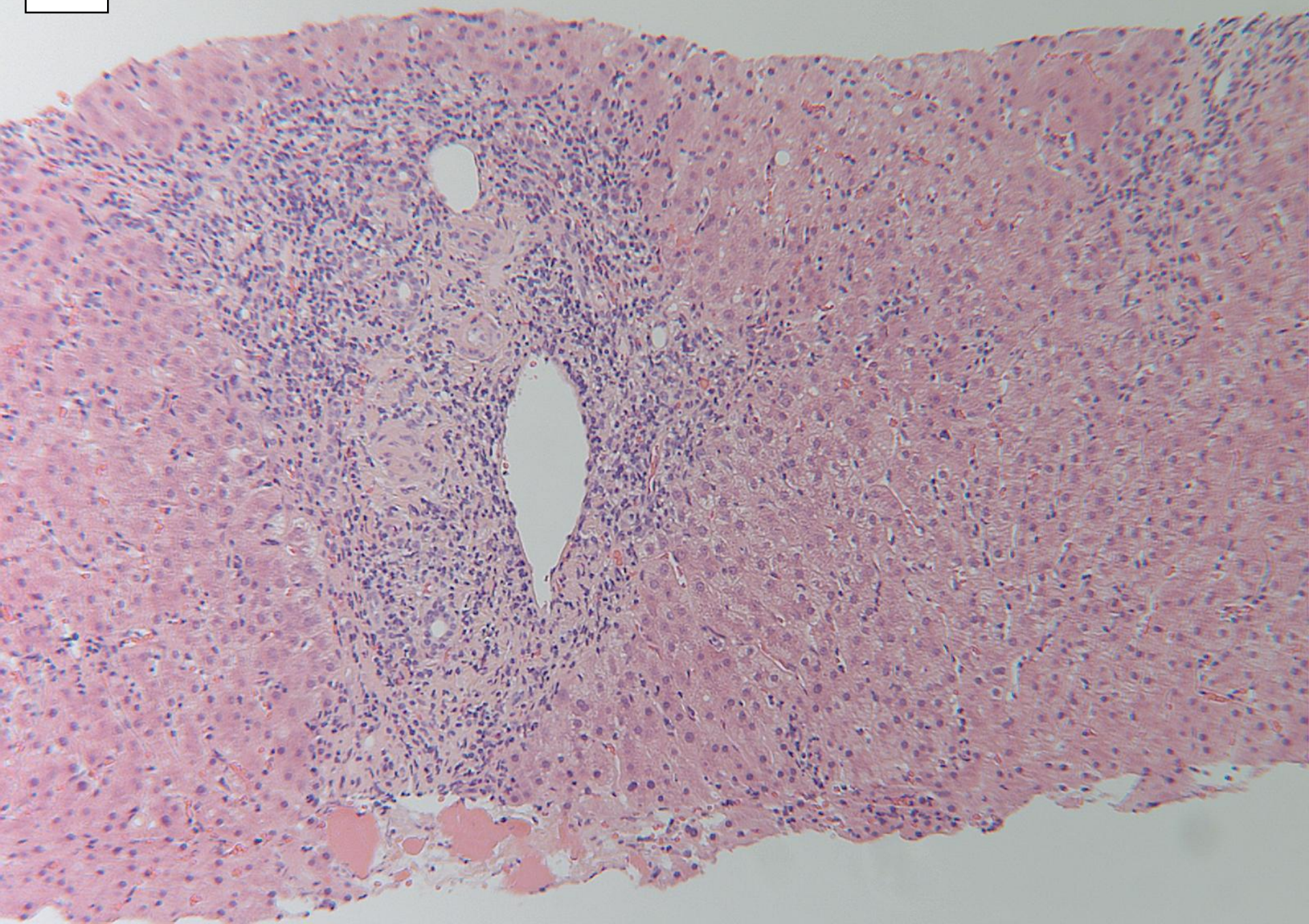
Percutaneous biopsy



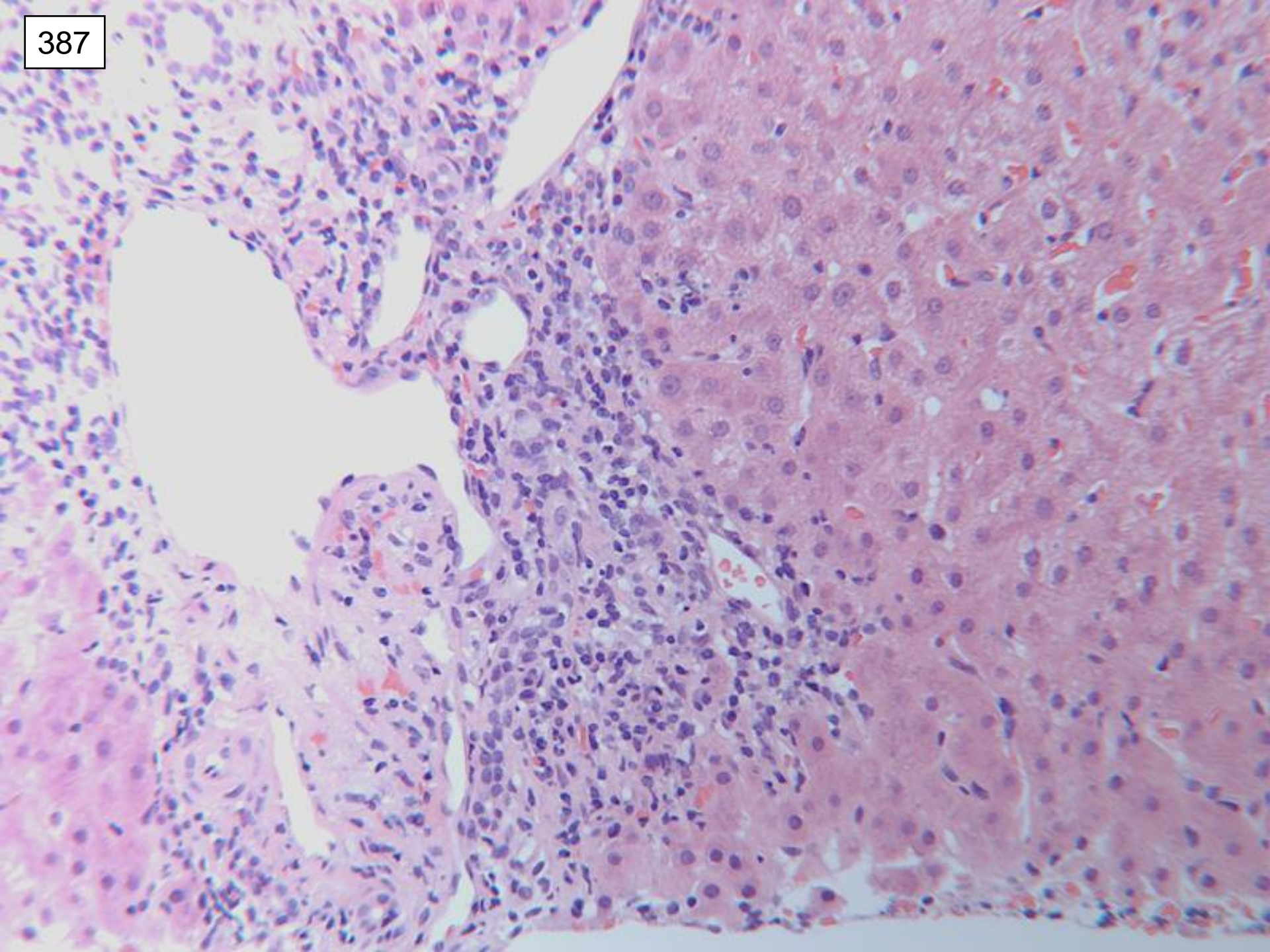
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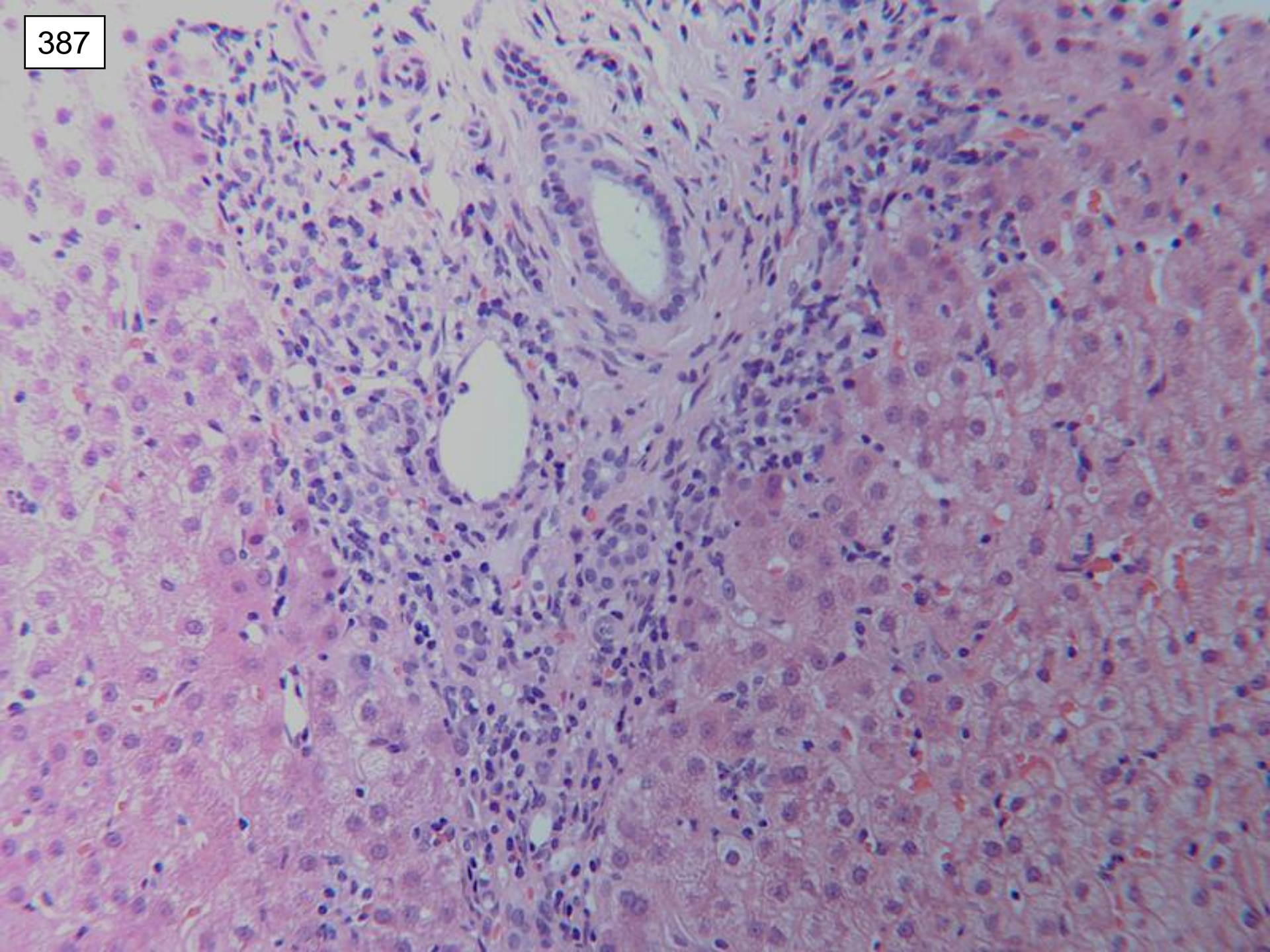
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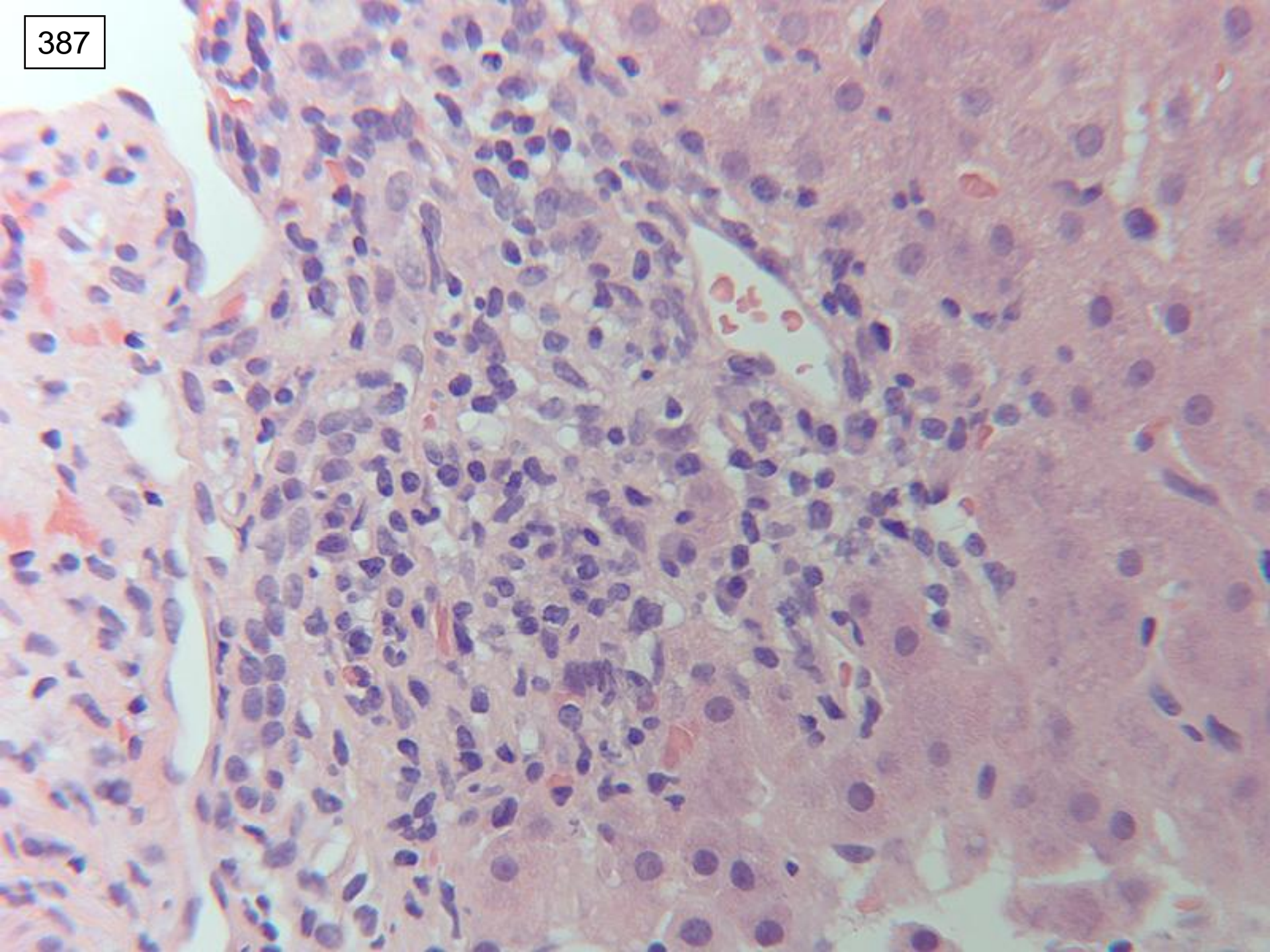
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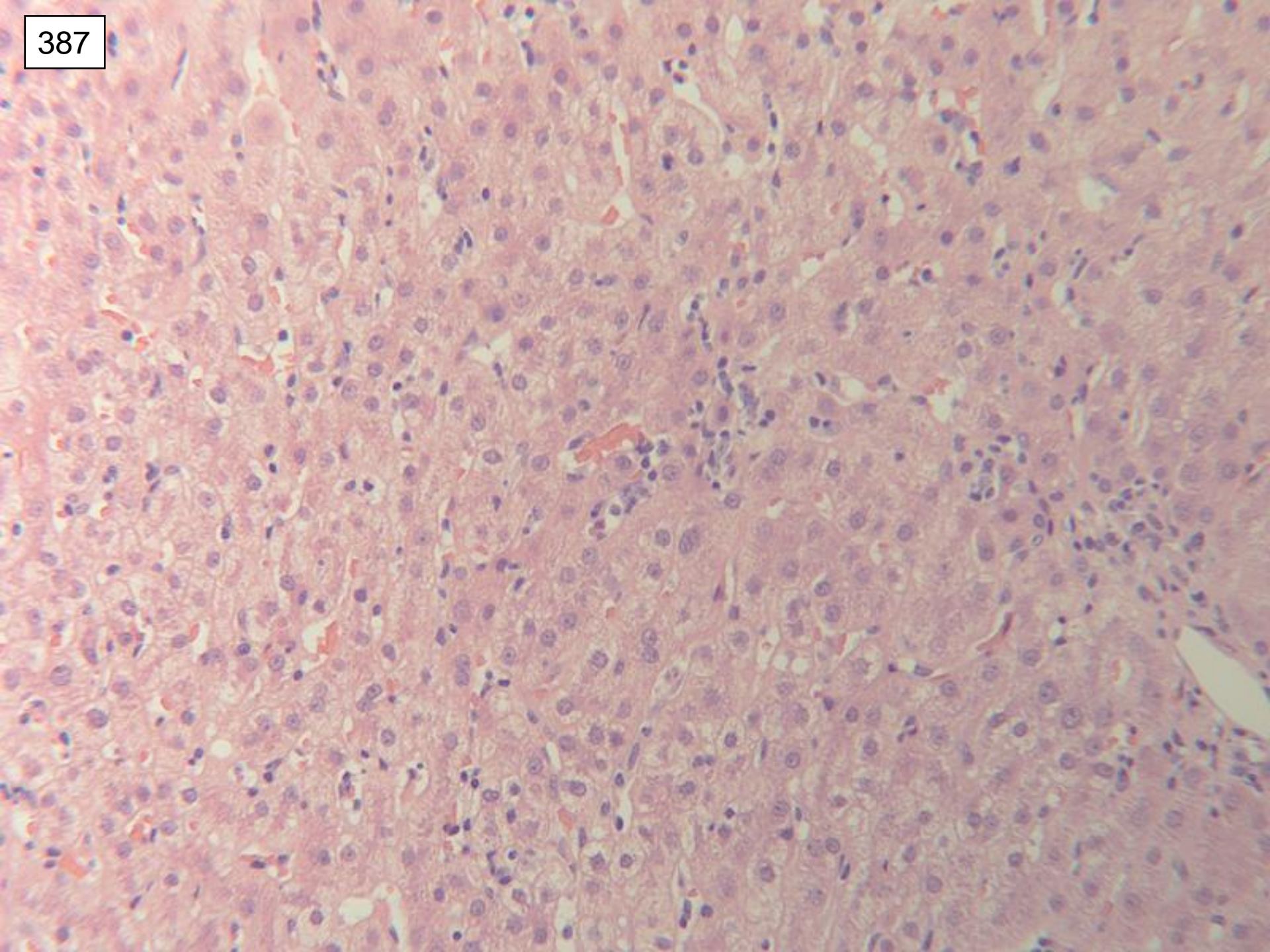


387



387





## Case 387:

### Pattern of Hepatitis

Acute: 10

Chronic: 30

Not specified: 29 (several - needs connective tissue stains)

Hepatitis not mentioned in response: 2

Biliary disease: 1

Plasma cells : 45 Interface hepatitis: 38

Eosinophils: 26 Granulomas: 6

Lobular inflammation, often commented, not specifically recorded in collation.

Bile duct degeneration : 8

No bile duct injury: 14

Specific individual responses – how to score?:

‘chronic active hepatitis – drug reaction to flucloxacillin’

‘biliary disease, ? small duct ?? PBC’

‘Favours PBC’

‘sclerosing cholangitis, primary or secondary’

‘acute cellular rejection’ as only clinicopath comment

‘chronic hepatitis in keeping with SLE. Vanishing bile ducts consistent with fluclox.’

### Aetiology:

Autoimmune as favoured aetiology: 29

AIH as only aetiology: 7

AIH not mentioned: 7

AIH or drugs, neither favoured: 13

AIH, ? precipitated by drugs: 2

Drugs as favoured aetiology: 13

Drug as only aetiology: 11

Drugs not mentioned; 1

Any of drug/AIH/viral: 2

Favours biliary disease: 4 (2 PBC, 2 PSC)

Many commented that AIH-like pattern was not typical of flucloxacillin drug induced liver injury

Suggested scoring: Is this case suitable for scoring??

Deduct marks if no mention of autoimmune, or if main diagnosis is other than a hepatitis process (ie biliary disease, SLE, rejection)

## Case 387:

Suggested scoring: Is this case suitable for scoring??

Deduct marks if no mention of autoimmune, or if main diagnosis is other than a hepatitis process (ie biliary disease, SLE, rejection)

Discussion at meeting:

agreed with suggested scoring –

On reviewing responses, 20 participants would have scored 0 points therefore there is insufficient consensus for scoring in this case, and it becomes an educational case.

Comment: this hepatitis with autoimmune features is not characteristic of a drug reaction to flucloxacillin – typically cholestatic or cholestatic hepatitis, often with large duct obstruction- like portal tract features of portal oedema, ductular reaction and cholangiolitis. Drug history may therefore be incidental in this case.

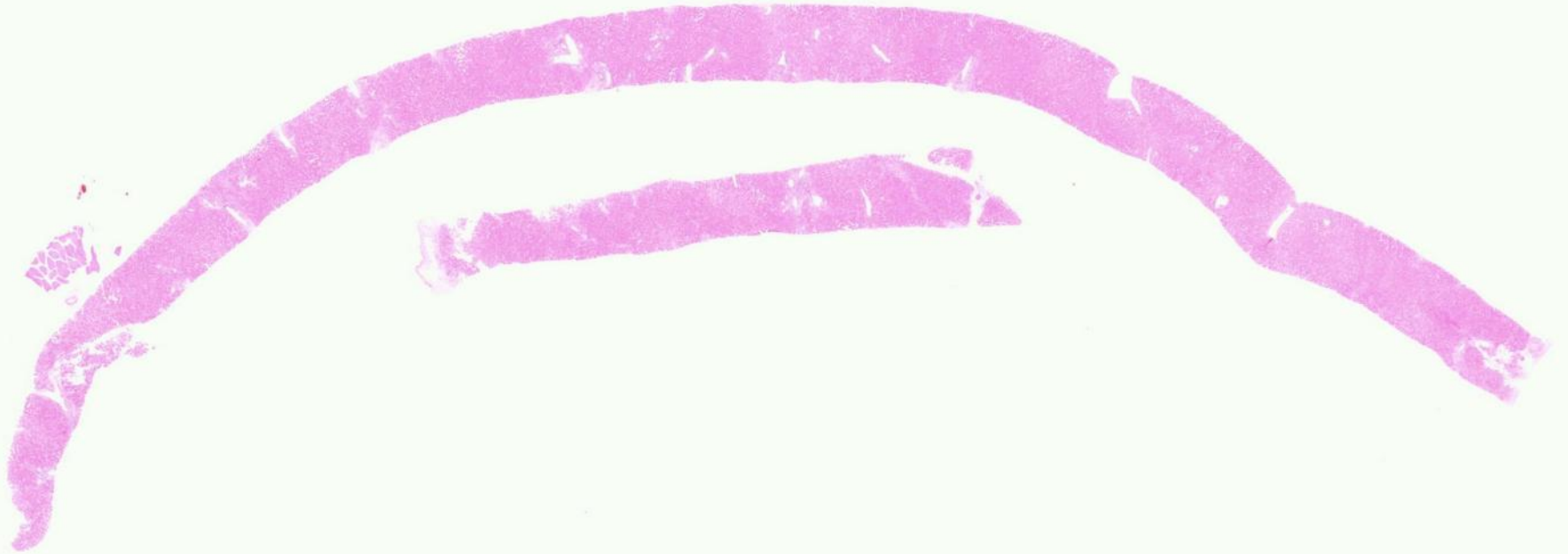
## **Case F1/388**

**26 M**

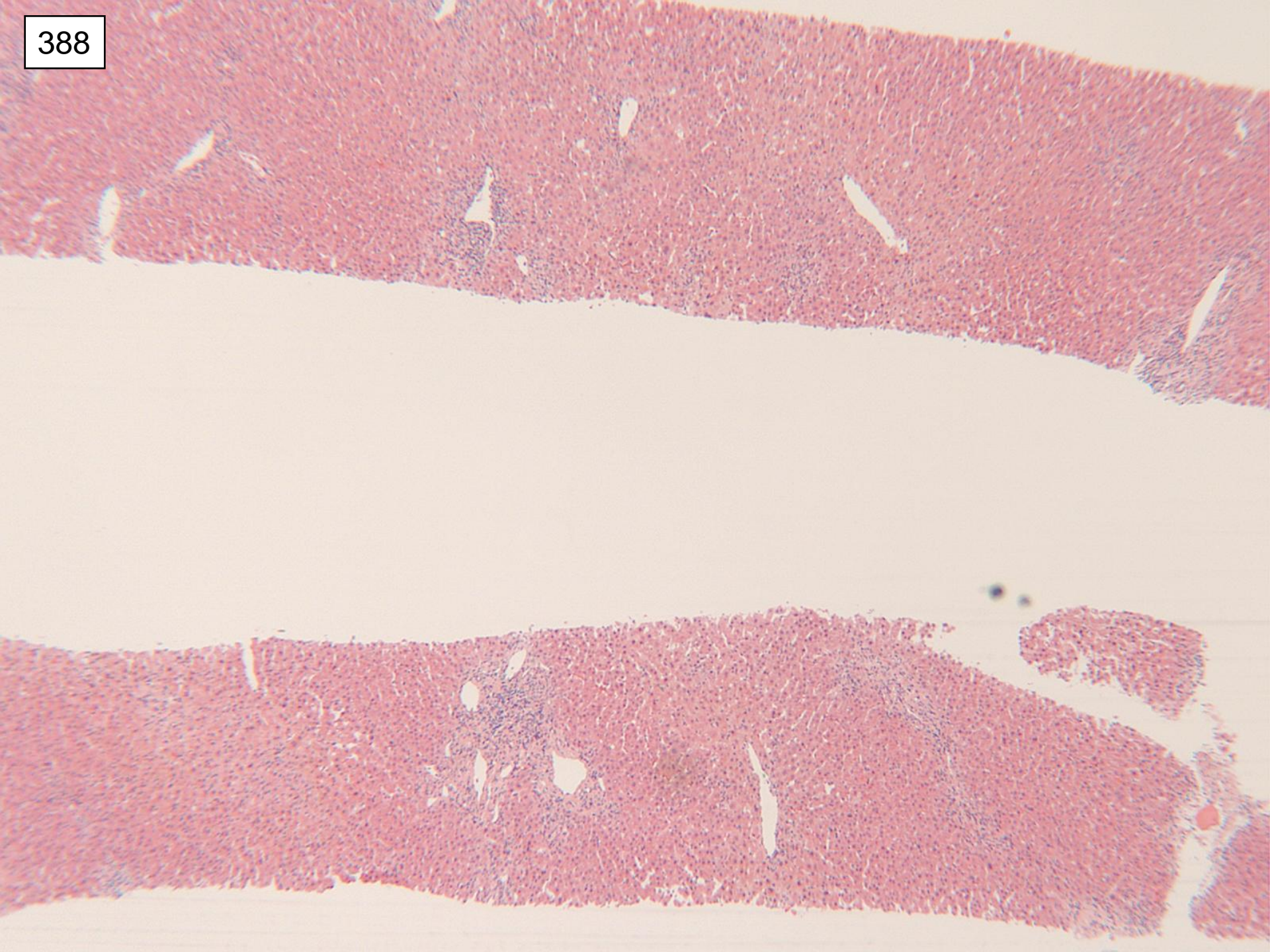
Acute hepatitis. Likely secondary to drug toxicity  
(body builder: on androgenic compounds).  
Negative viral and autoimmune screen

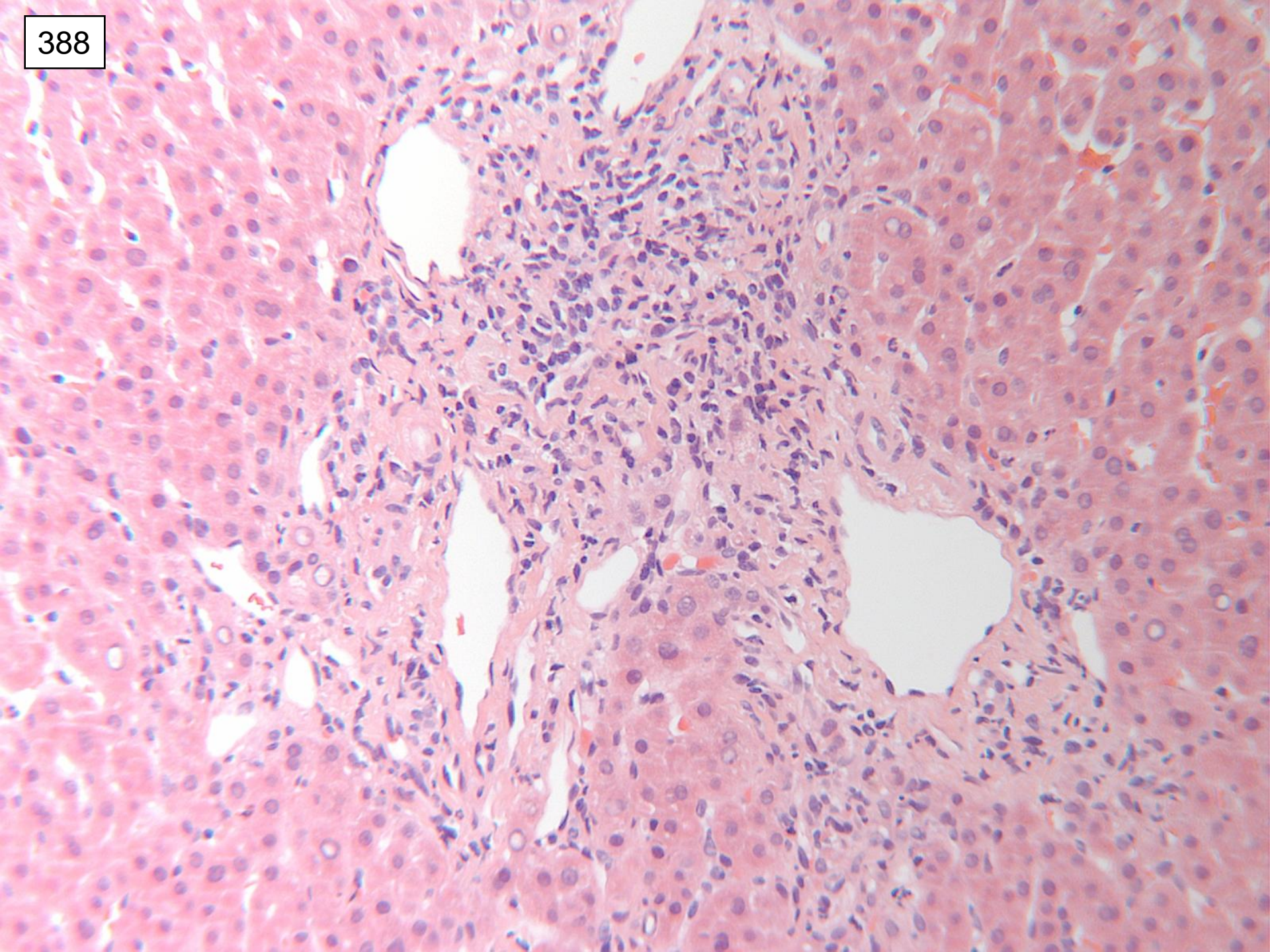
Liver core biopsy (please also see connective  
tissue stain on website)

388

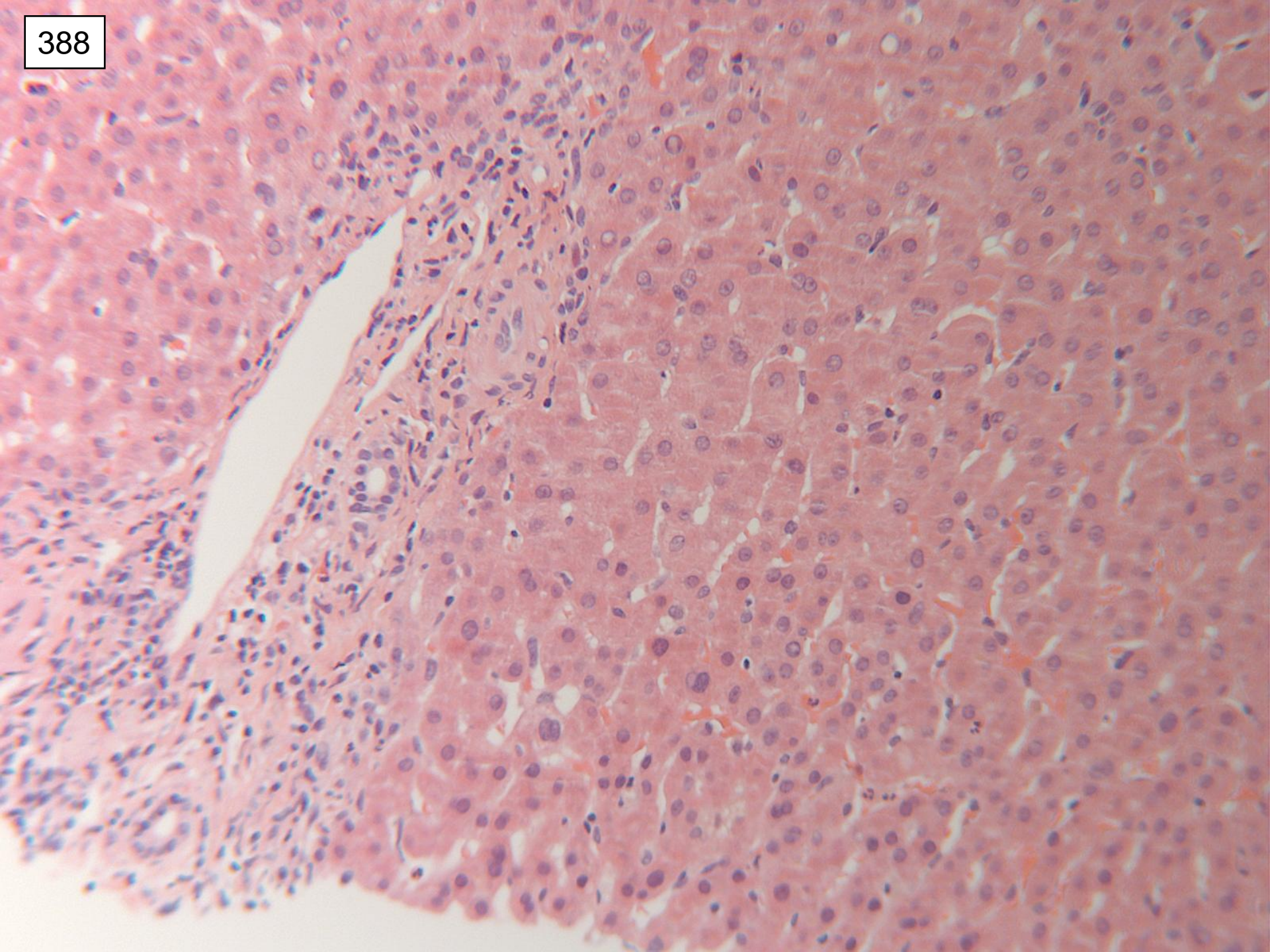


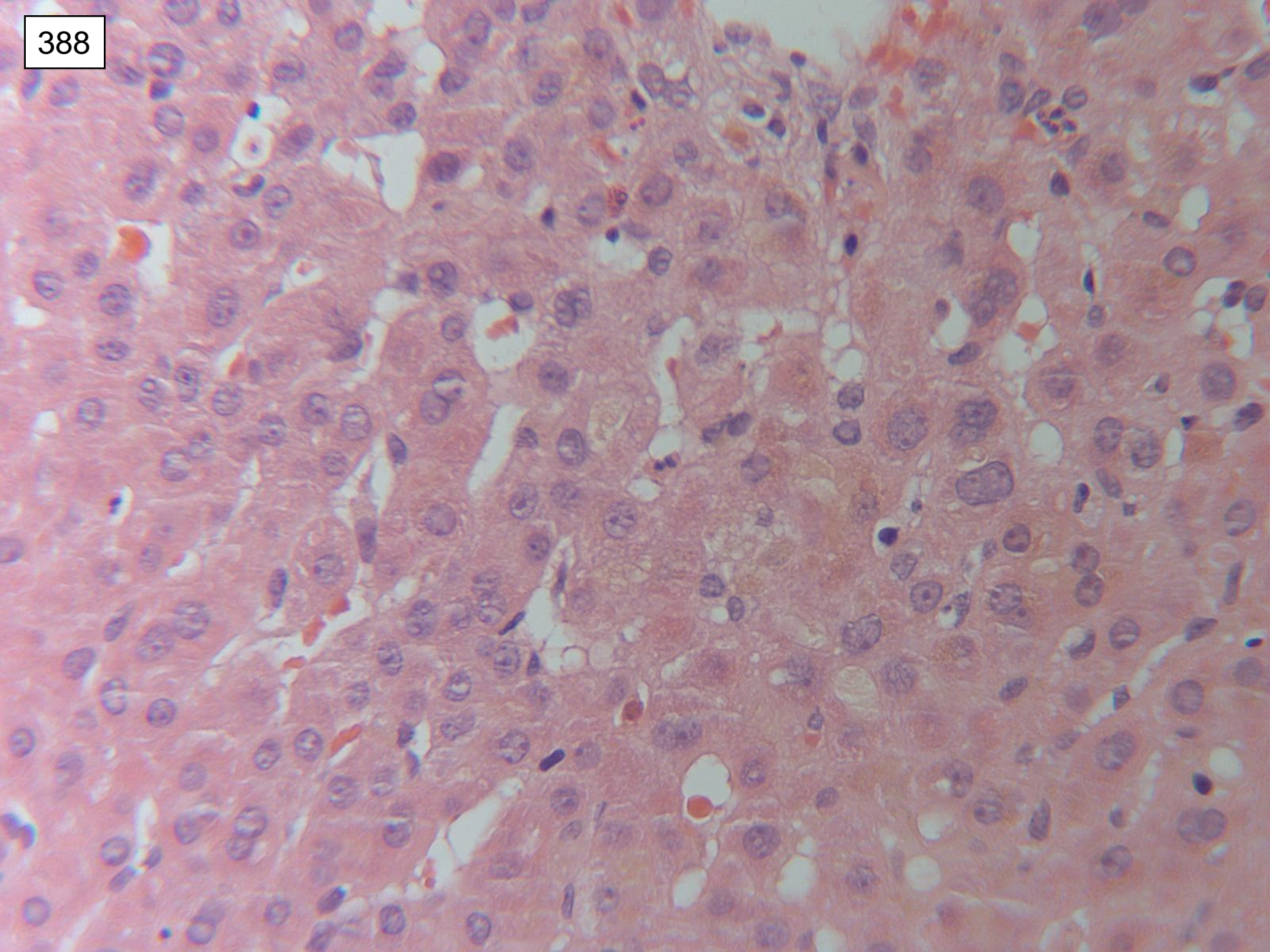
388



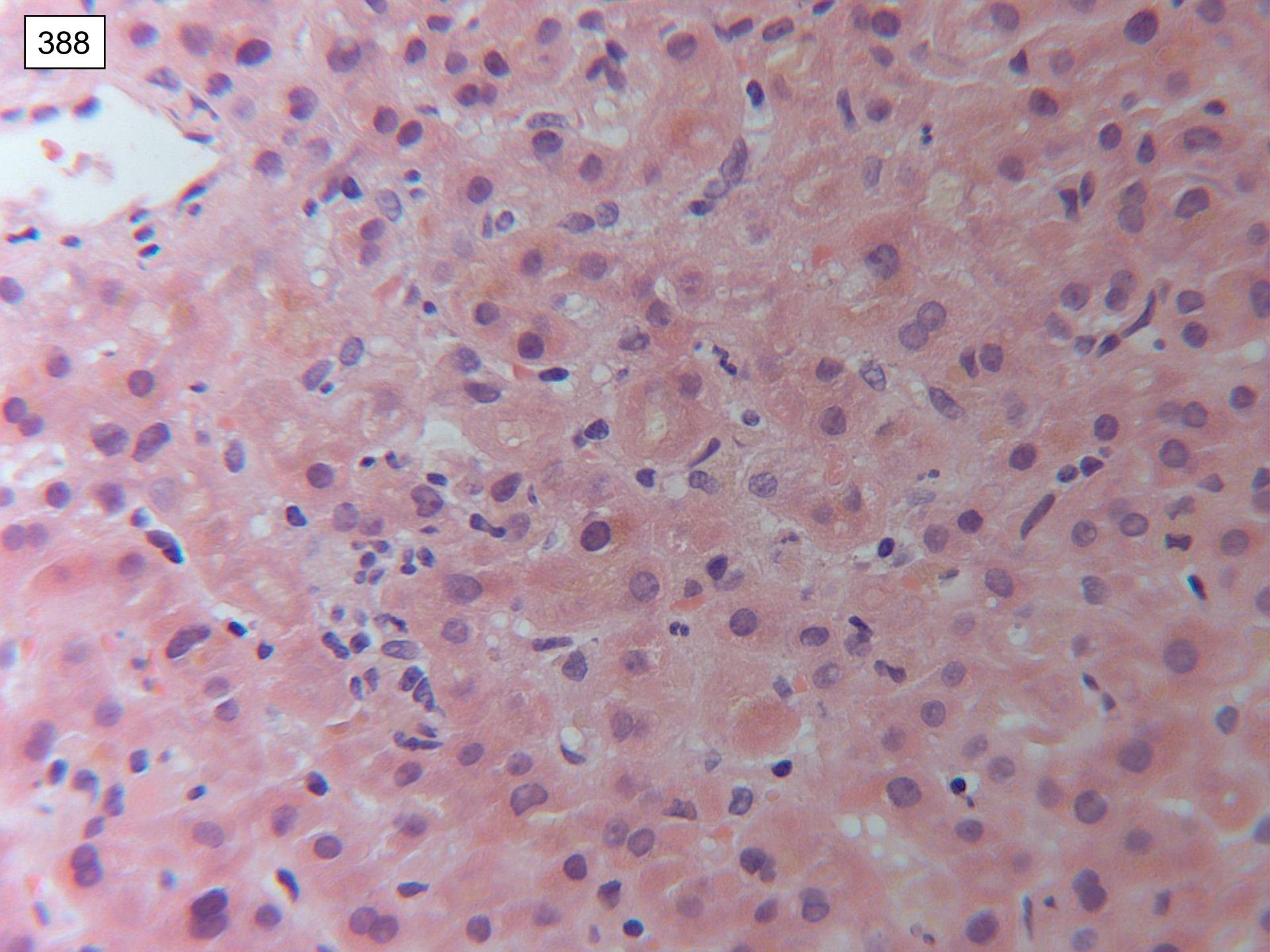


388





388





## Case 388: Responses

### Morphology:

Cholestatic hepatitis: 59

Cholestasis/bland cholestasis: 12

'cholestatic liver disease' 1

Cholestasis with ductopaenia: 2

'Chronic inflammation, interface hepatitis, cholestasis' 1

### Hepatitis: 5

'Acute hepatitis with confluent/bridging necrosis' 1

'acute hepatitis, nodular regenerative hyperplasia, vascular thrombosis' 1

Cholestasis not mentioned in report: 7

'no cholestasis' 1

### Aetiology:

Consistent with drugs, NOS: 32

Drug induced – androgenic steroids: 36

Consistent with drugs, but not typical of steroid cholestasis: 9

'suggestive of acute non-infective hepatitis' (drugs not mentioned)

'? NRH' (drugs not mentioned)

'cholestasis exclude a second cause of inflammation e.g. second drug or infection'

'mild portal inflammation and hepatocyte hyperplasia, nodularity,

'mild chronic hepatitis exclude hepatitis C'

No H&E slide: 2 (check with Louise if in same cell)

### Suggested scoring:

For full marks include mention of cholestasis and drugs.

Half marks if either missing.

Suggestions agreed

**Case F1/389**

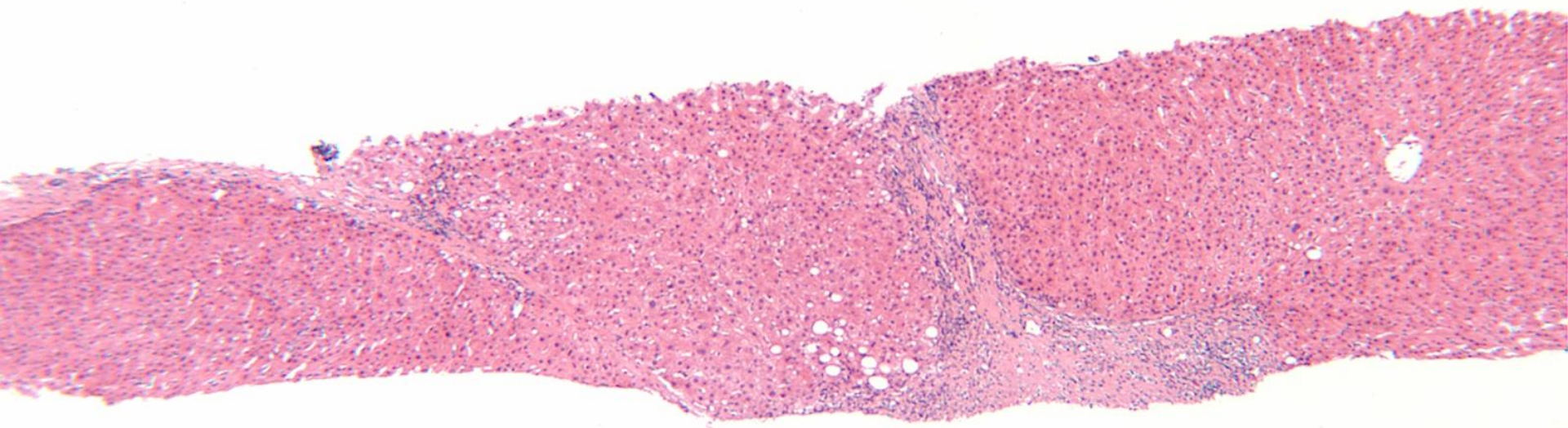
**40 M**

Cirrhosis

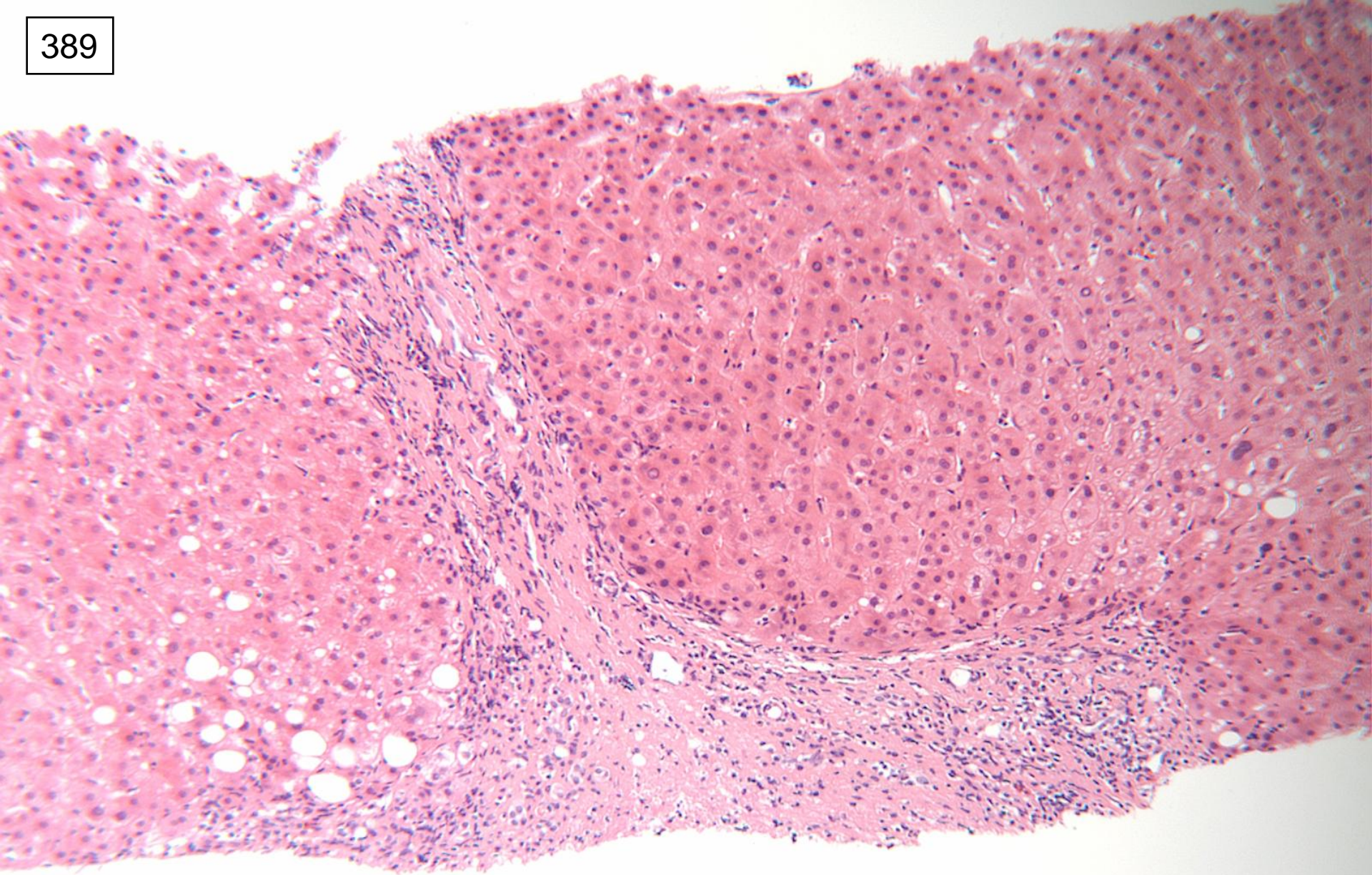
1 core 18mm long

389

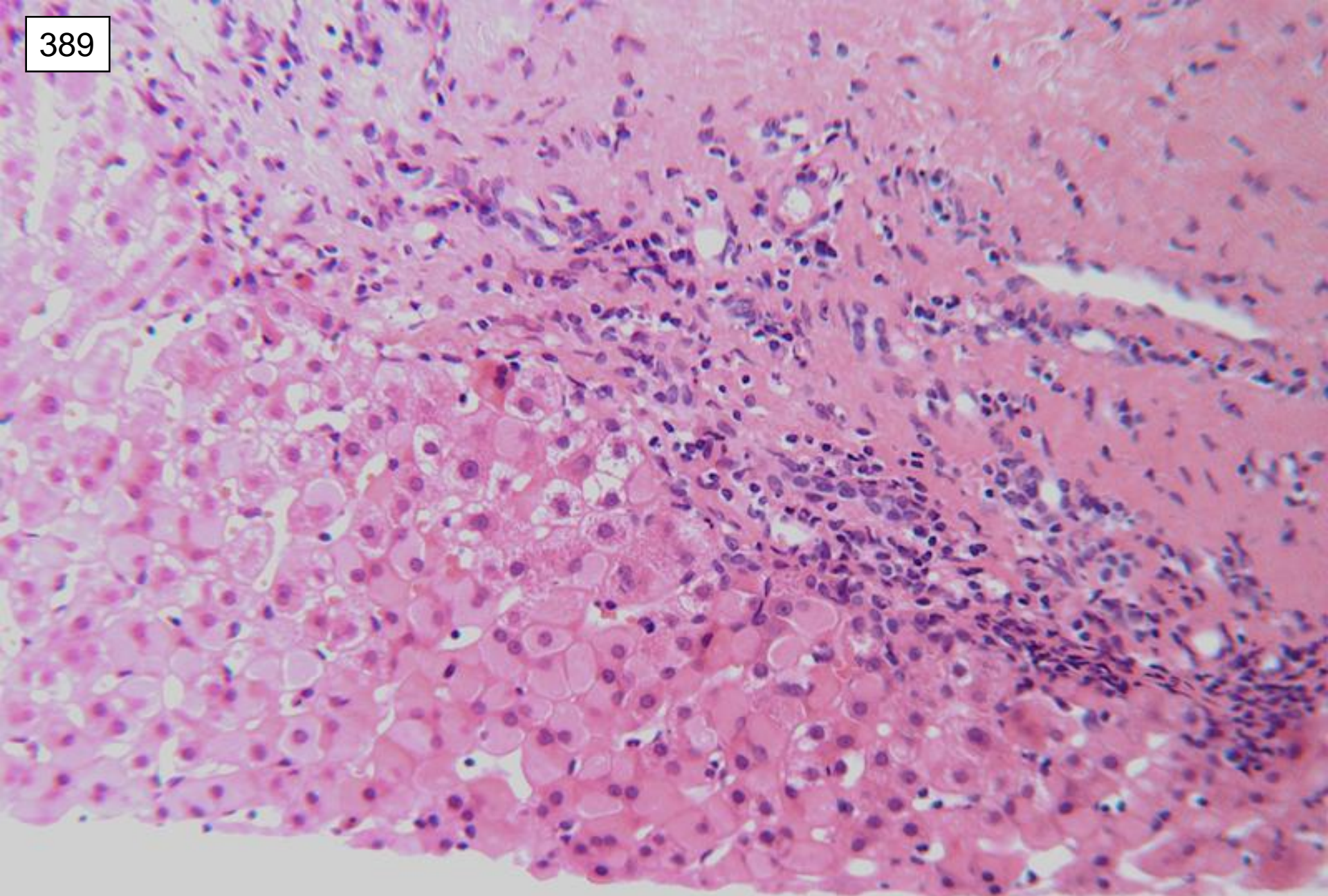


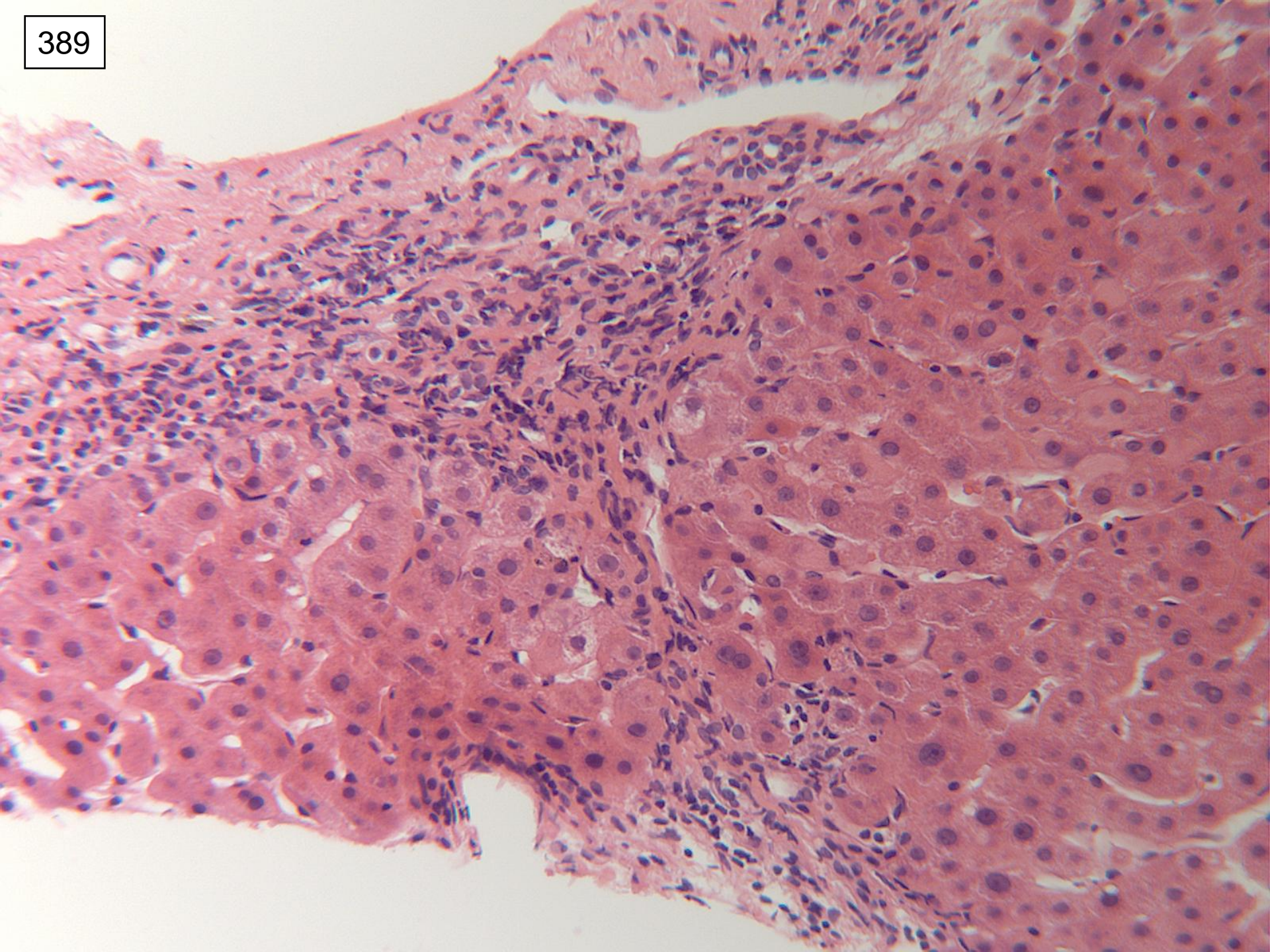


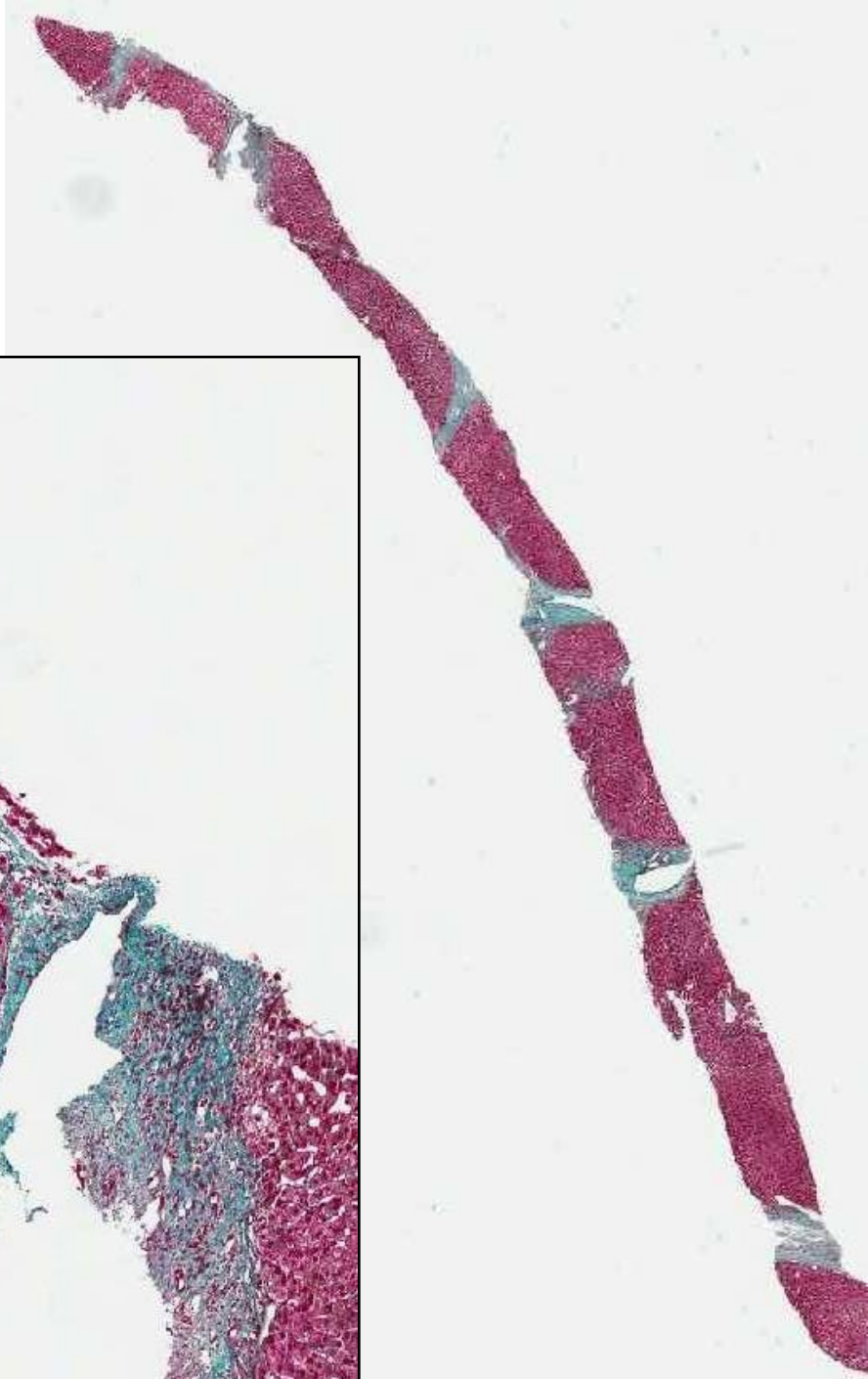
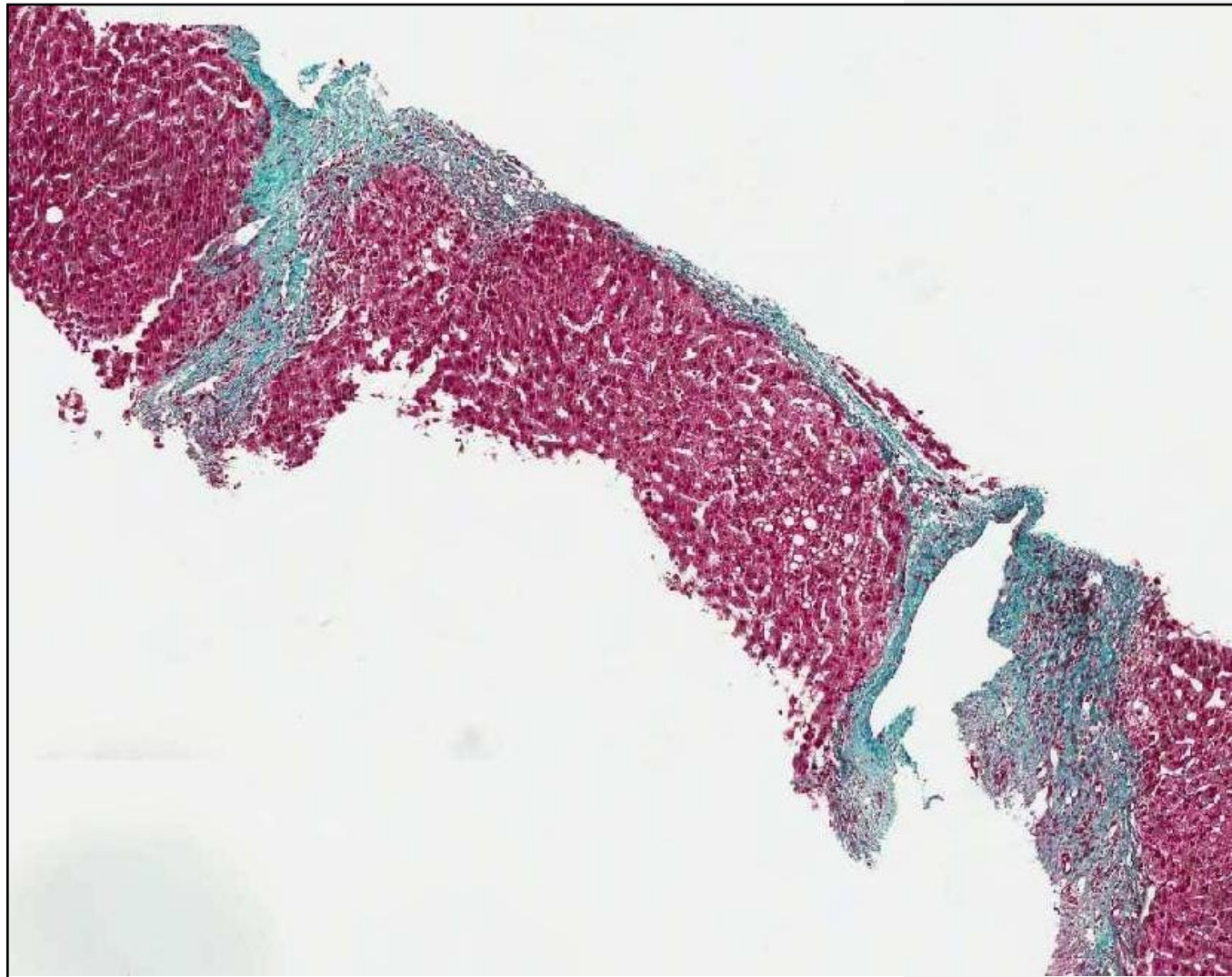
389



389







## Case 389: Responses

### Morphology:

**Ground glass hepatocytes: 66**

Ground glass not mentioned: 15

Steatosis: 42

Steatohepatitis: 3

No steatosis: 3

Large cell change: 8

**'cirrhosis and focus suspicious of HCC  
would send away to expert'**

### Stage:

**Cirrhosis and/or Ishak stage 6: 67**

Possible cirrhosis: 5

Not cirrhotic: 7

Ishak stage other than 6:

'Unable to confirm cirrhosis'

### Grade:

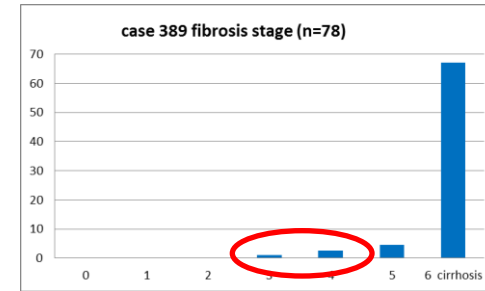
Minimal/inactive: 3

Mild inflammation: 53

Moderate: 2

Ishak grade (n=9):

Ishak grade	Number of responses
2	1
3	3
4	3
5	1
6	1



### Aetiology

**Hepatitis B +/- differential: 63**

? viral: 2

Hepatitis B with differential diagnosis of

AIH: 2

No aetiology suggested: 9

? ASH or NASH: 4

## Suggested scoring

For full marks: need possible or definite cirrhosis (Ishak 5 or 6) and hepatitis B.

Lose 5 marks if ground glass hepatocytes or ? viral without mentioning hepatitis B.

? lose 5 marks for suspecting HCC

## Case 389 contd:

### Suggested scoring

For full marks: need possible or definite cirrhosis (Ishak 5 or 6) and hepatitis B. Lose 5 marks if ground glass hepatocytes or ? viral without mentioning hepatitis B. ? lose 5 marks for suspecting HCC

### Discussion at meeting:

some members felt that responses not including 'possible or definite cirrhosis' should not be penalised, because the connective tissue stain was not available to people with poor broadband access. Staging will therefore be omitted from scoring.

NB. on review of responses, a minority (4 responses) explicitly stated that cirrhosis was not present – this would affect clinical management, is a clear departure from the consensus view and is not dependent of connective tissue stains. It is an example of the need for improved criteria and terminology for assessing stage.

The members requested that the connective tissue stains are also available as printed photomicrographs as in the past. The organiser will endeavour to provide these in future.

Scoring will be based on recognition of hepatitis B, with 0 points for no mention (13 responses) and 5 points for ground glass hepatocytes but no hep B (4 responses).

# Case F1/390

55 F

Antimitochondrial antibody +ve 1:1600.

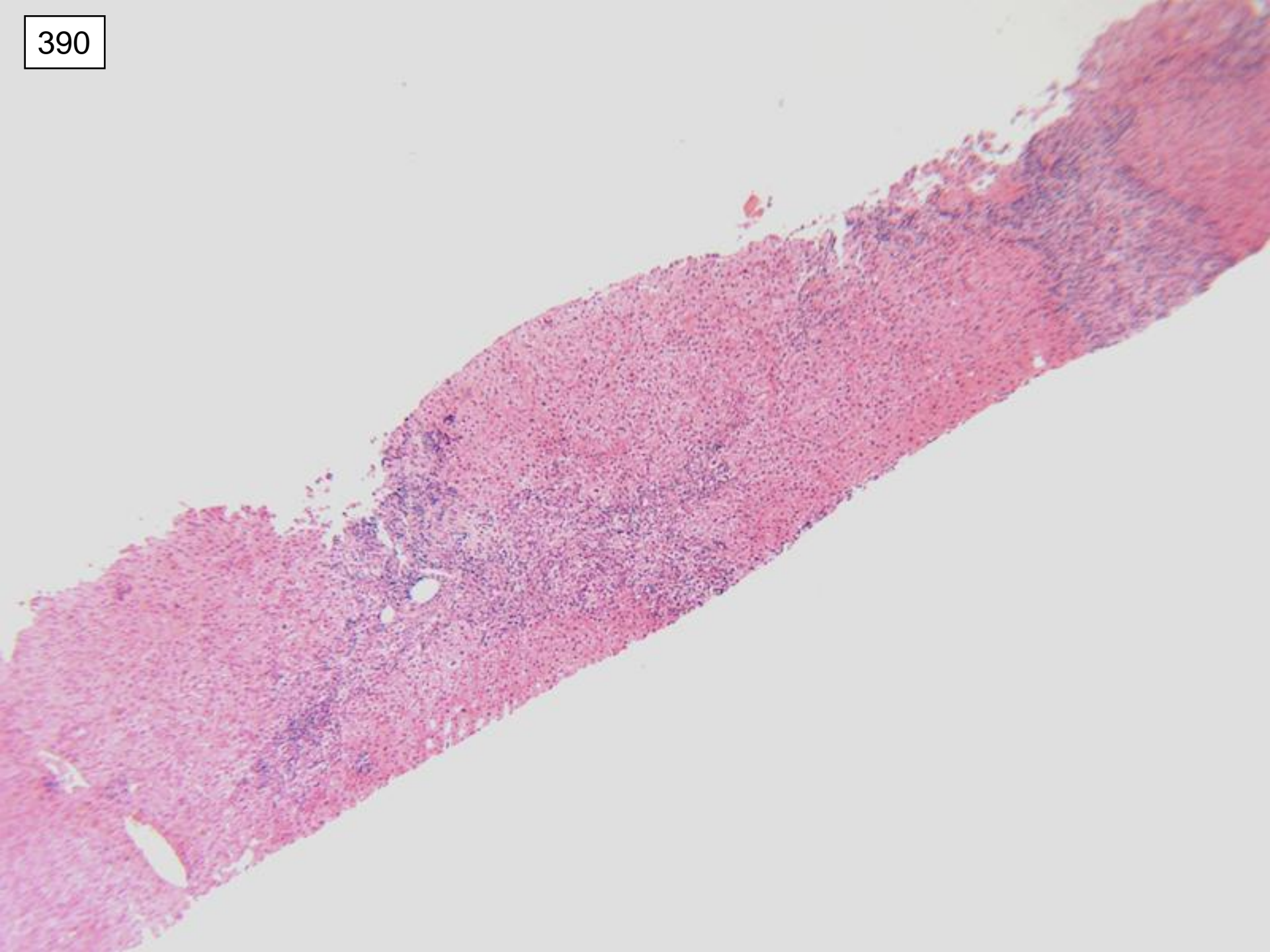
Anti SM +ve 1:100. ? overlap syndrome

ALP 843, ALT 555, Bili 15

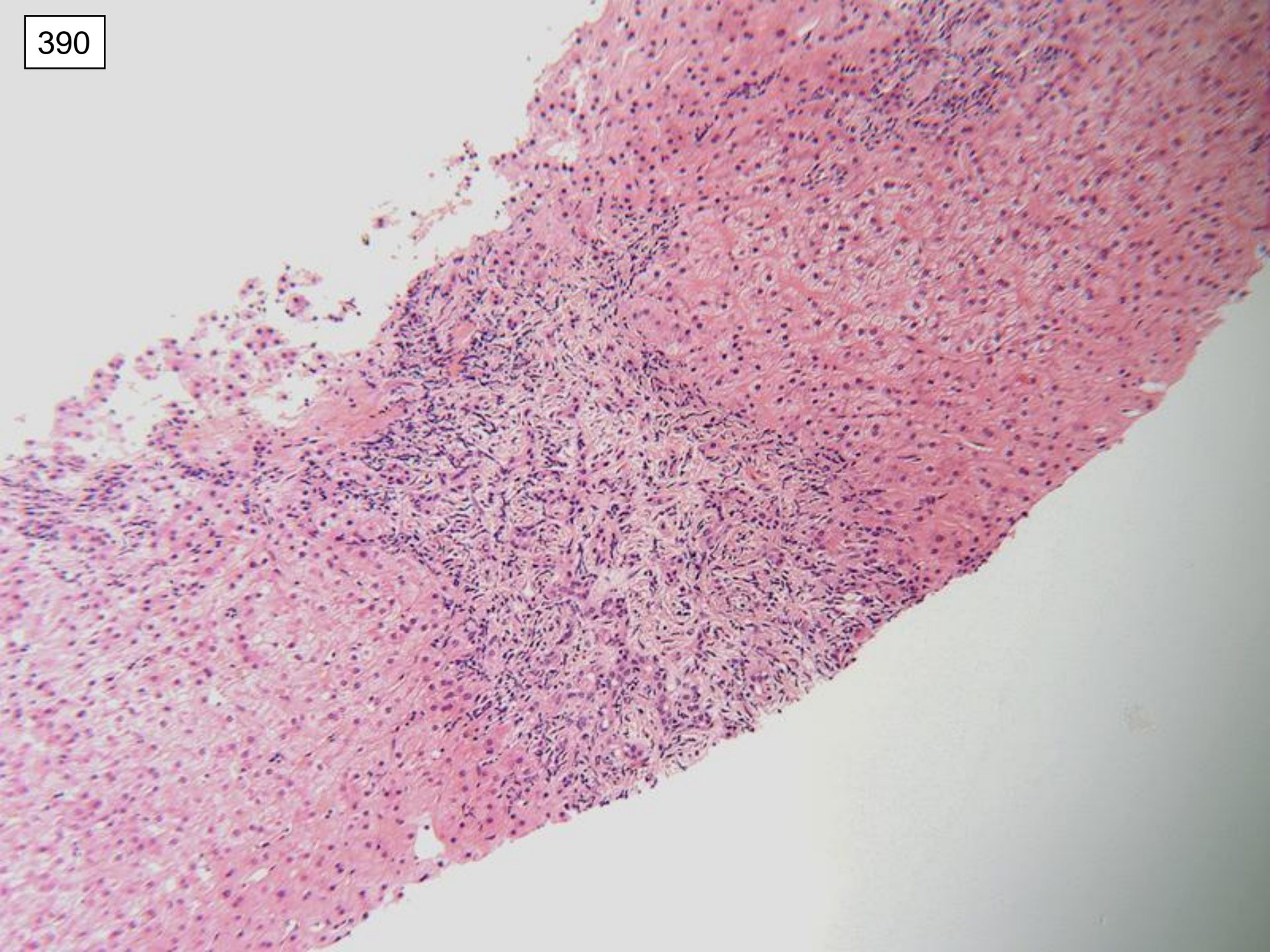
Liver core biopsy 20mm long (please also see connective tissue stain on website)

390

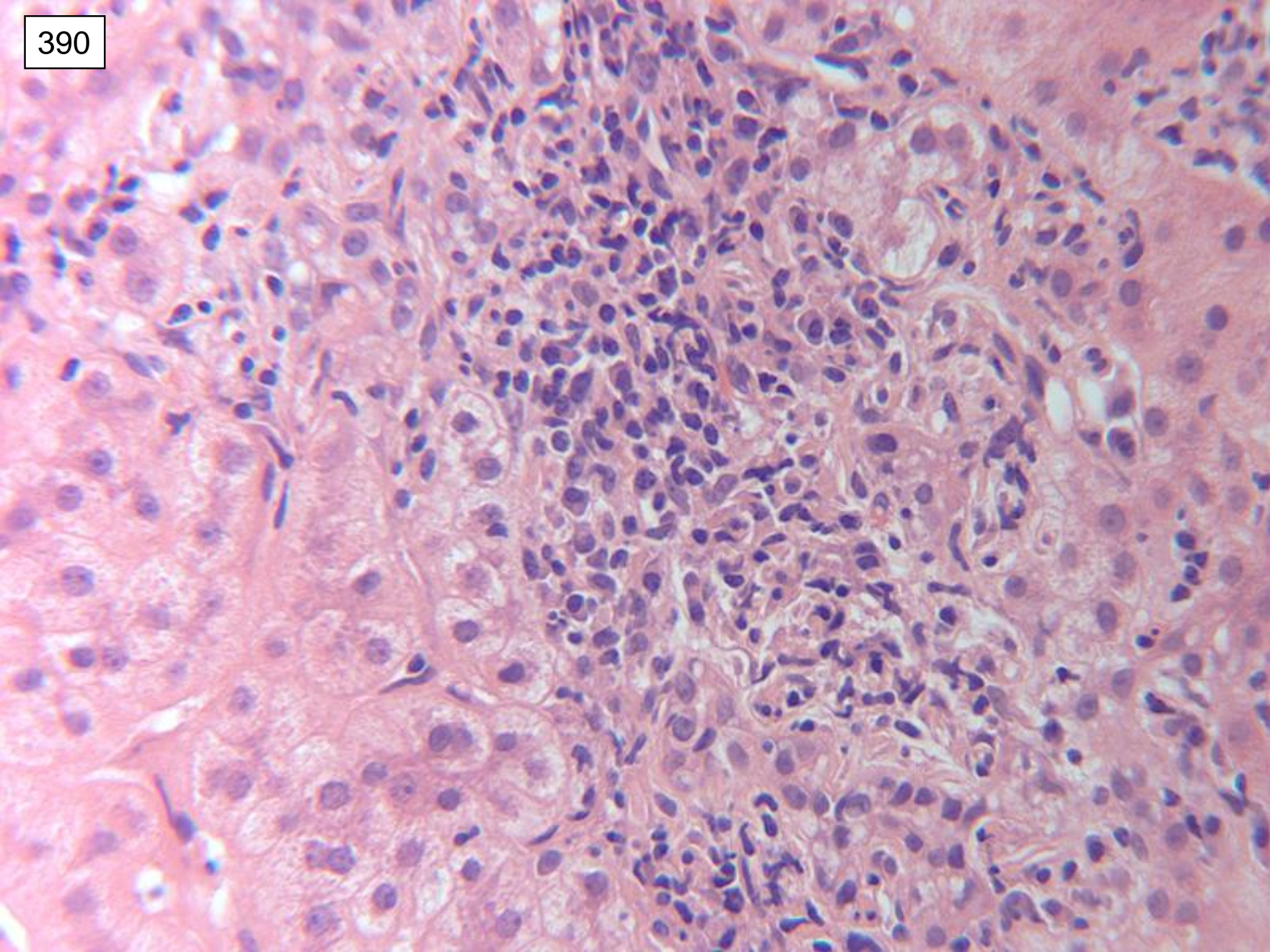




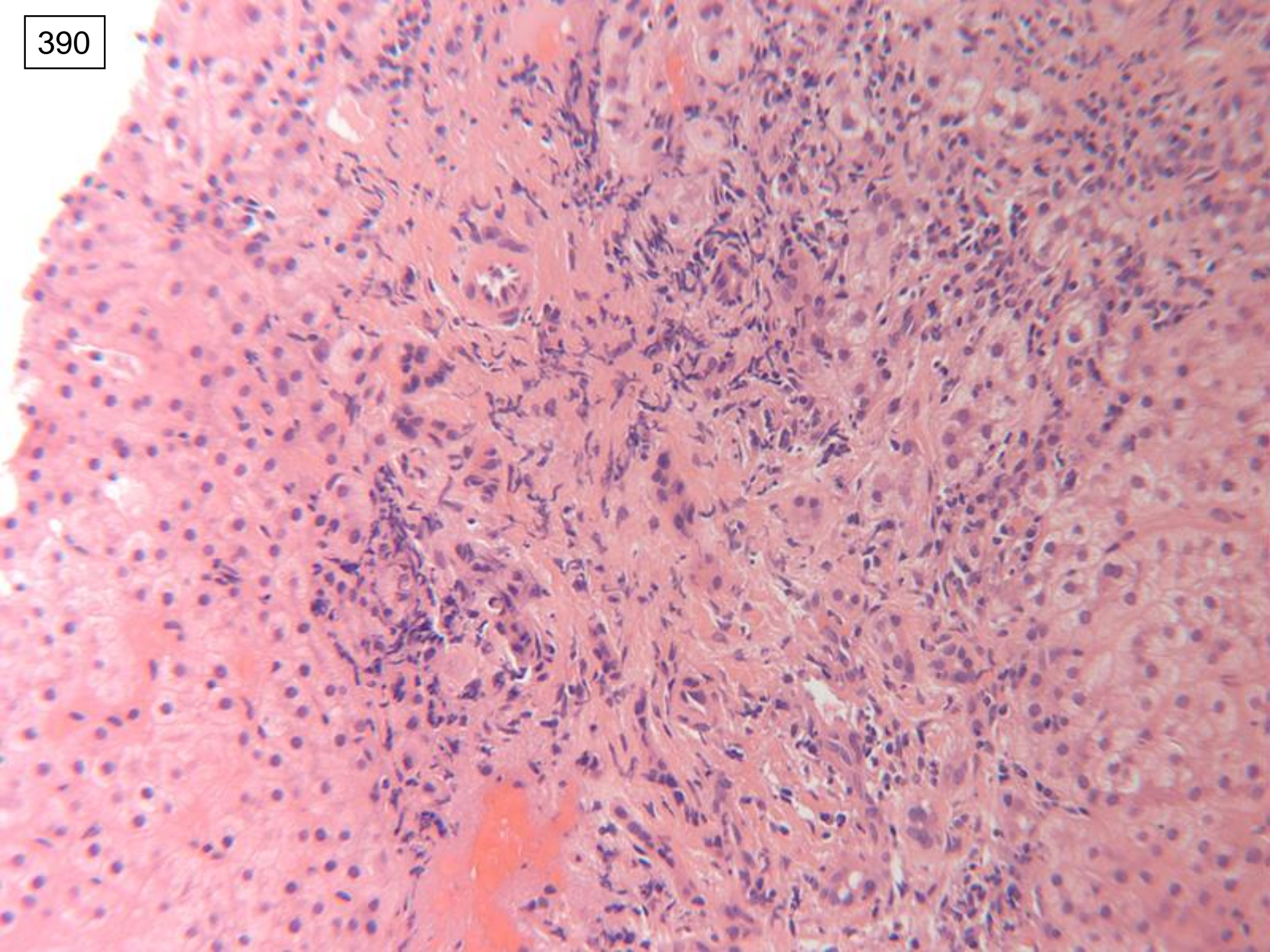
390



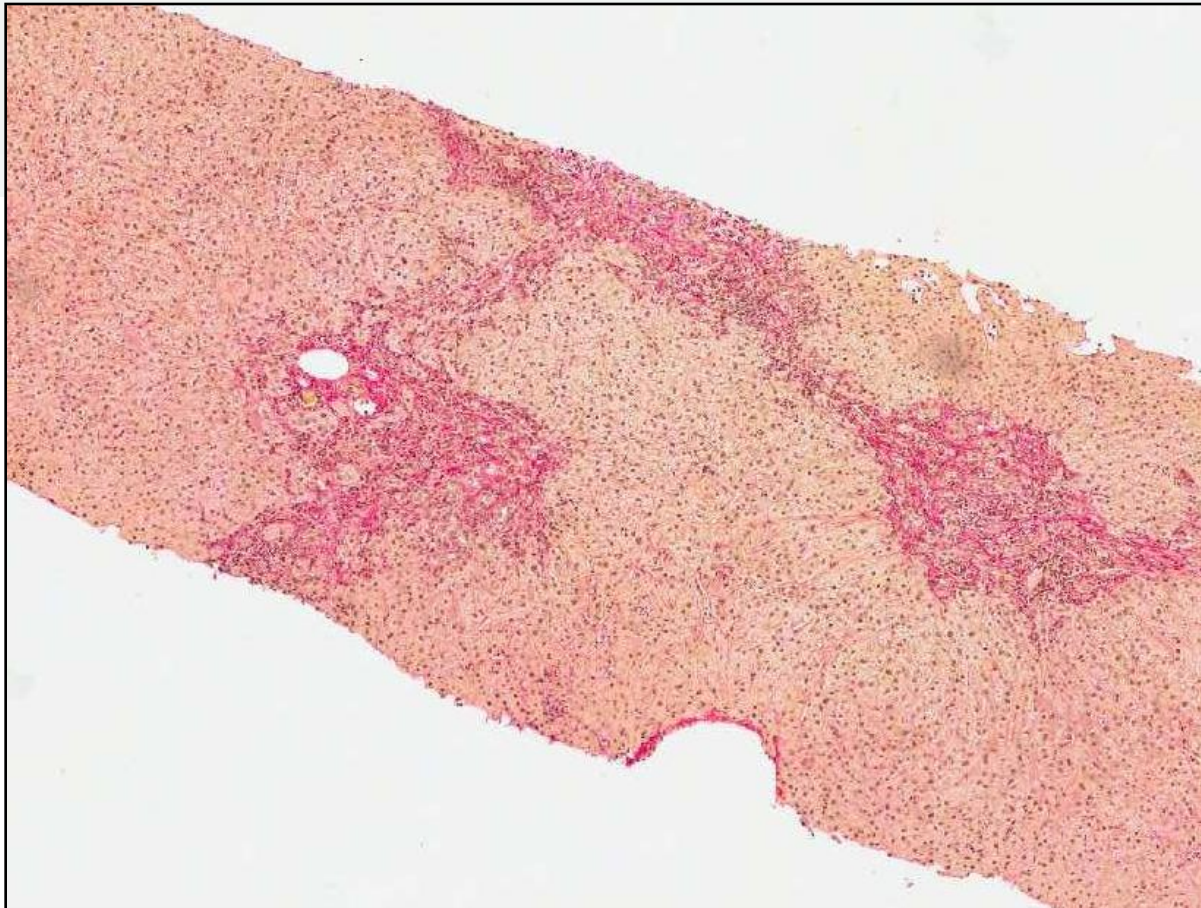
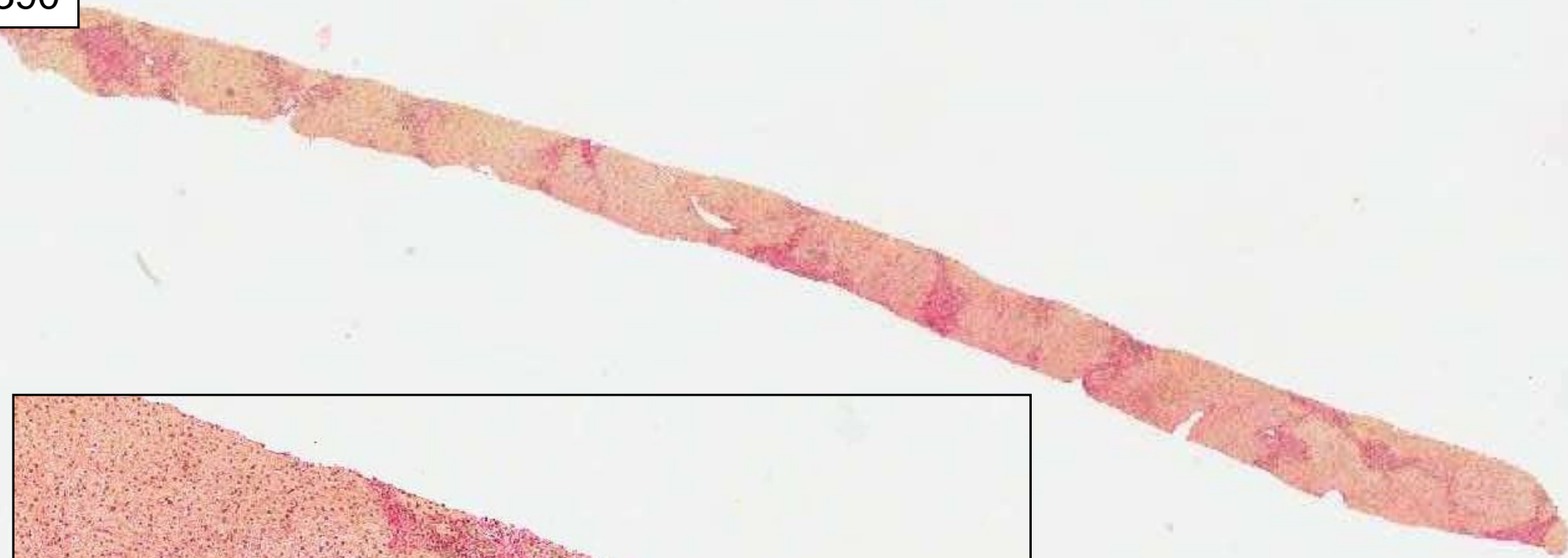
390



390



390



## 390: responses:

### Morphology

**Biliary features (ductular reaction, duct injury): 78**

**No biliary features: 2**

Ductopaenia: 30

No ductopaenia: 3

Granuloma: 2

'scars in portal tract – PSC'

Interface hepatitis: 55

Plasma cells: 47

Lobular inflammation: 24

Bridging fibrosis: 44

Moderate fibrosis: 9

'No significant fibrosis'

'early/developing cirrhosis'

Scoring: (Ishak n=8):

PBC stage 2:2; stage 2-3: 1; stage 3: 2

Metavir A2F4

Ishak grade (2 responses) 6, 10

### Aetiology

PBC and AIH overlap: 34

PBC and AIH overlap ,PBC dominant: 14

PBC and AIH overlap, AIH dominant: 4

PBC or overlap: 8

PBC only, not features of overlap: 14

**AIH only, not overlap: 2**

'Autoimmune cholangiopathy'

'advanced CAH; obviously an overlap' (as the only text written for morphol; clinicopath)

'AIH and ?PSC – for ERCP or MRIC'

**'acute hepatitis with confluent necrosis. Stage 4/6 most consistent with AIH'**

**'consistent with overlap' ( as only clinicopath comment – no mention of PBC or AIH)**

'not typical of autoimmune. Consider cholangiopathy or LBDO'

Needs orcein stain: 8

### Suggested scoring

Lose marks for no mention of biliary component of disease.

Or lose marks if no mention of overlap/AIH?

– would result in insufficient consensus and no scoring

## Case 390 contd

### Original suggested scoring by organiser:

Lose marks for no mention of biliary component of disease.

Or lose marks if no mention of overlap/AIH?

– would result in insufficient consensus and no scoring

### Discussion at meeting:

Sufficient information in clinical details alone for the diagnosis of PBC, - with raised alk phos and AMA this part of the diagnosis is not dependent on biopsy.

Indication for biopsy in this case was the clinical evidence of additional component of autoimmune hepatitis – diagnosis of ‘overlap’ requires histological evidence as well – i.e. presence of interface hepatitis and plasma cells, and biopsy to determine dominant pathological process.

Therefore scoring based on presence of ‘overlap’ or some other indication that there is both PBC and AIH. Responses re-evaluated on this basis: this can now give sufficient consensus for scoring as follows:

- no use of ‘overlap’ nor any indication that both PBC and AIH may be present  
6 responses, score 0
- Possibility of ‘overlap’ considered but excluded by absence of histological features of AIH – 6 responses, score 5.

# Case 391

37 M

Hepatitis C positive. Abnormal LFTs. For staging hep C before antiviral treatment.

One core 18mm long

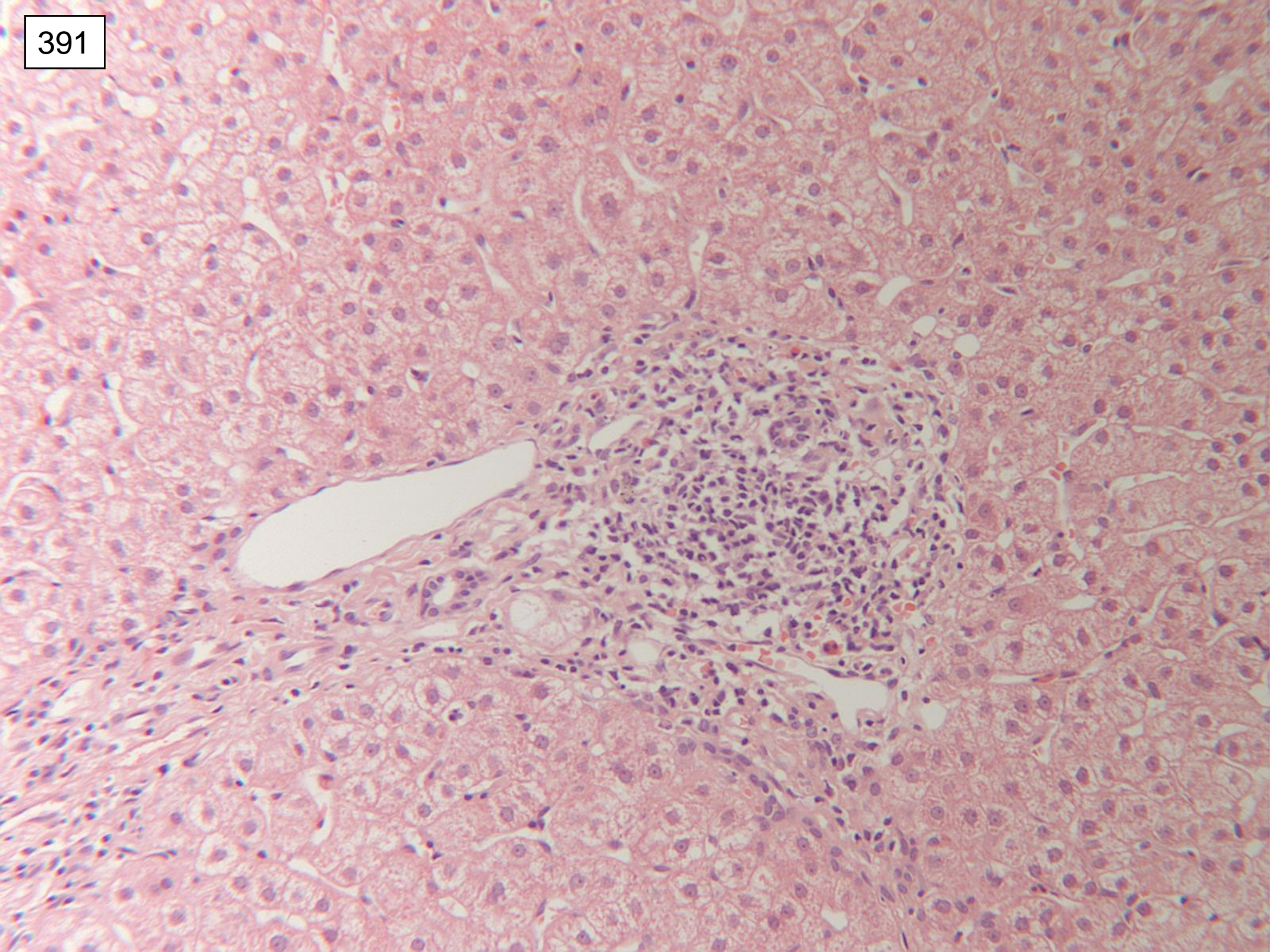
391



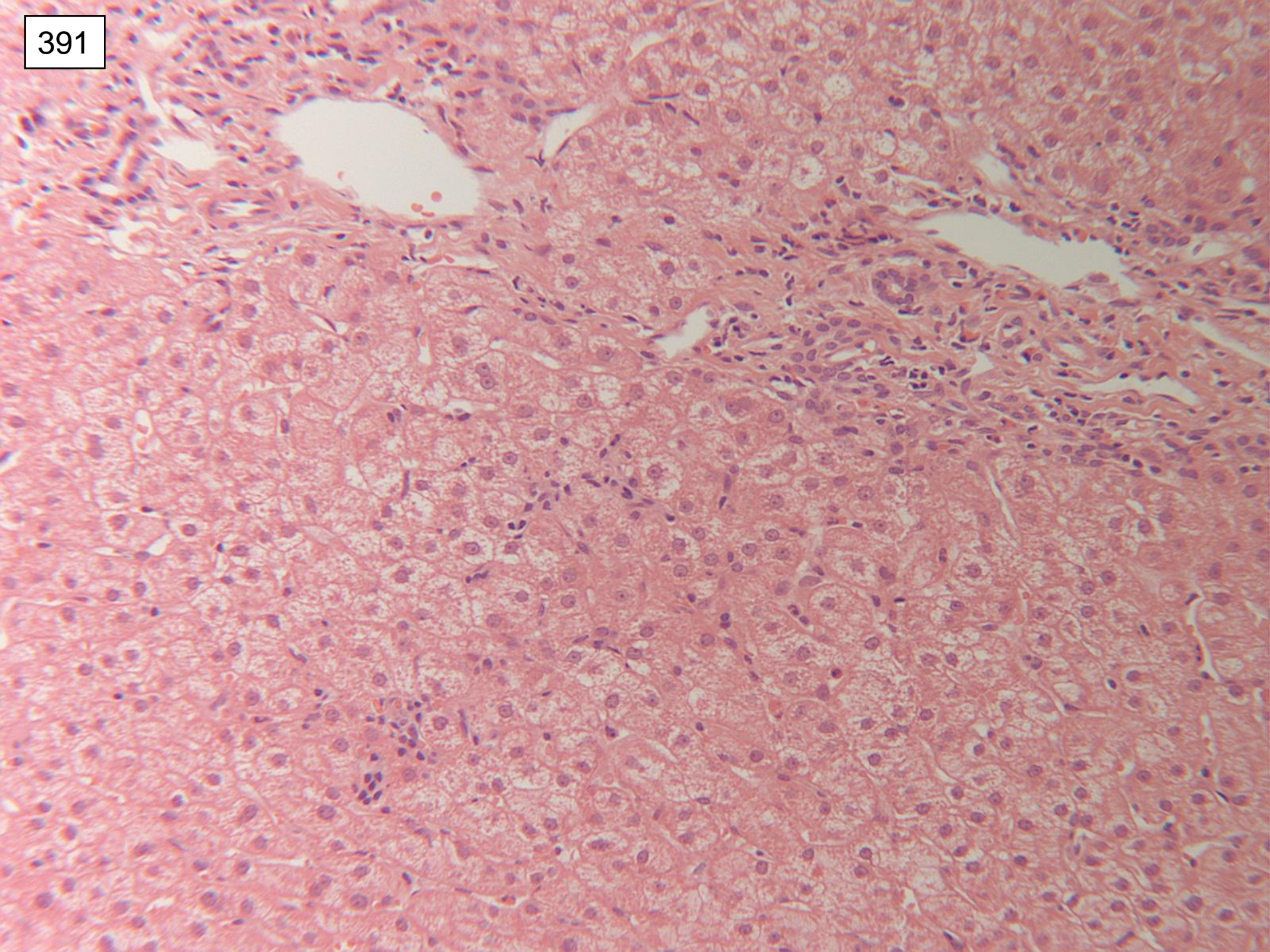
391



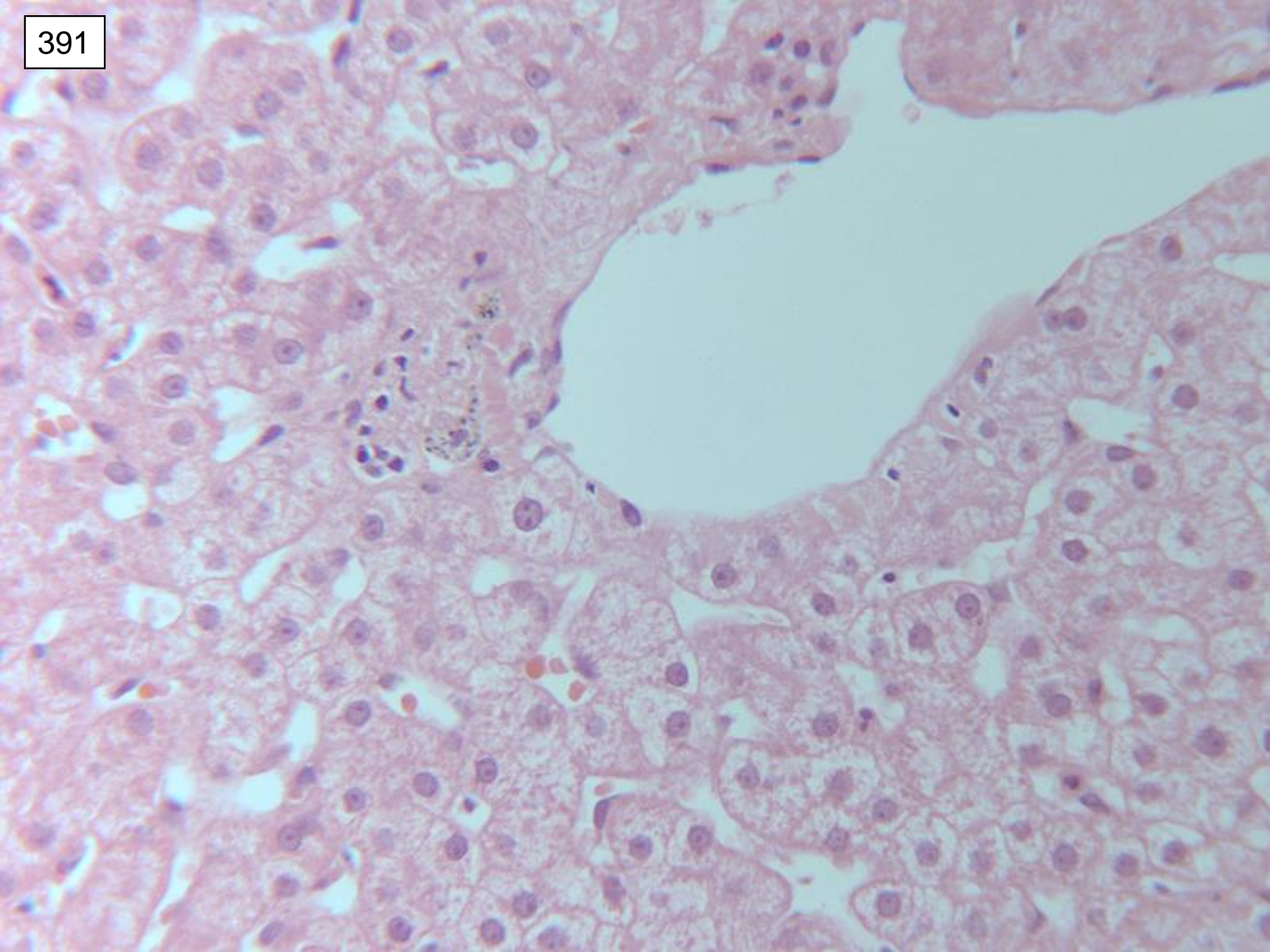
391



391



391



391



## Case 391; Responses

### Morphology & aetiology

#### **Hepatitis C: 73**

Hepatitis C not mentioned: 4

‘not look like hepatitis C’

‘CPH viral load’ as only response

### Fibrosis stage:

Ishak stage: 60 responses

#### Stage as text:

no fibrosis: 2

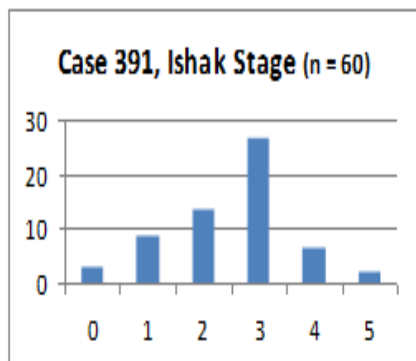
minimal fibrosis: 2

Mild: 12

Moderate: 4

Possible bridging fibrosis: 2

No stage given: 1



### Disease activity:

Ishak grade: 47 responses, see histogram

#### Activity as text:

None/Inactive: 0

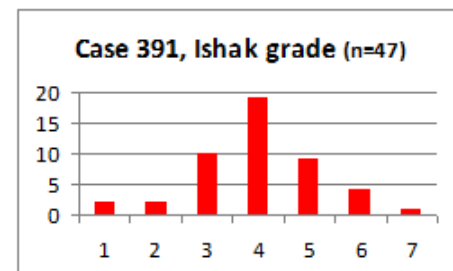
Minimal/no significant: 1

Mild: 34

Mild-moderate: 4

Moderate: 3

No grade given: 3



### Other scores:

Metavir (n=5): A1F1; A1F2; A1F3; A2F2; A2F2.

### Other comments:

Foreign material in portal macrophages, IVDU: 13

? also drugs (eosinophils in infiltrate) : 3

## Suggested scoring

Lose marks for not including hepatitis C or ‘does not look like hepatitis C’

? penalty for not including stage / grade – but not done, since there is so little agreement on what these should be!

Discussion at meeting: must also include comment on severity – lose 5 points if not

# Case F1/392

25 F

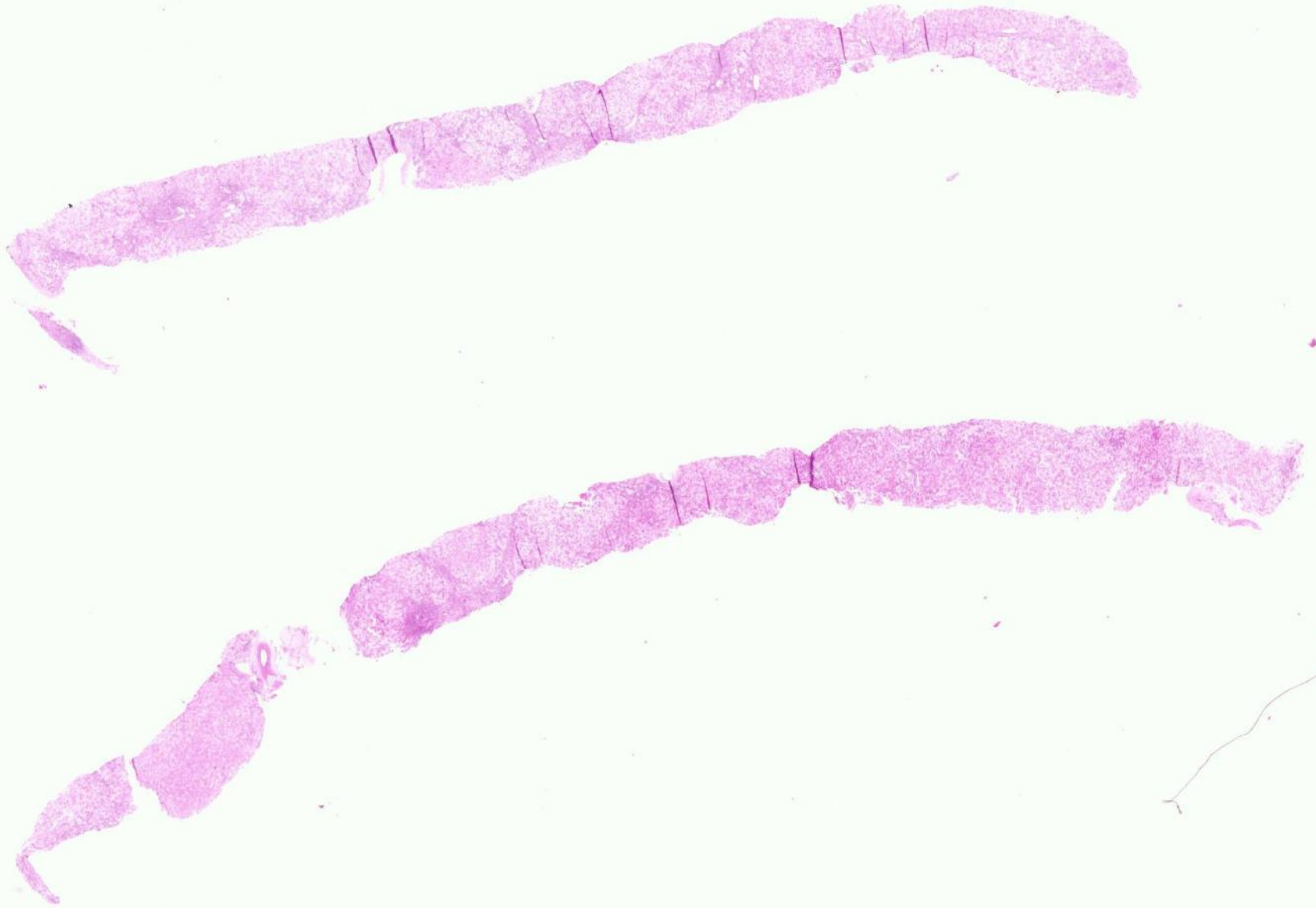
Admitted with acute intravascular haemolysis.

On admission: hepatosplenomegaly, jaundice, bilirubin 203  $\mu\text{mol/l}$ , Hb 6.3g/dl, coagulopathy, ALT 20u/l (<40); alk phos 33u/l (35-120), albumin 24g/l (35-48), GGT 248 u/l (0-38) caeruloplasmin 0.18 (0.24-0.63).

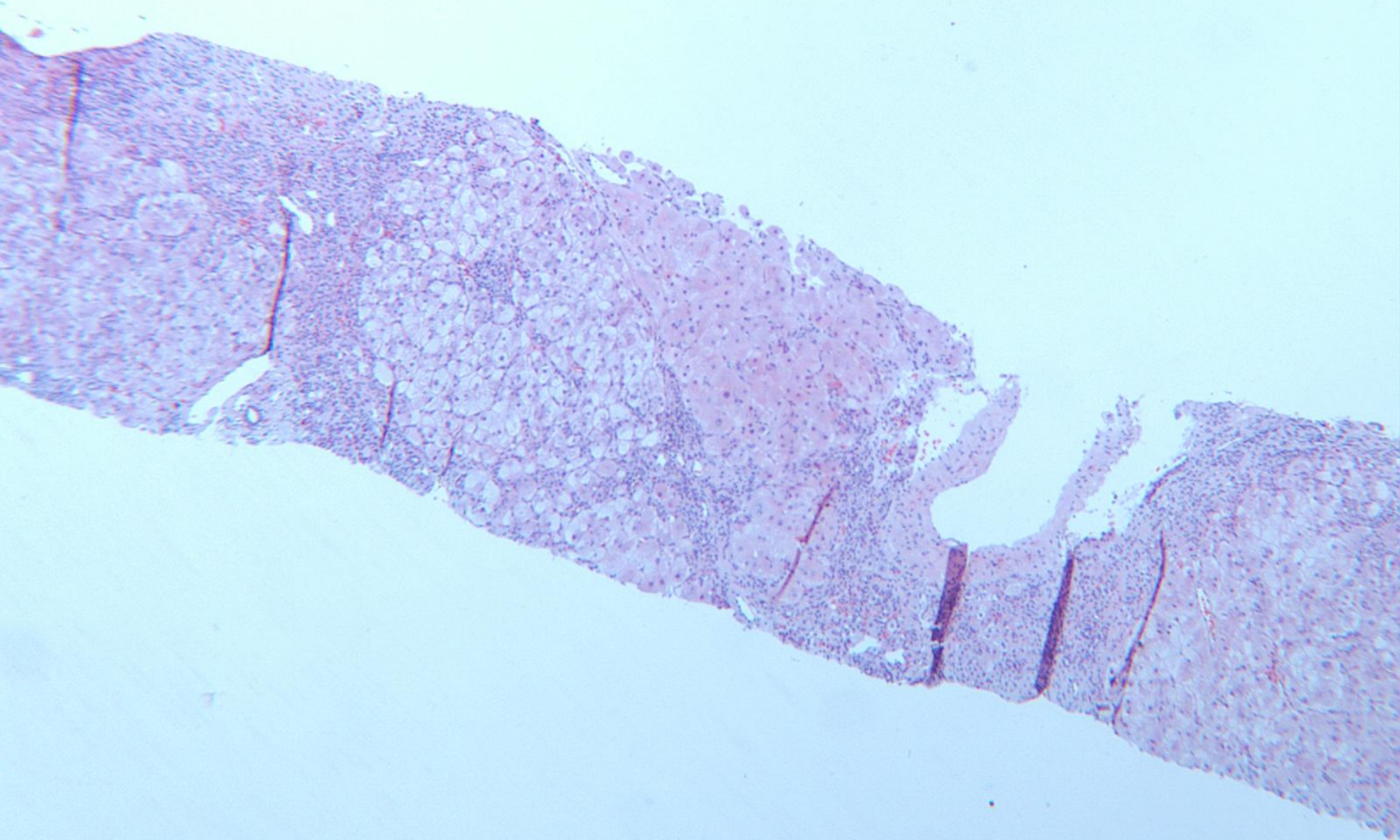
Marked coagulopathy, low albumin.

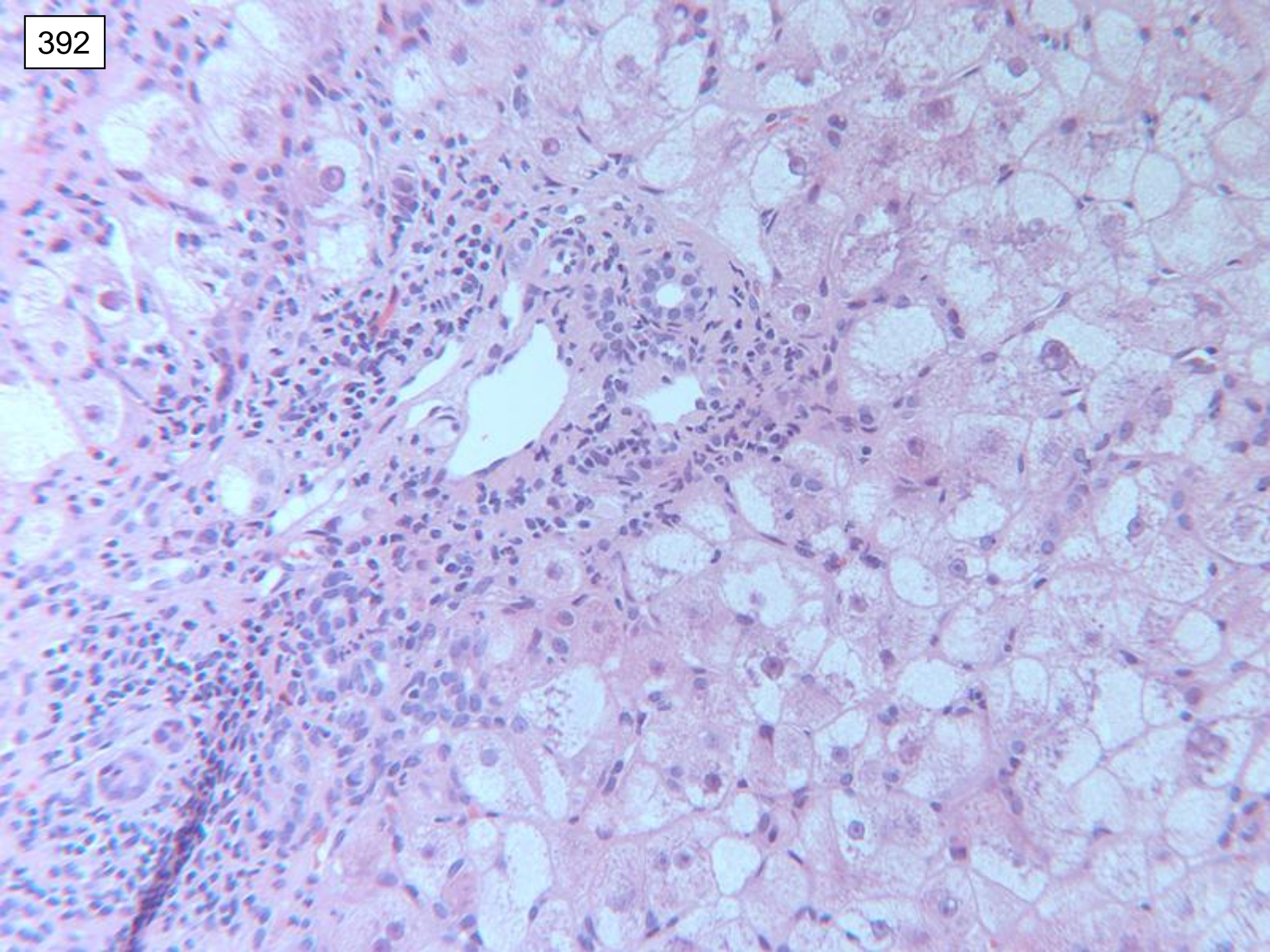
2 cores 15 and 17mm long (please also see connective tissue stain on website)

392

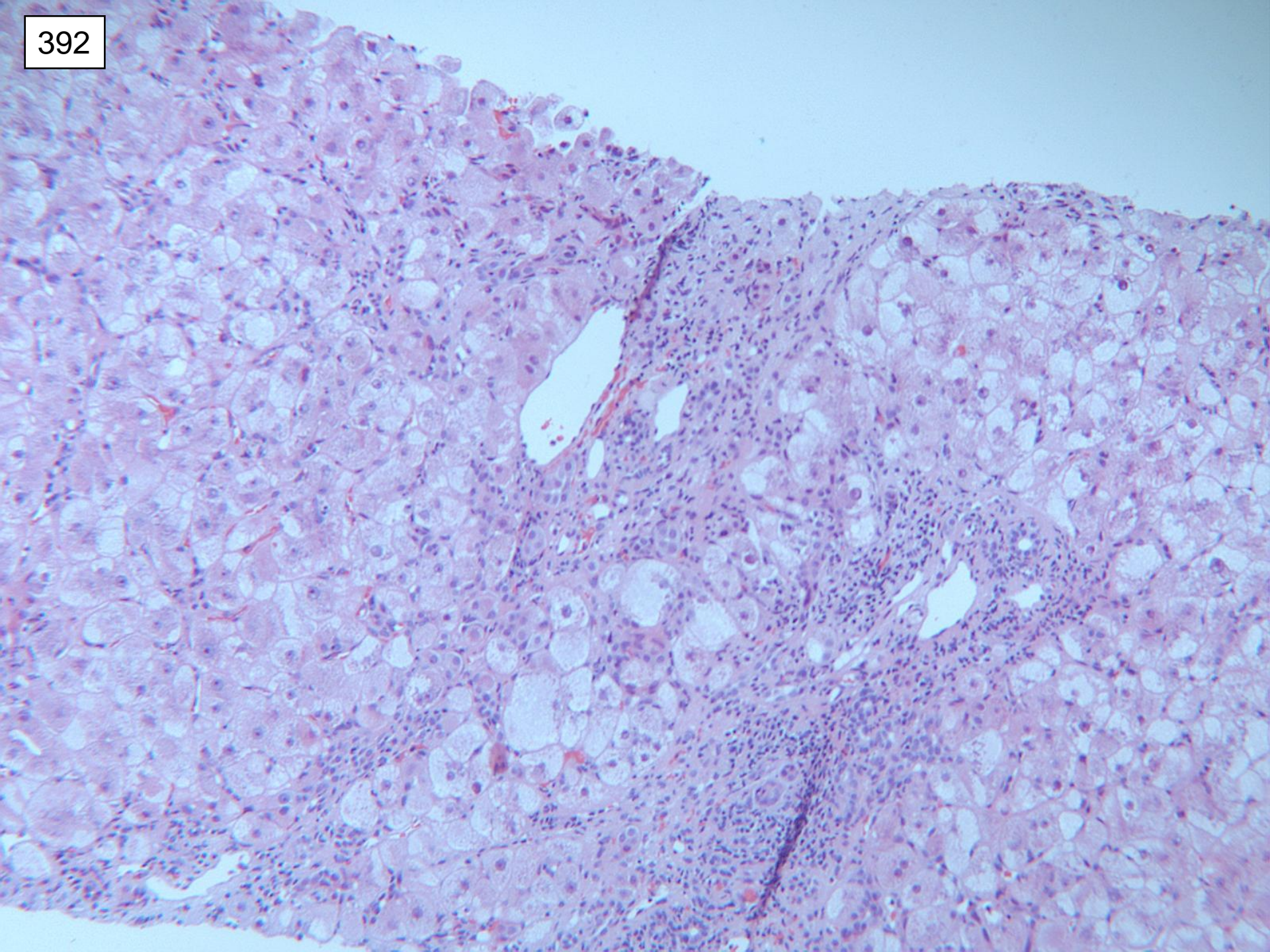


392

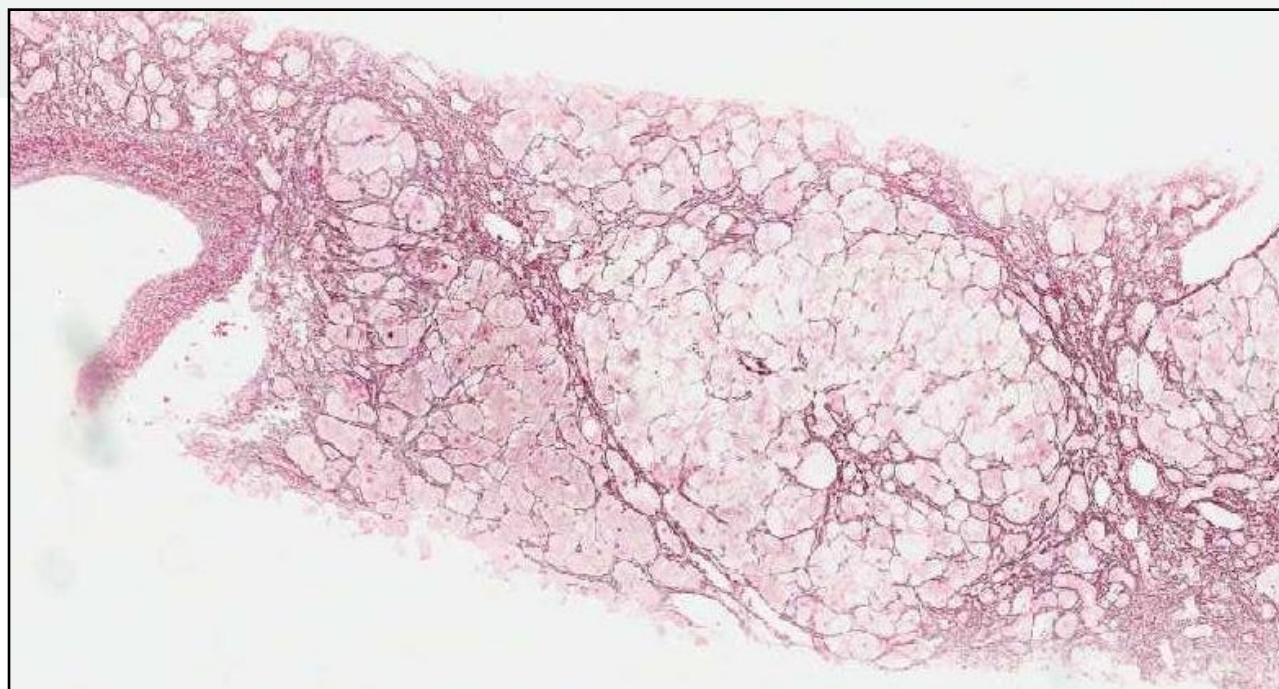
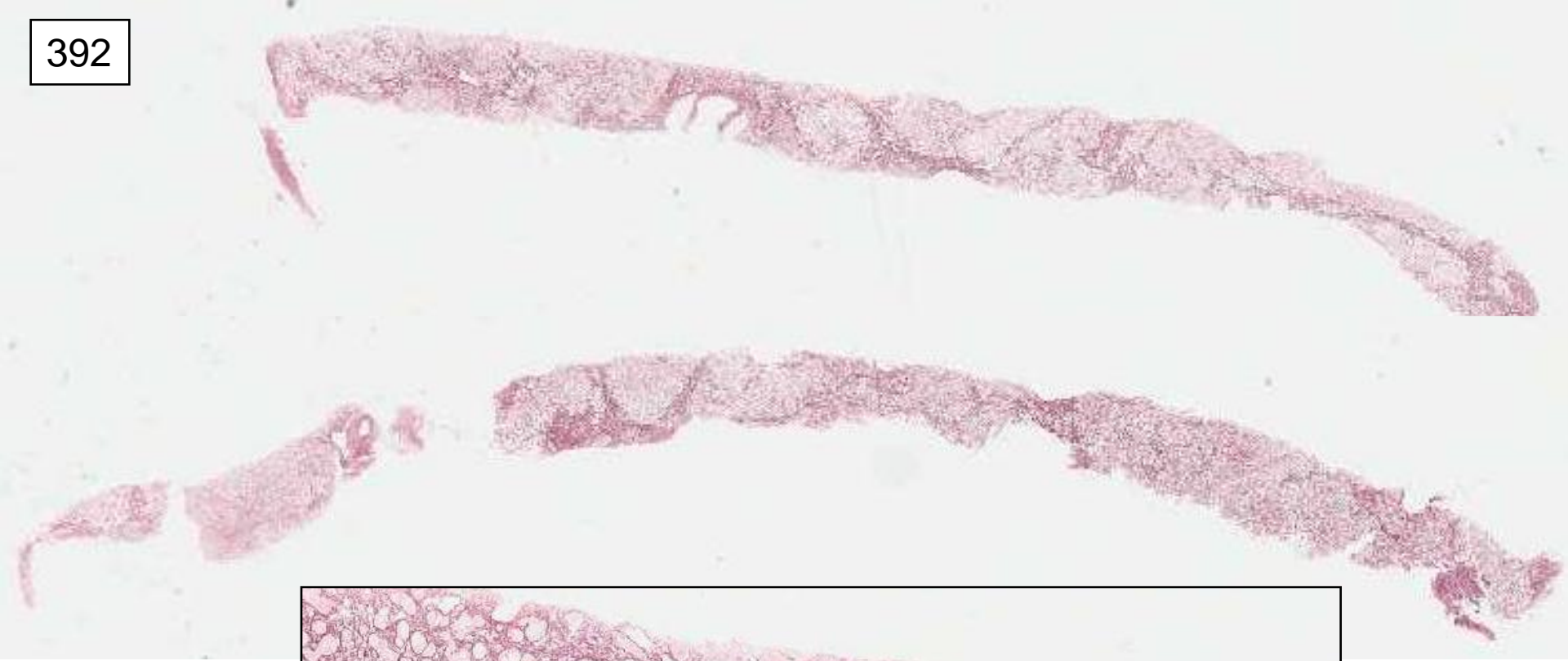




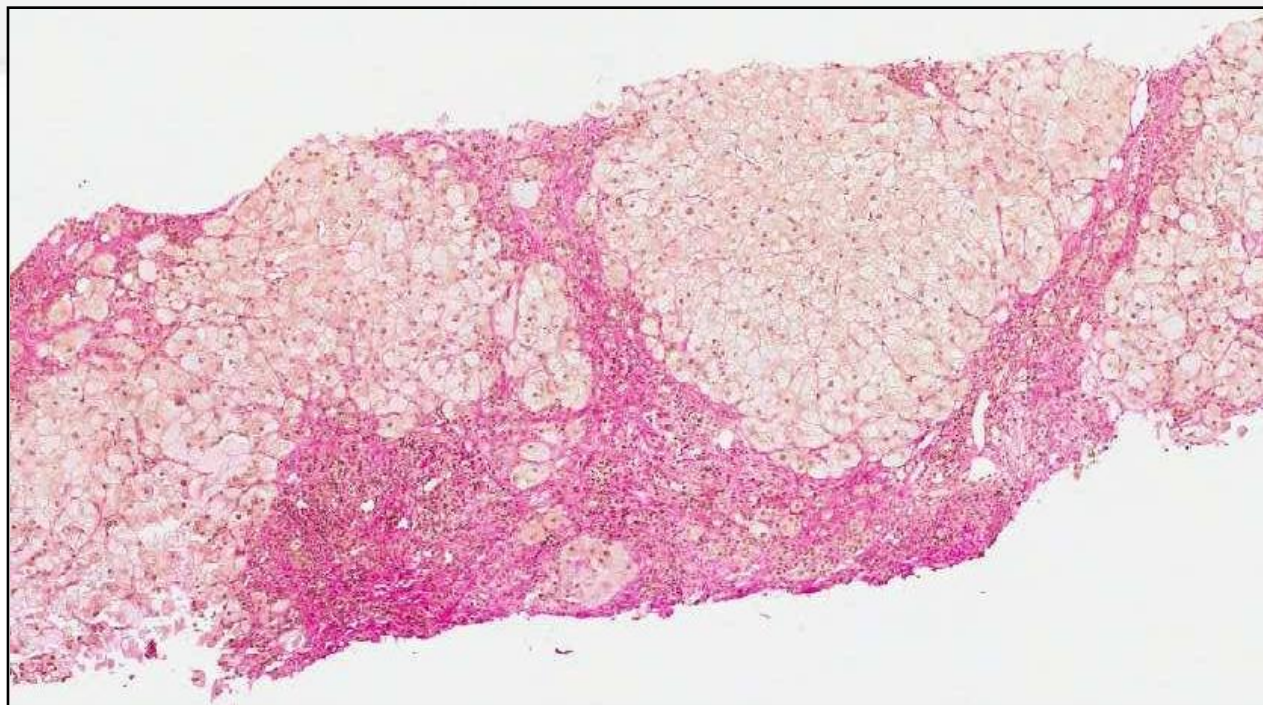
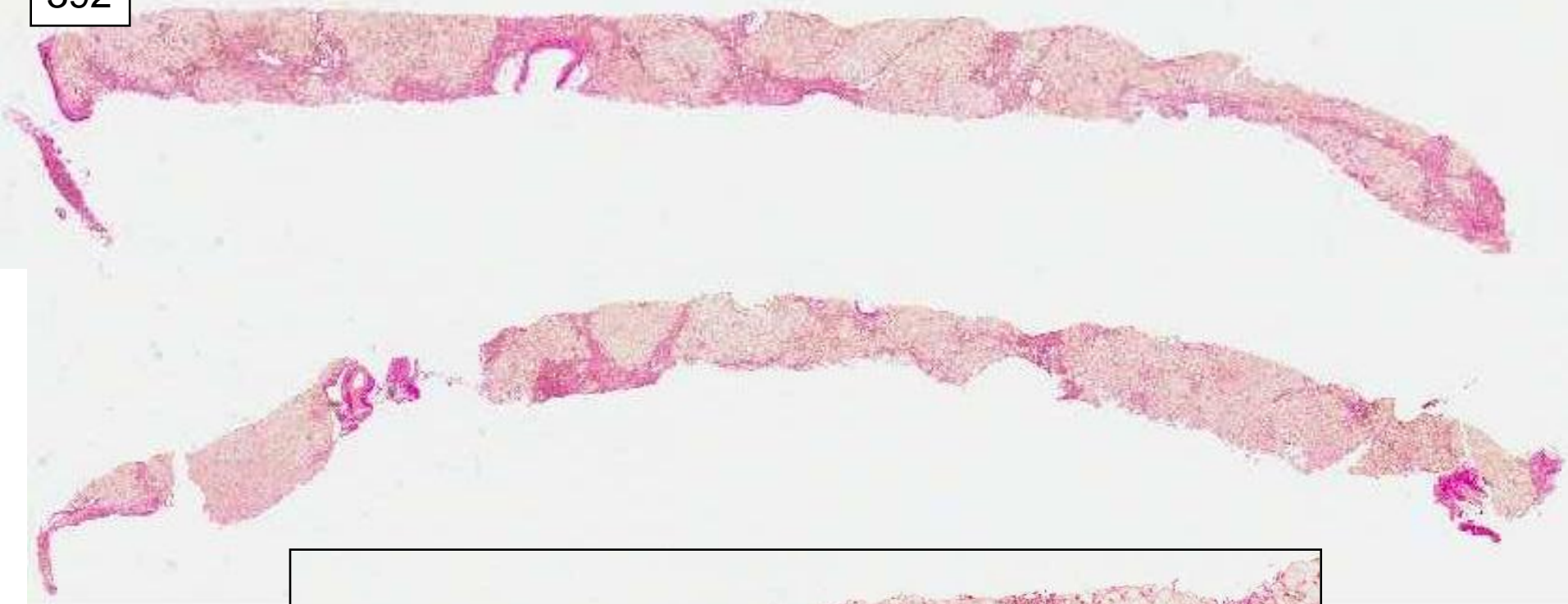
392



392



392



## Case 392: Responses

### Morphology

Cirrhosis: 48

Fibrosis, bridging, nodules ( not including cirrhosis): 17

Confluent necrosis: 8

'no significant fibrosis'

### **Ballooned/feathery/swollen hepatocytes: 66**

Mallory's : 19

(micro)steatosis: 9

### Aetiology

Consistent with Wilson's as most likely diagnosis: 51

Differential diagnosis that includes Wilson's but not most likely: 6

Wilson's not mentioned at all: 24

Acute or acute on chronic hepatitis: 12

Request for copper stains: 29

Individual responses not included in above:

'cirrhosis ? cause, ?metabolic'

'get second opinion'

'Hepatitis B?'

'alcoholic foamy degeneration ? Zieve's syndrome'

'ballooned hepatocytes suggestive of storage disorder ? Wilson's disease'

'cirrhosis possibly congenital biliary abnormality'

Alcohol related: 3

'acute on chronic hepatitis with biliary component'

'severe liver injury ? acute on chronic differential of metaolic and drugs'

### Suggested scoring

No consensus, not suitable for scoring.

Correct diagnosis is Wilson's disease – characteristic history, acute presentation with haemolysis, low caeruloplasmin, biopsy looks cirrhotic.

## Case 392 contd:

### Suggested scoring

No consensus, not suitable for scoring.

Correct diagnosis is Wilson's disease – characteristic history, acute presentation with haemolysis, low caeruloplasmin, biopsy looks cirrhotic.

### Discussion at meeting:

The correct diagnosis of Wilson's disease can be made from the clinical information supplied.

This is an educational case – since there was insufficient consensus this cannot be included for EQA scoring, but serves as a reminder of the importance of considering this diagnosis.

Masterclass - Summary of histopathological aspects of Wilson's disease provided by Alastair Burt – see next 2 slides.

# Liver biopsies and Wilson's disease

- summary of points by Alastair Burt

- Biopsy to investigation of abnormal liver function tests – copper associated protein usually due to chronic cholestatic disease, very unlikely to be Wilson's disease, although suggest the possibility in a young person with undiagnosed liver disease.
- Investigation for abnormal copper studies (low caeruloplasmin, raised urinary secretion of copper) – biopsy to confirm diagnosis of Wilson's disease and stage disease. Part of biopsy is sent to biochemistry for measurement of copper per dry weight of tissue.
- Investigation of siblings of patients with Wilson's with abnormal liver function tests

# Liver biopsies and Wilson's disease

- summary of points by Alastair Burt contd.

- Diagnosis of cause of cirrhosis
  - see copper-associated protein in periseptal hepatocytes
  - patchy small amounts in any cirrhosis,
  - large amounts in biliary disease,
  - irregular, all some nodules, none in others, may be Wilson's disease
- Can't screen for Wilson's because there are more than 300 variations of the abnormal gene, but can test family members
- Autoantibodies are not uncommon in patients with Wilson's disease – doesn't mean they have autoimmune hepatitis as well.
- Marked swelling of hepatocytes in this case – attributed to severe liver injury at presentation, not unusual in biopsies in Wilson's disease. .

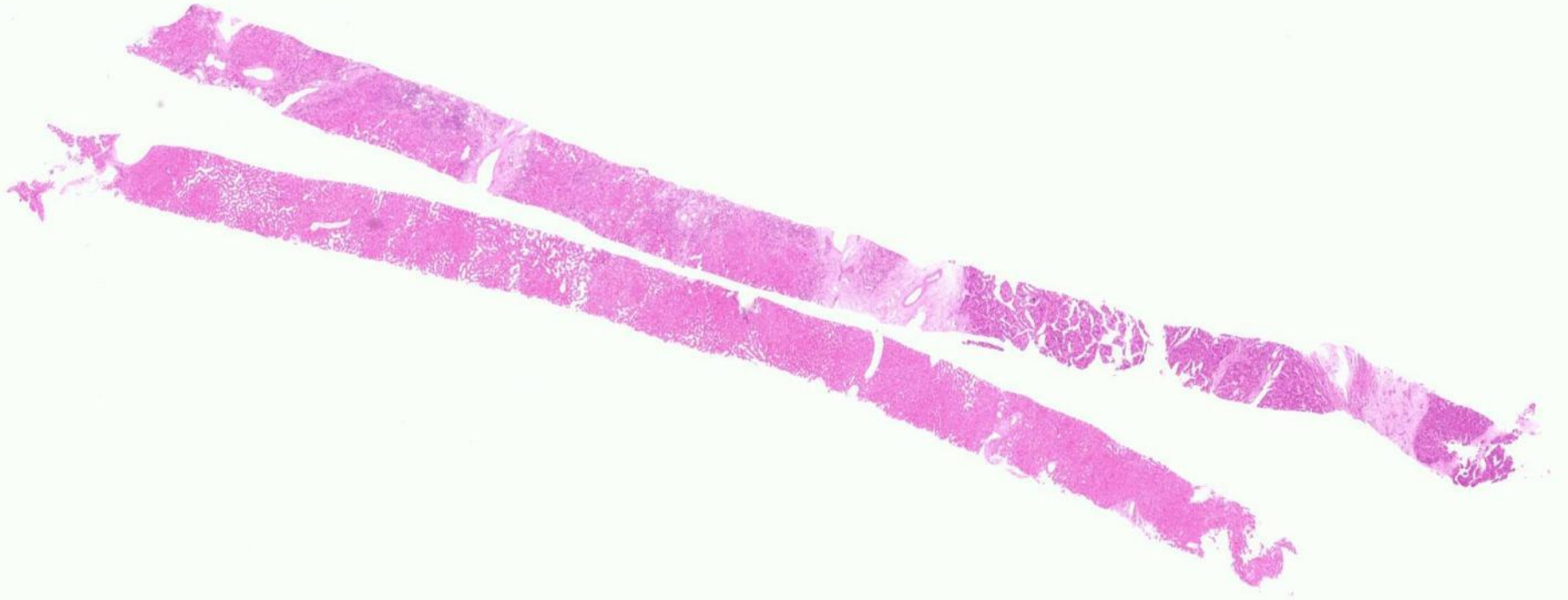
**Case F1/393**

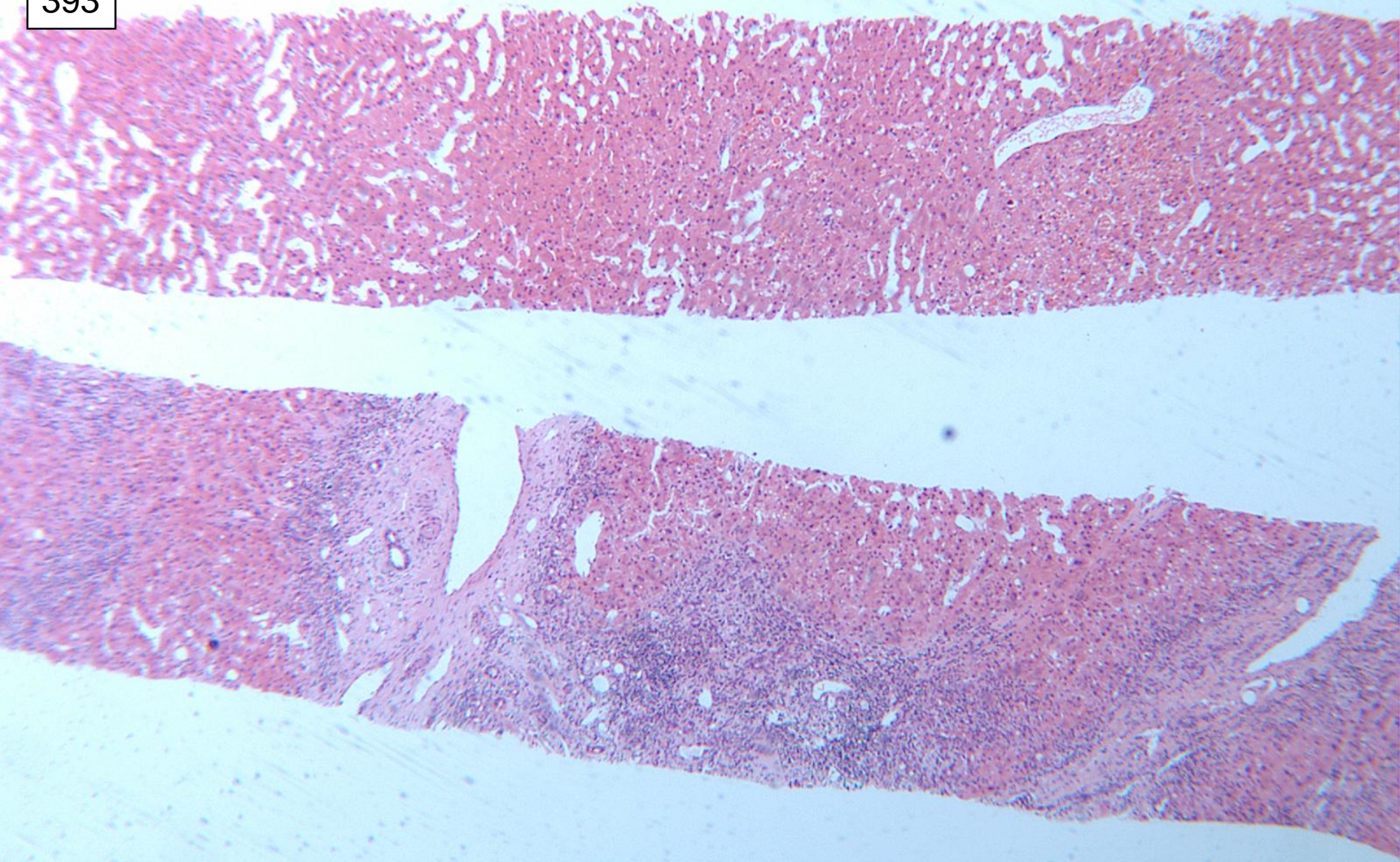
**76 M**

Mass right lobe of liver, likely HCC

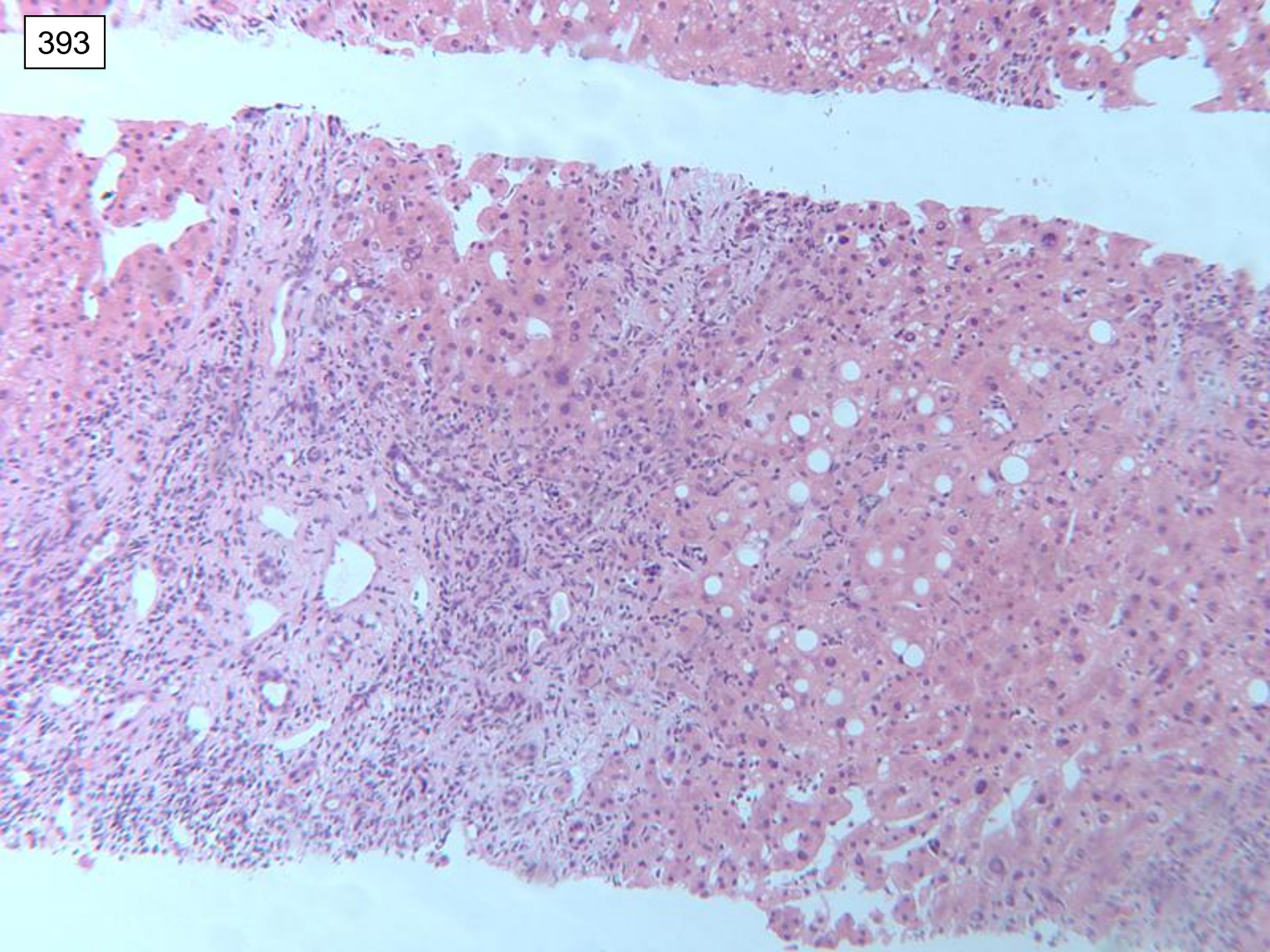
Two cores each 15mm long

393

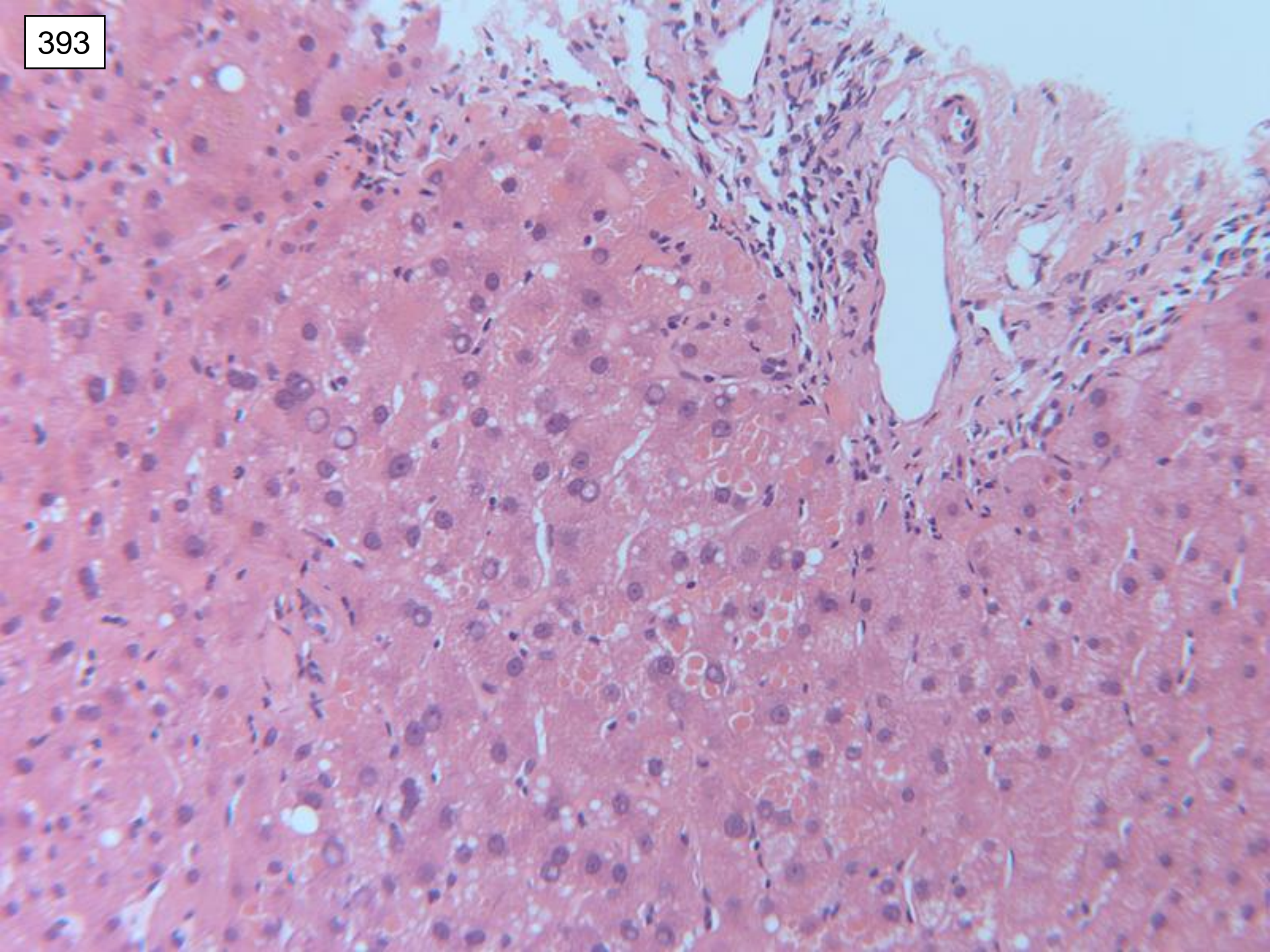


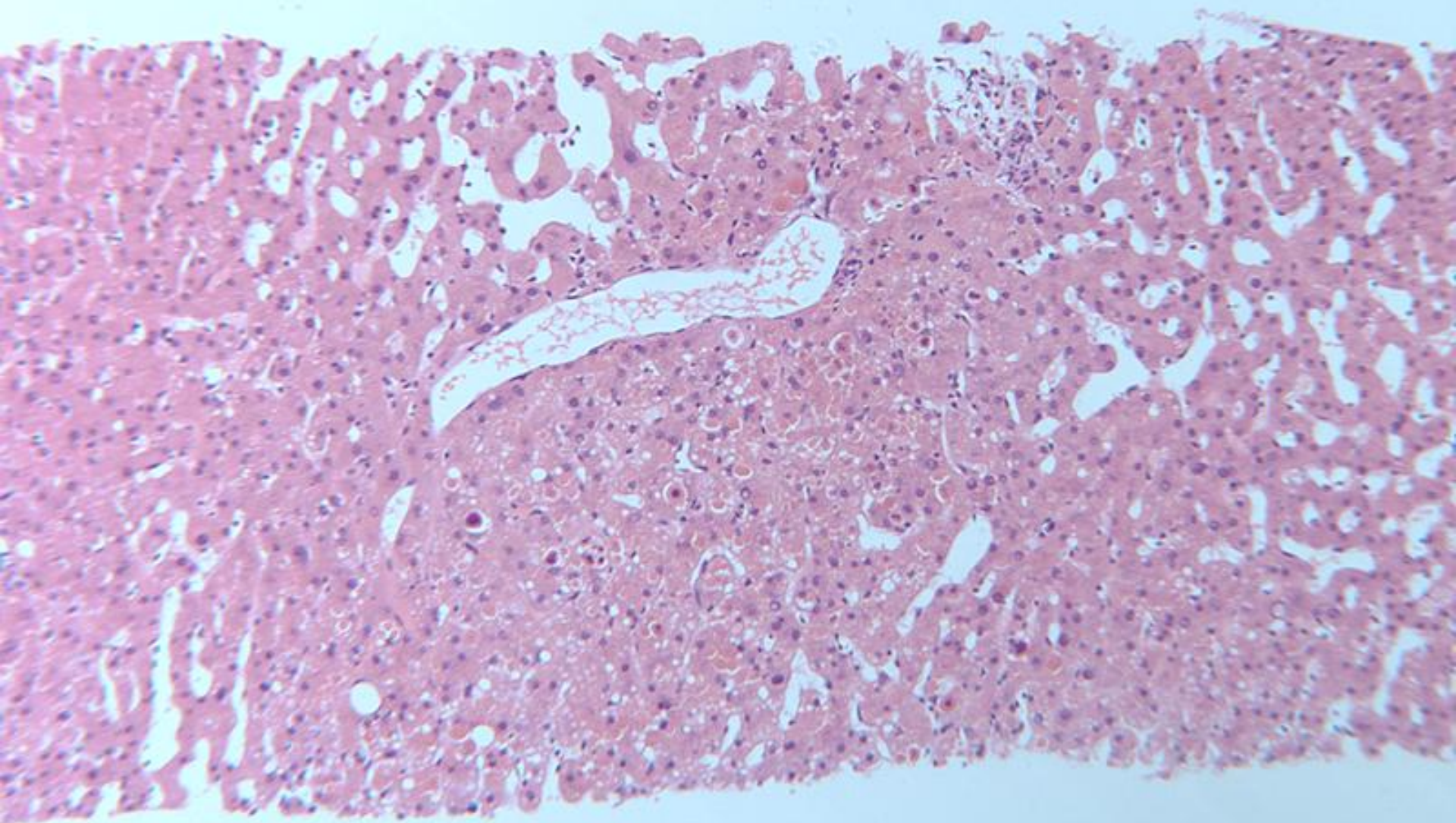


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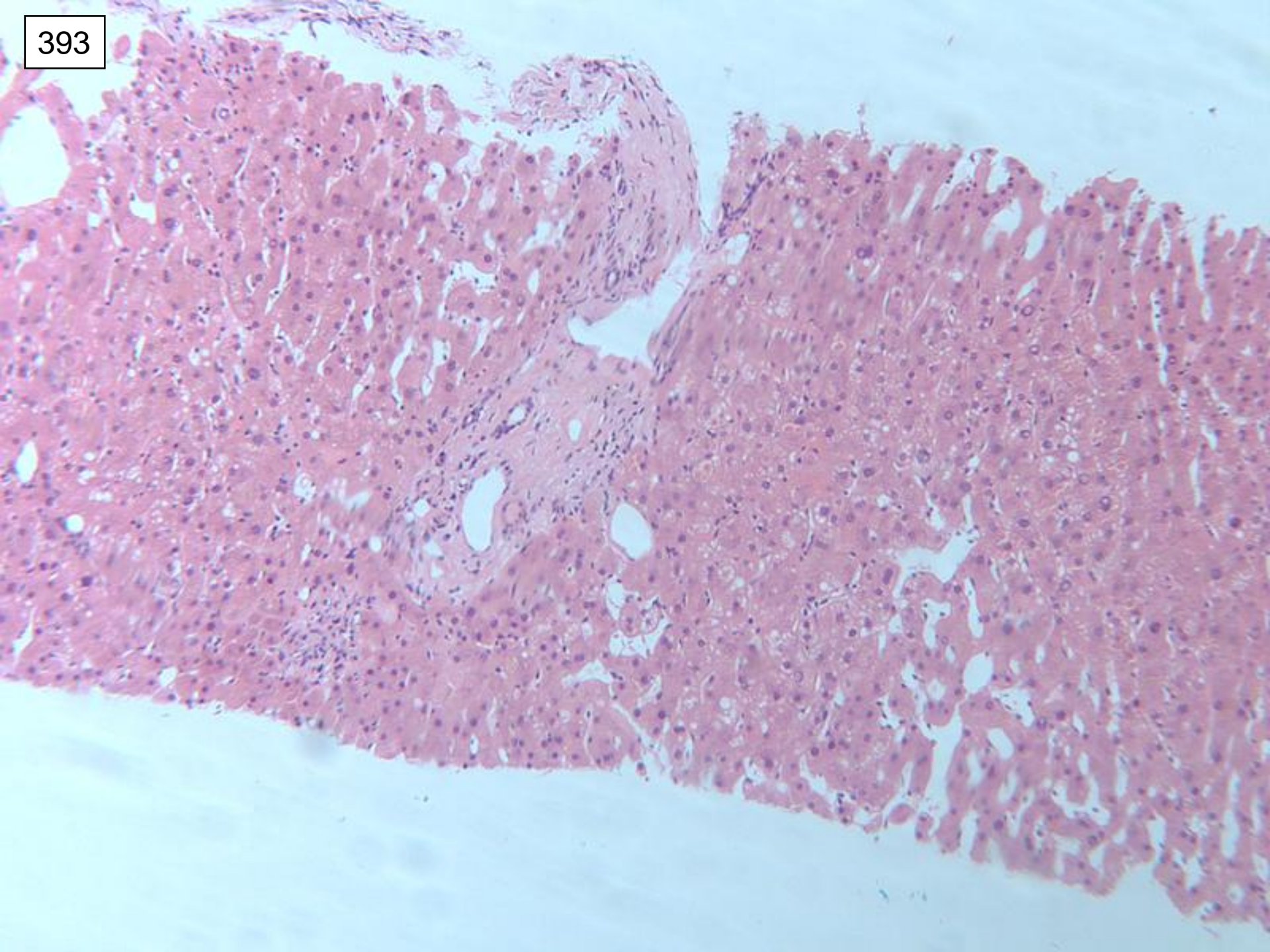


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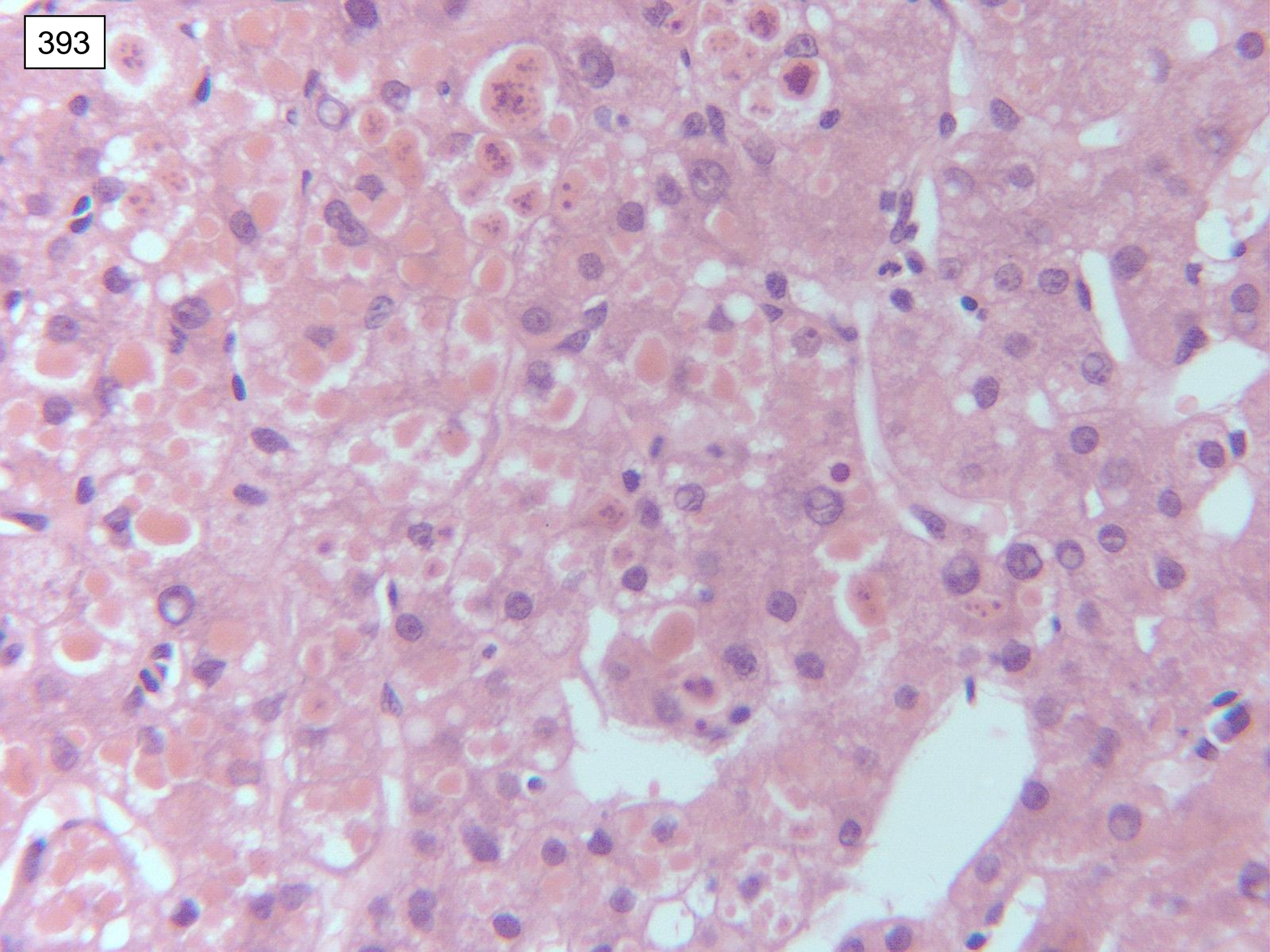


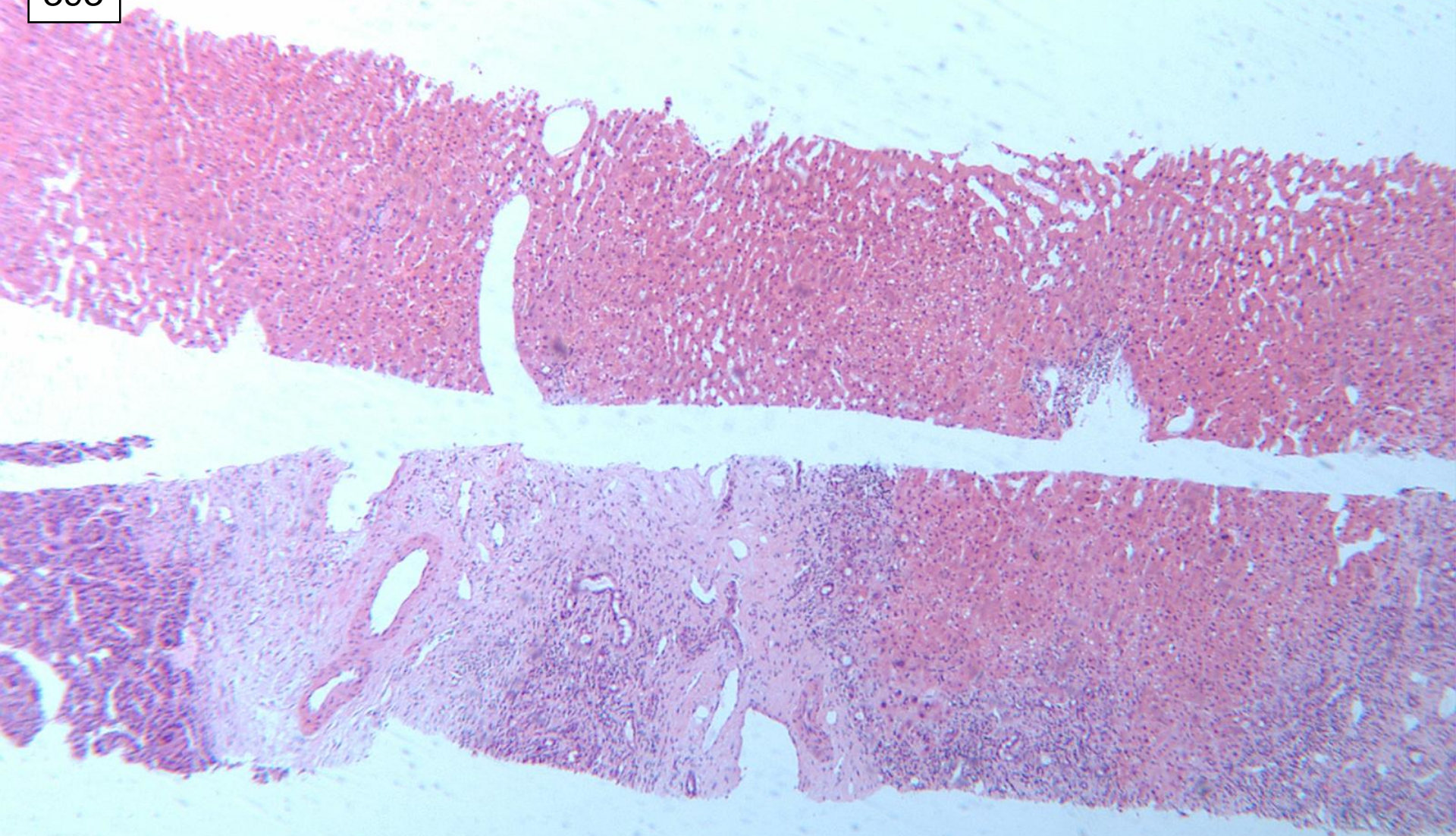


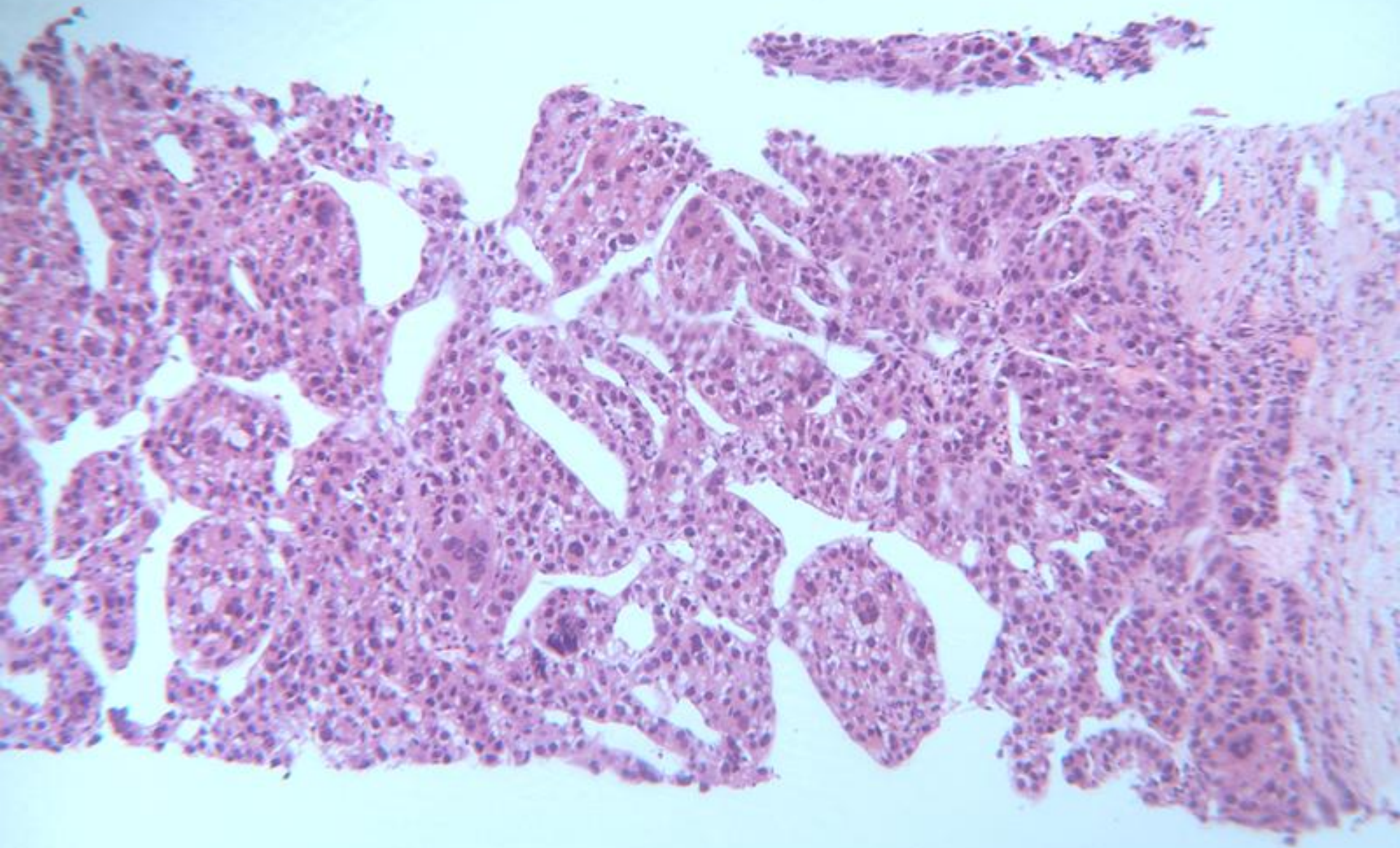
393



393







## Case 393: Responses

### Tumour:

#### **Hepatocellular carcinoma: 77**

Tumour differential diagnosis including HCC: 4

Request for HCC immunos: 16

### Background liver:

Cirrhotic: 27

Non-cirrhotic – changes related to nearby  
tumour: 43

Background fibrosis/stage not mentioned: 10

Alpha 1 antitrypsin deficiency: 46

Hyaline globules not stated to be  
A1ATD: 2

A1ATD not mentioned: 30

Fatty liver disease as aetiology: 4

### Suggested scoring

All responses included HCC as definite

or in differential with appropriate immunos.

Background liver – insufficient consensus on A1ATD to include for scoring.

Suggestions agreed

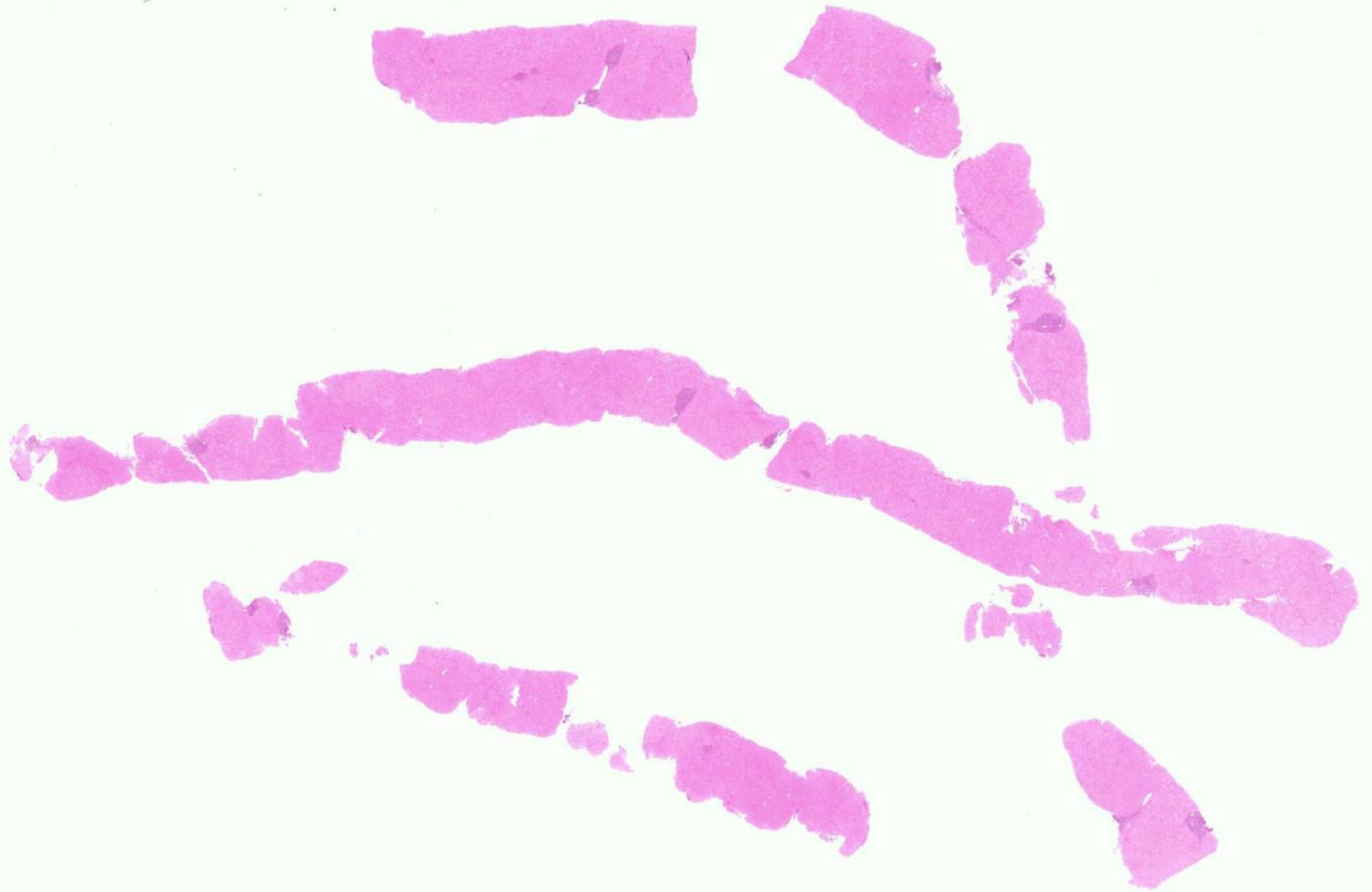
**Case F1/ 394**

**58 M**

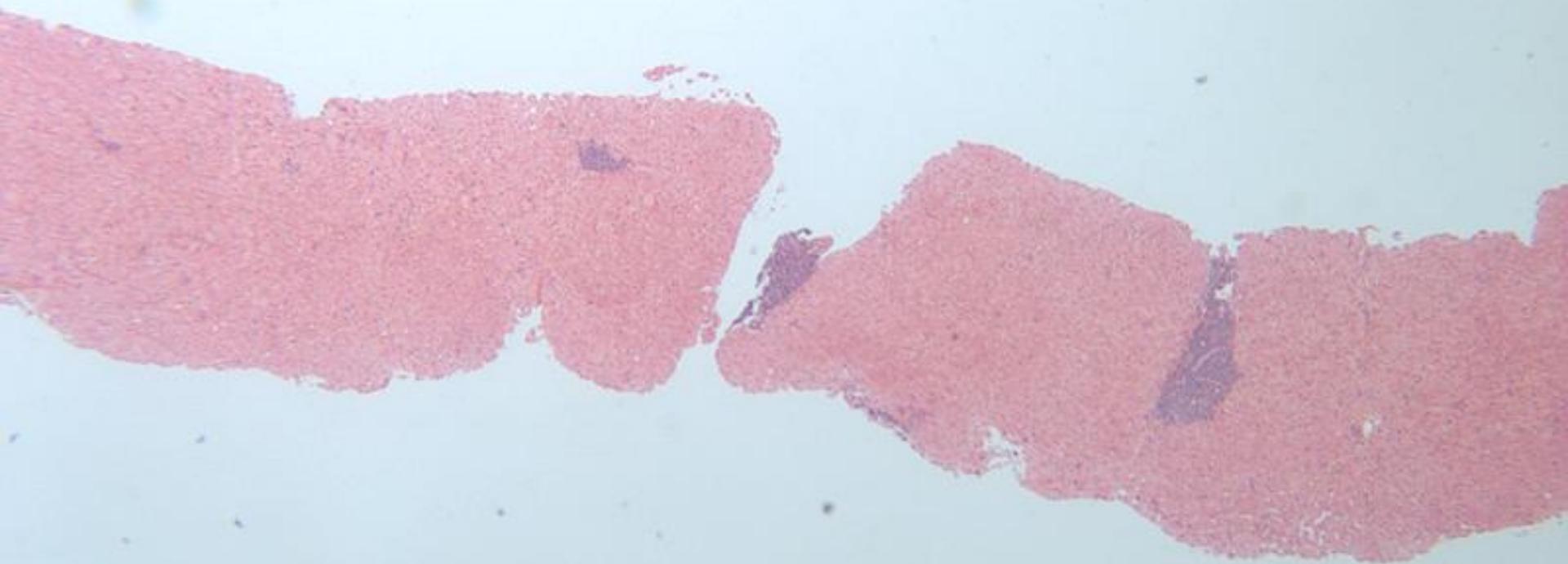
HCV genotype, RNA –ve after treatment

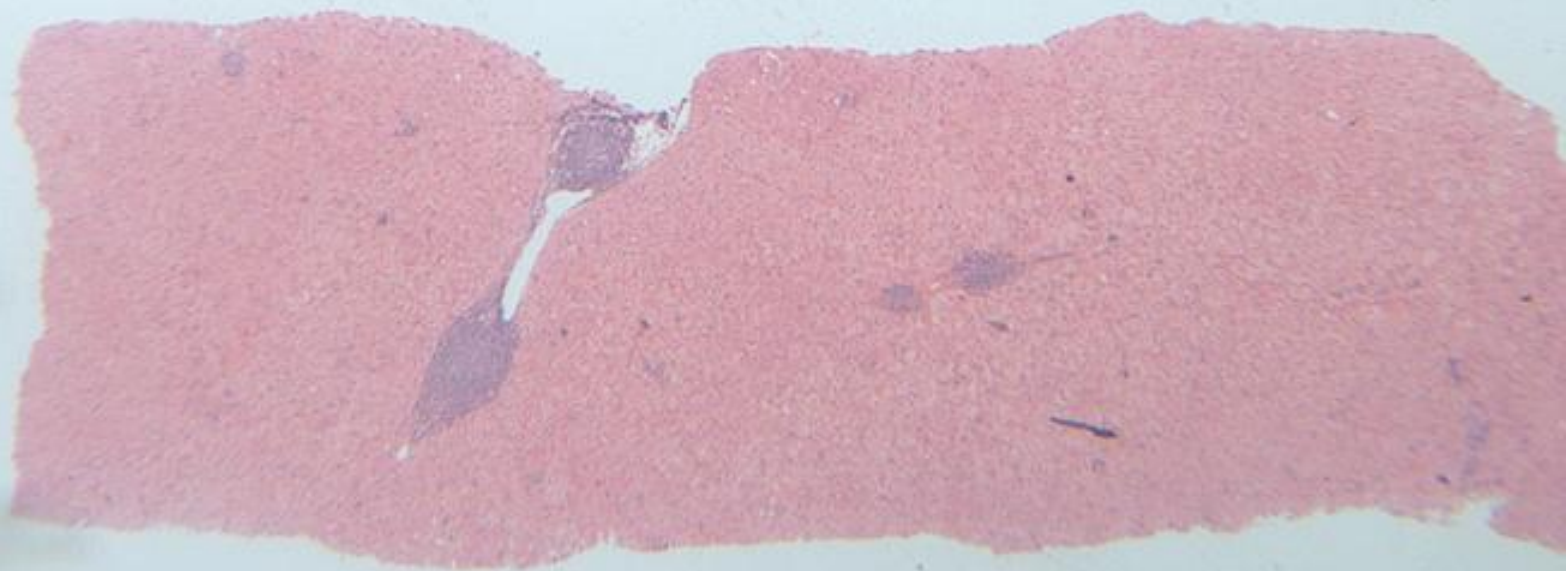
Three cores 20, 13 and 15mm long

394

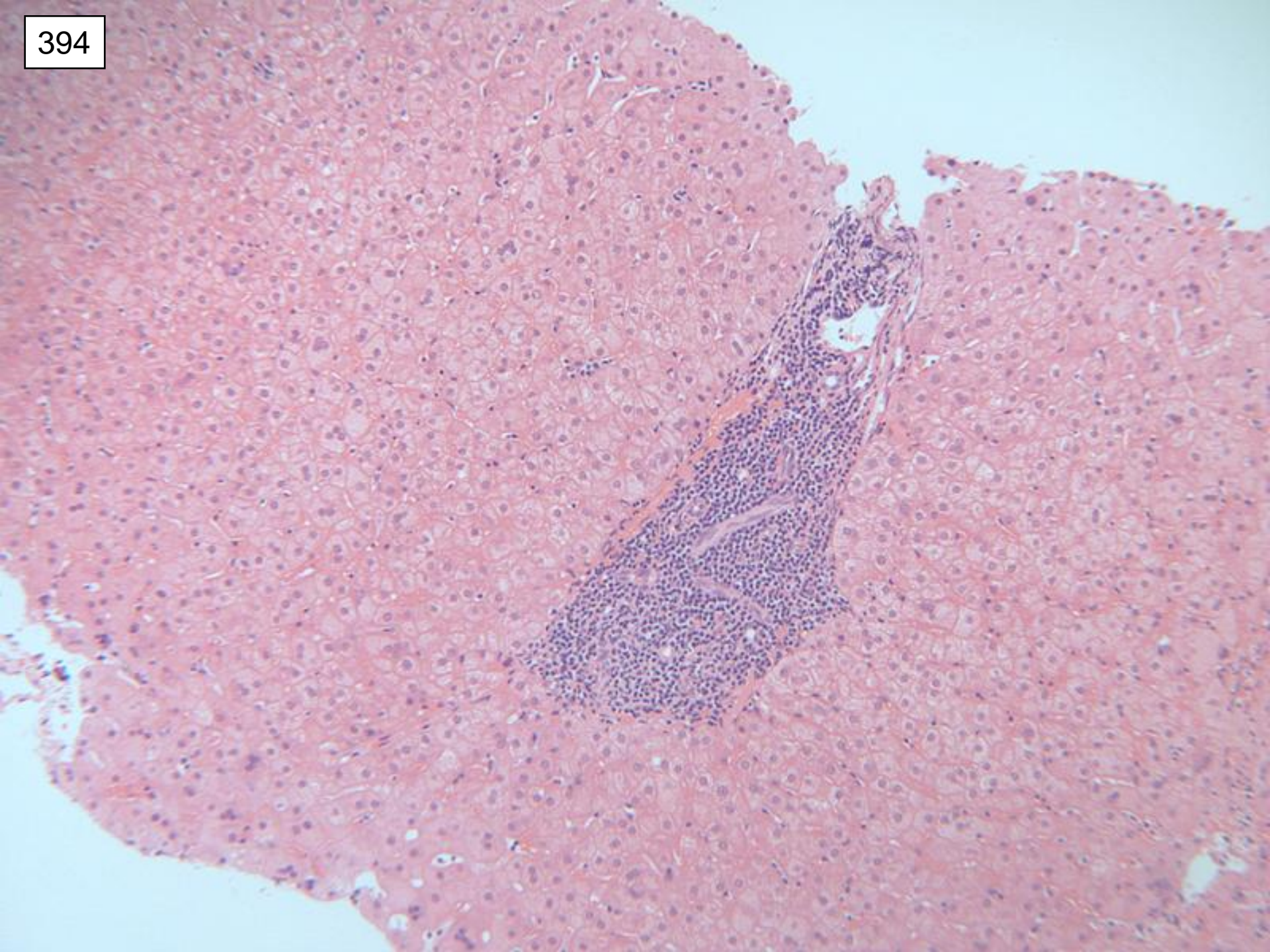


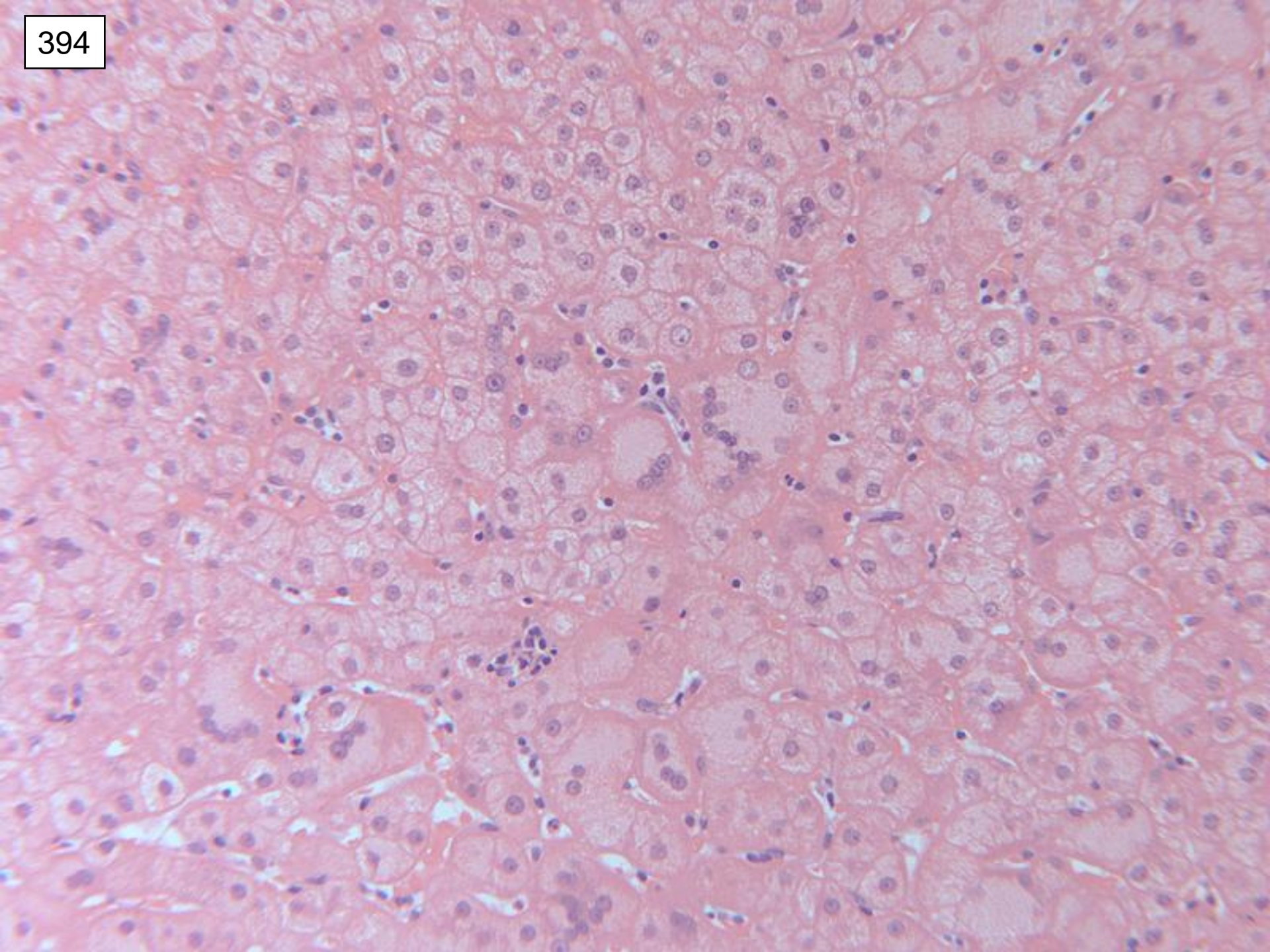
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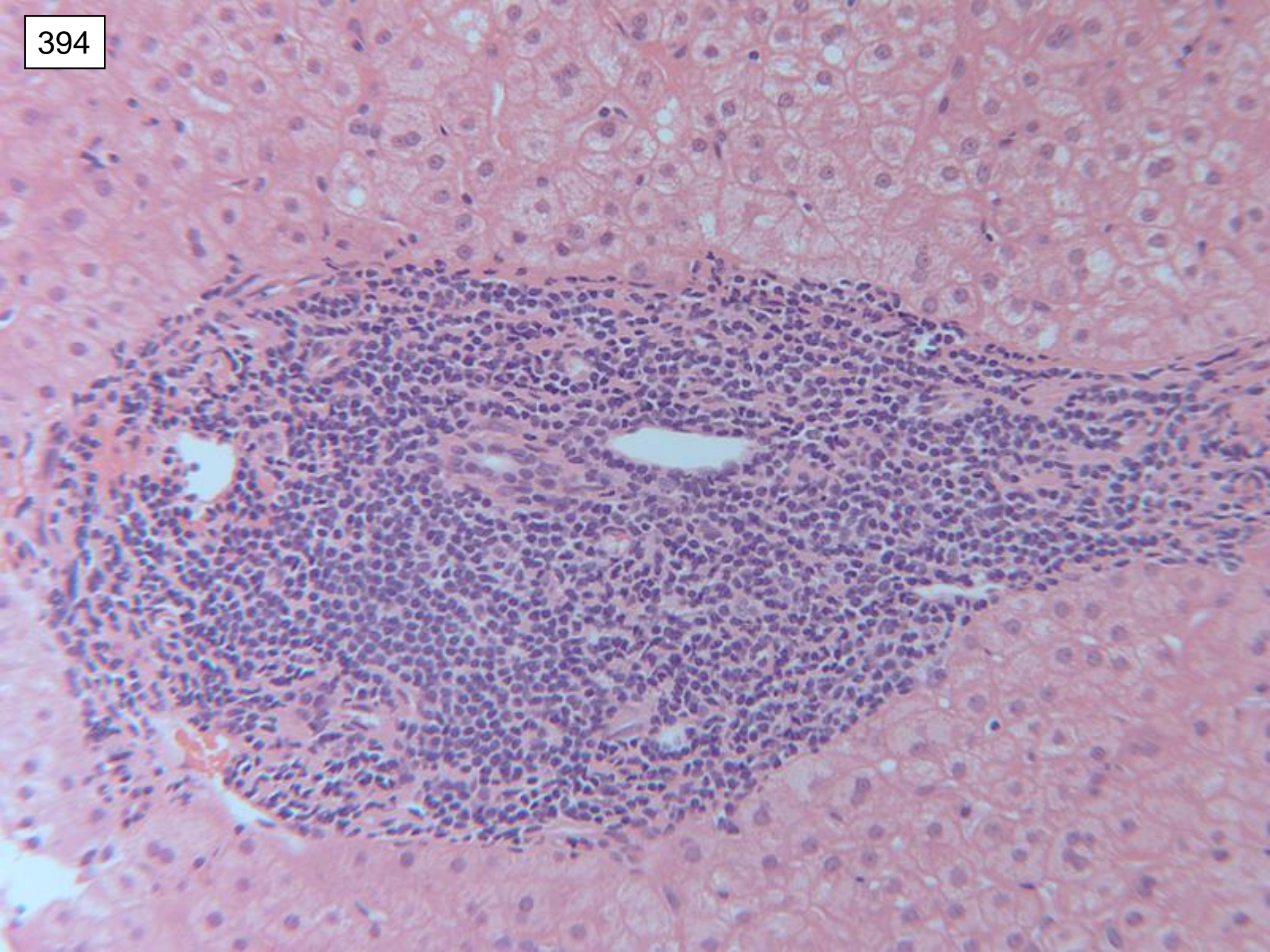


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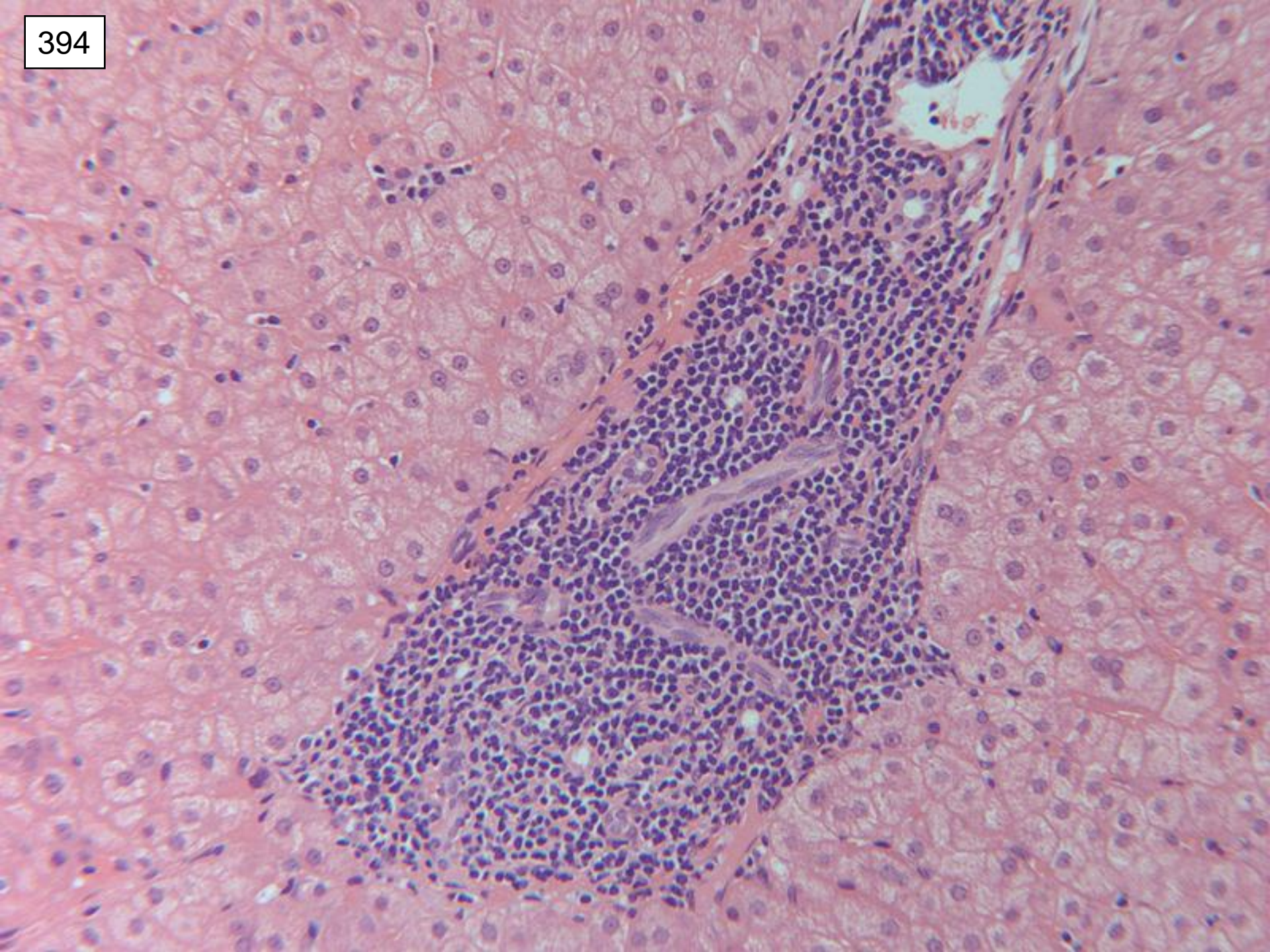




394



394



## Case 394: Responses

Hepatitis C: 40

Hepatitis C but lymphocytes monomorphic,  
possible/want to exclude lymphoma: 13

Lymphoma as most likely diagnosis: 26

Hepatitis C implied, not stated: 1

Hepatitis C and autoimmune hepatitis: 1

Ground glass hepatocytes/ possible hepatitis B: 13

Multinucleated hepatocytes specifically commented: 27

For hepatitis C responses:

Fibrosis stage:

Ishak stage: 38 responses -

Stage as text:

no fibrosis: 4

Mild: 2

Moderate: 1

bridging fibrosis: 1

No stage given: 1

Disease activity:

Ishak grade: 29 responses, see  
histogram

Activity as text:

residual: 1

Minimal: 1

Mild: 3

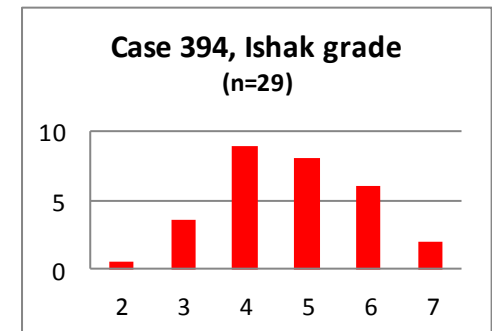
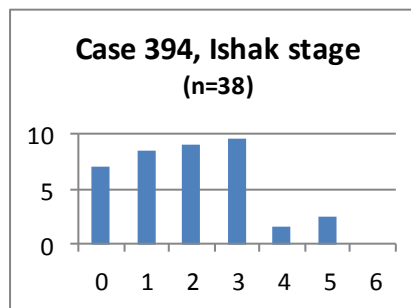
Mild-moderate: 4

Moderate: 3

No grade given: 4

Other scores:

Metavir: A1F0; A1F2; A0F1; A1F0 or 2.



Suggested scoring

No consensus, not suitable for scoring.

## Case 394 contd.

Very interesting result – original diagnosis was lymphoma, but clinical details frame the problem as a case of hepatitis C.

Are you more likely to recognise the lymphoma if you don't read the clinical information before looking at the slide?

Following the meeting: responses reviewed: 41 had some comment raising the possibility of lymphoproliferative process/lymphoma.

40 responses – hepatitis C only

Many considered the possibility of hepatitis B (often due to suggestion of ground glass hepatocytes on histology).

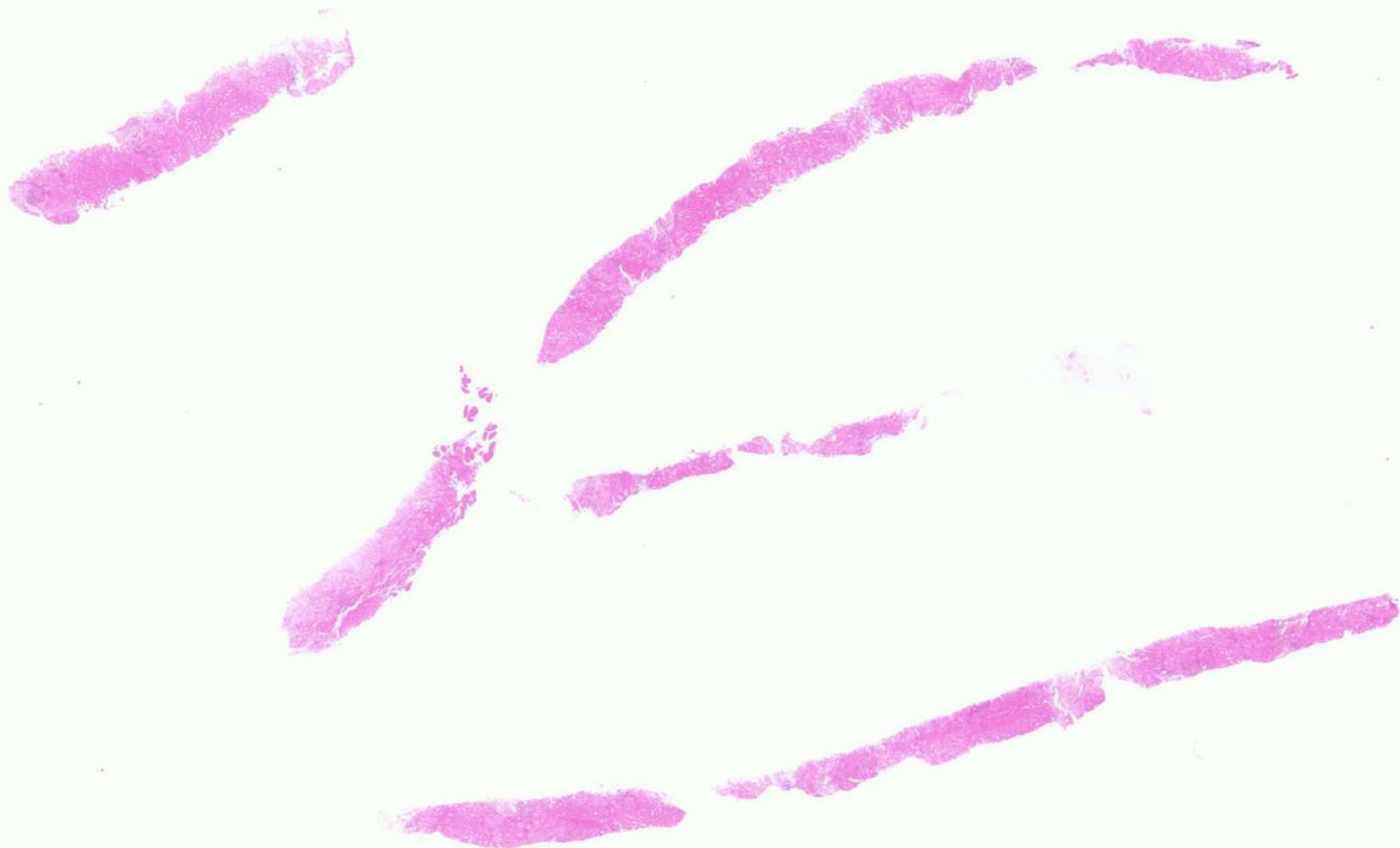
**Case F1/395**

**39 F**

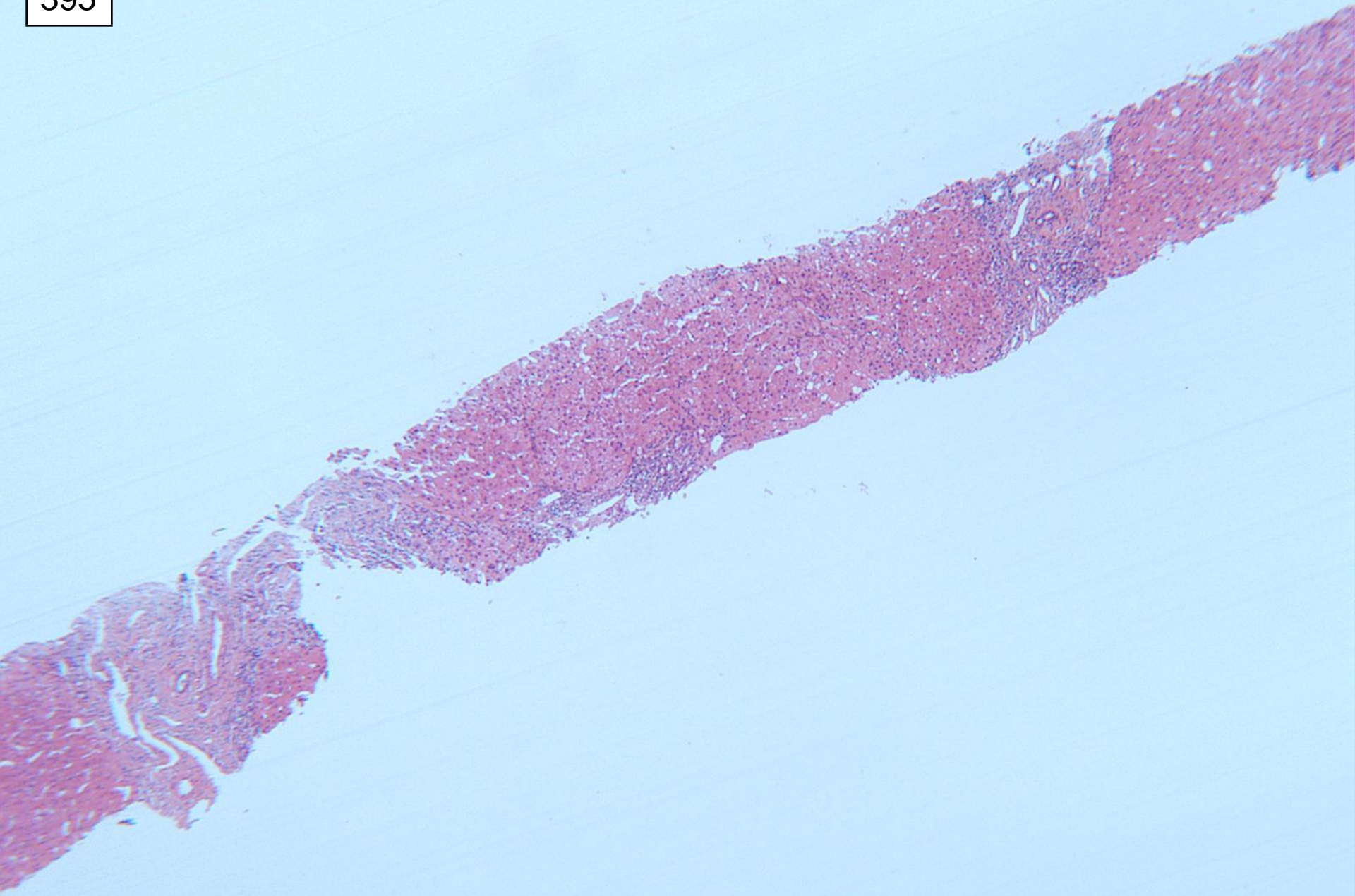
Hepatitis C virus positive.

Multiple cores (5) combined length 40mm

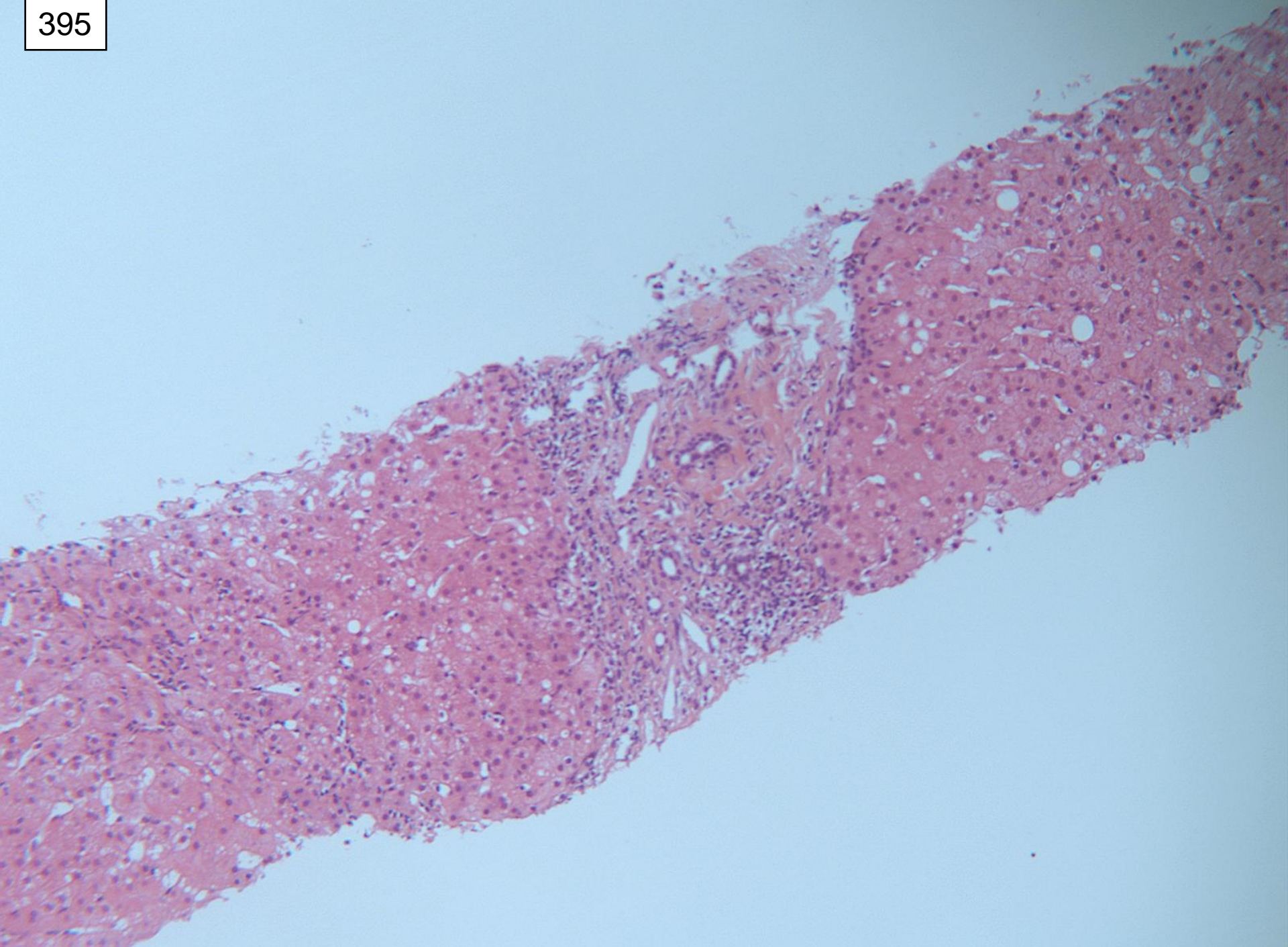
395



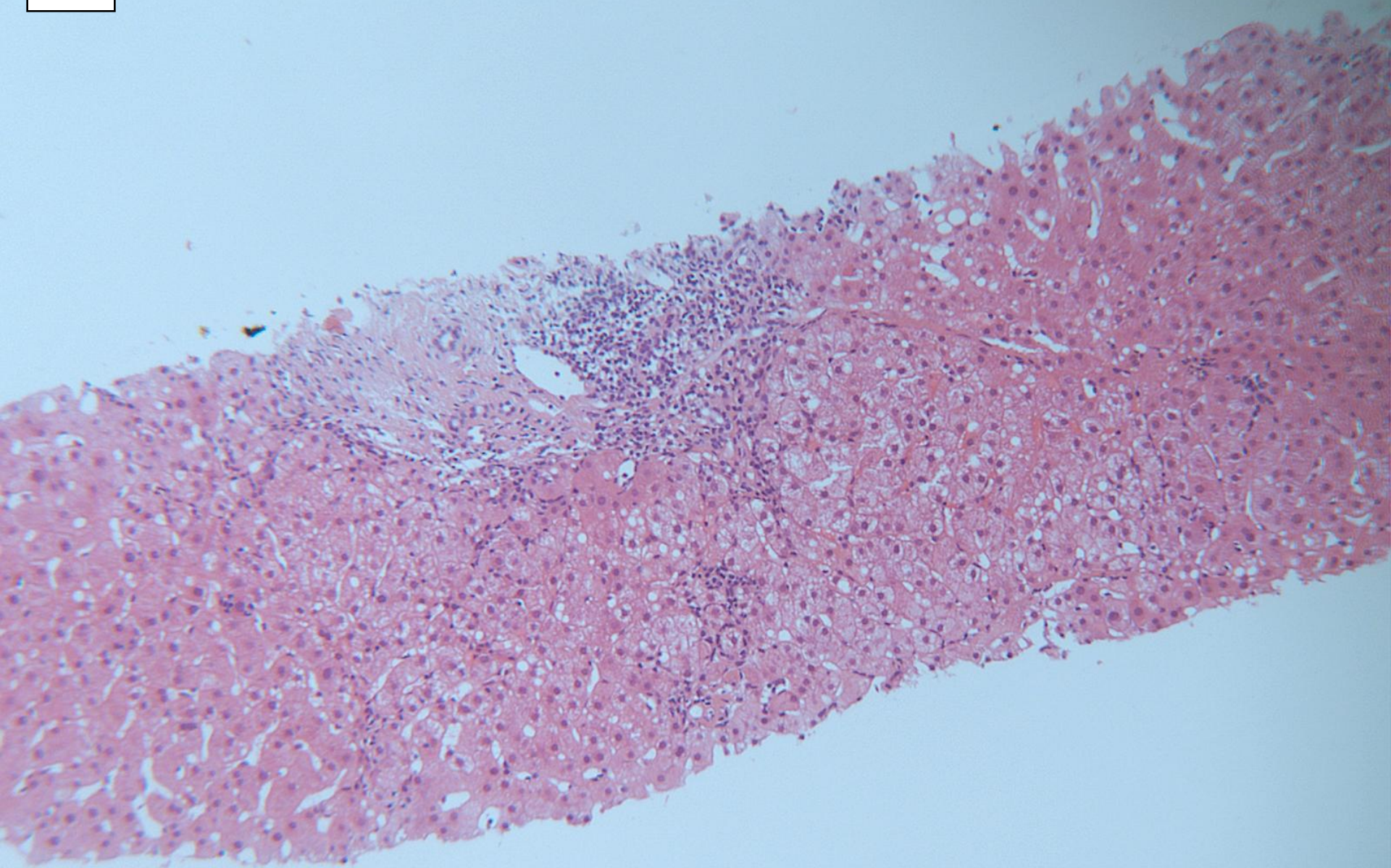
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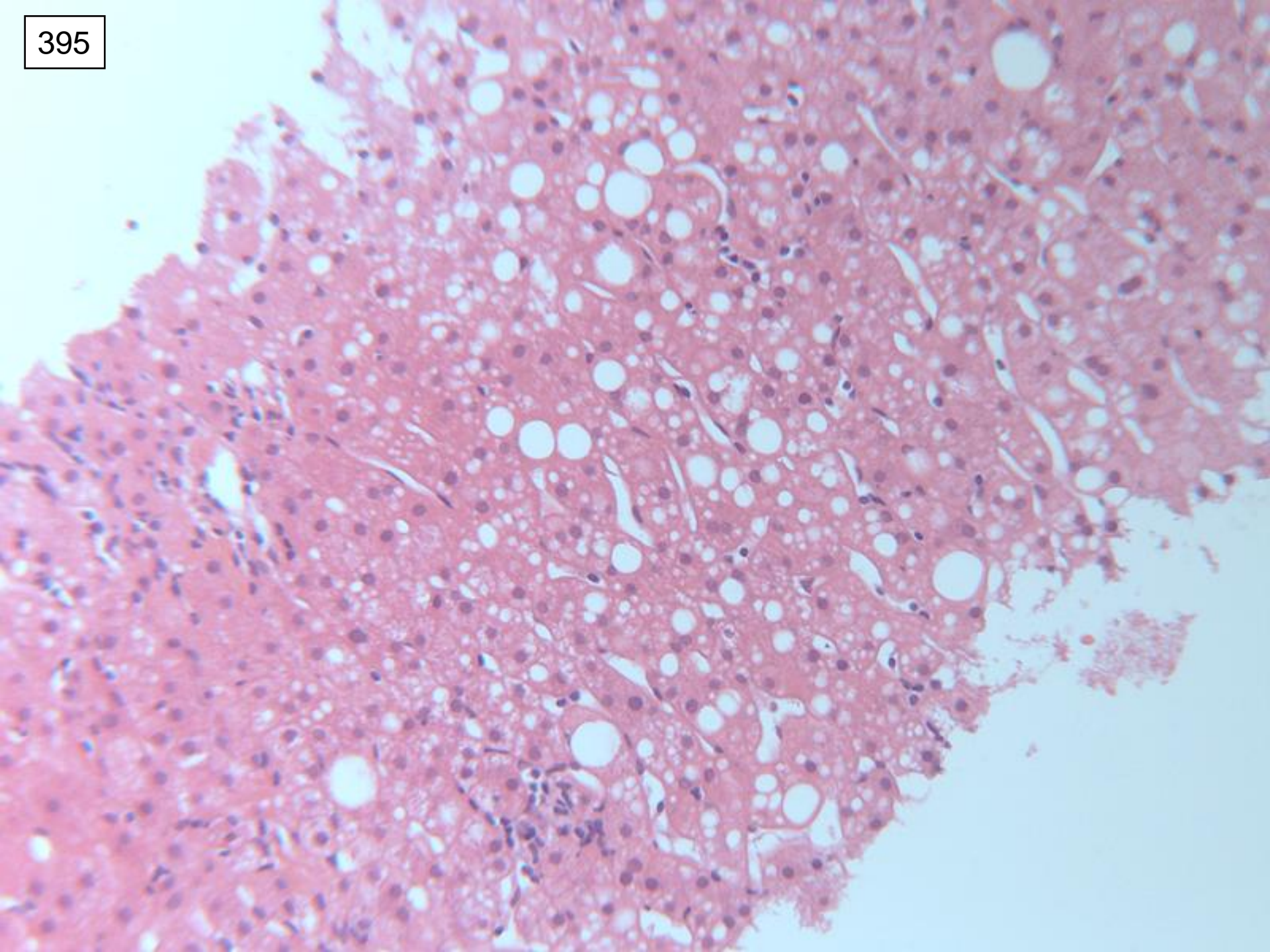


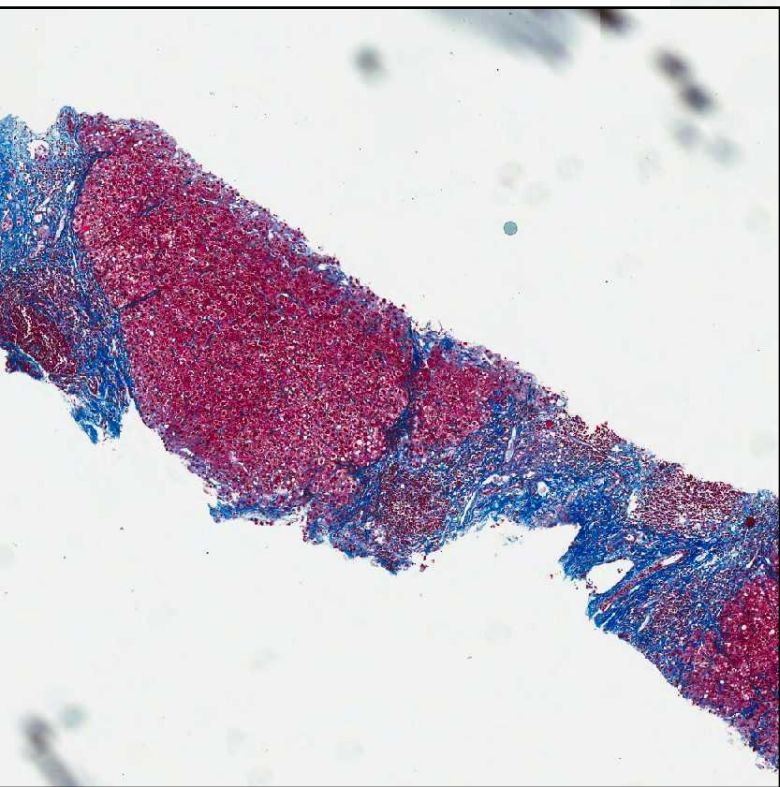
395



395







## Case 395 Responses

### Morphology & aetiology:

**Hepatitis C: 77**

**Hepatitis C not mentioned: 3**

Hepatitis C and PSC – bile duct loss  
and scarring: 2

Steatosis: 60

Steatosis not mentioned: 7

No steatosis: 2

‘exclude lymphoma’ 1

Consider other cause of fatty change: 9

Relation of fat to a specific hepatitis C  
genotype (3): 11

Hepatitis C and steatohepatitis: 5

‘CAH / viral load’

### Suggested scoring

As for case 391, lose marks for not including hepatitis C.

? penalty for not including stage / grade – but not done, since there is so little agreement on what these should be!

Discussion at meeting: suggested scoring agreed

Fibrosis stage:

Ishak stage: 54 responses - see histogram

Stage as text:

Moderate: 1

Severe:2

bridging fibrosis: 2

advanced: 2

significant: 1

bridging and nodules: 1

early/developing/incipient cirroisis: 5

probable cirrhosis: 2

cirrhosis: 6

No stage given: 1

Disease activity:

Ishak grade: 42 responses, see histogram

Activity as text:

Mild: 3

Mild –moderate: 1

moderate: 10

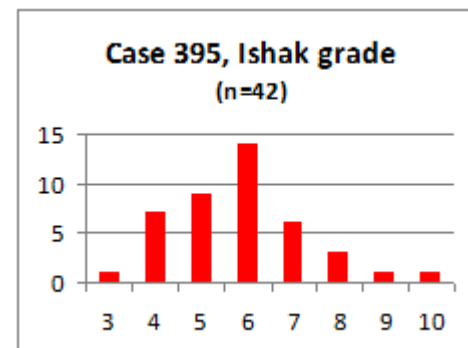
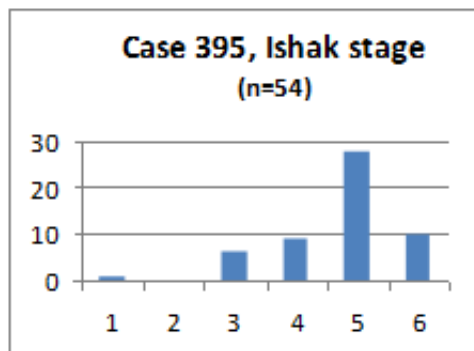
Moderate-severe: 1

Marked: 1

No grade given: 1

Other scores:

Metavir: A2F4; A2F4;A3F3; A4F3.



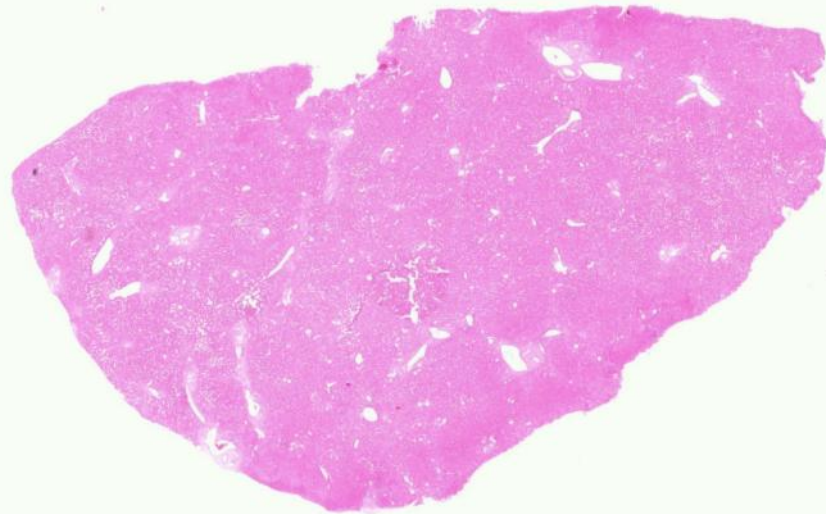
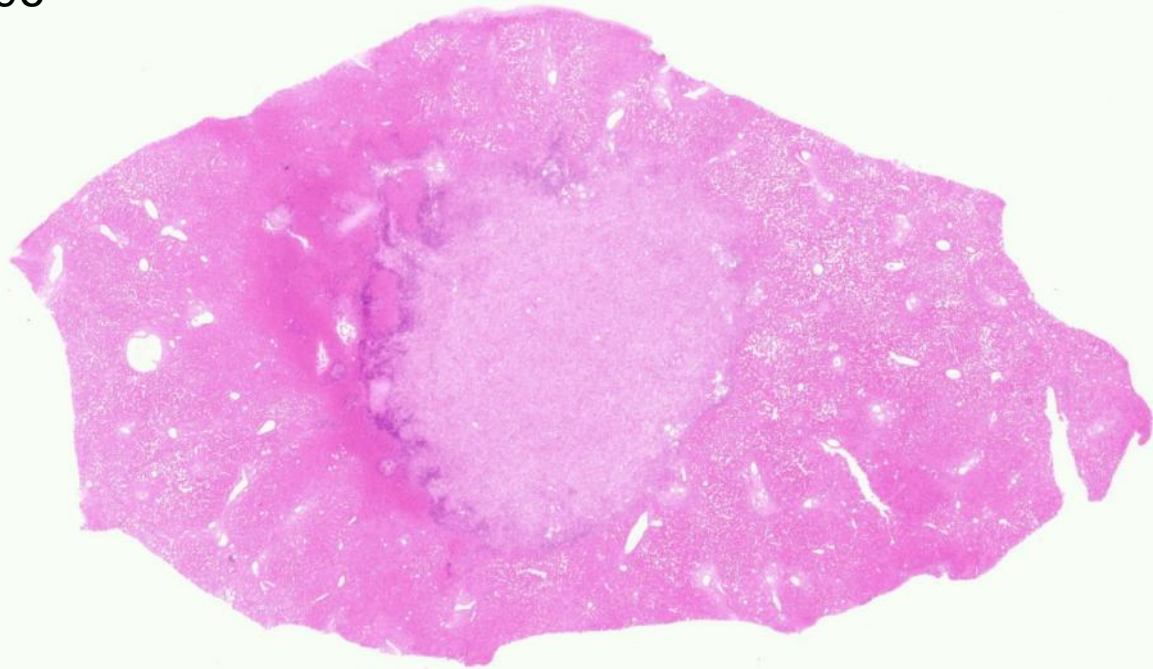
# Case F1/396

68M

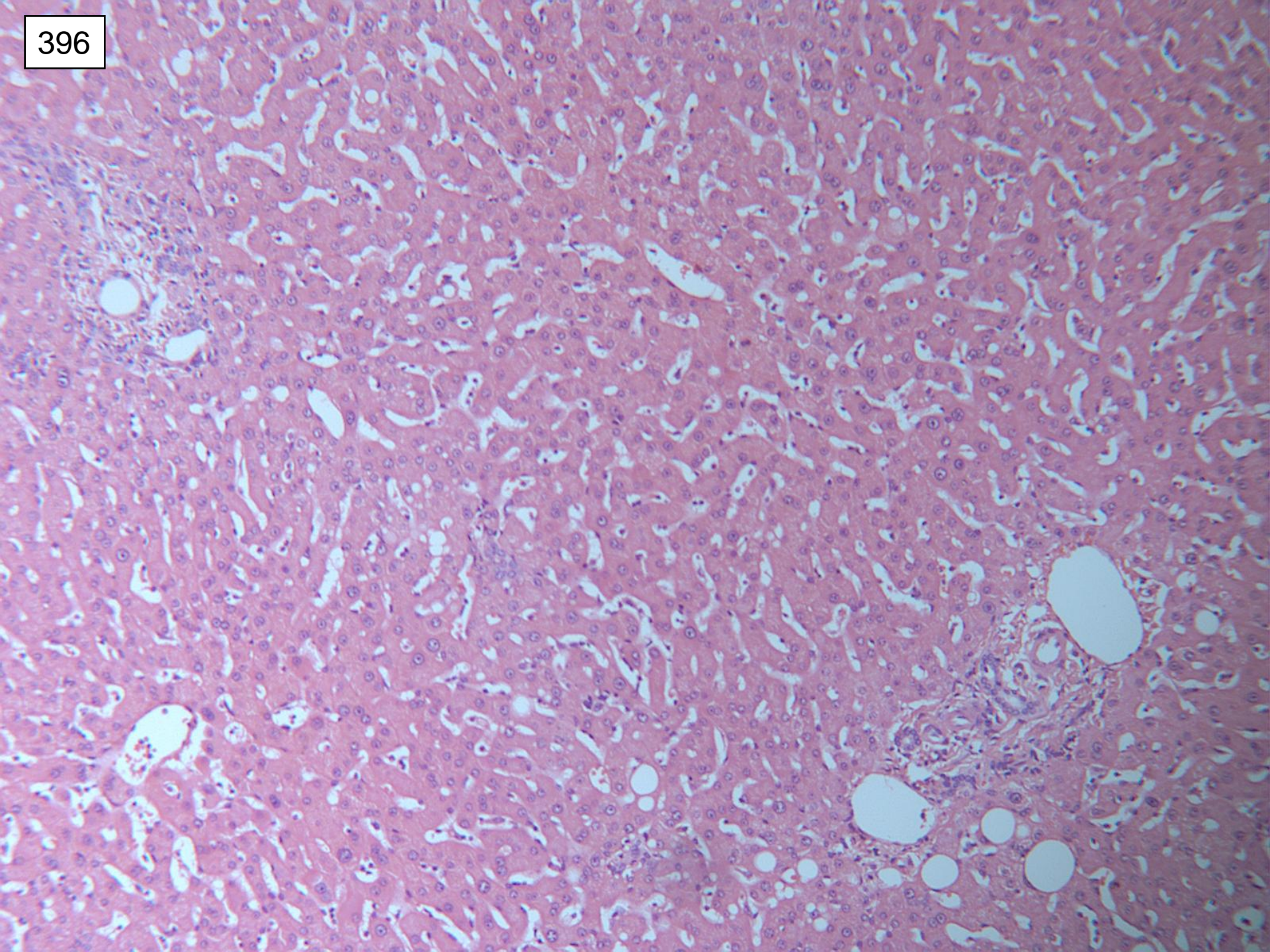
Palliative resection of T4 rectosigmoid carcinoma. Metastasis seen on liver surface and biopsied.

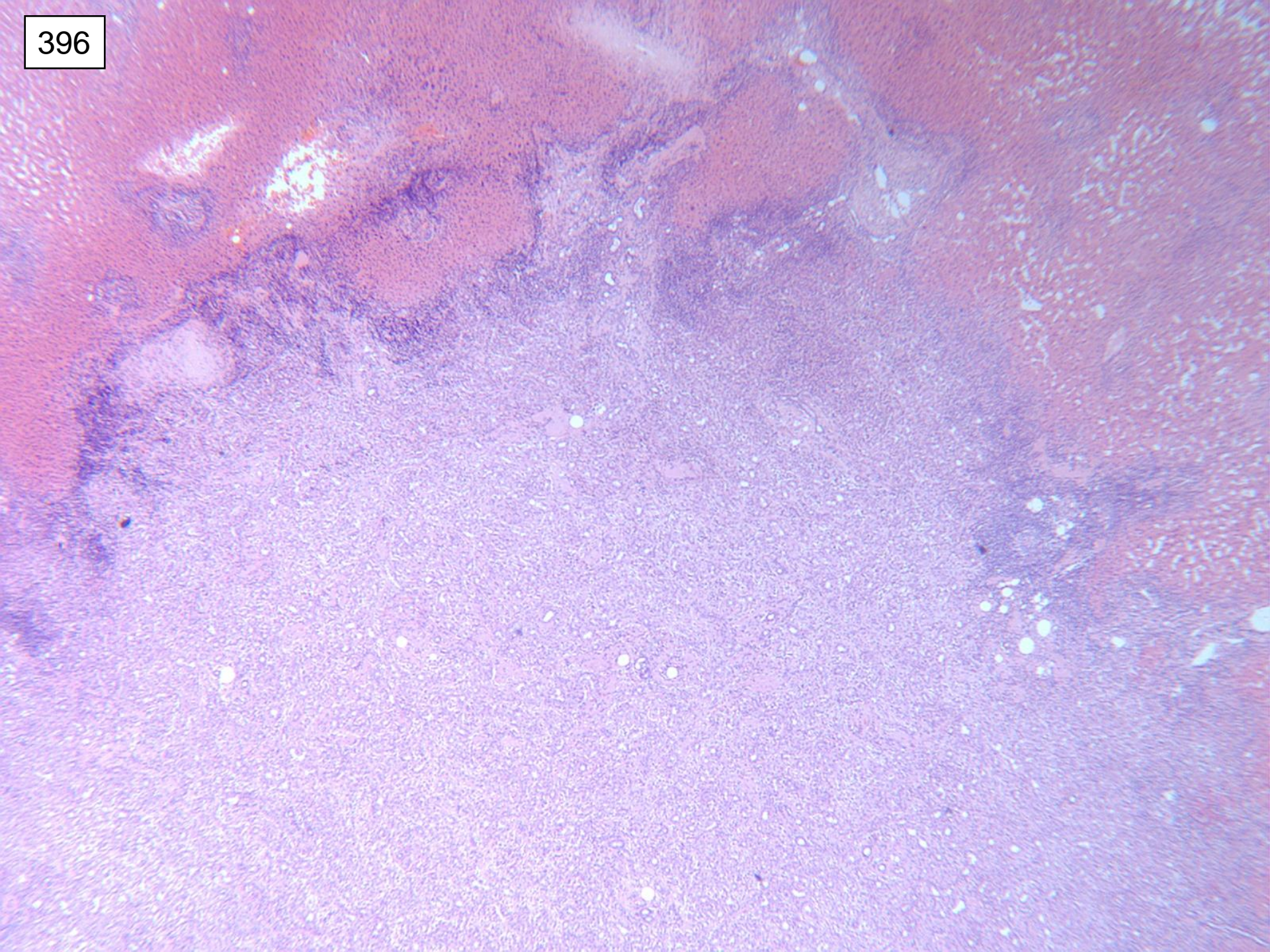
Wedge biopsy with white area 6mm diameter

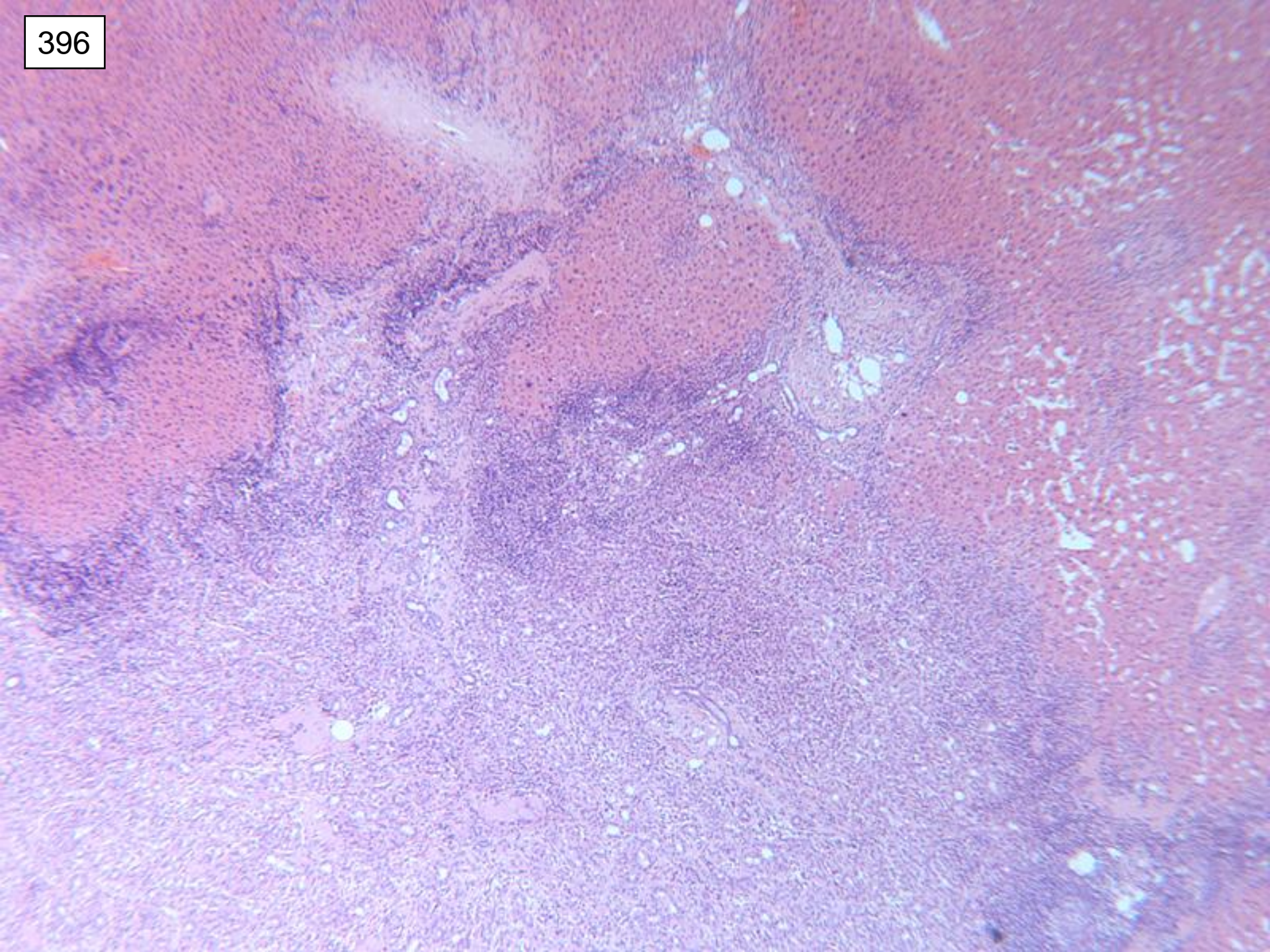
396

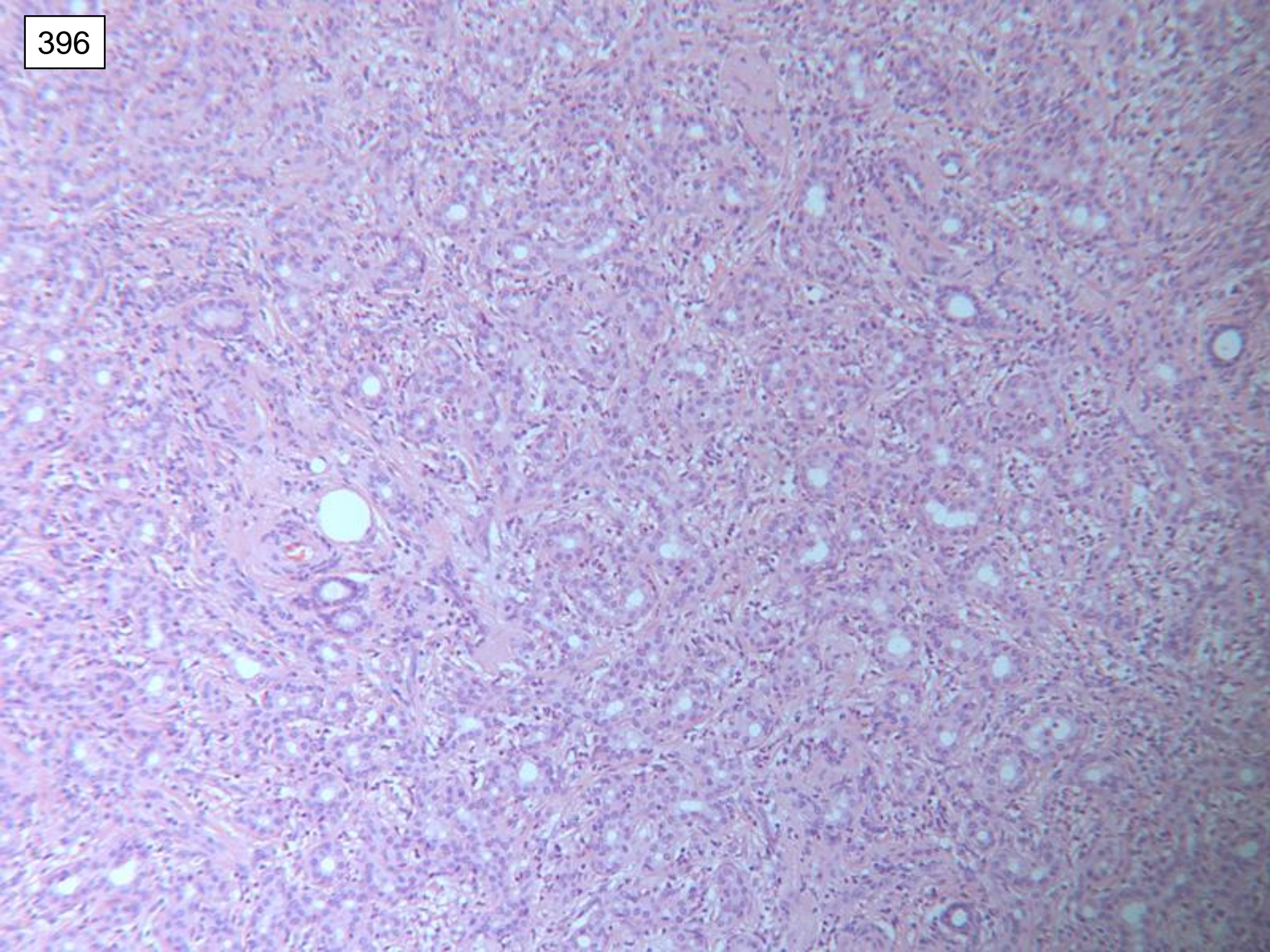


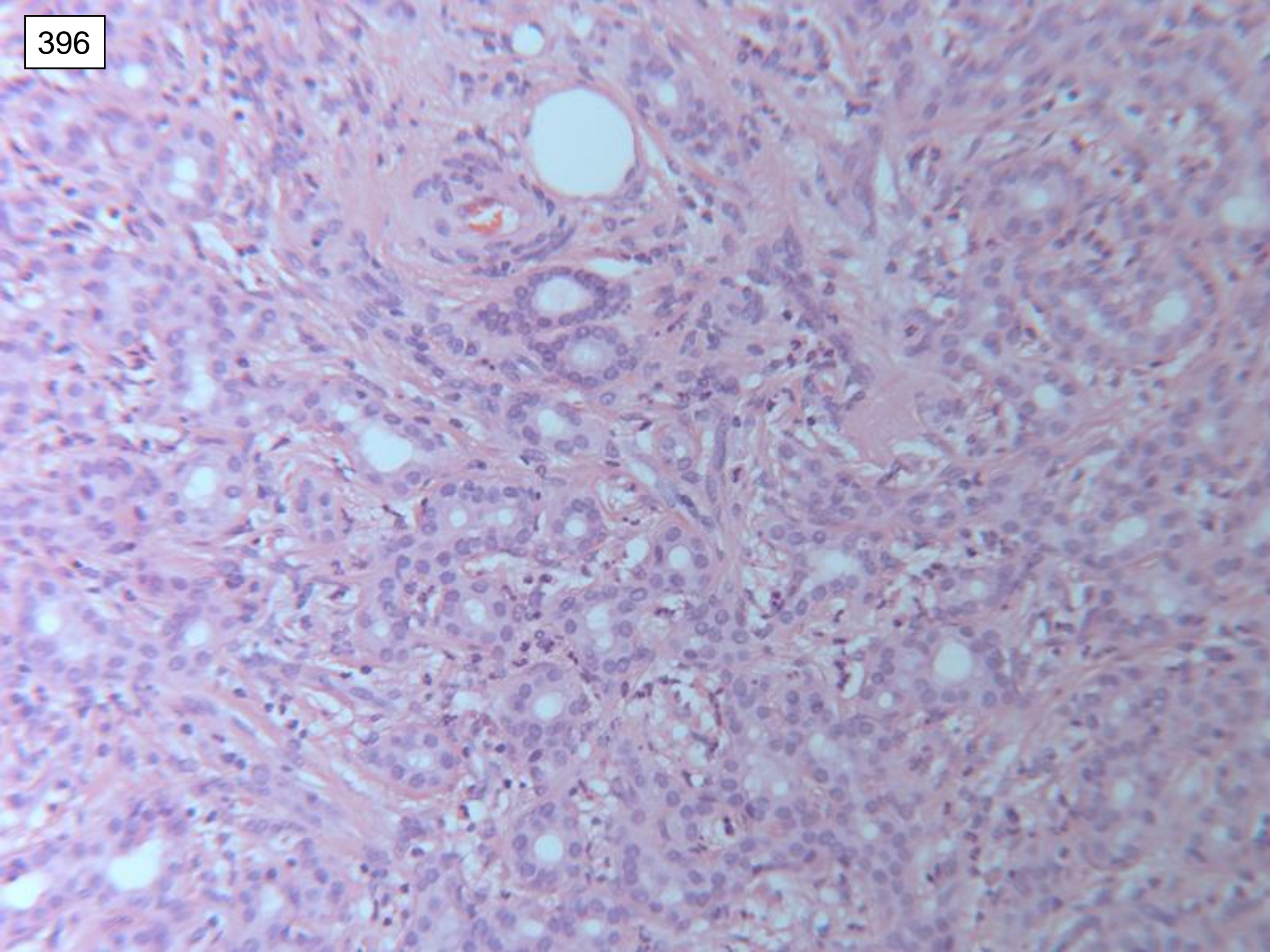
396











## Case 396: Responses:

Bile duct adenoma: 48

Bile duct adenoma/ peribiliary gland hamartoma (both names included): 20

Biliary hamartoma: 3

Von Meyenberg complex: 1

Bile duct adenoma or VMC: 1

? bile duct adenoma, request immunos: 7

Metastatic adenocarcinoma: 2 (of which 1 requested immunos to confirm)

### Suggestions for scoring:

Accept all except malignant diagnoses.

Illustrates confusion when a name is changed!

? reduce marks for responses that request immunos to be sure,

Also ? half marks for VMC.

Discussion at meeting: half marks for VMC and if immunos considered necessary to exclude metastatic CRC.

# Case F1/397

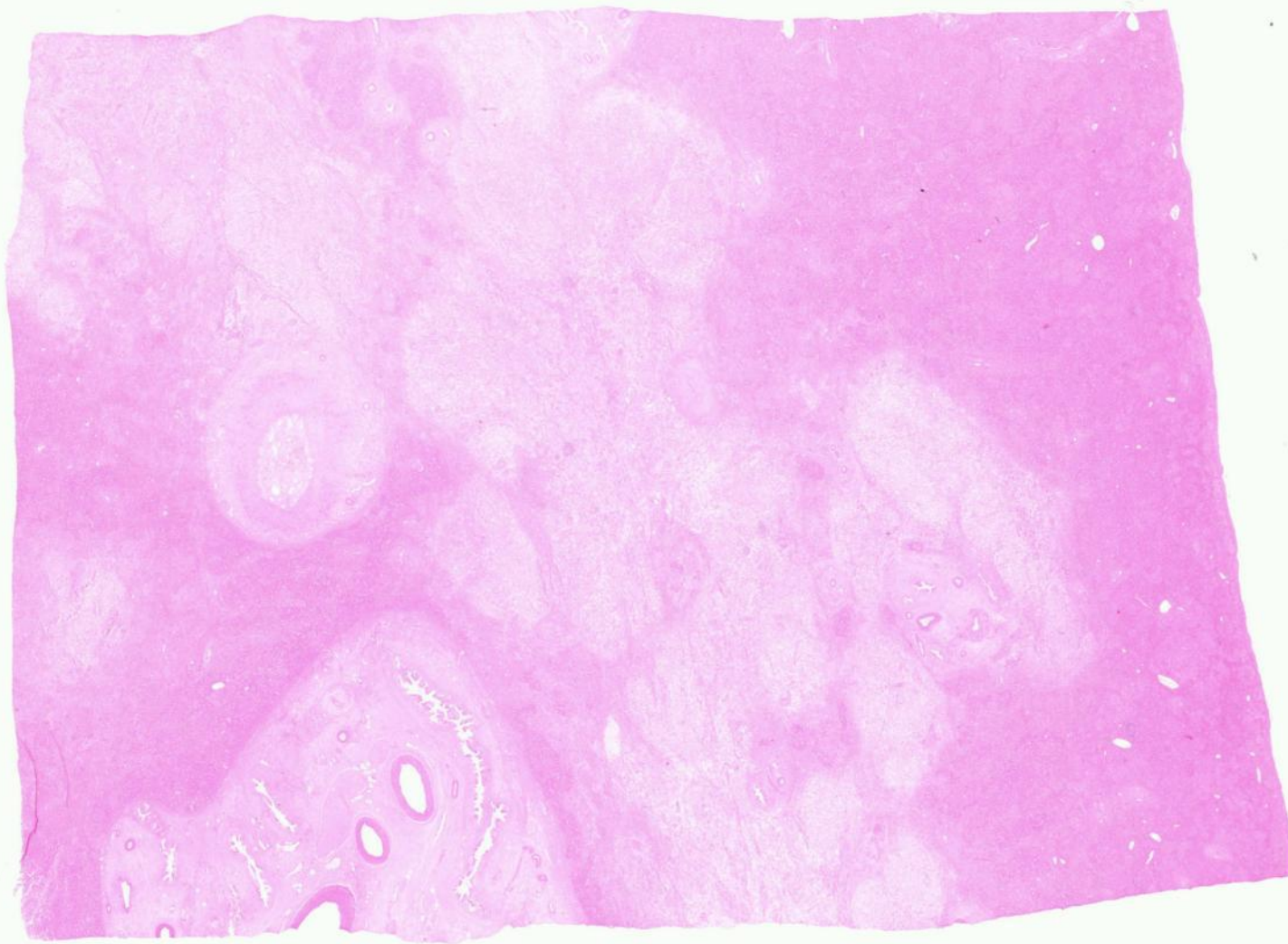
59 F

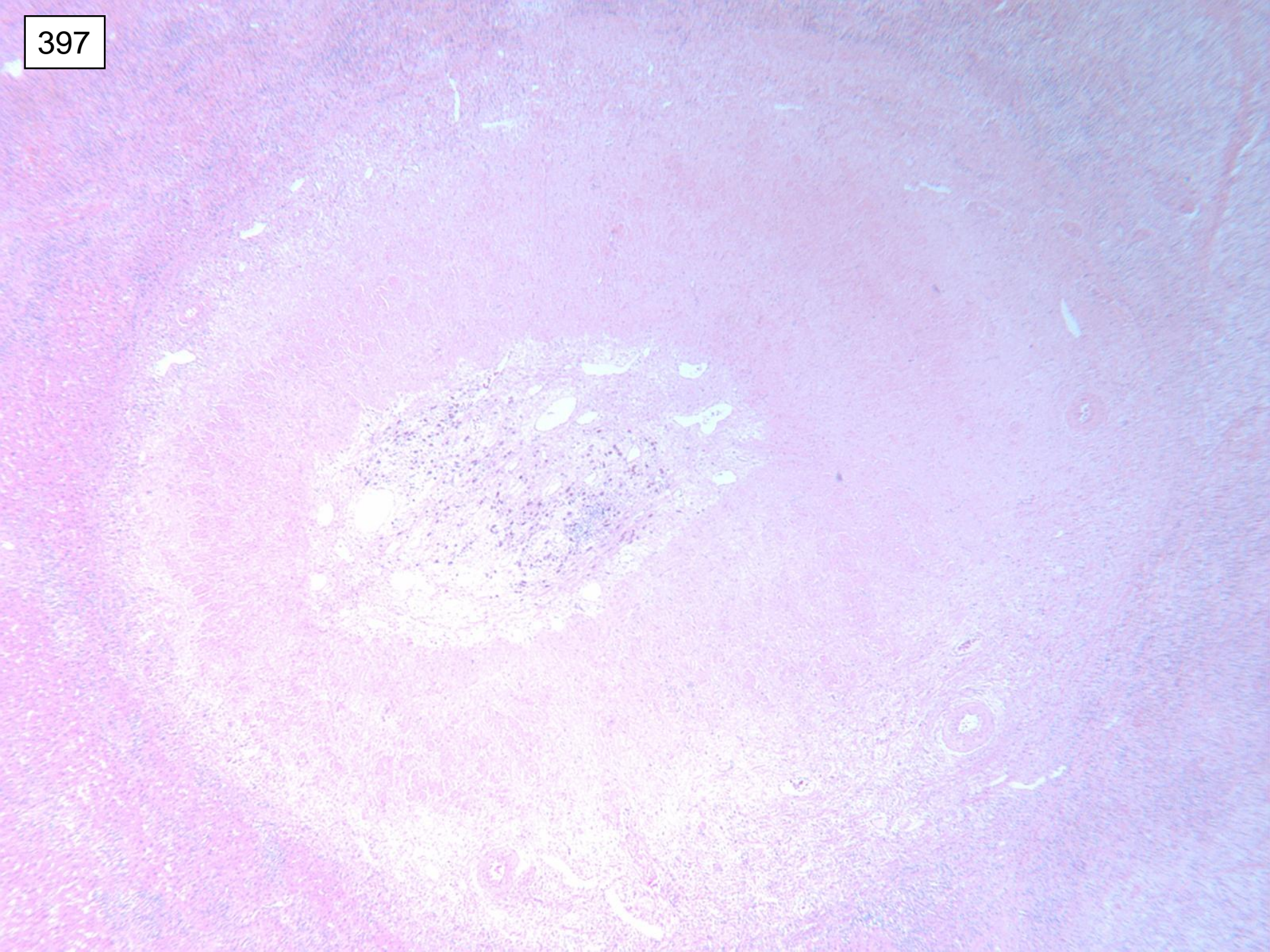
? cholangiocarcinoma

Left hemihepatectomy 390g.

Yellow lesion, 50mm maximum dimension.

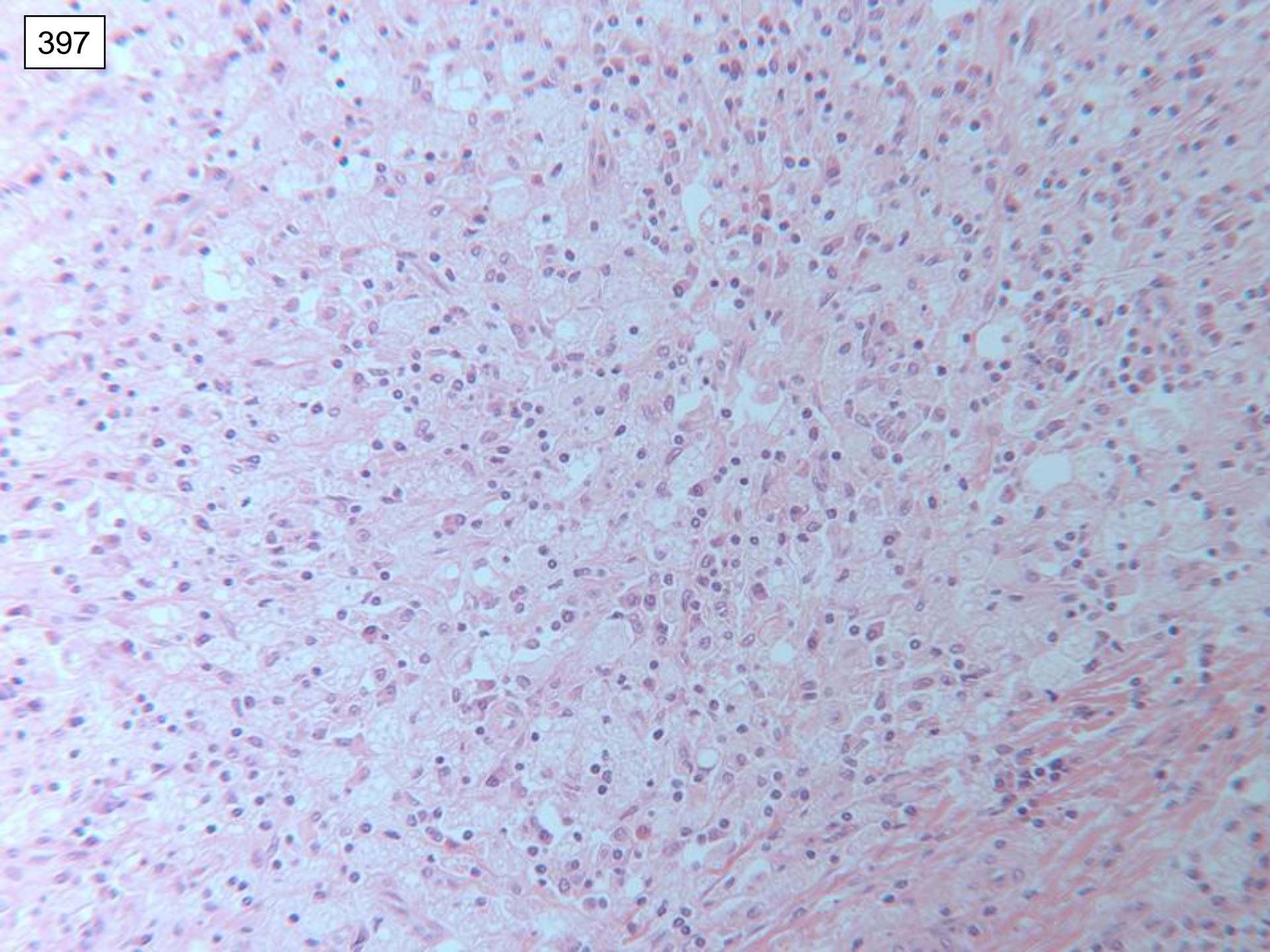
397



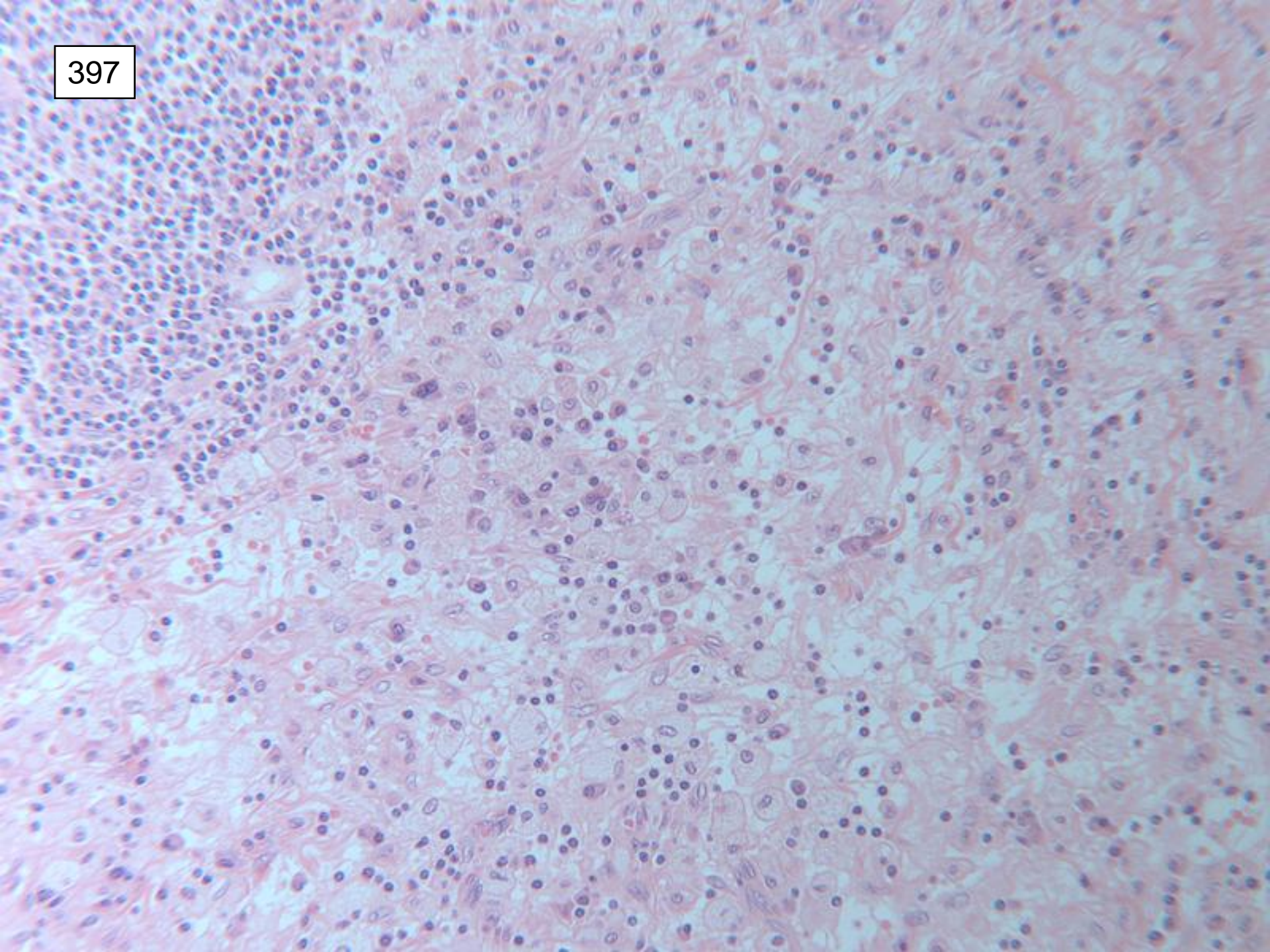




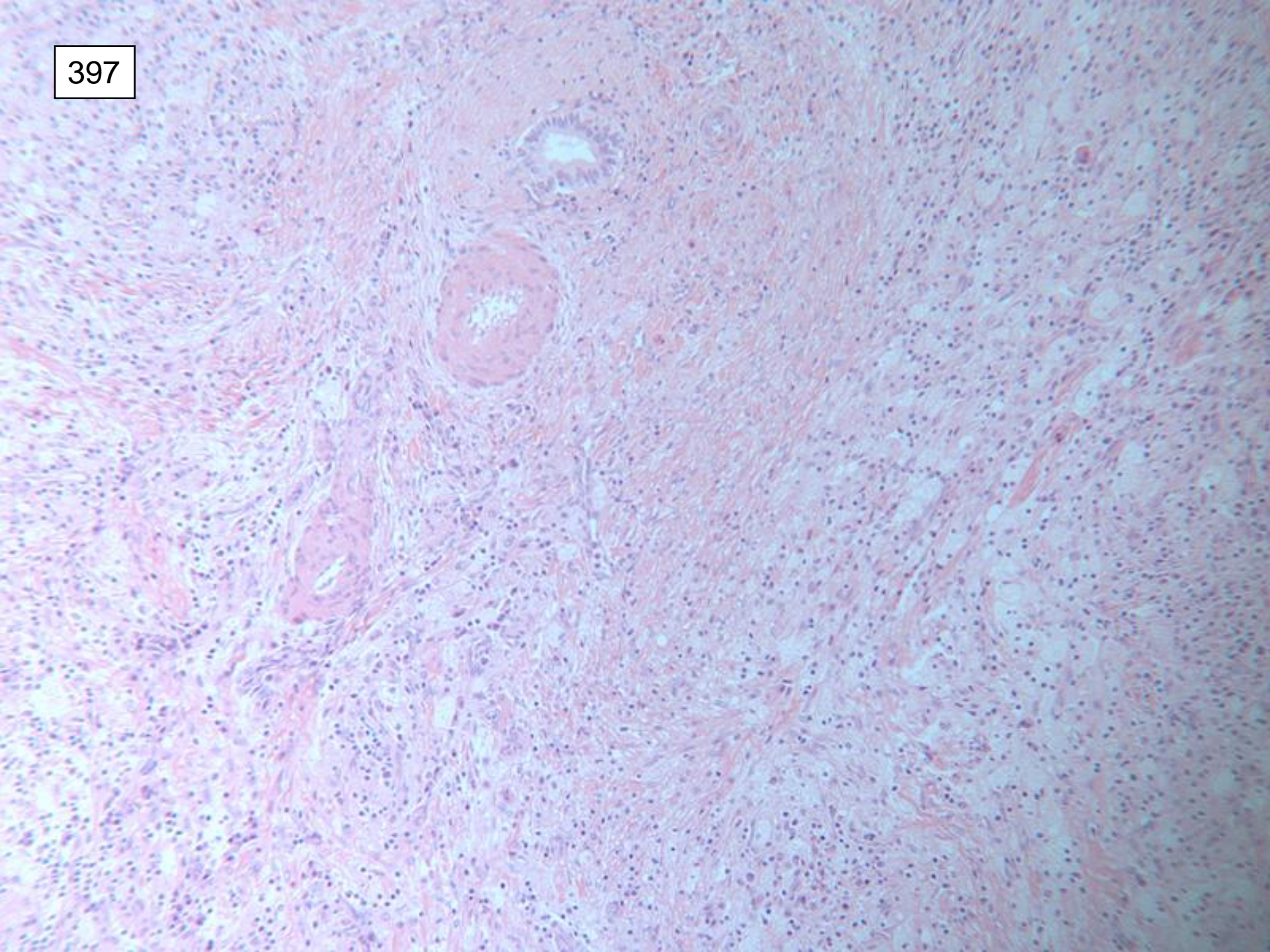
397



397



397



## Case 397: Responses:

An inflammatory/reactive process: (54)

Inflammatory pseudotumour: 20

Xanthogranulomatous: 26

Inflammatory pseudotumour or  
xanthogranulomatous: 2

Malakoplakia: 1

Infarcted liver: 5

A neoplastic process: (18)

Angiomyolipoma: 10

Focal nodular hyperplasia 4

Inflammatory myofibroblastic tumour: 2

Pecoma: 2

Individual responses outside above categories:

‘adenoma with steatosis’

‘? Langerhans cell histiocytosis’

‘histiocytic disease e.g. Rosai-Dorfman’

‘Cholangiocarcinoma’

‘Complete regression of carcinoma after  
embolization’

‘due to previous embolization – lesion  
destroyed’

‘clear cell tumour, primary HCC or  
metastatic RCC’

‘differential diagnosis – angiomyolipoma  
or fatty adenoma’

‘mesenchymal hamartoma/IMFT /liver  
cell adenoma, would send to Stefan’

‘Amoebiasis’

Description, no diagnosis: 1

Commented on thrombosed vessel: 38

Need more history: 15

Requesting immunos: 18

### Suggestion for scoring:

No consensus on reactive/neoplastic, therefore  
unsuitable for scoring.

Discussion: this was an inflammatory lesion  
Probably secondary to obstruction of the  
large duct, and not a neoplastic process.

The end