

# National Liver Histopathology EQA Scheme

Circulation G1  
Autumn 2012

Histories and photomicrographs

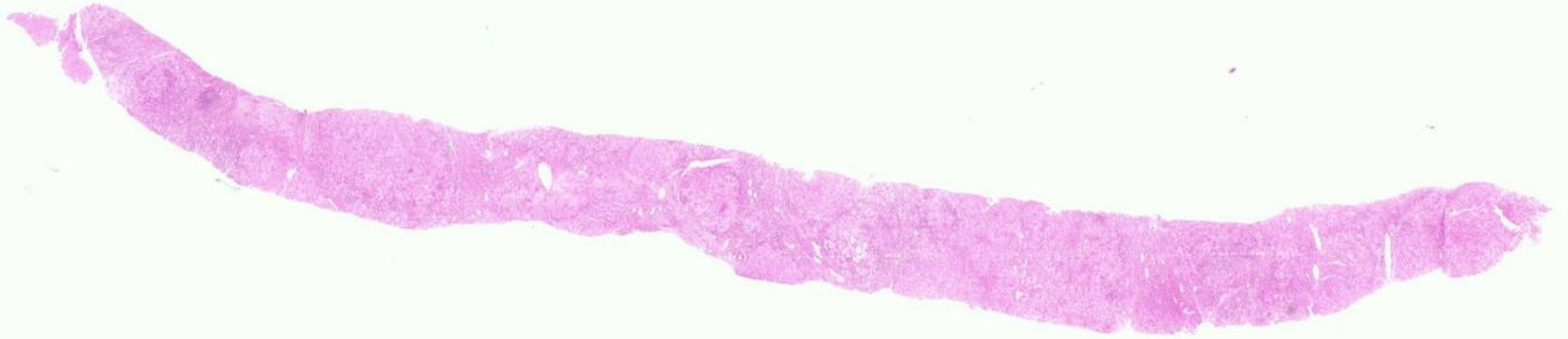
**Case G1/398**

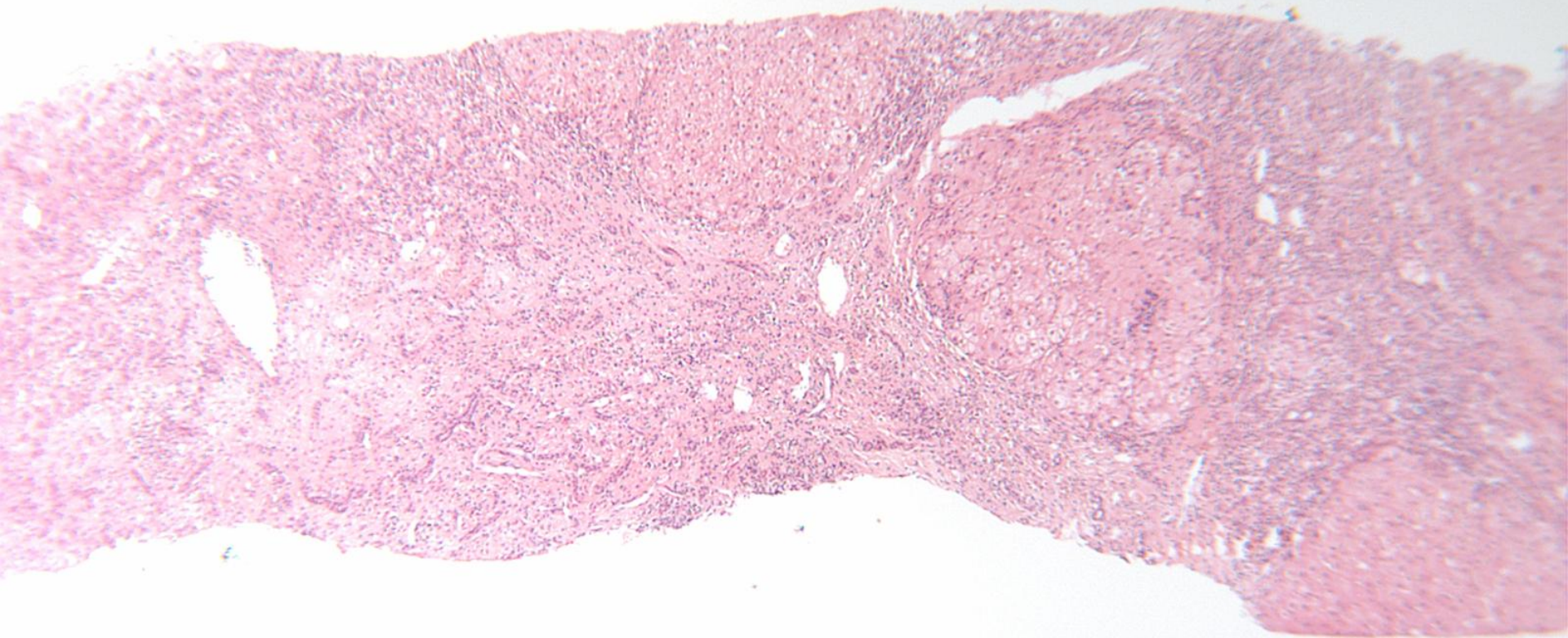
**42 M**

Hepatitis C PCR +ve. Ex IVDU. For HCV treatment.

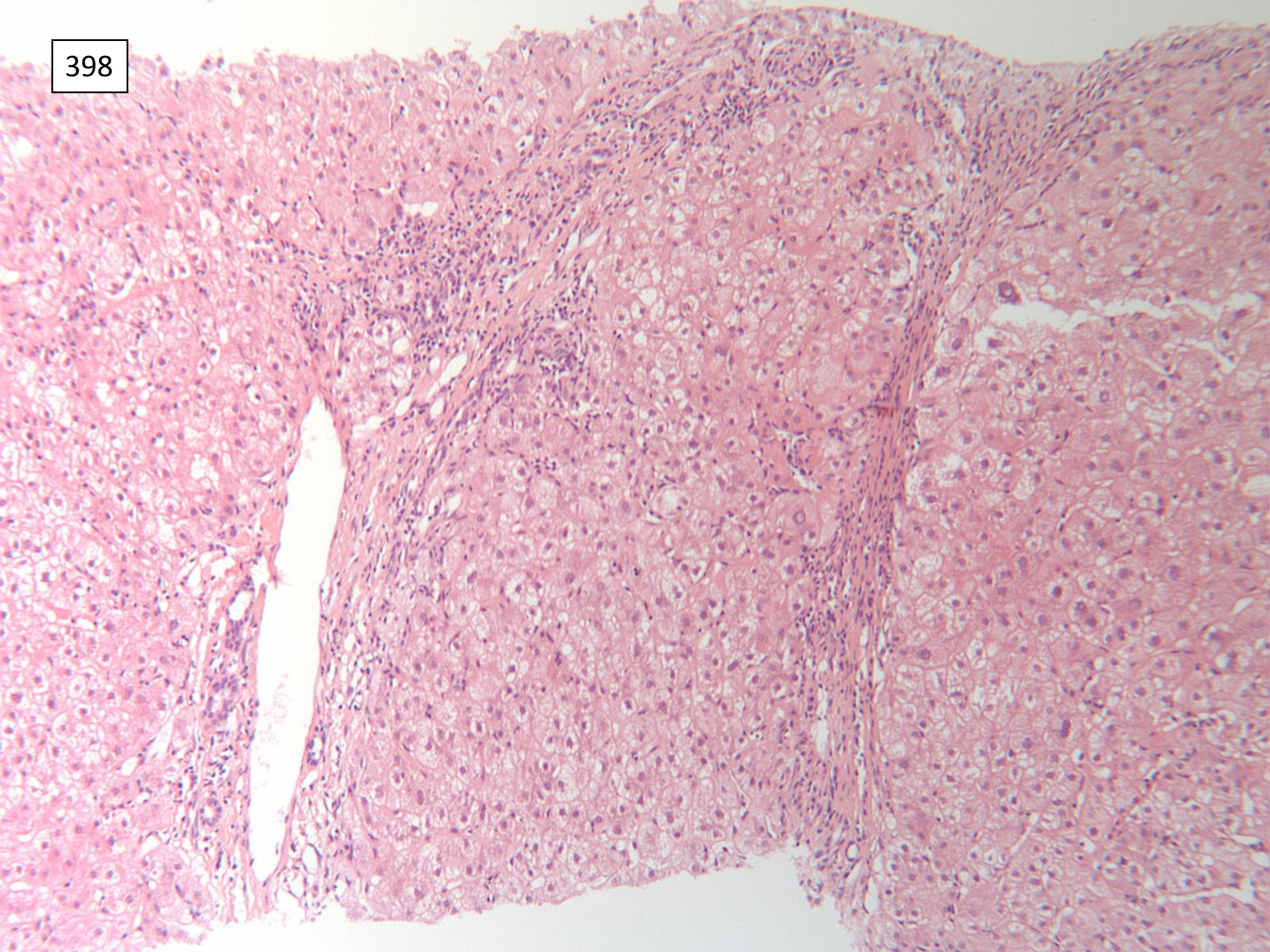
1 core 17mm long (please also see VG and retic on website)

398

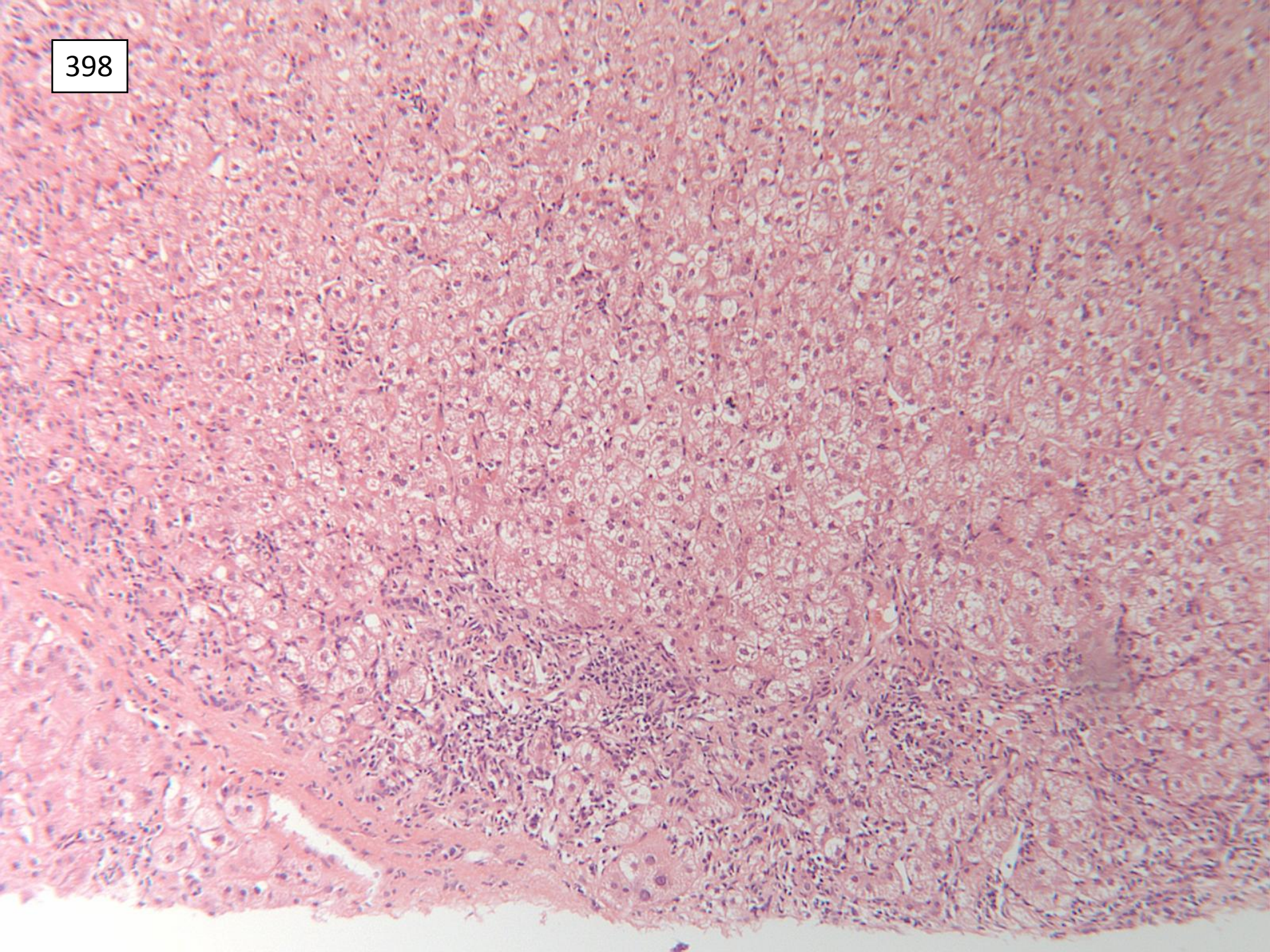




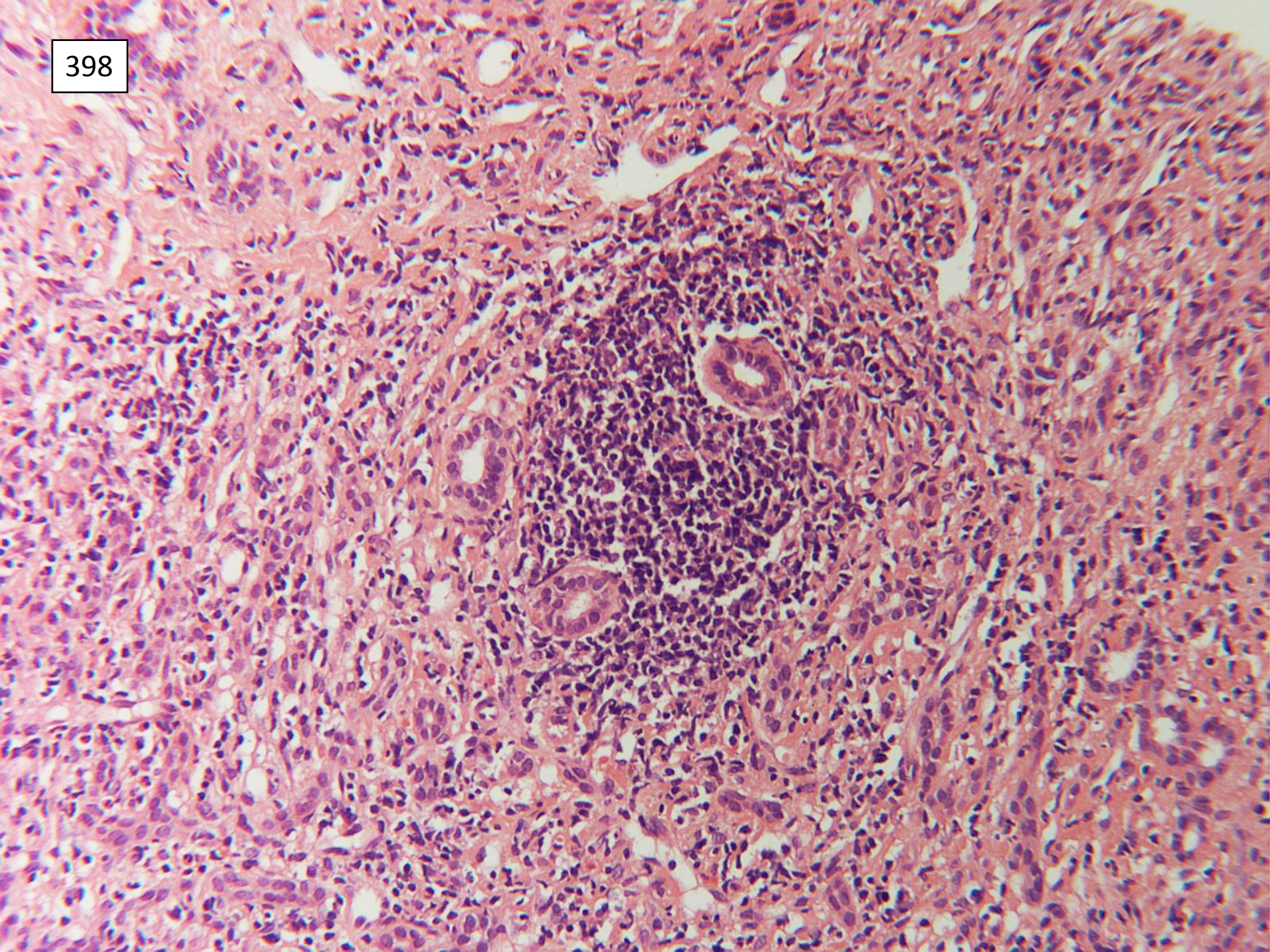
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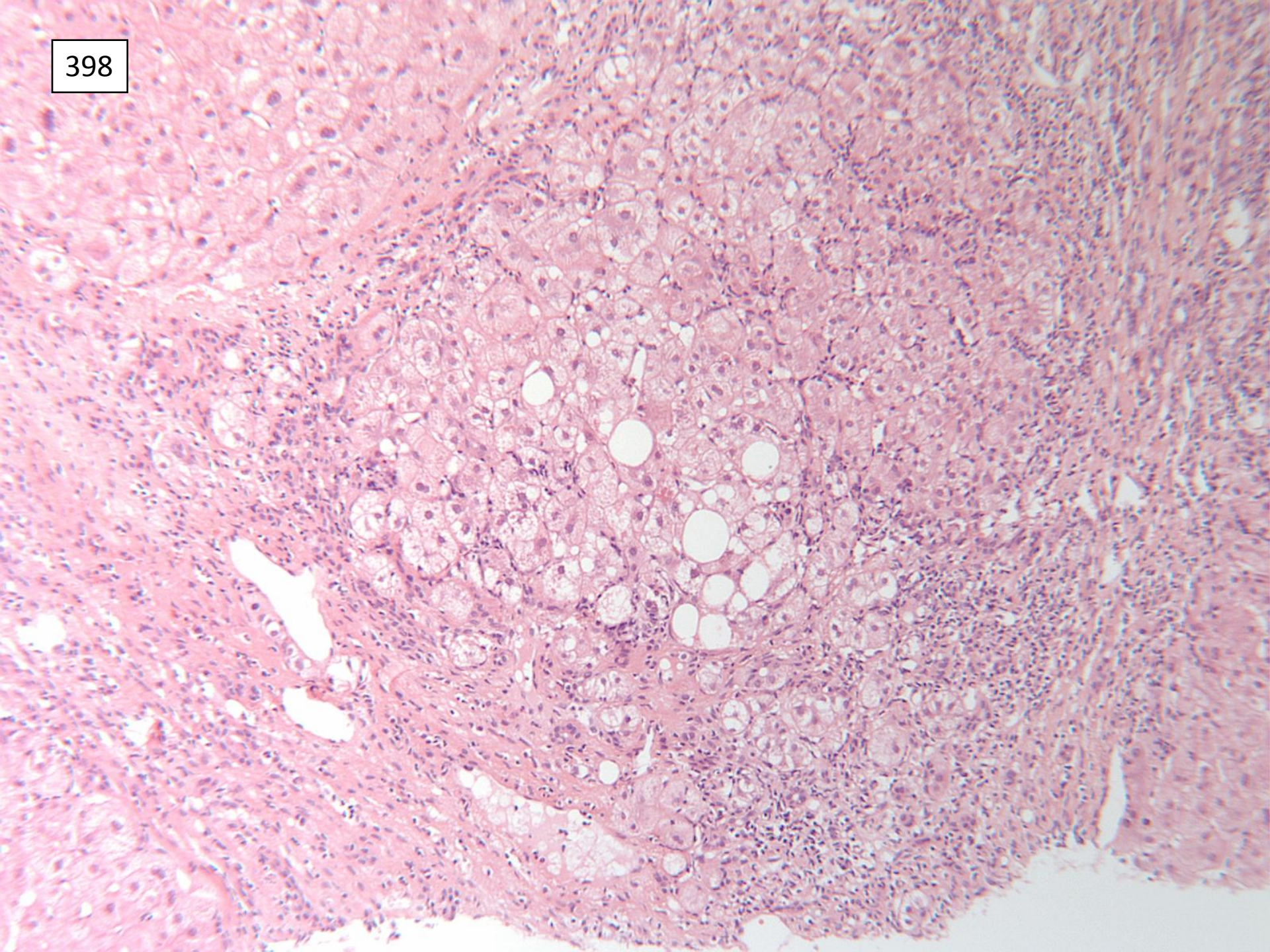


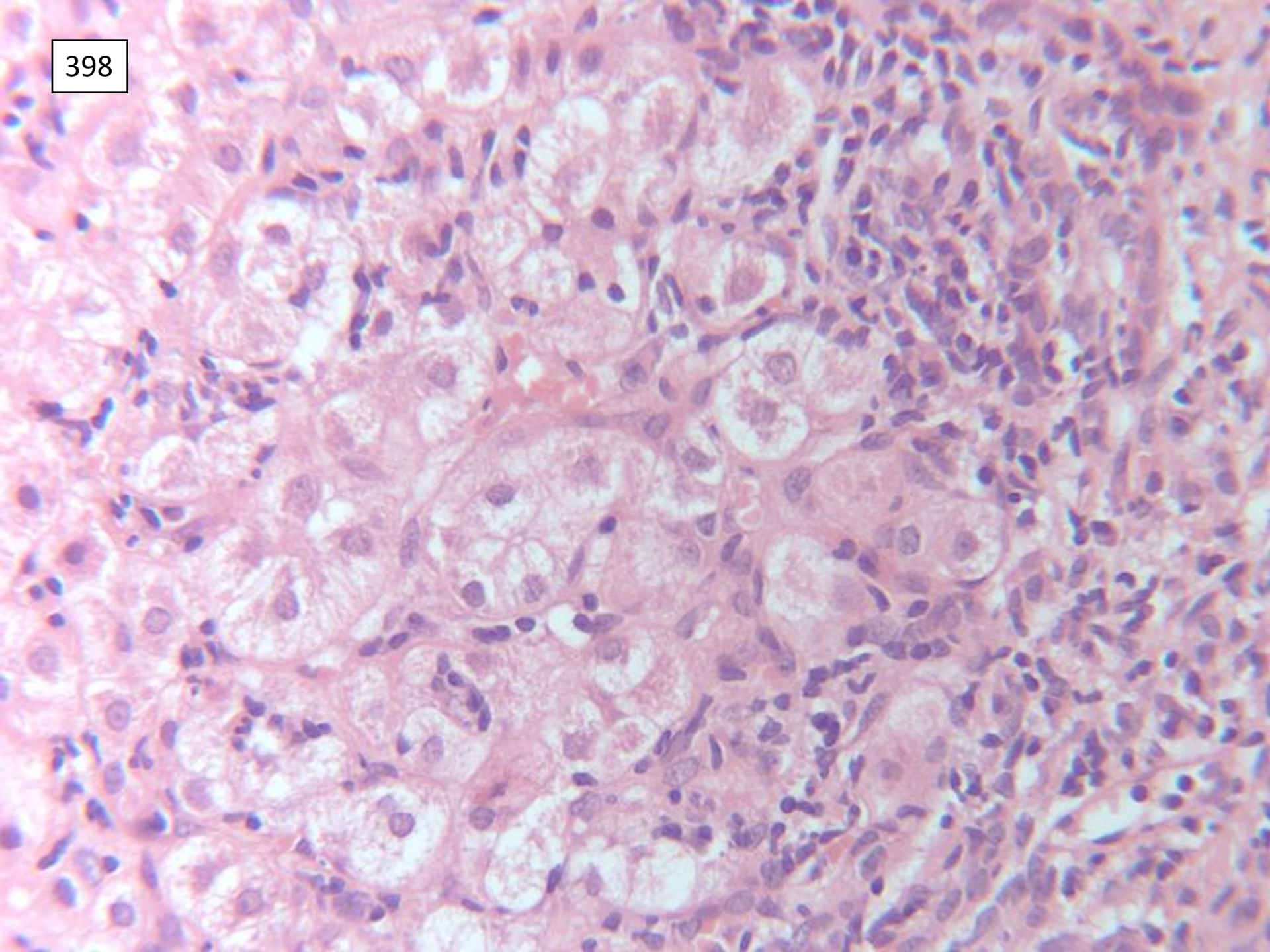
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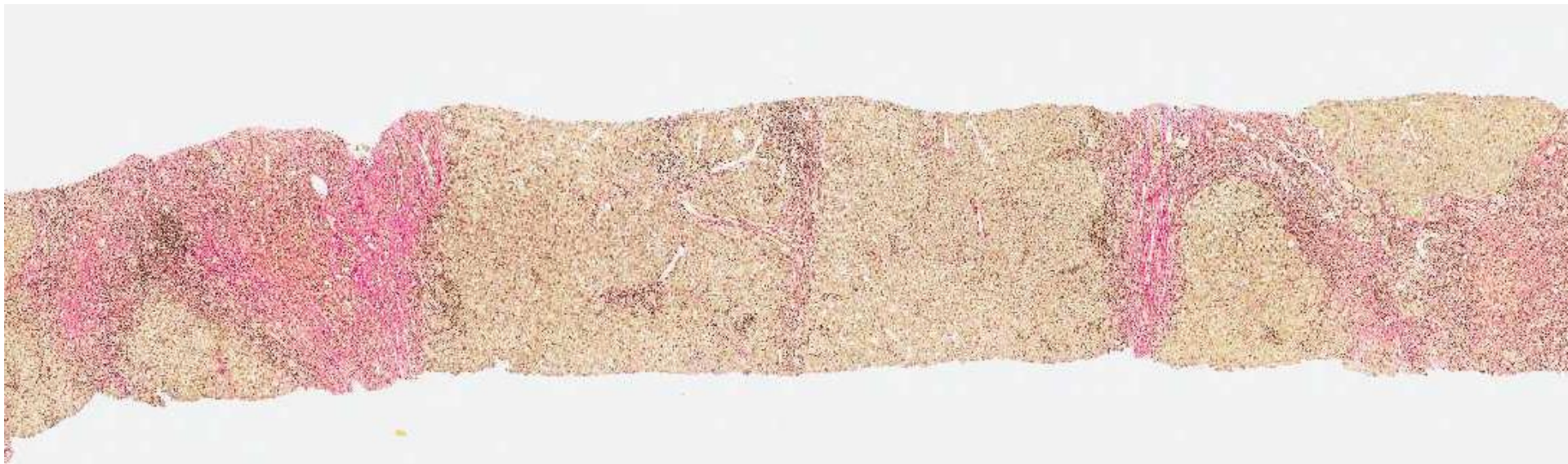
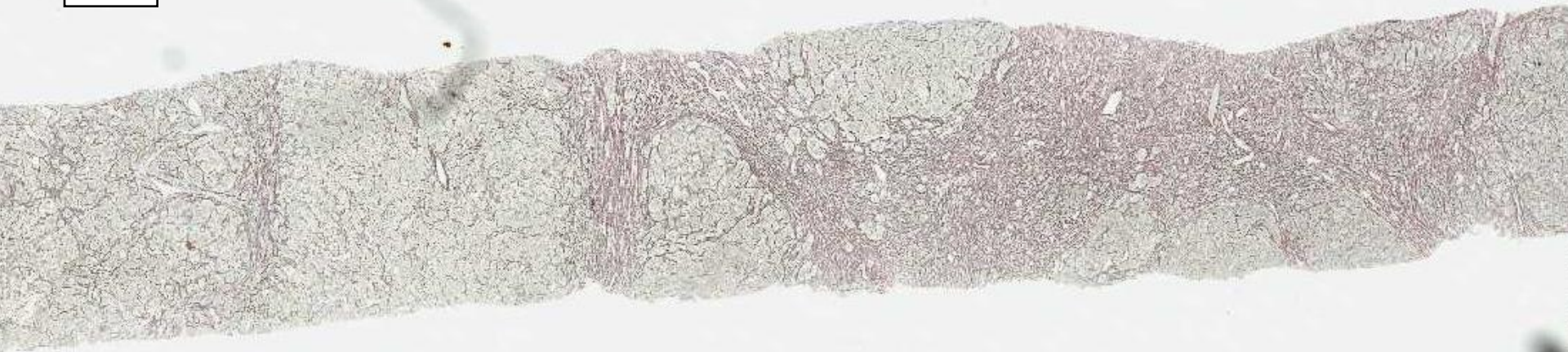
398







398



## Case 398

### Morphology and aetiology

#### **Hepatitis C 78**

Hepatitis C not mentioned 2

Also steatohepatitis – ALD or NAFLD 5

### Fibrosis stage:

**Cirrhosis and/or Ishak stage 6 = 75**

Stage not stated 1

### Disease activity:

Mild: 4

Moderate: 18

Marked or severe: 2

Ishak grade: 41 responses

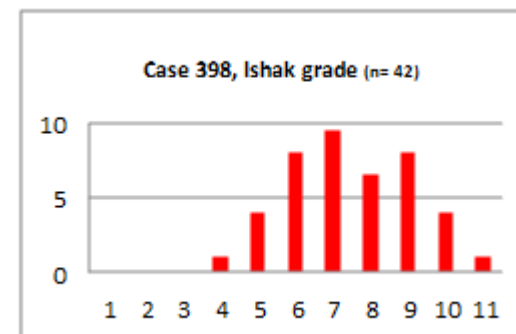
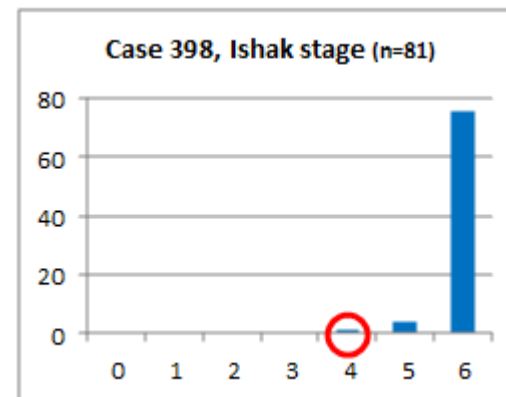
Metavir (n=6):

A1F4: 2

A2F4: 4

A3F4: 1

A2F3/4: 1



‘active cirrhosis, haemosiderin’, no mention of hep C (answered wrong case)

### Suggestions for scoring:

For 10 points – features are consistent with hepatitis C and include a stage that is cirrhosis / Ishak stage 5 or 6.

Suggestions agreed

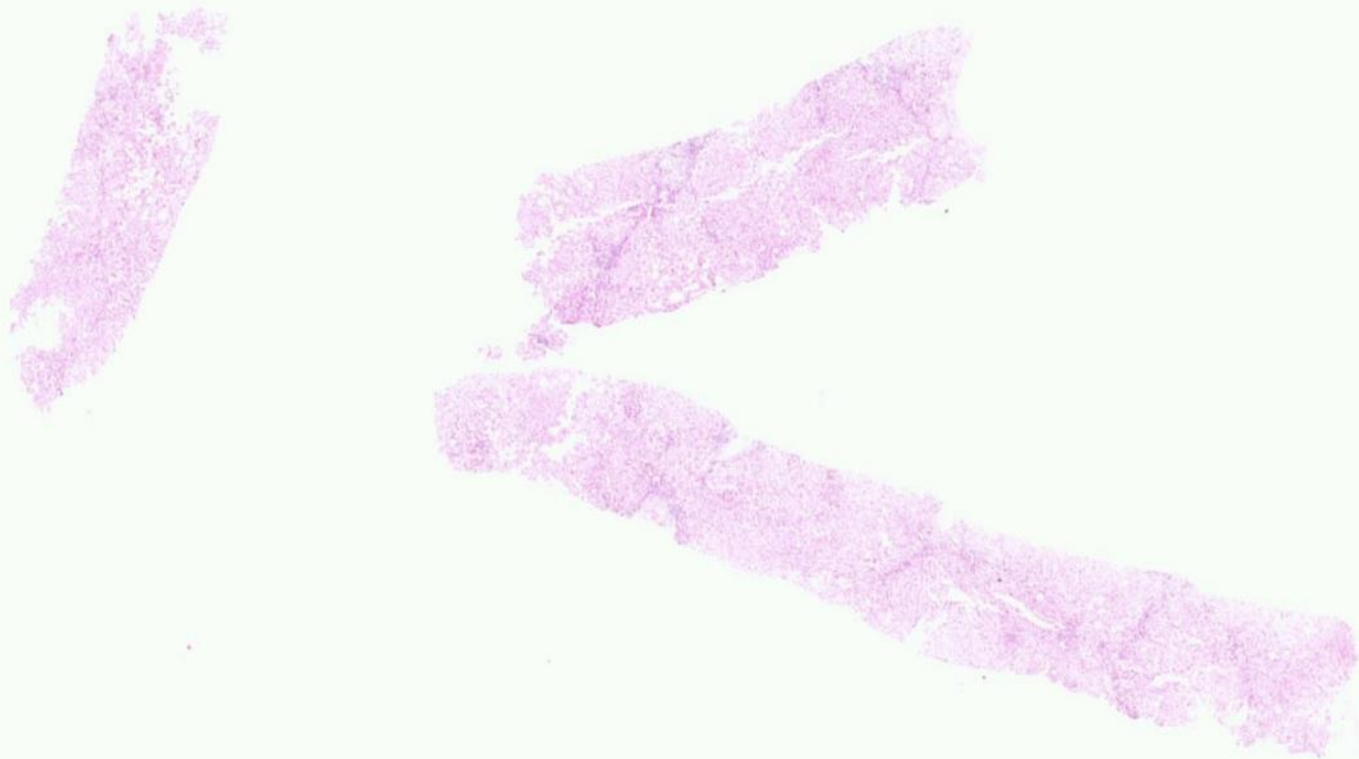
**Case G1/399**

**47 M**

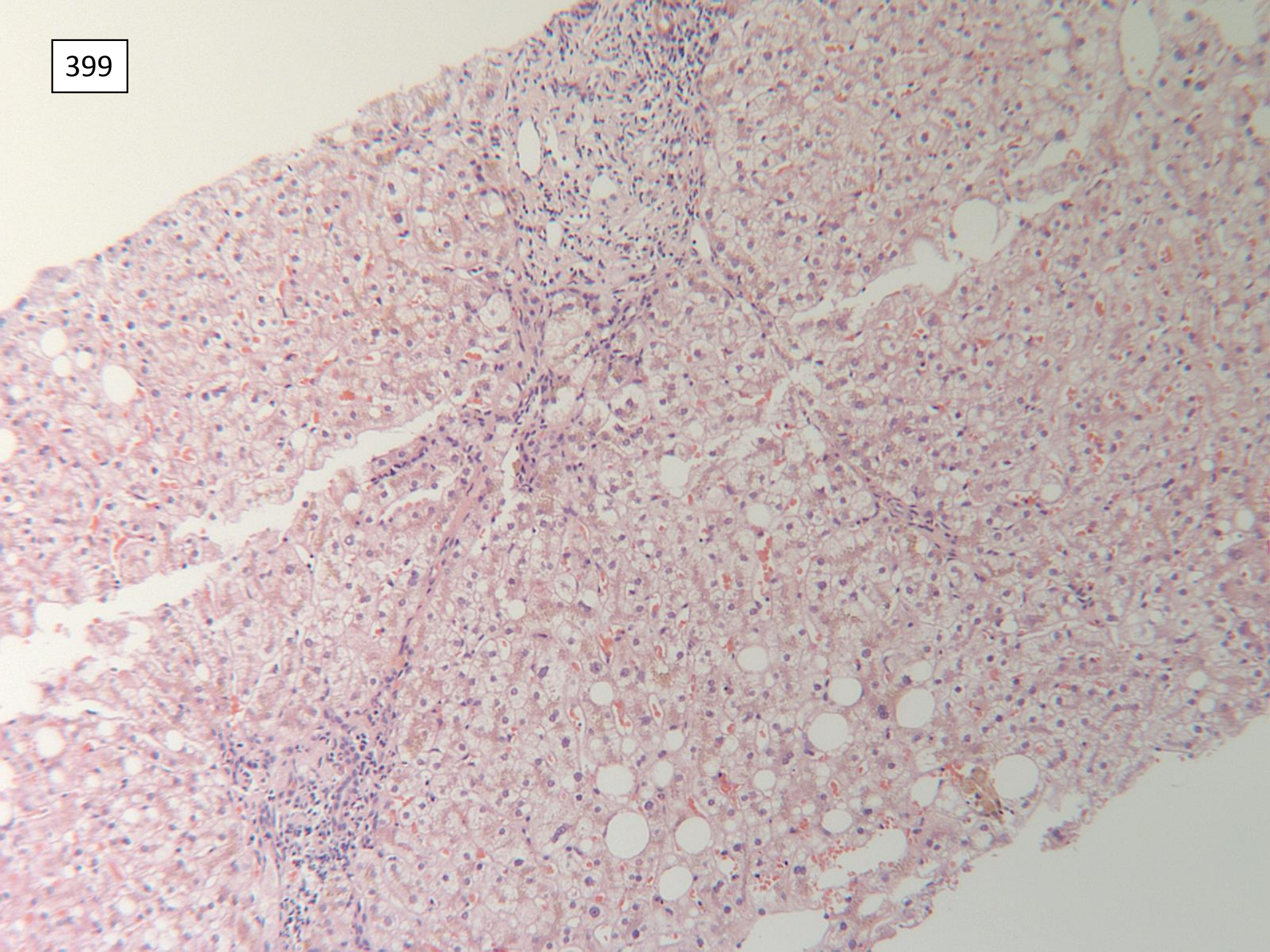
Haemochromatosis ? Cirrhotic

3 cores, 7, 3 and 2mm (please also see Perl's,  
VG and retic on website)

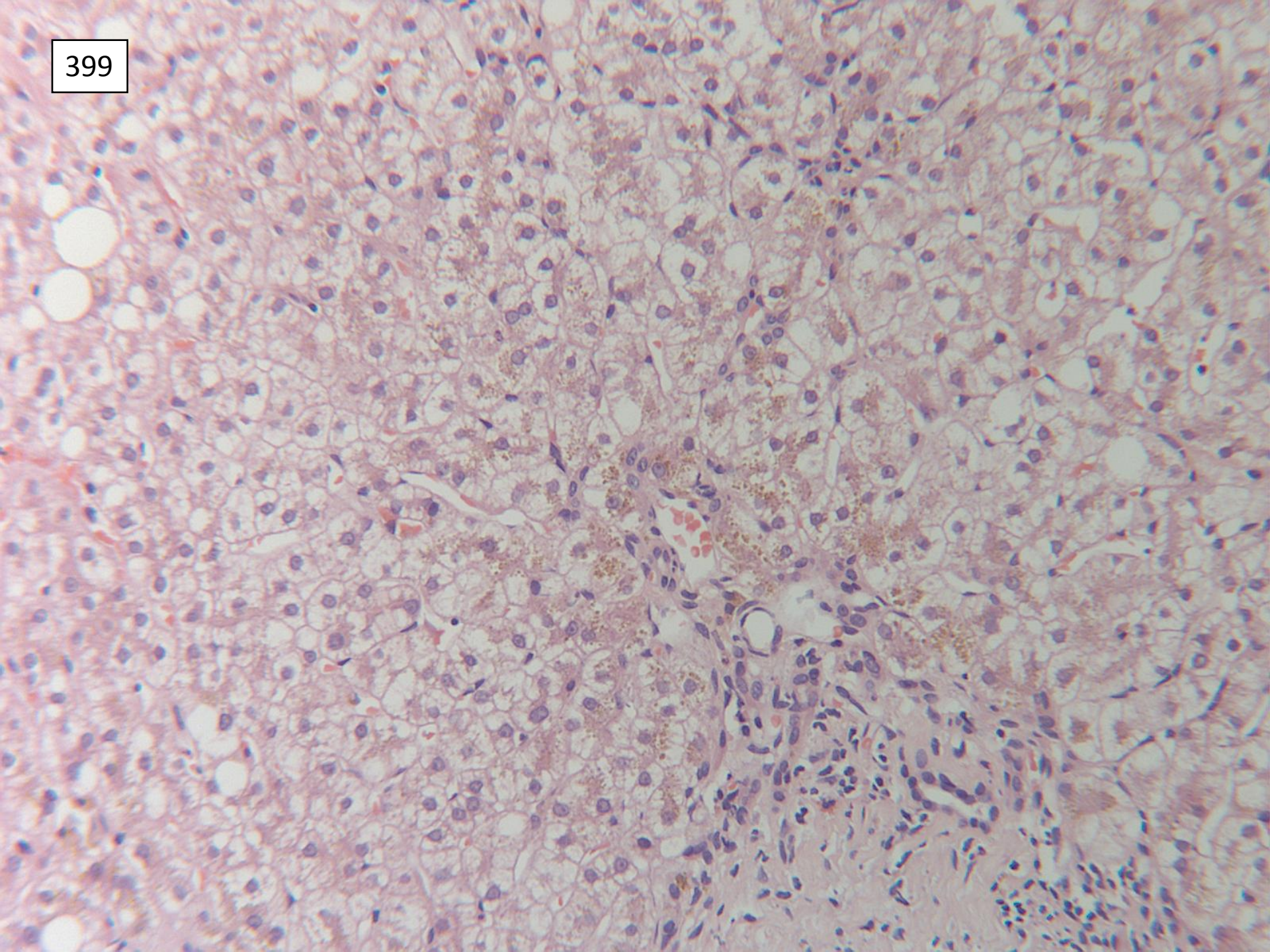
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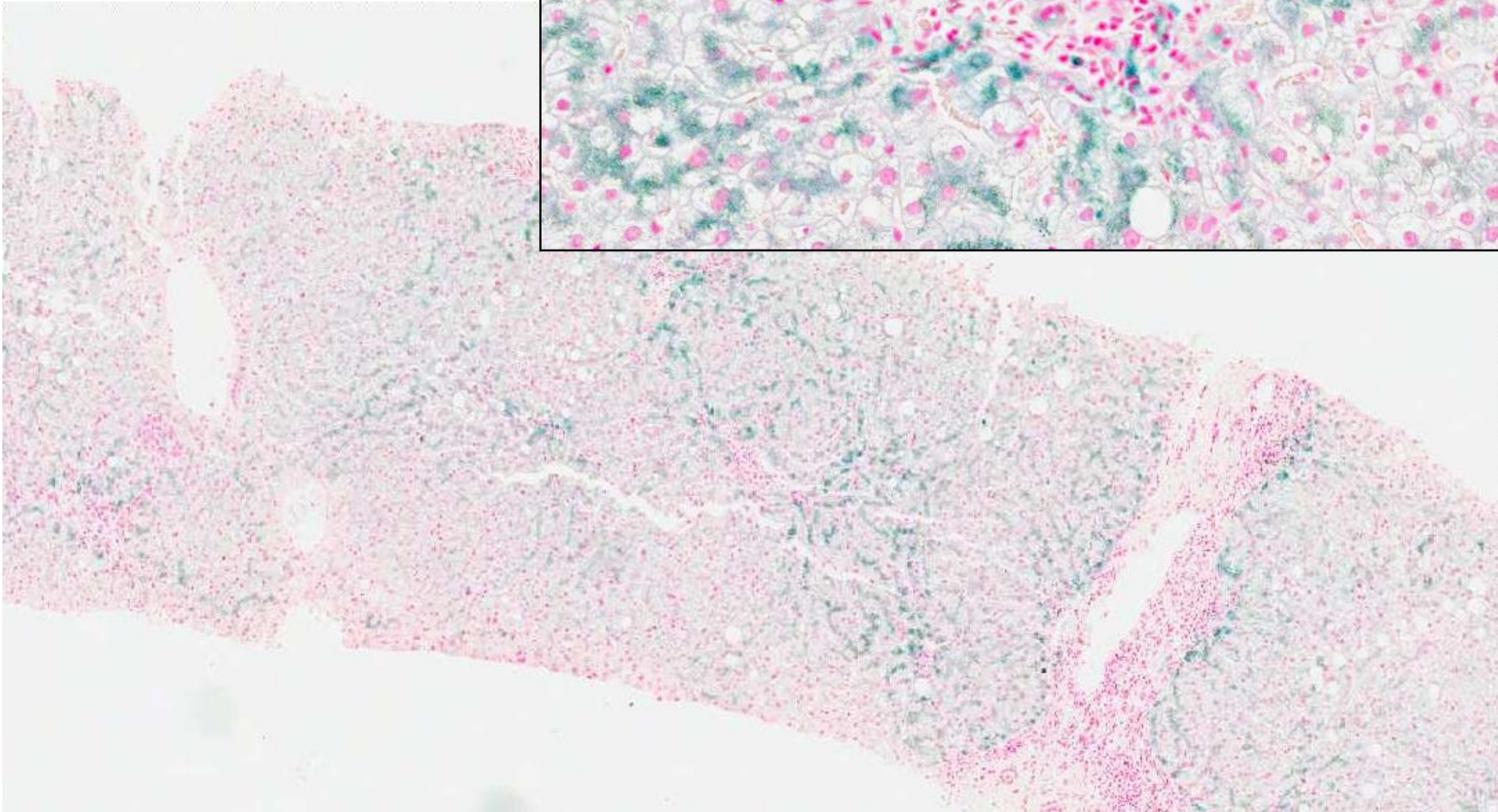


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399



## Case 399

### Morphology:

Iron: mentioned:

Severity: 'severe': 3

Not graded: 13

Not mentioned (just haemochromatosis): 1

Steatosis: 52

Possible steatohepatitis: 3

**Steatohepatitis: 1**

Fatty change not mentioned: 18

'chronic hepatitis' 4

### Aetiology:

**Haemochromatosis: 76**

**Haemochromatosis not mentioned: 1**

'non-complicated haemochromatosis' 1

### Stage:

Fibrosis:

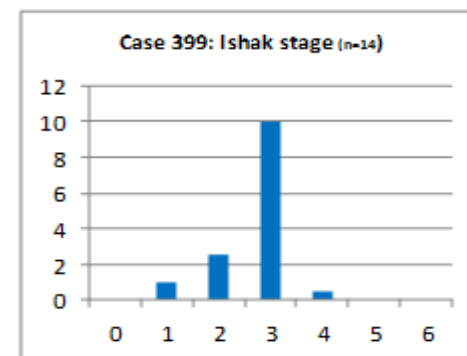
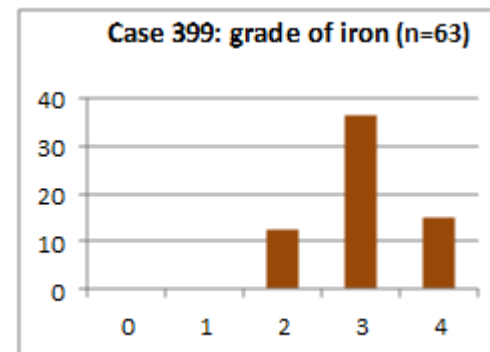
Mild 8

Portal fibrosis, no bridging: 11

Probable bridging: 6

Bridging fibrosis: 40

**1 each for early, incipient, evolving cirrhosis,  
'cirrhotic transformation'**



### Suggestions for scoring:

For full marks, response includes haemochromatosis, and a comment on fibrosis.

Score half marks for steatohepatitis and implication of cirrhosis.

Discussion at meeting: no deduction for steatohepatitis

## Case G1/400

32 F

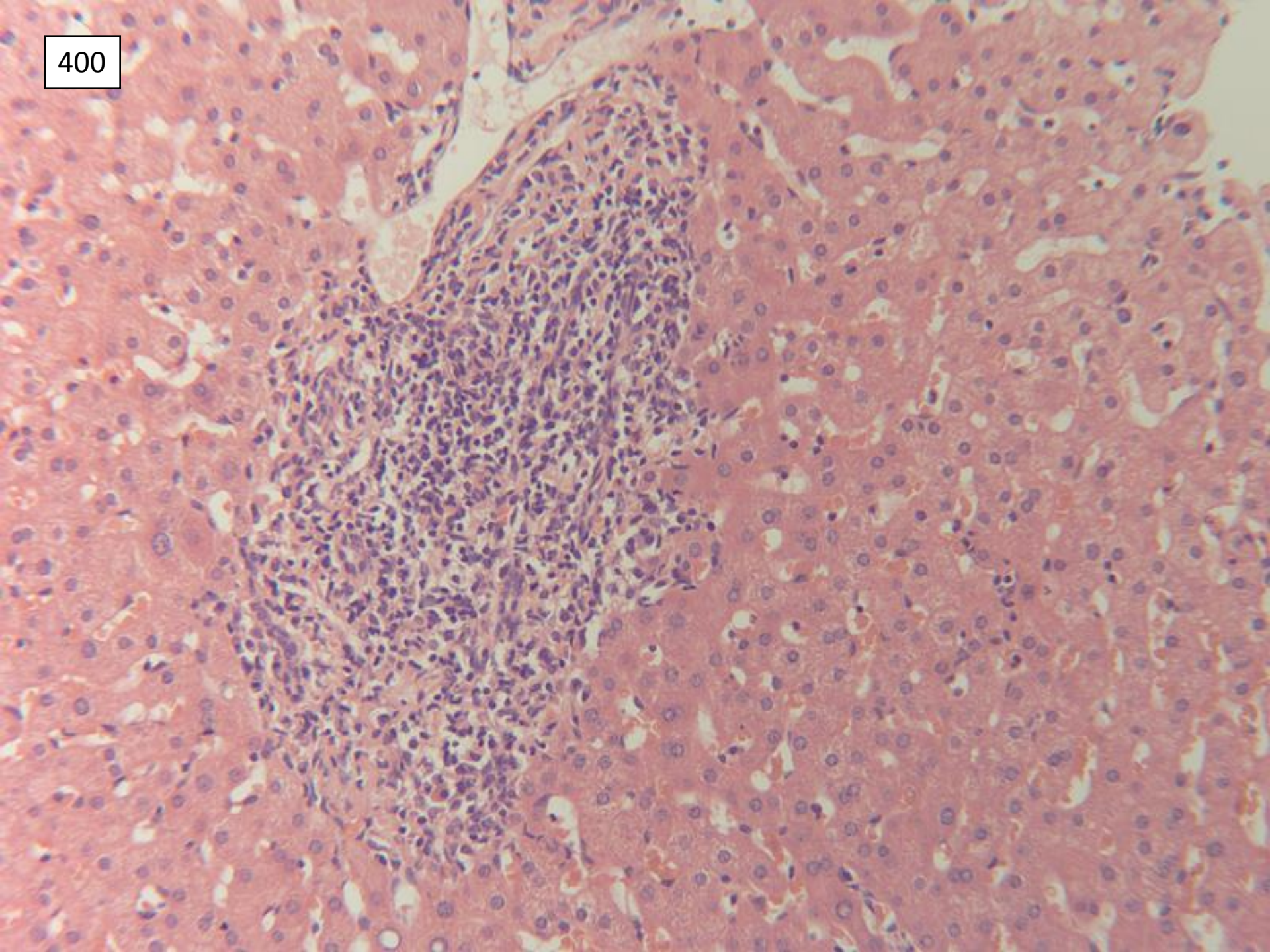
HBV Diagnosed 4 years ago, ? when acquired (African name). High viral PCR, Ag +ve, raised ALT. For staging.

1 core 14mm long (photomicrographs HbsAg and HbcAg; please also see retic and VG on website)

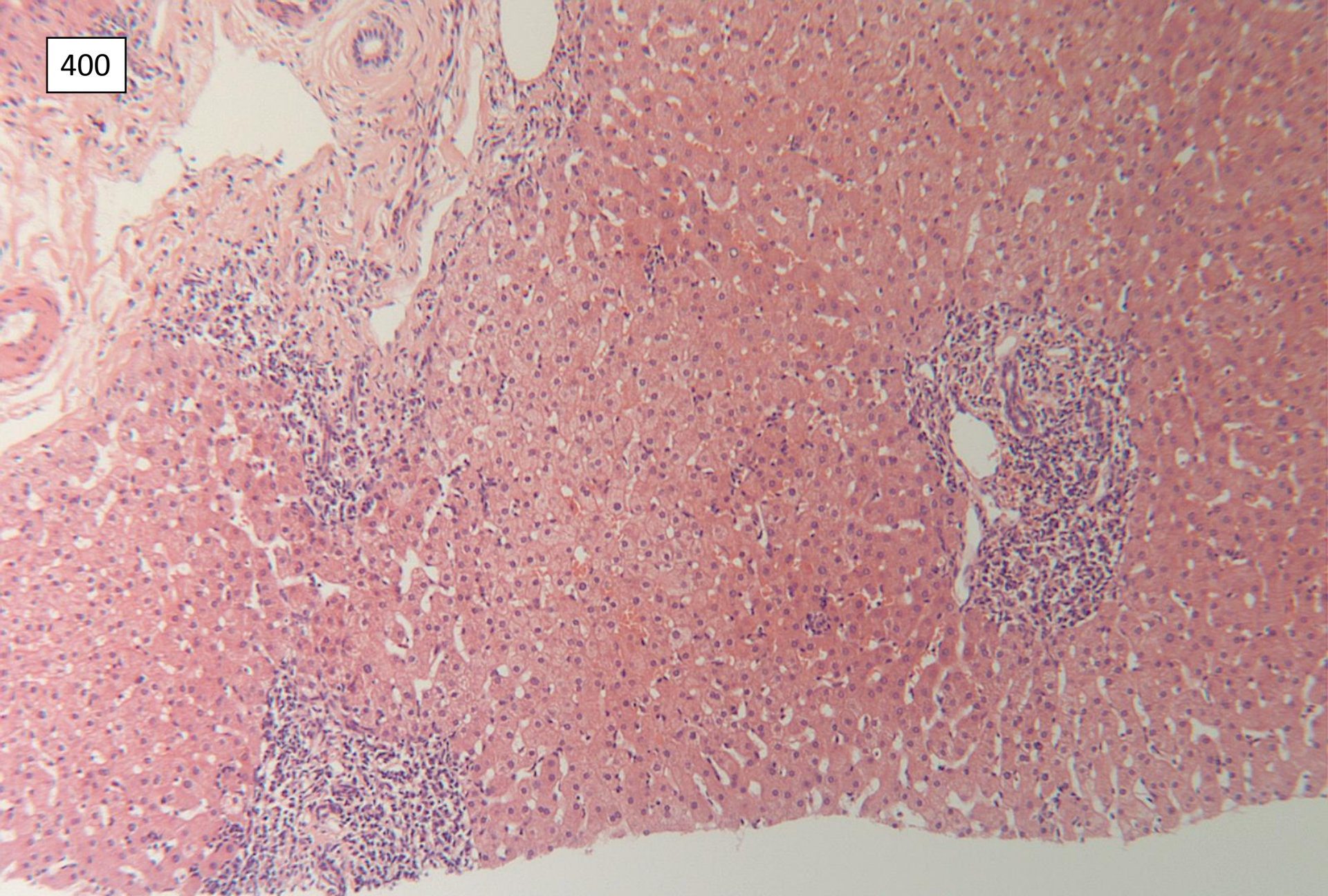
400



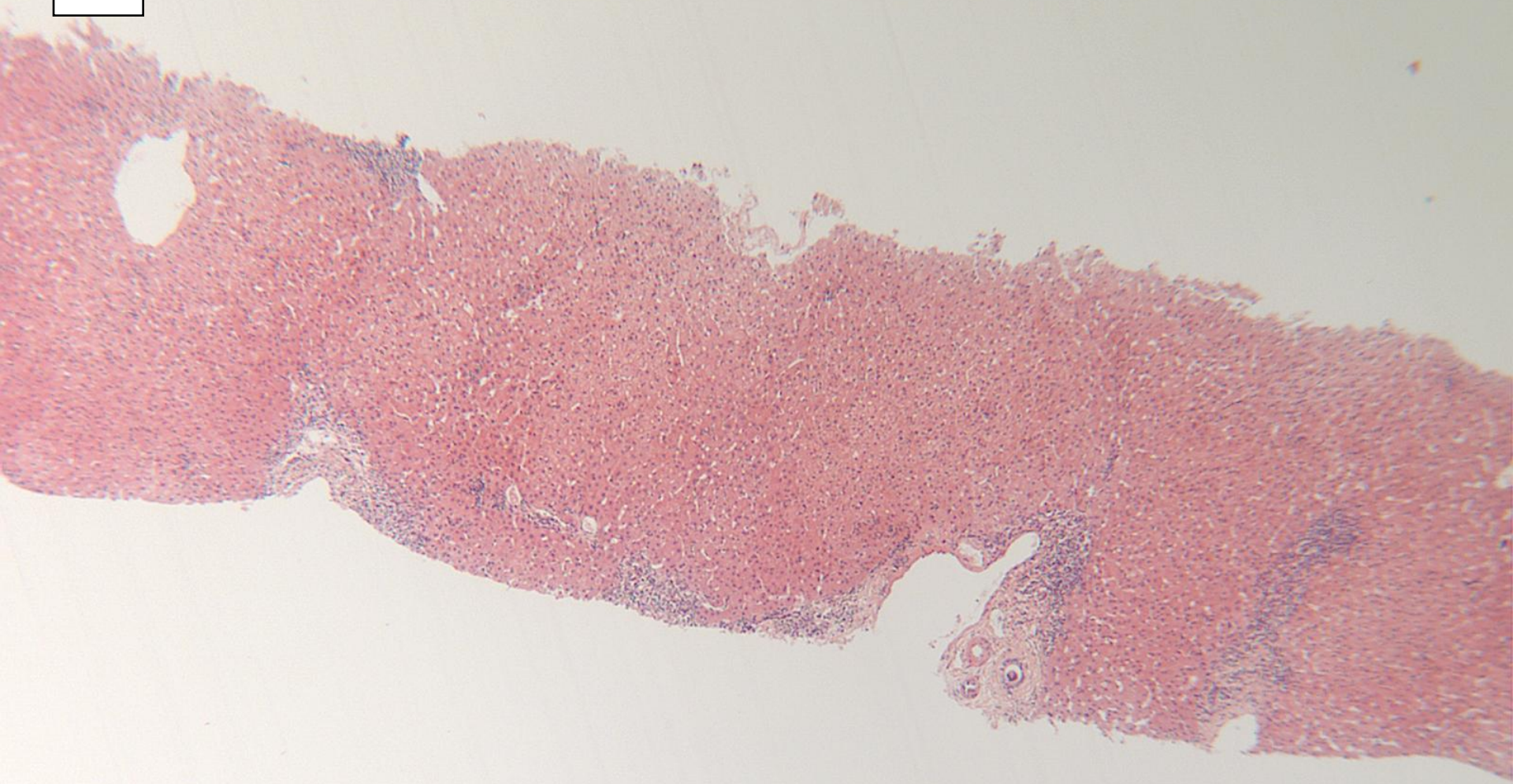
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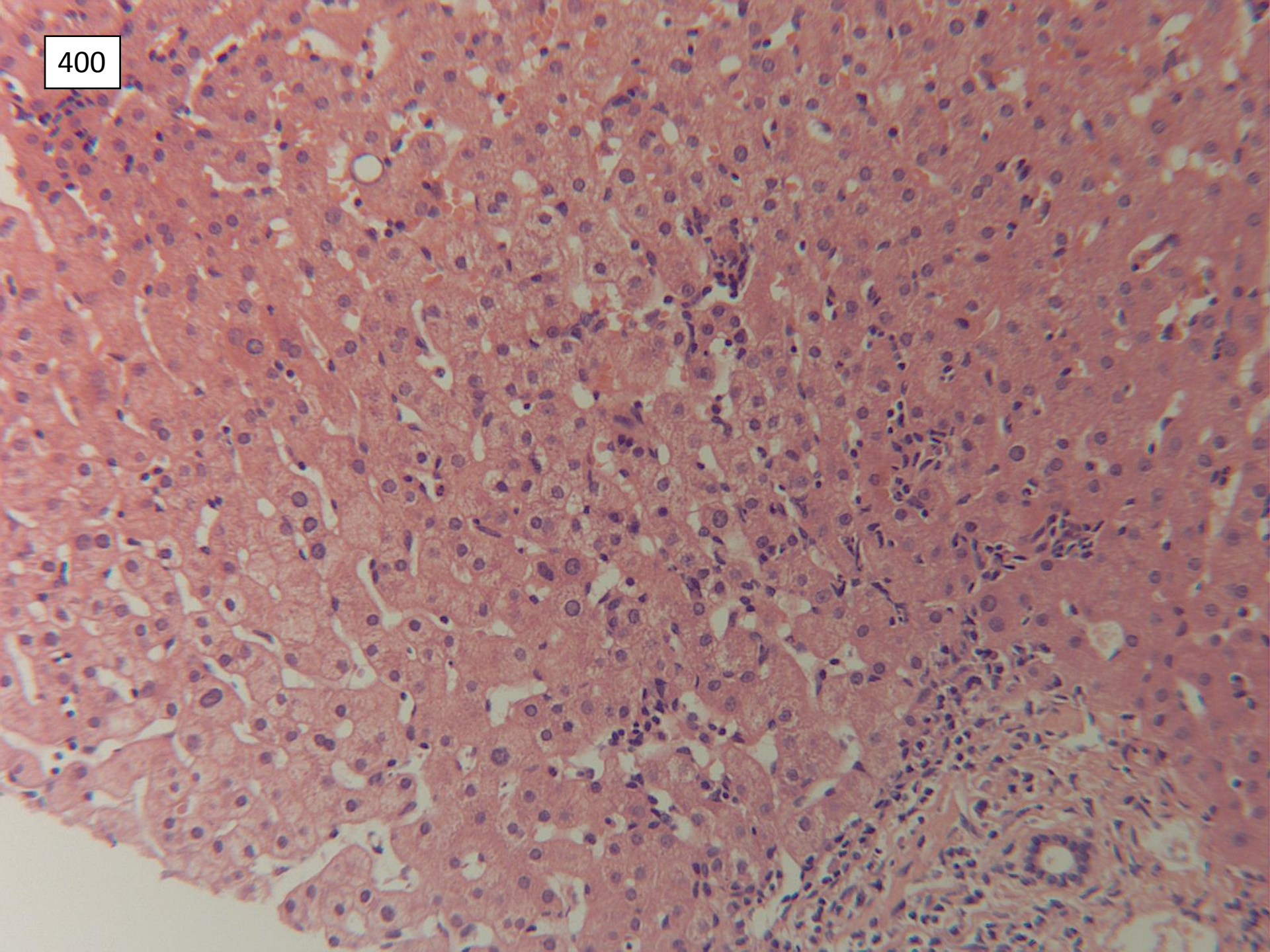
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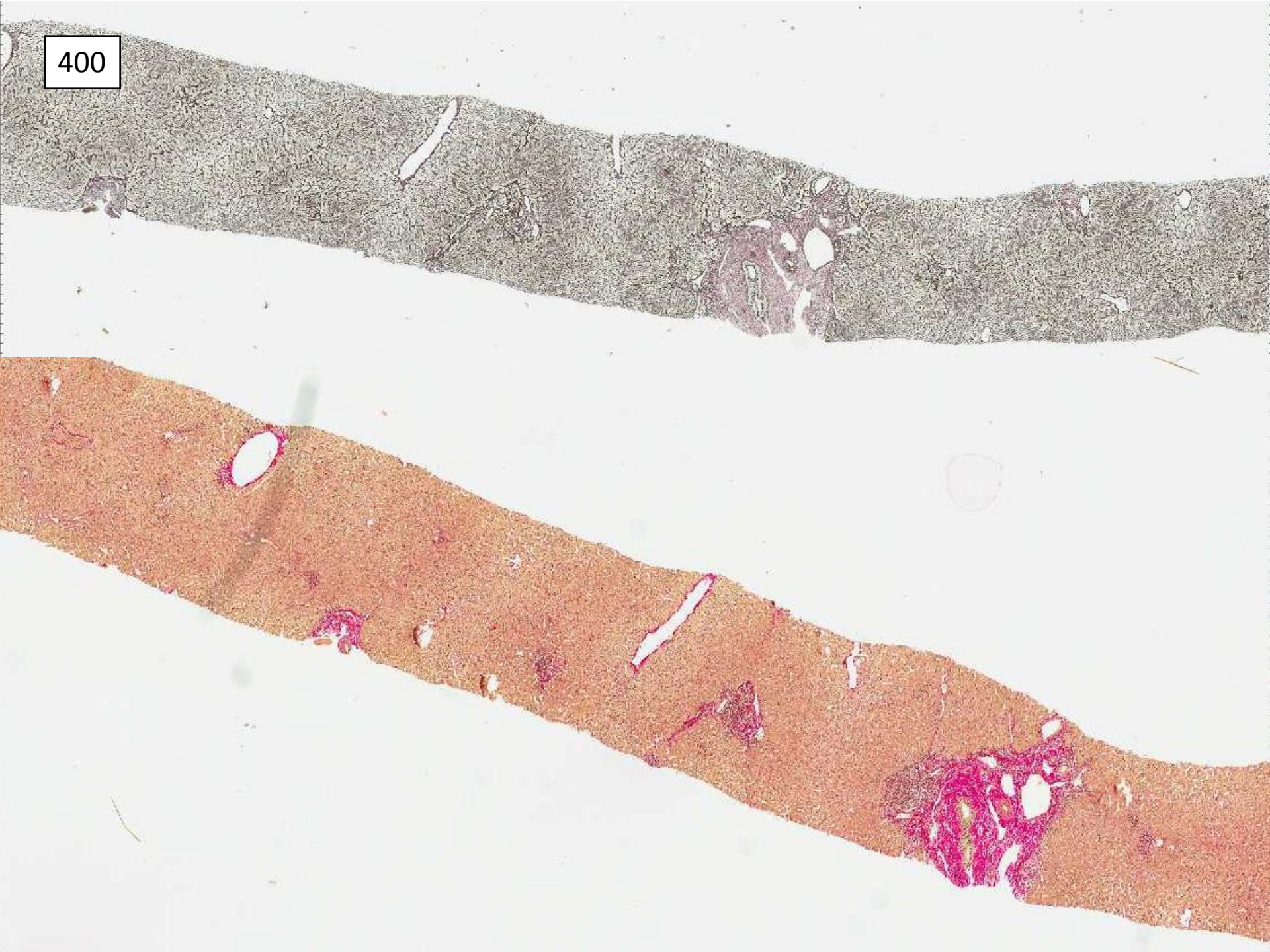
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400

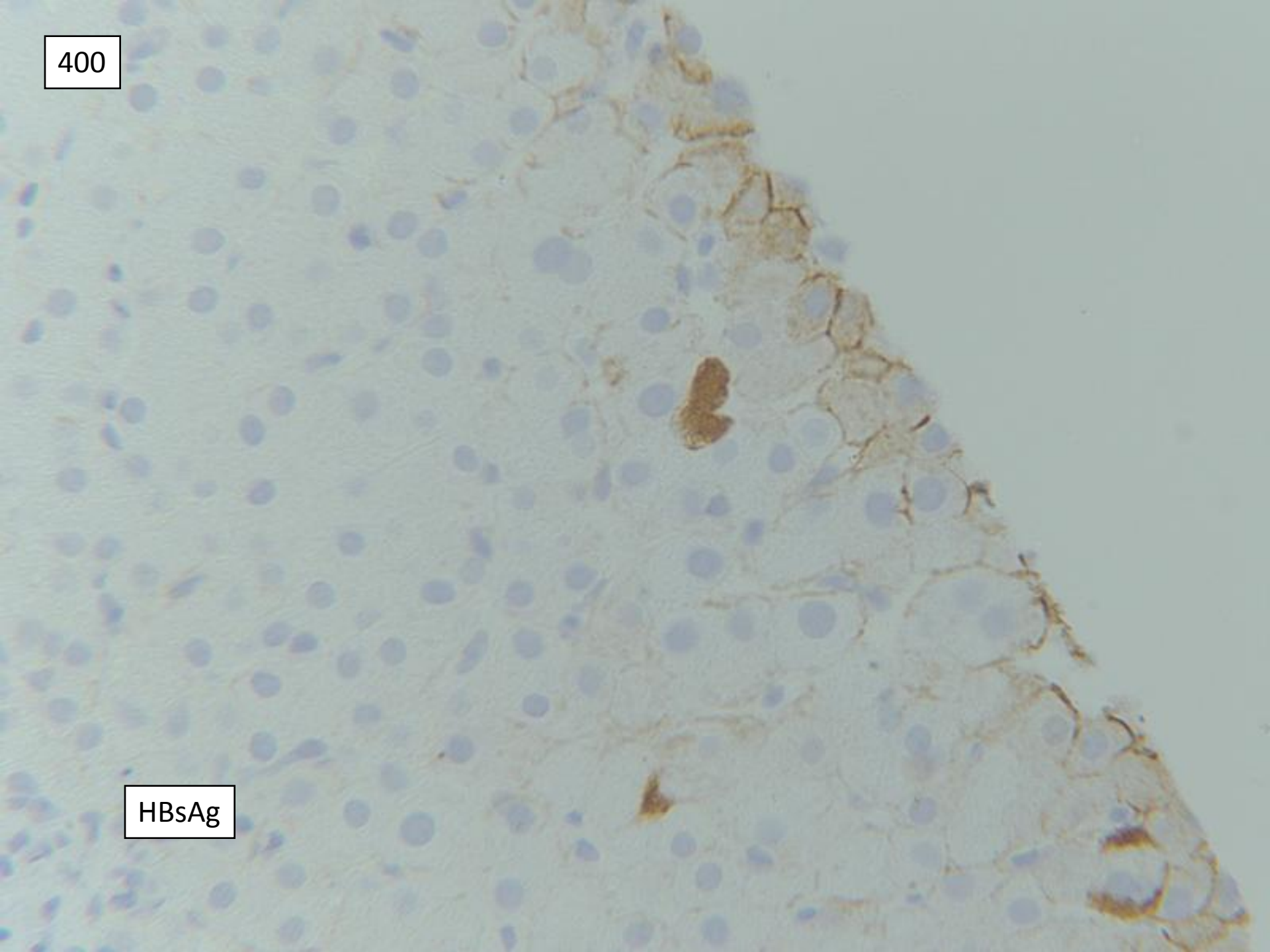


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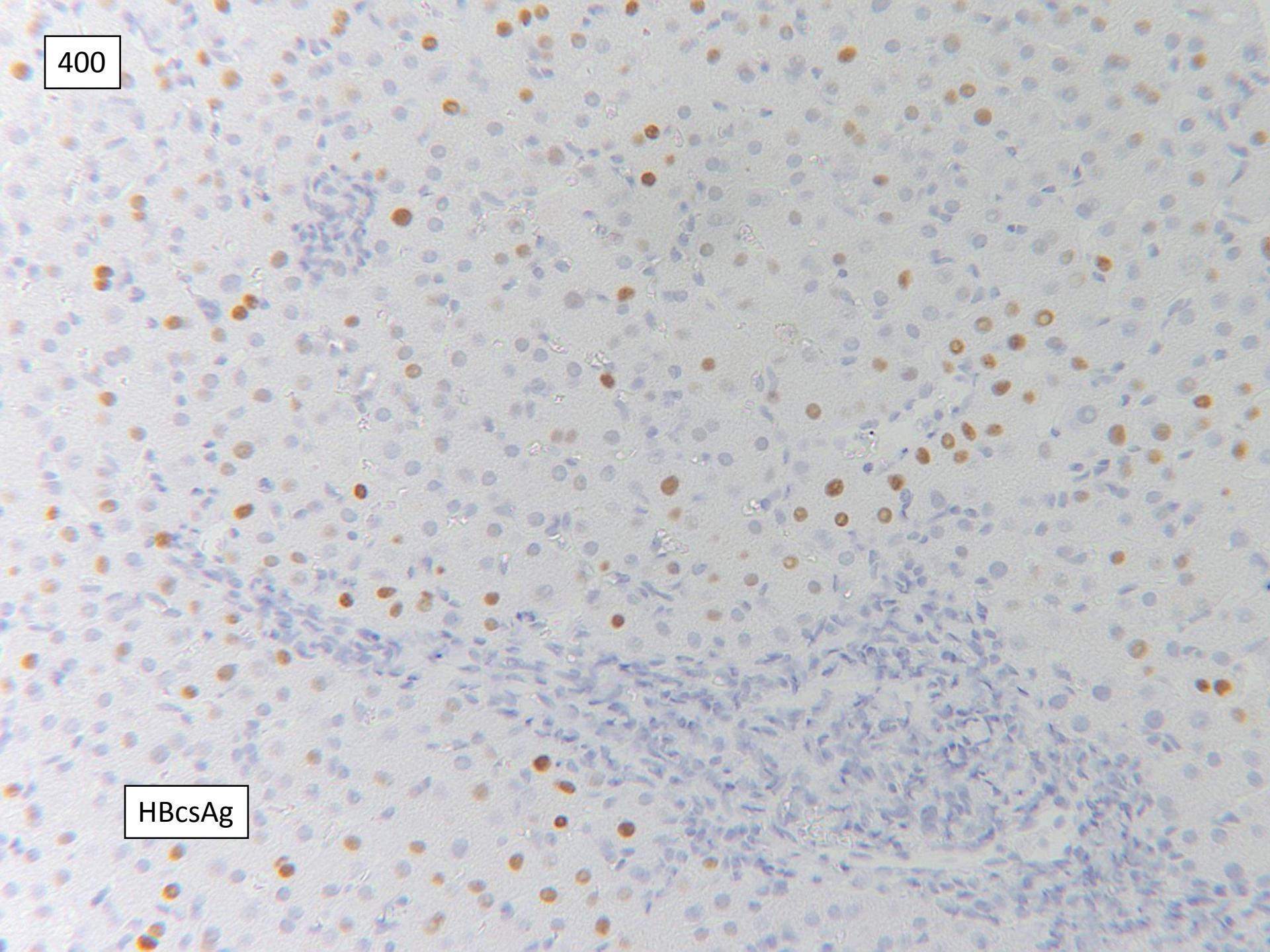
400

HBsAg



400

HBcsAg



## Case 400

### **Hepatitis B: 77**

Hepatitis B not mentioned: 1 (just 'CPH')

### Fibrosis as text:

No fibrosis: 5

'no significant fibrosis' 3

Mild fibrosis: 12

Fibrosis not mentioned: 1

### Activity grade:

Mild: 6

Mild-moderate: 5

Moderate: 10

Moderate-severe: 1

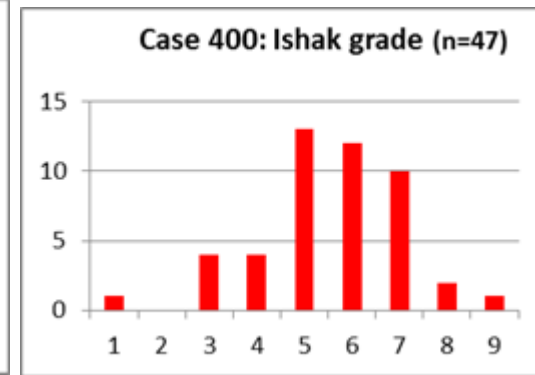
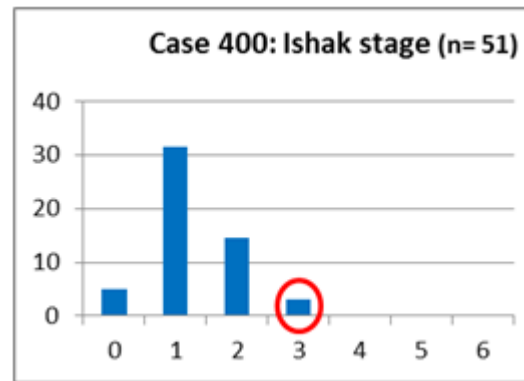
No comment on grade: 4

'prominent lobular component' 1

### Metavir:

A1F1: 3

A3F1: 1



Plasma cells prominent, check autoantibodies: 6

Exclude HIV: 2

Exclude BCS: 1

'Chronic hepatitis B and bile duct centred inflammation, exclude PBC/PSC' 1

'chronic persistent hepatitis grade 3 stage 1 (hep B not mentioned)'

'chronic inflammatory cells in portal tracts, spotty necrosis, - chronic hepatitis B'

### Suggestions for scoring:

For 10 points, include consistent with hepatitis B, and a comment on fibrosis.

? lose 5 points for Ishak stage 3, indicating bridging fibrosis

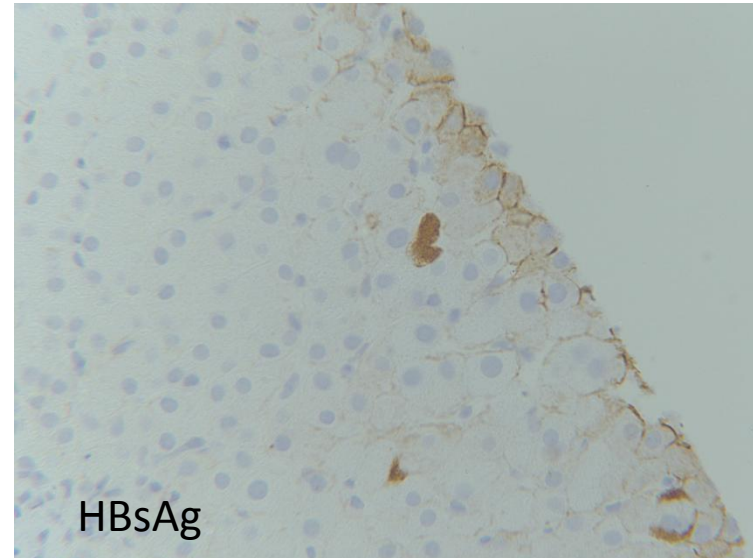
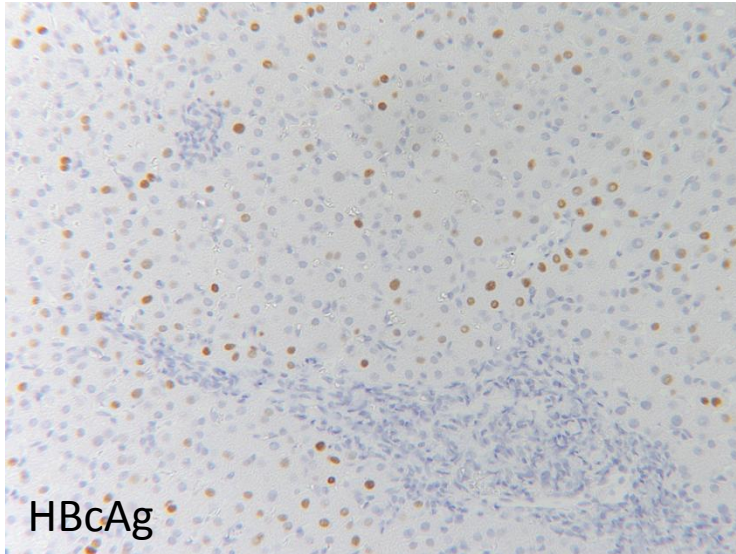
Discussion at meeting – no deduction for stage 3.

## Comment on hepatitis B immunos:

Immunos: hep B+ve 37

Indicated active replication: 10

No comment on immunos: 22



### Role of hepatitis B immunos??

This was submitted as an example of hepatitis B with lobular activity, probably as a result of immune clearance.

New treatments for chronic hepatitis B have been approved.

The following slides are from the 'masterclass' by Prof R Goldin on the role of immunohistochemistry in diagnosis and current indications for biopsy.

# HBV

## Indications for immunohistochemistry:

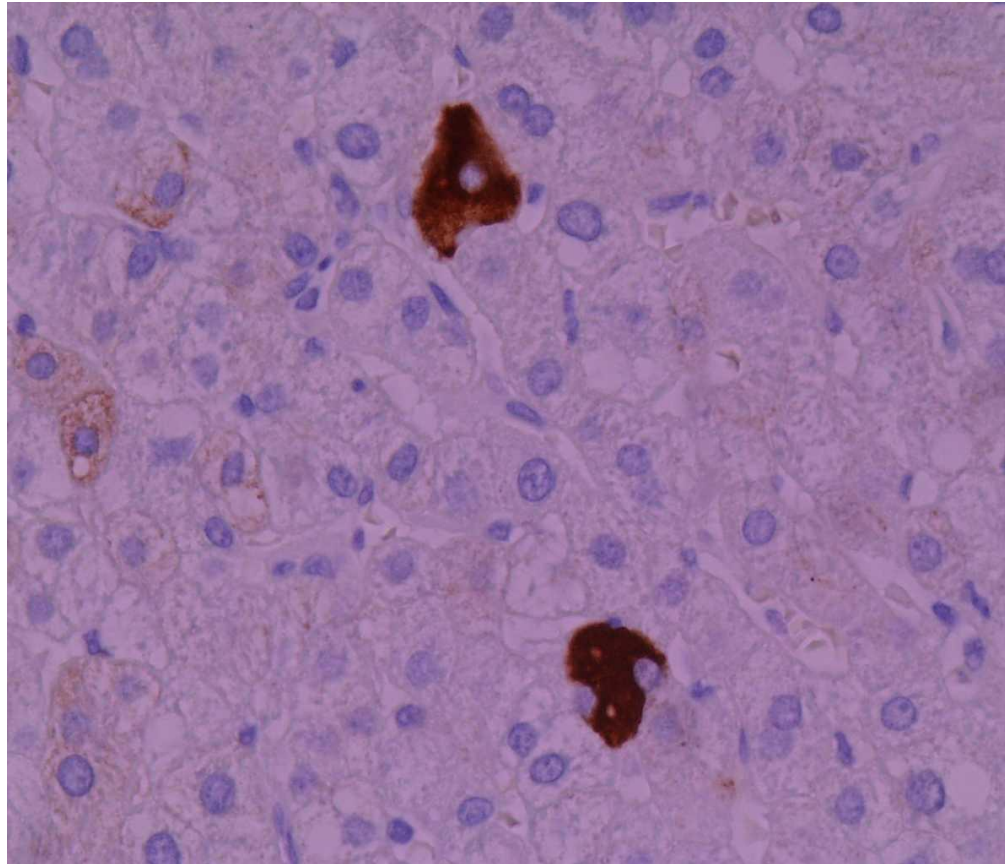
Most aspects of chronic hepatitis B can be deduced from viral DNA, serology and ALT, and so immunohistochemistry is rarely necessary.

It may be contributory in these circumstances:

1. Differential diagnosis of ground glass hepatocytes
2. Assessment of viral replication
3. Identification of immune escape (precore) mutant
4. Prominent lobular activity
4. Hepatitis in immunosuppressed patients

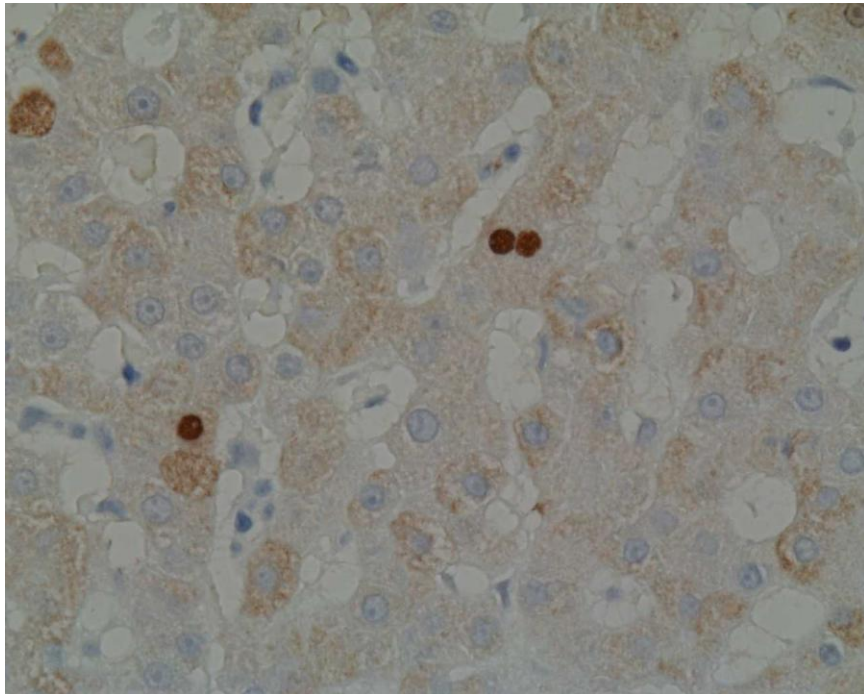
HBV: Ground glass hepatocytes

HBsAg immuno shows if ground glass is due to HBsAg (there are other causes)

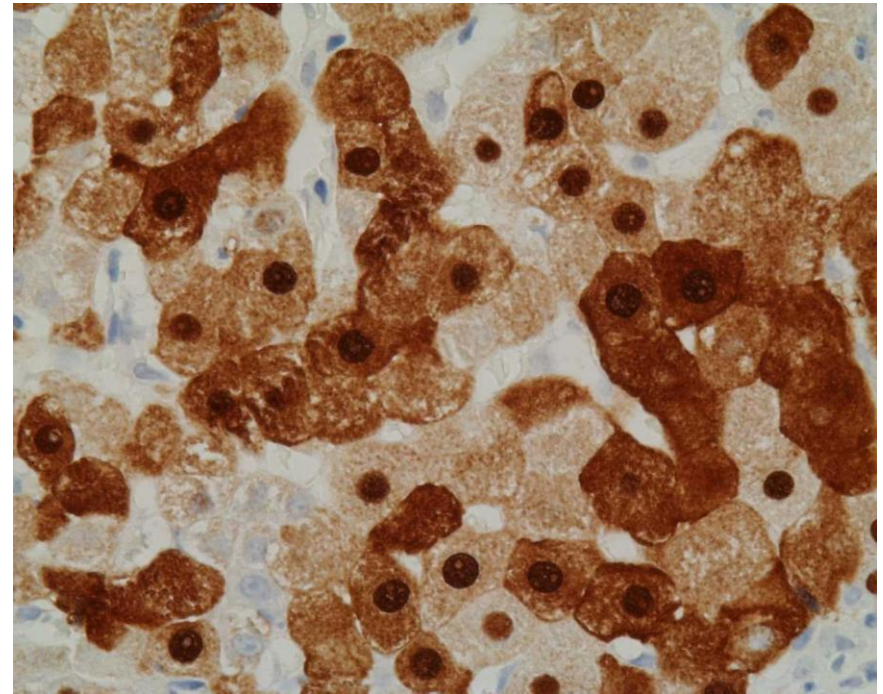


# HBV: HBcAg can give information about current viral replication

Inactive viral replication

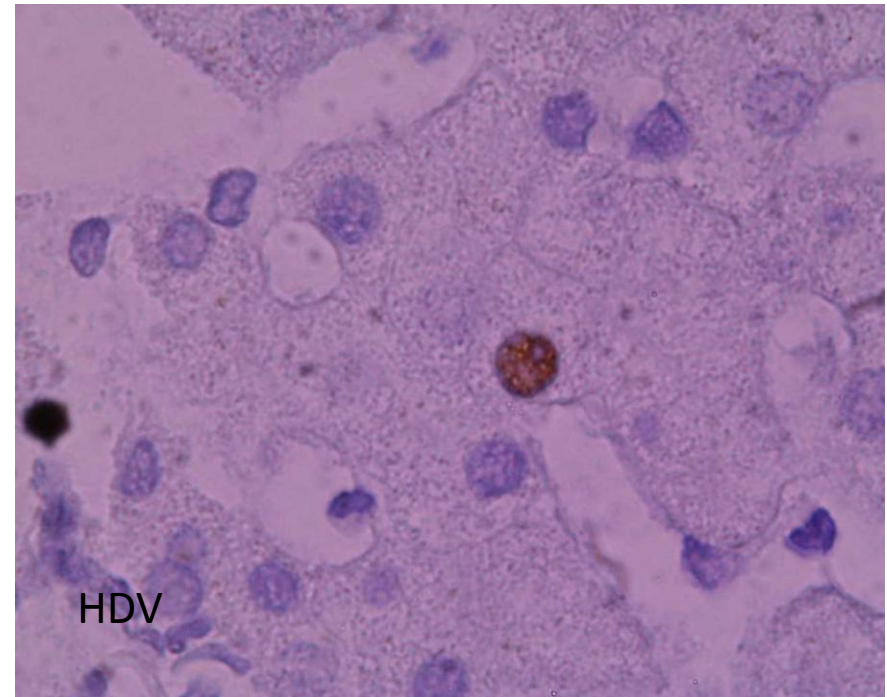
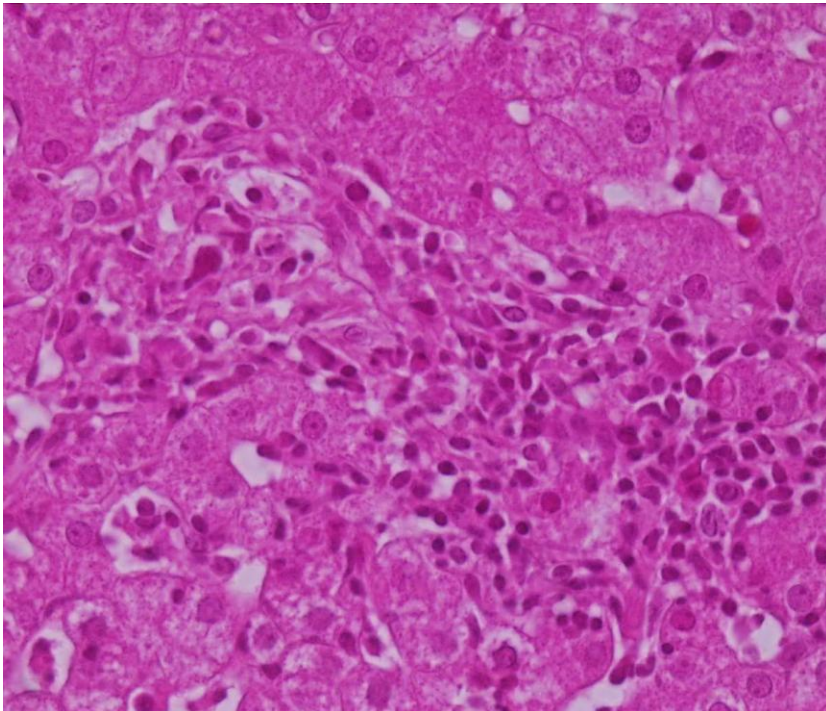


Active viral replication



# HDV

- prominent (cytopathic) lobular activity may be due to co-infection with HDV
- Immunohistochemistry – the antibody is not generally available, clinicians need to do a blood test

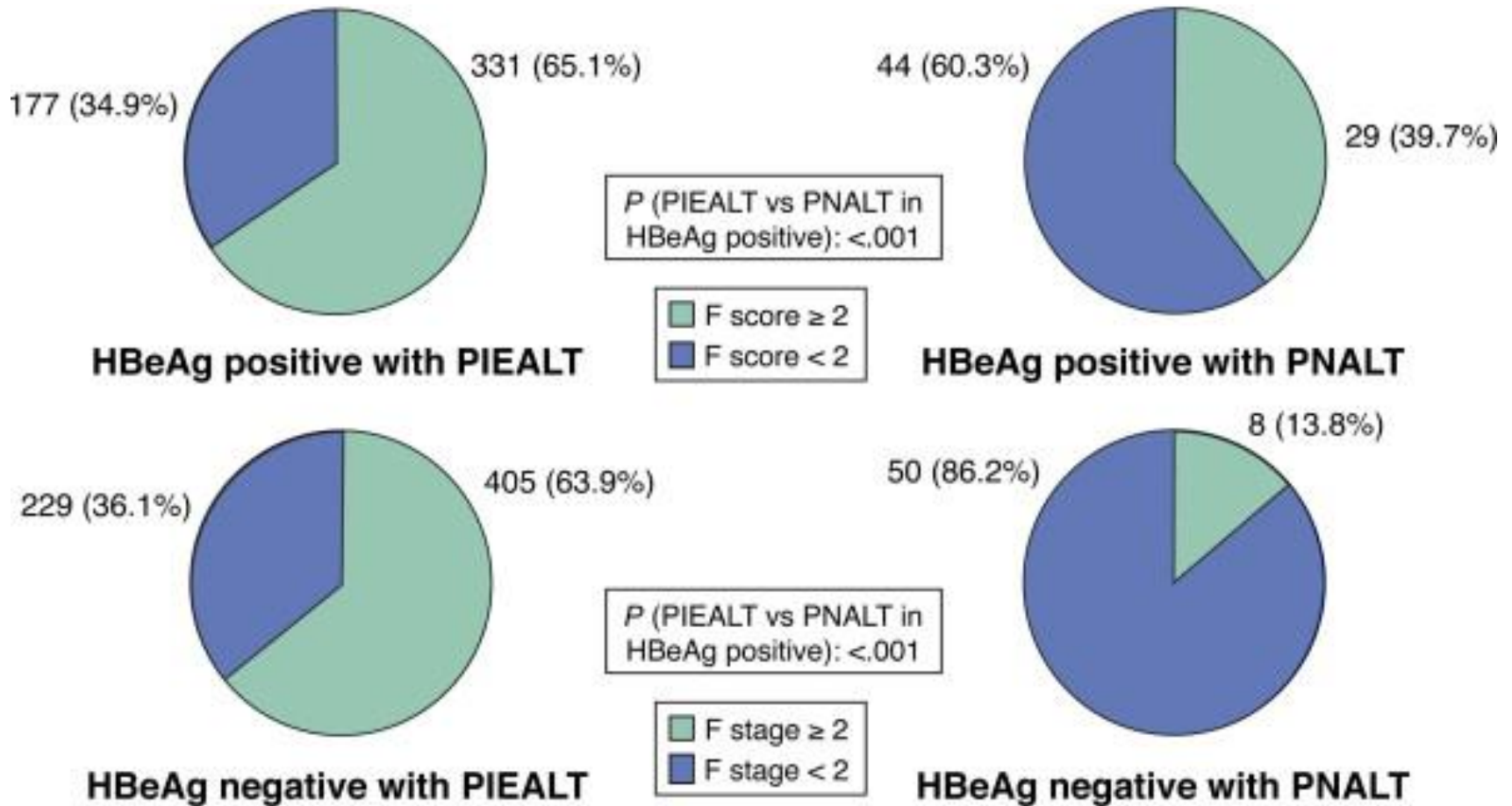


# Assessment Essentials for patients with chronic hepatitis B:

- HBV Serology
- HBV DNA
- ALT (several times if normal)
- AFP
- Comorbidities (HIV)
- Liver Ultrasound
- Biopsy – to assess disease severity – disease may fluctuate and histological severity cannot currently be predicted by non-invasive tests

# ALT and Histology

Metavir stage F2 or more (green) commoner if persistently elevated ALT, but also found persistently normal ALT especially if HBeAg positive



# Noninvasive Markers of Fibrosis in Chronic Hepatitis B



- Liver stiffness measured in 220 HBV patients
- Measured within 6 months of biopsy
- Correlation
  - Ishak fibrosis scores  $r = 0.67$
  - METAVIR fibrosis score  $r = 0.66$

# Not 'If ?' but 'When ?'

\* = active disease, biopsy indicated

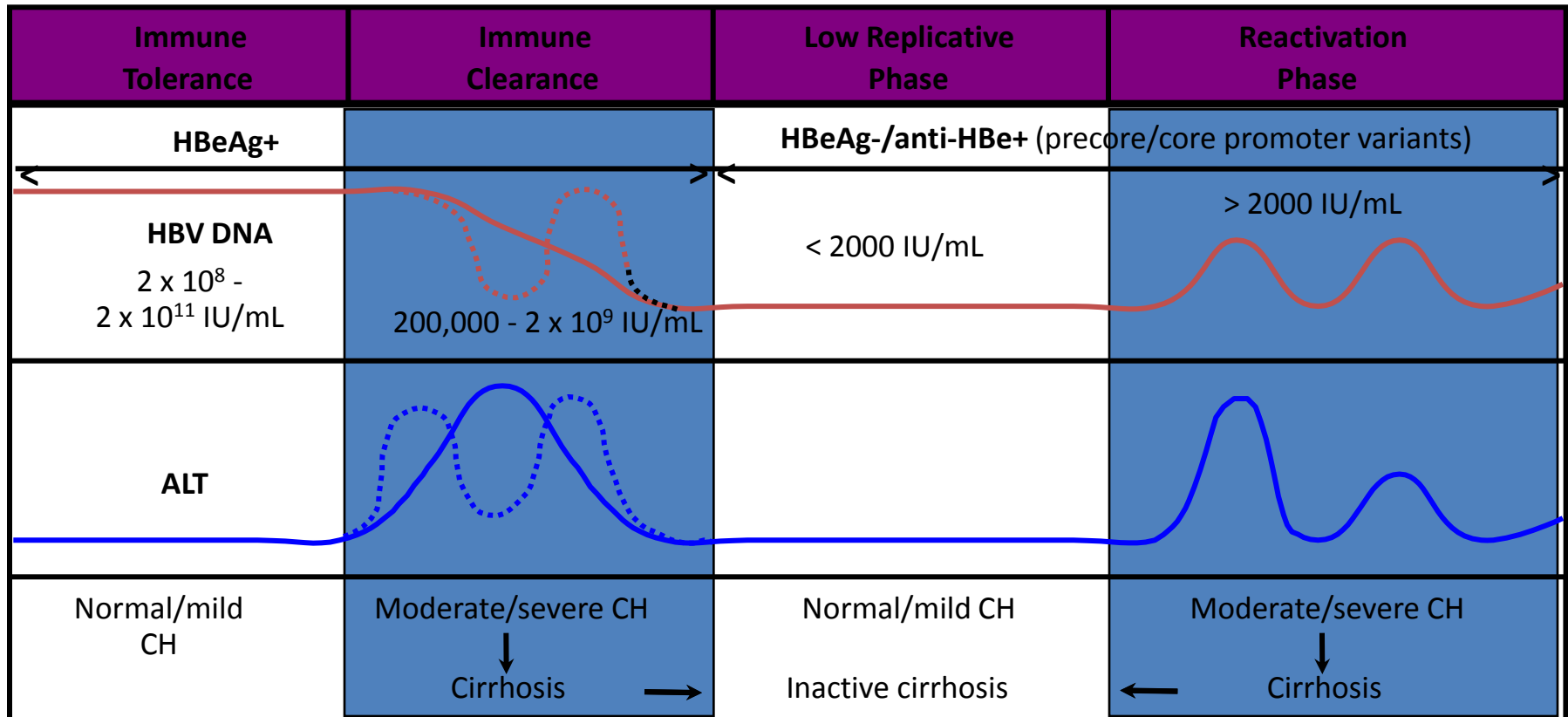
terminology for phases of chronic hepatitis B:

immune tolerance (high DNA, low ALT),

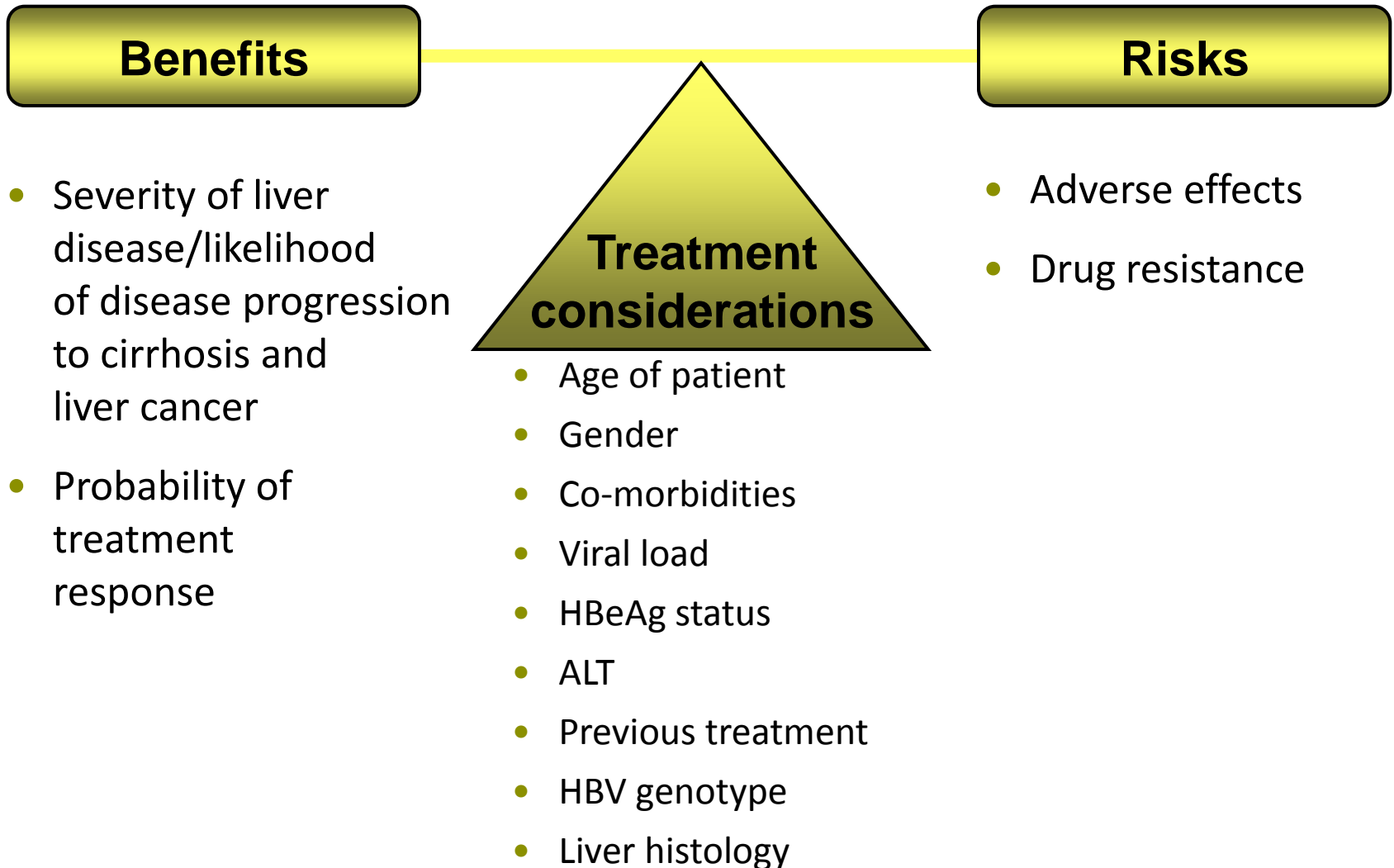
immune clearance (both fluctuating)\*

low replicative phase (both low)

reactivation phase (virus escapes immune control, both fluctuating)\*



# Who should be treated?



# Indications for treatment

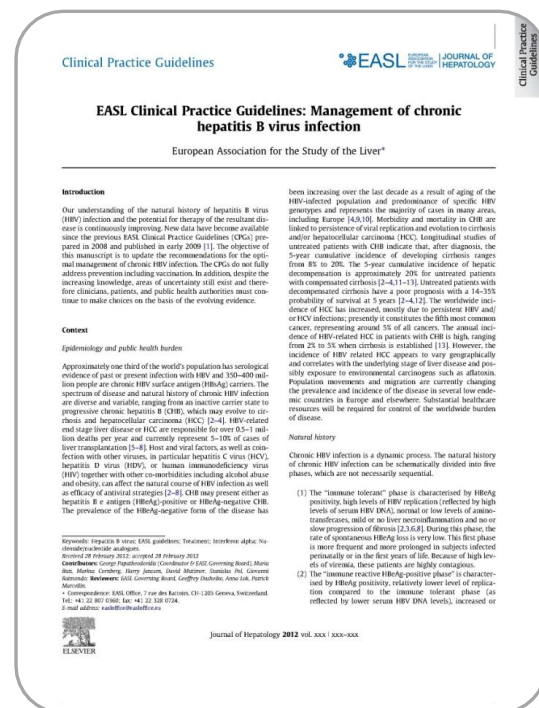
CHB patients should be considered for treatment when they have:

HBV DNA levels above 2000 IU/ml

Serum ALT levels above the upper limit of normal (ULN)

Severity of liver disease assessed by liver biopsy (or non-invasive markers once validated in HBV-infected patients) showing moderate to severe active necroinflammation and/or at least moderate fibrosis.

In patients who fulfil the above criteria for HBV DNA and histological severity of liver disease, treatment may be initiated even if ALT levels are normal.



# Indications for treatment... cont.

**The need for liver biopsy and treatment should be considered separately in the following subgroups of patients:**

- **Immunotolerant patients**
- **HBeAg(–)ve patients with persistently normal ALT levels and HBV DNA levels >2000 but <20,000 IU/ml, without any evidence of liver disease**
- **Patients with obviously active CHB**
- **Compensated cirrhosis**
- **Decompensated cirrhosis**

# AASLD Guidelines

HBeAg Status	HBV DNA	ALT	Management
Positive	> 10 <sup>5</sup> copies/ml	<2 x ULN	No treatment
Positive	> 10 <sup>5</sup> copies/ml	> 2 x ULN	Treat
Negative	> 10 <sup>5</sup> copies/ml	> 2 x ULN	Treat
Negative	> 10 <sup>4</sup> copies/ml	1 – 2 xULN	Liver biopsy
Negative	< 10 <sup>4</sup> copies/ml	< 1 x ULN	Observe
Positive or Negative	Any detectable	Cirrhosis	Treat

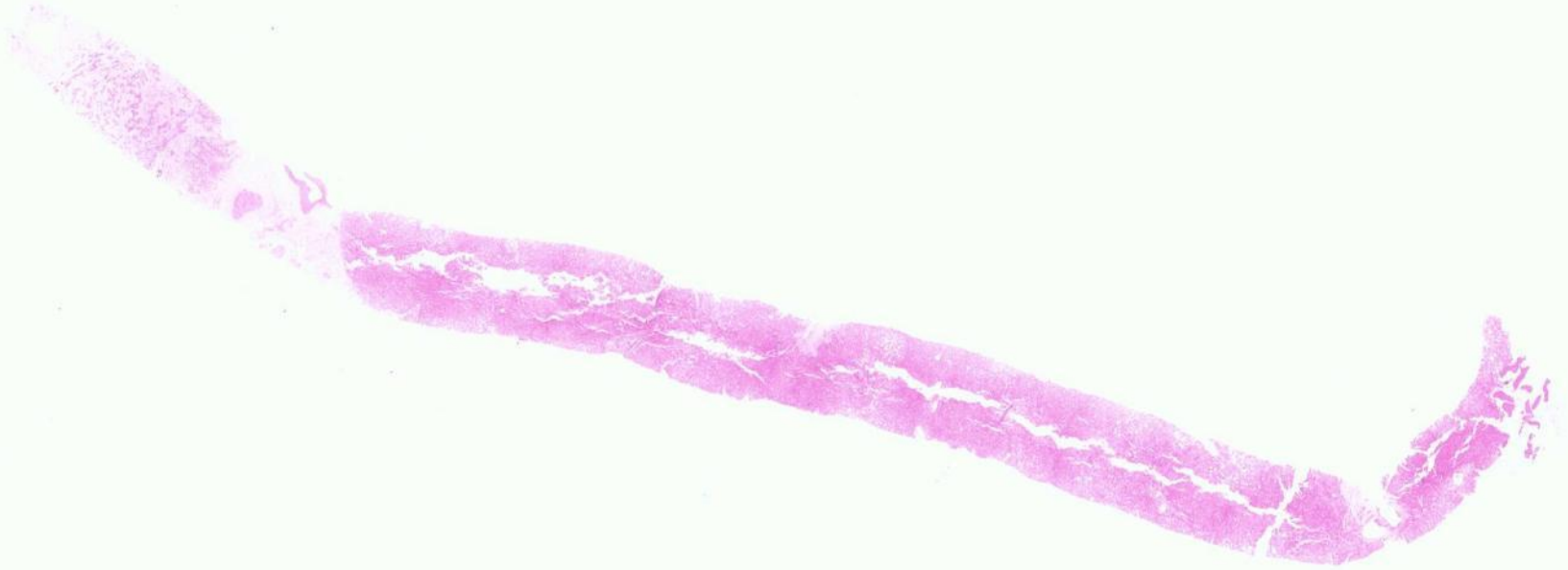
## **Case G1/401**

**37 M**

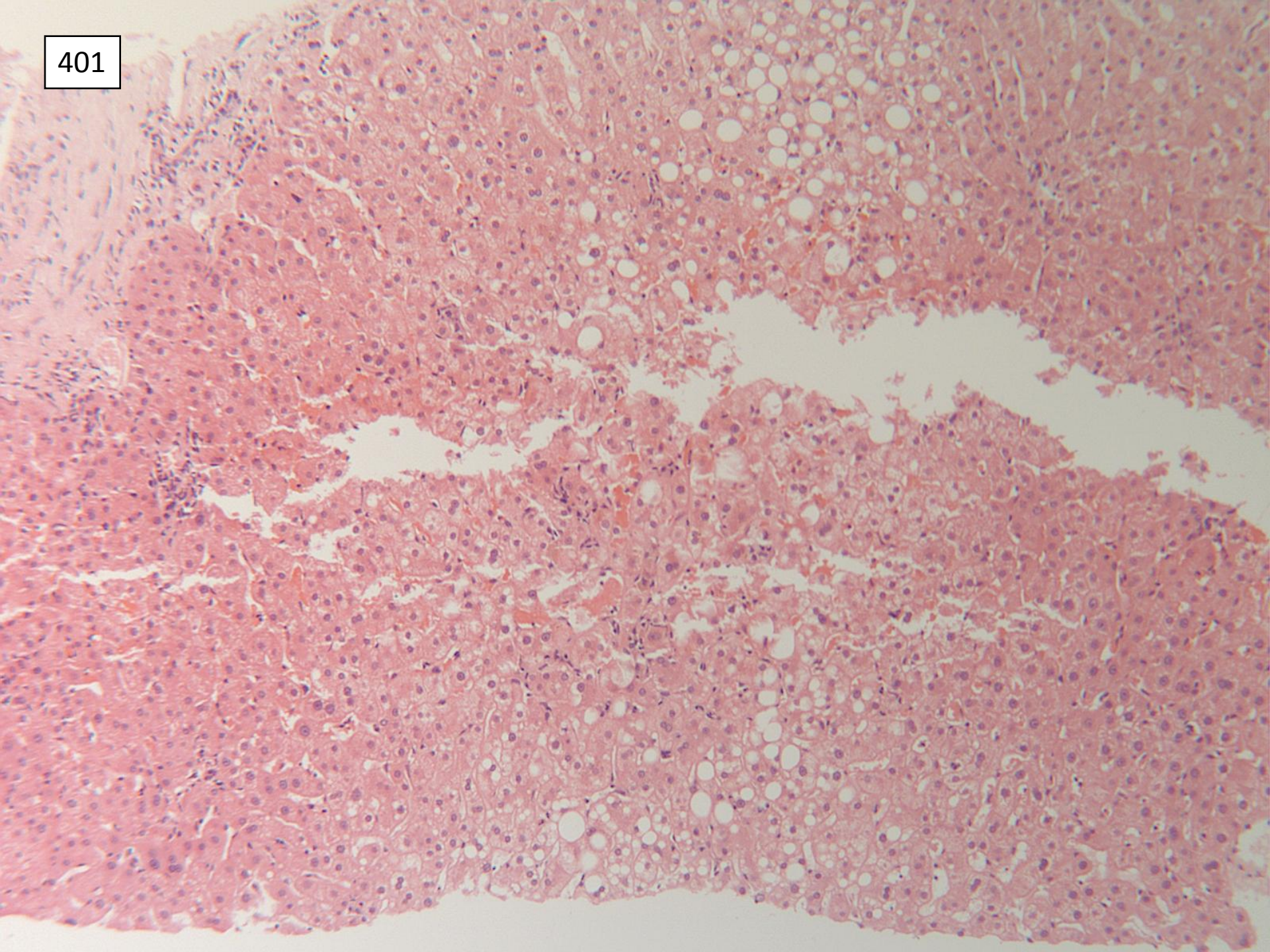
Deranged LFTs. High BMI. ?fatty liver disease

One tan core of tissue 14mm in length. All embedded. (anticipated connective tissue stains on website)

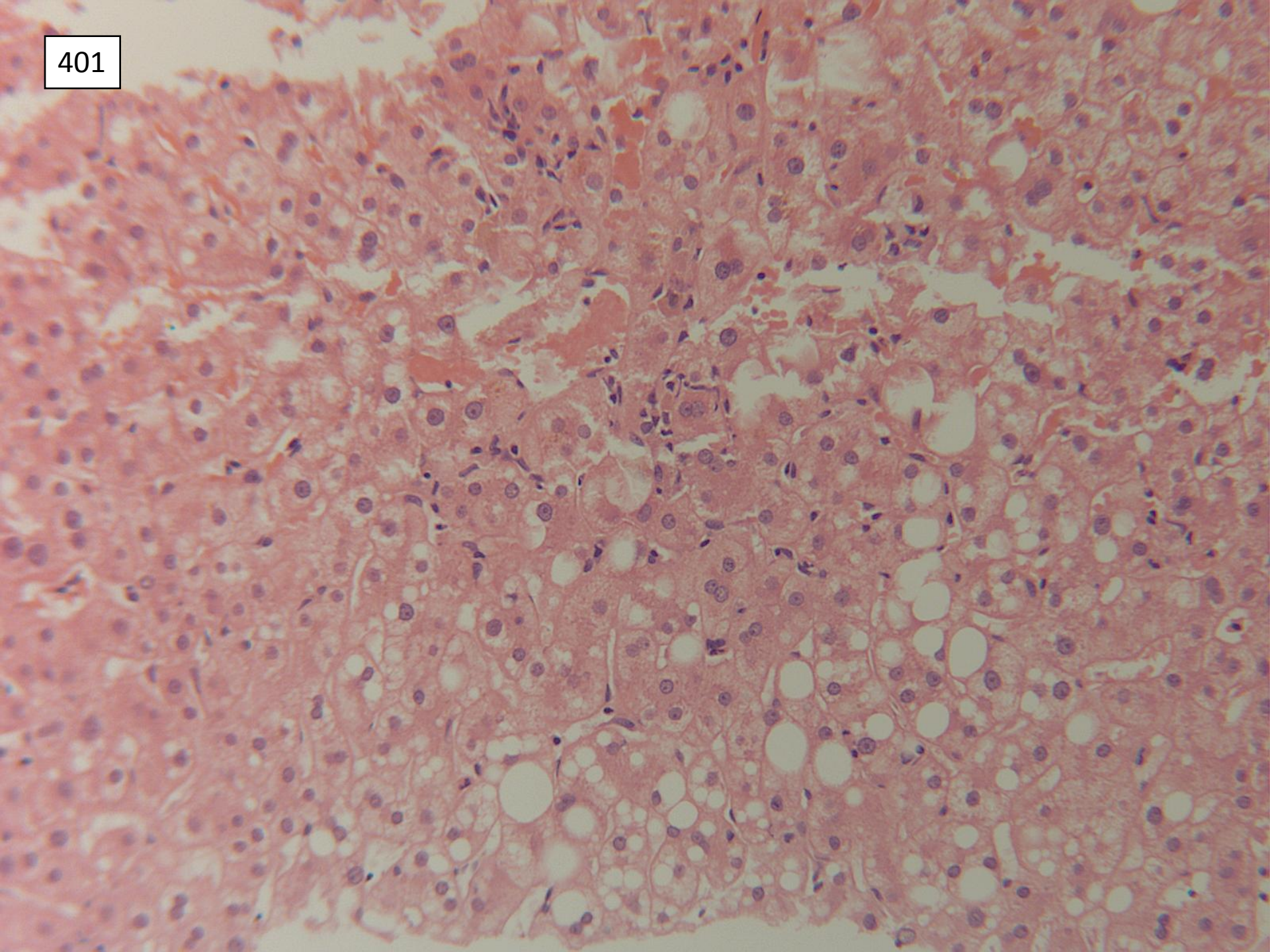
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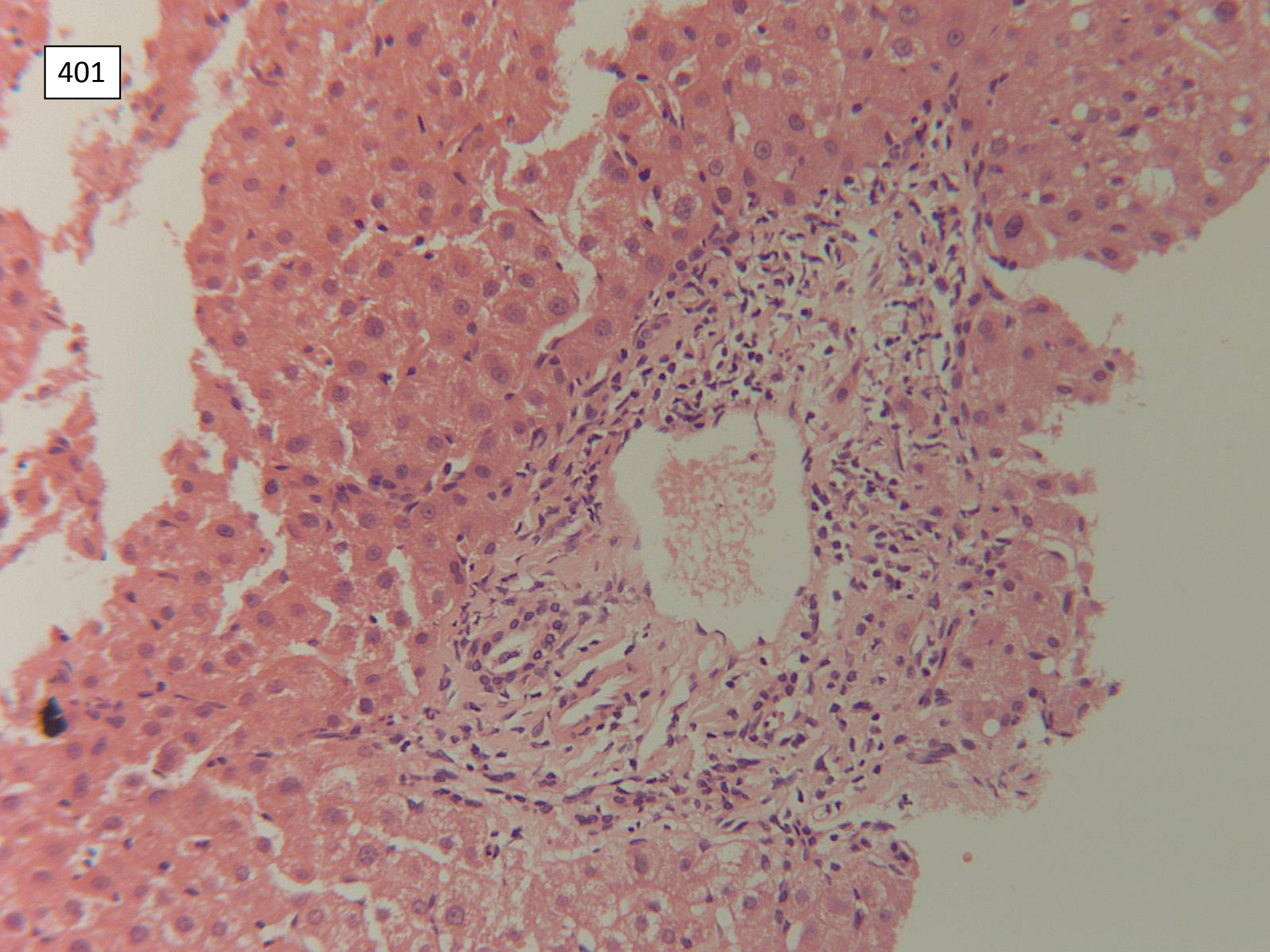
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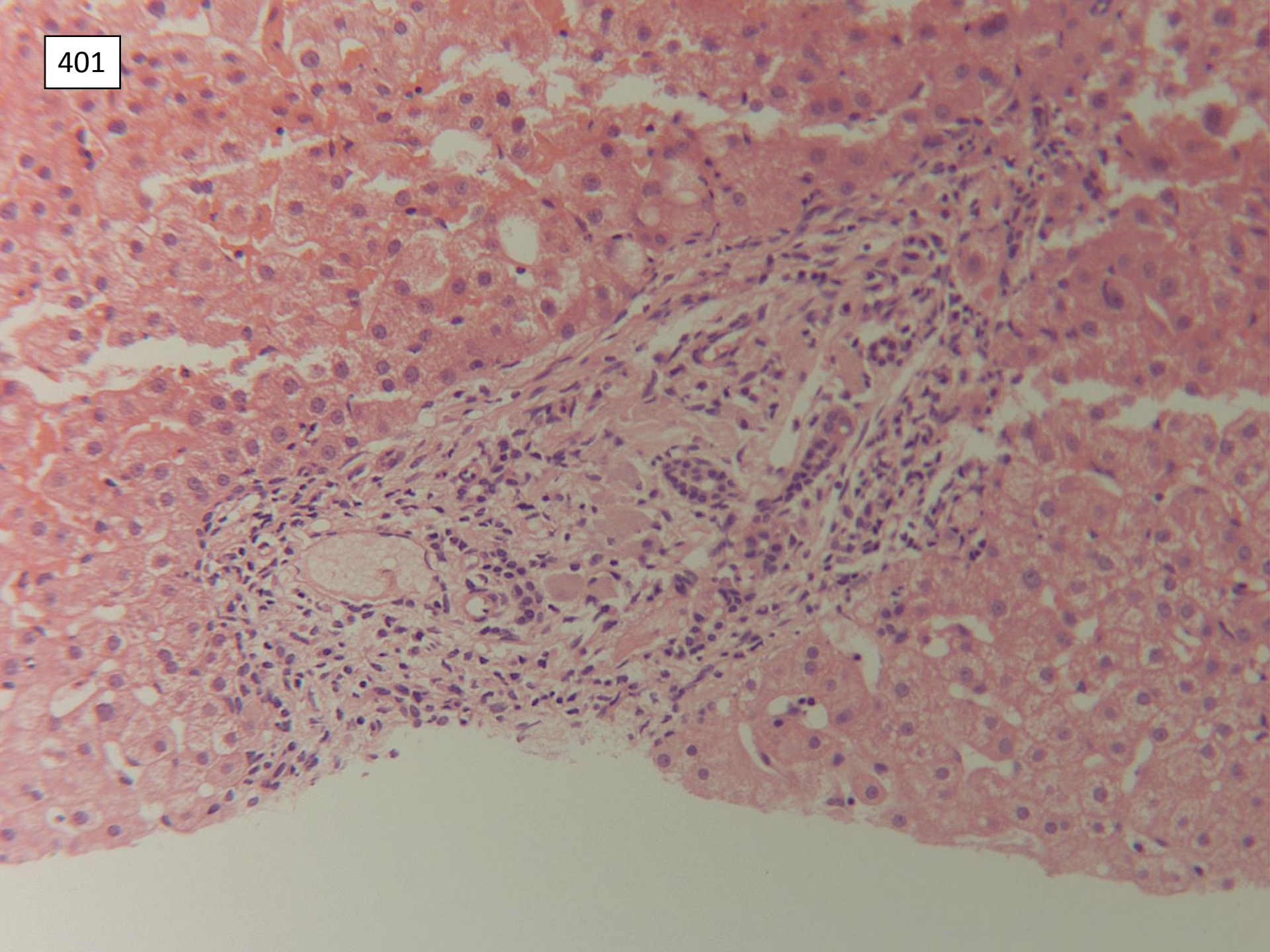
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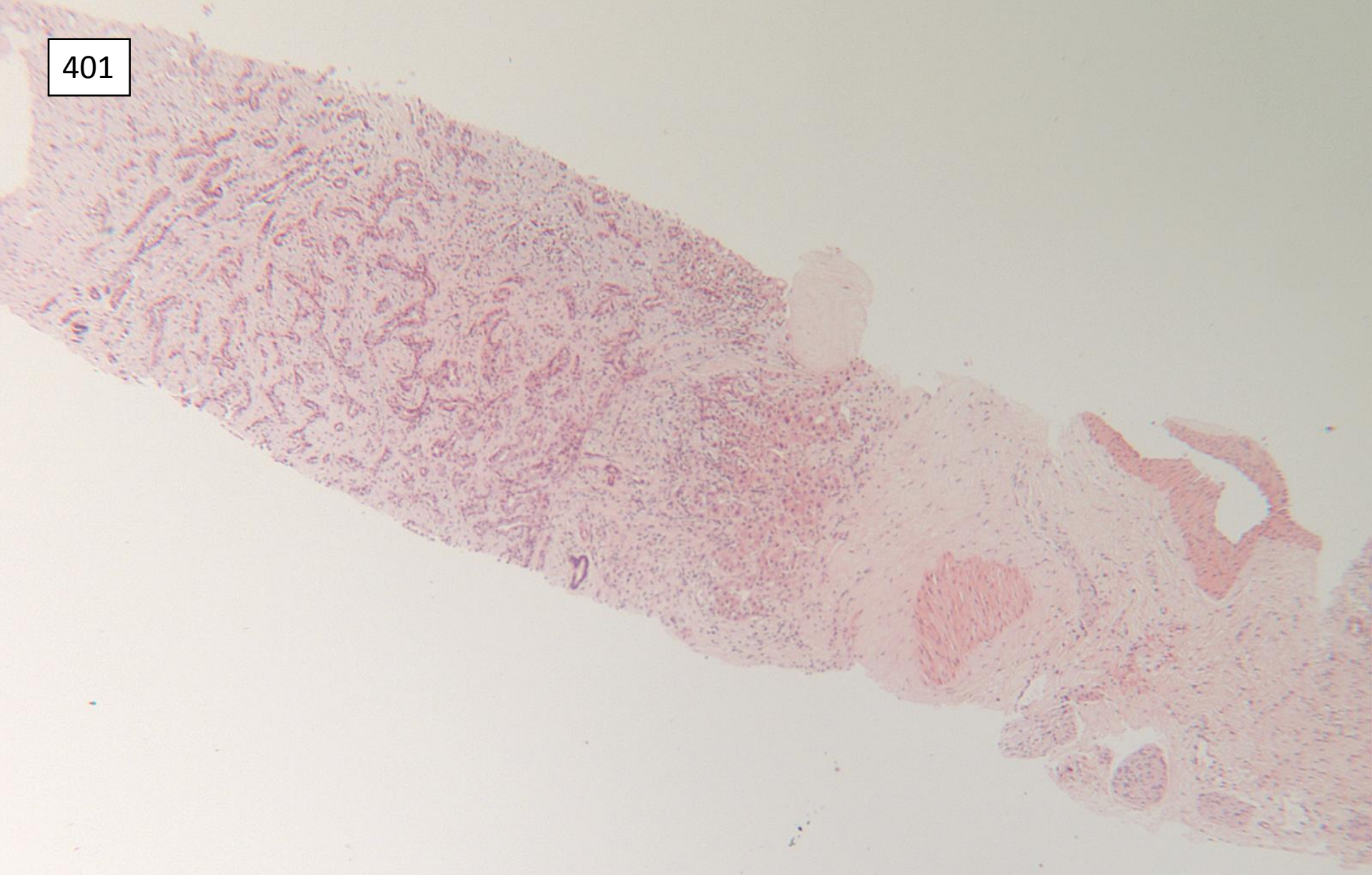
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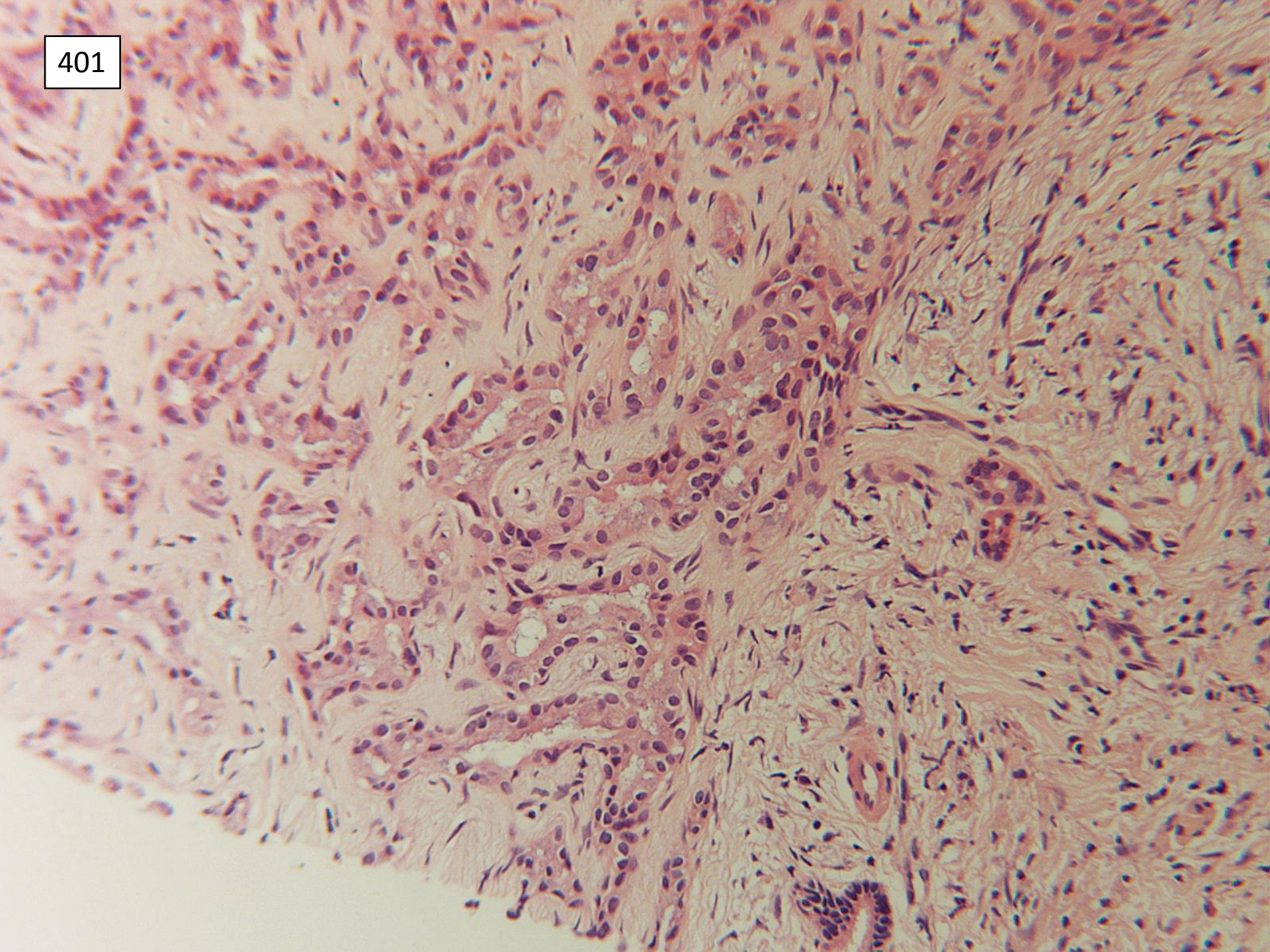
401



401



401



## Case 401

### Morphology:

Steatosis: 53

Borderline steatohepatitis: 7

Steatohepatitis: 26

**No mention of fat: 3**

Portal inflammation: 30

Bile duct adenoma: 33

Peribiliary gland hamartoma: 7

von Meyenberg complex: 4

description of lesion only: 11

any of above +exclude cholangiocarcinoma 7

**highly suspicious of CC: 5**

**definite CC: 1**

**adenocarcinoma, primary or secondary: 4**

lesion not mentioned: 11

clinical comment on alcoholic or NAFLD: 26

**alcoholic liver disease: 1**

mild chronic hepatitis ? cause, ? drug reaction: 5

cholestasis, ? drug: 2

‘mild chronic active hepatitis with moderate steatosis/NAFLD’

### Suggestions for scoring:

For 10 points include comment on fatty liver disease, and on focal lesion.

Score 0 for definite diagnosis of malignancy, and for no mention of steatosis.

Half marks for highly suspicious of CC or definite diagnosis of alcoholic liver disease

? suitable for scoring – are suggestions above appropriate?

Suggestions agreed – accepted for scoring

Peribiliary gland hamartoma is the current terminology for ‘bile duct adenoma’ since this is not neoplastic lesion

**Case G1/402**

**68 F**

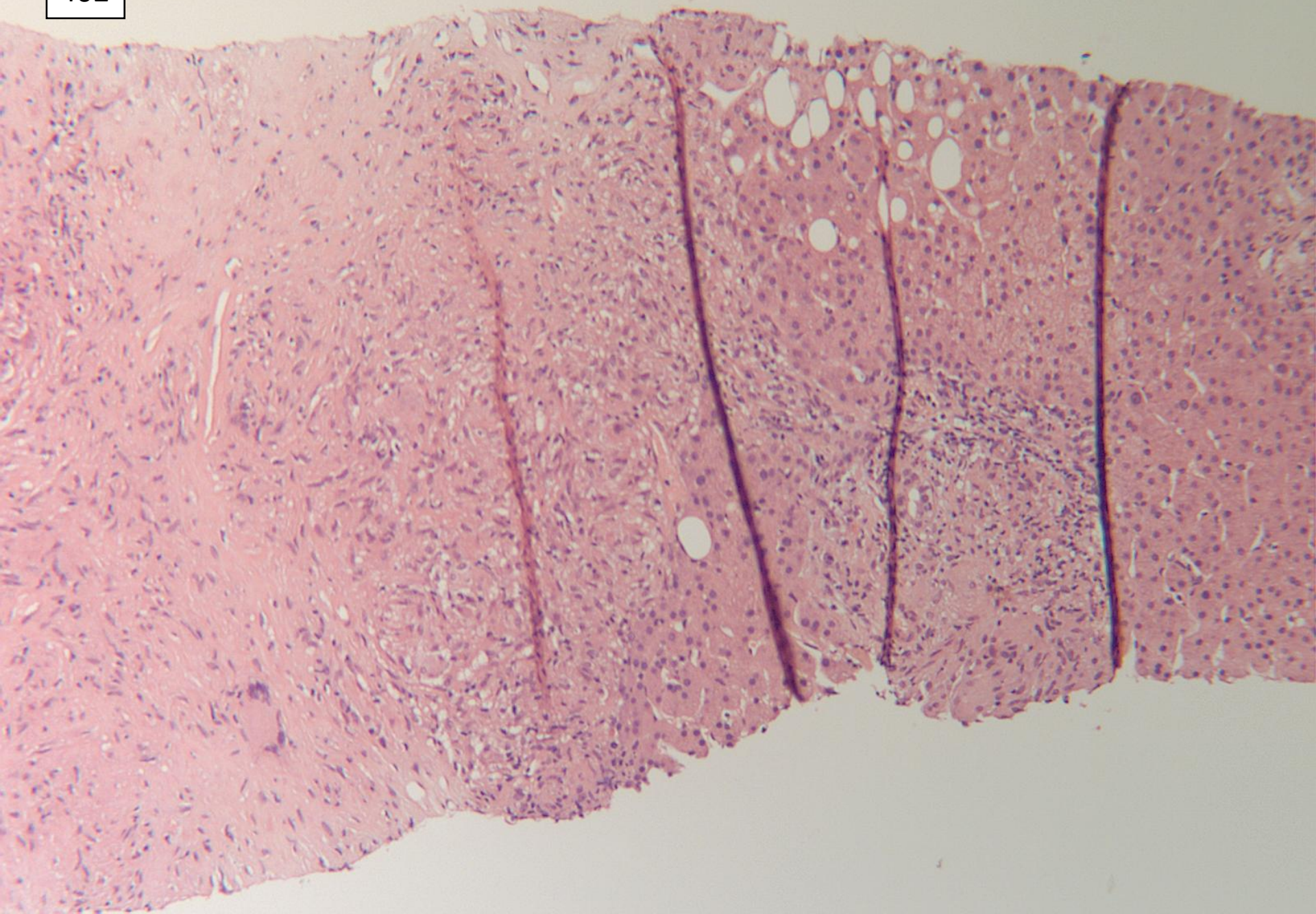
CT/US - heterogeneous liver echotexture ?HCC  
lesional biopsy

Tan Core 20mm (anticipated connective tissue  
stain on website)

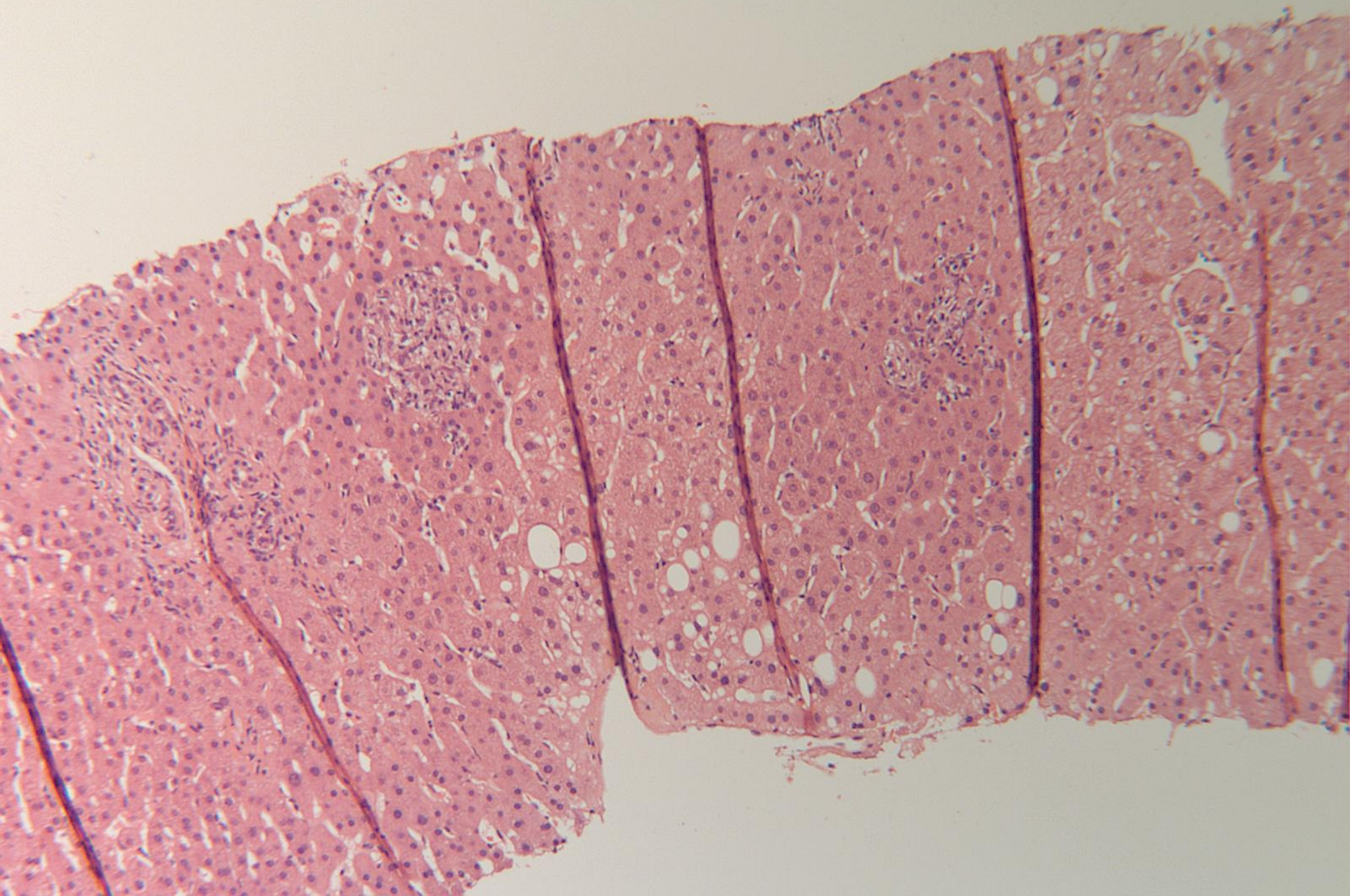
402



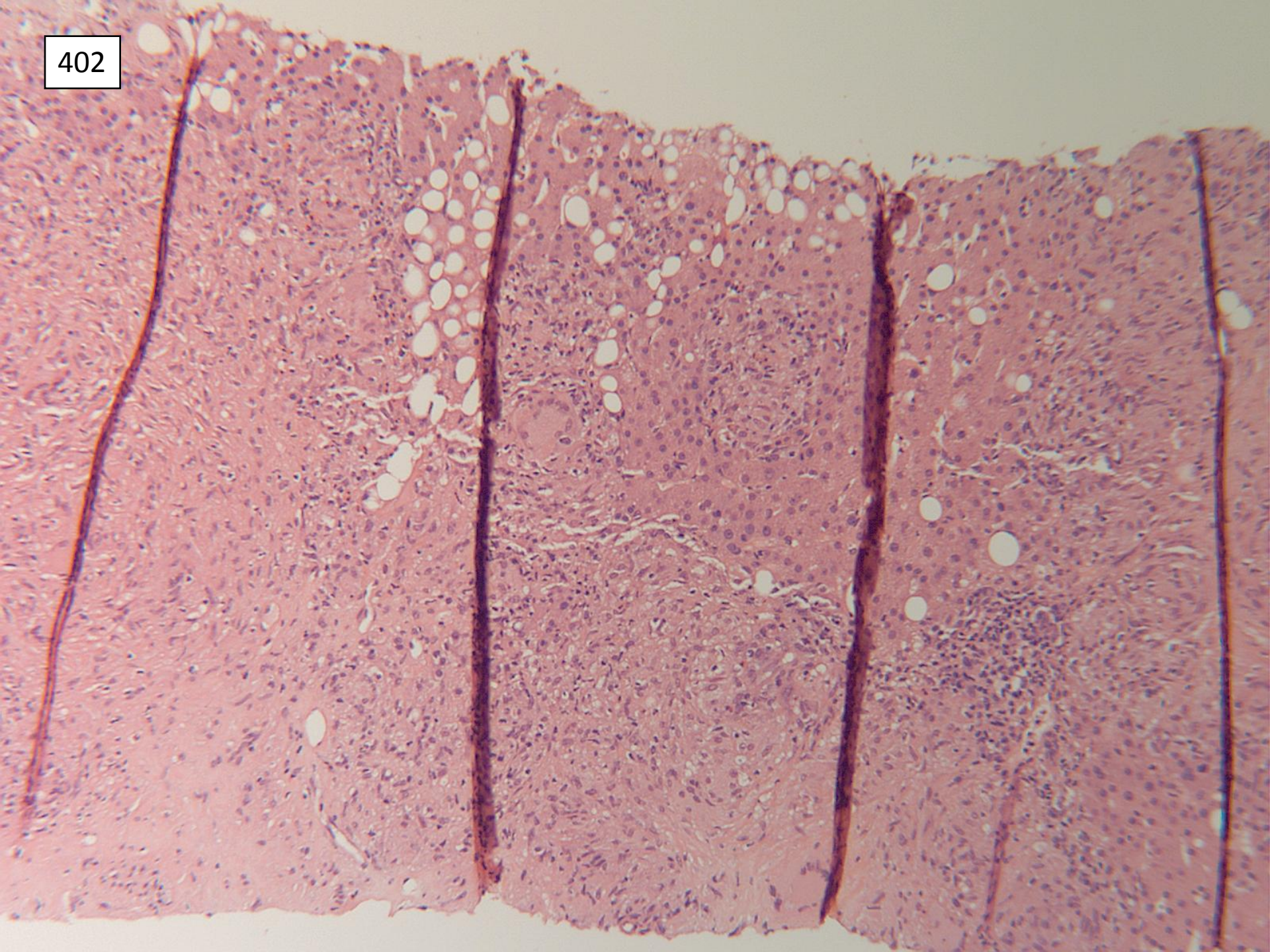
402



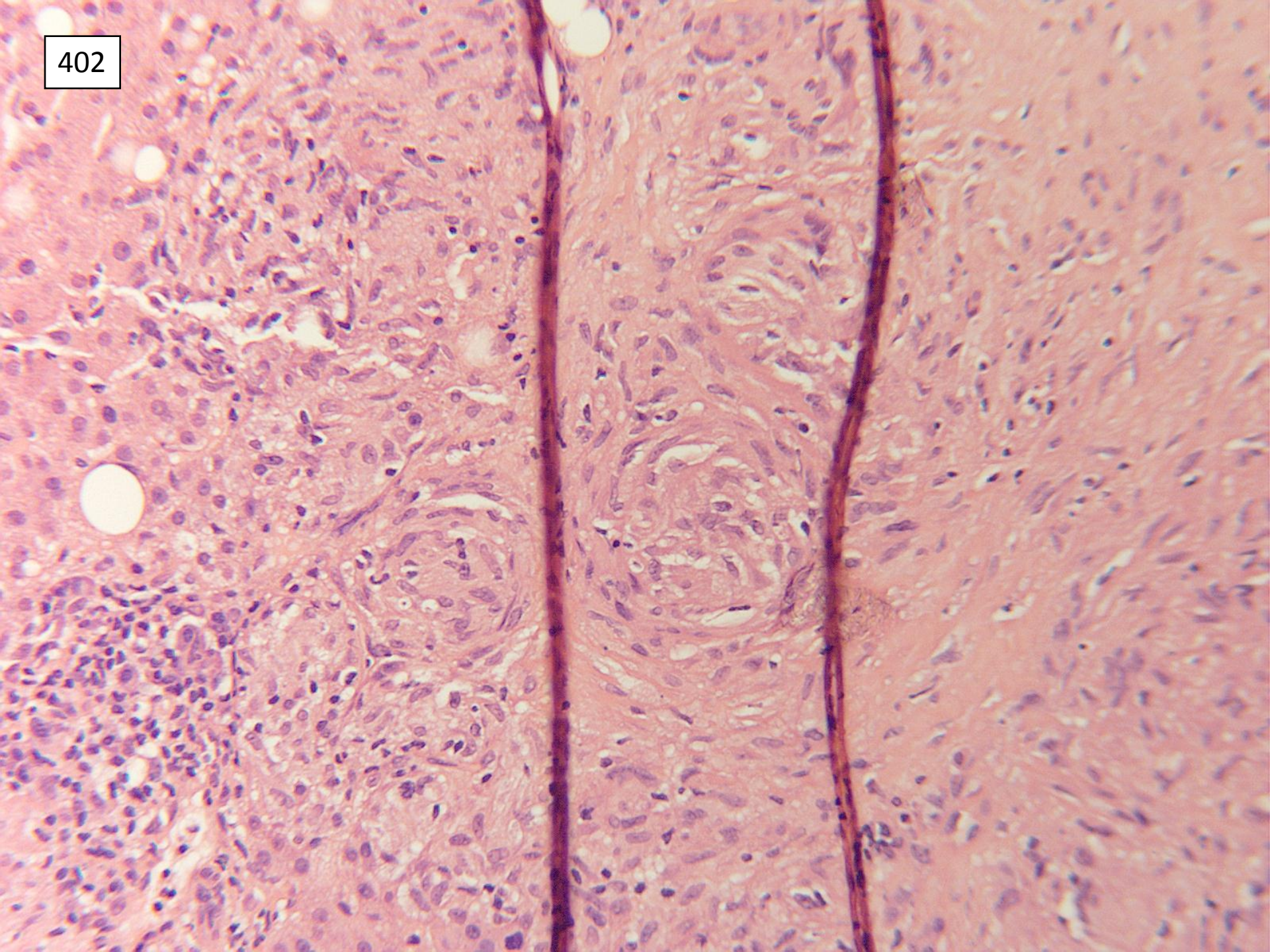
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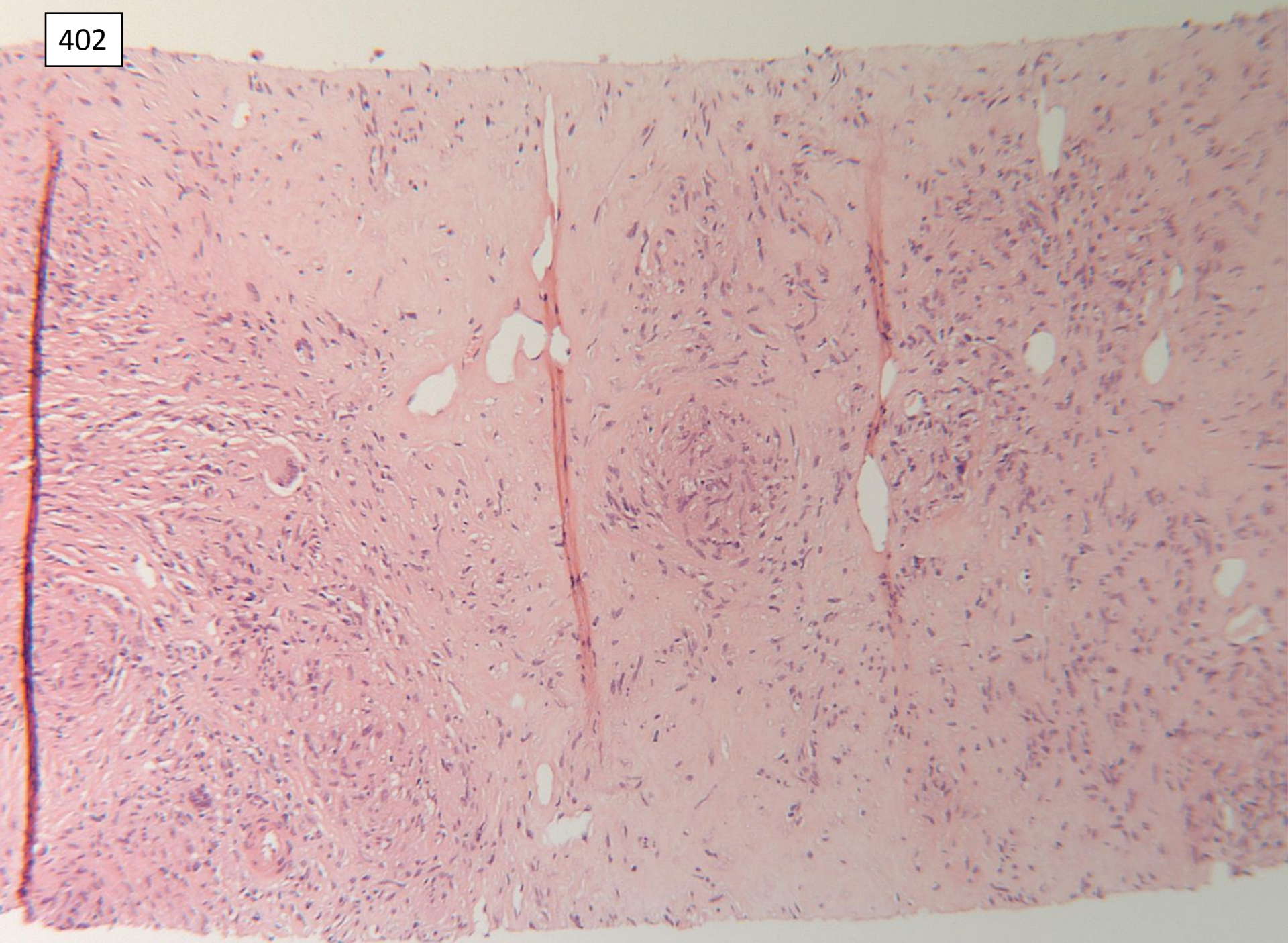
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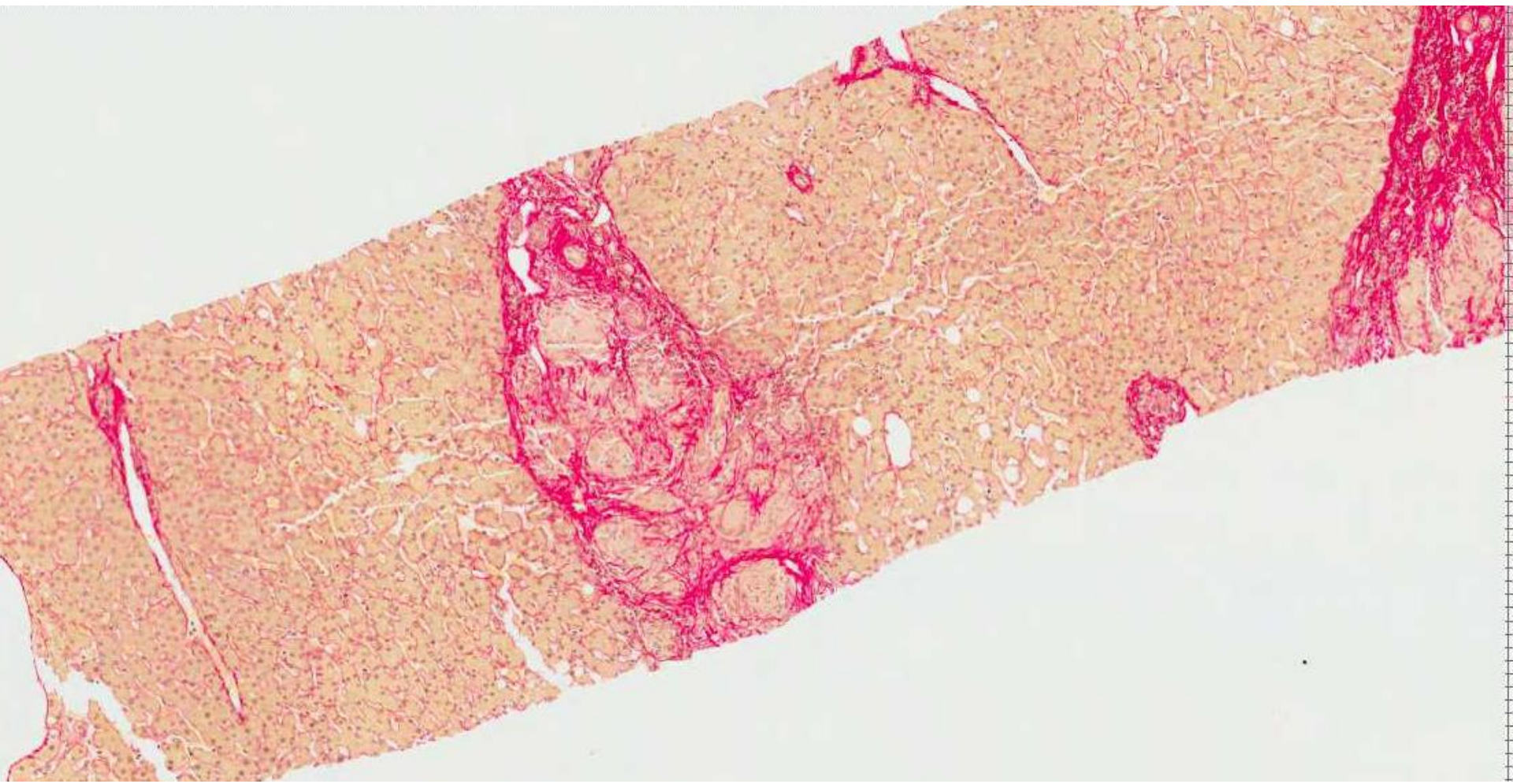


402



402





## Case 402

### Morphology

**Granulomas: 69**

**Granulomatous hepatitis: 11**

Fibrosis: 47

Fibrosis not mentioned: 23

Steatosis: 51

### Aetiology:

Sarcoid as only diagnosis mentioned: 14

Differential diagnosis, sarcoid favoured: 23

Differential diagnosis, various including sarcoid: 35

**Differential diagnosis of granulomas, sarcoid not included: 4**

**Differential includes peri-tumoral reaction: 4**

‘? Drug induced, exclude TB, sarcoid’

**No differential given for granulomas: 1**

**‘necrotising confluent granulomas, exclude TB’**

**‘granulomatous inflammation, no evidence of HCC’**

### Suggestions for scoring

For 10 points include granulomatous disease with sarcoid among differential diagnosis.

? half marks for ‘granulomatous hepatitis’ – this case is a confluent mass of granulomas visualised on imaging, and healing with fibrosis, characteristic of sarcoid, rather than a diffuse parenchymal inflammatory condition.

? half marks for results suggesting adjacent tumour.

## Case 402 contd.

### Suggestions for scoring

For 10 points include granulomatous disease with sarcoid among differential diagnosis.

? half marks for 'granulomatous hepatitis' – this case is a confluent mass of granulomas visualised on imaging, and healing with fibrosis, characteristic of sarcoid, rather than a diffuse parenchymal inflammatory condition.

? half marks for results suggesting adjacent tumour.

### Discussion at meeting:

'granulomatous hepatitis' no marks deducted. However, noted that this is a less suitable description, since implies a diffuse process presenting as a hepatitis, rather than a biopsy of focal lesion as in this case.

Half marks for suggesting response to adjacent tumour – on review of responses, all these indicated this was a possible differential diagnosis rather than the main diagnosis, so not penalised.

*The following slides are from the 'masterclass' presentation on hepatic sarcoid by Sue Davies:*

## Sarcoidosis and the liver

- Usually young adults, occ. children
- 3<sup>rd</sup> commonest organ involved; after lung, lymph node
- 17-90% of patients with sarcoidosis have liver affected but serious sequelae is rare.
- Sarcoid accounts for more than 10% of hepatic granulomata
- Raised AP ~1/3, mild ↑ALT; ↑ACE helpful
- Can cause non-cirrhotic portal hypertension, biliary type cirrhosis, hilar obstruction,

# Hepatic

- Portal and periportal based granulomata
- Confluent and increasingly fibrotic; may lead to coarse scars.
- MNGCs present; rare Schaumann and asteroid; can show fibrinoid necrosis
- Peripheral lymphocytes and eosinophils
- Portal hypertension with obstruction of fibrosed portal vein branches
  
- *Devaney Am J Surg Pathol 1993: 17: 1272-1280*

# CHOLESTATIC

## ~ PBC/PSC, cholangitic

- Ducts obscured and/or inflamed, fibrosis, ductopenia, ductular proliferation, cholate stasis
- Progressive fibrosis and cirrhosis, jaundice, pruritis; more common in young black males; AMA negative, no obstruction
- *Rudzki Am J Med 1975; 59: 373-387*

# Other

- INFLAMMATORY lobular or portal
- VASCULAR Granulomatous phlebitis of hepatic/portal veins leading to nodular regenerative hyperplasia like lesions
- *Moreno-Merlo Hepatology 1997; 26: 554-560*
- Budd-chiari like due to hepatic vein granulomata without thrombosis
- *Nakanuma Arch Pathol Lab Med 1980; 104: 456-458*
- MASS – sarcoidoma (<10%) – as in this case

## Case G1/403

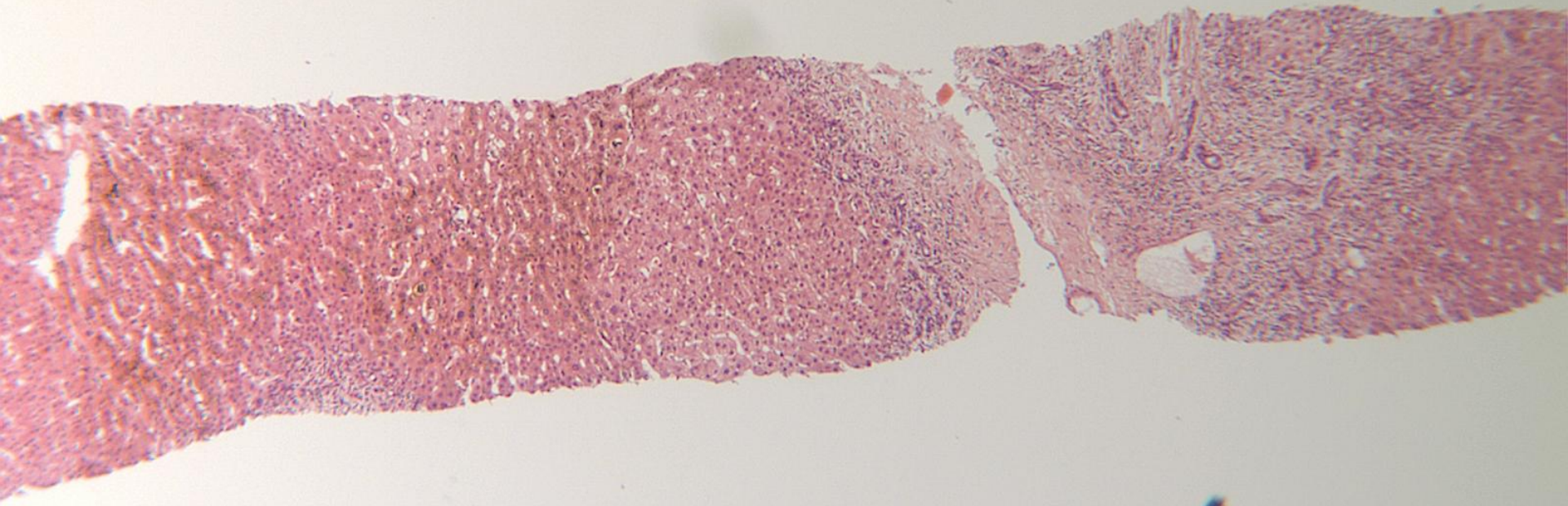
78 M

Admitted with liver dysfunction, worsening bilirubin/AST/ALT. Aetiology unclear. US guided biopsy.

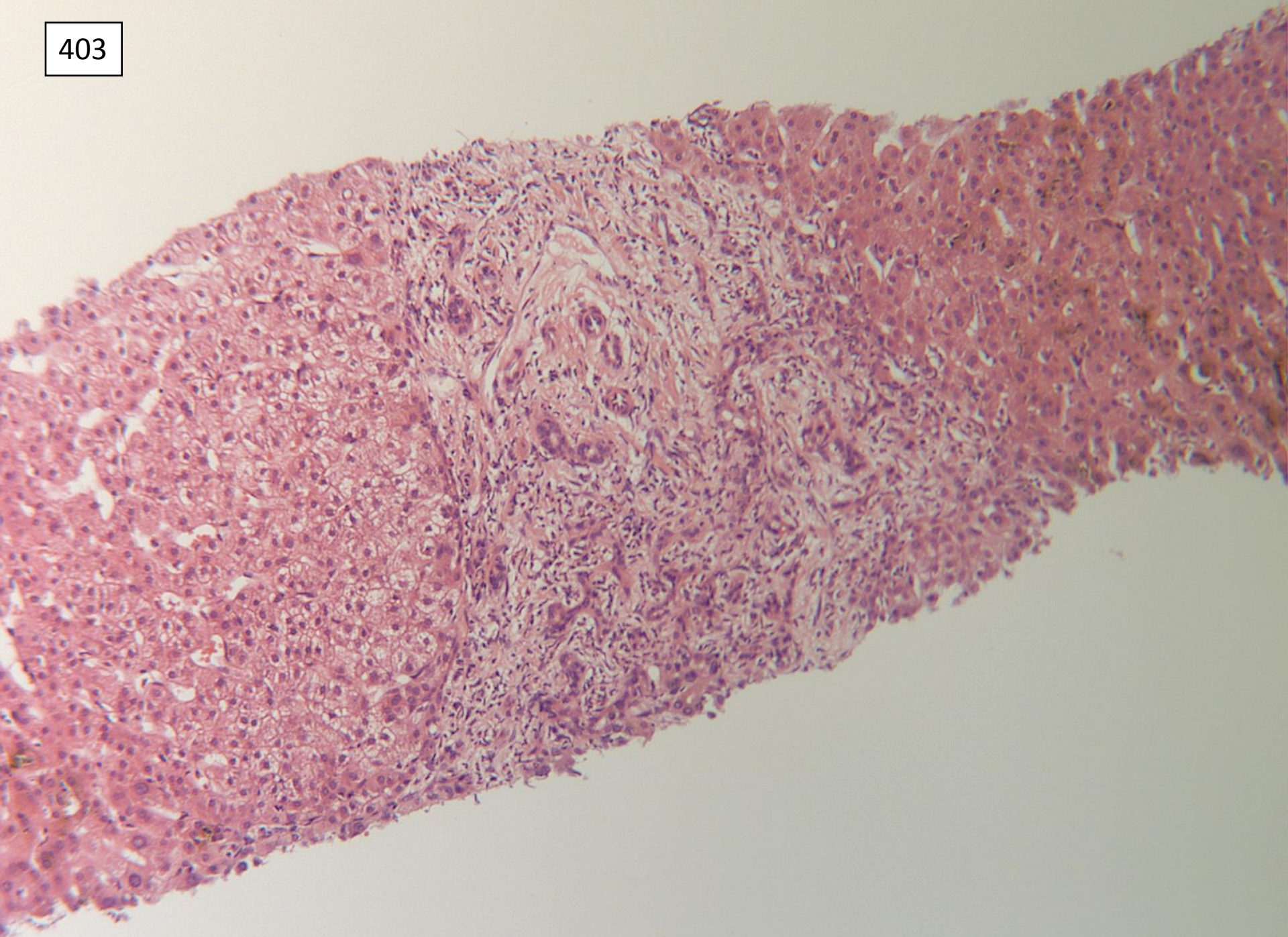
1 core 17mm (no connective tissue stain available)



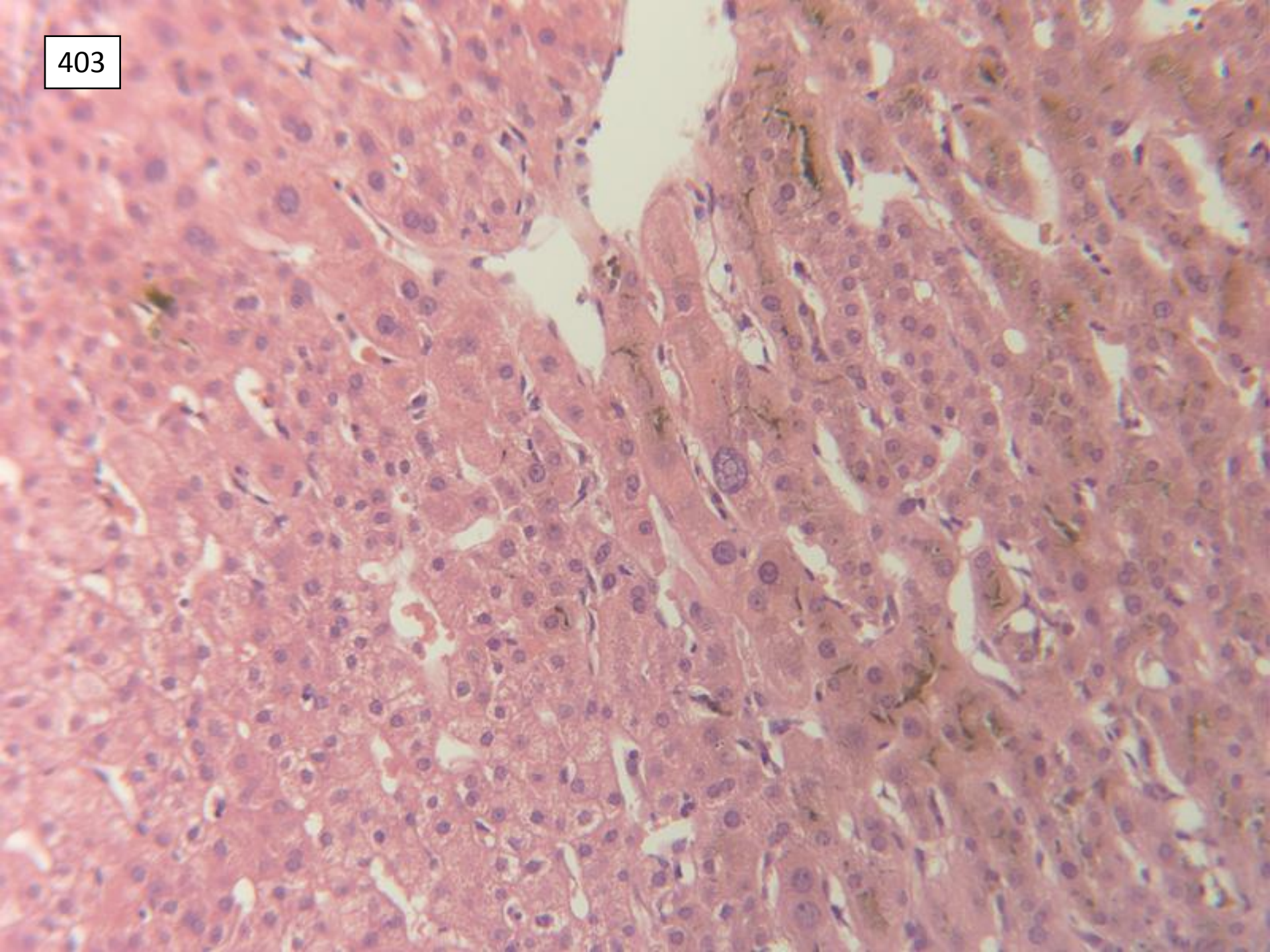
403



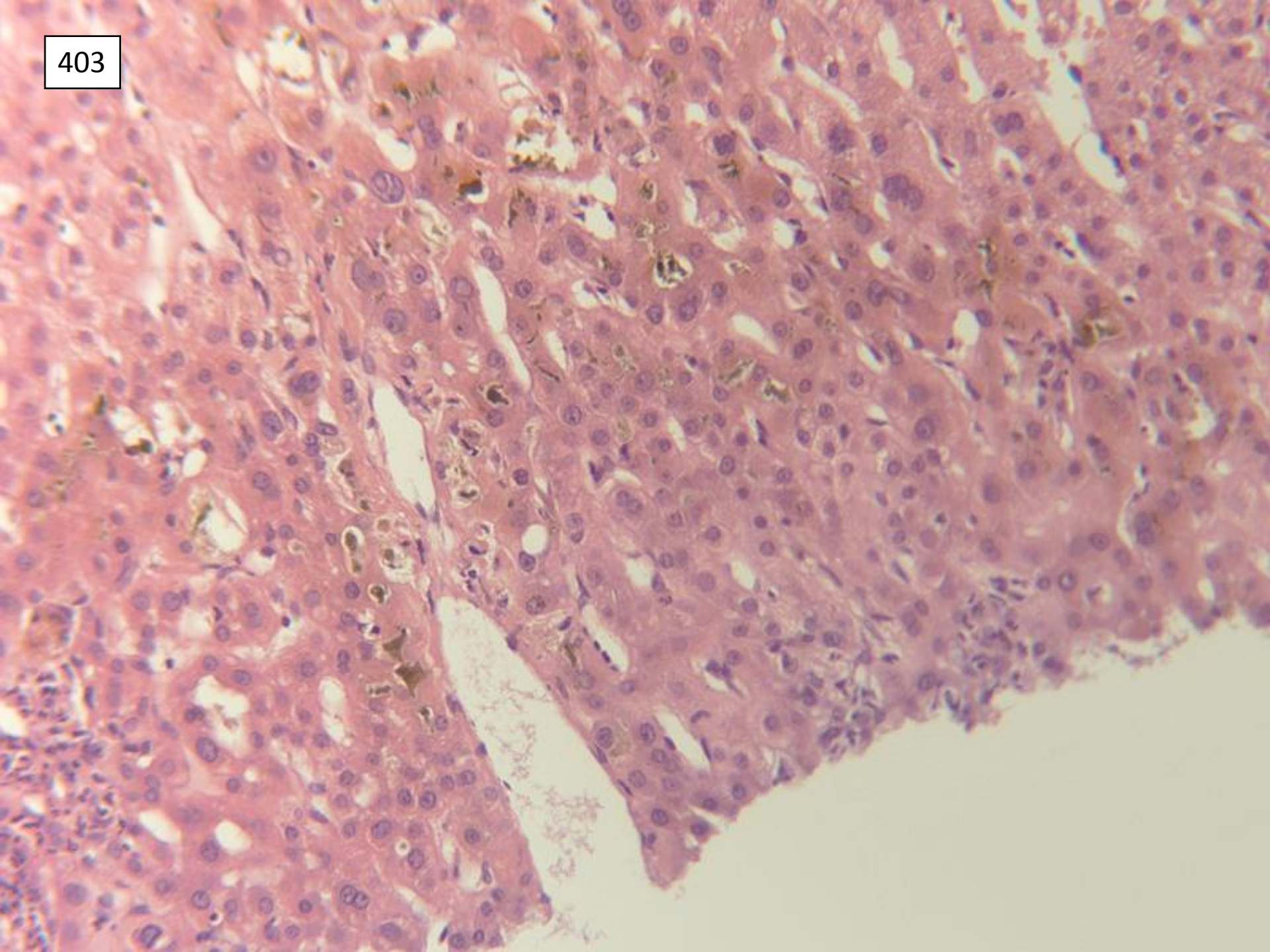
403



403



403



## Case 403

### Morphology

Biliary obstruction, without details: 15

### **Cholestasis: 74**

‘cholestatic hepatitis consistent with duct obstruction’ 3

Acute cholestatic hepatitis: 1

Chronic biliary disease – incl. fibrosis, ductopaenia, ?biliary cirrhosis: 4

### Aetiology:

### **Investigate for Large bile duct obstruction (LBDO) as most likely: 55**

LBDO or drug reaction: 11

Acute cholestatic – drugs most likely: 8

Chronic cholestatic disease with duct loss: 2

Disappearing bile duct syndrome: 1

Intrahepatic cholestasis: 1

Sepsis: 1

‘Drugs most likely – exclude alcohol and virus’

(What terminology for ductular reaction?

*Ductular reaction: 33*

*Ductular proliferation: 28*

*Ductular transformation: 3*

*Bile duct reduplication: 2*

*Biliary type interface: 2)*

of which 7 also included ‘needs biliary imaging’ and 7 do not

### Suggestion for scoring:

For 10 points an indication that large bile duct obstruction is likely and needs to be investigated by imaging.

Score 0 for any that make no mention of LBDO or need for imaging to exclude this = 7 responses.

## Case 403 contd.

### Suggestion for scoring:

For 10 points an indication that large bile duct obstruction is likely and needs to be investigated by imaging.

Score 0 for any that make no mention of LBDO or need for imaging to exclude this = 7 responses.

### Discussion at meeting:

Agreed suggested scoring.

On review: 5 responses made no mention of any of large duct obstruction/extrahepatic cholestasis/need for imaging = score 0.

Follow up information: MRI demonstrated early hilar cholangiocarcinoma, which was operable, and he remains well 1 year later.

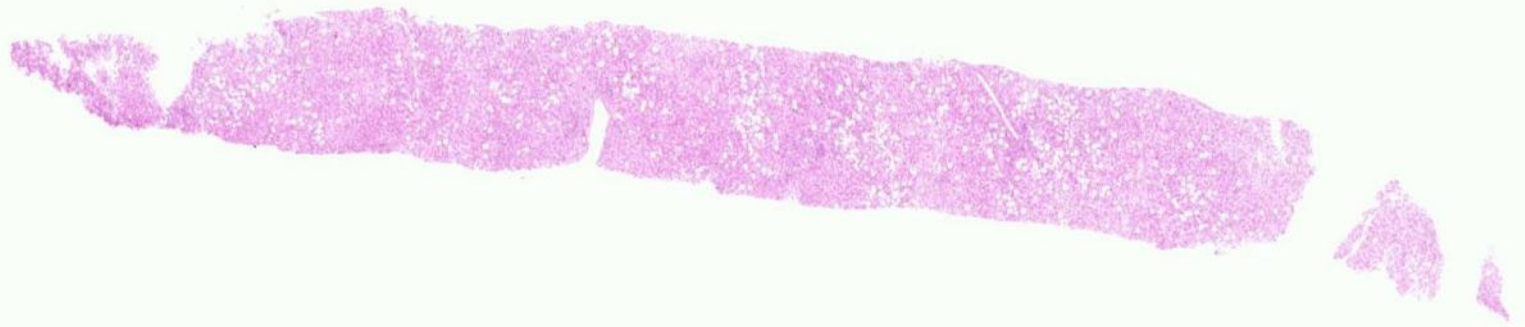
**Case G1/404**

**43 F**

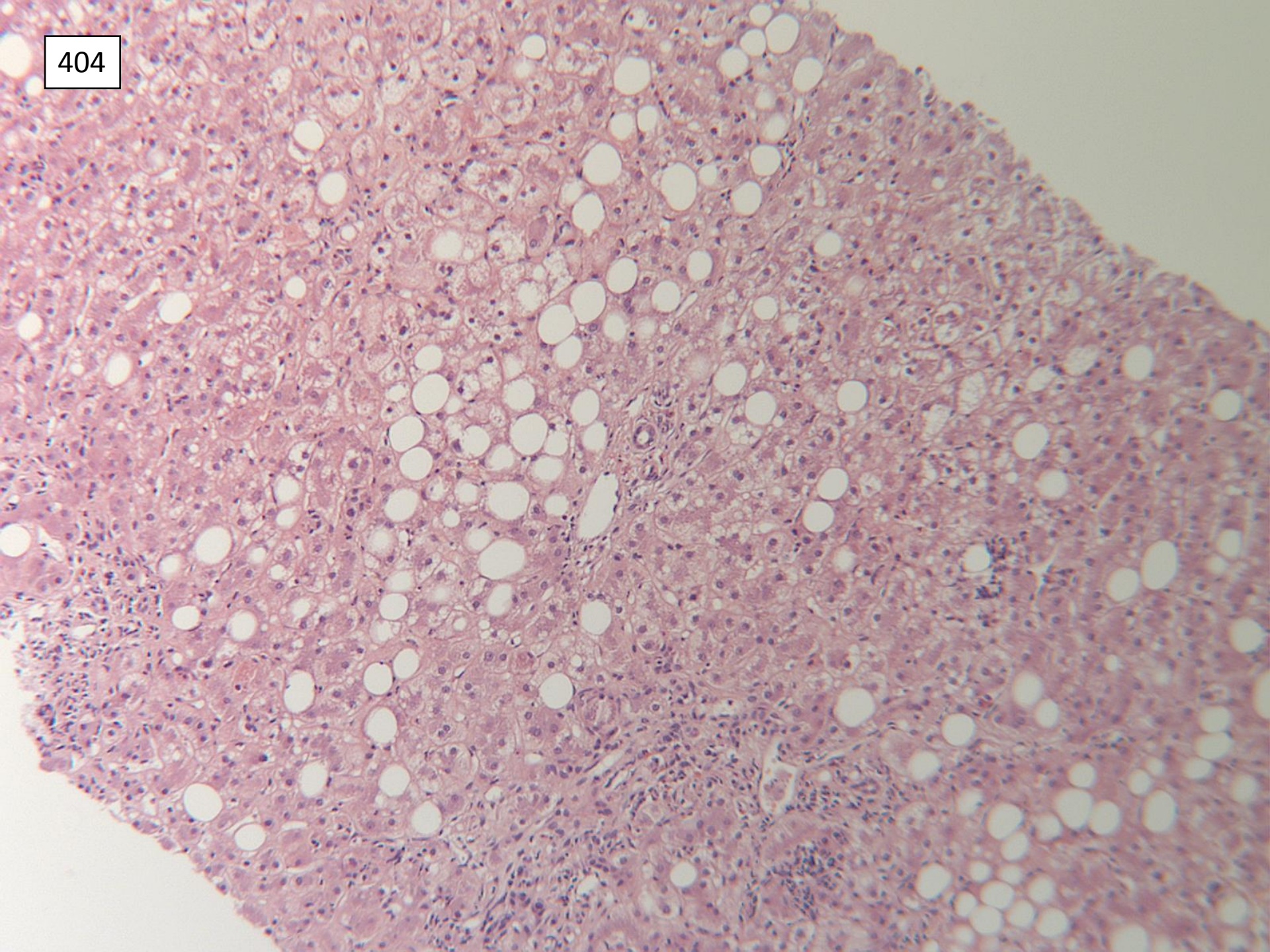
HCV PCR +ve Alcohol excess. deranged LFTs

1 core 15mm long (please also see retic and VG  
on website)

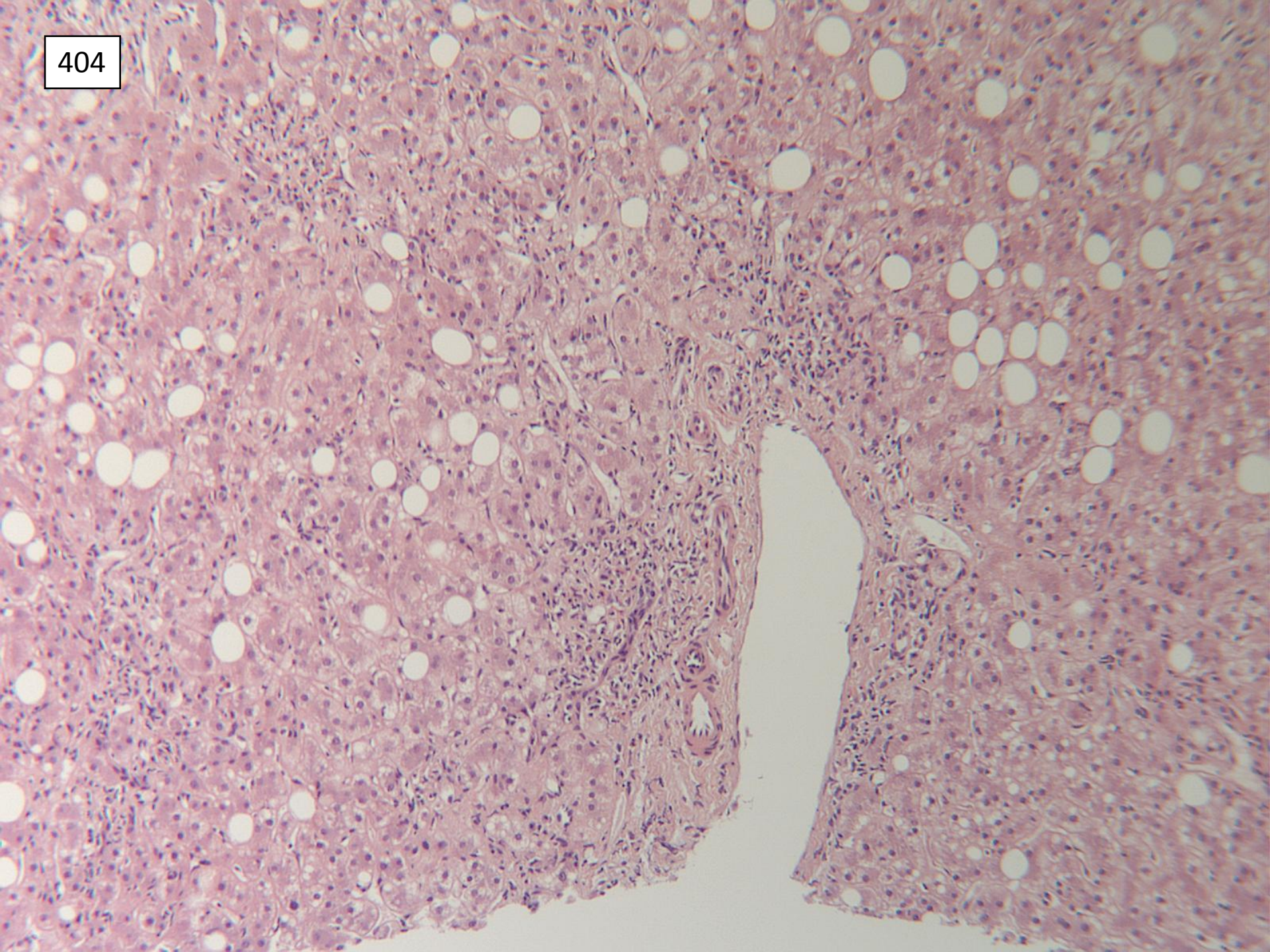
404



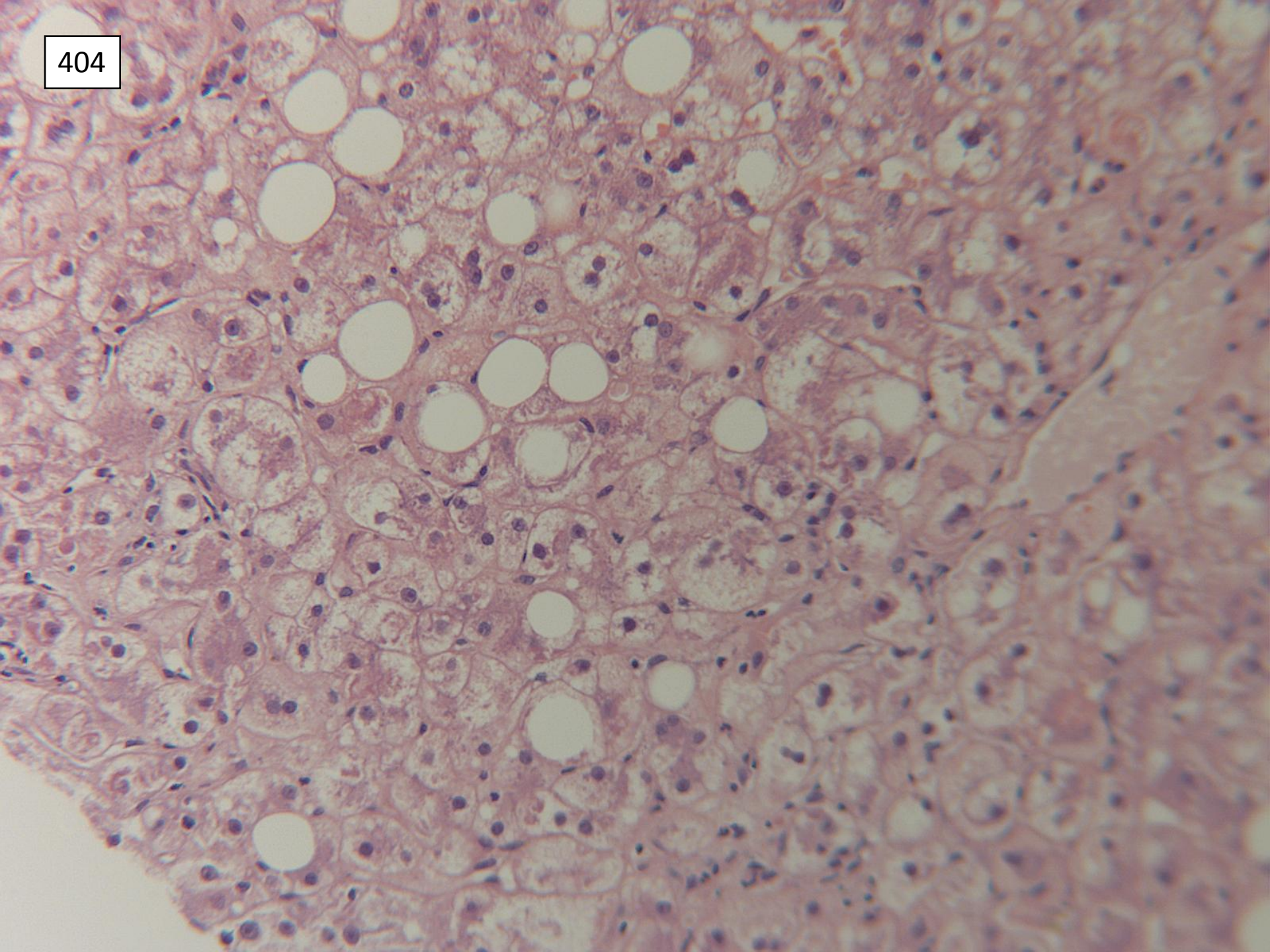
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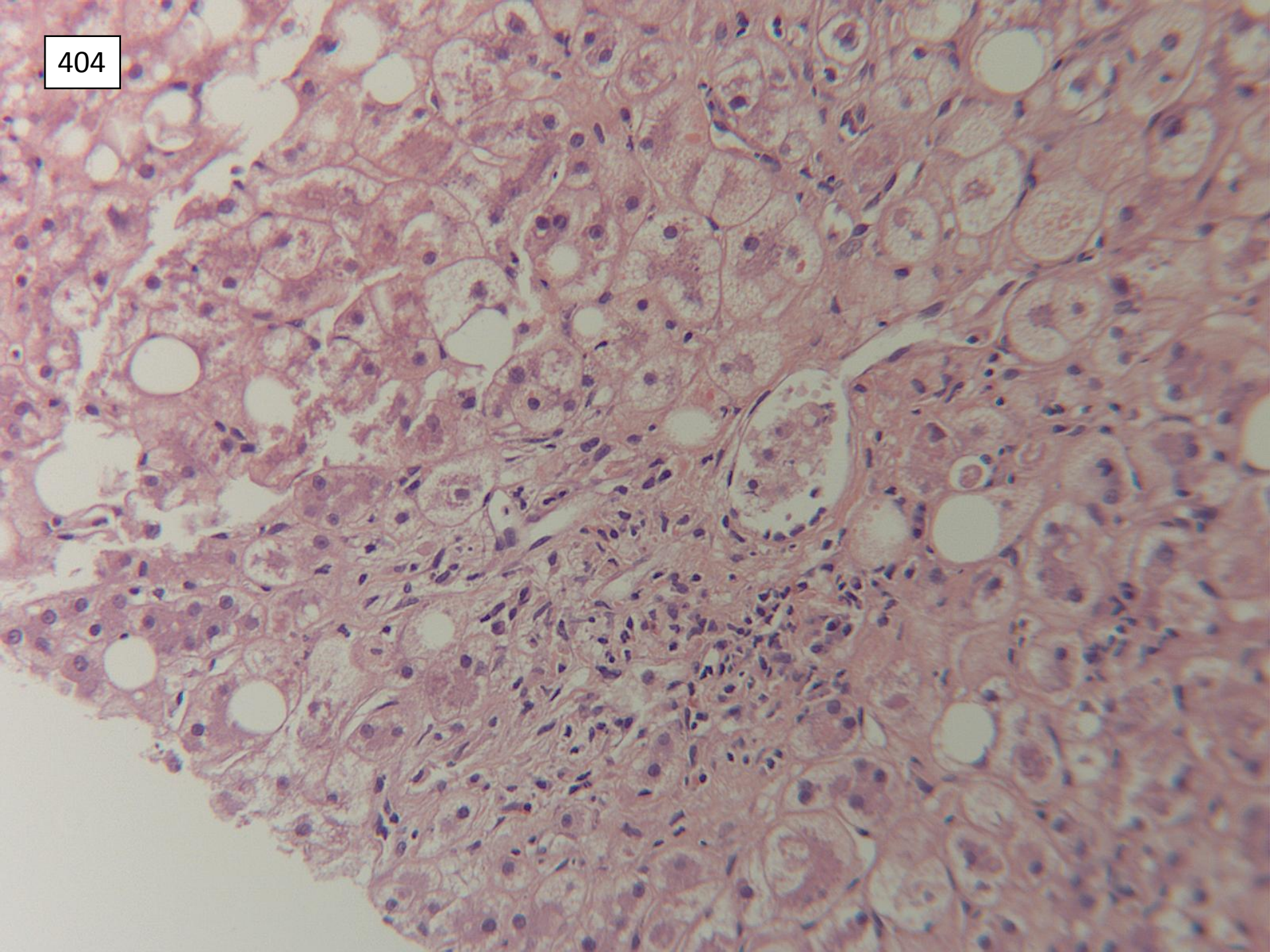
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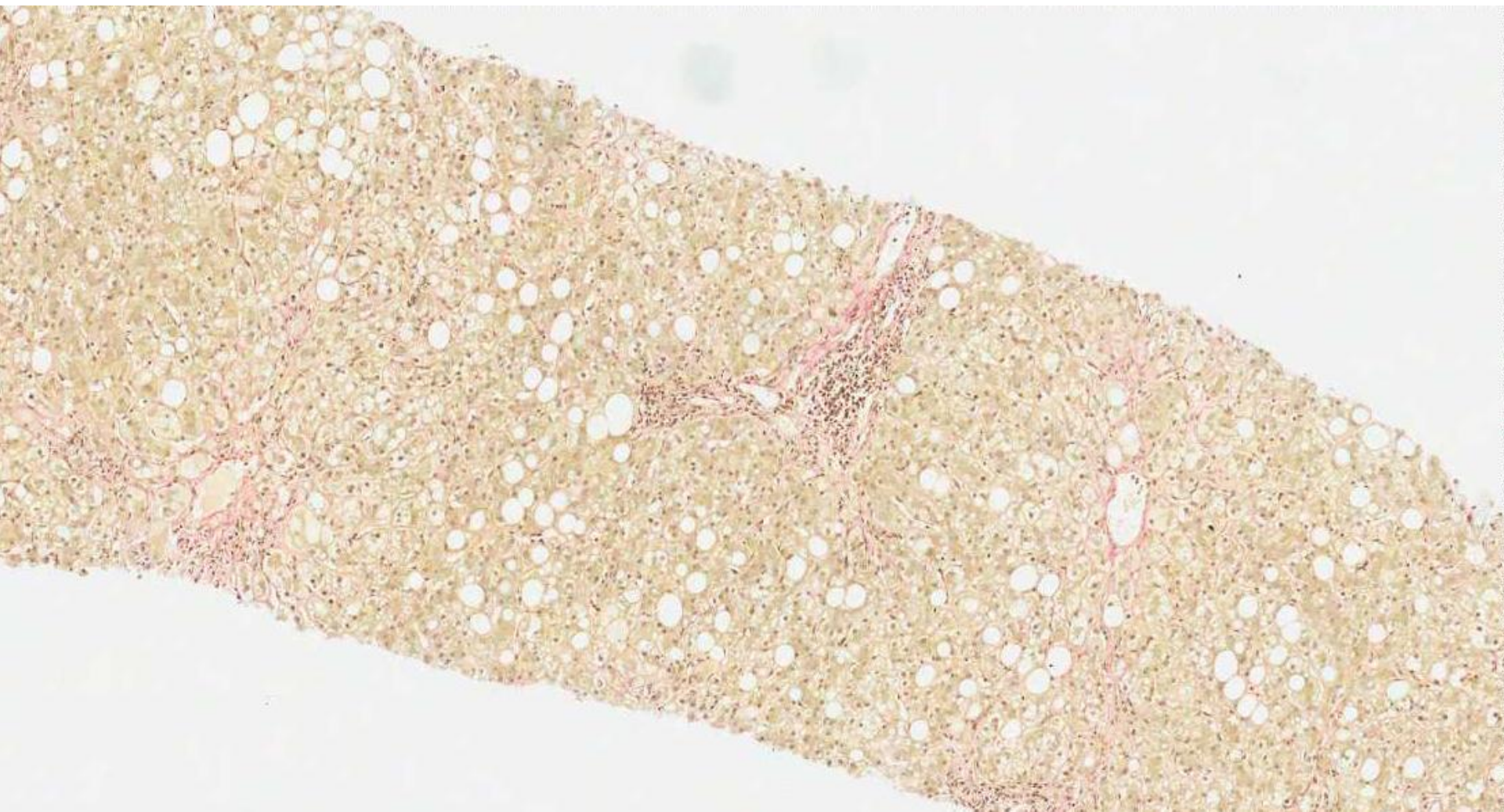


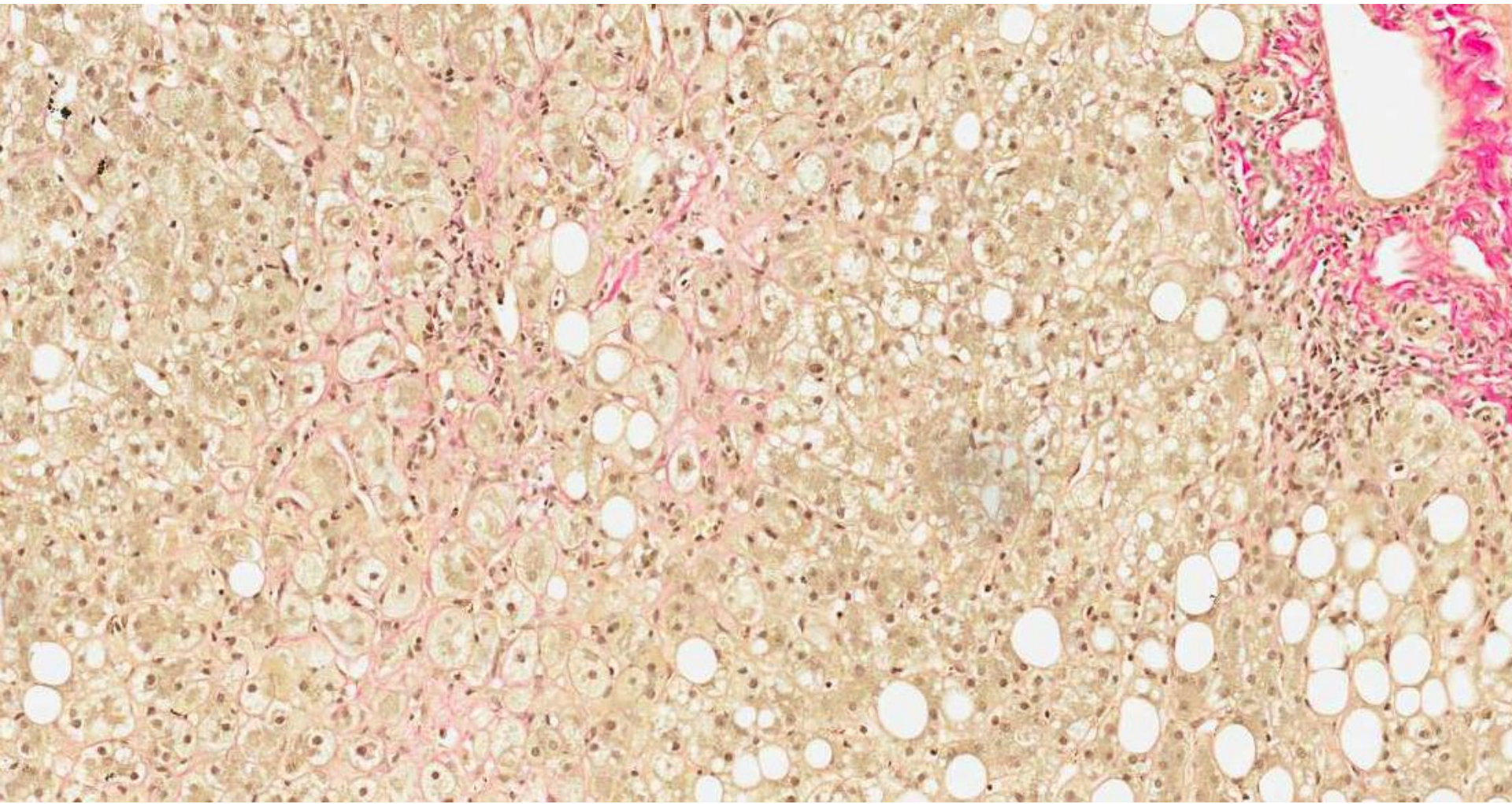
404



404







## Case 404

### Morphology

#### **Steatohepatitis: 69**

Description steatosis, ballooning, Mallory but 'steatohepatitis' not stated: 4

Comment on portal inflammation: 43

#### Aetiology:

Dominant steatohepatitis, minimum hepatitis C: 49

Alcoholic steatohepatitis only, hepatitis C not mentioned: 12

Steatohepatitis and HCV, can't tell which is dominant: 12

Chronic hepatitis C (with grade and stage) also steatohepatitis: 2

'fatty liver disease, likely alcoholic'

'Acute viral hepatitis C and ALD + eos ? drug reaction'

Scoring systems used:

11 Ishak stage, 13 Ishak grade,  
2 Kleiner, 1 Brunt, 1 Metavir.

#### Suggested scoring:

For 10 points need to include mention of both alcoholic steatohepatitis and hepatitis C.  
Half marks if imply hepatitis C is the dominant pathology, or if does not include the word 'steatohepatitis'

## Case 404 contd.

### Suggested scoring:

For 10 points need to include mention of both alcoholic steatohepatitis and hepatitis C.

Half marks if imply hepatitis C is the dominant pathology, or if does not include the word 'steatohepatitis'

### Discussion at meeting:

Accept alcoholic hepatitis as alternative for steatohepatitis in this context.

Half marks (5 points) if no mention of hepatitis C at all – 15 responses

A further 3 responses implied hepatitis C was dominant – also 5 points.

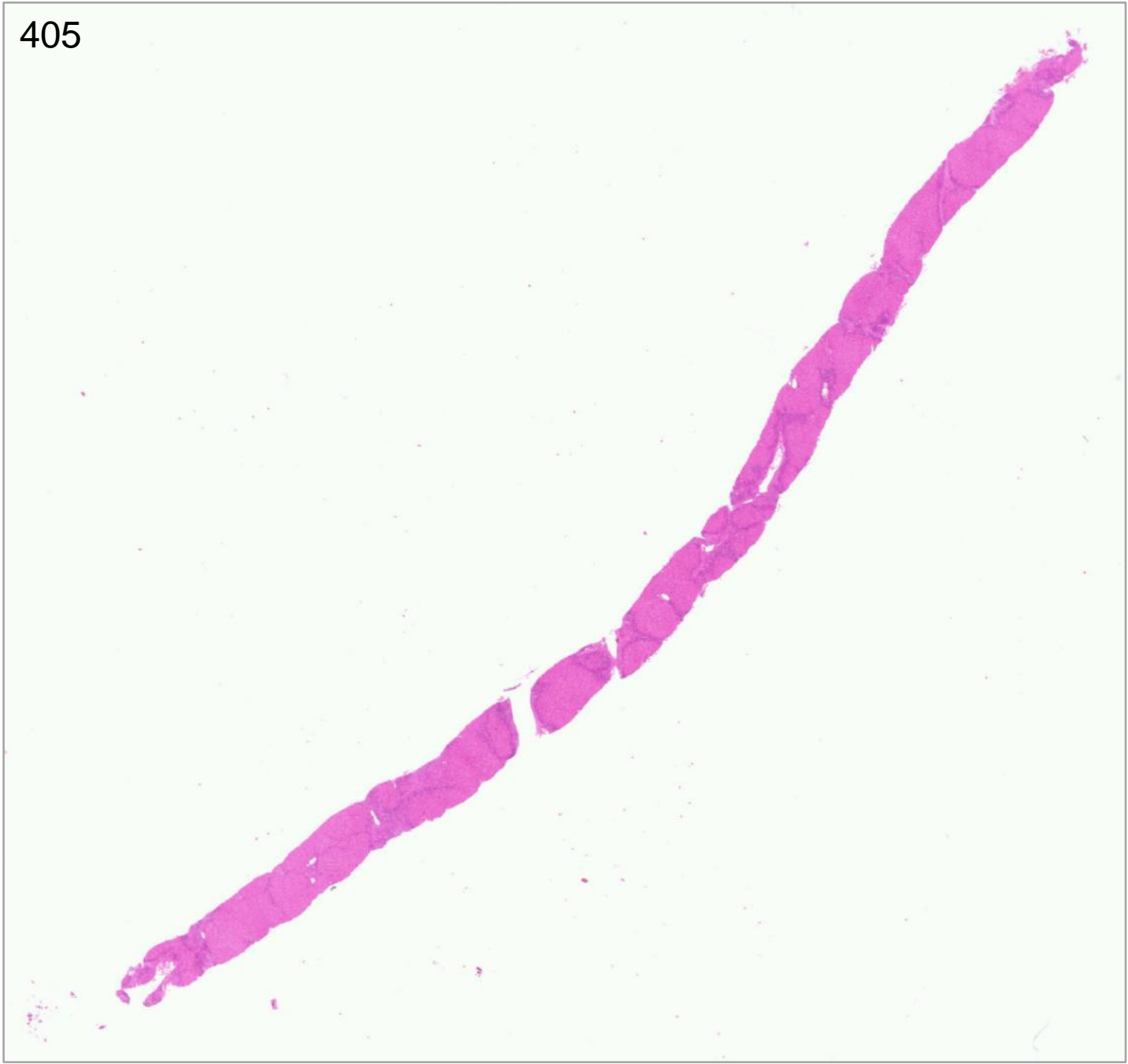
## Case G1/405

46 F

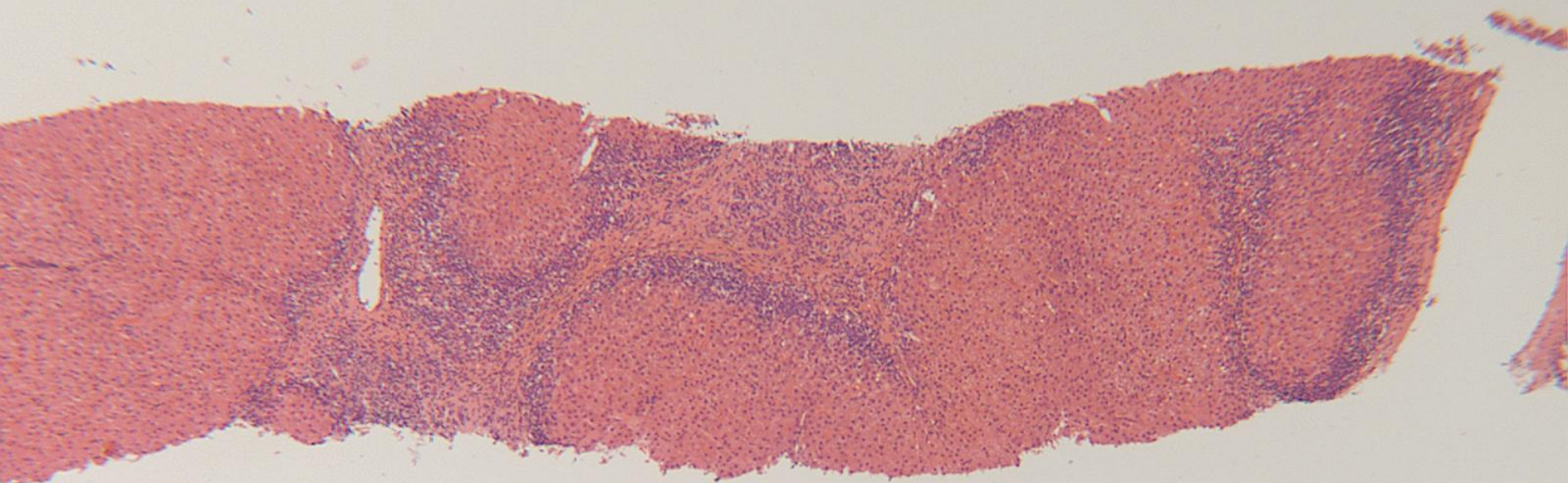
Abnormal LFTs, positive ANF, 1:1000, raised IgG

16mm core biopsy (photomic Shikata x10;  
negative for copper –associated protein; no  
other connective tissue stains available)

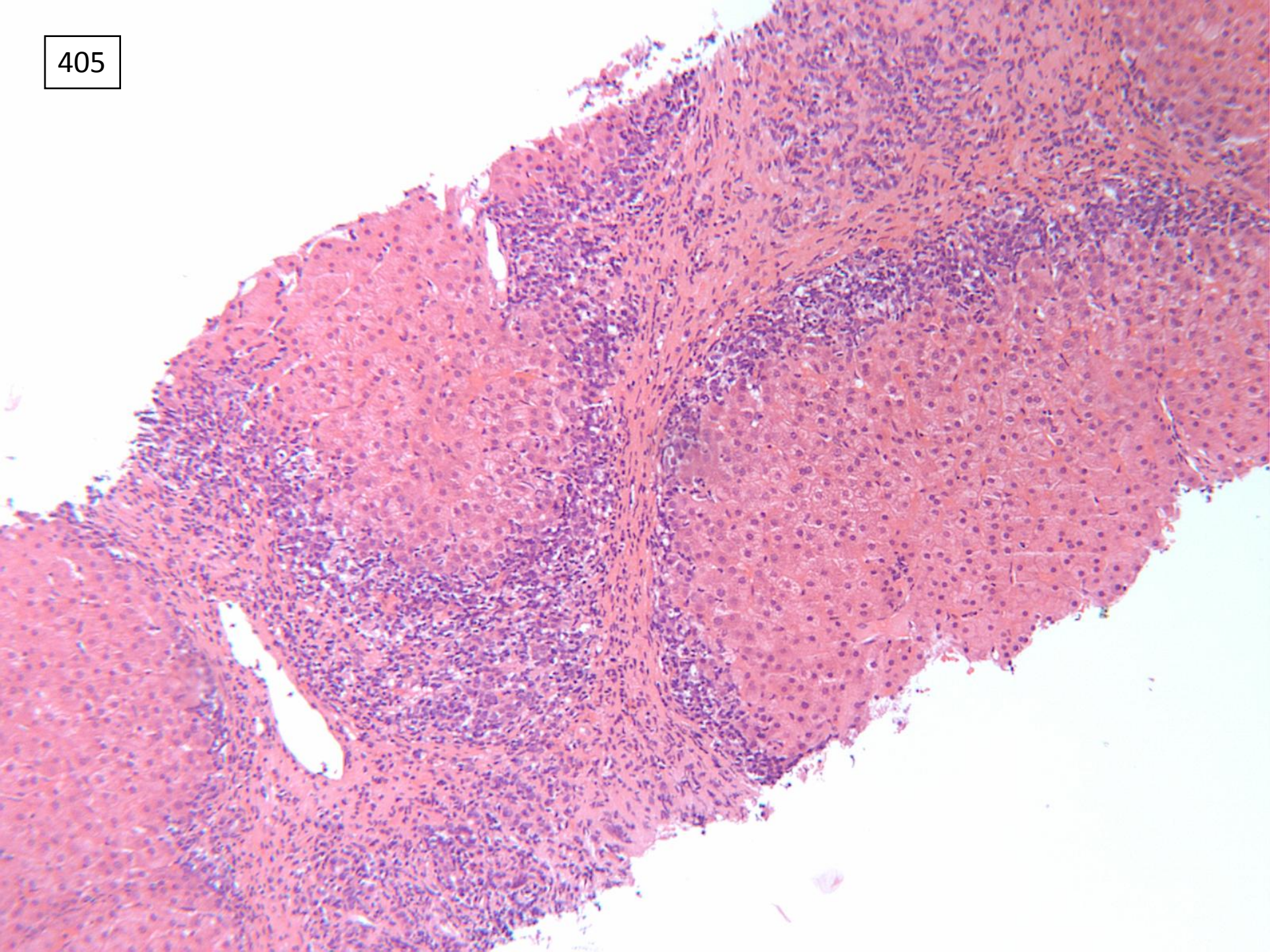
405



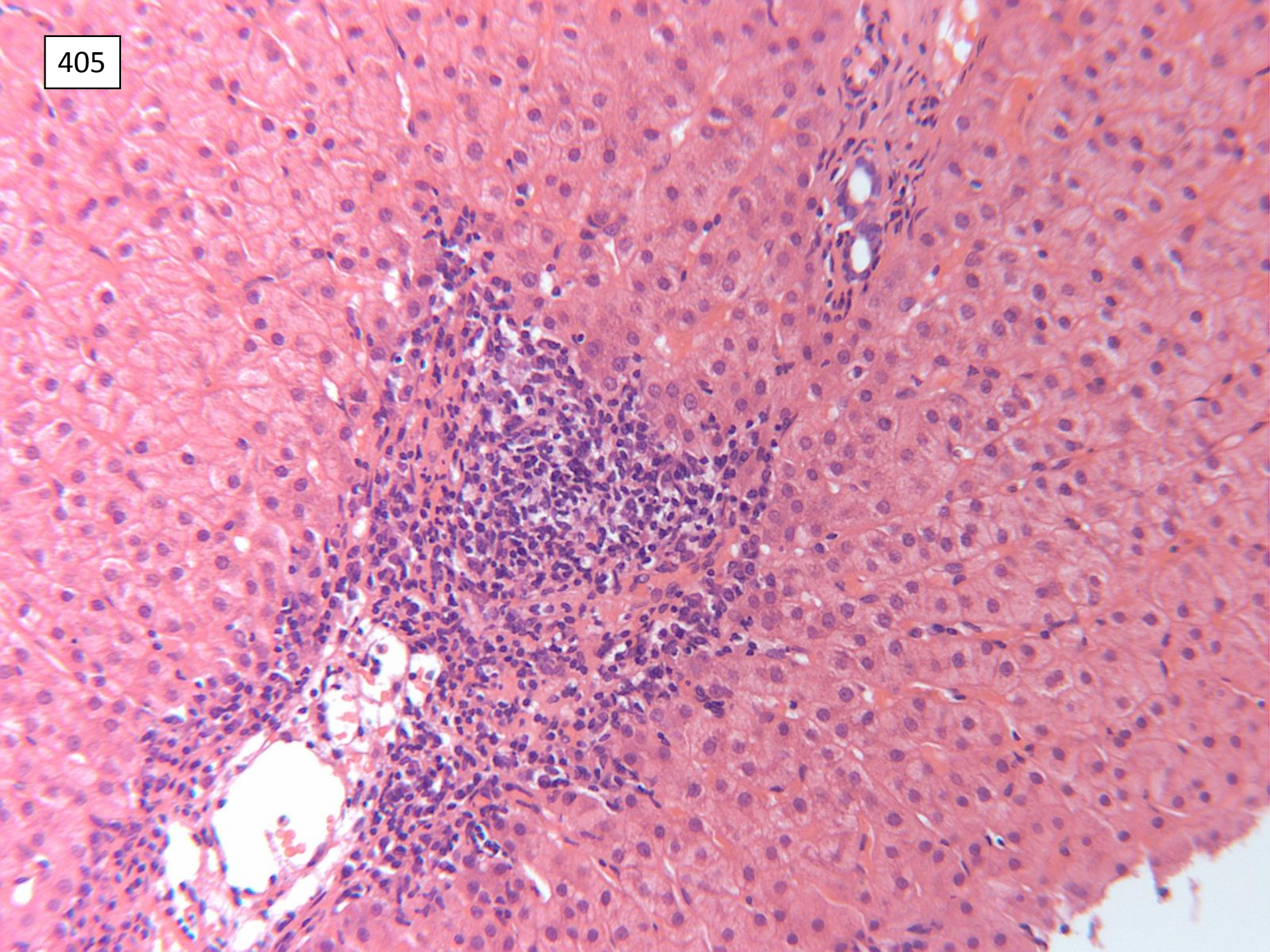
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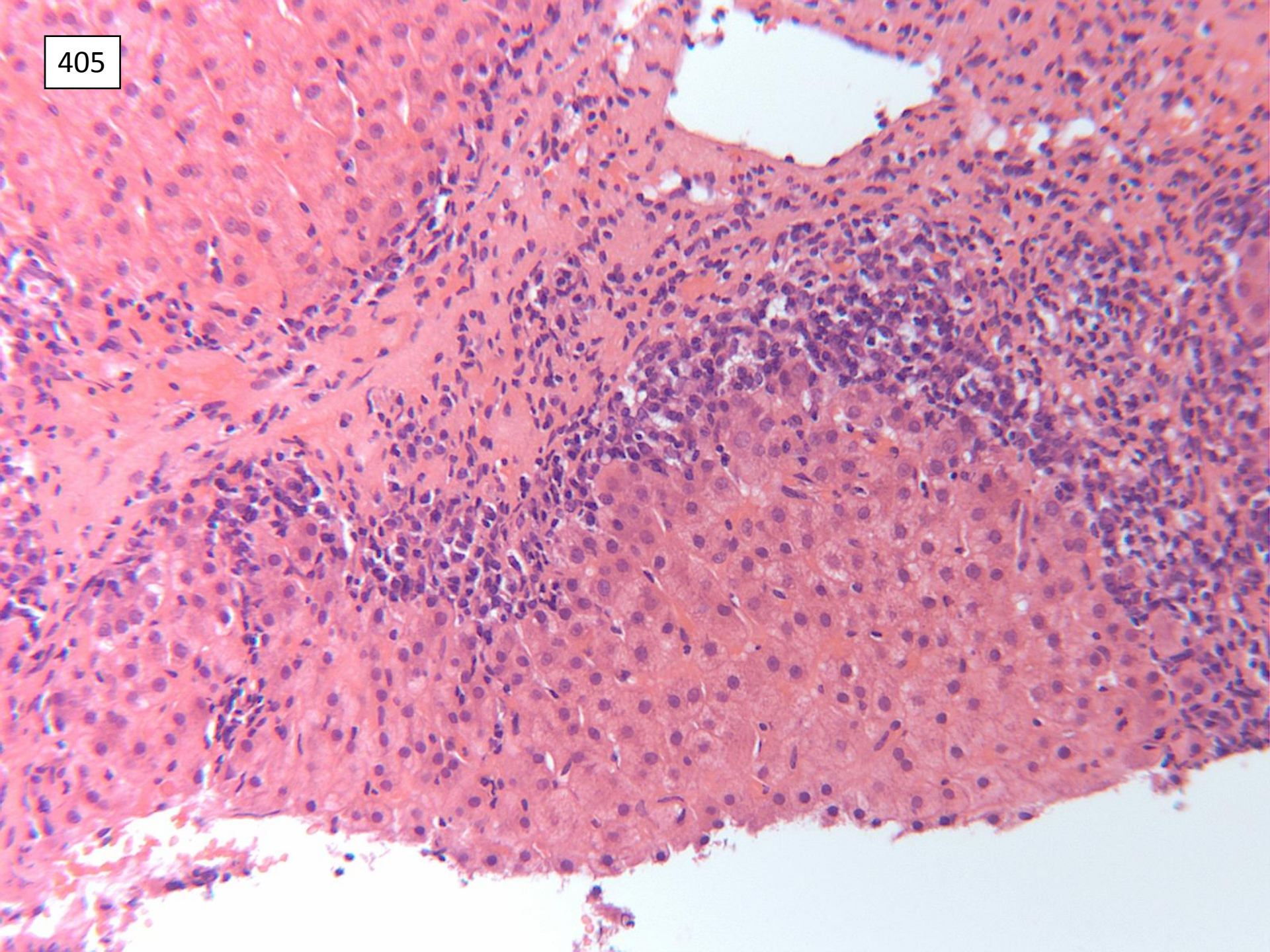
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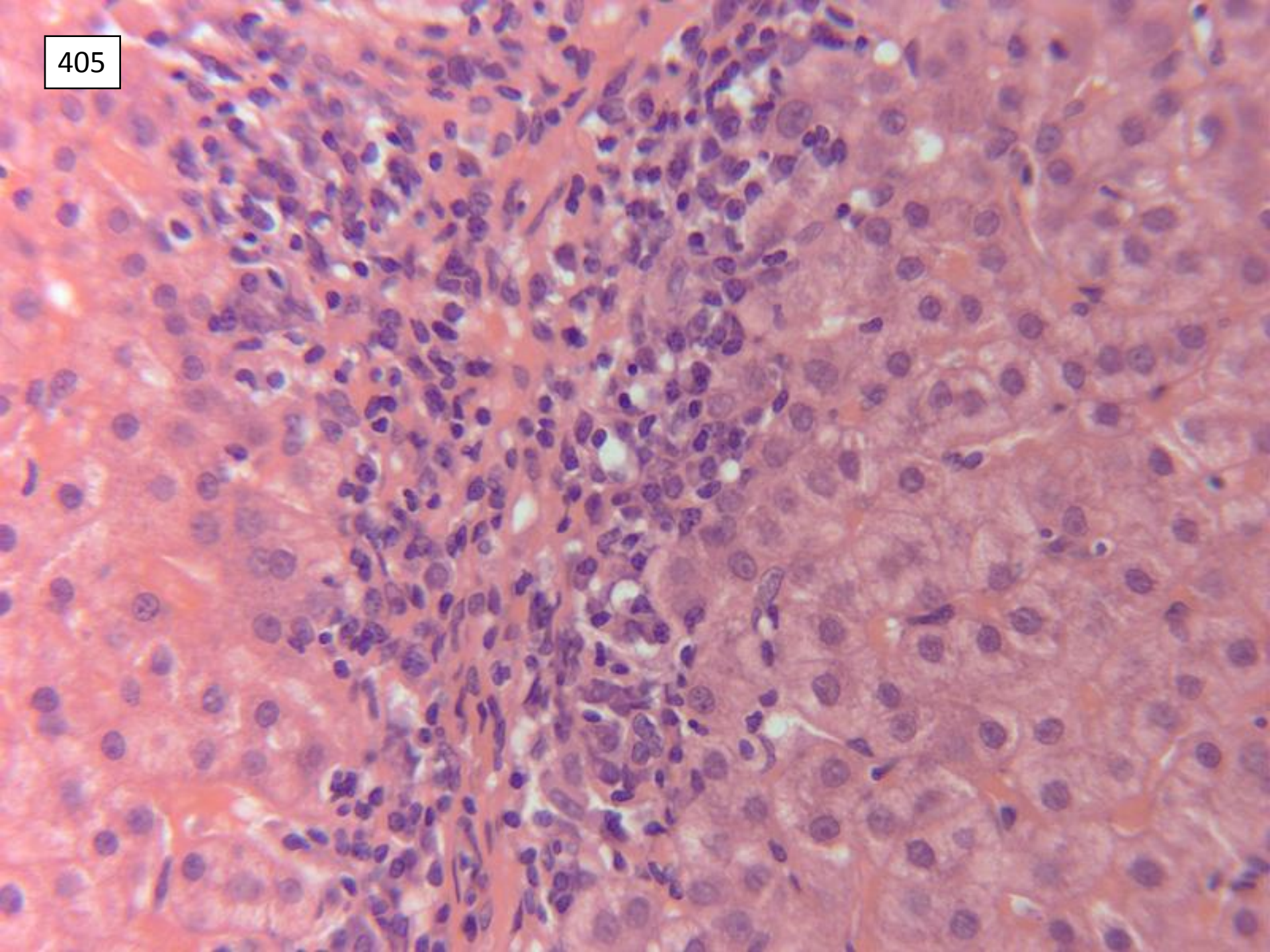
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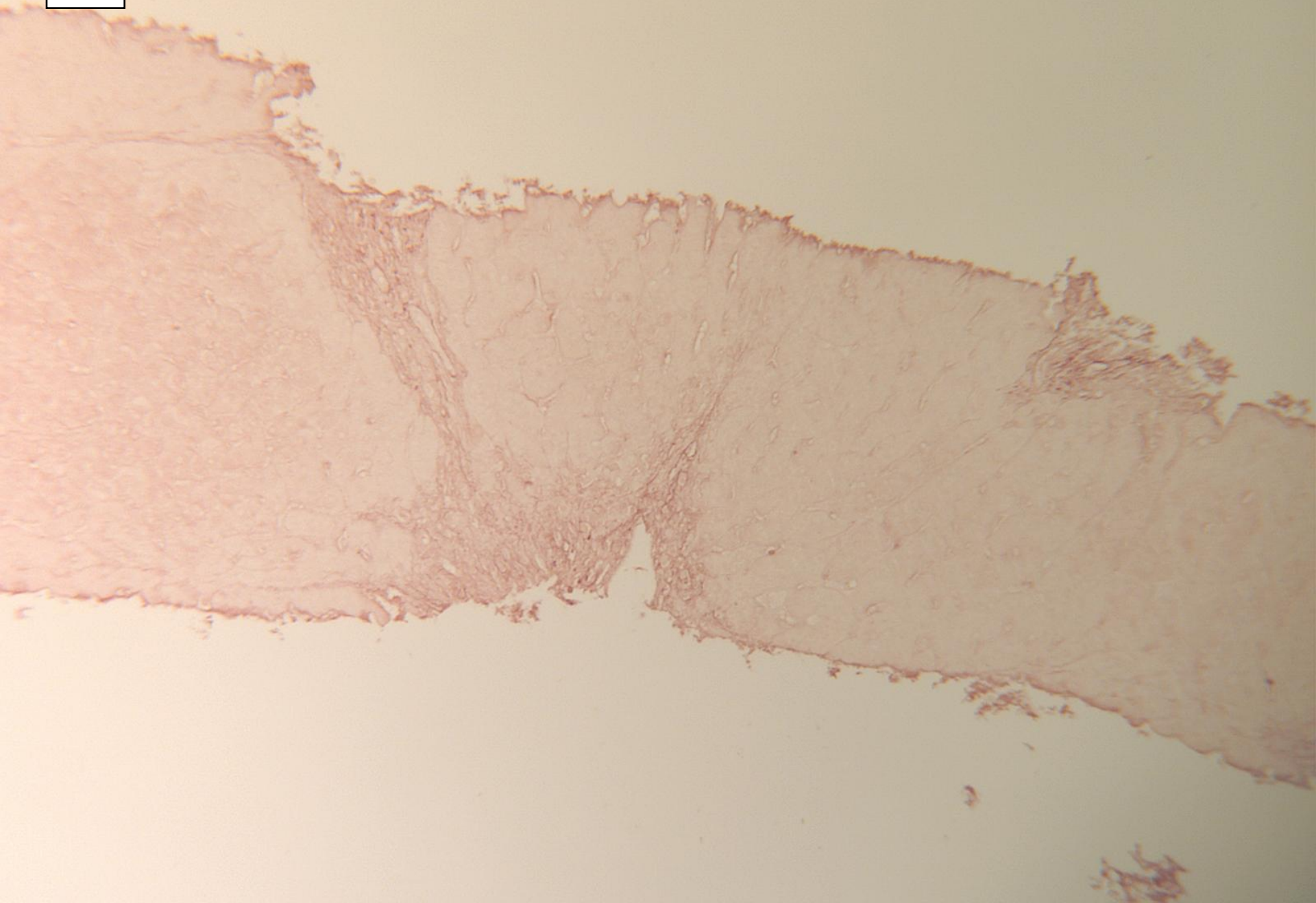
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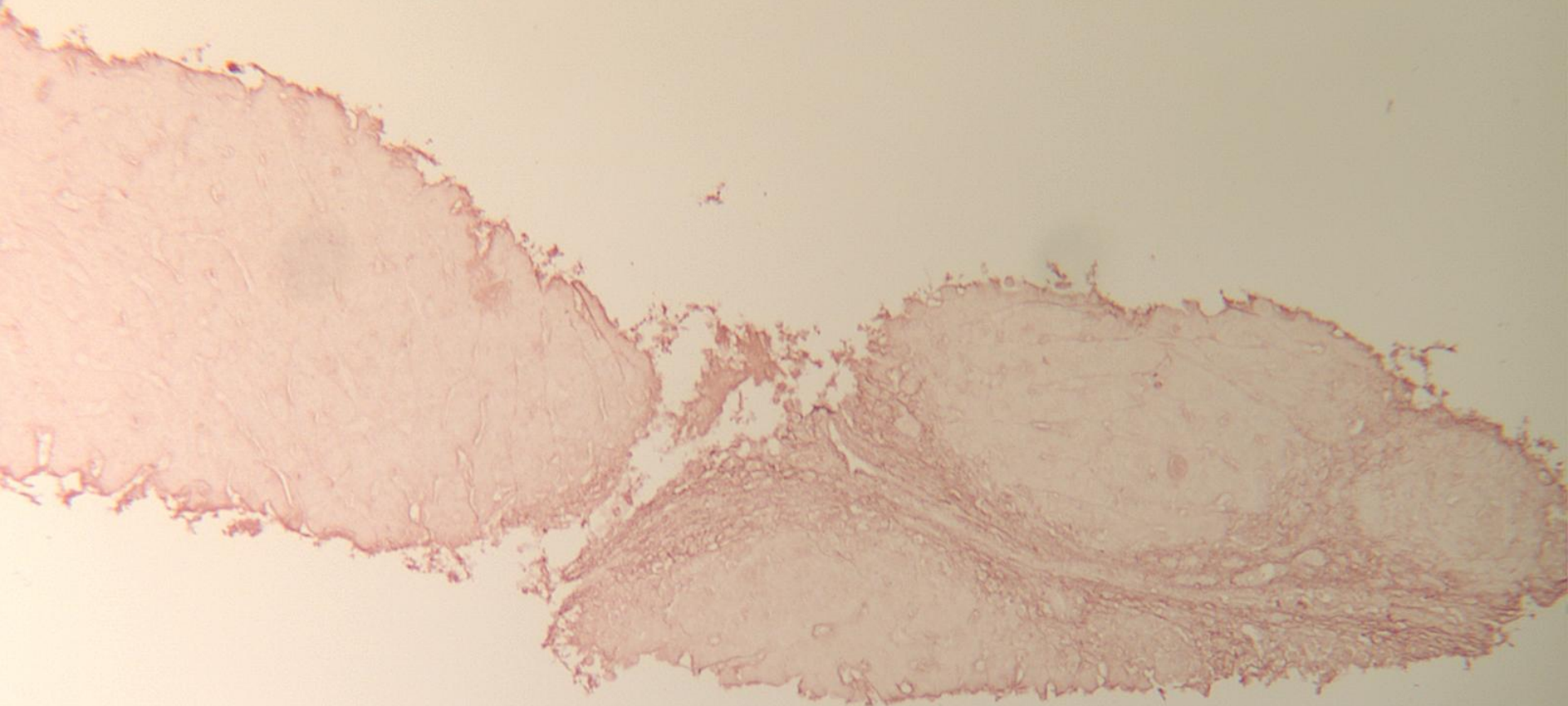
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405



405



## Case 405

### Morphology

**Plasma cell rich interface hepatitis: 71**

Plasma cells not mentioned: 8

? biliary component: 12

? granuloma: 3

### Stage:

Probable cirrhosis: 32

Possible/developing cirrhosis: 9

Bridging fibrosis: 15

Bridging necrosis or fibrosis: 11

Bridging necrosis: 1

Possible fibrosis: 1

‘scarring’ : 1

**Fibrosis not mentioned: 1**

Need connective tissue stains: 5

**No comment on disease stage: 3**

### Aetiology:

**Autoimmune hepatitis (AIH): 74**

Possible overlap: 11

‘drug-induced acute hepatitis mimicking autoimmune disease’

‘chronic active hepatitis, autoimmune type, pre-cirrhotic’

**‘biliary pattern cirrhosis, most likely PSC’**

**‘chronic active hepatitis with cirrhosis/lupus hepatitis, SLE’**

‘chronic hepatitis probably AIH, exclude virus and drugs’

‘severe hepatitis with confluent and bridging necrosis, consistent with AIH, exclude virus and drug’

**‘PBC ? overlap PBC/PSC (AIH not included)**

### Suggested scoring:

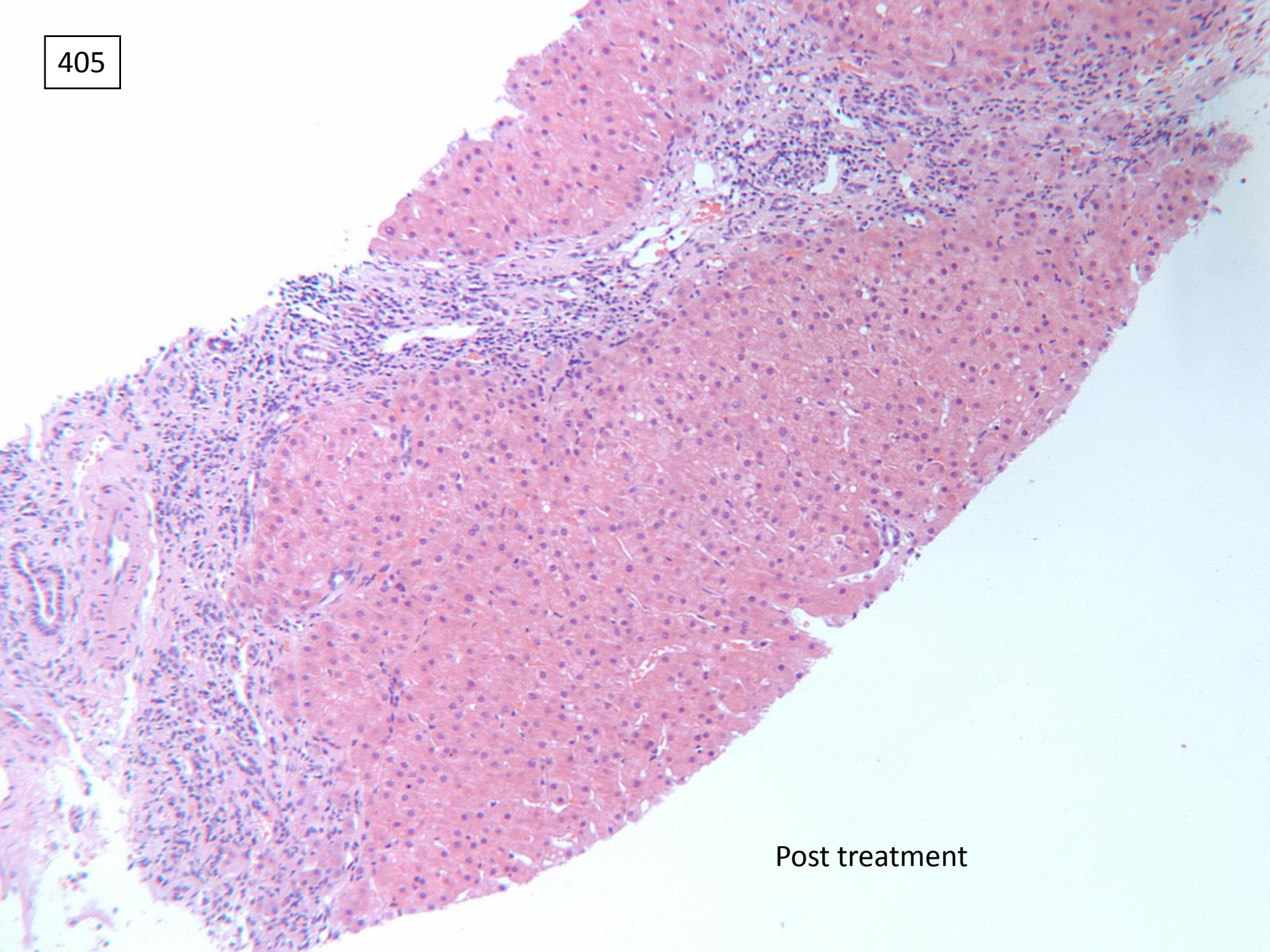
For 10 points, include autoimmune hepatitis and some comment on architecture/stage

score 0 if no mention of autoimmune hepatitis, or for obsolete terminology (lupus hepatitis)

half marks if no mention of fibrosis, necrosis or need for more stains.

Discussion at meeting – suggestions accepted.

405



Post treatment

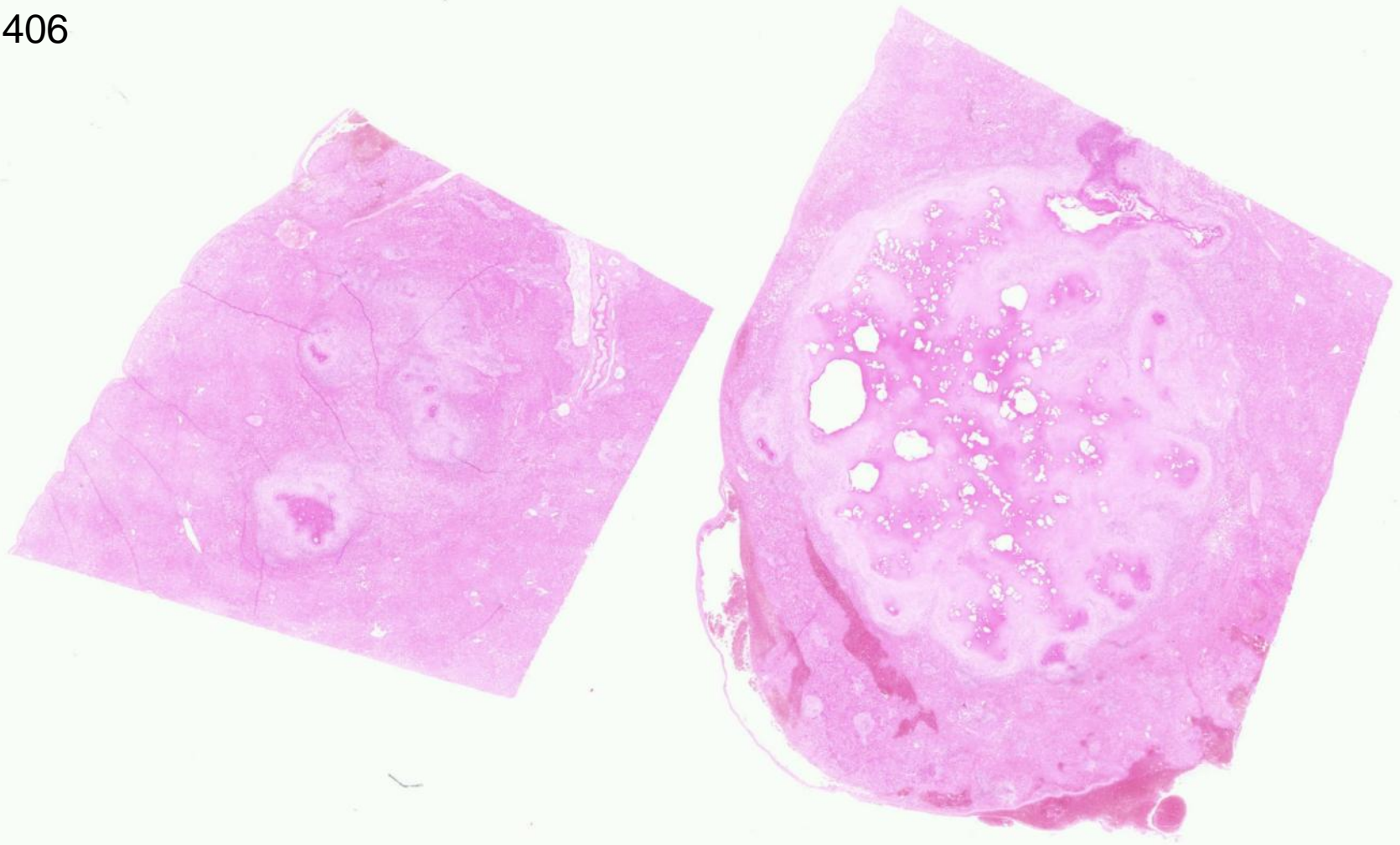
## Case G1/406

72 F

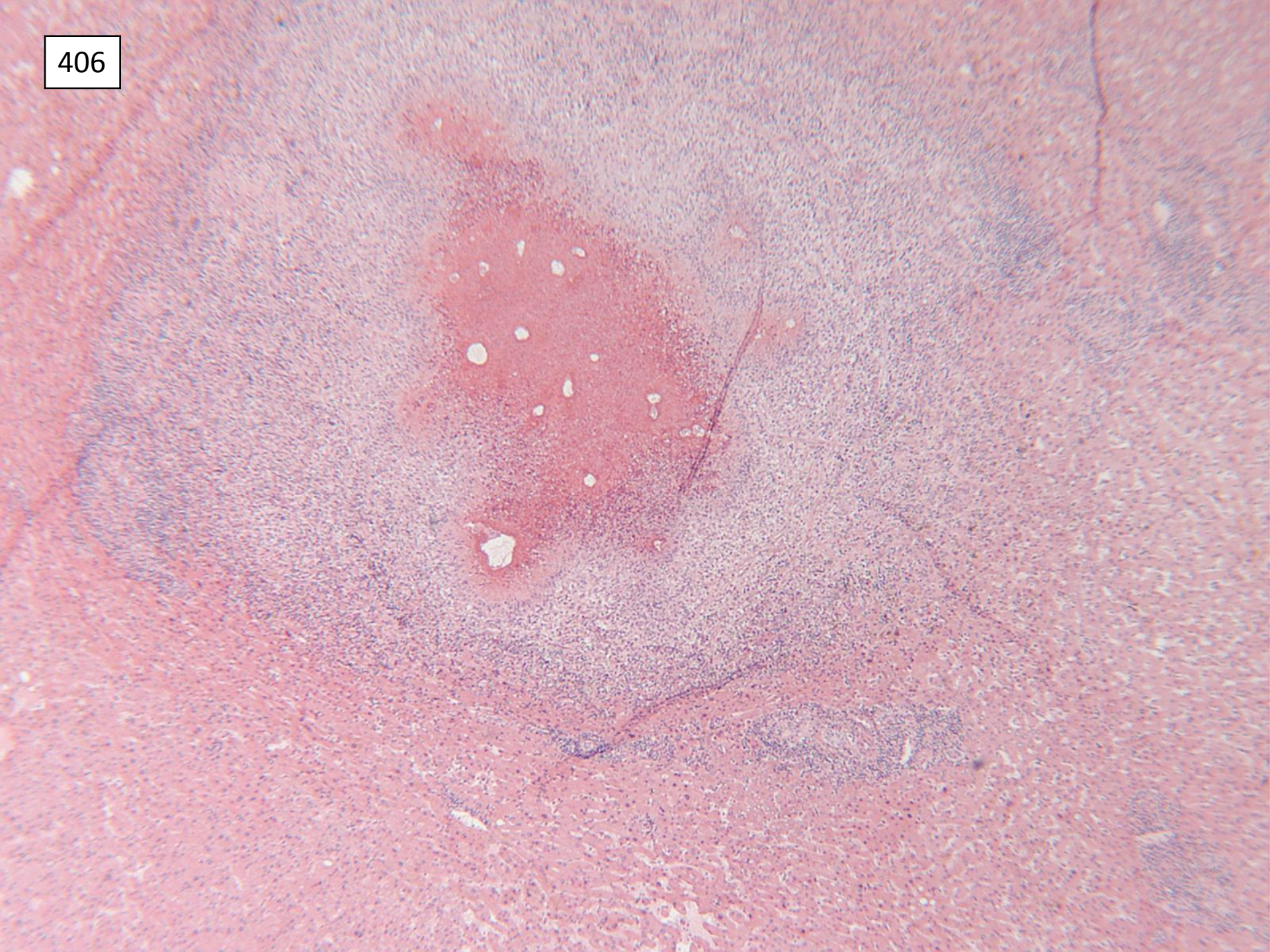
Liver Metastasis and colorectal primary segment VI.  
Stuck to diaphragm Gerota's fascia.

Irregular liver wedge 140x60x45mm with portion of diaphragm. Necrotic pale nodule 45 x 32 x 40mm close to surgical margin and diaphragm, adjacent smaller nodule, block 5 from smaller nodule

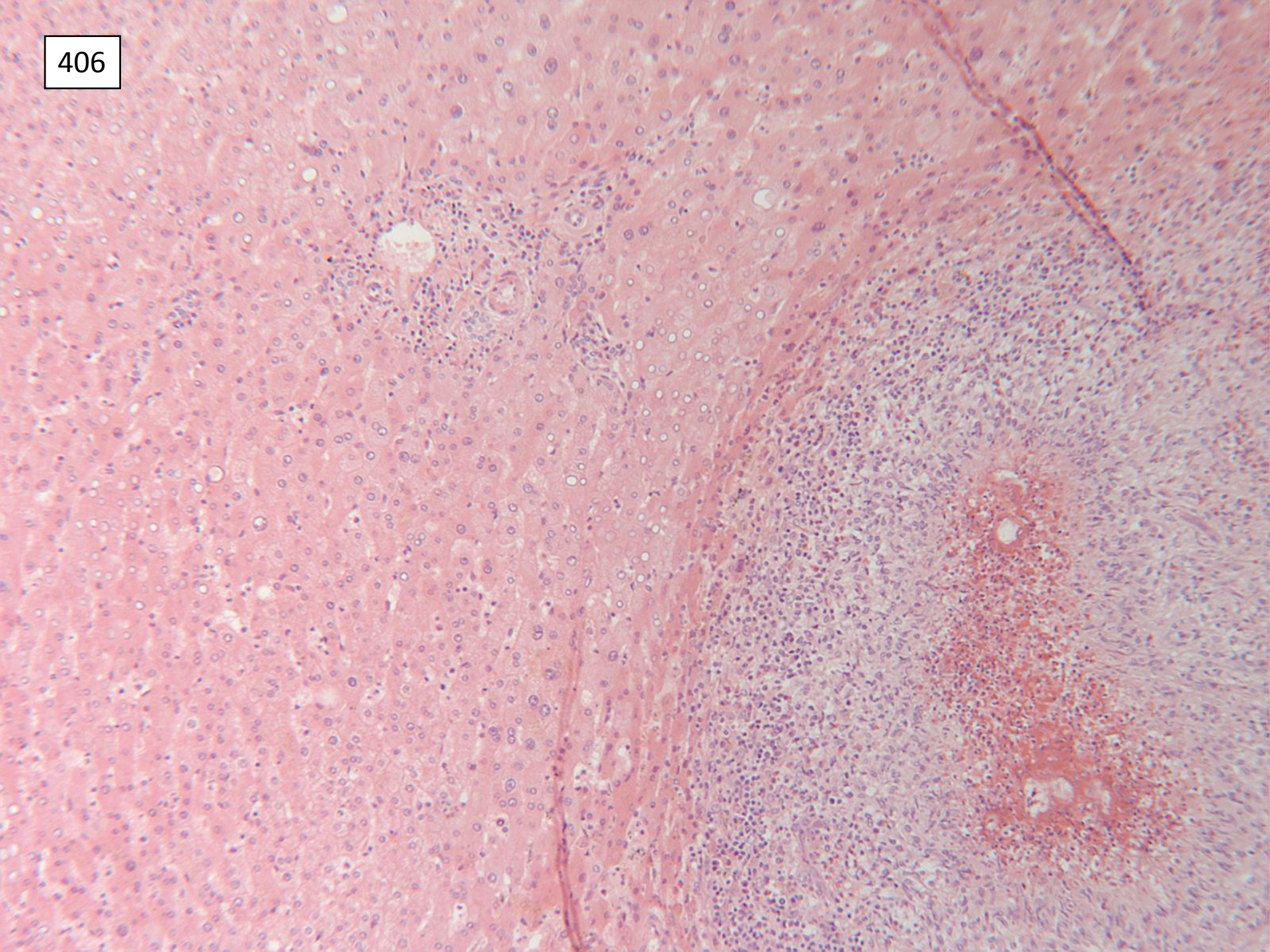
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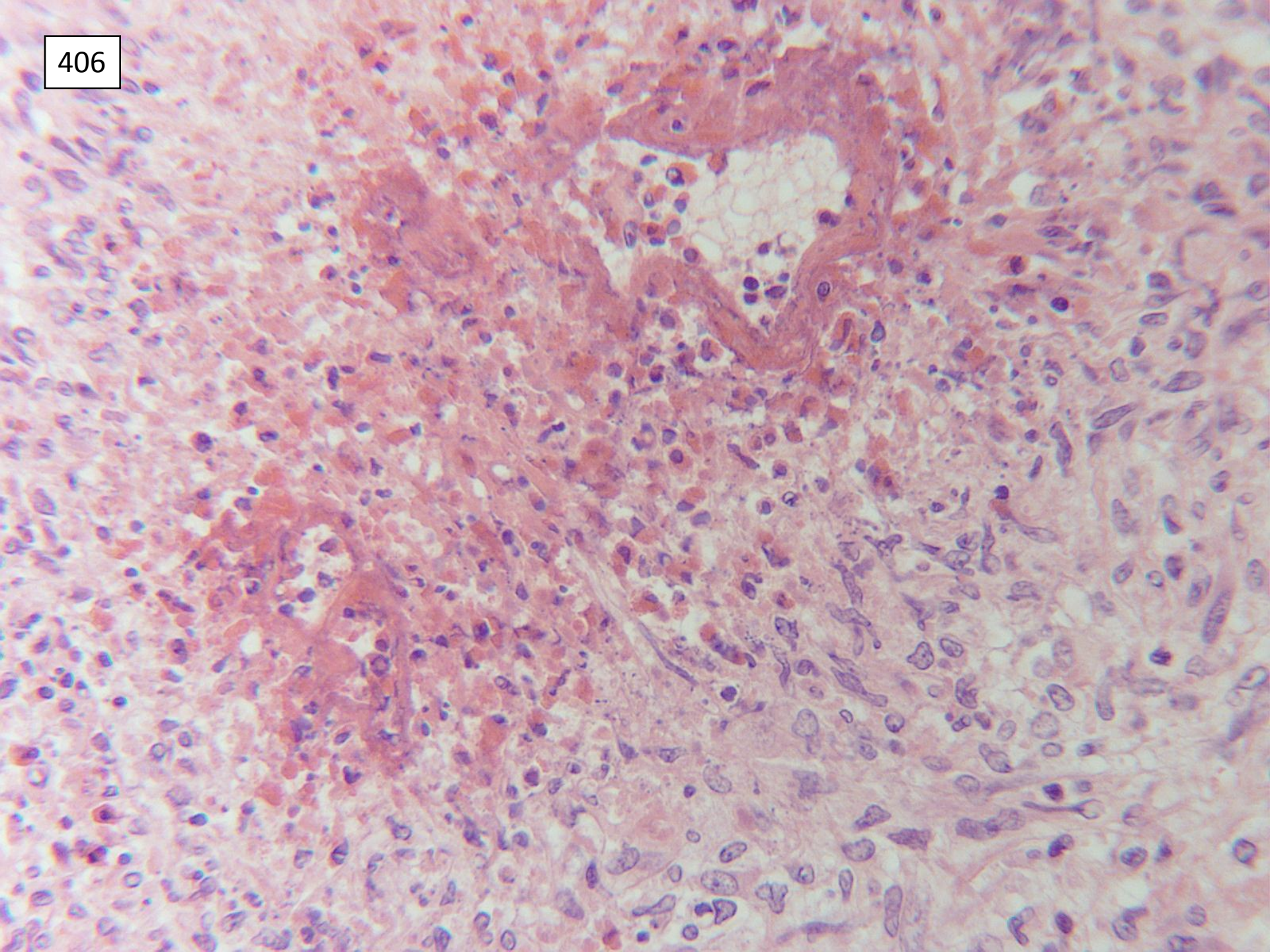
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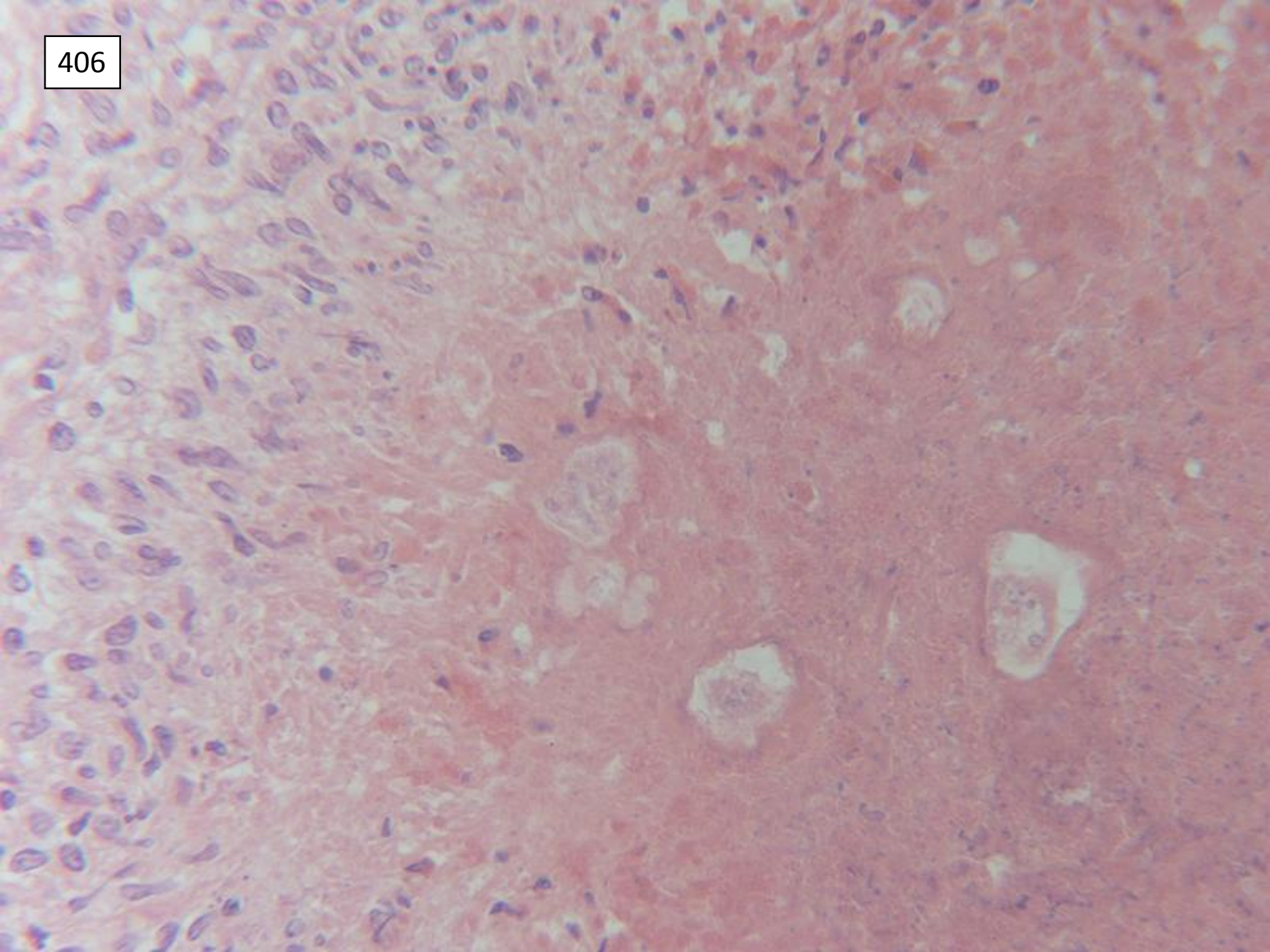
406



406



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## Case 406

### Morphology:

**Granulomatous/abscess/eosinophils/necrotic nodule: 71**

Granulomatous hepatitis: 1

Necrotic nodule, ? post chemotherapy for carcinoma: 5

Focal lesion not mentioned, sinusoidal obstruction syndrome: 1

### Aetiology:

Parasite – specifically hydatid: 24

Parasite – differential includes hydatid: 9

Parasite – miscellaneous, not mentioning hydatid: 31

Infective – bacterial, TB, fungal, actino: 7

Necrotic chitinous cyst: 1

Differential diagnosis includes necrotic tumour: 8

Probably necrotic tumour: 2

No mention of infective/parasitic cause: 3

‘ancient sclerosing haemangioma’

‘Oxaliplatin-related, no residual tumour’

### Suggested scoring:

For 10 points, need to recognise lesion is due to a parasite

Half marks for other infective origin,  
No marks for necrotic tumour or haemangioma.

? half marks for ‘necrotic chitinous cyst’

? half marks for responses including necrotic tumour in differential

Discussion at meeting: necrotic chitinous cyst accepted;

On review, for necrotic tumour in differential – main diagnosis was parasitic so not penalised.

Further information from submitting pathologist:

This patient had a rarely seen form of hydatid disease in the UK – *E. multilocularis* (alveolar hydatid) with lung lesions resected subsequently. (Case referred to Prof S Lucas).

This rare form is more virulent (multiple daughter cysts) but treated in the same way as the more usual *E. granulosus*.

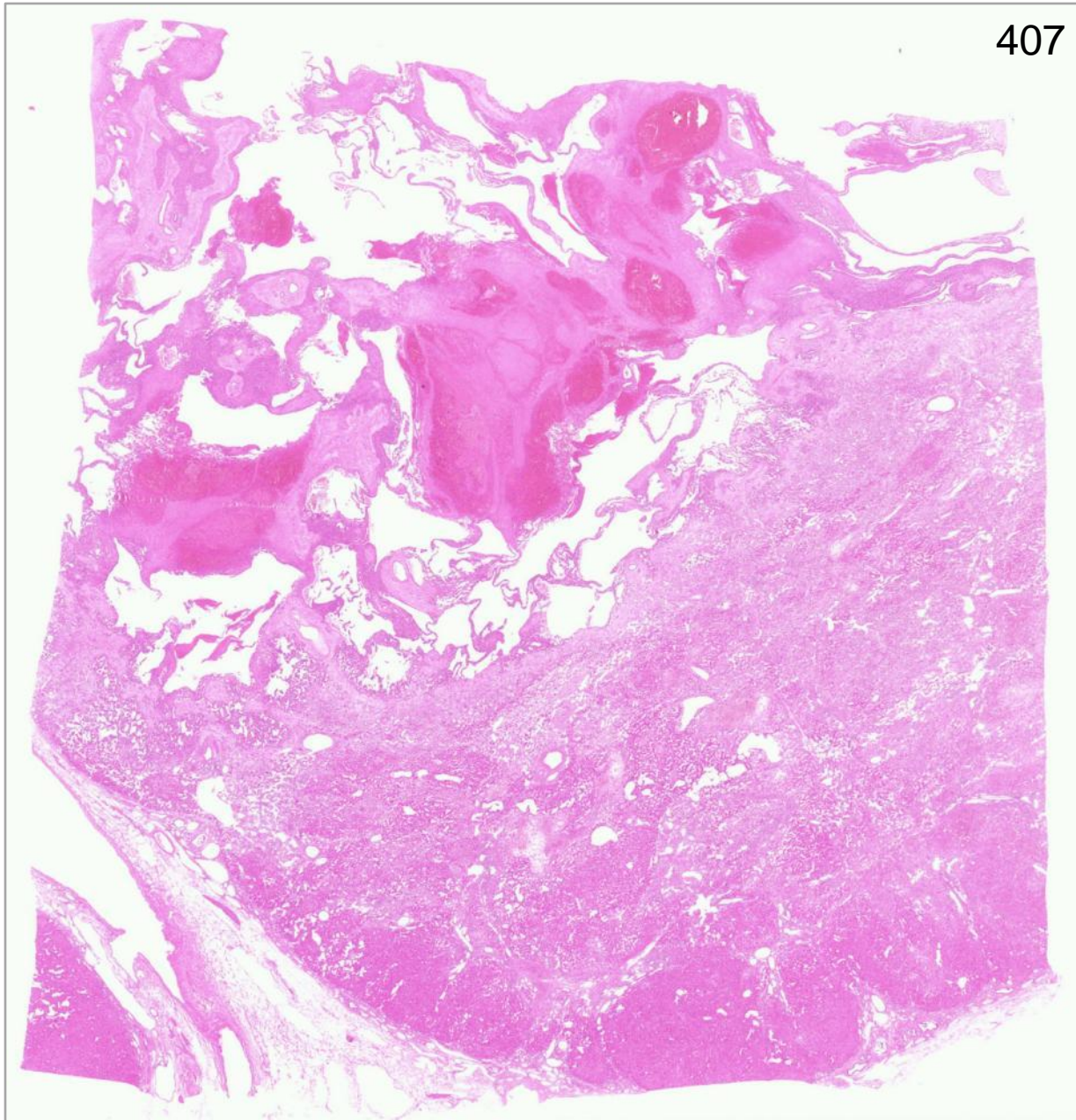
There was no evidence of metastatic colorectal adenocarcinoma in the liver or the lungs.

## **Case G1/407**

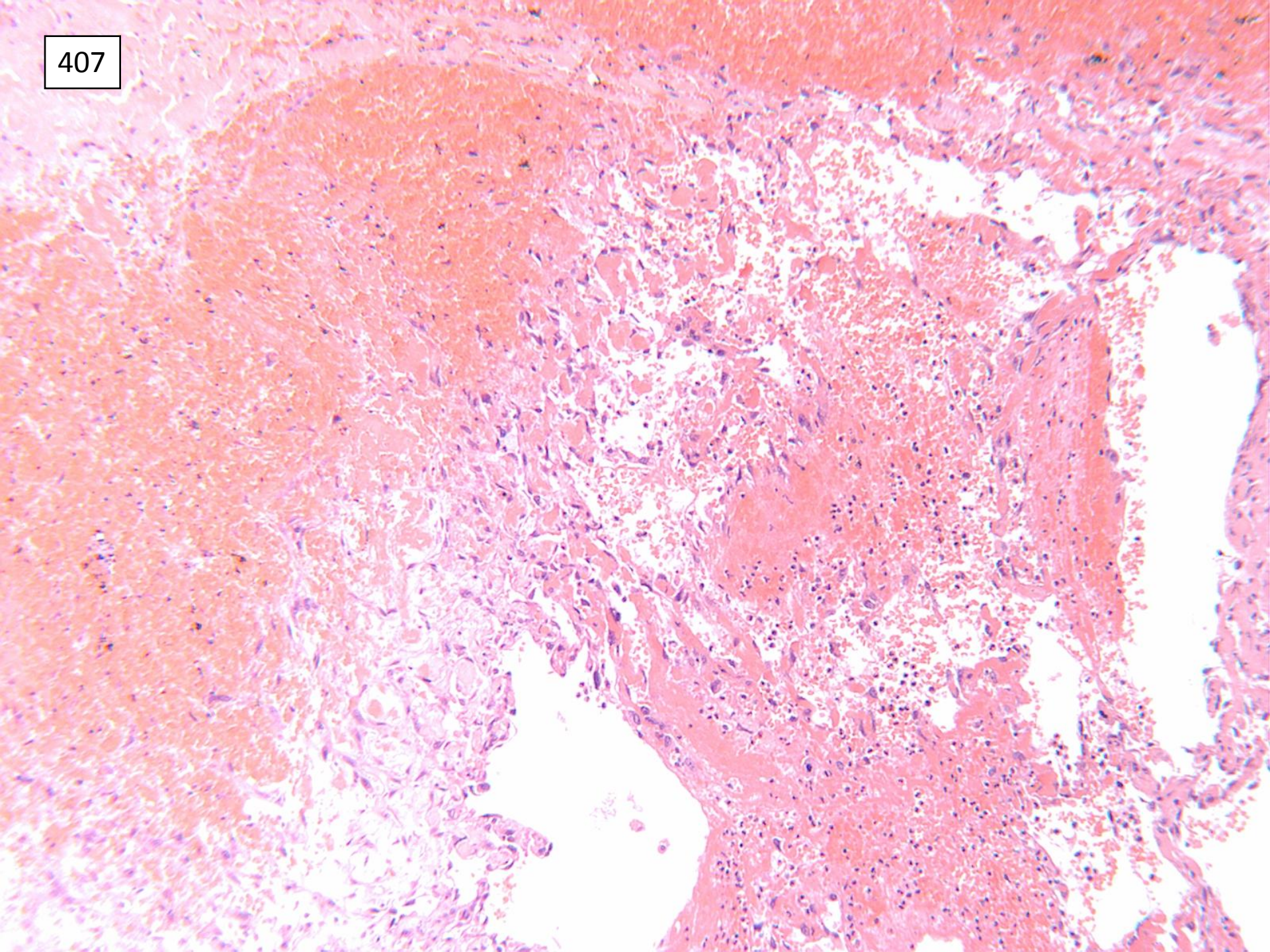
**62 M**

Cirrhotic Liver. HCC and 2-3 indeterminate lesions on CT. Ascites, banded varices, multiple lesions on MRI/CT felt consistent with HCC at HPB cancer MDM

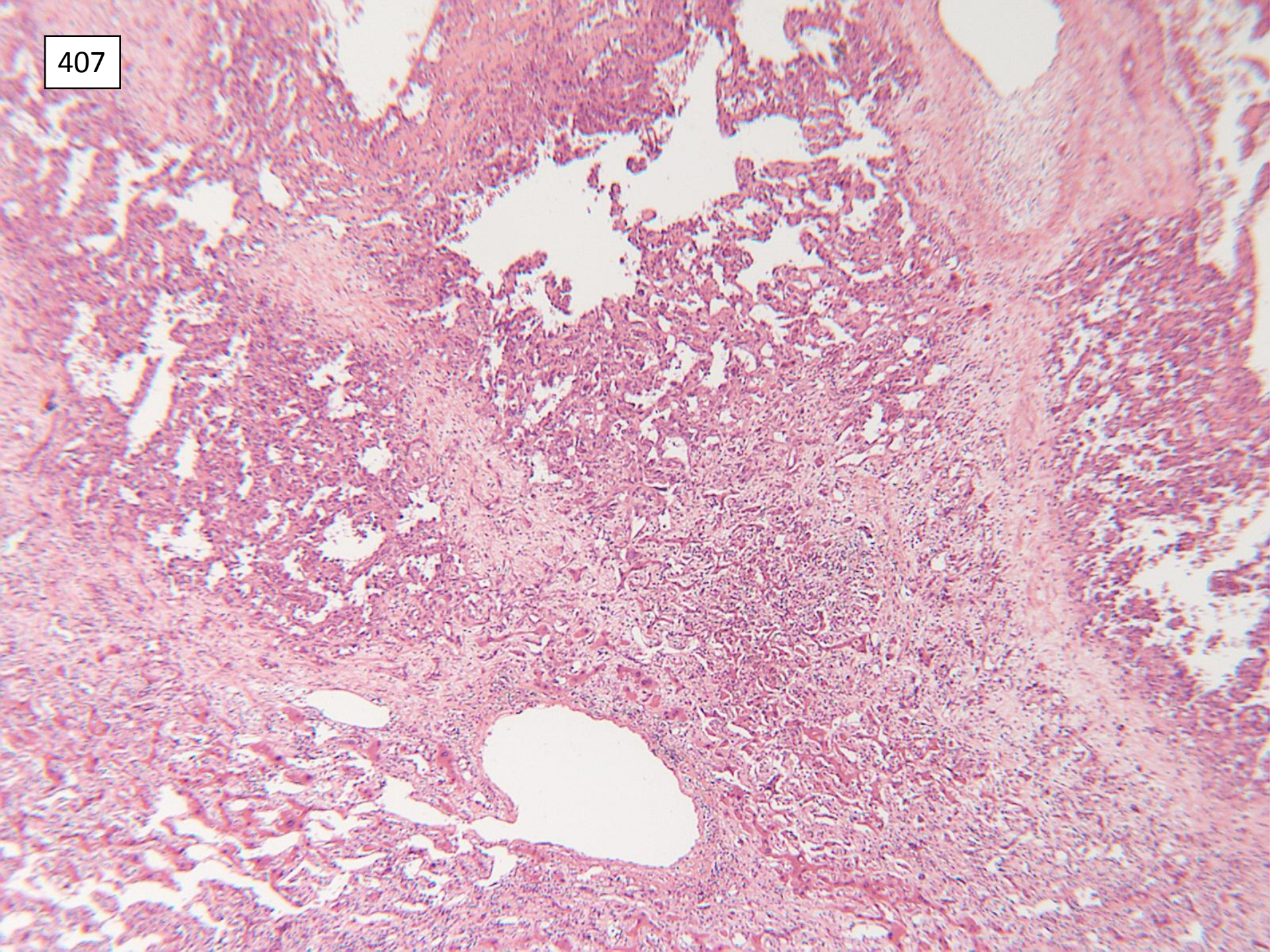
Vaguely nodular but not cirrhotic liver with numerous areas of vascular ectasia, 14 & 44mm lesions looking like sclerosed haemangiomas. No HCC like lesion



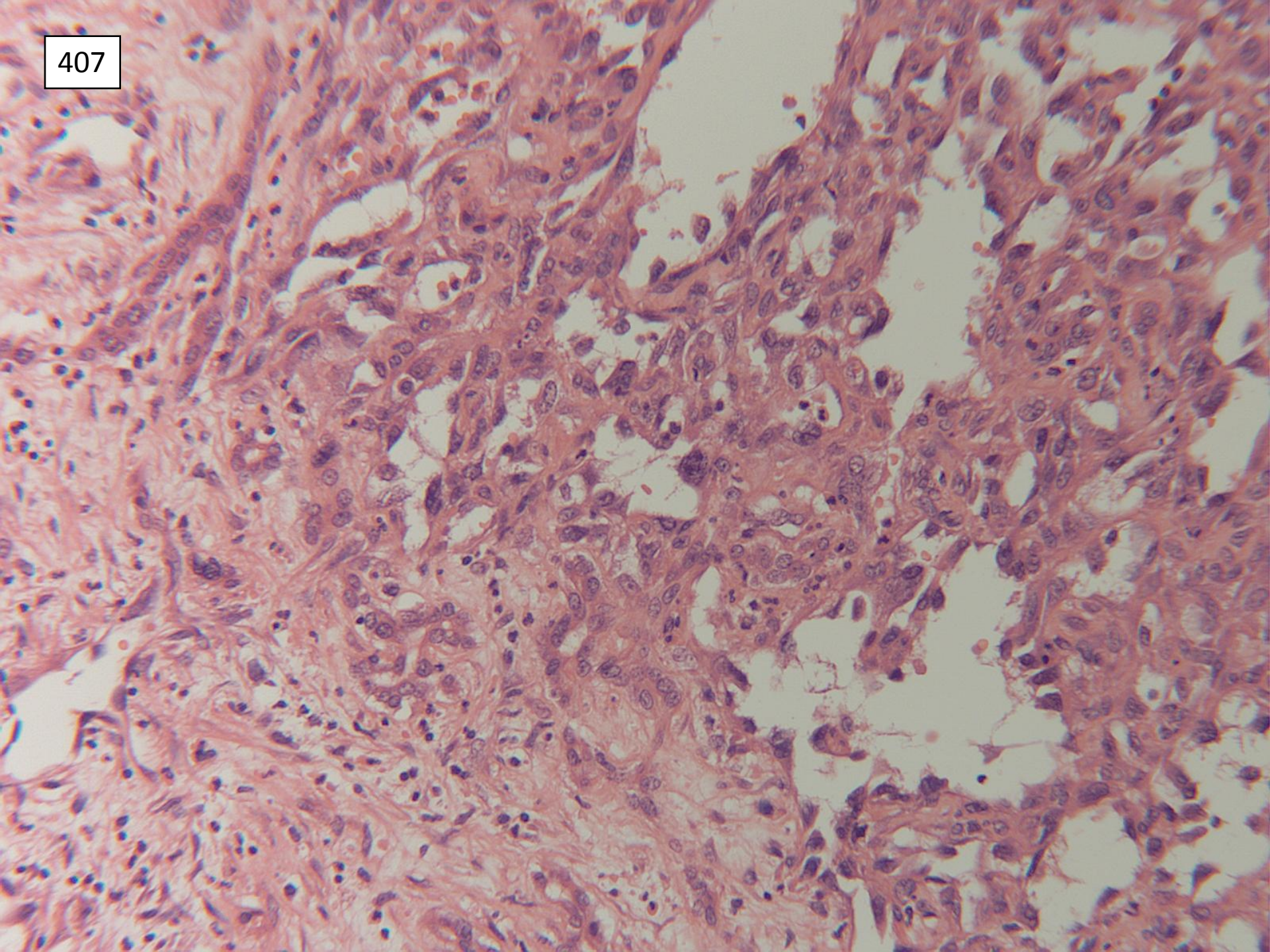
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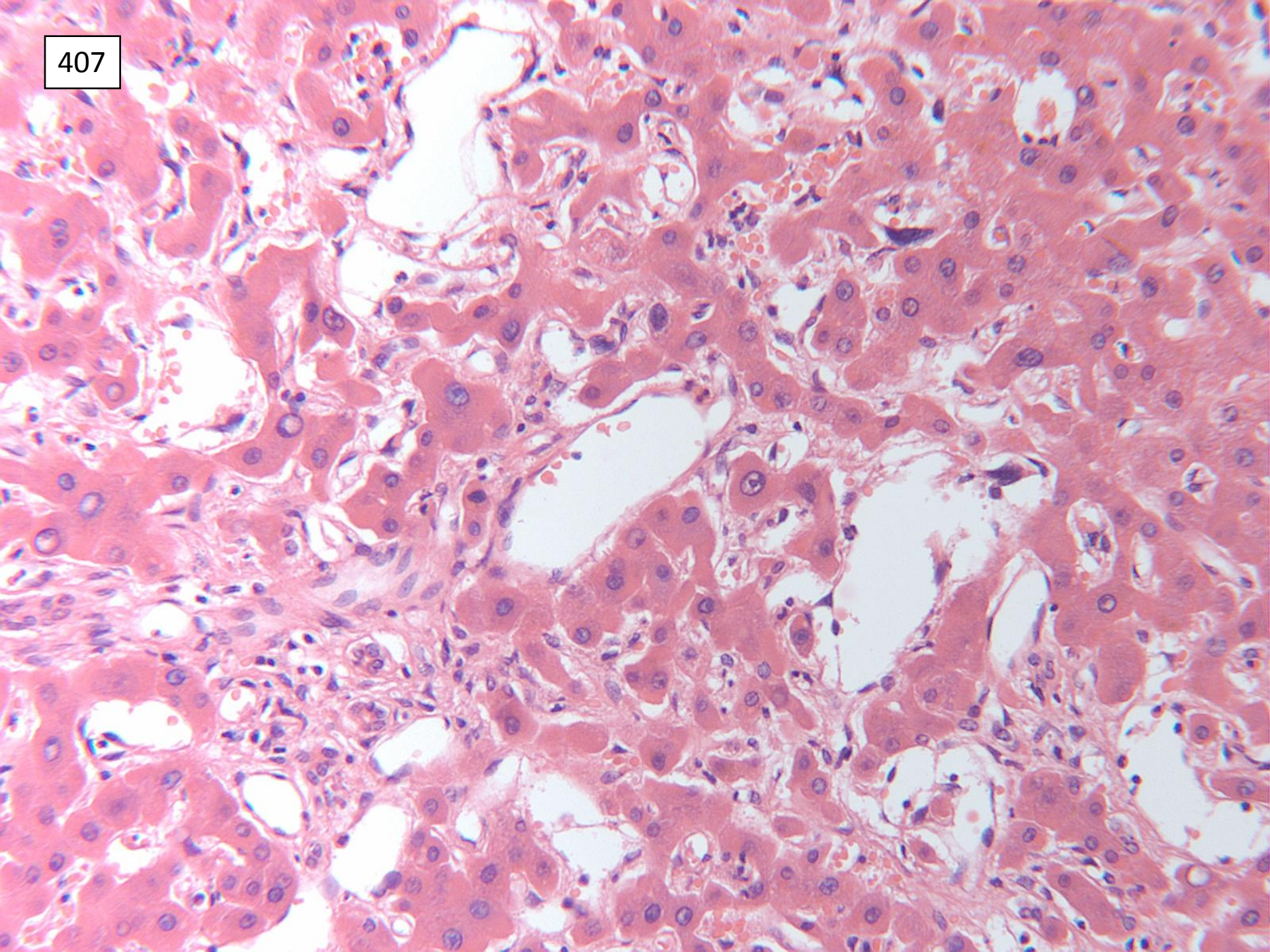
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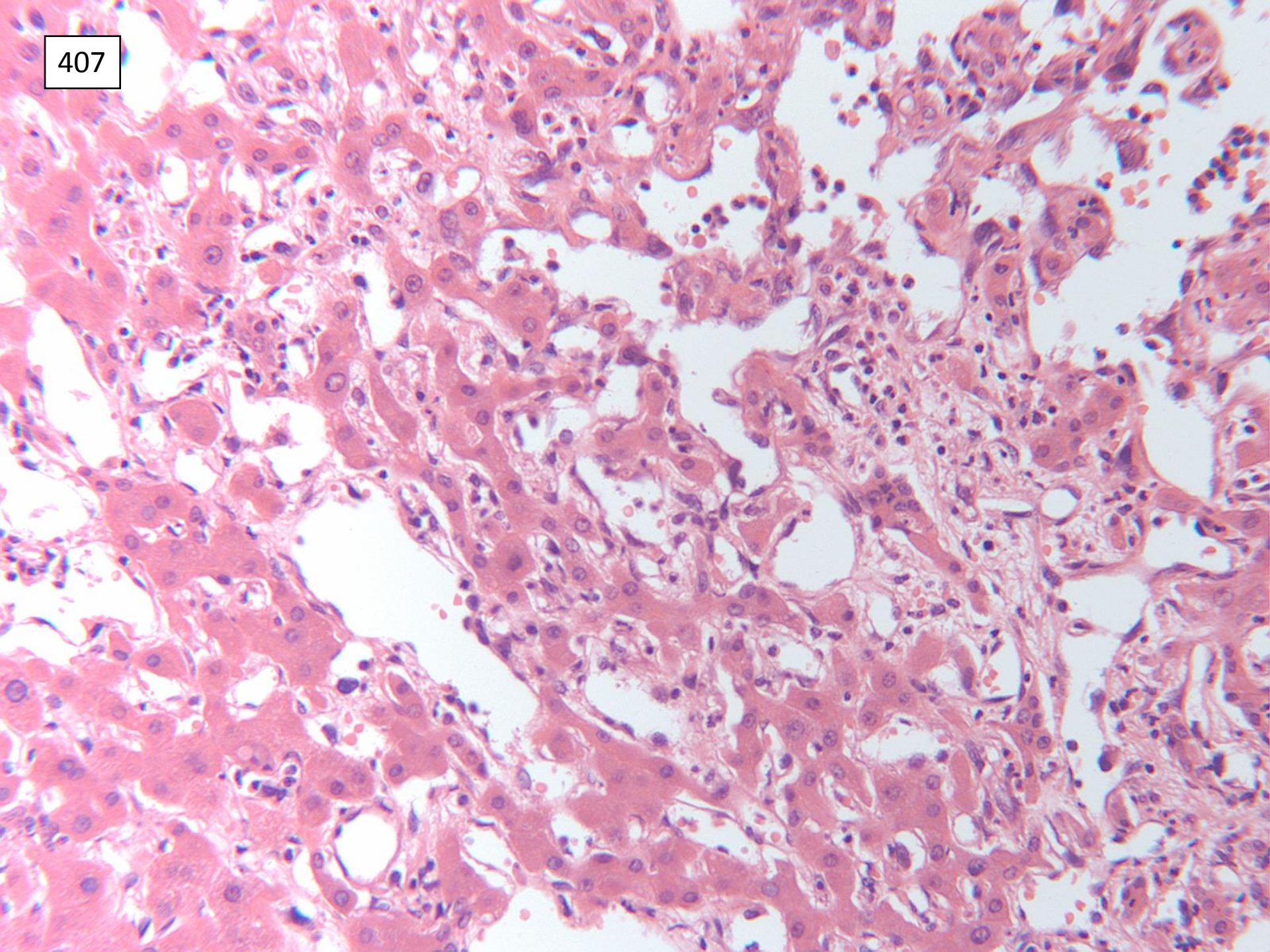
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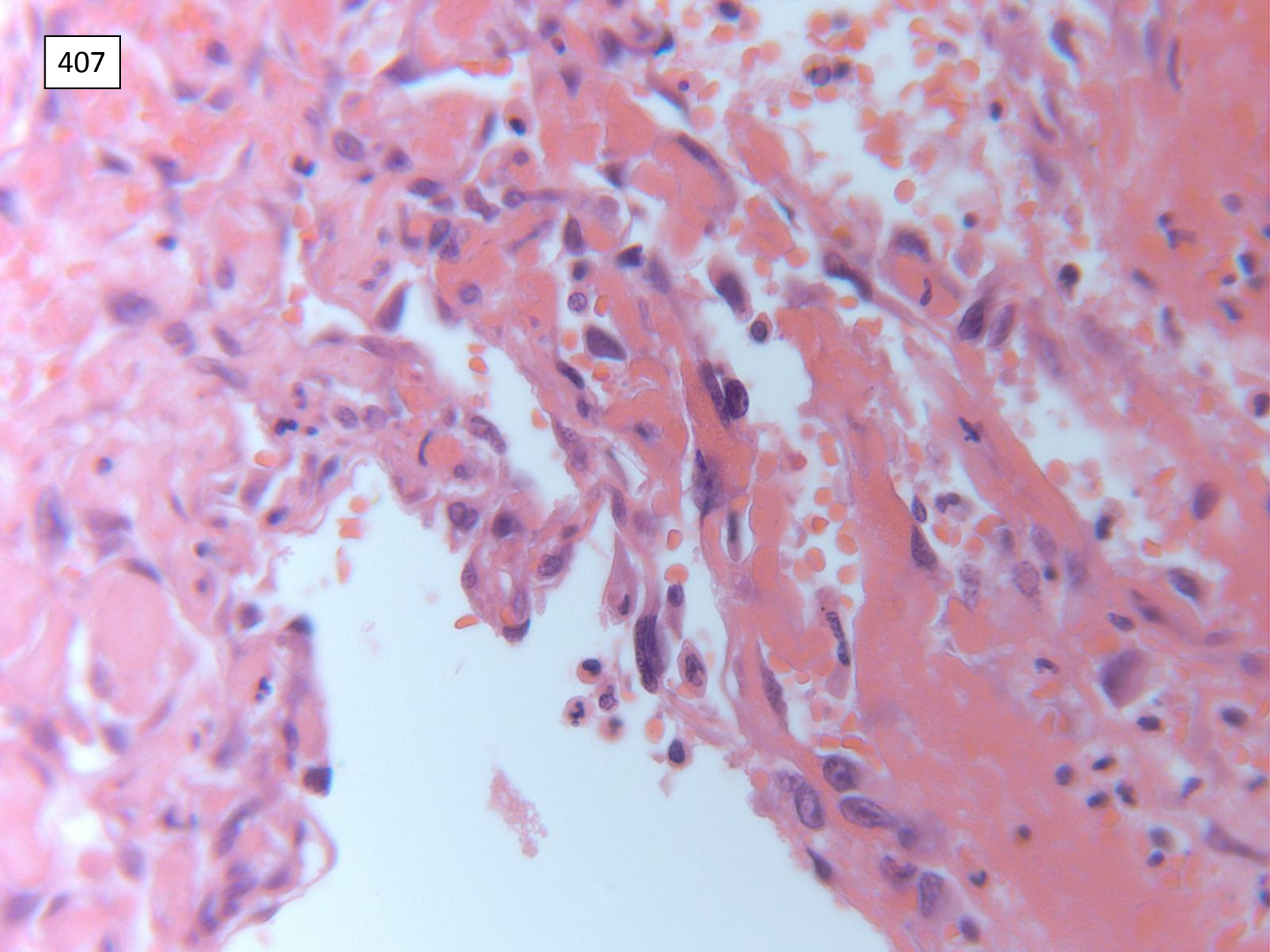
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## Case 407

### **Angiosarcoma: 69**

Angiosarcoma or haemangioendothelioma: 2

Angiosarcoma or Kaposi's: 1

Angiosarcoma or HCC: 1

HCC with unusual vascular component: 1

Epithelioid haemangioendothelioma: 1

Haemangioma with intravascular papillary endothelial proliferation, no angiosarcoma: 1

Sclerosed thrombosed cavernous haemangioma: 1

Peliosis hepatis: 1

Haemangioma with organisation: 1

Benign haemangioma: 1

### Suggested scoring:

For 10 points, angiosarcoma as only or clearly favoured diagnosis.

Score 0 for benign diagnoses and HCC.

? half marks for diagnoses including other malignancy in differential

Meeting discussion: suggested scoring accepted

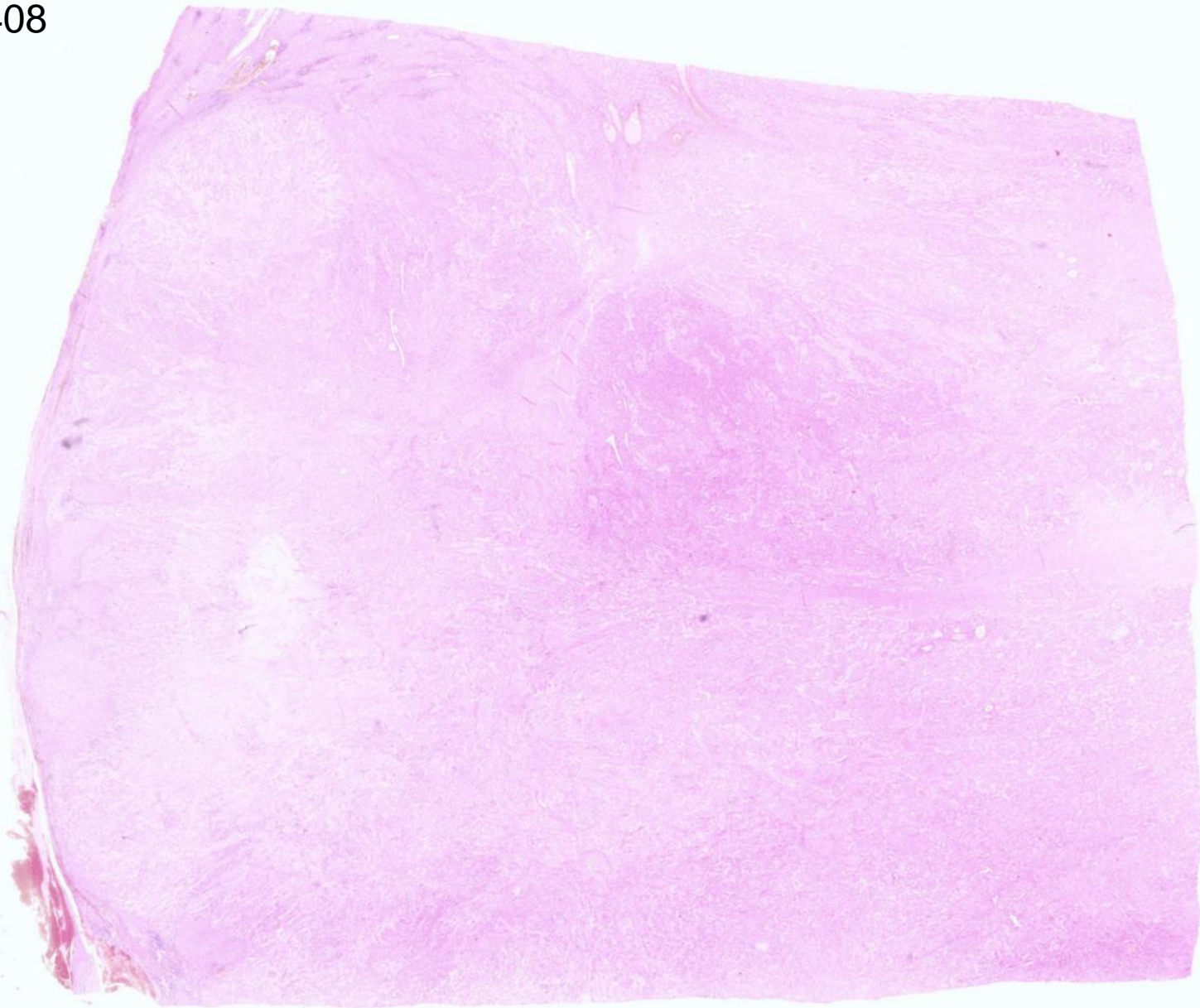
**Case G1/408**

**28 M**

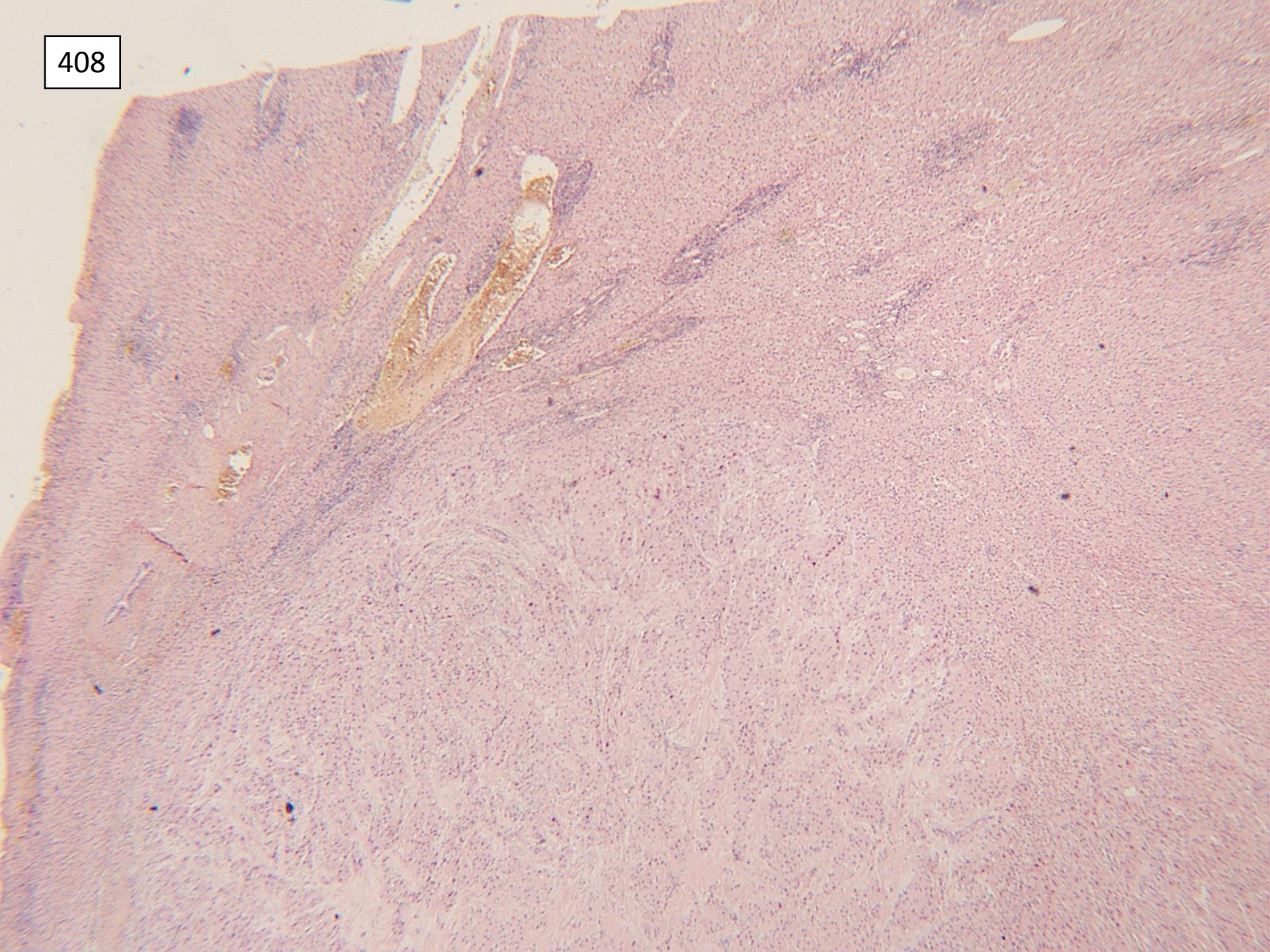
Left hemihepatectomy for tumour

Left lobe of liver measuring 150x140x80mm,  
with a circumscribed pale yellow tumour  
abutting the capsule. The background liver  
does not appear to be cirrhotic

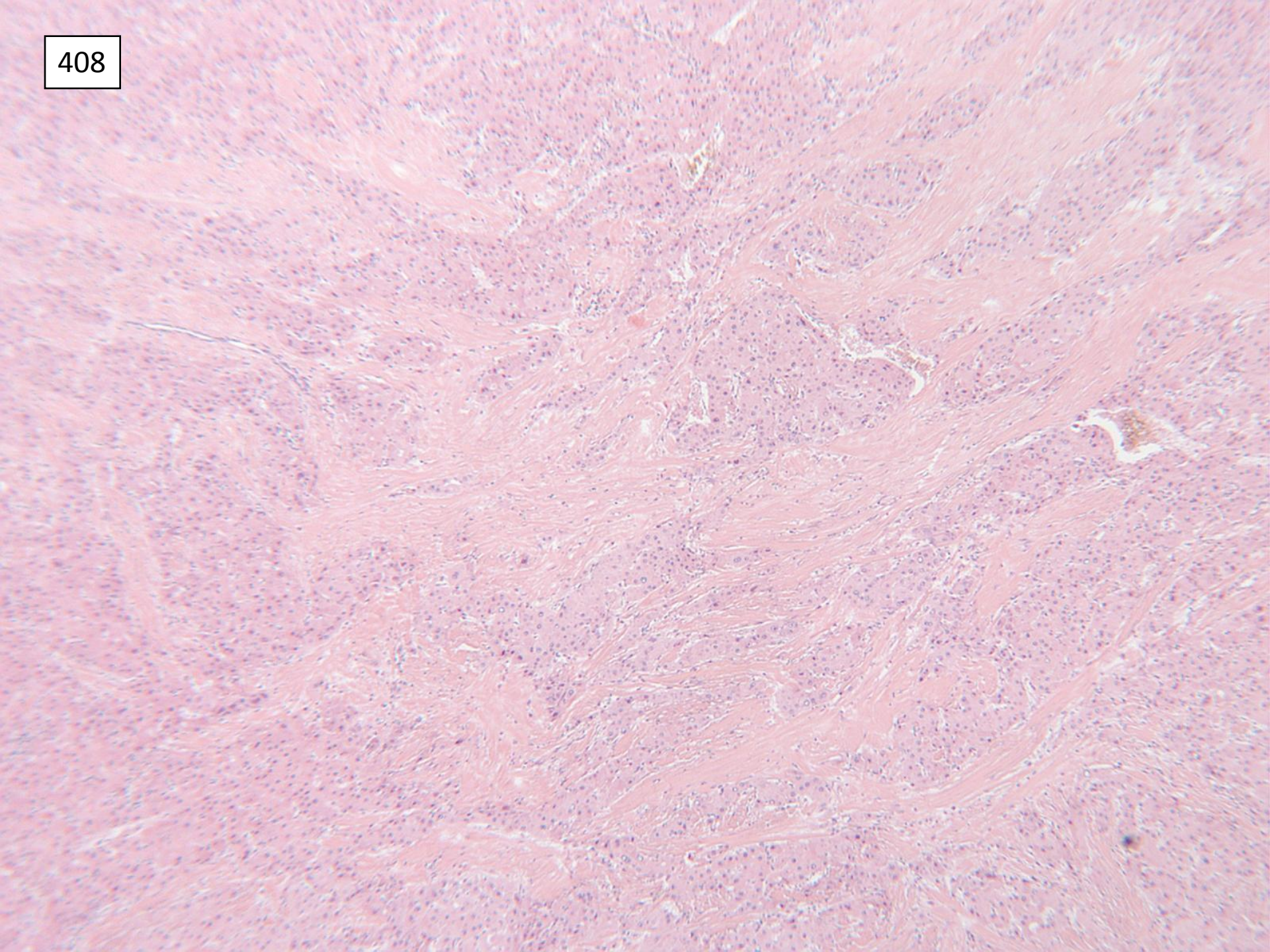
408



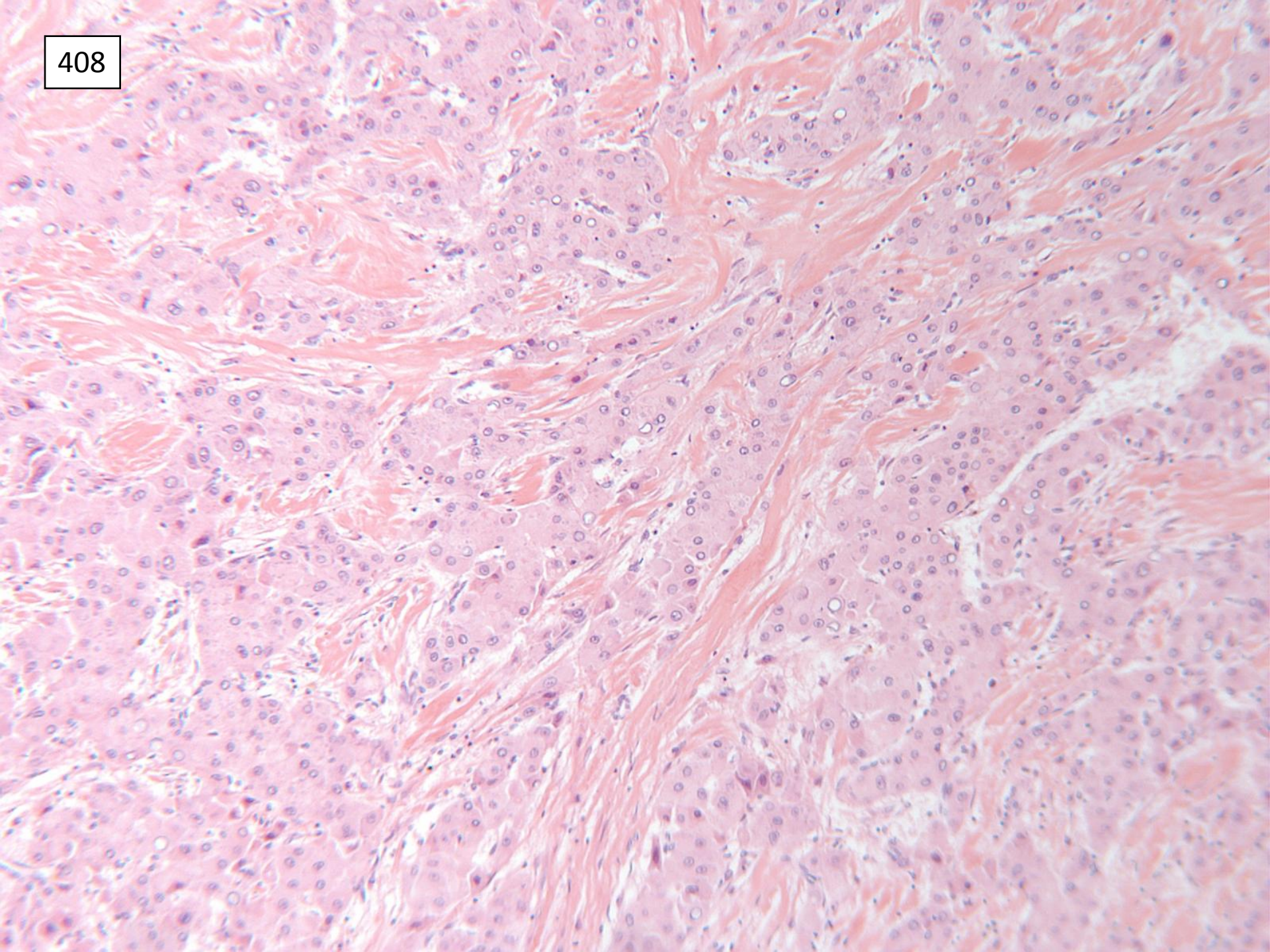
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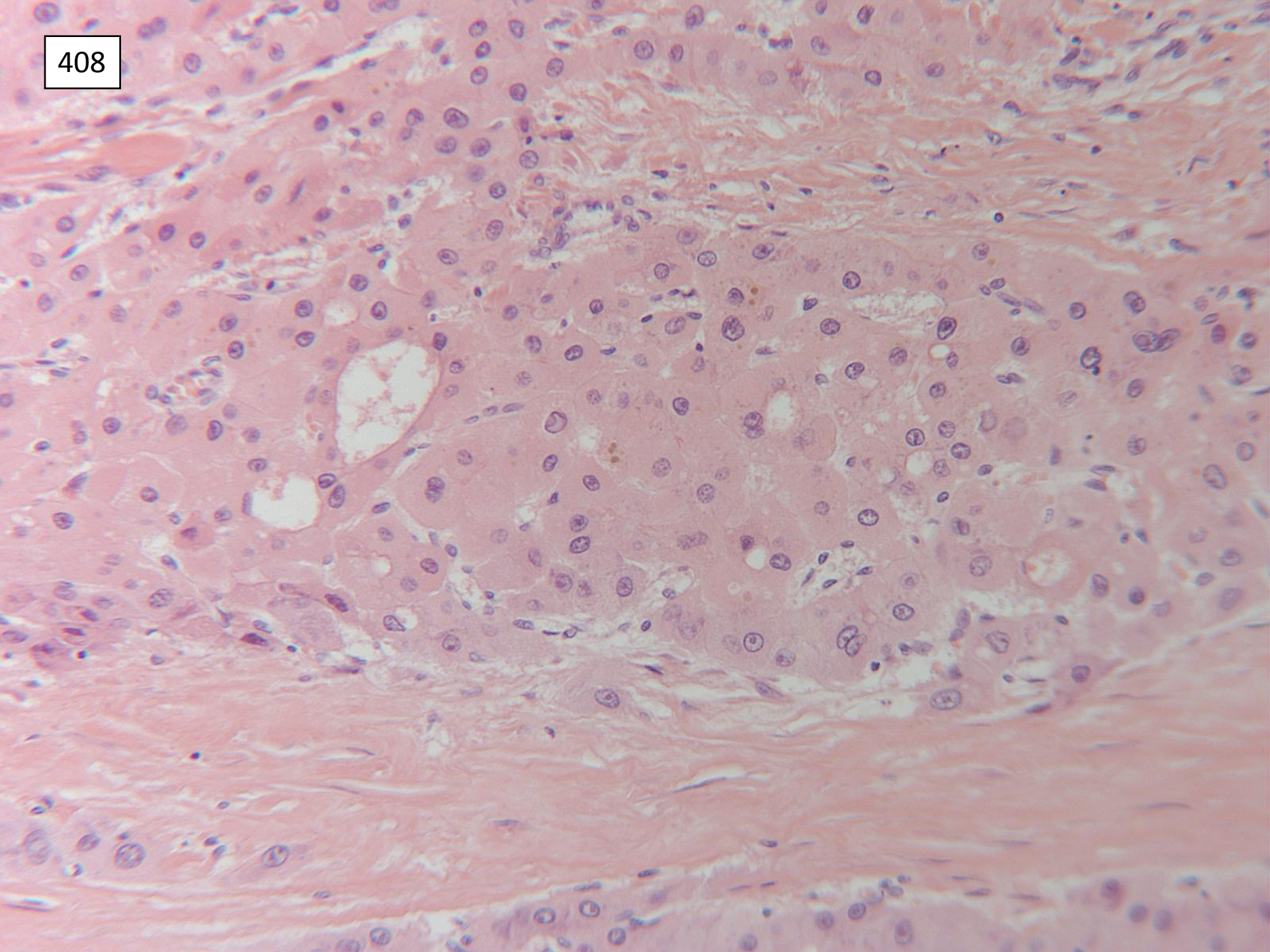
408



408



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## Case 408

**Fibrolamellar type of hepatocellular carcinoma: 75**

Fibrolamellar hepatoma: 1

HCC – does this have criteria for fibrolamellar HCC? 1

Favour fibrolamellar carcinoma, differential diagnosis considered FNH: 1

Well to moderately differentiated HCC: 1

Epithelioid haemangioendothelioma: 1

### Suggested scoring:

For 10 points – fibrolamellar as clear diagnosis.

Score 0 for non-HCC diagnosis

Score half marks for other responses that include fibrolamellar, or obsolete terminology (hepatoma)

Meeting discussion: suggested scoring accepted

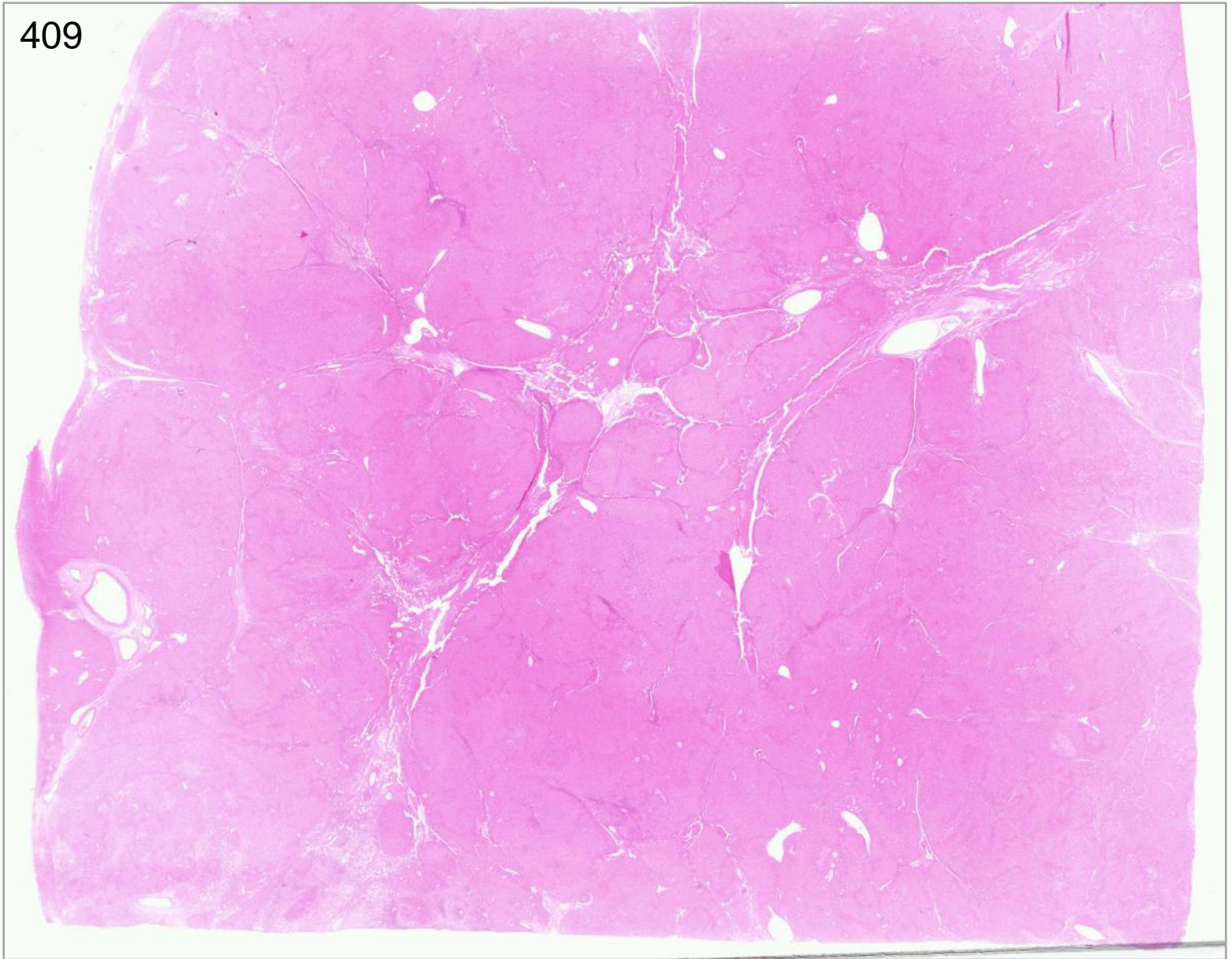
## **Case G1/409**

**30 F**

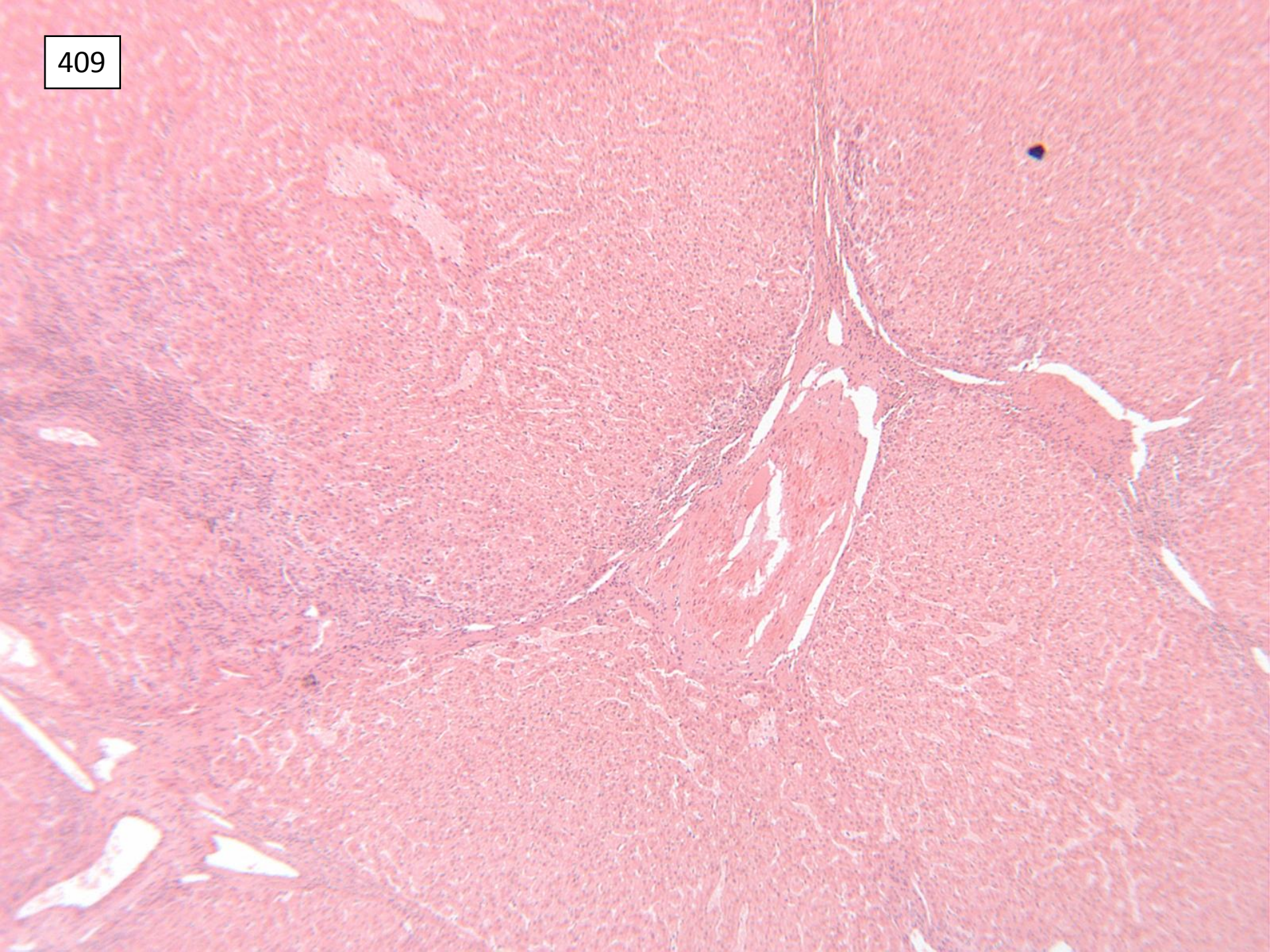
Non specific abdominal pain. Pedunculated tumour on imaging

Liver tissue imaging 60x50x35mm composed of the entire lesion, uniform brown with nodular appearance containing a central white scar

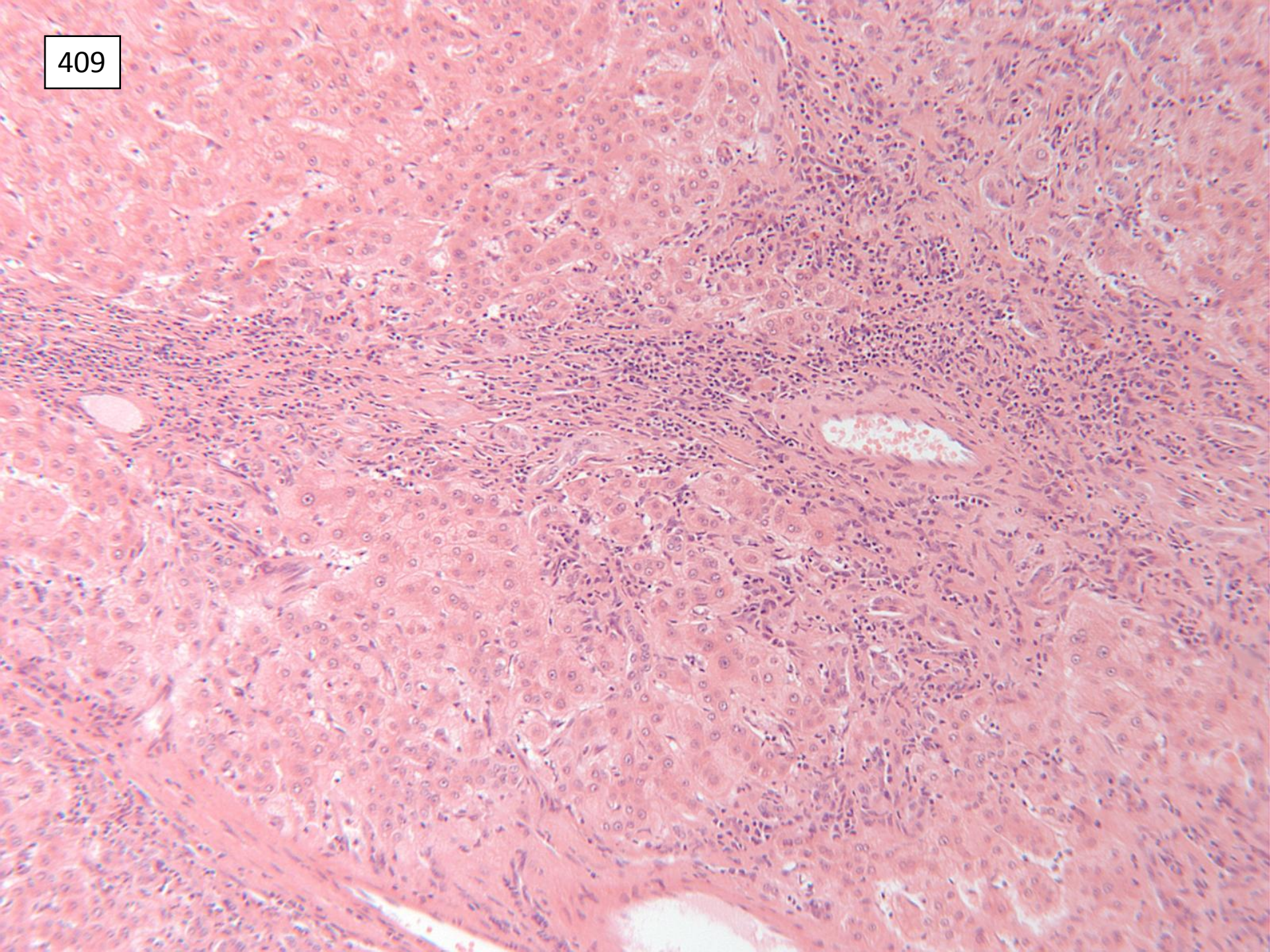
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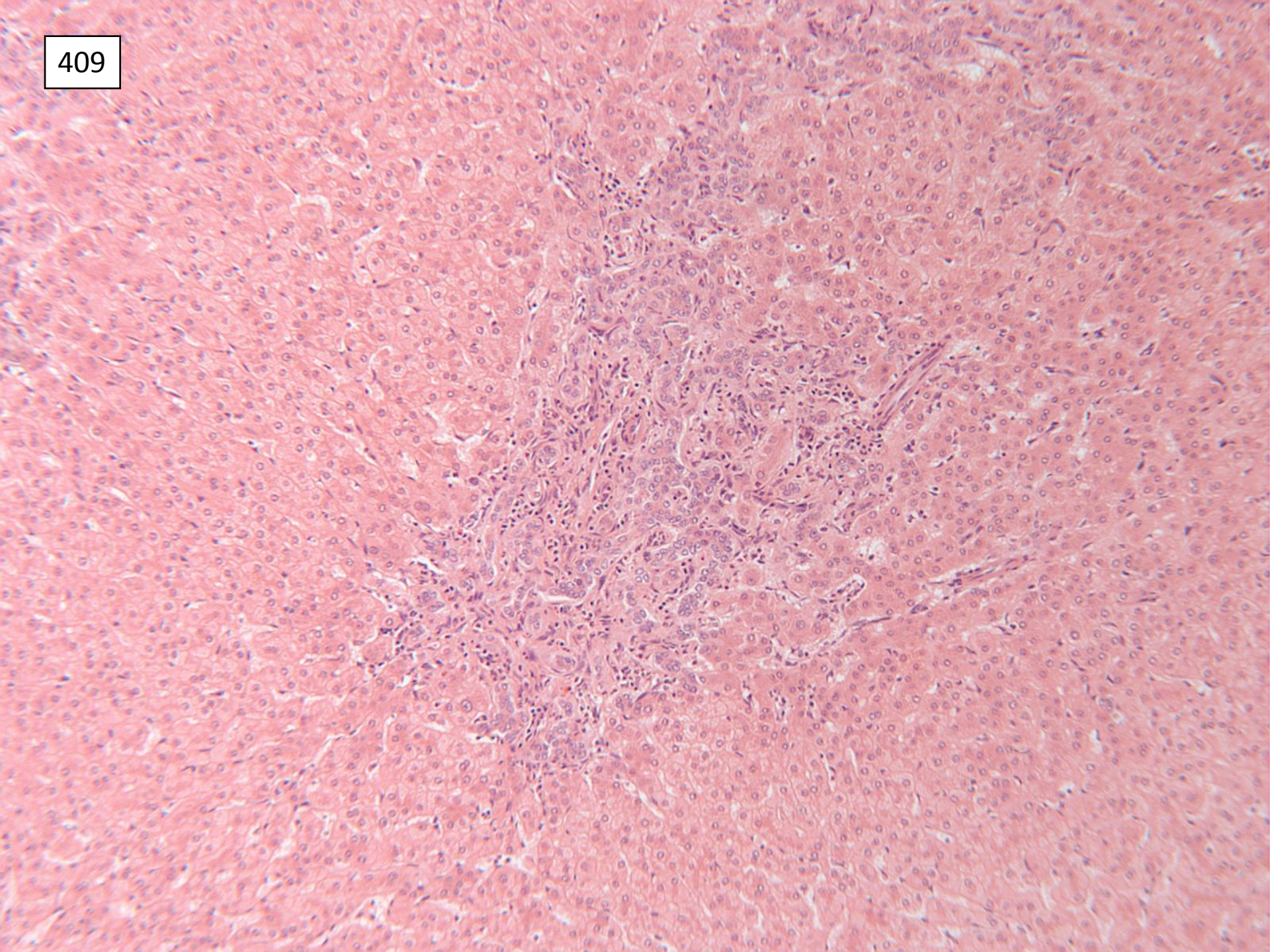
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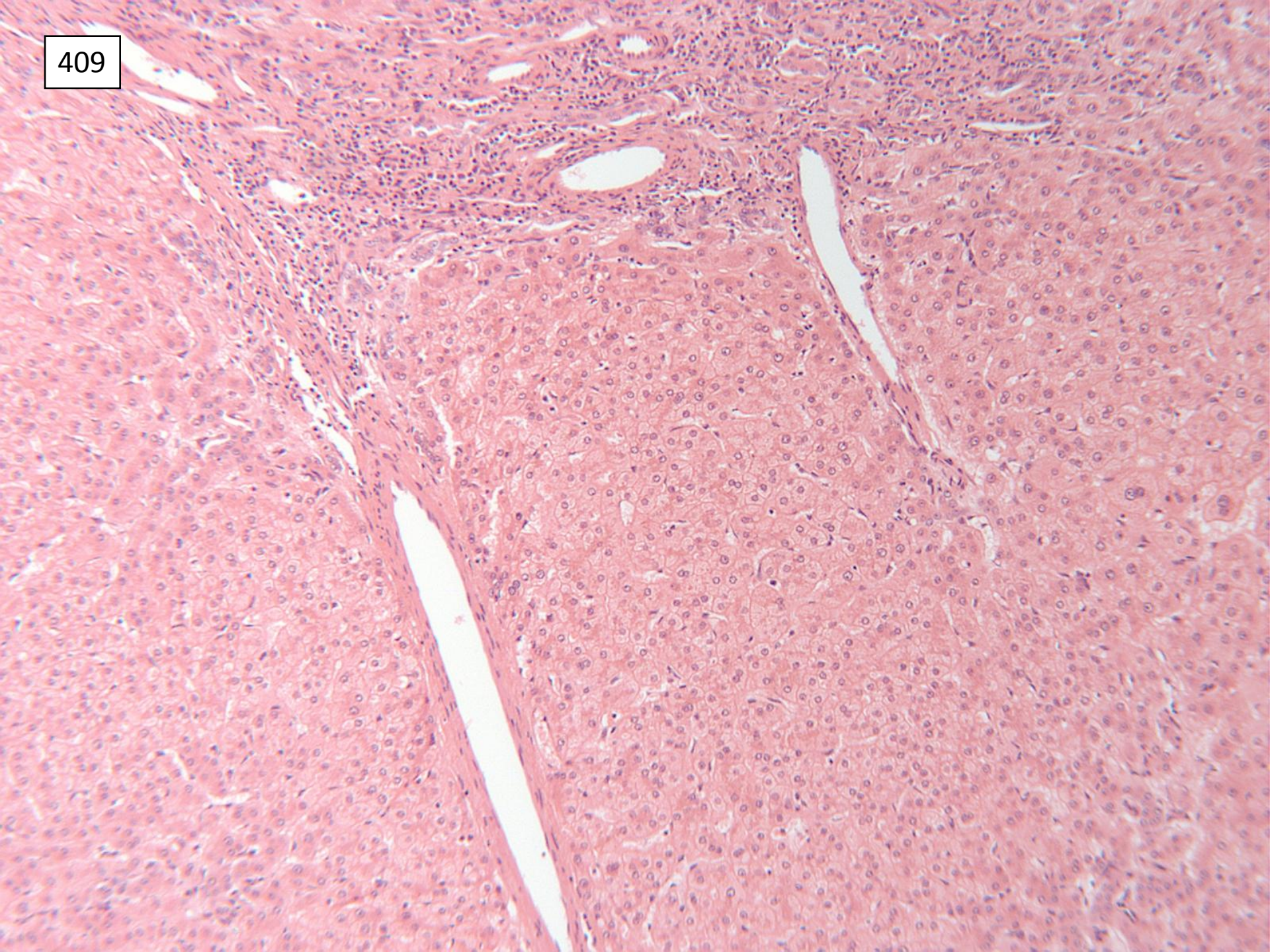
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## Case 409

**Focal nodular hyperplasia: 80**

**Favour hepatocellular adenoma: 1**

Suggested scoring:

For 10 points, clear diagnosis of focal nodular hyperplasia

Score 0 for adenoma

