correlate with the death of all cells in the cortex and congestion of the medulla on histology^{1,6}. The capsule and a thin rim of the peripheral cortex (1-2 mm) are spared because of its separate capsular blood supply ⁷.

In the majority of the cases, acute renal failure is due to acute tubular necrosis, and kidneys recover completely with supportive care. However, acute renal cortical necrosis complicating acute pancreatitis is a rare event, and recovery is unlikely.

The prognosis is very poor, nearly most end up in renal replacement therapy after a variable period. The majority of patients with the diffuse type of cortical necrosis will not recover renal function, while patients with patchy cortical necrosis may show some improvement in renal function but gradually develop the end-stage renal disease and only curative treatment is renal transplantation⁸.

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Hepatic Epithelioid Angiomyolipoma of the Liver: A Diagnostic Dilemma

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Epithelioid angiomyolipoma (AML) is included in group of the perivascular epithelioid cell (PEC) tumors, known as PEComas. These tumors are strongly associated with tuberous sclerosis. Most of these cases have been reported in kidney, and liver involvement is rare, with less than 50 cases described in the literature. Most cases of hepatic angiomyolipoma are misdiagnosed as adenomas or other diseases on radiology as some lack definite adipose tissue components. The final diagnosis could be reached through histology and immunohistochemistry testing.

Case Report

A 30-year-old female presented with vague abdominal pain and on evaluation was found to have a liver space-occupying lesion on ultrasound. Lab investigations showed anemia with hemoglobin of 10.5 g/dl (12-15.0 g/dl). Liver and kidney function tests were within normal limits. Contrast-enhanced CT abdomen revealed a large homogeneously hypodense mass without calcification or hemorrhage, measuring 8×7×5.5 cm in the left lobe of liver involving caudate lobe. The mass showed heterogenous centripetal arterial phase enhancement and remained slightly hyperdense, compared to normal parenchyma, on hepatic and delayed phases. A possibility of hepatic

adenoma was kept based on radiological findings (**Figure 1a,b**).

The patient underwent segmental liver resection of the mass with the specimen showing a partly nodular partial liver segmentmeasuring 8×8×3.5 cms, with the cut surface showing a well-defined black-brown vascular mass. (**Figure 2a**)

Microscopic examination of the lesion showed mainly epithelioid cells arranged in sheets and trabeculae having abundant eosinophilic cytoplasm and round nuclei. (Figure 2b)There was rich vascularized stroma with thick-walled vessels. Aggregates of foam cells with fine lipid droplets noted. (Figure 2c) The neoplastic cells are diffusely positive for HMB45, and negative for HepPar 1. (Figure 2d) There were no features suggestive of aggressive behavior in the form of vascular metastasis, pleomorphism or p53 expression.

The case was diagnosed as a hepatic epithelioid angiomyolipoma. The patient was well after resection and on regular follow up. Further evaluation for tuberous sclerosis was performed, but imaging of the brain scan was normal.

Discussion

In 2013, the World Health Organization (WHO) defined neoplasms with perivascular epithelioid cell differentiation (PEComas) as mesenchymal tumors composed of distinctive cells that show a focal association with blood vessel walls and usually express melanocytic and smooth muscle markers.¹

PEComas include angiomyolipoma, lymphangioleiomyomatosis, and clear cell 'sugar' tumor.²

AML can occur anywhere in the body, but most arise in the retroperitoneum, abdominopelvic region, uterus, and gastrointestinal tract; hepatic AML is rare.³

Most cases are asymptomatic and are detected incidentally on routine examination. As the lesion enlarges, cases can present with abdominal pain. Tuberous sclerosis is associated with over half of the cases of renal AML and 5-15% cases of hepatic AML.⁴

Epithelioid PEComas is a variant of AML composed almost exclusively of epithelioid cells with

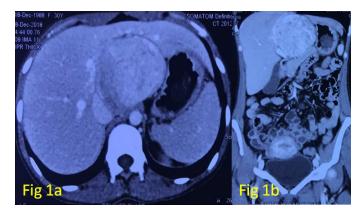


Figure 1: CT Scan showing a hypodense mass in the left lobe of liver.

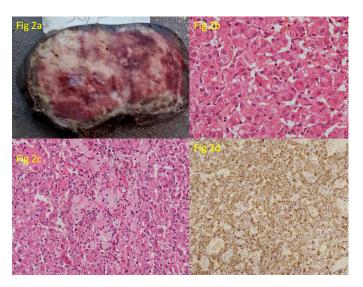


Figure 2 (a): Gross section of liver mass showing hemorrhagic well-defined mass. (b): Microscopy showing large epithelioid cells. (c): Mass showing foam cell with lipid droplets. (d): IHC HMB45 Diffusely positive within the neoplastic cells.

pronounced abnormal blood vessels and few or no lipocytes. ^{5,6} Due to the relative paucity of fat content, most cases are misdiagnosed as adenomas on radiology, as noted in our case. A definite diagnosis can be established only by histopathology and confirmed by immunohistochemical marker testing. Most cases of epithelioid AML are found in the kidney, and liver involvement is infrequent. The presence of solitary epithelioid AML usually indicates primary hepatic EAML, and surgical excision is the treatment of choice. Multiple lesions within the liver suggest the possibility of metastasis from renal epithelioid AML and have a poor prognosis.

Brimo *et al.* have summarized the pathological characteristics of renal EAML likely associated with malignant progression: $(1) \ge 2$ mitotic figures per 10 highpower field; (2) atypical mitotic figures; (3) $\ge 70\%$ of atypical epithelioid cells; and (4) necrosis. The presence of 3 or more features was highly predictive of malignant behavior.⁷

The criteria for malignant transformation of hepatic epithelioid AML are not well defined due to the scarcity of these lesions.^{8,9} Deng *et al.* have postulated that large tumor size, pleomorphic nuclei with high proliferation activity, and P53 immunoreactivity may predict the existence of malignant transformation of hepatic AML.⁸

Due to the rare association of these tumors with tuberous sclerosis and renal lesions, further evaluation of these patients is suggested as opposed to adenomas where surgery is curative. This report aims to increase awareness among pathologists of this rare entity.

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Secondary CBD Stone due to Curry Leaf Stems: A Case Report and Review of Literature

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Ingestion of a foreign body is not uncommon. Once it passes the pharynx, it usually comes out of the anus, unless it is a long, sharp, or a chemical-laden FB, when perforation/penetration is a possibility. However, FB in the common bile duct (CBD) is uncommon, and FB piercing common Bile duct (CBD) is very unusual and uncommon. The common foreign bodies in the CBD are usually left by surgeons or therapeutic endoscopist. They are non-absorbable sutures² or leftover parts of a tube or stent. Are Rarely ingested long and sharp FB penetrate CBD accidentally. Reported cases include a toothpick and a Ligaclip post lap cholecystectomy. Very rarely during blast shrapnel and metal fragments are seen after a blast injury, but vegetable and digestible FB causing CBD stone causing cholangitis is being reported for the first time.