subepithelial stroma. Although they have a benign clinical course, awareness of the pathologic and immunohistochemical spectrum of these cells is crucial in their correct differentiation from other lesions as microinvasive carcinomas, sarcomas, blue nevi and intermediate trophoblastic lesions, which also exhibit bizarre stellate cells. The differentiation with superficial myofibroblastoma is difficult since this entity does also share this cellular component that originates from a specialized band of subepithelial mesenchyme in the lower female genital tract

PP3-21
FOLLICULAR-LIKE PATTERN IN METASTASES OF FEMALE GENITAL TRACT LEIOMYOSARCOMAS AND RHABDOMYOSARCOMAS. A PITFALL IN DIFERENTIAL DIAGNOSIS

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INTRODUCTION: We present an unusual and unreported follicular-like change in the abdominal and vaginal metastases of four cases of leiomyosarcoma (LMS) and rhabdomyosarcoma (RMS) of the female genital tract; three of them originated in the uterus and the remaining one in the vaginal wall. RESULTS: This pattern was not present in the primary tumour and consisted in a moderately atypical spindle cell population, sometimes exhibiting lobular growth, which presented many pseudofollicular spaces with an apparent cuboidal lining and basophilic contents in their lumina. Primary tumours corresponded to 3 highly differentiated leiomyosarcomas of the uterus and vagina respectively and a carcinosarcoma with rhabdomyosarcoma component in the remaining one. Immunohistochemically, the tumour cells from the primary and metastases were diffusely positive for vimentin, actin, desmin, caldesmon and myosin in the last case, which demonstrated the smooth or striated muscle identity of the tumours. The luminal contents were positive for both mucicarmine and PAS stains. CONCLUSIONS: Since similar follicular- like spaces are characteristic of tumours such as juvenile granulosa cell tumour (JGCT)and small cell carcinoma associated with hypercalcemia (SCC with HC), this phenomenon should be taken into account in their differential diagnosis which should also include the alveolar patterns of various sarcomas as well as malignant melanoma which also may conform such pseudofollicular spaces.

PP3-22
REPRODUCIBILITY OF CERVICAL HISTOLOGIC INTERPRETATIONS BETWEEN PATHOLOGISTS

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Background: The interpretive reproducibility of cervical cytology and histopathology is critical to cervical cancer prevention programs. In the medical community, histopathologic interpretations are generally considered as the reference standard upon which treatment of cervical disease is based. Therefore the aim of our study was to determine the interpathologist and intrapathologist reproducibility of histologic cervical specimen interpretations at our Department. Methods: We reviewed 60 randomly selected histologic cervical specimens, which were originally diagnosed by one of four pathologists at our Department. The original number of specimens was equally distributed between the pathologists (each pathologist 15 specimens). After review we calculated intraobserver reproducibility for each pathologist (15/15) and interobserver reproducibility, where all the pathologists had to interpret all 60 histologic specimens. We also compared cytologic and histologic interpretations if cytologic interpretations were available. Results: The average interobserver agreement was 73,8% (70% - 78,3%). The lack of reproducibility was most evident for negative and less severe interpretations. For high grade SIL lesions the average reproducibility was 91,7% (88,9%-97,2%). The average intraobserver agreement was 76,7% (60%-86,7%), and for high grade lesions 93,8%. Cyto-histologic correlation showed excellent results (100%) for H-SIL lesions and moderate for low grade lesions. Conclusion: Interpretive variability is substantial in cytology and histopathology. Our results showed excellent reproducibility of cervical histologic specimens for high grade squamous lesions and only moderate for low grade squamous lesions, which is in concordance with some previous studies on larger series.

PP3-23
OVARIAN CELLULAR FIBROMAS: A CLINICOPATHOLOGICAL AND IMMUNOHISTOCHEMICAL ANALYSIS OF TEN CASES

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BACKGROUND: Traditionally, cellular fibroblastic tumors of the ovary were classified as either cellular fibroma (CF) or fibrosarcoma. A recent study suggests that cellular fibromatous neoplasms with bland cytology and elevated mitotic counts are associated with favourable prognosis and should be diagnosed as "mitotically active cellular fibroma" (MACF) rather than fibrosarcoma. In addition to clinicopathological features, immunohistochemistry may aid in further differentiating between CF and MACF, but its role has not been analyzed so far. METHOD: We retrospectively analyzed the clinicopathological and immunohistochemical features of 10 cases of ovarian cellular fibroblastic tumors diagnosed either as CF or fibrosarcoma in the last seven years. Patient records and archival pathology specimens were reviewed and immunohistochemistry was performed using pan-cytokeratin, EMA, vimentin, inhibin-alpha, calretinin, CD10, CD99, alpha-smooth muscle actin (SMA), desmin, S-100, c-kit, estrogen (ER), progesterone receptor (PR), p53, bcl-2, and MIB-1 antibody. RESULTS: Utilizing criteria proposed by Irving et al. the tumors were reclassified as CF (0-3 MFs/10 HPFs, n=5) and MACF (>4 MFs/10 HPFs, n=5). The mean age of patients with CF and MACF was 44 and 36 years, respectively. All tumors were unilateral, and the mean tumor size of CFs was 6.0 cm and 13.3 cm for MACFs. The majority of the tumors were solid; four of them had a cystic component, while ovarian surface rupture was present in one CF and one MACF. All tumors consisted of cellular, intersecting bundles of spindle cells showing slight or moderate pleomorphism. The mean highest mitotic count was 2.3 MFs/10 HPFs for CF, and 7.6 MFs/10 HPFs for MACFs. Follow-up of 4 to 79 months (mean 38 months) was available in 9 patients and was uneventful in all cases. One patient with MACF died 15 days following the operation as a result of the intercurrent disease. Immunohistochemical analyses showed that spindle cells in majority of the tumors were immunoreactive for vimentin, alpha-SMA, inhibin-alpha, calretinin, PR, and bcl-2. All tumors were negative for pan-cytokeratin, EMA, CD10, CD99, c-kit, ER, and p53, while one CF was positive for S-100, and one MACF showed positivity for desmin. In addition, the MIB-1 labeling index (LI) in MACFs was higher (mean 14.4%, range 10-25%), than that in CF (mean 5.6%, range 3-10%). CONCLUSION: Our results confirm the immunophenotypic similarity between ovarian fibromas and cellular fibromatous neoplasms, and suggest that the use of MIB-1 LI may help in differentiating between CF and MAFC.