Georgia Association of Pathology

# GAP News

March 2026

This Month's

## Outline

Editors: Natasha Savage, MD, FCAP
*Augusta University Medical Center*



GAP President's

## Letter

February 17, 2026

Thank you to all our members and sponsors who attended the Annual Meeting. It was truly a pleasure to see so many familiar faces and to welcome new colleagues into our community.

One important takeaway for me came from our Keynote Speaker, Paul A. VanderLaan, MD, PhD, who shared a practical "best practice" recommendation for lung cancer cases:

Clearly designate a preferred biomarker block and percentage of tumor in the pathology report. This simple step can meaningfully improve clarity, communication, and downstream patient care.

We were also honored to hear from Patrick Godbey, MD, of behalf of the CAP, and Brent Walker, JD, on behalf of the Medical Association of Georgia (MAG). Updates from these organizations are always important, and perhaps even more so in today's environment of digital pathology and artificial intelligence. I was very encouraged by the strong interest expressed by our members in engaging with the professional organizations that represent us—such as the CAP House of Delegates. I encourage each of you to participate at both the local and national levels. GAP is a great place to start!

Finally, a very special thank you to Faisal Saeed, MD, who has organized our Annual Meeting program for the past several years with exceptional dedication and skill. His leadership and attention to detail have elevated this event year after year, and his contributions are deeply appreciated. His shoes will indeed be hard to fill.

Thank you for your continued commitment to our profession and to the Georgia Association of Pathology.

Warm regards,
Keith A. Stevens, MD
President
Georgia Association of Pathology

# Beyond CML: A Step-by-Step Diagnostic Dissection of a Myeloid Neoplasm

*Authors: Jackson I. Savage[1], Scott Corley, MD[2], Natasha M. Savage, MD[2], Mei Zheng, MD, PhD[2]*

1. Georgia Southern University, BS applicant – College of Science & Mathematics
2. Medical College of Georgia at Augusta University, Department of Pathology

**Case:**

The patient is a 63-year-old male with a past medical history of coronary artery disease who presented to an outside emergency department (ED) with abdominal pain which had gradually worsened over the preceding week. Computed Tomography (CT) scan demonstrated massive splenomegaly, and complete blood count (CBC) revealed a marked leukocytosis. Concern for leukemia was raised, which prompted transfer to our facility. At the time of transfer, the CBC was notable for a white blood cell count (WBC) of 106.2 thousand/mm$^3$, hemoglobin of 11.4 g/dL with an MCV of 86.2 fL, and a mild thrombocytopenia of 138 thousand/mm$^3$. The manual differential count revealed neutrophilia with left shift as well as basophilia (12% basophils). 10% myelocytes and 12% metamyelocytes were noted with rare blasts (<1%). Monocytes and eosinophils represented <5% of the differential each. Many nucleated RBC (nRBC) were also noted. Ultrasound of the spleen confirmed severe splenomegaly measuring 25.5 x 25.4 x 10.2 cm with a total volume of 4621 cc (compared to a normal adult male spleen size 13 x 7 x 6 cm with volume of 350 cc).

The patient's history was extensively reviewed and included a single note from an ED visit in 2018 documenting mild thrombocytosis (466 thousand/mm$^3$) with a normal hemoglobin level of 15.5 g/dL and MCV of 75.9 fL without elevated hematocrit or red blood cell count. A CT Angiography (CTA) of the chest performed at that time demonstrated mild splenomegaly and borderline enlargement of the hilar and celiac lymph nodes.

Pathologist performed peripheral blood smear review confirmed leukocytosis with pronounced neutrophilia and left shift as well as basophilia. Polychromatic macrocytes were noted with occasional dacrocytes. NRBCs were readily identified and showed atypia including enlargement and pronounced nuclear budding, which was initially attributed to RBC precursor egress from the marrow as well as stress hematopoiesis. Despite the presence of some pelgeroid changes in neutrophils (Figure 1A), the marked left-shifted neutrophilia and accompanying basophilia raised primary concern for chronic myeloid leukemia (CML). Accordingly, fluorescence in situ hybridization (FISH) for t(9;22) and polymerase chain reaction (PCR) for *BCR-ABL* were performed on peripheral blood. In addition, karyotype, next generation sequencing (NGS), and flow cytometric immunophenotyping were performed on bone marrow aspirate.

Review of the bone marrow aspirate showed left shifted granulocytes with dysplasia to include pelgeroid neutrophils (Figure 1B), abnormal nuclear lobulation, abnormal cytoplasmic granules, and cytoplasmic hypogranulation (Figures 1C, 1E); dysplastic erythroid precursors with nuclear budding and basophilic stippling (Figures 1D-E); and megakaryocytes with nuclear hyperchromasia (Figure 1F). No significant increase in blasts was identified. Iron stain revealed decreased iron stores with ring sideroblasts (about 15%). The bone marrow biopsy was hypercellular with trilineage dysplasia and grade 2 reticulin fibrosis.

Flow cytometric immunophenotyping of the aspirate revealed a small population of aberrant myeloblasts (2.0%) with expression of CD34, CD117, CD13 (intermediate homogeneous), CD33, CD38 (variable), and HLA-DR (bright homogeneous). The granulocytes otherwise showed features of left-shifted hyperplasia with mild abnormal maturation pattern. Monocytes were minimal. The lymphocytes showed unremarkable immunophenotype. FISH for t(9;22) and PCR for *BCR-ABL* were negative. Considering the negative t(9;22) result, a Philadelphia chromosome-like (Ph-like) FISH panel was subsequently performed at the clinician's request and was also negative. Conventional karyotyping demonstrated no chromosomal abnormalities in 20 analyzed metaphase cells. NGS panel revealed mutations in *ASXL1*: p.W898Yfs*9 with a variant allele frequency (VAF) of 28.0%; *JAK2*: p.V617F†, VAF:42.0%; *NF1*: p.V2391F, VAF:5.63%; and *SF3B1*†: p.K666N, VAF:48.0%.

As CML is defined by the presence of the *BCR*::*ABL1*fusion resulting from t(9;22)(q34;q11), with negative FISH and PCR results, CML was excluded. The combination of leukocytosis (i.e., a proliferative process) and pronounced dysplasia was suggestive of the broad category of myelodysplastic/myeloproliferative neoplasms (MDS/MPN). Initially, atypical CML (aCML) was considered in the differential diagnosis. However, given that the NGS panel demonstrated high VAF mutations in *JAK2* and *SF3B1*, the likelihood of atypical CML was lowered in the differential diagnosis. Other MDS/MPN entities were therefore considered, including MDS/MPN with *SF3B1* mutation and thrombocytosis and MDS/MPN, not otherwise specified (NOS).

MDS/MPN with *SF3B1* mutation and thrombocytosis is defined as a MDS/MPN characterized by an *SF3B1* mutation, anemia, and sustained thrombocytosis. In light of the patient's documented thrombocytosis in 2018, MDS/MPN with *SF3B1* mutation

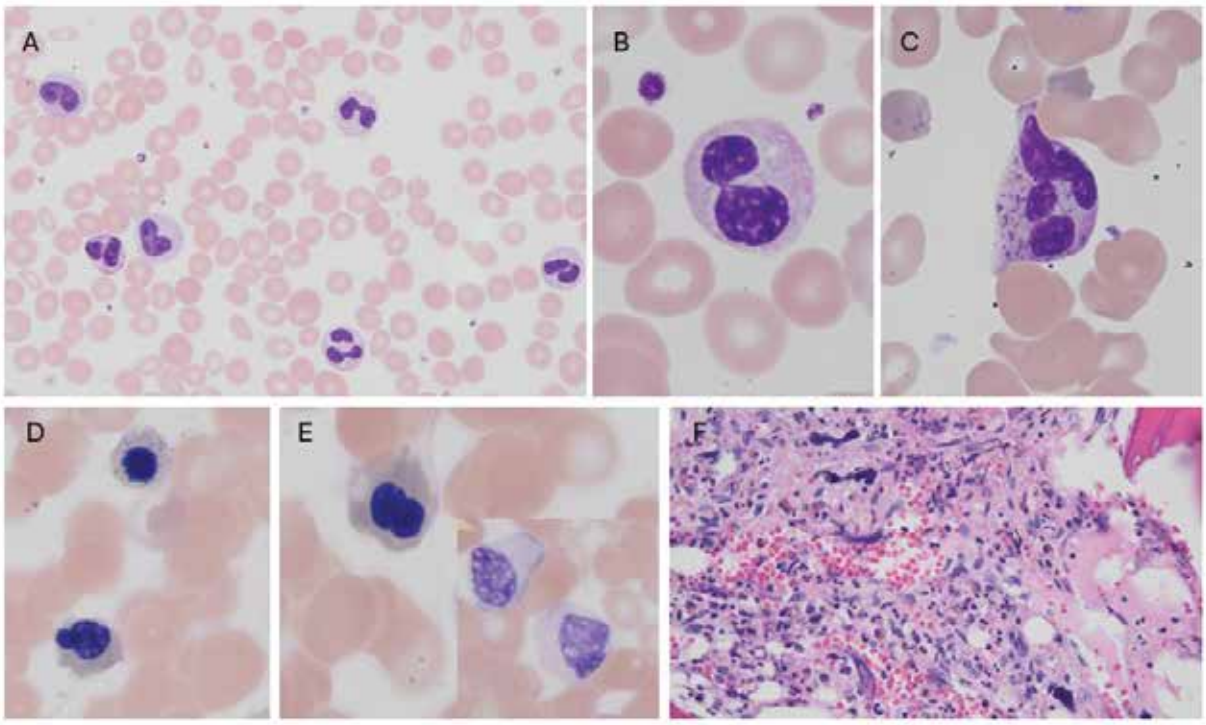


*Figure 1. Dysplasia in peripheral blood (PB) and bone marrow aspirate (BMA). 1A: PB pelgeroid neutrophils 200X; 1B: BMA Pelgeroid neutrophils X1000; 1C: Neutrophil with abnormal lobulation and abnormal cytoplasmic granules X1000; 1D: NRBC with basophilic stippling and nuclear budding X600; 1E: NRBC with nuclear budding; granulocytes with cytoplasmic hopogranulation X600; 1F: Fibrotic hypercellular marrow with myeloid hyperplasia and hyperchromasia of megakaryocytes X100.*

and thrombocytosis remained under consideration despite the advanced presentation with marked leukocytosis and massive splenomegaly without thrombocytosis. Specifically, the possibility that the disease course evolved from thrombocytosis to thrombocytopenia was considered. Findings supportive of MDS/MPN with *SF3B1* mutation and thrombocytosis included the coexistence of an *SF3B1* mutation (VAF 48%) and a *JAK2* mutation (VAF 42%), along with about 15% ring sideroblasts. However, arguing against this diagnosis was the absence of anemia in 2018 and the lack of persistent thrombocytosis at the time of the most recent admission.

The general picture of MDS/MPN include the well-characterized chronic myelomonocytic leukemia (CMML) as well as rarer entities such as MDS/MPN with *SF3B1* mutation and thrombocytosis, as defined in both the 5th edition of the World Health Organization (WHO) classification and the International Consensus Classification (ICC). Atypical CML has been renamed MDS/MPN with neutrophilia in the 5th WHO classification, whereas the ICC retains the terminology aCML, *BCR::ABL1*-negative. Previously the WHO considered juvenile myelomonocytic leukemia (JMML), a hematopoietic stem cell-derived myeloid neoplasm of early childhood with at least 90% of cases characterized by dysregulated activation of the RAS pathway, to be a MDS/MPN. Now the ICC classifies JMML as a "pediatric and/or germline mutation" associated disorder, and the 5th WHO categorizes JMML as a MPN. In this framework, JMML is grouped alongside more familiar entities such as CML, polycythemia vera (PV), essential thrombocythemia (ET), etc. Like in our case, MDS/MPN, not otherwise specified (NOS) is a clonal myeloid neoplasm with overlapping MDS and MPN features that does not meet criteria for another defined MDS/MPN, MDS, or MPN entity. For this entity, the ICC applies stricter proliferative criteria (numeric leukocytosis and/or thrombocytosis thresholds), while WHO 5th edition allows greater flexibility and relies more on integrated morphologic, clinical, and molecular assessment without fixed proliferative cutoffs.

Per ICC, the diagnostic requirements for MDS/MPN, NOS include cytopenia(s) (per MDS thresholds), <20% blasts in blood and bone marrow, thrombocytosis (platelets ≥450 thousand/mm$^3$) and/or leukocytosis (WBC ≥13 thousand/mm$^3$), and evidence of clonality by cytogenetic abnormality or somatic mutation. In the absence of demonstrable clonality, persistence of findings and exclusion of secondary causes are required. *BCR::ABL1* and other defining genetic abnormalities, such as those associated with eosinophilia and tyrosine kinase fusions, t(3;3), inv(3), or isolated del(5q), must be excluded. Our case meets the above diagnostic criteria. Comprehensive molecular testing is recommended to rule out other myeloid neoplasms, particularly advanced MPN with secondary dysplasia. Specifically, the presence of a *JAK2* mutation necessitates

careful clinicopathologic correlation and longitudinal review. As stated above, extensive review of this patient's electronic medical record did not reveal definitive features diagnostic of a MPN such as PV or ET.

MDS/MPN, NOS typically presents in older adults (median age ~70 years) with male predominance and heterogeneous clinical features, including splenomegaly, constitutional symptoms, and cytopenia-related manifestations. Approximately half of cases show cytogenetic abnormalities (e.g., trisomy 8, –7/del(7q), del(20q), or complex karyotype). Common mutations include *ASXL1, SETBP1, NRAS, TET2, RUNX1*, and *CBL*. Prognosis is poor, with a median overall survival of 12–24 months; leukemic transformation (≥20% blasts) is a major adverse event.

## Questions:

1. A 60-year-old male presents with abdominal pain and work up revealed splenomegaly along with leukocytosis due to neutrophilia with left shift. Dysgranulopoiesis was noted. Which aberration should make the astute pathologist give the most consideration to an advanced myeloproliferative neoplasm over MDS/MPN?
   a. *CSF3R*
   b. *ASXL1*
   c. *DNMT3A*
   d. *CALR*
   e. *EZH2*

2. Which feature below is most important when distinguishing aCML from CML?
   a. Presence of dysgranulopoiesis
   b. Lack of basophilia
   c. Lack of *BCR::ABL*
   d. Presence of >10% blasts
   e. Severe constitutional symptoms

3. A 60-year-old patient presents with splenomegaly and leukocytosis with neutrophilia without pronounced left shift or dysgranulopoiesis. Which mutation below would yield very strong support for chronic neutrophilic leukemia?
   a. *CSF3R*
   b. *ASXL1*
   c. *TET2*
   d. *RAS*
   e. *SETBP1*

## References:


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Arber DA, Orazi A, Hasserjian RP, *et al*. International Consensus Classification of Myeloid Neoplasms and Acute Leukemias: integrating morphologic, clinical, and genomic data. *Blood* 2022;140(11):1200–1228.

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## Answer Key:

Question 1: D; Question 2: C; Question 3: A.

# Get to know your GAP Board of Directors and Committee Members

*Author: Natasha M. Savage, MD, FCAP*

Natasha Savage (NMS), Hematopathologist at the Medical College of Georgia (MCG), serves as the Secretary/Treasurer for the Georgia Association of Pathology (GAP) and recently had the opportunity to interview members of GAP's Board of Directors as well as Committee Members. Below are her findings from these interviews.

**Question 1:**

**What is a typical day in your life as a pathologist?**

James Sikora (JS), Transfusion Medicine at Emory & GAP Board of Directors: My days as a blood banker in clinical pathology are mostly spent directing the blood bank and communicating with teams in the hospital that are transfusing blood products. In the lab, I am responsible for reviewing policies and regulatory documents as well as interpreting testing results. I then discuss the results with the front-line teams to make sure that patients are getting the blood products that they need in a safe manner.

Qun Wang (QW), Cytopathologist and Surgical Pathologist (Breast and GYN) at Emory & GAP Board of Directors: A typical day involves reviewing surgical pathology and cytology cases, integrating clinical and radiologic information, and rendering diagnoses that directly impact patient care. I also spent time teaching and participating in multidisciplinary tumor board discussions. Every day brings new challenges that keep the work engaging and rewarding.

Lara Harik (LH), Surgical Pathologist (GU) at Emory & GAP Board of Directors/Prior GAP President: A typical day is usually a mixture of clinical cases and consultations, administrative responsibilities, and academic activities to include teaching and research.

Dean Joelson (DJ), Private Practice Pathologist/Jack of All Trades & GAP Board of Directors/Previous GAP President: A typical day is not typical. It's the practice of medicine, and there is always a new challenge. But I sign out, gross, offer clinical consultations, deal with clinical laboratory issues, go to meetings, and try to squeeze in time to do all of the other (non-medical) things that need to be taken care of in life.

**Question 2:**

**Why did you choose pathology as a career?**

**QW:** I chose pathology because it allows me to understand disease at a fundamental level and plays a critical role in patient care. I was drawn to the intellectual challenges, diagnostic problem-solving, and the breadth of the field. Pathology offers a lifelong opportunity for learning and growth.

Mei Zheng (MZ), Hematopathologist at MCG & GAP News Editor: I chose pathology because it combines medicine, problem-solving, and scientific research while allowing me to impact nearly every patient's care. I enjoy being the physician behind the diagnosis.

**LH:** I stumbled on Pathology serendipitously when I was deciding on my specialty. I always loved using the microscope and love solving mysteries by using all the clues to get to the diagnosis. Pathology bridges the clinical world with experimental/research world and I am passionate about both.

**JS:** Pathology, specifically clinical pathology, attracted me because of the unique position between the laboratory and the patient. I have always loved working in labs throughout my education, and I enjoy interacting with all the different teams in the hospital. Clinical pathology was the perfect spot to have both of these.

**DJ:** I chose pathology because it wasn't like the rest of medicine. I realized pretty early in my third year that direct patient care wasn't for me, but pathology gave me the opportunity to still be an integral part of the clinical team. It was everything I liked about medicine with much less of what I didn't like.

**Question 3:**

**What is your favorite and least favorite things about being a pathologist?**

**QW:** My favorite part of being a pathologist is solving complex cases and contributing essential information that guides patient management. I also greatly value teaching and mentoring the next generation of pathologists. My least favorite aspect is the increasing administrative workload that can compete with time for diagnostic and academic work.

**JS:** My favorite part of being a pathologist is forming relationships with other healthcare workers throughout the hospital. Forming these bonds and facilitating communication is rewarding. The part of pathology that I do not enjoy is navigating the institutional obstacle course that is sometimes required to introduce new initiatives. I am learning more and more about it every day, hopefully it will become easier.

**DJ:** My favorite part of the job is putting together pieces of a puzzle to come up with a coherent diagnosis. I also enjoy the collaborative aspect of the job—I interact with just about every physician in the hospital, and those relationships are incredibly fulfilling. My least favorite part is the fact that I'm always on call. Always.

**LH:** Most favorite is contributing in a central way to patient diagnosis and treatment. Least favorite is some tasks are tedious, repetitive, and time consuming- a great opportunity for AI to assist in the future.

Pat Godbey (PG), Private Practice Pathologist/Jack of All Trades including Advocacy & GAP Board of Directors/Previous CAP President: One of the best things about practicing AP/CP pathology is that I get to interact with all the other specialties. That's fun to me. I have already talked with an internist, surgeon, pulmonologist, ED physician, dermatologist, ENT, and radiologist today.

**Question 4:**

**If you were to have a different career in a fantasy world, what would it be and why?**

**QW:** In a fantasy world, I would be a writer or historian. Both involve careful observation, analysis, and telling meaningful stories, skills that closely parallel what we do in pathology.

**LH:** I would be an artist, painting and creating.

**JS:** In a fantasy world, I would be an explorer. I love meeting new people, seeing different cultures, and experiencing things that are new to me. Any kind of travel whether by land, air, or sea would bring joy to me.

**DJ:** I would own a conifer nursery. And sell people plants they didn't know they wanted.

**MZ:** In a fantasy world, I would be a master of color and form, crafting powerful works of art reminiscent of Van Gogh's Starry Night and Picasso's Guernica. This path reflects my love for discovering patterns and my deep desire for boundless artistic freedom.

**NMS:** Forgive this author but I had to chime in. When I am dealing with challenging situations, I frequently daydream about this fantasy career. I am a book editor – any book from trashy novels to great pieces that will be read years from now in some prestigious college's lit class. I am at home in my pajamas with my schnauzer next to me. Somehow my editing only involves the book, me, the schnauzer, a piece of paper, and a pencil (no computer or other technology in sight) as well as my favorite blanket, cozy chair, and coffee (glass of Bordeaux blend after 7 PM). Weirdly, there are no deadlines and somehow my edits are always exactly what is needed. OK, back to work (honestly, I can't complain as it is truly the best career out there).

**Question 5:**

**Why did you become a member and leader of GAP?**

**QW:** I became involved in GAP because of its strong sense of community, commitment to education, and dedication to supporting pathologists throughout their careers. Serving as a leader allows me to give back to the profession and help foster mentorship, collaboration, and growth within our field.

**JS:** I wanted to join and help lead GAP to help bridge the divide between academic and private practice pathologists and clinical and anatomical pathologists. Becoming more aware and active in the political arena was another reason.

**LH:** State societies are an essential component of building a pathology community. Pathologists in the same state share patients and laboratory circumstances. I believe it is important to work together to make sure that 1) pathologists' expertise is protected, 2) pathologists are adequately reimbursed, and 3) pathologists retain governance of their laboratories.

**DJ:** I go way back in the GAP, and, at the beginning, it was an opportunity to build something and create a valuable resource and engine for advocacy for the pathologists in Georgia. At some point, it just gets into your bones, and now the GAP is kind of a home away from home.

**Question 6:**

**What was your favorite thing about GAP annual this year?**

**DJ:** My favorite thing about GAP this year is my favorite thing every year—the opportunity to see, meet, and reconnect with pathologists across our state. Also, it's neat meeting the residents and medical students who are the future of our profession.

**JS:** My favorite part of the annual GAP meeting (this year and all the others I have attended) is meeting new pathologists in Georgia and reconnecting with those that I have met in the past. It is great to catch up and share knowledge.

**QW:** My favorite part of the GAP Annual Meeting was the opportunity to serve on the Organizing Committee and Abstract Review Board, reconnect with colleagues, friends, and trainees, and engage in high-quality educational sessions. The enthusiasm, collegiality, and shared passion for pathology made the meeting especially memorable.

# 2026 GAP Abstracts: Winners Recognized

*Author: Natasha M. Savage, MD, FCAP*

This year, GAP leadership was privileged to review almost 20 abstracts for our annual GAP conference held in Atlanta, Georgia. These abstracts reflected the outstanding work of our colleagues to include our Georgia pathology residents as well as medical students.

Four abstracts were selected to be orally presented as part of our Annual Educational Conference on Saturday, January 10, 2026. These included: A Multi-Scale Clinical and Genomic Framework to Characterize Ovarian Cancer Disparities in Georgia, presented by Navya Katragadda and Labdhi Mehta (MCG students); Exploring the Validation of Bone Marrow Biopsies using a Digital Pathology System Approved for FFPE Cut Sections, presented by Yeon-Whan (Joe) Choe (Emory resident); Age Matters: Genomic & Immune Features of Pancreatic Ductal Adenocarcinoma by Age, presented by Sarah Mai (MCG student); and Salivary Gland Fine Needle Aspirations Showing Bland Oncocytes are Associated with a Low Risk of Neoplasia and Good Prognosis, presented by Seniha Irem Sahin (Emory resident).

The remaining abstracts were presented as posters. For many of us, reviewing and watching these posters and presentations was a highlight of the meeting as it assured us the future of pathology is in good hands.

Although it was challenging given the high quality of work observed in the aforementioned posters, GAP annual attendees chose three poster winners; their abstract introductions are highlighted below.

### 3rd place: Denton Lord (MCG student)

**Title:** "The integration of Pathology and Clinical Informatics: Building Pathology-Driven Data Extraction Protocols in Precision Oncology Research"

**Introduction:** With pathology-driven data serving as the foundation of precision oncology decision-making, efficiently extracting this data becomes crucial to creating high-quality research for these patient populations. This study identifies and synthesizes best practices in formulating retrospective chart review protocols in precision oncology, allowing for extraction of pathologist-reported and laboratory-generated data such as genetic profiling and immunohistochemistry (IHC) assessment.

The utilization of electronic medical records (EMRs) for retrospective chart review (RCR) research is one of the most common ways to efficiently produce data in the EMR era. In precision oncology research, RCR methodologies are effective for various reasons: they are inexpensive, require few resources, and do not necessitate an intervention. Additionally, utilizing the granular information obtained from pathology assessments, these methods create the opportunity to analyze these therapies directly alongside the pathologist's clinical assessments that informed decision-making. With this opportunity there is a major obstacle at hand: pathology report structures are inconsistent and variable among the variety of EMRs available. For these reasons, there is a call to create standardized procedures to ensure that the desired information is extracted both as efficiently and as accurately as possible. This study identifies the best practices of manually extracting data for precision oncology research, as well as details the gaps in traditional cancer research that this protocol addresses.

### 2nd place: Francisco Avila (Emory resident)

**Title:** "Uterine Extramedullary Hematopoiesis: A Case Report and Review of the Literature"

**Introduction:** Extramedullary hematopoiesis (EMH) refers to the formation of trilineage hematopoietic cells outside of their normal location in the bone marrow. Although rare, multiple reports have described EMH within the gynecological tract (EMHGT). We present a case of EMHGT in a patient with essential thrombocythemia (ET) and provide a review of the current literature.

### 1st place: Sarah Monteiro (Mercer student)

**Title**: "Unusual Presentation of *CDH1* Mutation in a Male and Clinical Implications"

**Introduction:** Germline *CDH1* (E-cadherin) mutations are previously established to have a high lifetime risk of hereditary diffuse gastric cancer (HDGC) and, in females, lobular breast cancer (LBC). Current guidelines recommend endoscopic surveillance for those at risk and annual breast imaging starting at age 30 for females. However, screening practice still remains variable, often being tailored to individual patient presentations, making certain associations (male LBC or prostate cancer) poorly characterized in literature. We report the case of a 72-year-old male with a pathogenic *CDH1* germline variant who, within the span of one year, was diagnosed with prostate adenocarcinoma, lobular breast carcinoma, and gastric adenocarcinoma.

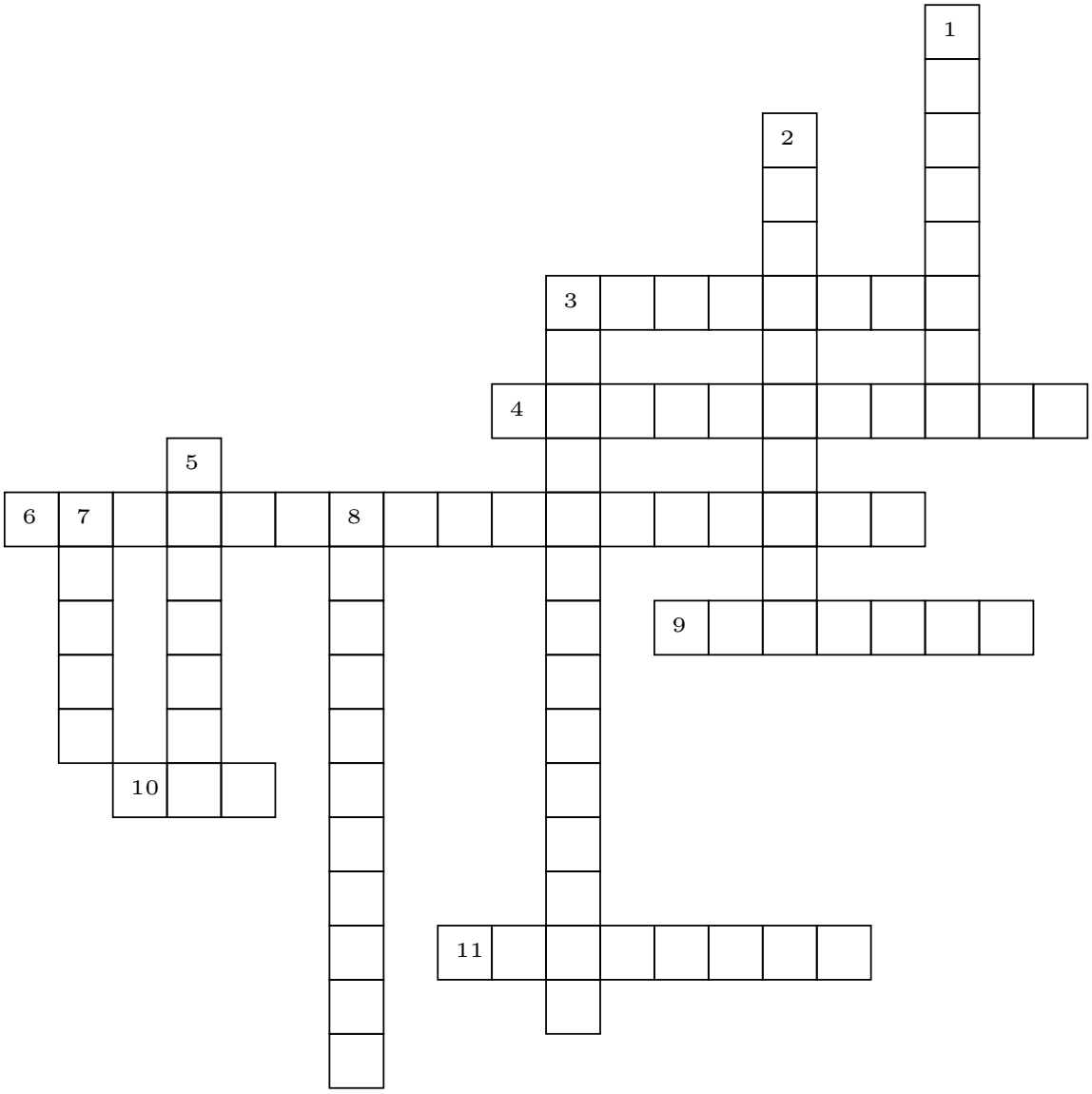
# Pathology Crossword

### Across

3. Branch of pathology that traditionally includes surgical, cytology, and autopsy
4. Purple/blue nuclear stain used in histology
6. Pathologist most likely to say anisopoikilocytosis
9. Post-mortem examination to determine cause of death
10. The best state society whose former president is Lara Harik and current president is Keith Stevens
11. Malignancy of lymphoid tissue

### Down

1. Branch of pathology that traditionally includes chemistry, hematology, microbiology, and transfusion medicine
2. Specialist who evaluates cells for diagnosis
3. Malignant tumor arising from glandular epithelium
5. Malignancy arising from connective tissue
7. Pink/red dye used in H&E staining
8. Physician who diagnoses disease by examining tissues, cells, and fluids



# Pathology Word Find (20x20)

**Find these words:**

ADENOCARCINOMA
ANATOMIC
AUTOPSY
CLINICAL
CYTOLOGIST
EOSIN
GAP
HEMATOPATHOLOGIST
HEMATOXYLIN
LYMPHOMA
PATHOLOGIST
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# Introducing GAP's New Resident Committee Chair

*Author: Natasha M. Savage, MD, FCAP and DIO at MCG*

GAP has been fortunate to have Dr. Ekaterina Menshikova serve as our Resident Committee Chair. She is a current fourth-year AP/CP resident and chief resident at Emory. We thank her for her significant contributions and wish her well in all future endeavors, pathology-related and otherwise. GAP Board of Directors received submissions from numerous residents interested in serving as the next Resident Committee Chair; we selected Madison (Maddie) Cassell. Below is a brief bio followed by some Graduate Medical Education (GME) stats from a GME nerd and DIO (Designated Institutional Official) at the Medical College of Georgia (MCG).

Maddie is a first-year resident at MCG in Augusta, Georgia. She was born and raised in Springfield, Missouri, but the South is now her home. Maddie moved to Tennessee for college, playing volleyball at UT-Chattanooga. She quickly fell in love with the Smoky Mountains and hiking during her four years there. She then moved further south to Columbia, South Carolina to complete a master's degree in biomedical sciences, followed by medical school at the University of South Carolina School of Medicine-Columbia. She met her husband in medical school, and they were fortunate enough to couples match last March (he is a PGY-1 anesthesiology resident). Outside of the hospital, they love spending time with their families and kitten (Wellington), as well as working in their home and yard. Maddie is a self-proclaimed old soul who loves to garden, read historical fiction and American history (she love Thomas Jefferson and Abraham Lincoln), and spend intentional time with her people. She is looking forward to meeting everyone at GAP and is excited for this opportunity and all it may bring. MCG already loves her, and the state is blessed to have her and our other amazing pathology residents and fellows who are truly our future.

GAP quickly acknowledged that to be successful, they had to ensure the success of Georgia's pathology residents and fellows. To help support this success, they granted free GAP membership to interested Georgia pathology residents/fellows and establish a Resident Committee so their voices could be heard. We hope that early GAP involvement shows them the rich career opportunities in Georgia along with a network of seasoned colleagues eager and able to support their future development.

In 2024-2025, there were 142 ACGME-accredited pathology residencies in the US and 518 fellowships. In Georgia, there are only two ACGME-accredited pathology residencies, Emory and MCG. Emory is ACGME approved for 36 residents and was first accredited in 1952. MCG is ACGME approved for 14 and was first accredited in 1958. MCG has an ACGME-accredited forensic pathology fellowship and Emory has multiple ACGME-accredited pathology fellowships (e.g., 3 selective pathology, forensics, hematopathology, cytology, medical microbiology, transfusion medicine, pediatric, neuropathology, dermatopathology, molecular genetic). Morehouse also sponsors an ACGME-accredited forensic pathology fellowship. Finally, MCG and Emory support several non-ACGME accredited pathology fellowships. These high functioning GME programs are keys to our future success in ensuring Georgians have access to well-trained and connected pathologists. GAP is committed to support these keys to success.

# Introducing GAP's New Education Committee Chairs

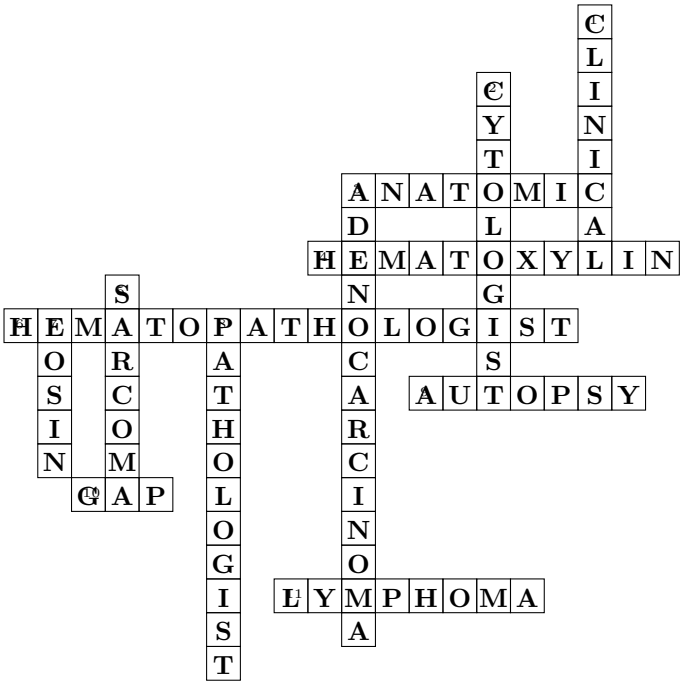
*Author: Natasha M. Savage, MD, FCAP*

GAP has been fortunate to have Dr. Faisal Saeed serve as our Education Committee Chair. During his tenure, he oversaw our Annual GAP meetings which provided our members with excellent educational content as well as networking opportunities. Although he will continue to serve as a GAP Board Member, he is passing the torch of Education Committee Chair to two highly capable individuals. Below is a bit about our new Co-Chairs. We look forward to the excellent Annual Meetings which will transpire under their leadership.

Brooj Abro, MD, is an Assistant Professor of Pathology and Laboratory Medicine at Emory University School of Medicine, where she serves as Associate Program Director for the Pathology Residency Program and Associate Director of the Hematology Laboratory. She is board-certified in Anatomic and Clinical Pathology and Hematopathology. Dr. Abro earned her medical degree from Aga Khan University in Karachi, Pakistan, and completed her residency and hematopathology fellowship at Washington University in St. Louis, where she also served as Chief Resident. She has authored multiple peer-reviewed publications, contributed to book chapters, and served as lead editor of *The Washington Manual of Hematopathology*. She has been recognized for her contributions through several honors, including selection as a 2025 ASCP 40 Under Forty honoree and recipient of the 2025 Educator Impact Award from the Department of Pathology at Emory University. Dr. Abro is active in national and regional professional organizations and serves on various committees within the American Society for Clinical Pathology (ASCP), the College of American Pathologists (CAP), and the Georgia Association of Pathologists (GAP).

Dr. Sandra Gjorgova Gjeorgjeivski is an Assistant Professor in the Department of Pathology and Laboratory Medicine at the Emory University School of Medicine, where she serves as Rotation Director of the AP Foundations Rotation and Rotation Director of the Bone and Soft Tissue Pathology within the Anatomic and Clinical Pathology Residency Program. She completed residency training at Corewell Health William Beaumont School of Medicine, followed by fellowships in Surgical Pathology at the Mayo Clinic and Bone and Soft Tissue Pathology at the Cleveland Clinic. Dr. Sandra Gjorgova Gjeorgjievski has authored numerous peer-reviewed publications in leading journals, contributed book chapters, including the "Hibernoma" chapter in the World Health Organization ed. *Soft Tissue and Bone Tumours*. 6th edition and "Soft tissue neoplasms" in Abdul-Karim FW, Sturgis CD. *Differential Diagnoses in Surgical Pathology Tumors and Their Mimickers*. Her excellence in teaching and service has been recognized with multiple institutional awards, including the Golden Apple Award for best anatomic pathology teacher and the Anna Lee Boyett Award for outstanding support of residency education. She holds active leadership and service roles on national, regional, and institutional committees, including participation in the ISPY2 Pathology Working Group, Pathology Communications Committee and Welcoming Committee of the Department of Pathology and Laboratory Medicine, and serves as the Chair of the Anatomic Pathology Educational Committee at the Department of Pathology and Laboratory Medicine, Emory University School of Medicine.

# Pathology Crossword Answers



# Pathology Word Find Answers

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| Y | Z | V | D | B | O | K | R | V | W | C | I | A | H | Q | L | D | C | H | Z |
| Z | V | U | F | O | R | V | V | L | H | X | Y | X | C | T | O | J | E | G | F |
| D | P | C | C | X | D | I | T | Z | W | L | Y | M | P | H | O | M | A | N | W |
| M | A | A | Y | J | W | G | C | P | L | K | Y | D | D | I | A | C | S | P | N |
| X | D | H | G | W | S | E | P | D | J | N | A | S | N | T | U | I | P | O | B |
| J | E | Z | E | N | M | C | A | D | Y | M | V | N | O | H | T | O | S | K | O |
| W | N | L | Q | P | X | S | W | N | O | R | F | P | E | C | T | F | L | G | T |
| L | O | N | I | P | P | P | D | C | A | R | A | M | Z | O | S | R | A | Y | Y |
| W | C | E | A | B | H | B | R | P | E | T | A | U | G | T | I | R | C | P | U |
| E | A | F | Z | Y | E | A | L | Y | H | T | O | S | P | R | G | B | I | L | C |
| O | R | L | R | V | S | E | P | O | O | O | U | M | U | F | O | M | N | C | Y |
| S | C | U | E | F | M | V | L | X | A | E | Q | E | I | A | L | H | I | G | T |
| I | I | K | T | R | U | O | Y | K | V | Z | G | A | K | C | O | Z | L | F | O |
| N | N | I | B | B | G | L | E | D | A | L | U | M | A | R | H | N | C | X | L |
| G | O | C | X | I | I | G | Z | U | U | F | P | F | P | J | T | E | W | D | O |
| W | M | N | S | N | S | R | F | J | H | V | Z | N | V | H | A | X | A | W | G |
| X | A | T | K | W | F | N | D | B | J | V | K | N | D | H | P | S | A | B | I |
| A | U | T | O | P | S | Y | S | M | V | M | M | T | J | I | W | M | X | Q | S |
| S | R | J | R | O | T | H | H | Z | N | Q | O | U | M | R | U | D | S | D | T |
| Q | I | R | J | G | N | T | D | L | I | F | A | A | B | K | J | V | N | X | O |

**Words:**

ADENOCARCINOMA
CLINICAL
GAP
LYMPHOMA
ANATOMIC
CYTOLOGIST
HEMATOPATHOLOGIST
PATHOLOGIST
AUTOPSY
EOSIN
HEMATOXYLIN
SARCOMA