differently. Although class II test results appear to be satisfactory, class I test results show very heterogeneous levels of success with different IHC tests/antibodies, ranging from <40% to near 90% with most tests being suboptimal. More extensive PT testing needs to be developed for class I tests, which account for a great majority of clinically used IHC tests.

### CANADIAN IMMUNOHISTOCHEMISTRY QUALITY CONTROL (CIQC): AN ACADEMIC PROGRAM PROVIDING PROFICIENCY TESTING TO CANADIAN CLINICAL IMMUNOHISTOCHEMISTRY LABORATORIES. M. Copete, J. Garratt, B. Gilks, D. Pilvadzic, E. Torlakovic. U Saskatchewan, Lions Gate Hospital, BC, U British Columbia, General Jewish Hospital and McGill U, Que, U Toronto, Ont.

External quality assurance (EQA) is an important component of quality control/quality assurance measures for clinical laboratories, and it includes immunohistochemistry (IHC) testing. Although it is essential for proper IHC test calibration, only a few programs offer proficiency testing (PT) to clinical laboratories. Recently, the Canadian Immunohistochemistry Quality Control (CIQC) was created to support EQA for clinical IHC testing. It is an academic program affiliated with the Canadian Association of Pathology and provides several challenges in both class I and class II IHC tests. Tissue microarray (TMA) design is used by the CIQC for PT. Ten runs have been completed since inception. Unstained slides from TMA blocks are sent to participants. The stained slides are returned to the CIQC, which scans all results for digital/virtual microscopy, performs expert assessment by the team of pathologists, and performs statistical analysis to provide information on kappa values and concordance with reference results. Although class II test results appear to be satisfactory, class I test results show very heterogeneous levels of success with different IHC tests/antibodies, ranging from <40% to near 90% with most tests being suboptimal. More extensive PT testing needs to be developed for class I tests, which account for a great majority of clinically used IHC tests.

### NEONATAL TEETH IN 6-WEEK-OLD BABY WITH BILATERAL CLEFT LIP AND PALATE. CASE REPORT AND REVIEW OF THE LITERATURE. C. Haberland, J. Persing. Yale–New Haven Hospital, Conn.

The presence of teeth at birth or shortly thereafter is rare. We present a 6-week-old Hispanic baby girl with a nonsyndromic bilateral cleft lip and palate with a neonatal tooth on the right maxilla adjacent to the cleft. Clinically, the tooth had yellow dysplastic enamel, gingival inflammation, and mobility. An occlusal radiograph showed a calcified tooth-like structure lacking a root, and a second outline of a tooth structure apical to it. Owing to feeding difficulties, the tooth was extracted. One week later, the patient presented with an erupted second tooth-like structure at the previous extraction site. This tooth was also extracted. Review of the literature showed that natal teeth occur more frequently (3:1) than neonatal teeth. Overall, the incidence of natal/neonatal teeth is between 1:8,000 to 1:10,000 in patients without orofacial clefts. However, natal/neonatal teeth have been reported to occur in 2% of patients with unilateral cleft lip and palate and in 10% of patients with bilateral cleft lip and palate. Clinically, the teeth usually appear with an opaque yellow-brown irregular enamel and are mobile. Histologically, they present with dysplastic and/or hypomineralized enamel, irregular dentinal tu-