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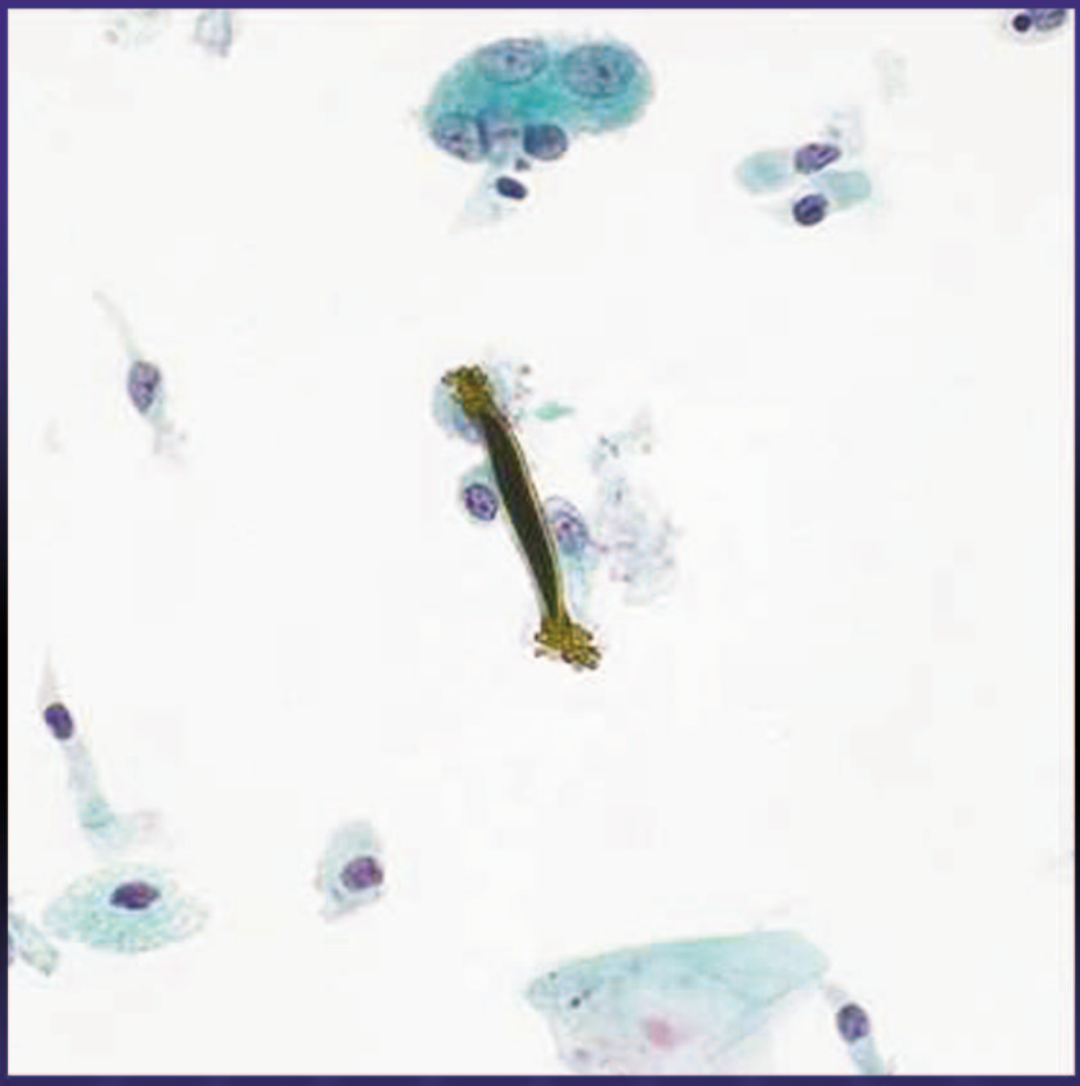

BAC British Association for Cytopathology

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please see inside back cover for co-opted members

Editorial

Sharon Roberts-Gant

This edition gives us an international feel with Alison and Paul sharing the Madrid ECC meeting and Hedley updating us on cervical screening in Moldova.

As you can image there is a lot of discussion on the national front with the impending changes to the cervical screening programme, the BAC are supporting the cytology community with the 'Preparing for the Future' day meeting on the 13th October in Nottingham. Alan also discusses the future roles for those working in Cytology, the UK is not the only country looking at the needs of pathology and how we may develop to help deliver the future service, Alan brings together some of the roles that are being considering internationally and those that would help here in the UK. The BAC has opened a Twitter account, the social media platform opens up a mechanism for easily sharing educational material and discussion, read all about it on page 16. There are a couple of educational articles as well as the chance to do some JBL and David Carter shares his Trade Liaison experience with us.

The next edition is April 2019 by which time the bids for HPC primary screening across England should have been evaluated. There are many working hard to prepare proposals for consideration as a provider for the future service, others trying to manage with insufficient staffing and rising backlogs and all of us are very concerned with the uncertainty of the future, I sincerely hope that this situation is remedied within the next few months and that we can all start to look forward to a positive future.

Thank you to all of the contributors in this edition.

Sharon

Editor: Sharon Roberts-Gant

Copy date for April 2019: 5th February 2019.

INFORMATION FOR CONTRIBUTORS

Articles for inclusion in SCAN can be emailed to the editor if less than 1MB in size or supplied on CD/DVD or memory stick. Text should be in a standard text format such as a Word document or Rich Text Format (rtf file). Please supply images as separate files in tiff or high quality jpeg files at a resolution of not less than 300 dpi (600 dpi if the image includes text). 35mm slides and other hard copy can be supplied for scanning if no electronic version is available. Graphs are acceptable in Excel format.

If you are unable to supply files in the above formats or would like advice on preparing your files, please contact Robin Roberts-Gant on 01865 222746 or email: robin.roberts-gant@ndcls.ox.ac.uk

BAC British Association for Cytopathology

President's Piece

Paul Cross

The long hot summer and excitement of the World Cup are beginning to fade. The strains of "Footballs coming home" are receding…long distant memories. Some of us (and that translates as me) can remember the hot summer of 1976 and have also lived through all three England World Cup semifinals. This shows longevity if nothing else. Sadly it also means I can remember an era of cervical screening when labs routinely had backlogs of 3-4 months, had severe staffing problems and the cervical screening offered to women was not good, something I thought I would never have to live through again. How wrong I was. As I write this England is still working through the fog and lack of clarity around the introduction of primary HPV. We look with envy at the approach used in Wales and Scotland, who have overtaken England in their organisation and announcements of their plans. The BAC is not alone in pushing for decisions. We have been working very closely with the RCPath, IBMS, Jo's Trust and other bodies to push for decisions, clarity and a way forward. The collective voice is acknowledged and heard, but there appears to be an inertia and inability to move forward. And while we wait the ability of many labs to offer the level of service they are used to doing or would wish to gets harder and harder. Increasing turnaround times and rising backlogs are a reflection of this. The BAC has tried hard to help improve the situation, and along with others has given advice that would help alleviate the current problems, and improve the cervical screening offered to women. No one will be happier than me if this is all resolved by the time you read this.

Like many UK based cytology colleagues, I was lucky enough to contribute to and attend the 41st European Congress of Cytology in Madrid in June. Once again delegates from all over the world were educated and informed about many aspects of cytology. You cannot underestimate the amount you can learn from such a meeting. The formal presentations are but part of this, seeing the variation in approach, new innovations and discussing them with keen cytologists from across the globe is so refreshing and educational. The next ECC is in Malmo, Sweden, in June 2019. I would encourage anyone with an interest in cytology to attend. The BAC runs standalone and joint cytology meetings, and again these are excellent ways of maintaining and developing your cytology skills and knowledge. We are already planning meetings for 2019 and beyond. Dates for meetings are advertised in SCAN and on the BAC website (and Twitter - see below!), so keep your eyes peeled for such announcements.

One of the things I have learned over many years and from bitter experience is that good communication is difficult. As an association we have the BAC website and emails and even good old paper letters. We now also have an active BAC Twitter account that can help with rapid and frequent communication. Now I would not say I am a natural Tweeter, but even I have seen how good it can be at sharing information, ideas, links and just thoughts quickly and often in real time. Many members will know this, and will wonder why we have taken perhaps so long to join the modern world of social media. Well we have. So please do look at it, join in, contribute, and share.

There is also much happening around diagnostic cytology. We are inputting into discussions about the training and exam process for Pathologists with the RCPath, and about the guidance for clinical responsibility of cytology services. The updated RCPath Cytology Pathways document should be out for consultation by now, and this will help all of us with the cytology services we offer. We are working with both the IBMS and RCPath in developing the ASD in diagnostic cytology role, through the Cytology Conjoint Board. Some things take time, and not everything we would like to happen will happen. However, we are and will work to promote cytology and cytologists, whatever their backgrounds and skills.

I write this on the train on my way back from another BAC Executive meeting. These meetings are always busy and packed, but to see the enthusiasm and commitment of the Executive members, and their willingness to debate, get involved and volunteer ideas and time to the field of cytology is impressive. I am always grateful to my Exec members for all their dedication. None of us have to take on these roles, but we have all chosen to do so. We all believe in cytology and its use in modern clinical medicine. Long may this continue.

Chairman's Column

Alison Cropper

Six months have passed since the cold, snowy, February Sunday when I wrote my first Chairman's column, and I really don't know where the time has gone since. It's now a gloriously hot, sunny August Sunday, and whilst the weather couldn't be any more different unfortunately not a lot has changed on the cervical cytology front with regards to the implementation of primary HPV primary screening.

It is without doubt a time of great frustration and mounting concern for those of us working in cervical screening labs, as many of us contend with sustained high workloads, reducing numbers of staff and increasing backlogs. I have spent considerable amounts of my time at work the last week or so responding to patient complaints and enquiries from the media and MPs about the current TAT in my own lab, and I am sure this is a becoming a familiar situation for colleagues in other labs too. However, we, the staff, will keep the service going during transition because that is what we do best and always have done, but I have to say it is becoming increasingly difficult, and that light at the end of that tunnel some days seems to be moving further away!

I really do hope that by the time this edition of SCAN hits your letter boxes in October that we have some idea and concrete facts about how/when procurement of the new HPV primary screening service is going to happen, and that will give us a solid base on which to begin to rebuild the robust, quality screening programme that we have been so used to working in and is the envy of much of the rest of the world. We had a programme to be rightly proud of and I hope that will continue as we enter the new era.

On other fronts I'm pleased to say there is more positive news!
The ASD in cervical cytology has had its 100th successful candidate, with 3 passes this year. Numbers for this examination and both the DEP and ASD in non-gynae cytology are on the increase which is really good to see. And while numbers are at an all-time low of registrants for the Diploma in Cervical Screening I hear from a number of Cytology Training Centres that numbers are going to be on the increase very soon so, ever the optimist, all is not lost! (Someone said to me today that I was always a 'glass half full'. I'm glad I am; it's what keeps me going.)

The BAC Spring Tutorial held in March was, as ever, hugely successful thanks to Ash Chandra and the team who put together a very well received programme of lectures and practical microscopy sessions. The event was over-subscribed but a similar programme will form part of the IAC symposium that is to be held in London in December at the new Royal College of Pathologists HQ. Booking is now open for that event – details on the BAC website.

Another international cytology meeting, the ECC (last held in Liverpool in 2016 when the BAC hosted the congress), was held in Madrid in June and the BAC held a symposium within that programme. Our speakers focussed on what is happening in the UK with cytology at the moment – primary HPV roll-out, extending roles and alternative educational / career pathways for cytologists.

Building on these themes, and acutely aware of the levels of uncertainty around at the moment, BAC have decided to hold a one day meeting in Nottingham in October, when we hope invited speakers will be able to address some of these concerns and offer suggestions, practical advice and solutions and HR guidance as to what cytologists can / should be doing to prepare for their futures, whether it be remaining in cervical cytology / other Pathology disciplines or changing direction and expanding their career pathways into other areas and roles.

Because we know how important this is to our members there will be no registration fee for this meeting, which will be jointly hosted by the IBMS, which many BAC members are also members of. Both organisations hope as many cytologists as possible, their clinical leads and their managers will be take up the opportunity to attend. Our AGM will now be held in this meeting and not within the IAC in December as originally planned.

We have a short timescale in which to organise this meeting, but Alison Malkin and the meetings sub-committee, along with colleagues from the IBMS, are already well underway with this and I am sure it will be the 'must attend' meeting for many cytologists this year.

One aspect of the meeting we hope it is not too short notice for is our commercial partners, whose sponsorship of our events is invaluable, but this time

it will be the first one for many years that has been organised without David Carter as the BAC commercial partners' representative, and I want to finish this article by publicly thanking David for his years of hard work, commitment, professionalism and dedication to the BAC and NAC beforehand in this role.

As previous chair of the BAC Meetings sub-committee I worked closely with David on many meetings, symposia and conferences, and he never failed to deliver on any aspect of the commercial side to these events, some of which I know would just not have been viable or successful without his input. David stood down at the BAC executive meeting in March and a recruitment process is underway to replace him, which will be difficult as he's left big boots to fill!

The Executive have already thanked David with cards and gifts as tokens of our appreciation, but I think it only right and proper to now thank him publicly, and the photo gallery elsewhere in this edition will, I am sure, remind us what he has contributed to BAC & NAC over the years – not least his fancy dress outfits! Thanks David.

41st European Congress of Cytology, Madrid 10-13th June 2018

Dr Paul Cross, President BAC

After a fallow year in 2017, the 41st ECC was held in Madrid earlier this year. Notwithstanding the quality and content of the scientific meeting itself, Madrid as the venue no doubt helped attract a large turnout of delegates. Whilst again the majority were from Europe (which includes the UK!) there were many speakers and delegates from North America and the Far East also. The venue was a large hotel to the north of the city, not too far from Real Madrid's football ground, although I personally never even got a chance to visit it. The meeting commenced on the Sunday with a plethora of satellite national symposia, and also some national cytology business meetings, as well as the IAC and QUATE examinations. We forgot in the UK that we have a well laid out set of nationally and professionally recognised cytology examinations. This is not the case in many other parts of Europe and further afield, and qualifications like the ones offered by the IAC and EFCS (QUATE) are the only way of objectively demonstrating competency and skills attainment. The meeting officially opened that night, and after a drinks reception delegates drifted away to catch up on gossip or sample the night life.

Membership recruitment in Madrid

Over the next three days the meeting was in full flow. Parallel sessions meant that many decisions had to be made about what to take in, and on several occasions this was a hard choice. I took in as many cervical cytology and HPV related sessions as I could. It was fascinating to see the approach used across Europe, and the varying states of delivery of cervical screening programmes. Those that had, or were moving to implement an HPV primary service, as we are in the UK, had had very similar issues to the ones we are and will face. Some spoke of success, but in many the path to implementation had been hard, and not without hiccups. Was there much we can learn? Yes, in part, but the differing health delivery models and laboratory set ups did shape how and what could be done. However, again we must not forget that many countries have no plans currently to make such a move, and still rely on conventional non-LBC Pap smears.

One developing theme of international cytology meetings is to try and develop consensus cytology systems for terminology and reporting. Bethesda has cervical and thyroid, Paris has urine, Milan salivary and now Madrid was making a move for serous fluids. This was played out formally in the open sessions, but with much behind the scenes discussion about this also. Whilst this sort of approach must be the way forward I feel, one cannot underestimate the strong differing national and personal views about this approach, including which city the system may be named after. Despite issues, the meeting did back a move to try and develop such a system. This will take a year or so, but be aware that it will appear one day. One observation is that there aren't many tissues or body sites left to develop systems for! One session I really enjoyed was the plenary session on the revised Bethesda Thyroid cytology reporting system. In summary the basic classifications have not changed, but the analysis of the use and risk of malignancy for each category has been updated. The talk was a very good and easy to follow explanation of the system and its use. It was gratifying to see its comparability with the other world thyroid cytology systems, including the RCPath Thy one.

The BAC had a session one afternoon, and covered a range of topics, from HPV to EBUS. A relatively small but enthusiastic audience was present, with interesting discussions post talks. More on this elsewhere.

Thyroid ECC

The commercial stands were very accessible and well visited. Seeing new kit and commercial ideas, speaking with knowledgeable company representatives and acquiring literature (and pens!) was also useful. Food was served, often in grab boxes, so people could attend sponsored

Trade ECC

lunchtime meetings. The posters were all viewable on electronic poster boards spread around the room, and specific ones could be called up if desired - all very high tech to a traditional poster man like me.

The ECC is also used as a chance to hold a meeting of the EFCS members and the national societies affiliated to the EFCS, of which the BAC is the UK one. On this occasion Martin Totsch had completed his term of office, and after a vote Beatrix Cochand-Proillet was elected as the new EFCS President. Beatrix is probably best known for her scientific work, but she is also very active politically with cytology internationally.

The meeting finished late on the Wednesday. I was speaking in what was one of the very last sessions, and had the unusual experience of having both the Chairs for the session having to leave to catch planes, and so shortly after this the session, and also the meeting, closed.

Once again I found the mix of scientific topics and sessions informative and educational. A few points sank in and came home with me. The ability to catch up with colleagues from the UK and around the world is great, and much is learnt over coffee and biscuits. The 42nd ECC meeting is being held at Malmo, in Sweden, 16-19th June 2019. Put in your diaries now.

Case Presentation

Dr Nwamaka Ikpa, Histopathology ST5
Aberdeen Royal Infirmary

FNAC of subcutaneous nodule—a potential diagnostic pitfall.

Fine-needle aspiration cytology (FNAC) can be a valuable preoperative diagnostic investigation of skin lesions and subcutaneous nodules. Here, we present a case which can pose diagnostic difficulty, especially to the young cytopathologist.

Case Presentation:

A 21 year old male presented with a three -month history of a left sided neck lump. This had gradually increased in size and was slightly tender. He had no symptoms of infection or weight loss. Full blood count and erythrocyte sedimentation rate were within normal limits and viral hepatitis and HIV screens were negative.

On examination, the lump was 15 x 20mm, smooth, rubbery and mobile.

Clinically, it was thought to be a lymph node and a fine needle aspiration was performed.

Slides received were stained with Pap and Diff Quik and a cell block was prepared from the needle washings.

The features are illustrated below - what is your diagnosis?

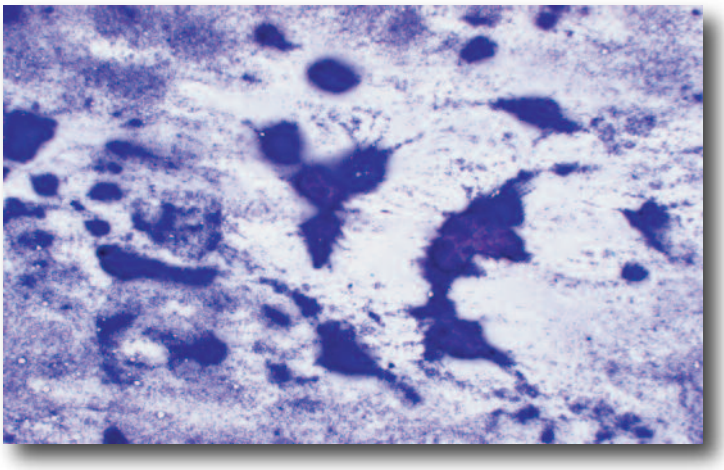

Figure 1. FNAC of left neck lump- Stained by Diff Quik

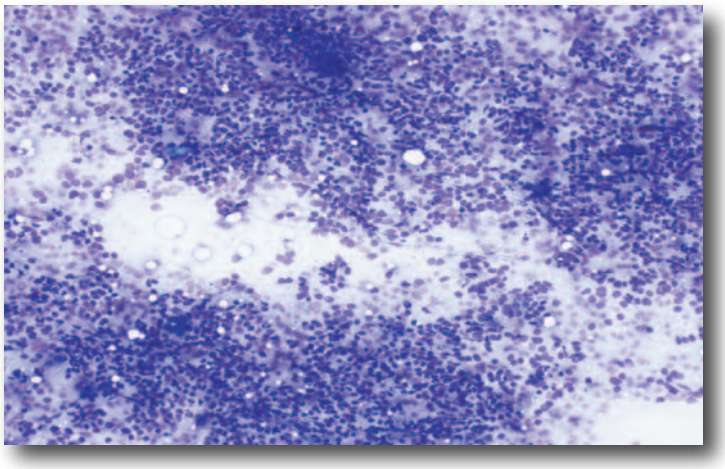

Figure 2. FNAC of left neck lump- Stained by Diff Quik

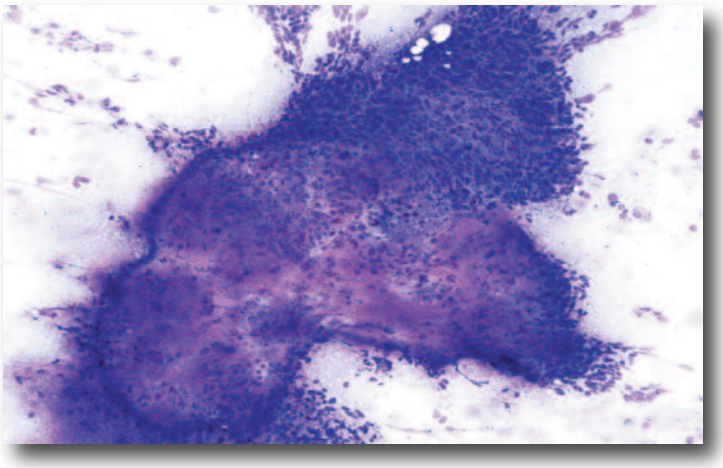

Figure 3. FNAC of left neck lump- Stained by Diff Quik

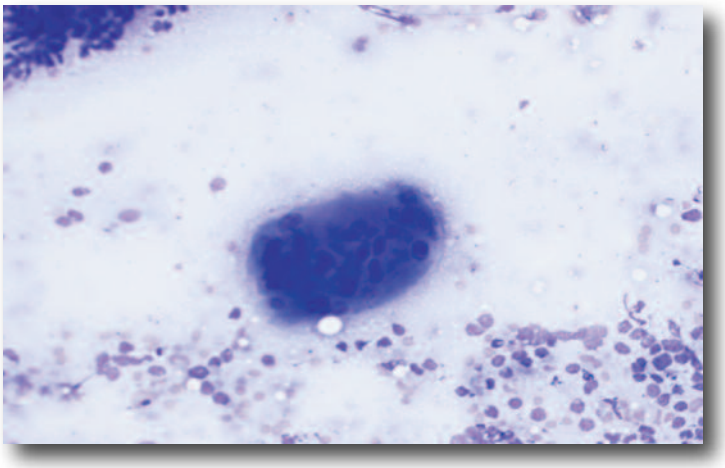

Figure 4. FNAC of left neck lump- multinucleated giant cell (Diff Quik)

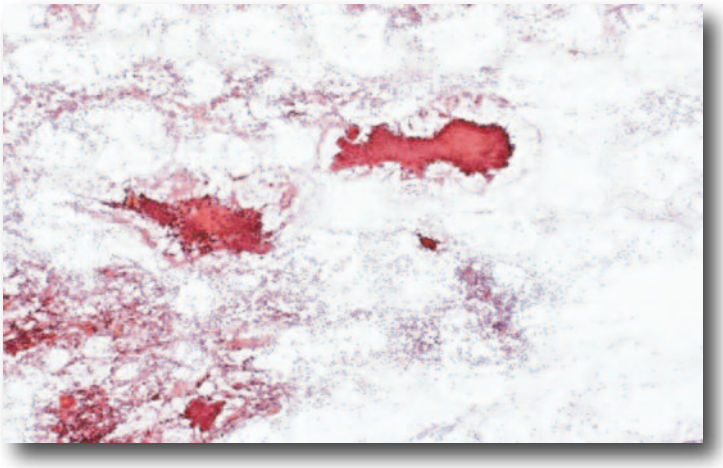

Figure 5. FNAC of left neck lump- Papanicolaou stained slide

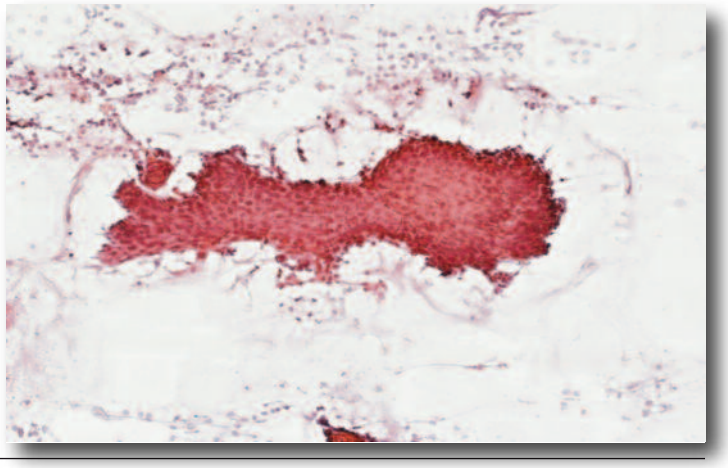

Figure 6. FNAC of left neck lump- Papanicolaou stained slide

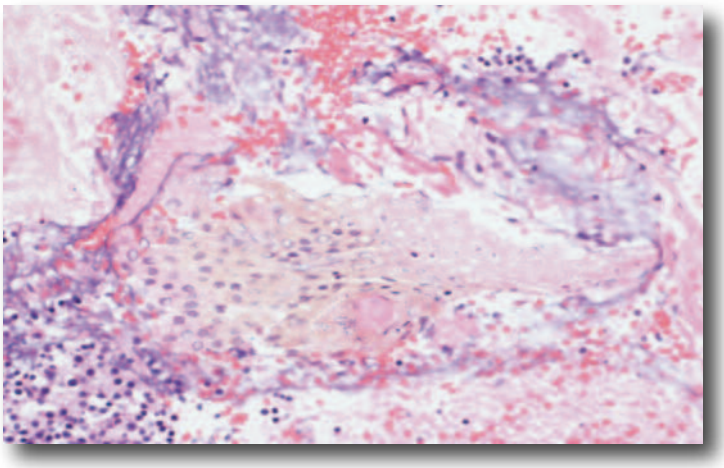

Figure 7. Cell block left neck lump- Hematoxylin and eosin stain

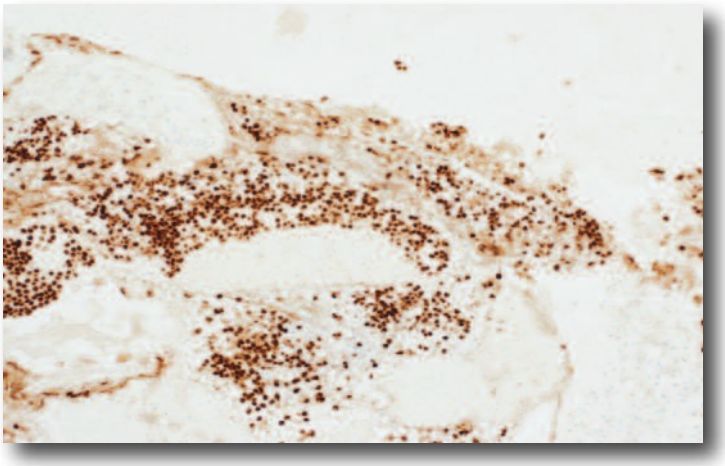

Figure 8. Cell block left neck lump- p40 immunohistochemistry

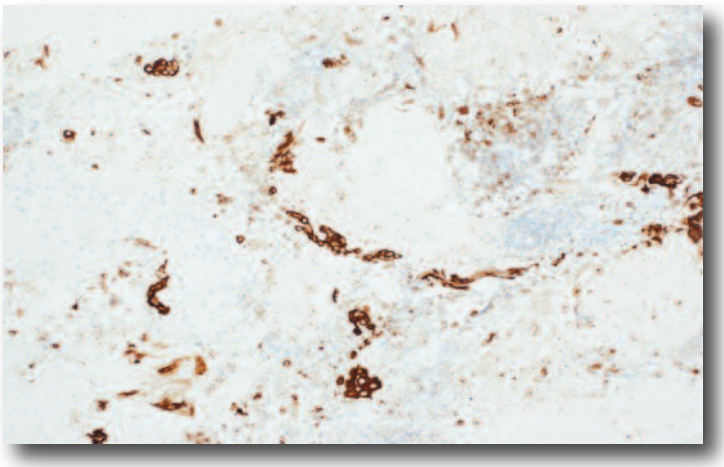

Figure 9. Cell block left neck lump- Cytokeratin 5/6 immunohistochemistry

Cytological Findings:

Cytological assessment showed a cellular aspirate (Fig 1), comprising abundant, poorly cohesive, slightly variably sized cells with even nuclear chromatin and minimal cytoplasm, imparting a basaloid appearance (Fig 2). In places, the cells formed cohesive sheets and there was some pink amorphous material associated (Fig 3, 4 and 5). Scattered multinucleate giant cells were present (Fig 4).

The cell block preparation was also cellular and showed that these basaloid cells surrounded the eosinophilic material within which "ghost" squamoid cell outlines were visible (Fig 7). The basaloid cells showed nuclear positivity with p40 (Fig 8) and there was also some cytokeratin 5/6 positivity (Fig 9), indicating squamous differentiation.

Taking into account these cytological features together with the age of the patient, site, duration of the lesion and cytological features, a diagnosis of pilomatrixoma was made. Subsequent excision of the lesion with histology confirmed the diagnosis.

Discussion:

Pilomatrixoma (calcifying epithelioma of Malherbe) is a benign skin appendage tumour. It expresses differentiation towards hair matrix; hair shaft formation is therefore not a feature [1]. Clinically, it presents as a solitary slow growing dermal or subcutaneous nodule, commonly seen in young adults but with a bimodal pattern, the first peak being 5-15 years and the second 50-65 years, with a female preponderance [2]. Surgical excision is curative although there is a local recurrence rate of 2-3% [1].

Importantly, FNAC of pilomatrixoma may result in over diagnosis of malignancy. [3] Common differentials include basaloid squamous cell carcinoma and basal cell carcinoma. The cytological characteristics of pilomatrixoma are the presence of basaloid cells, calcium deposits, naked nuclei, shadow ("ghost") cells, giant cells and an inflammatory background [4]. The basaloid cells are large, round and regular with ill-defined cytoplasmic margins and basophilic nuclei, with evenly dispersed chromatin and large nucleoli. Nuclear overlapping and moulding are noted in few cases, and an occasional mitotic figure may be present[4]. Small squamous cells with small, dark nuclei and scanty dense cytoplasm can also be present, usually in the centre of basaloid cell clusters as well as multinucleated giant cells associated with the basaloid cell clusters, squamous cells and keratin fragments. Other important findings are the absence of background necrosis and the presence of fibrillary pink material surrounding the basaloid cells singly and in clusters.

When the smears are predominantly composed of basaloid cells, potential diagnostic differentials include small cell carcinoma and skin appendage tumours. On the other-hand, if ghost cells or foreign body giant cells predominate, the cytologic differential diagnosis includes epidermal inclusion cysts or giant cell lesions. In our case, the FNAC showed sheets of basaloid cells, ghost cells and the characteristic pink amorphous material (Fig 3 & 7).

Summary:

This case highlights the importance of considering pilomatrixoma in the differential diagnosis of dermal or subcutaneous nodules in the head and neck as well as other sites, particularly in young adults, as these swellings can be mistakenly diagnosed as primary/metastatic malignancies leading to unnecessary radiation/surgery. Sheets of degenerate anucleated and keratinized squamous cells (ghost cells), cluster of basaloid cells, mild nuclear pleomorphism, dispersed nuclear chromatin, occasional large nucleoli, mild to moderate cytoplasm, calcified debris, scattered giant cells, nuclear overlapping, and nuclear moulding in the clusters are potential pitfalls leading to the misinterpretation of malignancy.[5]

It is also important to note that not all diagnostic features of pilomatrixoma are present in each case. In about 40% cases, characteristic cytological findings are absent and the rate of correct identification of by FNA is 44% [4]. Thus, cytopathologists, who play an important role in the preliminary diagnosis, should keep in mind the variability of the cellular composition of these lesions to avoid misinterpretation.

References:

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BAC Symposium, ECC 2018, Madrid

Alison Malkin FIBMS, FACSLM.
Lecturer in Clinical Cytology and Cellular Pathology, School of Biological Science, Dublin Institute of Technology

The programme for the BAC Symposium, held on Monday 11th June, spanned a wide range of topics from pHPV Screening in the UK, extended roles for BMS's, the UK Code of Practice for Non-Gynae Cytology as well as FNA, ROSE and ancillary testing. As a companion session of a larger conference, the attendance was as expected however this did not take away from the quality of the presentations and the subsequent discussions.

The first speakers, Alison Cropper and Kay Ellis presented on the current status of pHPV in the UK. This was a joint talk, as at the time, there had been very little information or guidance on the implementation of pHPV screening, especially in England. The experiences of both speakers highlighted how the lack of information regarding laboratory structure, the procurement process and staffing requirements for the eventual role out of pHPV screening is leading to uncertainty and is presenting significant challenges to cytology laboratories to maintain turnaround times, in addition to staff retention and an environment of low morale and de-motivation of a highly skilled workforce. In circumstances where mitigation has been implemented, this has brought its own challenges and added to the burden. It was clear that the lack of guidance, policy and especially communication is putting laboratories under extreme pressure in an already challenging time.

The next speaker, Mr Allan Wilson, presented on the expansion of BMS roles in diagnostic cytology. The various educational routes available through the Institute of Biomedical Science (IBMS) were presented and explained. These routes are all part of a structured educational programme facilitated by the IBMS and have the potential to provide opportunities for staff to diversify, especially in the current climate. There was discussion from the floor in relation to eligibility and support for staff with these qualifications. This is an area of interest for many members in light of the uncertainty of job roles and potential need to re-skill or training in Non-gynae cytology and will be addressed in our upcoming meeting in October (see programme elsewhere).

Dr Paul Cross followed with his talk on the UK Code of Practice (CoP) for Non-Gynae Cytology. A historical overview of how the BSCC CoP's evolved and how the RCPath Tissue Pathways align with these then led on to the rationale for revising the CoP guidelines. These include the changes and development in the role and use of cytology especially with increased utilisation of ancillary tests such as immunocytochemistry and molecular techniques. As in the previous presentation, changing staff roles, in particular, extended practice of BMS's in Non-Gynae cytology, service delivery and management was also considered. Consistency and standardisation of terminology is another factor, with the increase in revised reporting documents such as the Paris and Milan systems, as mentioned in his article elsewhere in this publication. In conclusion, the RCPath Tissue Pathways is currently under development and once released, the BAC will look to build on this to aid cytology practice and service delivery.

The final speaker of the session was Dr Anthony Maddox. His presentation on the role of FNA and Rapid On-Site Evaluation (ROSE) was of particular interest to me as I would be an advocate of BMS attendance at FNA for one of the key reasons presented, which is appropriate sample

management. Using mediastinum as an example, the four potential benefits of ROSE; Specimen Management (adequacy), Diagnostic, Process and Ancillary Tests were evaluated. Based on literature reviewed, there was no significant benefit of ROSE for diagnostic yield, however there was evidence that ROSE could improve adequacy in certain settings, reduce the number of sites sampled and the need for additional procedures. With increasing demand for molecular testing, these benefits of ROSE can aid in acquisition of sufficient material for testing and there is a move towards the utilisation of cytological material for molecular testing. The role of the BMS in ROSE and potential for further extended practice was touched on, followed by a final summary highlighting the benefit of ROSE in sample management; adequacy and efficiency of service which concluded the presentation.

As chair of the session I was aware that I may need to have questions to ask the speakers, in case there were no questions from the audience, however I never had an opportunity to ask my own as all the talks generated much discussion from the audience and panel, and the challenge for me was then to ensure everyone got their say while trying to keep to time. Much of the discussion centred on encouraging trainee medics into cytopathology, the uncertainty surrounding pHPV and what future roles may be available for cytology staff. I think the engagement in these discussions from the audience is reflective of the changing and challenging times that cytology is going through, as well as delivering a programme that is reflective of current developments and opportunities. Many of the discussion points and the feeling of uncertainty expressed by our members have driven the programme development for the BAC/IBMS Meeting on 13th October, which will be widely publicised and hopefully attract many of our respective members. The programme and venue for this meeting is listed elsewhere in this edition and we look forward to seeing you there.

Dates for the diary 2019:

IAC 2019: 5th – 9th May, Sydney, Australia

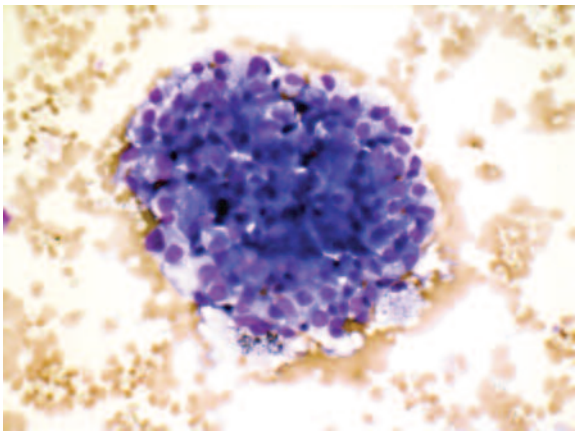
ECC 2019: 16th – 19th June, Malmömässan, Malmö, Sweden

IBMS Congress: 22nd – 25th September 2019, ICC, Birmingham, UK

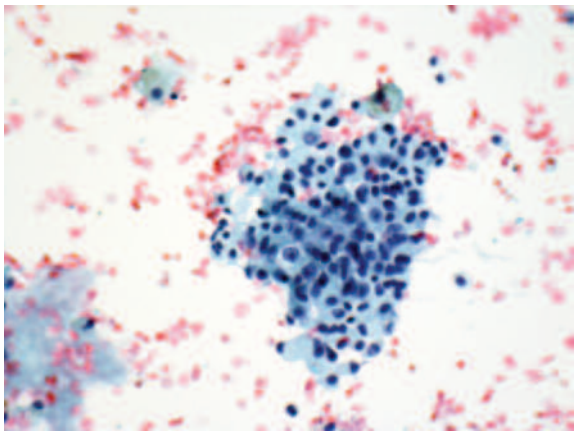
Breast FNA – test your knowledge

Dr Louisa Onuba MBChB MSc FRCPath
ST5 Histopathology Registrar, Royal Free Hospital, London

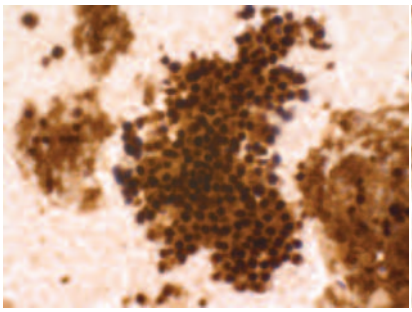
69F with previous history of breast cancer 20 years ago, presented with a haemorrhagic breast cyst which was aspirated.



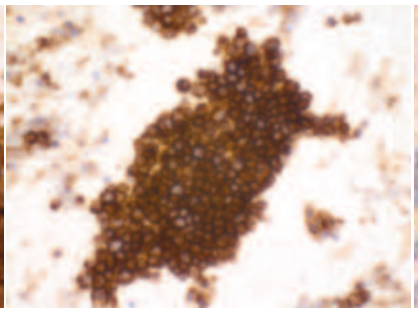
Modified Giemsa



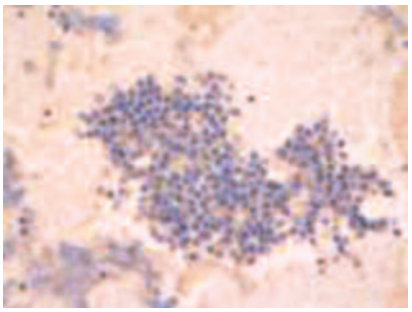
Papanicolaou



GATA3



E-cadherin



CK5

1. What cytological findings would you most expect to see with a benign breast aspirate?

A. Papillary groups with fibrovascular cores, admixed myoepithelial cells, mild atypia

B. Hypercellular, single cell population, pleomorphic cells, 3D groups

C.Hypercellular, single cell population, plasmacytoid cells, single file arrangement

D. Myoepithelial cells, bland ductal epithelium cells, monolayer sheets, stromal fragments

2. Based on the images provided what is the most likely diagnosis and 'C' reporting category according to UK NHSBSP guidelines?

A. Fibrocystic change, C2

B. Invasive ductal carcinoma, C5

C. Papillary lesion, C3

D. Fibroadenoma, C2

3. What immunohistochemistry could you perform to confirm a primary breast lesion?

A. HCC

B. GATA3

C. TTF1

D. PSA

E. None of the above

4. Aside from P63, what other myoepithelial marker(s) might you use?

A. SMMHC and CK5

B. BerEp4

C. Napsin A

D. Calretinin

E. All of the above

5. Name some prognostic and predictive immunomarkers in breast pathology?

A. GATA3

B. ER, PR, HER2

C. ROS1

D. ALK1

E. All of the above

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1. www.expertpath.com
2. RCPath breast dataset
3. *Diagnostic Cytopathology 3rd Edition*, Winifred Gray and Gabrijela Kocjan. Churchill Livingstone 2010.
4. *Breast cytopathology Essentials in cytopathology*, Syed Ali and Anil Parwani. Springer 2007
5. *Diagnostic cytopathology: A text and colour atlas*, Chandra Grubb. Churchill Livingstone 1988.

See inside back cover for answers.

Impact of CARAF on cervical smears in patients 60 years and over

Dr Joanna Round,
Dr Louise Smart
Department of Cytology,
Aberdeen Royal Infirmary

Introduction

On Monday 6 June 2016 the age range of cervical smear screening in Scotland changed from 20-60 years to 25-64 years to be in line with rest of UK at the recommendation of UK National Screening Committee. There was also change in frequency of checks in women 50-64 to be 5 yearly rather than 3 yearly. These changes were promoted as CARAF; Change in Age Range and Frequency 2016.

Aim

To assess the impact of this age change in women 60 years and over; in particular assessing significant pathological diagnoses whilst also considering impact on women with unsatisfactory smears requiring repeat investigations.

Data collection methodology

Aberdeen Royal Infirmary cytology department processes cervical smears from NHS Grampian, NHS Highland, NHS Western Isles, NHS Shetland and NHS Orkney. A retrospective analysis of data from all cervical smears processed by Aberdeen cytology department during 6 June 2016- 4 June 2017 was undertaken. In this time period, a total of 68 065 of smears were processed and 9407 of these were from patients 60 years of age and over and 58 065 smears from women under 60 years. A comparison was made of the percentage of cytological diagnoses made in these two age brackets. Analysis was made of the histological diagnoses made as a result of the high grade cytological smear referrals in the women 60 years and over. As variation in unsatisfactory smears was significantly different a further assessment was made to quantify unsatisfactory smear rates in different age categories for further comparison. These data results were taken from a similar year period however slight variation in dates (data was from 1 July 2016 - 30 June 2017).

Results

Smear Diagnosis categories	Aged 25- 59 years		Aged 60-64 years	
	Percentage	Total	Percentage	Total
Negative	88.72	52042	93.92	8835
Unsatisfactory	2.21	1298	4.49	423
Borderline	4.12	2419	0.81	76
Low grade dykaryosis	4.05	2374	0.64	60
High grade - moderate	0.46	270	0.06	6
High grade - severe	0.41	238	0.03	3
High grade - ? invasive	0.02	14	0.01	1
Endometrial or other	0.005	3	0.03	3
Total	**100**	**58658**	**100**	**9407**

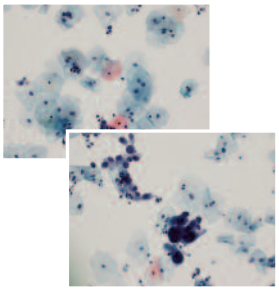
Table 1 shows comparison of pick up rates for various smear diagnosis categories in different age groups (above and below 60 years of age). Note the percentage is calculated out of the sub group of total smears per age group (rather than total for entire year).

Age	Number of unsatisfactory smears	% of total unsatisfactory smears
25-29	116	6.73
45-49	146	5.47
60-64	470	27.2
Total	**1724**	**100%**

Table 2. Comparison of unsatisfactory smears per 3 separate age ranges (Data from 1 July 2016 - 30 June 2017).

Smear diagnosis	Outcome
High grade dyskaryosis- moderate	No significant pathology (benign lletz)
High grade dyskaryosis - moderate	No significant pathology (benign lletz)
High grade dyskaryosis - moderate	CIN 1 (on lletz)
High grade dyskaryosis - moderate	CIN 1 (on lletz) (note subsequent HG severe smear and lletz showing CIN 3)
High grade dyskaryosis - moderate	CIN 3 (on lletz)
High grade dyskaryosis - moderate	Microinvasive SCC (on lletz)
High grade dyskaryosis - severe	CIN 2 (on lletz)
High grade dyskaryosis - severe	CIN 3 (on lletz)
High grade dyskaryosis - severe	Endometrial carcinoma
High grade dyskaryosis - ? invasive	No significant pathology (on biopsy)
Endometrial or other malignancy	No significant pathology (on biopsy)
Endometrial or other malignancy	Endometrial carcinoma
Endometrial or other malignancy	Endometrial carcinoma

Table 3. Thirteen patients 60 years or over had a significant abnormal smear result (high grade dyskaryosis or worse). The table shows the corresponding histological diagnosis for these patients.



Number of unsatisfactory samples	number of women
1	327
2	36
3	8*

Table 4 shows the number of unsatisfactory samples/woman during the period studied. * These 8 women were referred for colposcopy

Discussion

It is shown from table 1 that the finding of cervical abnormalities is considerably lower in patients 60 and over compared to patients under 60. The only exception to this is the detection of endometrial abnormalities which was the same number (3) in both age categories (however a larger percentage in patients 60 and over due to the total number of smears the percentage calculated from being a smaller number). It is interesting that the positive predictive value of high grade squamous dyskaryosis seems low in this age group with only half of the cases having a high grade lesion found at colposcopy. The unsatisfactory rate was proportionally higher in patients 60 and over with table 2 showing that the rate of unsatisfactory smears is significantly higher in patients 60 compared to other selected age groups, with 25% of all unsatisfactory smears being in this age group and older. An unsatisfactory sample has potential for anxiety for the patient as it requires a repeat of the uncomfortable intimate procedure and extends the time waiting for the result. 44 women did attend for repeats but only 64 of the remaining 327 still within 3 months of the end of the study period.

Summary

In Aberdeen's annual cohort of smears in women 60 and over there was not a high pick up of significant abnormalities. However there was a high level of unsatisfactory results, which meant women needed repeat smear adding anxiety and discomfort to a cohort of women who previously would not have been tested in Scotland. Despite this it is worth noting that at the individual level, 3 high grade CINs and a microinvasive carcinoma, as well as 3 endometrial cancers were detected as a result of the age change which is significant and possibly lifesaving for the women involved. While the introduction of HPV primary screening may avoid the 4 cases with no pathology, the 3 endometrial cancers would not be detected.

Cervical screening in The Republic of Moldova

Hedley Glencross
Advanced Specialist Biomedical Scientist, Cytology Department, Queen Alexandra Hospital, Portsmouth

BAC members and readers of SCAN will be aware that I visited The Republic of Moldova (RM) in June 2017 to conduct a series of laboratory assessment visits as part of a project to introduce a cervical screening programme into the country. During the intervening period I have worked closely with Dr Philip Davies, Director General of the International Cervical Cancer Prevention Association and Dr Mary Brett, Consultant Pathologist from Southmead Hospital, Bristol and the South West Cytology Training Centre, to develop a training programme for local cytopathologists and cytology screeners, as a central part of this project.

RM as a former soviet socialist republic has no history of operating a cervical screening programme, with the majority of cervical cytology being undertaken using air-dried smears stained with Romanowsky-Giemsa. As a consequence the incidence of and mortality rate from cervical cancer has remained stubbornly high, currently the second highest in the European area. So a significant part of the project is to introduce alcohol fixation and Papanicolaou staining of conventional cervical smears, reporting these smears using a modified Bethesda Reporting System, including management recommendations.

Mary and I were invited to RM to develop a training course and deliver this training in August this year.
To help the delivery of this and subsequent training, during July, locally-based smear takers were trained in the collection and fixation of cervical smears. Approximately 1,000 duplicate samples have been collected for use in setting up a staining protocol and as a locally produced training resource. Whilst this was being done, Mary & I with Philip's input developed a revised version of the four-week introductory course as a training programme to be delivered over the nine-day period of the course. We also developed the modified Bethesda Reporting System (mentioned above), with some helpful input from Dr Ritu Nayar (co-editor of the 2014 Bethesda Reporting System) by way of personal communication with Mary. Similarly, management recommendations were also developed at this time, based on those used by the NHS CSP before the introduction of LBC, again modified for use in RM.
Mary and I have both just returned to the UK after what I am happy to say turned out to be a successful visit.

We both arrived in Chisinau on 18 August with workshop sets of (gifted) archived conventional cervical smears, our presentations and the training programme we had devised. Sunday was spent labelling slides and finalising our initial lectures, due to be delivered the following day. I was both excited and apprehensive being in a foreign country, having to work with simultaneous translation into Romanian and not knowing quite what to expect from the students. On reflection, I suspect they must have felt equally apprehensive too!

Day 1 began with a series of short introductions, followed by scene-setting lectures from Mary and Philip. We then conducted a slide and MCQ test, much as would be done in the UK, but I imagine very strange to them. We let them act as they would do normally, which included some copying of results and often what seemed to be only a cursory look at the slides. The results were interesting, but also helped shape some of the subsequent work on the training course, as the concept of management was something entirely new to many of the participants. What we found surprising was the use of long and complicated free text reports, often using terms like 'big inflammation' rather than simply explaining the presence or absence of abnormalities.

Mary lecturing

Day 2 was concerned with normal anatomy, physiology, histology and cytology, with Day 3 moving to the histology and cytology of squamous abnormalities and cancer. These two days were a mixture of lectures, individual microscopy work and multi-header review, during which I think the students, began to warm to us as much as we began to warm to them as well. Not least because we encouraged them to question, discuss and engage

as much as possible, again something new to them we were told subsequently.

Hedley at the multi-header

The course then continued along similar lines, covering glandular abnormalities, organisms, inflammatory changes, unsatisfactory smears, pitfalls and lookalikes, again using a combination of lectures, individual microscopy work, multi-header discussion and testing. The tests were mostly conducted under what I termed 'English rules' - these being no collaboration, no copying and full use of the screening time.

Testing the students

Additionally, the cytopathologist and screener groups were split on occasions to undertake separate work. Mary spent this time with the pathologists discussing management and reporting, whereas I spent my time setting up the local Papanicolaou staining method, with some success, so much so that a cursory look at a small number of the stained duplicate smears revealed three abnormal slides.

As we were on site, Mary, Philip and I were also able to finalise a new cytology request form and we have developed an outline of a reporting form, which will also be introduced in the coming weeks. Now the initial course has finished, the participants in their laboratories will begin to receive alcohol fixed smears, staining these with Papanicolaou and reporting them using the modified Bethesda Reporting System. Over the coming two months any histology arising from the cytology reports will be correlated to highlight any mismatches or inconsistencies.

Papanicolaou stained cervical smears

During November, Mary will return to RM to review and discuss these non-correlating cases and revisit some of the initial course by way of follow-up. I too hope to be part of this next visit. A further period of monitoring will occur too before a final week's course and exam in February 2019 to complete the training programme, when all participants will receive a certificate.

A second, smaller group is now also under training using this format, run by two local pathologists, Dr Ruslan Pretula and Dr Eugeniu Cazacu, who both attended the initial training course. Mary and I are being given daily reports on the progress of the training by Philip, so we can give any feedback or advice as appropriate.

Plans are under development for rolling out training and providing an organised screening programme for the whole country in the coming years. We are grateful to the BAC for endorsing two key guideline documents to be used in the RM Cervical Screening Programme.

This has been an interesting and enjoyable experience for us. Our hosts in the University Department of Pathology have been wonderful in their support, even when our requirements have tested their patience at times, always going the extra mile and always with a smile. And mentioning smiling, our students who started the course looking rather dour and formal ended it as what appeared to us to be a much closer knit and happy group of people.

What is the role of Twitter in present day pathology?

Yurina Miki, Miguel Perez-Machado, Christian Burt

@Britishcytology. Following the launch of the BAC Twitter account a few months ago, it seems fitting to dedicate an article to the potential applications of social media platforms, namely Twitter, for professional purposes in pathology. With so many social media platforms dotting the web, including Twitter, Facebook, Instagram and YouTube (to name only a few), navigating the ever-evolving and fast-paced world of social media can seem like a fairly daunting and challenging task. However, the power of social media as a tool for education, networking and collaboration is undeniable, and it is no surprise that an increasing number of pathologists, along with professional pathology organisations and peer-reviewed pathology journals, are now making use of social media platforms. In this article, we discuss the various ways in which pathologists can effectively use Twitter in a professional capacity, while exploring the benefits and potential risks of using this social media platform.

Twitter was created by Jack Dorsey, a university student at the time, and his companions in March 2006. Its success as a social media platform is reflected in its 328 million active users and boils down to its succinct and rapid manner of information sharing. A single post or "tweet" is limited to 280 characters, which ensures that the information shared is to the point and quick to read, factors that contribute to the rapid pace of Twitter in comparison to other social media platforms. In addition, the "retweet" function on Twitter (i.e. the ability to share another person's tweet with one's own followers) as well as the ability to tweet in real-time helps promote the quick circulation of information to a wide audience.

So, how can pathologists use Twitter in the professional setting to its full potential? One of the most high-impact uses of Twitter is for educational purposes. For pathologists, Twitter can be used to share slide images or photomicrographs of prototypical, rare or difficult pathology cases (a tweet can contain up to 4 attached images). For those just starting out on Twitter, capturing high quality images may seem like a time-consuming process (not all of us are lucky enough to have cameras attached to our microscopes and access to Photoshop). However, it doesn't have to be so complicated – there are online tutorials on taking images freehand using just our smartphones alone, as well as on white balancing to enhance the quality of images and on creating watermarks to ensure that owners of the images are adequately recognised (both of which can also be done with a smartphone). And, why stop there? To really maximise the impact of a tweet, one can embellish the post with a link to other online resources, a hashtag or a @username. A hashtag is a topic label for the tweet (e.g. #cytopathology); it can be placed in front of a word or string of words (no spaces or punctuation marks allowed though). It essentially allows a Twitter user to quickly search for a subject matter that is of interest to them; equally, it allows the user to ensure that their tweet reaches a particular target audience. In a similar manner, incorporating a @username to a tweet allows information to be reached to a wide audience. By mentioning a Twitter user by their handle, they will be informed of the tweet that mentioned their @username – this may spur a virtual interaction, be it in the form of a reply or a retweet; the latter would mean that the original tweet would be shared by the @username's followers, thereby enhancing the reach of the original tweet. As a result, the interaction and discussions generated by a single tweet can surpass geographic boundaries, making it accessible to pathologists of all backgrounds and expertise.

In addition to using Twitter as an educational platform, another popular use of Twitter is for networking and sharing up to date information during scientific meetings and conferences. Participants can instantly tweet relevant updates, highlights or summaries of presentations and posters in real-time (known as "live tweeting") to their global followers. This, in turn, serves as a catalyst for exciting and active discussions on new topics, creates 'Q&A' forums, facilitates networking and raises the profile of the presenters (not to mention the profile of the meeting itself). It also provides an opportunity for those who are not physically in attendance at the meeting to be part of the experience. Of course, the success of live tweeting is highly dependent on the activity of those self-sacrificing individuals who actively tweet at meetings and the number of followers they have, but also the level of engagement by the hosting organisation with Twitter.

Other beneficial applications of Twitter include its use as an advertising platform for upcoming courses, meetings and conferences. Professional pathology organisations also use it to highlight their involvement

in public engagement activities and to raise the profile of the speciality to the public. Similarly, for peer-reviewed pathology journals, Twitter can be used to announce new publications and featured articles, allowing Twitter users to keep up to date.

A further use of Twitter is its function to create short surveys or polls. Although it may not be able to create the most comprehensive or elegant of surveys (i.e. only allows one question to be asked at a time with a character limit on answer options and a time limit on how long the survey remains open), it allows for a quick and effective way to poll opinions on a topic. In fact, the survey function on Twitter might be more aptly used for educational quizzes, creating a more fun way of learning and teaching amongst the Twitter community.

There is no doubt that social media platforms represent an invaluable tool for sharing and transferring knowledge and for developing collaborative partnerships. However, it is important to highlight certain risks of using social media, which are mainly related to the highly public and accessible nature of the platform. One such concern is the risk of breaching patient privacy and the medicolegal risk that this entails. When sharing pathology images for educational purposes, it is imperative that images are anonymised and case descriptions do not contain any patient identifiable information. An informative article by Crane and Gardner include helpful recommendations when sharing images on social media, such as limiting the clinical history, categorising age by decade, and delaying the posting of images for easily identifiable (e.g. very rare) cases.

Another concern often raised is the lack of a peer review process for the content that is posted on social media. Although this may be quite liberating, how can one validate or trust what is said on social media without the time-honoured peer review process that plays such a central role in scholarly publishing? The answer is not complicated – the same principles used when checking the accuracy of any published work can be applied to social media content, such as cross-checking references or conducting a literature search. The former is difficult as Twitter posts do not formerly contain citations; however, it is becoming increasingly more common to find a link to a peer-reviewed article (via PubMed) incorporated into a post. Furthermore, one can argue that a post-publication review process of sorts does occur on social media; in other words, a tweet is subject to scrutiny by anyone belonging to the Twitter community, who may subsequently give immediate feedback in the form of a comment, challenge or concern. Although the major drawback is that anyone, whether an expert in the subject matter or not, can participate in this process, it would be interesting to see how this "crowdsourcing" phenomenon will influence the traditional peer review process in the future.

Despite the risks, there is an increasing number of pathologists who are becoming prominent users of social media in a professional capacity. When used appropriately and responsibly, the power of social media platforms, such as Twitter, is undeniable. It can provide incredible opportunities for learning and educational advancement, drive collaboration and build professional connections, and ultimately allow us to become better pathologists for our patients. The role of social media will no doubt evolve and continue to challenge the boundaries of human communication, but there is no time like the present to dive in and start tweeting.

Dr Yurina Miki, Dr Miguel Perez-Machado and Mr Christian Burt are part of the media subcommittee of the BAC executive and are currently involved in managing the Twitter account for the BAC.

Follow the BAC on Twitter: @Britishcytology
Follow the official journal of the BAC, 'Cytopathology', on Twitter: @CytopathologyJ

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CEC: Journal Based Learning

PHE Guidance (Cervical screening): Cytology Reporting Failsafe (1st August 2018)

https://www.gov.uk/government/publications/cervical-screening-cytology-reporting-failsafe/cervical-screening-failsafe-guidance

1. Outline the role of the commissioner of screening services in England (1)

2. What is the failsafe procedure if a woman fails to attend for a routine invitation for cervical screening? (2)

3. If a woman fails to attend for an early repeat sample, at what point is the GP informed? (1)

4. What does the result/action code E9S mean? (1)

5. How would the call recall system identify inappropriate lab recommendations for routine recall in a case of incompletely excised CGIN after 2 years of follow up? (1)

6. What happens if the call recall system rejects a test result issued by the laboratory? (1)

7. How does a woman get a follow up invitation at an appropriate time if she moves to a different part of the country? (1)

8. What are two implications for failsafe if a woman asks for her results to be sent to a different address and not to her home address? (2)

9. How would individuals who identify as male but require cervical screening be invited? (1)

10. Give 3 responsibilities of the cytology laboratory with regards failsafe (3)

11. Who is responsible for ensuring that laboratory failsafe systems are in place? (1)

12. Give a reason when it is appropriate to close laboratory failsafe (1)

13. Who is responsible for ensuring that a woman is referred to colposcopy? (1)

14. List 2 responsibilities of colposcopy with regards to failsafe of patients following direct referral (2)

15. What is the role of a CSPL with regards failsafe? (1)

Name…… CEC Number……

Enjoy ☺ Please send or email your completed JBL to:

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Helen Burrell (BAC CEC Officer)
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Please remember to make a copy of everything before it is sent — there have been one or two losses in the post. Thank you

Future roles in cytology – the new Cytotechnician

Allan Wilson, Lead Biomedical Scientist in Cellular Pathology and Advanced Practitioner in Cervical Cytology, Pathology Department, Monklands Hospital, Airdrie.

Introduction

The challenges our profession is facing and the pace of change in cytology have forced all cytologists to try and predict what the workforce will look like in the future. I was fortunate to be asked to speak at the recent European Cytology Congress (ECC) in Madrid on "the profile of the new cytotechnician". You will probably have already guessed that the title of this presentation did not originate in the UK; the term "cytotechnician" is not one that is used in the UK and immediately caused a bit of a stir as we stopped using the term "technician" many years ago as it was felt that it does not describe the complexity or level of the scientific tasks carried out by biomedical scientists.

The proposed title of the presentation highlighted the differences in roles and titles across the world. The title "Cytotechnologist" is widely used in many countries and we have struggled over the last 20 years with the use of the title "Consultant Biomedical Scientist". Titles shouldn't matter but for many they do and although they are usually clearly understood within the country where they are used there is often a translation issue between countries and they are also poorly understood by other professional groups.

Why do we need a new "Cytotechnician"?

It would be nice to assume the answer to this question is a recognition of the skills and experience and high level of practice within the current biomedical scientist workforce. However, as with the introduction of the advanced practitioner role in 2000, it is more to do with a looming crisis in pathologist recruitment across Europe and a forecast of a national shortage of pathologists. This may seem a bit negative as there is no doubt that the clinical contribution of advanced practitioners/consultant biomedical scientists is well recognised and has been crucial in the delivery of the UK cervical screening programmes over the last 20 years.

The other issue driving the review of future roles is the impact of HPV primary screening. There is no doubt that the introduction of HPV primary screening will lead to a reduction in both biomedical scientists and cytoscreeners. It is perhaps convenient to try and marry the shortage of cytopathologists with a group of highly trained staff who are looking for alternative roles and come up with a "marriage of convenience". This is too simplistic and whatever new roles emerge for staff who will no longer be primary screening we have to demonstrate clinical value and a benefit to patients.

There is no doubt that the future delivery of the service in the UK will be dependent on biomedical scientists with what we still call advanced practice. As these roles have now been firmly embedded for 20 years there is an argument to stop using the term "advanced". I would also argue that it is not just the future delivery of the service that is dependent on this role but also the current service. Although parallel roles in histopathology have been slow to emerge I suspect biomedical scientists will also have a key role in the future delivery of this service; once the histopathology training programmes are established we will not be able to put the genie back in the bottle.

There is another pressing need for a new role in cytology. The gradual decline of specialist cytopathologists has led to a loss of "cytology champions". We have lost powerful proponents of our speciality and we need to fill this gap quickly during this uncertain period. Biomedical scientists have already stepped into some of these leadership roles but we need more to step forward to ensure the cytology voice is heard by key decision makers.

"Cytopathologist Pathologist Extenders"

Yes, a bit of a mouthful! This is a proposed title from a recent USA paper by Sweeney & Wilbur to describe individuals who are now stepping into roles such as:

- Pre-screening of biopsy specimens
- Screening special stains for organisms
- IHC calculations of positive indices (e.g. Ki67)
- Morphologic molecular procedures such as FISH, and chromogenic ISH
- Rapid on site evaluation (ROSE) for FNA and EBUS samples
- Pre-screening of lymph node dissections
- Creation of tissue microarrays (TMA)

The above list demonstrates that our colleagues across the pond are serious about developing new roles for cytotechnologists. Particularly interesting is the pre-screening of biopsies and other roles such as

screening special stains and lymph node dissections which attempts to re-cycle pattern recognition skills. Many of these tasks have now been included in the American cytotechnologist courses as the USA plans for life after HPV primary screening. The impact in the USA is likely to be cushioned by the use of co-testing which will avoid the dramatic drop in cytology we are facing in the UK.

What other roles are being considered?

Within the UK cytology departments are already starting to position themselves for life after HPV primary and some have already decided that they will not bid for the new service. Staff are already being released form cytology to train in other areas such as histopathology, andrology and biopsy pre-screening. Extension into other more traditional cytology roles such as ROSE in EBUS and EUS non-gynae cytology and training of registrars are more firmly established.

European Cytotechnologist survey

As part of my preparation for the Madrid presentation I carried out an email survey among leading European Cytotechnologists to get a feel for how our European colleagues are planning for HPV primary. A brief summary is listed below:

- New roles are variable not just between countries but within countries
- ROSE at EUS and EBUS clinics was common
- Perhaps not surprisingly, HPV and molecular testing featured prominently
- Reporting of non-gynae cytology
- Reporting of abnormal gynae cytology
- Pre-screening of biopsies and resections e.g. colon, sentinel nodes and TESE biopsies
- Working between histopathology and cytology

The overall impression was one of opportunism. There was little evidence of a national or strategic approach to the impact of HPV primary more of a local "under the radar" approach which was dependent on the level of support from Pathologists. Although some of these new roles are potentially transformational, for example, pre-screening of biopsies, there are no structured training courses available.

Back to the USA

I would like to quote from the Sweeney and Wilbur paper again:

> *"That cytotechnologists are the most appropriate base for the pathologist extender role has been well recognized. Cytotechnologists receive training in morphology and screening techniques and are familiar with systematic and methodical specimen evaluation. Data from US federal proficiency testing programs in gynaecologic cytology clearly show that cytotechnologists perform better at screening tasks than pathologists"*

Perhaps this should not come as a surprise but it is helpful to identify an evidence base that can be used to re-cycle the screening skills of biomedical scientists and cytoscreeners.

One more quote that I think is helpful:

> *"These extender changes are not unique to pathology, although pathology practice has been late to implementation. Clinical nurse practitioners and physician assistants now routinely perform tasks that a decade ago would have been considered the firm territory of the MD. Other notable advanced practitioners have seen successful incorporation into pharmacy, anaesthesia, and physical therapy practices. However, regulatory and reimbursement issues obstruct the process in pathology disproportionately in comparison with other specialties"*

I have been beating this drum for a few years now. Although we do not face the same reimbursement issues that exist in the USA, we are still behind nurses, radiographers, pharmacists and other health professionals in the move to what is widely described as "advanced practice". The barriers to advance practice in pathology are slowly being eroded but the pace of change will not deliver enough trained staff to meet the challenges of the forecast shortage of pathologists.

However, we should be rightly proud of the achievements of the histopathology reporting training programme that has now delivered the first five successful biomedical scientists who are now practicing as consultants within specialty areas. The RCPath and IBMS should be congratulated on this ground breaking approach that is unique to the UK. I suspect more courses and routes to train biomedical scientists to pre-screen and report histopathology will emerge.

Advanced Practice

Advanced practice will not flourish unless we can demonstrate a clinical need. We cannot assume that filling roles previously carried out by medical staff is advanced practice, there are obvious opportunities in niche specialist areas such as bone marrow reporting and of course cervical cytology. Engaging with patient facing clinicians is vital to establish advanced practice roles; otherwise the roles will be invisible to our clinical colleagues.

What about advanced qualifications in the UK?

Advanced practice in the UK is usually dependent on attainment of the IBMS qualifications. The well-established Advanced Specialist Diploma (ASD) in cervical cytology now has more than 100 successful candidates but the uptake has declined over recent years mainly due to uncertainty around the future of cervical cytology. Despite some years of low pass rates, the overall pass rate is 57.5%. Candidate numbers are slowly increasing and the need to train more biomedical scientists to sit the ASD has been recognised by all professional bodies and is vital to the future of the cervical screening programme. The recent relaxation of the entry criteria will hopefully lead to an increase in interested candidates

The IBMS Diploma in Extended Practice (DEP) in non-gynae cytology has been offered since 2004 but candidate numbers were very low in the early years. After the introduction of the ASD in non-gynae cytology in 2015, interest in the DEP has risen as it is a mandatory entry criterion for the ASD. 43 candidates have sat the DEP and the overall pass rate is 55.1%. Three candidates have passed the ASD but the numbers are certain to rise as successful DEP candidates take the next step up to the ASD.

Roles in HPV primary screening

I have so far focussed on non-cytology roles but there is no doubt that strong detection and morphology skills will still be required to maintain the screening programme. In addition to traditional cytology skills, knowledge of molecular pathology and screening algorithms will be key to the success of the new service. Key skills and knowledge will be around understanding the science behind the range of available HPV tests, their respective advantages and disadvantages and how they can be best utilised in the screening programme.

What skills and attributes will be needed by the new "Cytotechnician"?

Apart from the obvious cytology skills, the cytologists of the future will need all of the following:

- Flexibility & adaptability
- To be clinically connected
- Audit skills and a thirst for knowledge in related areas
- Expertise in molecular pathology
- Leadership and management skills and strong commitment to team working
- Cross lab discipline knowledge and contacts
- R and D awareness to help develop the service
- Greater clinical awareness as will often deputise or take over from pathologists
- Combined cytology and histology skills in some areas

These skills will ensure these individuals are the new "cytology champions"

What will the new "Cytotechnician" do?

I have already outlined a list of potential roles to deliver the service of the future. It is unlikely that one individual will fulfil all these tasks as sub-specialisation has already emerged and will continue to evolve. There are perhaps three broad areas where the new roles will focus:

- Biomedical scientist experts in non-gynae cytology who will report a growing range of non-gynae specimens are already providing a focus for non-gynae and participating in MDT's. This role will continue to develop as more holders of the ASD emerge,
- There is no doubt that this new group of cytologists will become the HPV primary screening managers of the future. The experience of leading the pilot sites and labs who have partially converted to HPV primary will produce confident skilled experts in this area. The combination of a strong scientific background in HPV testing and many years' experience of screening is a powerful combination.
- Development of skills in morphology, pattern recognition and detection will lead to biomedical scientists expanding their roles to include biopsy reporting, A first step could be cervical biopsy reporting but this extension will undoubtedly grow

As with current advanced practitioner posts, no two roles will be the same and will be dictated by, clinical need, individual's skills, and local arrangements.

What do we need to do to deliver the "new Cytotechnician"

To use management jargon, we need a gap analysis to identify what is required to bridge the gap between where we are now and where we want to be. However, there are some steps we could take now. This is not just the responsibility of professional bodies and managers, we all need to take responsibility for building the road towards the cytologist of the future:

- Start a dialogue with all staff groups in your laboratory about future roles
- Design local training programmes and competency assessment procedures
- Explore the qualifications available to help staff start on this pathway.
- Identify, design and deliver qualifications if required.

- Network! Communicate and exchange best practice across traditional boundaries
- Engage with other professional groups in your area with similar issues e.g. radiography
- Become professionally active, join if you are not already a member and lobby for what you think is required

Get out the lab!

- Become pathway focussed – audit against whole pathway requirements, not just the lab. This will lead to service improvement
- Always consider the service from a patient and clinician perspective
- Optimise the sample by engaging with the sample takers e.g. FNA training for radiology registrars
- Engage with clinical teams on TAT's. How can we improve the pathway and TAT?
- The "new cytotechnician" needs to be pathway focussed and engaged with the clinical teams around them
- Get out of the silo mentality! Network across sites
- If we demonstrate how effective cytology can be and help clinicians with their patients we will gain their support for the service and for future developments.

What's in a name?

To try and bring this all together perhaps we should come back to the title that we started with. Does the title "Cytotechnician" do justice to the evolving role I have discussed above? Within the UK the answer is certainly a resounding "No"! New titles will emerge but the title of Consultant biomedical scientist certainly fits this new role.

The way forward

It has been very difficult to look forward with any confidence over the last few years because of the uncertainty facing our specialty. Over the last few months the fog of confusion and uncertainty has begun to lift and at last we can see the beginnings of the plan to move to HPV primary. We may not like what we hear but we can at least start to plan for delivery of the service and manage the impact on staff and related services.

Development of new roles must be a collective responsibility, professional bodies can develop exams and portfolios but this will be of little benefit if candidates and employers do not recognise their value. We must learn from the DEP experience which initially failed to attract candidates as it offered few opportunities to advance; it was only the link to the ASD that improved the uptake as it then had a place in a professional pathway with financial rewards. It is vital that biomedical scientists engage with the professional qualifications and prepare themselves for the emerging roles in cytology.

Professional bodies often compete against each other for members, influence and political gain. This is often not healthy and is simply a diversion from advancing the specialty or staff group they represent. The recent tripartite cooperation between the BAC, IBMS and RCPath is a powerful statement that has proved difficult to ignore by the key decision makers who had previously kept us at arm's length. The lessons learned from this closer relationship will hopefully bear fruit as we develop advanced roles to deliver the cytology service of the future. However, professional bodies are only as influential as their combined membership. Declining membership of professional bodies will weaken our collective voice; we need all hands to the pump at this difficult time. Join, engage and become active.

Terminology for Serous Fluid Cytology

The IAC & ASC are collaborating on developing a reporting terminology for serous fluid cytology. We encourage you to complete this survey to gauge your views on serous fluid cytology reporting. The survey will guide the authors on issues that you would like to be addressed in developing this terminology. An introduction to the terminology will be presented at the forthcoming IAC tutorial in London, 3-5 December 2018.

https://uwmadison.co1.qualtrics.com/jfe/form/SV_7aiFnS6JUsdzMlD

The British Association for Cytopathology (BAC) and the RCPath are delighted to be hosting the IAC tutorial in London at the new premises of the RCPath. The tutorial covers a ide range of topics, providing up to date information by international experts in the field. The talks are followed by Power Point based slide seminars on the topics covered with plenty of opportunity to interact with the faculty during and after sessions.

VENUE: The Royal College of Pathologists, 6 Alie Street, London E1 8QT

DATES: 3-5 December 2018

Full details and registration form; https://ww.rcpath.org/event/iac-tutorials.html

Monday 3. December 2018 DAY ONE

Gynecological and Non-Gynecological
and Exfoliative Cytology

09.40 Opening Remarks, Introduction of Speakers and Tutorial Outline
Prof Syed Ali (Course Director), Dr Rachael Liebman (RCPath Vice-President), Dr Paul Cross (BAC President)
10.00 Lecture – Gynae Cytology
Dr John Smith
10.45 Unknown Case Discussion – Gynae Cytology
Dr John Smith
11.30 Coffee Break

Urine Cytology

12.00 Lecture
Dr Ashish Chandra
12.45 Unknown Case Discussion
Dr Ashish Chandra
13.30 Lunch break

Effusion Cytology

14.30 Lecture - Serous Effusions
Dr Ashish Chandra
15.15 Lecture - Ancillary Testing In Effusions and FNA Samples
Prof Fernando Schmitt
16.15 Close

Tuesday 4. December DAY TWO

Aspiration Cytology
Lymph Node Cytology

09.00 Lecture
Prof Philippe Vielh
09.45 Unknown Case Discussion
Prof Philippe Vielh
10.30 Coffee Break

Salivary Gland Cytology
11.00 Lecture
Prof Philippe Vielh
11.45 Unknown Case Discussion
Prof Philippe VielhSyed Ali
12.30 Lunch break

Thyroid Cytology
13.30 Lecture
Prof Syed Ali
14.15 Unknown Case Discussion
Prof Syed Ali
15.00 Special Presentation – An Introduction To IAC: Why Should You Become A Member?
Prof Robert Osamura
15.15 Coffee Break

Unknown Case Discussion
15.45 All speakers Prof Fernando Schmitt
17.00 Close. Unwind with the Speakers – An informal chat

Wednesday 5. December 2018 DAY THREE

Lung Cytology
EBUS & EUS Cytology
EBUS
09.00 Lecture
Prof Fernando Schmitt
09.45 Unknown Case Discussion
Prof Fernando Schmitt
10.30 Coffee break

Pancreas Cytology
EUS Pancreas
11.00 Lecture
Prof Syed Ali
11.45 Unknown Case Discussion
Prof Syed Ali and Dr. Miguel Perez-Machado
12.30 Lunch break

13.30 Neuroendocrine tumours
Prof Robert Osamura
14.15 Close. Unwind with the Speakers – An informal chat

Membership Details

Please email or write to Christian Burt if any of your contact details change.

Email: mail@britishcytology.org.uk

Christian Burt
BAC Administrator
Institute of Biomedical Science
12 Coldbath Square
LONDON EC1R 5HL

A change of trains with 007 – a stepping down not a terminus

David Carter

The journey so far started when the earth's crust was still warm and we went pterodactyl spotting at lunch times. The lead up to accepting the Trade Liaison role for the NAC was being taught or working with Liz Hudson, Jan Gauntlet, Dulcie Coleman and Mina Desai. After attending many cytological meetings as a delegate or as a commercial representative, I was honoured to be recommended for the role by Barry Gower and Colin Smith (the originals for Exhibition and Trade Liaison). The brief was to grow the meeting with special reference to the Commercial side to increase revenue and expand the meeting to enable the Association to continue to grow and prosper.

My personal objectives included this and also to bring all the parties together by creating a "brand" and an experience that would be successful by giving all a "happy shopping experience" so that you all would come back for more. This would be done by engendering an ethos of respect, enjoyment and professionalism. This journey saw the role extend and develop into Trade Liaison for the NAC, BSCC and BAC. Internally the role also extended into Entertainments Manager and many more facets besides.

Over the years there have been so many highlights and periods of enjoyment. Initiatives included Best Dressed Stand completion, themed evenings, and record pack down award. Digital photography was adopted very early on with shows given on the stand on the Sunday morning along with the now famous hangover stand. At the height of our meetings we had over 30 companies and over 400 delegates. Dealing with that workload along ensuring one's own stand and equipment (let alone workshops) was set up and providing the entertainment was sometimes a stretch but never a chore.

As a journey it has been so full of fun and together we have obtained great successes such as hosting IAC and ECC.

I have laughed with you, cried with you (when we buried our own far too early) danced with you, played for you, been to hospital with delegates, answered police questions and acted as a bouncer, AV technician, MC and porter. It's been an absolute privilege to serve you all and thank you for the support, encouragement, memories and friendships that will endure forever.

The journey isn't over as I am only stepping aside and will be in background to help and give advice if needed. I will be in contact with you personally, through business or via the IBMS where I have the pleasure of being Liaison for the commercial

Scientific Advisory Panels (Inc. Cytopathology) on behalf of the Companies Members Committee.

As you well know the market place and cytology landscape is changing rapidly. Fresh ideas and energy are needed so my last task for you is to write the job specification for the next part of the journey. This is now completed and I wish my successor all the very best and hope they have as much fun as I did.

I hope the path I have helped steer has been as an enjoyable one for you as it has been for me. To help demystify the title of this article - York Railway Museum was my last meeting and 007 my NAC Membership number; rather apt giving the peace keeping and mediation needed when representatives from Amnesty International gate crash one of our famous parties!

I mentioned success earlier on; a measurement of that success is how well our meetings and Association are seen and regarded by our commercial partners. The commercial companies not only thank us for our meetings but really look forward to them. This is unique and I am proud to have played my part in this. Before I leave I would like to offer a big thank you to Colin and Barry for the opportunity and the various committee members of the association and societies along the way as it's been the most brilliant time and experience. I will miss it, I will miss you.

BAC British Association for Cytopathology

IBMS INSTITUTE OF BIOMEDICAL SCIENCE

Preparing for the Future

Saturday 13th October

DoubleTree Hilton Hotel, Nottingham

Programme

9 – 10am	**Registration**
10am	**Welcome**
10.10am	**Implementation of HPV Primary Screening** David Wells, Head of Pathology Services Consolidation, NHS Improvement
10.30am	**Union Advice** Unite representatives
11.15am	Refreshment Break and Trade exhibition
11.45am	**Experiences from Wales and Scotland** Panel of speakers
12.30pm	**Supporting Alternative Roles** Dr Ash Chandra and Dr Tony Maddox (Including individual case studies)
1.15pm	Lunch
2.30pm	**BAC AGM**
3pm	**Assessing your options** Sarah May, IBMS
4pm	**Planning for change** Wendy Leversuch, HSL Pathology
5pm	**Close**

BIRMINGHAM CYTOLOGY TRAINING CENTRE

BCTC gynaecological cytology courses are provided in SurePath *and/or* ThinPrep LBC

Please see our website for a full list of courses:

https://www.bwc.nhs.uk/cytology-courses

Courses IBMS CPD registered as appropriate

NHSCSP TRAINING IN CERVICAL CYTOLOGY

NHSCSP Training Introductory Courses - *tba if required*

Follow-on Course - 12-16 November 2018

Pre-Exam Course - 8-10 May 2019

UPDATE COURSES IN GYNAECOLOGICAL CYTOLOGY

28 September 2018 (MDT Cases and Squamous Lesions) ThinPrep - FULLY BOOKED

16 October 2018 (Squamous Lesions and Small Cells) - SurePath

22 October 2018 (HPV Update and Glandular Lesions) ThinPrep - FULLY BOOKED

23 November 2018 (MDT Cases and Squamous Lesions) ThinPrep- FULLY BOOKED

Provisional dates for 2019:

29 January 2019; 27 February 2019; 29 March 2019; 15 May 2019; 28 June 2019

BIRMINGHAM HISTOPATHOLOGY COURSE

10-22 June 2019

(plus optional personal revision time during course weekends & Mon-Tues 24-25 June 2019)

This two-week course provides topic based lectures on systemic pathology, slide review of selected cases followed by discussion and a revision session including mock exam in preparation for the FRCPath Part 2 exam.

PREPARATION FOR THE CERTIFICATE IN HIGHER CERVICAL CYTOPATHOLOGY TRAINING (CHCCT)

18-19 February 2019; 9-10 September 2019

The programme for this course is a combination of lectures workshops and multiheader sessions. Includes a mock exam and is particularly suitable as revision for the Certificate in Higher Cervical Cytology Exam Following this course participants are welcome to attend for personal revision.

NON-GYNAECOLOGICAL CYTOLOGY FOR TRAINEE PATHOLOGISTS

11-15 February 2019; 29 April -3 May 2019; 2-6 September 2019

The programme for this course is comprehensive and includes the salient aspects of diagnostic non-gynaecological cytology. This course includes a mock exam and is particularly suitable as revision for the FRCPath Part 2 exam

AUTOPSY PATHOLOGY COURSE

24-25 September 2018

This two-day course addresses the fundamentals of the autopsy including external examination, dissection techniques, post-mortem toxicology and suspicious deaths. The course is aimed at Stage C/D trainees in Histopathology and Consultant Pathologists practicing autopsies.

INTRODUCTORY COURSE FOR ST1s

26-30 November 2018

Introduction to Gynaecological and Non-Gynaecological Cytology including Autopsy element for regional ST1s

TRAINING OFFICERS' MEETINGS

19 October 2018; 5 April 2019

LBC Conversion Courses and *ad hoc* workshops can be arranged on request—please contact BCTC

LBC Sample Taker Initial and Update Training sessions are arranged regularly throughout the year

For further details and reservations please contact Amanda Lugg or Louise Bradley

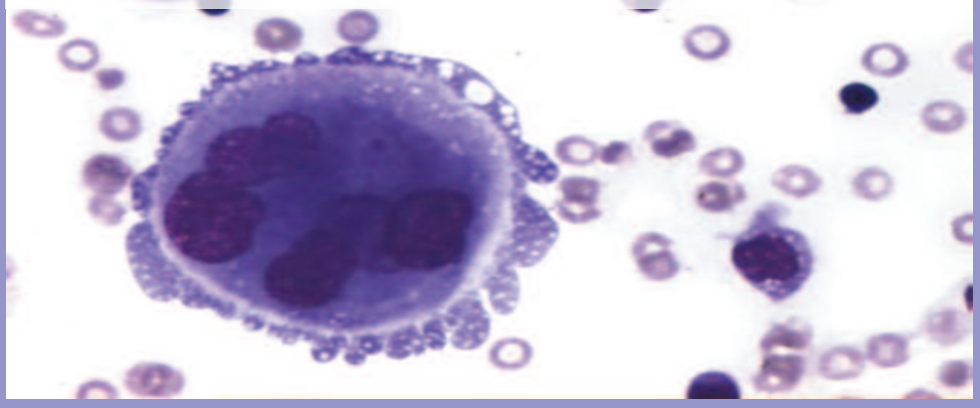
Birmingham Cytology Training Centre, Birmingham Women's Hospital, Birmingham, B15 2TG

Phone: 0121 472 1377 Ext 5081/5082 | Email: bctcenquiries@bwnft.nhs.uk

Website: https://bwc.nhs.uk/cytology-training-centre

NEPSEC North of England Pathology and Screening E

Non Gynaecological Cytology



Training Opp 2018/

Courses in Expert Practice Diagnostic Cytology

These courses cover serous fluids, urine and respiratory cytology and are ideal for anyone wishing to further their experience or workings toward the IBMS DEP

20th, 21st, 22nd, 23rd November 2018

Exam Practice for the Diploma of Extended Practice in Non-Gynaecological Cytology

Ideal for anyone taking the IBMS Diploma of Extended Practice in Non-gynaecological Cytology

16th – 17th May 2019

Non-Gynae Cytology Workshops

Ideal for non-medical staff new to diagnostic cytology wishing to gain experience in sample collection and preparation techniques

Early 2019

Three Day Update Course in Consultant Biomedical Scient

It includes elements of Gynae Hi and MDT cases amongst other t

14th – 16th November 2018

Your Role as a Cervical Scree Hospital Based Programme C

This course is developed in asso AMG to guide both experienced the role and covers many differe CSPL may encounter. **Early Ju**

Breaking Bad News A one-day communication sk

A one-day communication skills communication challenges, facil associated theory.

Early June 2019

For further information contact our Admin Team: sht-tr.nepsec@nhs.n

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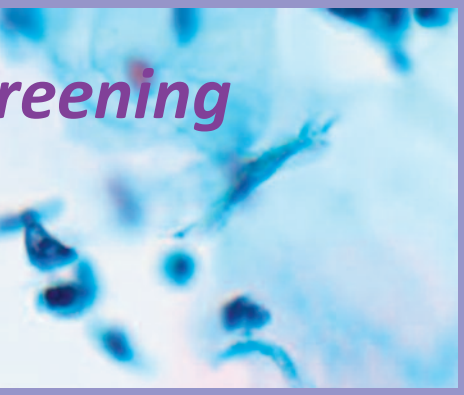

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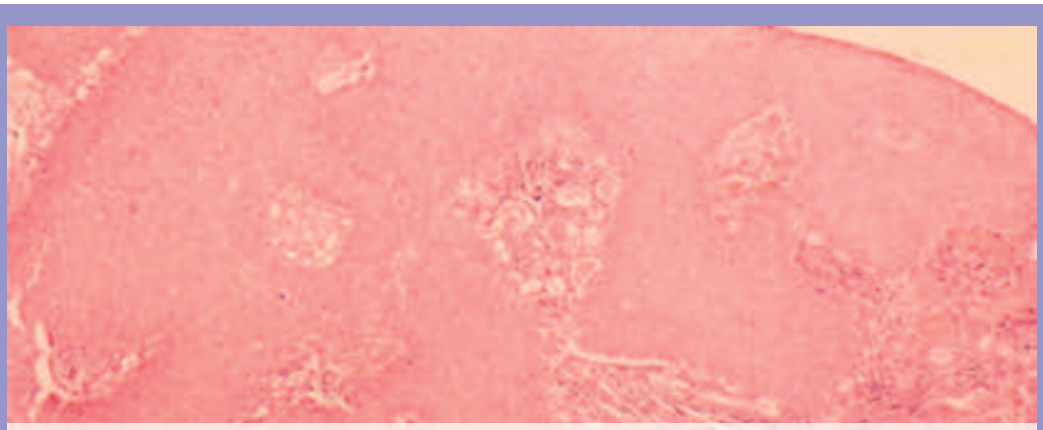

Histopathology

BMS Reporting in Histopathology

Stage A & C GI & Gynae Exam Preparation Day

These days are specifically for those working towards stage A or C part of the BMS reporting qualification

Stage A – Spring 2019

Stage C – Summer 2019

A Course for the Expert Role in Specimen Dissection

This course is suitable for BMSs who intend to train as Histological tissue specimen dissectors, in particular those undertaking the RCPath/IBMS Diploma. It covers all the mandatory elements and a selection of specialist modules including:

Gastrointestinal and Hepaobiliary; Gynaecology; Breast; Skin; Osteoarticular and Soft Tissues; Genito-Urinary; Exam and Portfolio; Endocrine & Head and Neck

Commencing on 6th & 7th November 2018 with the Introductory Modules. Specialist module sessions are - scheduled throughout 2019.

Scottish Cytology Training School

Programme 2018-2020

No course fee is charged for Gynae cytology courses to employees of Scottish NHS Trusts

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Application forms available on request from:
scts@nhslothian.scot.nhs.uk

NHSCSP Accredited Training Centre

Courses held at
The Bioquarter, Royal Infirmary of Edinburgh, 1st Floor, Building 9, Edinburgh Bioquarter, 9 Little France Road, Edinburgh. EH16 4UX

Unless states (QEUH) Glasgow

Non-NHS Labs – price on application
All courses are Liquid Based Cytology (ThinPrep)

Introductory Course
18th February – 15th March 2019
2nd – 27th September 2019
£1000

Introductory Course Part 2
19th November – 23rd November 2018
18th November – 22nd November 2019

Update Course
7th November – 8th November 2018 (QEUH)
5th December – 6th December 2018
6th February – 7th February 2019
19th March – 20th March 2019
5th June – 6th June 2019 (QEUH)
6th November – 7th November 2019 (QEUH)
4th December – 5th December 2019
5th February – 6th February 2020
£100 per day

Pre-Exam Course
21st August – 23rd August 2019
(for October Exam)
£250

Workshops – BMS Medical/Consultant Staff
27th November 2018
26th November 2019
£100

ST1 Intro to Cervical Cytology
2nd September – 6th September 2019

Course for Colposcopists
8th & 9th May 2019
£100 per day

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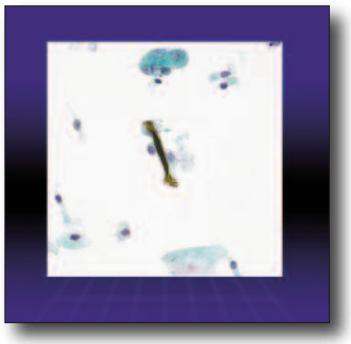
Front Cover image:
Asbestos fibre in a respiratory cytology sample. The editor is indebted to Dr Paul Cross, Queen Elizabeth Hospital, Gateshead Health NHS Foundation Trust.



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