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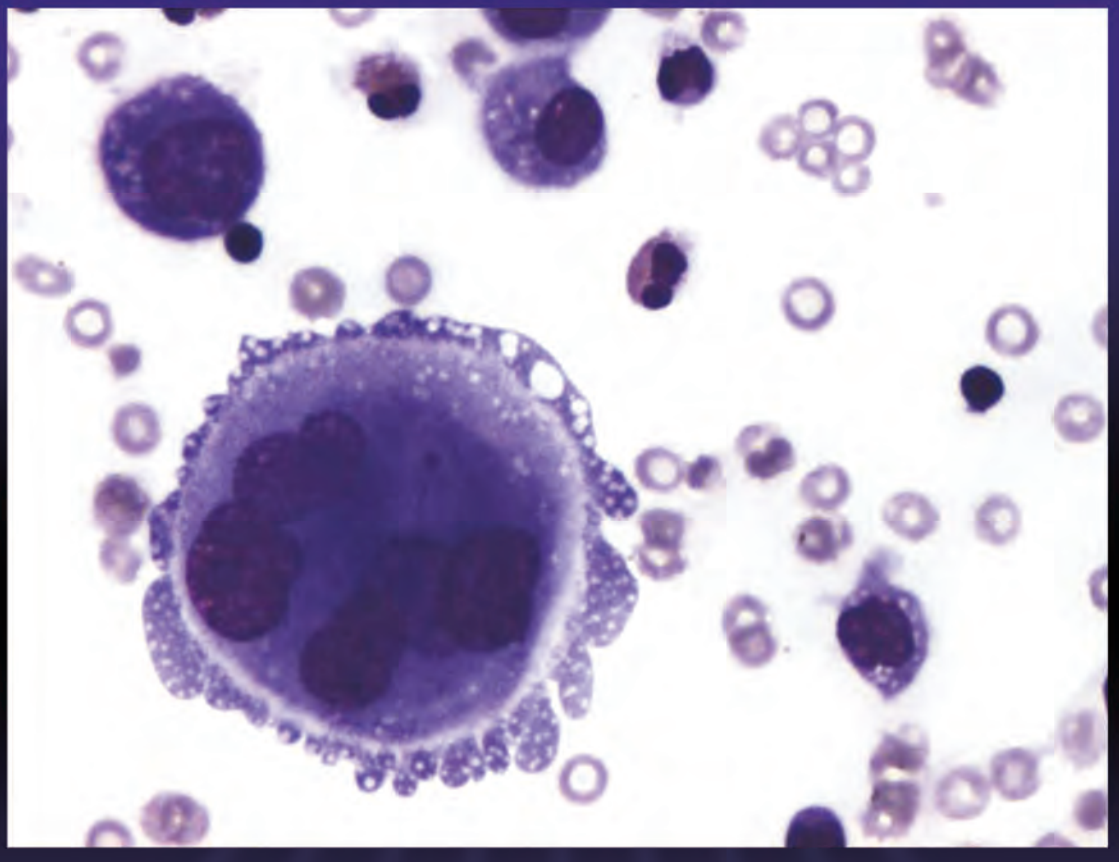

BAC British Association for Cytopathology

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Editorial

Sharon Roberts-Gant

Here we are again the pre-Chrismas edition of SCAN! In this edition I hope we have something for everyone.

There are updates from the subcommittees, conferences reports / feedback (although not our own), some 'coffee break' reading with horoscopes, crossword and an insight into the workings of a large laboratory.

Jenny Davies continues to organise CPD for us and we have a couple of quizzes and a case study. The IBMS have kindly agreed to the reproduction of their registered science technicians and registered scientists article which introduces the new voluntary registers for these staff and explains their purpose.

The Olympics did not pass us by — Dr Mina Desai was a torch bearer. Mina was recognised for her contribution to the NHS Cervical Screening and her work in raising awareness of cancer prevention amongst women particularly from minority ethnic communities.

I hope you enjoy this issue. Any suggestions for future articles are welcome. Articles for the next edition of SCAN should be sent to Andrew Evered.

Sharon

Copy date for April 2013: 5th February 2013, Editor Andrew Evered.

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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 column

Karin Denton

By the time you read this the annual scientific meeting will have been and gone, and I hope those of you who attended will have enjoyed it and found it interesting. We know that attendance at the meeting will be lower than in the past, and we know there are many and complex reasons for this. In particular, the number of cytoscreeners registered is particularly low. This is a concern because the BAC is fully committed to serving the interests of the profession as a whole, including all grades of staff. But we know these are challenging times in cytology. BAC members are stressed by the prospect of mergers, competitive tenders, TUPE, and redundancy. Even for those working where service configuration is not changing, there is often a problem with funding training. One of the main drivers for the merger of the BSCC and the NAC was to form a single Association which could be strong in the face of these and other challenges — so to all those members feeling stressed I would say please stay engaged with the Association, tell us how we can help, and we will attempt to do so.

There is a lot for the executive to work on over the coming months, and its not just keeping an eye on quality during the process of mergers. In cervical cytology, there is the issue of major changes to commissioning in England, a possible HPV primary screening pilot, and potential changes to programmes involving automation and HPV testing in Wales and Scotland. In diagnostic cytology, we are still trying to address the falling profile of this work in the UK, which is so out of step with the rest of the world, as well as working with others to look at further extended roles.

So have a look at what the BAC is doing, and if we aren't doing something you think we should be, let us know!

Chairman's Report

Allan Wilson

Arithmetic was never one of my strengths but as this is my third report for SCAN I must now have been in the chair for one year. It has been an eventful year in the world of cytology as the pace of change continues to gather speed. The previously static or slowly evolving profession that we all knew and loved is now embracing changes that we could not have contemplated a few years ago.

Our Association must adapt quickly to meet the challenges that have emerged from changes in the screening programme and scientific advances. The recently published 3rd edition of the ABC document reflects the changes that we are facing and I suspect a 4th edition will be required sooner than the 11 year gap between the 2nd and 3rd editions.

By the time this issue of SCAN is circulated, the 1st BAC scientific meeting which was held last month will be a distant memory. I hope those of you who attended enjoyed the conference and left feeling informed and enthusiastic to face the challenges ahead. It is fair to say that we have struggled to attract delegates to cytology meetings over the last few years. Falling delegate numbers at BSCC and NAC meetings was a driver for merger and the formation of the BAC. At the time of writing delegate numbers for Keele are not yet as great as we had hoped, but I am sure that the usual late booking surge will no doubt have produced a healthier figure. This has been the cause of much head scratching among the executive. At a recent teleconference we identified many reasons for falling delegate numbers including lack of funding, meeting venue, uncertainty about the future of cytology and refusal to release staff to attend meetings. However, we need to hear the thoughts of our members; your executive genuinely wants to design a meeting that is attractive to all members, feedback from our membership is essential to this process.

Partly based on falling delegate numbers, the Executive has decided to move to holding scientific meetings every two years rather than annually. This decision was not made lightly but based on our experience of organising both NAC and BSCC ASM's and the potential clash every second year with IBMS congress. The plan is to alternate annually between a 2-3 day scientific meeting and two tutorials held in the spring and autumn. Our next scientific meeting will be in 2014. Alison Cropper will provide more information in her report in this issue of SCAN

Elsewhere in this issue of SCAN, Paul Cross will summarise the results of our first on-line survey. This has been a great success and will be used to inform decision making within the executive. As I indicated in my last report in SCAN there will be more web based surveys as we try and build a database that reflects the practice and practitioners of Cytopathology in the UK.

A group chaired by Louise Smart has been established to review the BSCC code of practice for cervical cytology. One of the issues identified when writing the first version of this document was the lack of an evidence base for some of the guidance. Where evidence is found to be

lacking in the review, website surveys will be used to provide evidence of professional practice. We are reliant on our membership to respond to these requests and help produce an updated code of practice that is based on what is actually happening in cytology labs. It is indicative of the changing times we are facing when we must review the code of practice only two years after Nick Dudding chaired the group who wrote the last edition, perhaps we should pencil in the next revision to start in 2014.

Members of the executive have been speaking at regional cytology meetings over the last year. I attended the Scottish meeting in May and Fraser Mutch attended the Southern Society meeting in June. This provides an opportunity to report on BAC executive activities and to get feedback from local delegates. I am keen to build on these links and to hear how the BAC can help ensure they continue to thrive and to investigate the possibility of breathing life into dormant societies around the country as there are now only four active regional societies. Your executive is particularly keen to hear from anyone who was previously involved in a now dormant regional society who is interested in re-launching the society; we will provide whatever support we can.

Steady progress has been made to launch a non-gynae cytology EQA scheme and to develop an "AP" style exam for non-gynae. The information gathered from the website survey will establish the demand for the EQA scheme and a full proposal to establish the new exam will be submitted to the conjoint board for discussion at the next meeting in January 2013.

The BAC has had a challenging first year, we continue to evolve as a professional body but the changes facing our profession require a different approach form the executive and from our membership. Decision making must be rapid and more than ever we must be proactive. We continue to use teleconferencing to make decisions between scheduled executive meetings but it is vital that we communicate these decisions effectively within the executive and to all our membership. It is equally important that our membership is confident that any questions or concerns will be speedily addressed. The membership email distribution list is now live and if anyone is not receiving emails from the BAC please contact Christian Burt on christianburt@ibms.org. The website is now well established and will be used in conjunction with email to communicate frequently and effectively with our membership.

Eurogin 2012

Dr Karin Denton

In July, a small contingent of cytology from UK cytology attended Eurogin, an annual conference held in various attractive European venues, and traditionally heavily driven by the HPV agenda. On this occasion the conference was in Prague, which was hot and sunny at a time when the UK was neither, though with sessions running from 8 am to 7 pm there wasn't a lot of time to see it.

This year, there was a lot of time devoted to HPV related disease elsewhere in the body, emphasising the fact that this is a conference about HPV rather than just about cervical cancer prevention.

I was there with my colleague Kath Hunt, and enjoyed watching her give a presentation on our experience with the Cervista HPV platform in Bristol. I was slightly concerned because in the programme I was listed as giving the talk, and Kath said she would turn up dressed outrageously and say anything she wanted, safe in the knowledge that both the appearance and content would be attributed to me. In the event they got her name right, but I would have been quite happy either way.

We both thought it was important to have a cytology presence there, because too often HPV experts forget that in the UK at least, cytology remains a very effective means of preventing cervical cancer. Having said that, it is depressing to hear sensitivity of cytology quoted as less than 50% in some other European countries. We desperately need to ensure we are not dragged down by this kind of statement.

I learnt about the big high profile studies, like Athena in the US, and the useful information it has given us on for example the significance of HPV genotyping, and there were the beginnings of some useful thoughts about HPV types and effect on colposcopy outcomes.

Much of the rest of the world has a very different approach. It was fascinating to hear that in Brazil, colposcopy is cheap but cytology is very expensive, and we were frankly appalled at a talk about a project offering HPV testing to women in Mexico, finding lots were positive, but having no infrastructure to identify those who needed treatment.

The manufacturers of HPV testing platforms were able to present all their latest research but sadly the piece of work which everyone in the UK will be looking out for, the detailed outcomes from the comparative study of Genprobe, Abbott, Roche Cerivsta and HC2, wasn't ready. This will be published at IPV, the next big HPV meeting to be held in Costa Rica in December. Sadly, I'll have to give that one a miss.

Dr Peter A Smith – An Appreciation

Dr T Giles

Dr Peter Smith has been elected as the first Honorary member of the British Association for Cytology, the highest honour which the society can bestow. In celebration of this I present a personal view on the exceptional contribution he has made to cytology in the United Kingdom.

Peter developed an interest in cytology early in his career as a result of a training attachment to Australia during which he worked with recognised giants in the country, such as Greg Sterrett and Svante Orell. Almost to the day he retired he would still quote lessons he had learnt from these teachers, 'don't call things cancer unless you have a reason to call them cancer!' being a typical example. This experience put him in a strong position to begin his Consultant career and so it was with confidence and enthusiasm that he commenced in Liverpool in 1985.

Most of us look forward to a settled period to establish ourselves when we first start a new job, but Peter was not to get this luxury. It was soon apparent that there were significant problems in the cervical screening department and Peter had the unenviable job of tackling this, which would turn out to be the first major cervical cytology scandal the country had seen. Not only did this result in a formal enquiry, but also an appearance in the national press. One article reported that Peter had personally reviewed 40 000 cervical smears. Clearly not everything written in the press is accurate, but Peter's superhuman reputation was already becoming established.

The work involved in sorting out this problem put an understandable strain on Peter, and I am sure at times the barbed wire fence outside his office felt more like a means of keeping him in rather than keeping local criminals out, but we can now recognise that this gave Peter many of the skills that he used to drive cytology forward. Certainly when another major scandal emerged in the Kent and Canterbury laboratories, there really was only one man to call and Peter found himself investigating his second major cervical cytology failure. In many ways, the experiences in Australia and the turmoil he arrived to in Liverpool are the bedrock on which his career are built.

I first came to know Peter when I was a trainee in Liverpool in 1994. At this time Peter showed himself to be incredibly knowledgeable and approachable, always willing to share his skills and enthusiasm for the subject. The legacy Peter leaves is not only the standard now expected in cytology, but the enthusiasm and skills which the next generation possess to allow cytology to continue as a core discipline in the diagnosis and management of patients.

Peter offered his time freely to the BSCC, rising to be Chairman of the society between 1998 and 2001 and subsequently President. He lead the society with authority and determination and again faced troubles. Once again he found himself in the national press, having the stressful experience of appearing before cameras on the BBC defending the society. This was not the first time he had appeared before camera, though. Any of you who still have the original BSCC video on taking cervical smears will see Peter performing professionally at the start of this.

Peter still had one major contribution to cytology to make. When medical politics started to seriously consider breaking down professional boundaries, one of the first areas to consider was the reporting of cervical cytology. The Institute of Biomedical Science and Royal College of Pathologists were charged with working together to develop an advanced role for Biomedical Scientists allowing them to report abnormal cervical cytology and provide clinical advice. With his experience of running the BSCC Certificate of Competence in cervical cytology, Peter was again an obvious choice, and he worked with Eileen Hewer to develop the Advanced Biomedical Scientist practitioner role which quickly became established and is now a key role in the cervical screening service.

As Peter's career moved towards retirement he continued to take on leading roles. He has chaired the Cytopathology Sub-Committee of the Histopathology Standing Advisory Committee of the Royal College of Pathologists, been chairman of cytopathology examiners to the Royal College of Pathologists and represented Cytopathology on the Advisory Committee on Cervical Screening to the Department of Health. Even in retirement he has remained the chairman of the QUATE examination in Europe, and remains an active assessor for Clinical Pathology Accreditation services.

This whistlestop tour has really only scratched the surface of Peter's career. His contribution has been immense and many of his achievements underpin the practice of cytology in the UK today. I am delighted the BAC has recognised this by awarding him honorary membership and personally can think of few more deserving of this honour. As he retires he will be an immense loss to the discipline. The responsibility now passes to those remaining to continue his work and ensure the benefits that cytology bring to medicine are not lost.

Meet the BAC Executive

Melanie Buchan

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I am a cytology screener based at Derby and I absolutely love my job!

I was delighted to have been considered, nominated and proposed for the BAC Executive Committee election and so imagine how thrilled I was when I discovered I had been successful in the recent ballot! Thank you to all who voted for me.

I have been with the NHS since 2001 and started my Cytology career in April 2007 when I trained at the Leicester Royal Infirmary and qualified in August 2009. I thoroughly enjoyed studying for my City & Guilds Diploma in Cervical Cytology and have gained a real passion and enthusiasm for the subject.

I very much enjoy the Journal Based Learning exercises and would urge all Screeners out there to have a go at them, especially as we now receive the Cytopathology Journal as part of our BAC Membership.

I would like the BAC, its website and linked publications to be the focal point for its members, providing effective communication of information as well as reassurance and support with regard to future developments affecting cytology. I am looking forward to contributing to the promotion of the BAC and helping it to achieve its aims. I am also keen to represent the role of Screeners especially in today's ever evolving and challenging discipline of Cytology.

Outside of work, I enjoy country walks, gardening, visiting galleries & museums and listening to The Archers!

So tell us what you want, what you really, really want!

Well, the Meetings sub-committee have had a really busy time since the merger of the BSCC and NAC to form the BAC in 2011, a decision ratified by the membership of both societies at their respective AGMs held within the joint conference at Keele University in July 2011.

No sooner had that conference finished and we were planning for the inaugural conference and AGM of the BAC, which will be held September 14-15th 2013, again hosted by Keele University. By the time you read this article in Scan the conference will have been and gone, but a full conference report and photos will be appearing in the next edition.

Delegate feedback from the joint conference in 2011 was all taken into account when planning the recent 2012 event, with the main change being the move from July to September, the most preferred month by far. However, it was too late to look at alternative venues because those which would be most suitable for the BAC tend to get booked up several years in advance. However, this is already being addressed for the next conference which will be held in September 2014.

Please note the year — 2014. Allan Wilson has already mentioned in his Chairman's report that this has not been an easy decision for the BAC Executive to make, but as he has explained, with our decreasing membership and the ever increasing financial pressures that both we in the Cytology profession and our commercial colleagues who have traditionally sponsored our meetings are working under, we felt that there was no option in the short term. It would be wonderful to think that this is just a temporary measure and that in the not too distant future annual scientific meetings can be resurrected for the BAC and go on to be as successful as both the BSCC and NAC have enjoyed in the past.

Rest assured, however, that the Meetings Sub Committee are diligently working away to provide a variety of educational events for 2013, commencing with a joint meeting with the Association of Clinical Pathologists to be held in London on June 6-7th — the theme will be 'Screening' and we thought it was too good an opportunity to miss a joint meeting with that topic! Watch the BAC website for more details as they emerge.

A day meeting will also be held in the autumn, hopefully to include much more in the way of morphology talks and workshop style microscopy sessions following the huge success of the BAC Spring Tutorial in March 2012 at Guys and St Thomas' Hospital in London. Many thanks go to Dr Ash Chandra, who organised and hosted a programme of non-gynae lectures and workshops that attracted a capacity audience.

We are always looking for new ideas for format / venue / content of scientific meetings and will aim to deliver what our members want, so please do not hesitate to get in touch and let the Meetings sub-committee know

exactly what it is that you want (what you really, really want). Our contact details can be found inside the front page of this Scan and also on the BAC website — we look forward to hearing from you — I can assure you that your thoughts, ideas and suggestions will be very much appreciated.

Alison Cropper, Chair
Dr Paul Cross
Kay Ellis
Dr Fraser Mutch
David Carter, CellPath Ltd (trade liaison officer)

Meetings Sub Committee

BAC Publications update

Like all societies, we try hard to keep our membership informed and up to date. We are using regular email shots to alert members to significant issues, and remind them of major events such as the recent ASM in Keele. It is imperative that we have up to date email addresses for every member – if yours changes (which seems to happen very regularly with NHS changes these days!) make sure we have your new one. The website is also updated and again you need to visit it regularly to keep an eye on developments in cytology and the BAC in particular. We undertook our first survey via email and the website – as I write this article the survey is still on going, but the power of using such an approach to harness views from all of you involved in cytology is amazing. Again, the survey results are only ever as good as the number of responses we get – take part and contribute on the next ones! We aim to use the survey approach more often, and use it to help shape BAC thinking but also help ensure any guidance etc. is as much reflective of current and future thinking and practice as we can.

The website itself is still in its infancy, but developments in the near future should be a greater educational content, a commercial suppliers' page, and a greater members' interactive approach with a members' only area. The latter will require a secure log on, and details of this will be announced soon. We also are keen to help place adverts for cytology posts (at a modest cost!) to help encourage the BAC website as the place to go for all matters cytological. The website is visited from all parts of the UK, but also all around the world – if you have any ideas or suggestions again please contact us. The website is for your use so help us develop it for you!

Production of SCAN and Cytopathology is also of great importance to the BAC. They are very different journals with very different aims. Cytopathology continues to be the scientific peer reviewed journal, with content from all over the globe, and is the chosen journal of many other cytological societies within Europe. It aims to be the leader in its field. SCAN is a more members' journal, with more BAC related material, often scientific but also more light hearted. Again, contributions are welcome!

Dr Paul Cross
On behalf of the Media/Publications SC

Education Sub-Committee

BAC Bursary
One of the main aims of the BAC is to support education and training. With that in mind, a Bursary Scheme has been established to offer financial support to assist members of the BAC to undertake educational or training opportunities that might not otherwise be possible. An application form is available to download from the BAC website. Funds are not unlimited and the granting of funding is entirely discretionary. It will be necessary to demonstrate the benefit to the individual and the individual's department in undertaking the activity. Also, it is not intended to substitute for financial support that should be provided by an employer, e.g. attendance at Update Courses.

Regional Societies
On the 26th of May, I attended the Southern Cytology Society meeting in Guildford to give a short presentation about our new Association. Although it was a blistering hot Saturday, the meeting was very well attended and the audience listened with interest despite it being late in what had been a long day. Afterwards, a couple of people told me they were having problems with non-receipt of either SCAN or Cytopathology. If you are in a similar position, please contact Christian Burt (christianburt@ibms.org).

The BAC is very keen to provide support to regional cytology societies although it would appear that no more than four are currently active. If you are the Secretary of a society, active or not, please get in touch with us.
The BSCC previously provided each active society with a free place at the Annual Scientific Meeting and the BAC has agreed to carry on this tradition.

Modernising Scientific Careers
A draft Learning Guide for Cytopathology for use in the Scientist Training Programme has recently been released and the BAC will be providing professional input into the production of the final document. If you have any questions or comments about this or training issues in general please let us know (fraser.mutch@nhs.net).

BAC Subcommittee structure

Education SC (ESC)
Fraser Mutch (chair)
Jenny Davies (CEC)
Karin Denton
Tom Giles
Alison Copper (CSC chair)

Meetings SC (MtSC)
Alison Cropper (Chair)
Paul Cross (Scientific programme)
Fraser Mutch (ESC chair)
David Carter* (Company rep)*
Kay Ellis

Non-gynae working group (NGWG)
Tom Giles (Chair)
Paul Cross
Louise Smart
Allan Wilson

Membership SC (MSC)
Louise Smart (chair)
Christian Burt
Sue Mehew
Allan Wilson
Mina Desai

R&D subcommittee (R&DSC)
Mina Desai (chair)
Karin Denton
Andrew Evered * (website)
Jackie Jamieson*(IBMS)

Publications/website SC (PSC)
Paul Cross (chair)
Andrew Evered*(website)
Amanda Herbert (Cytopathology)*
Sharon Roberts-Gant (SCAN)*

Additional Roles/proposals

- No formal finance subcommittee, an ad hoc group of Treasurer, shadow/deputy treasurer and the chairman will discuss finance issues
- Jenny Davies to be BAC representative on IBMS Cytopathology SAP
- Karin Denton, Tom Giles, Fraser Mutch and Alison Cropper to be BAC representatives on NCCETC. This representation will be under regular review
- Sue Mehew and Tom Giles to be NCCETC exam subcommittee representatives
- BAC representative on ACCEA to be Mina Desai
- BAC representative to RCPath to be Karin Denton
- EFCS and Cytopathology editorial board : Allan Wilson and Karin Denton

Summary of Roles

Melanie Buchan	ESC			
David Carter*	Company Representative	MtSC member		
Rosie Clarke*	NQAAP rep			
Alison Cropper	Chair CSC	ESC member	NCCETC	
Paul Cross	Programme lead MtSC	NG WG member	Chair of PSC	
Jenny Davies	ESC member	CEC organiser	IBMS rep	
Karin Denton	President	ESC member	NCCETC	RCPath
Mina Desai	R&DSC chair	MSC member	ACCEA	
Kay Ellis	Treasurer	MtSC member		
Andrew Evered*	Webmaster	PSC member	R&DSC	
Tom Giles	Chair of NGWG	ESC member	NCCETC	NCCETC ESC
Amanda Herbert*	Cytopathology editor	PSC member		
Jackie Jamison*	R&D SC member			
Sue Mehew	Secretary	MSC member	NCCETC ESC	
Fraser Mutch	ESC chair	MtSC member	NCCETC	
Sharon Roberts-Gant*	Editor SCAN	PSC member		
Louise Smart	Chair of MSC	NGWG member		
Allan Wilson	Chair	NGWG member	MSC member	

*Co-opted members

Research and Development Sub-Committee Update

Dr. Mina Desai, Chair, Research and Development Committee

NEW REVISED AMERICAN GUIDELINE FOR CERVICAL SCREENING

The American Cancer Society (ACS) guidelines for the early detection of cervical cancer was last reviewed in 2002. From 2009 to 2011, the American Cancer Society, American Society for Colposcopy and Cervical Pathology and American Society for Clinical Pathology worked together and convened an expert panel to develop new screening recommendations based on systematic reviews and available evidence. 6 working groups were formed to address the following topic areas.

1) Optimal cytology screening intervals.
2) Screening strategies for women aged 30 years and older.
3) Management of discordant combinations of cytology and HPV results (eg, HPV positive, cytology negative and HPV negative, ASC-US results).
4) Exiting women from screening.
5) Impact of HPV vaccination on future screening practices.
6) Potential utility of molecular screening (specifically, HPV testing for primary screening was assessed as a potential future strategy).

They were specifically directed not to consider financial cost in making their recommendations

A consensus symposium was held in Bethesda on November 17 through 18, 2011 to discuss, revise as necessary, and vote on the final recommendations. This symposium was attended by 25 organisations.

I was the only outsider (outside of America and Canada) who was invited to attend this symposium. I was allowed to give my opinion but I had no voting right. I thoroughly enjoyed this symposium. I learned quite a lot. The Americans do it differently and although the culture is different, the process was very democratic and the decisions were not financial driven.

The following recommendations came out of this process:

American Cancer Society Guidelines for the Early Detection of Cancer

Cervical cancer

- **Cervical cancer screening (testing) should begin at age 21.** Women under age 21 should *not* be tested.
- **Women between ages 21 and 29 should have a Pap test every 3 years.** Now there is also a test called the HPV test. HPV testing should *not* be used in this age group unless it is needed after an abnormal Pap test result.
- **Women between the ages of 30 and 65 should have a Pap test plus an HPV test (called "co-testing") every 5 years.** This is the preferred approach, but it is also OK to have a Pap test alone every 3 years.
- **Women over age 65 who have had regular cervical cancer testing with normal results should *not* be tested for cervical cancer.** Once testing is stopped, it should not be started again. Women with a history of a serious cervical pre-cancer should continue to be tested for at least 20 years after that diagnosis, even if testing continues past the age of 65.
- **A woman who has had her uterus removed (and also her cervix) for reasons not related to cervical cancer and who has no history of cervical cancer or serious pre-cancer should *not* be tested.**
- **A woman who has been vaccinated against HPV should still follow the screening recommendations for her age group.**

Some women — because of their history — may need to have a different screening schedule for cervical cancer.

The new screening recommendations also address follow-up (eg, the management of screen positives and screening intervals for screen negatives) of women after screening and future considerations regarding HPV testing alone as a primary screening approach, and screening strategies for women vaccinated against HPV16 and HPV18 infections.
I would highly recommend to our members to read the following article:
American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology screening guidelines for the prevention and early detection of cervical cancer.
Saslow D, Solomon D, Lawson HW, Killackey M, Kulasingam SL, Cain J, Garcia FA, Moriarty AT, Waxman AG, Wilbur DC, Wentzensen N, Downs LS Jr, Spitzer M, Moscicki AB, Franco EL, Stoler MH, Schiffman M, Castle PE, Myers ER; ACS-ASCCP-ASCP Cervical Cancer Guideline Committee.
CA Cancer J Clin. 2012 May;62(3):147–72. doi: 10.3322/caac.21139. Epub 2012 Mar 14.

References

1) American Cancer Society. Detailed Guide: Cervical Cancer. Accessed at http://www.cancer.org/Cancer/CervicalCancer/DetailedGuide/index on March 15, 2012.
2) American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology screening guidelines for the prevention and early detection of cervical cancer. Saslow D, Solomon D, Lawson HW, Killackey M, Kulasingam SL, Cain J, Garcia FA, Moriarty AT, Waxman AG, Wilbur DC, Wentzensen N, Downs LS Jr, Spitzer M, Moscicki AB, Franco EL, Stoler MH, Schiffman M, Castle PE, Myers ER; ACS-ASCCP-ASCP Cervical Cancer Guideline Committee. *CA Cancer J Clin*. 2012 May;62(3):147-72. doi: 10.3322/caac.21139. Epub 2012 Mar 14.

An update from Scotland on the role of HPV testing

Allan Wilson

The Scottish Cervical Screening Programme (SCSP) is considering the potential role of HPV testing within the programme. As part of this process an HPV Workshop was held on 23rd April 2012. The workshop was attended by a wide range of SCSP professionals including representatives from laboratories, colposcopy, screening co-ordinators, sample takers and primary care. All Scottish cytology laboratories were well represented. After presentations setting the scene, the delegates split into break out groups including one group which included all the laboratory representatives.

The main options discussed were:

1. **Primary HPV testing with cytology triage**
2. **HPV triage of BNA/mild dyskaryosis**

The discussions centred around the recently published Healthcare Improvement Scotland evidence notes on triage and primary testing which can be found on the BAC website. These two documents are excellent summaries of the current evidence base for triage and HPV primary testing. However, the evidence is mainly from unvaccinated populations and there is limited evidence from younger women as most trials have been carried out in situations where screening does not start until age 30.

The group agreed that the prevalence of abnormal smears will decrease when vaccinated women enter the programme and this will reduce the sensitivity of cytology. The impact of vaccination in the older cohorts should already have been noted as they are now being screened. If the age of first screening changes to 25 the impact would begin at a later date. The 17yr old girls vaccinated in 2008 will be 24 in 2015

1. Primary HPV testing with cytology triage

There was consensus that the evidence generally supported this option. The group agreed that all women in the screening programme should be offered the same primary test and supported the proposal already under consideration to change the start of screening to 25yrs.

Reasons for adopting primary HPV testing for all women:

- Evidence it is beneficial in women over 35yrs
- No evidence of harm in women under 35 yrs
- It is the test of choice in a vaccinated population because of sensitivity
- Negative HPV allows an extended recall period because of high negative predictive value
- Programme management would be simple

The group agreed that a negative HPV test would permit an extended screening interval to 5 or 6 years. Triage of HPV positive smears with cytology would be required but again the group felt that all ages should undergo same triage.

Due to concerns about the impact on colposcopy and usefulness of colposcopy for low grade lesions the group felt that follow-up by cytology+/- HPV testing rather than referral to colposcopy would be more cost effective and no worse than the current situation.

2. HPV triage of borderline/mild dyskaryosis

The group unanimously agreed that this option should was not appropriate for the SCSP for the following reasons:

- There is poor logic in using a less sensitive test as the primary test followed by a less specific test
- It would not be cost effective in mild dyskaryosis as 80% are HPV +ve
- With cytology as the primary test the screening interval would remain at 3 years (older women particularly would not benefit from high negative predictive value)
- Limited evidence/value in younger women
- Not realistic in near future as primary HPV test best option in a vaccinated population
- Programme management would be complex (if younger age groups managed differently)

Summary

- Evidence for HPV primary testing in women over 35yrs is strong.
- Evidence excludes vaccinated women but by 2015 they will be included in SCSP thereby logical to include all age groups from the start
- It is illogical to introduce HPV triage of borderline/mild dyskaryosis smears

Issues to be addressed before implementation

The group was also asked to consider issues that would need to be addressed and any information that would be required before implementation of HPV testing. Issues that were highlighted and discussed are outlined below:

- HPV testing will result in fewer cytology samples, the reduction being greatest if primary HPV testing for all age groups is adopted. This will impact on staffing levels.
- Cervical samples will be mostly positive and it has yet to be decided who will screen the slides.
- Where will HPV testing be done?
- Should/could it be at the same location/laboratory as cervical cytology?
- Could the same staff do HPV testing and cytology?
- Development of an appropriate cytology triage protocol for HPV positive women is required.
- Modifications to the national computer system (SCCRS) would be required and the timescale should be calculated as a priority before implementation date was set. A working group is probably required.
- Should the new programme be implemented in phases or as a "big bang"
- Consideration should be given to a review of commissioning, funding, organisation and governance of the new programme.

SACC HPV symposium 24th May 2012

The conclusions of the workshop were discussed at a symposium at a meeting of the Scottish Association for Clinical Cytology (SACC) on 24th May. The speakers included Professor Heather Cubie from the HPV reference lab, Allan Wilson, cytology consortia manager and Dr Sheila Nicoll, chair of the QA group. The presentations and discussions are summarised below

Impact of vaccination

Scotland has high vaccination uptake in schools even in deprived areas but a significant decline in catch up programme for girls out of school. As women are invited for their first screen at age 20, by 2013, 50% of 1st ever smears will be from vaccinated women. There has already been a decline in HPV 16&18 prevalence in women attending for 1st smear. HPV 16 is by far the most common HPV type in Scotland

2nd generation HPV vaccines

New approaches to vaccination including nonivalent (9 HPV types) VLP based vaccines and therapeutic HPV vaccine for those already infected to prevent progression to cancer are also are under development.

Which HPV test?

Approximately 30 tests are commercially available, not many are CE marked and even fewer are FDA approved. For the screening programme an HPV test must be able to predict high grade disease, does not need high sensitivity but must be clinically relevant.

Scottish Test of Cure Study — HPV test comparison (STOCS-H)

This study is assessing the same five HPV tests as the NHSCSP but in a test of cure population. Positive rates vary between 17-25% depending on test used. Analysis of clinical relevance is underway. Full results are due late summer 2012 and will be used to inform the decision on which test will be used for test of cure.

Where should we do HPV testing?

The Scottish HPV Reference Lab provides validation panels to 34 labs approved for triage in England. The breakdown of labs performing HPV testing in England is approximately 66% cytology labs and 33% virology labs. There is good intra and inter lab correlation with no major problems. Most labs are using Roche Cobas. Scotland may well have a different approach to HPV testing.

What does Scotland need for HPV testing?

Very few HPV testing labs will be required due to high throughput platforms, probably only 2-4 sites combined with cytology labs but with access to molecular and virology expertise for problem solving. This is an ideal opportunity for cross training and new specialist portfolios and a review of skill mix.

Issues still to be addressed

- The potential role of self sampling for HPV testing
- Changes in HPV types in the vaccinated population may require a test that includes genotyping
- More studies are required to determine HPV prevalence in Scotland
- Age of first and last screen is under review
- Determination of cost effectiveness at different age groups and savings from increasing screening intervals
- Algorithms for HPV positive, cytology negative women
- How do labs maintain staffing levels in this period of uncertainty – should labs be recruiting?
- Funding for the SCSP

The next steps

The Scottish Breast and Cervical Screening National Advisory Group (NAG) has established an HPV reference group. This group will report in October 2012 and make recommendations as to the role of HPV testing in the SCSP.

Allan Wilson

HPV — The Global Battle, Rome 2012

Louise Smart

I was fortunate attend the 11th International Workshop on Lower Genital Disease entitled "HPV The Global Battle" held in Rome in April 2012. Over two days, 55 speakers from all over the world, including Mina Desai, Amanda Herbert, Anna Szarewski, Lesley Turnbull and Patrick Walker from the UK, presented on a wide range of topics related to cervical HPV. These covered natural history, epidemiology, disease manifestation and treatment with, not surprisingly, particular emphasis on screening strategies involving HPV testing and on HPV vaccination. Presentations were in English but the acoustics poor until my colleagues and I discovered the simultaneous transmission headphones, perfect unless we accidentally pressed the button for Italian. For most of the conference there were parallel sessions so attending all the talks was impossible. Nevertheless, some speakers spoke on several occasions and topics were re-visited over the course of the conference. I opted for the screening and cytopathology sessions — these were extremely popular, with delegates crammed in, sitting on the floor and queuing outside. At one point, even the guest speakers had to stand! Had I realised I would be reporting for SCAN, I might not have generously given up my seat and sneaked off to the Trevi fountain — I would certainly have made more notes. Nevertheless, here is an overview of the main themes of these sessions:

The first plenary session covered the **global picture of infection and cervical cancer.** F Bray (France) explained that cervical cancer is the 3rd most common cancer in women with an estimated 529 000 new cases worldwide in 2008. More than 85% of the global burden occurs in developing countries especially parts of Africa, South-Central Asia and South America, where it accounts for 13% of all female cancers and 88% of deaths. Rates are lowest in Western Asia, North America and Australia/New Zealand (Cancer Mondial — Globocan C15). Correlation between HPV prevalence and cancer incidence is not as strong as expected and there are also time trends within populations, indicating geographical and other factors are involved. Not surprisingly, a combination of lack of screening programmes and changing prevalence of HPV disease has resulted in some population cohorts showing a rise in incidence. In higher resource settings, declining incidence may be offset by population increases.

A comparison of the **approach to cancer prevention across the five continents** was presented. Patrick Walker from the UK outlined England's Test of Cure and HPV triage programmes and explained that the English school based vaccination programmes has achieved 80% uptake. High coverage will be essential for the success of vaccination and it was suggested several times during the conference that achieving effective coverage may include vaccinating males. V Tsu (USA) explained that, at the other end of the spectrum in low resource settings, the key is to minimise the number of visits for screening assessment and treatment. Visual inspection with acetic acid (VIA) has proved to have a particular benefit in women in their 30s, reducing the incidence of cervical cancer by 38% and death by two thirds. A simpler version of HPV testing, particularly with options for self collection, could be used in low resource settings and vaccination with careful planning and training can achieve high coverage of 80-95%. She emphasised that in such settings screening and vaccination can be complementary but require different approaches and pace of implementation. In some Eastern European countries (P Davies, Belgium) screening and vaccination programmes have been established but their effectiveness is compromised by the fact that women themselves have then to pay for screening tests and vaccines.

The first Cytopathology session covered the molecular basis of cervical carcinogenesis and introduced the topic of improving the predictive value of cytopathology by ancillary **HPV-DNA and RNA testing** and the use of **molecular markers** to enhance detection of disease. These themes were expanded the following morning at the session with the long strange title of "What a Long Strange Trip it's Been" which focused on **future cervical cancer prevention.** It was stressed throughout the conference that HPV 16 is by far the most important type in the development of cervical neoplasia. As M Tommasino (France) explained, there are variants of HPV16 such as HPV 16 E6 350T that carry a higher risk of persistent infection; susceptibility to HPV variants may depend on the geographic and genetic background of the host with some variants being more pathogenic in some populations than others. Virus integration with loss and disregulation of viral genes underlies the development of CIN and cancer. P16 is a well known cell cycle regulatory protein influenced by the viral E7 gene. It is overexpressed in HPV infection and, as it is a biomarker of HPV transformation, may predict disease (ie CIN). However, there are other potential molecular markers involved in cellular transformation such as the PDZ protein NHERF-1. This is degraded by HPV-16 but not by other types and which may therefore distinguish HPV 16 infections.

C Meijer (Netherlands) discussed the role of **HPV DNA primary testing** with cytology triage including findings from the POBASCAM and VUSA-screen studies, highlighting that high risk HPV(HR-HPV) testing was more sensitive but less specific than cytology. 20% of those infected with HR-HPV develop the precursor lesions and 1-2% develops cancer. To avoid overburdening colposcopy clinics, the Netherlands investigated several triage strategies (considering a strategy feasible if the negative predictive value exceeded 98%). The resulting recommendation for the Netherlands, who screen from 30years, is that primary HR-HPV testing with cytology at baseline and 6 months in those who are positive gives the best specificity and sensitivity. A Ferenczy (Canada) reported that in Quebec, where screening is also from age 30, HR-HPV primary testing was introduced in March 2011 to replace annual cytology which had reporting backlogs of 5-6 months! Although results are still incomplete, the main benefit has been a vast reduction in cytology tests as less than 7% are HPV positive requiring cytology triage. In their setting, colposcopy referrals have also reduced. M Bibbo (USA) gave a USA picture reiterating that the 10 year incidence of CIN3 in HR-HPV negative women is only 0.87%. A negative HR-HPV represents a very low risk of developing CIN over the next 5-6 years allowing screening intervals to be lengthened. However, there needs to be a strategy for triage following HPV primary screening as the positive predictive value of HPV 16/18 positivity is only 20%. In HR-HPV positive younger women HPV16 is highly prevalent whereas in older women other genotypes are more important. In the USA, where screening begins at a younger age, the ACS-ASCCP-ASCP screening guideline 2012 (Am J Clin Pathol 2012:137:516-542) recommends cytology alone in the 21-29 age group and HPV and cytology co-testing for those 30-65 years. HPV vaccination will decrease the incidence of CIN3 and appropriate strategies for triage of HR-HPV positive women will be required but, as yet there, is no USA consensus.

For the meantime, in most countries, HR-HPV testing will remain the standard adjunctive test, but molecular tests of similar sensitivity but greater specificity for the detection of high grade CIN may ultimately supersede HR-HPV testing. The potential role of **HPV mRNA testing** was presented by D French (Italy). HPV mRNA testing has a higher specificity and lower sensitivity than HPV DNA testing. If used in triage of HPV DNA positive women it can reduce the number of colposcopy referrals; it may also have a role in test of cure. There is however a relationship to age with mRNA testing, proving a useful biomarker of high grade CIN in those over 30 who are HPV-DNA positive, but in those under 30 there is less correlation with the presence of high grade CIN.

L Dillner (Sweden) continued the theme of looking beyond HPV testing to the use of other **molecular markers** either to further triage women who are HPV positive/cytology negative or as an alternative to cytology triage. In addition to assessment of viral genotypes, viral load and HPV mRNA, he discussed host cellular molecular markers that may may relate to disease development such as p16, ki67, MCM2, telomerase and DNA methylation. He suggested that it would be valuable to archive LBC samples ie a "cytology biomank" to assess potential new markers. K Petry (Germany) presented findings from the Wolfsberg screening programme study from 2006-11. Only 6.3% of women over 30 were HPV positive, and in their setting, 5.3% were cytology negative (1% cytology positive) with triage by cytology missing 50% of CIN or worse (CIN3+) lesions. Introducing p16/Ki-67 immunostaining as a triage tool instead of cytology gave sensitivities of 91.9% and 96.4% and specificity of 84.5% and 79.8% for CIN2+ and CIN3+ respectively. Considering HR-HPV primary screening in the long term, he postulated that that the test(s) required to triage HPV positive women may need to change between first and subsequent screening rounds. The first HPV testing screening round requires a sensitive triage test for CIN3+ to detect all hidden prevalent lesions. In subsequent screening rounds, however, most HPV infections will be new. As the risk of CIN2+ will be low it may be necessary to have a (molecular) triage test that can estimate the risk of developing a new high grade lesion.

F Carlozzi (Italy) returned to the theme of the potential of **self sampling tests** in developing countries with high cervical cancer incidence and no access to cytology based screening, and also in developed countries such as Italy where response to cytology screening invitation may be as low as 40%. Their Italian study found that among non-responders a self-sampler mailing strategy had, on average, a higher performance and increased compliance compared to standard cytology recall. In China, where there is no screening programme, self sampling compared favourably with LBC samples and better than visual inspection in detection of CIN. Unfortunately, specificity of self sample HPV tests is low. This means a further visit for subsequent triage with a more specific test as it is not possible to perform reflex cytology on self samples. The solution would be an effective molecular triage test that could be done the positive self sample.

The Friday afternoon cytology session focused on the **role of cervical cytology in the post vaccination area.** Mina Desai (UK) gave comprehensive talk during which she highlighted how, with a successful high uptake vaccination

programme, the UK nations were considering strategies for dealing with the potential two thirds reduction in the levels of CIN 2/3. In England, HR-HPV testing in primary screening will be trialed by the Sentinel sites. She highlighted how in Scotland, the national integrated call-recall and cytology database may facilitate the monitoring and managing of future change. It was surprising to hear from C Bergeron (France) how a comparable European country such as France is expecting a much lower uptake of vaccine. She also debated the problem of vaccination leading to reduced levels of high grade dyskaryosis, in turn affecting the positive predictive value of cytology.

Overall I found this an informative and enjoyable conference. It was surprising to learn just how much the design, uptake and use of technology of screening programmes varied even within Europe (there was a whole session devoted to LBC versus conventional cytology). It was clear, however, that HR-HPV testing will play a central role in the future of screening worldwide.

In addition to the two days of presentations, on Saturday morning there were colposcopy and cytology and workshops with Drs Turnbull and Desai showing their

endurance by leading training sessions on screening errors, small and pale dyskaryosis, and atrophic vaginitis/squamous carcinoma — especially impressive as, by this time, the torrential rain of the first two days had been replaced by glorious sunshine. In contrast to scientific meetings in the UK there was wine served with lunch which went down rather well. On the other hand, there were no social events organised as part of the conference; nevertheless, that allowed the Scottish contingent some time to take in the sights — Colosseum, Spanish steps, Trevi fountain (again) and to sample some genuine Italian restaurants.

BAC Olympic torch bearer

Dr Mina Desai CBE, BAC Executive member and consultant cytopathologist from Central Manchester University Hospitals NHS Foundation Trust, carried the Olympic torch through the Hindley area of Wigan, greater Manchester. The torch passed through Wigan on 31 May 2012 as part of its historic tour of the UK on its way to the Olympic Stadium in London in time for the Olympic Opening Ceremony.

Dr Desai was nominated by the Olympic Committee to be a torch bearer in recognition of her contribution to the NHS Cervical Screening Programme and, in particular, her tireless work in raising awareness of the importance of cancer prevention amongst women particularly from minority ethnic communities.

After completing her journey with the torch, Mina said: "I am delighted to have been involved in this historic event. It really is a great honour. My son was worried that I would be too small to carry the torch, and I was concerned that they were going to ask me to run, which I'm not very good at! However, all went very well, and I'm just thrilled."

"It was brilliant. Thousands of people of all ages were out in the street to cheer me on a rainy day. Children had made special Olympic torches in the school. Balloons and flags were flying and there were lots of cheers. Bands were playing on the street. It was a fantastic experience. It was a great honour to be a part of sport and Olympic history."

Mina kindly also brought her Olympic torch to the BAC ASM in Keele, in order to help raise funds for Jo's Trust.

Registered Science Technicians and Registered Scientists:

Two New Voluntary Registers for Institute Members

We are pleased to announce the launch of a major new membership service that will strengthen our representation of the entire biomedical science workforce, both within and outside the NHS. The Institute, an established licensed body with the Science Council for the award of Chartered Scientist, has now been awarded two new licenses, those for Registered Scientists and Registered Science Technicians.

The creation of these two new voluntary registers is a major piece of work for the Science Council, in direct response to the Government's drive to recognise and grow the UK technician workforce, which is seen as playing a major role in supporting the science and engineering sectors. This is also a major piece of work for the Institute in response to our members' survey which indicated the wish for the Institute to provide qualifications and offer more services to biomedical support workers.

A concern that is sometimes raised in respect of professional qualifications is that of transferability when changing jobs or profession. The new Science Council registers apply across the whole UK science sector and have the same relevance or 'currency' in health, research, the chemical industry, physics, food science, minerology, marine sciences, the armed forces – the list is long. This is an important benefit for the science technician workforce as it provides a sector-wide benchmark of achievement as does the designation of Chartered Scientist at the Master's level of professional practice. It supports flexibility and mobility in employment, which is of growing importance in a changing employment environment.

How do I become a Registered Science Technician or Registered Scientist?

In July the Institute will commence a 'grand parenting' period for current members and will send an electronic invitation to all current Associate members who are in employment (students are not eligible applicants must be practising members) to apply for admittance to the Science Council Technicians register and to all current Licentiate members who are in employment to apply for admittance to the Science Council Scientist Register. This grandparenting period will operate from 1st July 2012 until 31st December 2012. After this date all existing members wishing to be admitted to one of the new registers will be required to undergo a full assessment against the respective criteria below. Application forms for Registered Science Technician and Registered Scientist will be available for download on the Institute's website along with comprehensive guidance for both applicants and mentors/supervisers.

The launch of these new registers will complement the planned introduction of Institute qualifications for biomedical support staff (the IBMS Certificate of Achievement parts 1 and 2), which will be available by the end of this year. This qualification is being developed to offer affordable choice and recognition for this growing sector of the biomedical science and healthcare workforce.

Registered Science Technician eligibility criteria:

- Hold a Level 3 qualification (including IBMS Certificate of Achievement Part 1)
- Have at least one year's professional experience in the field of biomedical science
- Demonstrate evidence of Continuing Professional Development
- Have the support of a Chartered IBMS member
- Be an Associate member of the Institute (not a student)

Registered Scientist eligibility criteria:

- Hold an appropriate Level 5 qualification (including IBMS Certificate of Achievement part 2)
- Have two years professional experience in the field of biomedical science
- Demonstrate evidence of Continuing Professional Development
- Have the support of a Chartered IBMS member
- Be either an Associate or Licentiate member of the Institute

Some Associate members may be eligible to apply for Registered Scientist if they hold a level 5 qualification (or equivalent) such as the City and Guilds qualification in Cervical Cytology) and can visit the Institute's website to download the Registered Scientist application form

Assessment of equivalence through practice

The Science Council requires a route for demonstration of equivalence for those members seeking registration as a Registered Science Technician or Registered Scientist by virtue of their scope of practice but who do not possess a Level 3 or Level 5 qualification. These individuals will be assessed on the basis of being able to demonstrate that

they have an equivalent level of attainment through the application of their knowledge in their scope of practice. Assessment of this is based on their current scope of practice which requires them to demonstrate they meet the Science Council Standards for Registered Science Technicians and Registered Scientists respectively.

What will it cost?

The charge for registration is £16.00 per year, which will be in addition to the Institute membership fee. Those individuals who take up this offer under our grandparenting arrangements will receive their 2012 registration free of charge.

How does this relate to HPC registration?

The Science Council voluntary registers are entirely separate from the HPC statutory register and should not be confused. That is not to say that some HPC registered Licentiate members may wish to also be a Registered Scientist on the Science Council register, but it is not a requirement for employment and is a matter of personal choice. It is likely that Registered Scientist will be most attractive to those individuals who are appropriately qualified but not eligible for HPC registration or for whom HPC registration is not required for employment – e.g. members working in research or industry.

What is the value of voluntary registration?

Entry to any register indicates that a set of standards have been met in terms of qualifications and skills and continue to be met as evidenced by annual renewal and revalidation. With the increasing requirement for quality and professional standards registration is becoming an important issue and has been the subject of several pieces of work and publications. These Science Council voluntary registers, for which the Institute holds a license to register eligible individuals, enable a sector wide recognition of achievement in science and the establishment of professional benchmarks. This is an important step, particularly for the emerging technician workforce with their particular set of skills, which will be helping to deliver the UK science agenda. Science has been and now provides recognition at all professional levels: Registered Science Technician, Registered Scientist and Chartered Scientist.

'This article first appeared in the July 2012 issue of The Biomedical Scientist and is reproduced by kind permission of the IBMS.' Editor.

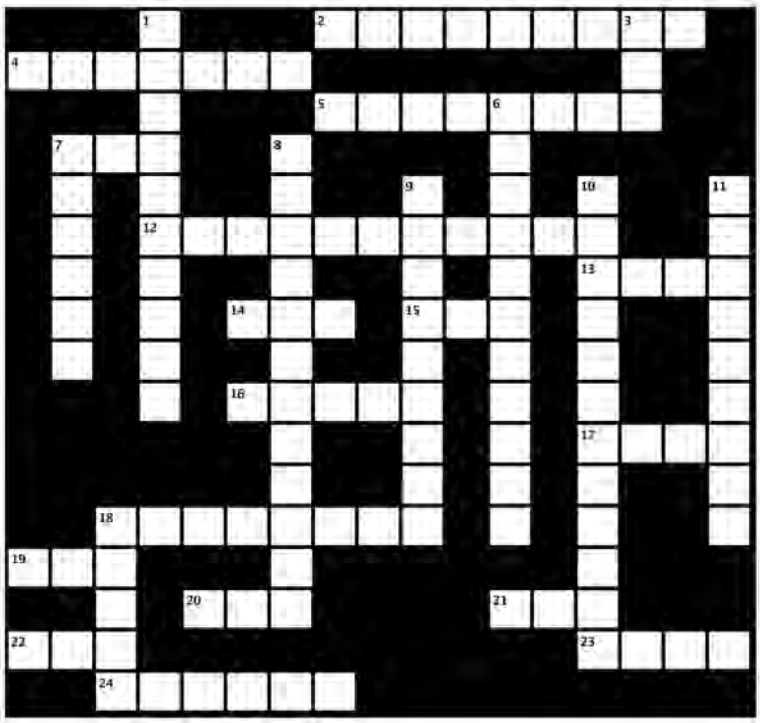
Cytology Crossword

Across

2. 'Angry' BAC Executive Member (4,5)
4. Cell division (7)
5. NHS HPV vaccine (8)
7. Standard Operating Procedure (1,1,1)
12. Mature squame (11)
13. Any number divisible by 15 across (4)
14. Place of work (short) (3)
15. Number of pieces of glass on 7 down (3)
16. Computer's rodent friend (5)
17. American Pathologist who discovered cancer-inducing viruses (4)
18. BAC Executive Treasurer (3,5)
19. Need this to see (3)
20. Proves useful when writing! (3)
21. Elephant's trunk (1,1,1)
22. Lubricant (3)
23. Surrendering to Low Grade in ABC3 (4)
24. Low Grade type of HPV (6)

Down

1. Specialist examination of the cervix (10)
3. Another type of 24 across (3)
6. Often seen with IUCD insitu (11)
7. Found in our Cytology playground (6)
8. Extracted from logwood (12)
9. Background debris (9)
10. Characteristics are no longer normal (12)
11. BAC Executive Olympic Torch Bearer (4,5)
18. Location of BAC ASM 2012 (5)



Crossword compiled and created by Melanie Buchan

Answer on page 30

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WALES
POSITION VACANT
VOLUNTEERS REQUESTED

CEC News – Autumn 2012

Jenny Davies

New certificates are now being issued; the next stage is to get stickers for the front of your books to replace the NAC logo. I will do that as I go along when I have them. The scheme is ticking along nicely and I will endeavour to keep on top of incoming books so I don't get too much of a backlog, but please do be patient in challenging times. Congratulations to Fiona McQueen in Edinburgh, who was the first CEC member to achieve the 500 credits and therefore first to receive a new design certificate. Well done Fiona, and also to those who have since followed suit.

Discussions are underway to try to have a closer working system between the CEC database and the membership database which are completely separate at present. When you submit your CEC book for validation, the rules were to submit a copy of the current membership card. If you do not know your BAC membership number, I can chase up your records with Christian Burt, so don't worry about that for the time being.

If you haven't already transferred to the new scheme, please send your book to me even if you haven't reached the 300 points – and I will bring them forward into the new one to maximize the use of the new scheme credits.

Transferring individuals to the new scheme has proved to be fairly easy and straight forward, but don't be alarmed if I contact you to get up-to-date credits to transfer. You will not lose any — CREDITS ARE NOW CARRIED OVER: I am carrying over credits in excess of 300 to the new book. **PLEASE DO NOT USE THE NEW GUIDELINES UNTIL YOU HAVE TRANSFERRED TO THE NEW SCHEME.** This will confuse things (i.e. me!) when I am doing the paperwork; I will sort that out.

Well done once again to everyone participating in the scheme, please keep it up.

Journal Based Learning

Now on to this issue's JBL exercise. One JBL – 10 questions – 10 credits. This time there is a bonus of 5 credits if you wish to reflect on the article. For submission, same instructions as before - photocopy the page and send your answers to me, or your Local Officer, for marking – there is no need to send your book.

Please try to do the JBL's as they come up in each issue of SCAN. JBL's more than 12 months old should be considered closed. Only one submission of each JBL will count.

Remember to keep a copy. Please include your name, CEC number, and as we are not receiving your book, your return address.

Membership Update

By August we had a healthy membership of 627 with 272 consultant (medical/BMS) members, 339 biomedical scientist and cytoscreener members and 16 honorary/junior pathologists. Nevertheless we are keen to widen our membership as much as possible and particularly would like you to encourage your cytoscreener and trainee pathologist colleagues to join. Information on how to join is available on the website (http://www.britishcytology.org.uk/membership/aboutus.asp#join)

Members have highlighted the need to have a handy note of your membership number and therefore we will ensure that membership cards are issued with the next round of subscriptions towards the end of the year. **We are looking to develop a members' only area of the BAC website, and your membership number will be required to gain access.**

Louise Smart
Membership committee

Type 1 & Type 2 cervical carcinomas; some cervical cancers are more difficult to prevent with screening

R.M. Austin & C.Zhao

Cytopathology 2012, **23**, 6 – 12

1. In spite of an average 50% sensitivity for the detection of cervical neoplasia, what reasons have the authors cited for the potential 85% of cervical cancers being prevented by 3 yearly screening?

2. Type 2 cervical cancers fall within one or more of which broad categories?

3. In the authors' experience, from which cervical cancers do the majority of litigated cases arise?

4. Which genotypes of HPV appear to lead to a more rapid progression of cervical carcinoma?

5. Why has HPV 18 been singled out as particularly a risk for development of cervical carcinoma?

6. a) What reasons have been given for the potential false negatives in younger women?

   b) What is different about the tumour that may develop?

7. What particular difficulties for detection do endocervical adenocarcinomas pose?

8. Why is Pap & HPV co-testing of particular interest?

9. What challenges have been cited as reasons for decreased effectiveness of cervical screening of older/post-menopausal women?

10. What suggestions have the authors made for the increased detection of type 2 cervical carcinomas?

Reflective bonus – 5 credits: (optional)

On reading this review, what are your thoughts on the challenges for providing a cervical cancer prevention service to women?

Name..... CEC number (if known).....

CEC Scheme Sponsorship

On behalf of the BAC Executive, and I am sure all the members, I would like to express my thanks to the following companies for the support they have loyally shown in the development and growth of the CEC Scheme. Now that the scheme is changing, I hope that this support will continue, and indeed that the group will grow to support the ongoing developments of CEC.

Leica Microsystems (UK) Ltd Lisa Howard Tel: 01908 246246 e-mail: lisa.howard@leica-microsystems.com website: www.leica.com 2011/12	**Nikon UK Ltd** Chay Keogh Tel: 0181 541 4440 e-mail: Chay.Keogh@nikon.co.uk website: www.nikon.co.uk 2011/12
Thermo Fisher Scientific Helen Tucker Tel: +44 (0) 800 0189396 e-mail: helen.tucker@thermofisher.com website: www.thermo.com 2011/12	**Pioneer Research Chemicals Ltd** Julie Jarman Tel: 01206 791781 e-mail: sales@pioneerresearch.co.uk website: www.pioneerresearch.co.uk 2012/13
Source BioScience Healthcare Emily Shaw Tel: 0115 973 9012 e-mail: Emily.Shaw@sourcebioscience.com website: www.sourcebioscience.com 2012/13	**Olympus Medical** Sarah Sankey Tel: 01702 616333 Ext: 3565 e-mail: Sarah.Sankey@olympus.co.uk website: www.olympus.co.uk 2012/13
Hologic (UK) Deborah Purvis Tel: 01293 522080 e-mail: ukreception@hologic.com website: www.hologic.com 2012/13	**Carl Zeiss Ltd (Rene Hessler)** 15 – 20 Woodfield Road Welwyn Garden City Hertfordshire AL7 1JQ Tel: +44 1707 871200 e-mail: micro@zeiss.co.uk website: www.zeiss.co.uk 2012/13

This list will be regularly reviewed for each issue of SCAN, and on the BAC Website. If any of the companies listed above have any changes of details to report at any time, please let Jenny Davies know by e-mail — jenny.davies@cmft.nhs.uk

Membership Details

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

Email: mail@britishcytology.org.uk

BAC Office, 12 Coldbath Square, London EC1R 5HL

Case study: Malignant Melanoma

Bobbie Thompson, Cytology Department, Royal Hallamshire Hospital, Sheffield

In 2012 a 51 year old female attended for routine cervical screening following a previous negative sample in 2005. She had a completely negative smear history but the clinical details given on the form were; on metronidiozole, on examination cervix looks awful, discharging growth. Seen by doctor — urgent Gynae referral. The presence of an abnormal discharge was also indicated on the form.

LBC Sample

The sample was moderately cellular with areas of necrosis/diathesis. The abnormal cells were present in loose aggregates or as single cells. The cells varied in size, had a high nuclear: cytoplasmic ratio, nuclei with irregular outlines, with occasional prominent large nucleoli and infrequent intra-nuclear inclusions

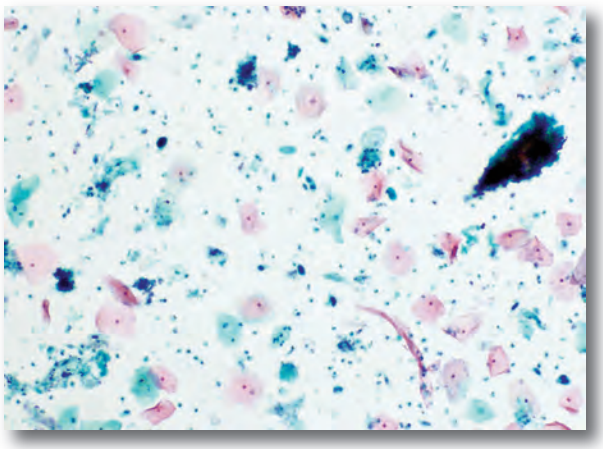


Figure 1 shows screening power magnification of sample (X100 magnification)

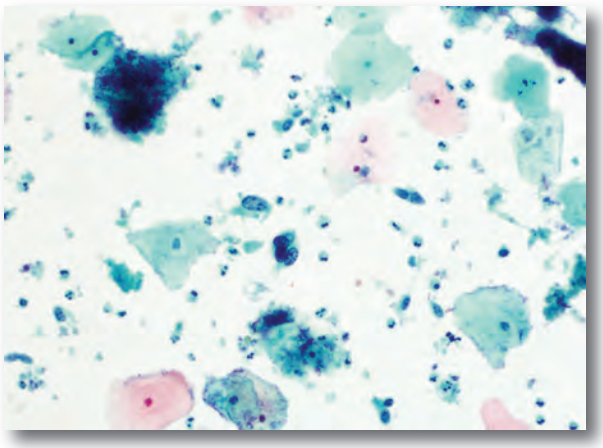


Figure 2 shows 2 malignant nuclei along side tumour diathesis (X200 magnification)

The report: Severe ?invasive – Gynae referral noted.

Histology: Clinical Details; 4 cm at least friable cervix mass –anterior lip and right cervix. Bulging through the os.

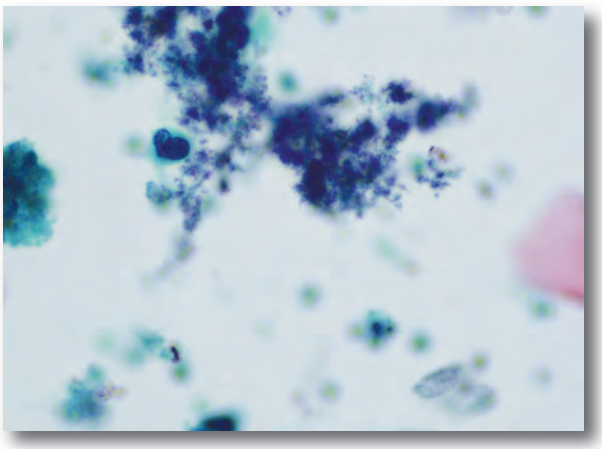


Figure 3 show a higher magnification (X200) of single malignant nuclei, no brown pigment is identified.

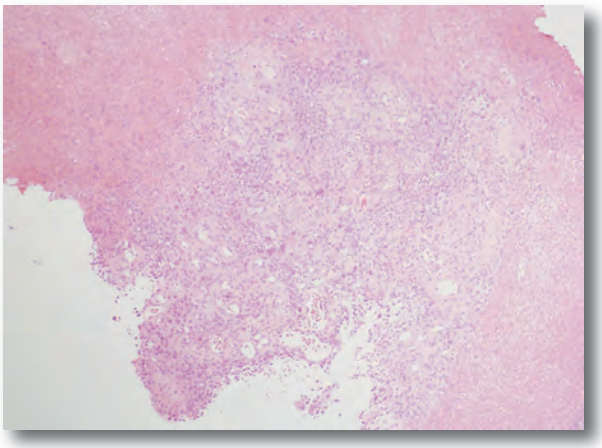


Figure 4 shows biopsy at X40 magnification, no normal epithelial tissue seen

Macroscopic: wedge shaped piece of friable tissue 23x23x13mm with separate fragments up to 10mm in maximum diameter.

Microscopically: the tissue consisted entirely of an ulcerated focally necrotic tumour comprising fascicles of spindle shaped cells; no normal cervical mucosa was identified.

Fine granular pigment with the histochemical properties of melanin was seen in a few cells. Abundant mitotic figures were present (10-15/mm^2).

Immunohistochemically the tumour cells were positive for melanin markers S100, HMB-45 and Melan-A.

The tumour did not appear to express epithelial markers MNF116, AE1/AE3 and cytokeratin 5/6, smooth muscle markers D33 and smooth muscle actin or DC34.

Diagnosis: The appearances are those of a malignant melanoma. The main differential diagnose of leiomysarcoma and spindle cell squamous cell carcinoma are effectively excluded histochemically. It is not possible to determine whether tumour is a primary at this site or metastatic in nature on basis of this biopsy.

The cervix was subsequently removed which revealed a huge necrotic tumour and no normal tissue was identified. Palliative surgery was abandoned due to the rapid tumour progression.

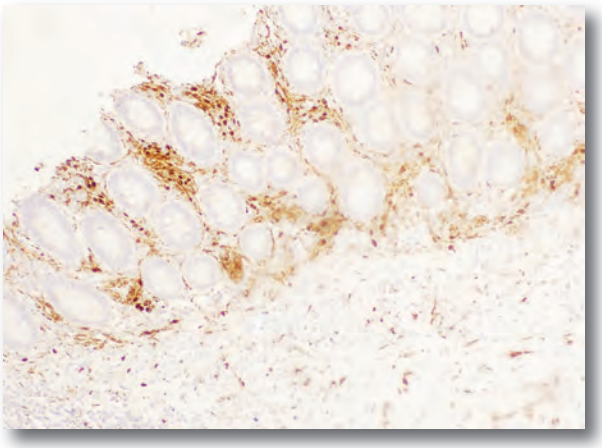


Figure 5 shows positivity for S100, a marker for melanoma (X100 magnification)

Discussion

Malignant melanoma is usually a disease associated with areas of skin exposed to the sun but can also be present in non-exposed sites such as the genital tract. The incidence of malignant melanoma in the cervix is extremely rare with primary malignant melanoma of the cervix accounting for less than 2% of cases of malignant melanoma affecting the female genital tract[1]. In the literature it suggests that a common symptom is abnormal vaginal bleeding, although that wasn't suggested in this case, however on examination there was clearly an abnormal appearance to the cervix and an abnormal discharge. The usual form of presentation is a polypoid exophytic pigmented mass or non-pigmented in amelanotic melanomas which constitute up to 55% of cases in the cervix[1].

The cytology of malignant melanoma offers a broad spectrum of morphology ranging from small regular round cells to pleomorphic bizarre cells. Intracytoplasmic brown pigment may be present and this must be differentiated from haemosiderin pigment. This wide spectrum of cytological presentation can prove difficult and can offer a differential diagnosis of a benign lesion to an anaplastic carcinoma[2]. With LBC the residual sample can be used to produce a cell block for subsequent immunohistochemical markers and as the diagnosis has a high probability of being mistaken for another entity due to the rarity of disease, markers are essential.

Malignant melanoma is a very aggressive neoplasm with a poor prognosis. There is no standard or consensus for treatment. The average survival reported ranged from 6 months to 14 years [1] with the majority not surviving the first 3 years. Teixeira et al 1998 gave the 5 year survival rate at 40% for stage I and 14% for other stages despite good therapeutic results. The mean age for incidence is 53 years[3].

Conclusion: Malignant Melanoma is an extremely rare finding in cytology and due to the very aggressive nature and poor prognosis the cervical screening programme offers no protection or prevention of the disease.

With the potential introduction of high-risk HPV testing as the primary screening tool in the NHSCSP, cases such as this, diseases that are not HPV driven, have the potential of testing negative and therefore being missed by screening. Although detection of these diseases is not the aim of the screening programme, sample takers must be made aware that significant diseases may give a negative result with HPV testing and therefore women with symptoms or an abnormal looking cervix must be referred for investigation.

References

1. Calderón-Salazar L, Cantú de Leon D, Montiel DP, Almogabar-Villagrán E, Villavicencio V and Cetina L. Primary Malignant Melanoma of the Uterine Cervix treated with Ultraradical Surgery: A Case Report. *ISRN Obstetrics and Gynaecology* 2011

2. Gupta N, Dudding N and Smith JHF. Cytomorphological features of extra-genital matastases in SurePath™ cervical liquid-based cytology: a series of eight cases. *Cytopathology* 2011

3. Jahnke A, Makovitzky J and Briese V. Primary Melanoma of the Female Genital System: A Report of 10 Cases and Review of the Literature. *Anticancer Research* 2005 **25** 1567–1574

4. Teixeira JC, Salina JR, Teixeira LC, Aparecida LA and Andrade LDA. Primary melanoma of the uterine cervix figo stage IIIB. *SÃO PAULO Medical Journal* 1998 **116** (4); 1778–1780

Acknowledgement to Mr J Crossley for his help and suggestion with this article.

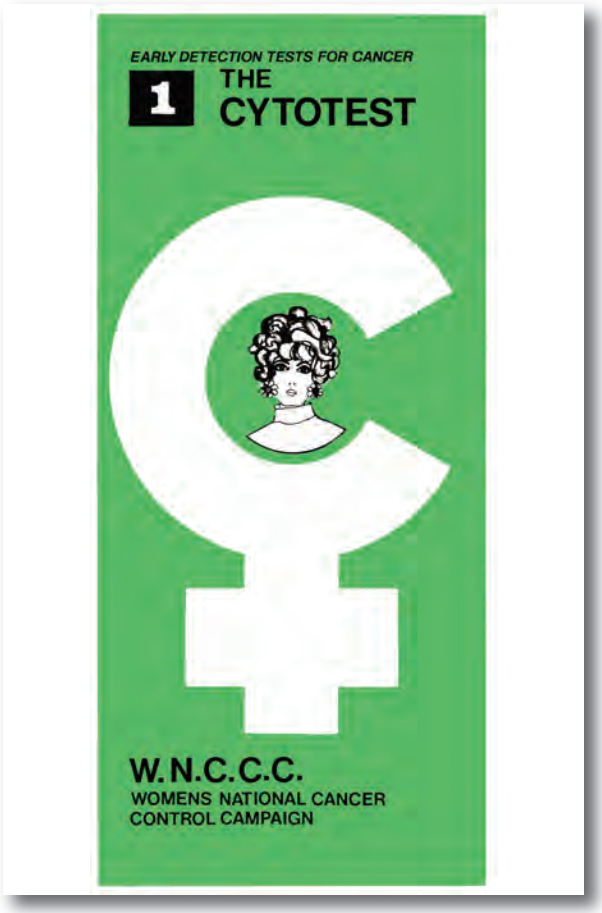
The Good Old Days?

Melanie Buchan

During my time in the Cytology Department at the Leicester Royal Infirmary, I recall a very industrious sunny afternoon spent by my colleagues clearing an office that once belonged to our Laboratory Manager, Mr Ian Smith, who had retired after 32 years of service.

Lots of nostalgic photos emerged, together with many years' worth of journals, some very old training resources and all manner of leaflets. Naturally, most of this was deemed as being too old and of no real value or use to anyone and eventually it was destined for the waste paper bin.

Curiosity got the better of me and I felt compelled to retrieve some of the more interesting-looking items… and I am so glad I did! The amusement value alone has proved priceless — some of the gynaecological leaflets have brought many smiles and laughter to all those who have read them!



Is anyone else reminded of the Twink Home Perm?

My pride and joy has to be **The Cytotest** leaflet produced by the Women's National Cancer Control Campaign (WNCCC). This charitable organisation emerged in the mid-60s; its aim was the promotion of women's health in Britain and to promote facilities for screening for cervical cancer.

It is thought the leaflet was published around 1968 to accompany a short film sponsored by the WNCCC, entitled 'Calling All Women' — "two women discuss cervical cancer and the ease of arranging a cancer prevention test"… I can't wait to view this production!

WHAT IS THE CYTOTEST?

The cytotest is a simple early detection test for cancer at the entrance to the womb.

DO I HAVE TO UNDRESS?

Yes, you will have to remove your pants because the doctor will make a gentle internal examination to take a sample of the natural moisture from the vagina or front passage.

WILL THEY TELL ME AT ONCE IF I AM ALL RIGHT?

No, because the sample will have to be carefully tested. Don't worry if they keep you waiting for a week or two – it may take a little time if they are very busy.

IS THAT ALL?

Yes, if the test is negative. You will be asked to come back some time later. Try to remember your medical card number so that your recall can take place without any difficulty and if you should change your address, don't forget to let the Health Authority know.

WHAT WILL HAPPEN IF IT IS NOT ALL RIGHT?

The cytotest picks up many small things that are not cancer at all – so don't worry if your doctor asks you to come back for further tests. These problems can easily be treated and will save you trouble later on – so do keep the appointment.

WHAT HAPPENS IF THERE ARE EARLY CANCER SIGNS?

You will be asked to come back for more tests. Then, if they suspect that cancer may develop, you will probably be asked to have a small operation. The tiny area, usually no larger than your little finger nail, will be removed and you will be home again in a day or so. This operation will not affect your married life and you will still be able to have children.

In some cases no operation will be necessary but your doctor will ask you to go back for regular check-ups until the signs have disappeared.

It is very important that you should keep these appointments and if you change your address you should register with a new doctor as soon as possible.

DOES THIS TEST MEAN THAT I WILL NEVER GET CANCER?

No, but if you have this test regularly, this particular form of cancer will be discovered at a very early stage and not given a chance to develop.

SHOULD EVERY WOMAN HAVE THIS TEST?

Young women usually have the cytotest as a matter of course when they visit the family planning clinic or are having babies. It is therefore particularly important that older women should make sure that they have the test regularly. From the age of 35 every woman can be tested by her own doctor as well as at local health clinics and family planning clinics.

ASK YOUR DOCTOR OR HEALTH AUTHORITY FOR DETAILS.

•

TAKE YOUR NATIONAL HEALTH NUMBER WITH YOU WHEN YOU GO FOR THE TEST.

•

REMEMBER –
THE CYTOTEST COULD SAVE YOUR LIFE.

Spot the word 'Cervix'

After reading the literature, I think it notable that the word 'cervix' is nowhere to be found! Instead there is a reference to *'the entrance to the womb'*. Also, there is no mention of what is tested other than *'a sample of the natural moisture from the vagina or front passage'* … talk about dumbing down! I had to smile when reading the reassurance given about *'a small operation'* which *'will not affect your married life'* …

What really struck me is the vague approach — the lack of any detailed, helpful information and the casual reporting schedule, certainly no 14 day TAT to worry about!

Proof, if ever it were needed, that the good old days, were not necessarily so. It is important to embrace changes and move with the times… were it not for the NHSCSP we would have a totally chaotic system with some extremely confused patients!

And what happened to the Women's National Cancer Control Campaign? I hear you all ask… the organisation ceased to be, in 1996 and their Headquarters address is now home to the Qatar State Embassy — times they are a changin' indeed.

A Big Lab Under the Microscope — Derby Undergoes Metaplasia

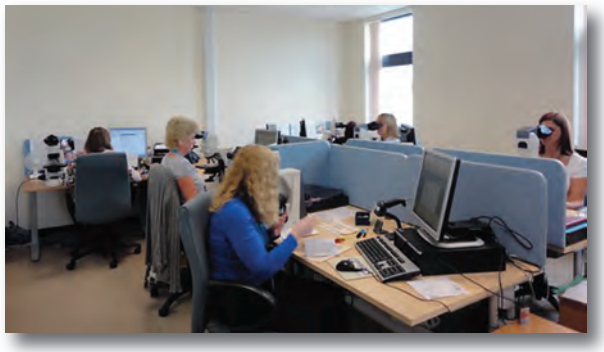
By Melanie Buchan

The dawn of the rationalisation of cervical cytology is now upon us, with the Royal Derby Hospital proudly boasting one of the largest Cytology Laboratories in the UK, and it is certainly the biggest in the East Midlands

1st June 2011 witnessed the final stage of the consolidation of 4 NHS gynaecological cytology laboratories from Chesterfield Royal Hospital, King's Mill Hospital and Nottingham City Hospital joining the already large team at Derby – all being merged under the one roof at the Royal Derby Hospital with a combined grand total of 170,000 cervical cytology samples.

East Wing of Screening Room 1

The decision to centralise the North-East Midlands cytology service was not a proposal welcomed by all and not everyone transferred. For some, the practicalities of part-time hours coupled with limited pay, home commitments and travelling were obstacles that could not be overcome. It came as no surprise to learn that only AFC Pay Band 4 and above were considering the transfer. Derby already had a team of 17 screening staff with support from 6 clerical and 5 laboratory staff — and as large as it was, it needed as many established staff as possible to transfer across to the Derby site in order to cope with the increased workload. A minefield of logistical issues had to be considered, and in particular, the very sensitive issue of the transfer of staff, indeed those affected did not have to make a decision of commitment until the very day of the transfer.



West Wing of Screening Room 2

A huge amount of strategic planning came to the fore in order to enable the transitional period to be as smooth as possible not only for the staff concerned but also for the service users. Accordingly, the merge was a gradual process, starting in October 2010 when 4 staff transferred from Chesterfield, this was followed with another 5 moving over from King's Mill in February 2011, and finally, 10 staff from Nottingham completed the merge in June 2011. This meant a new total of 36 screening staff based at Derby which was estimated as being enough to cope with the predicted increase in samples but now there was an obvious shortfall in support staff. A prompt recruitment drive in the early part of 2011 soon swelled the numbers to 60 members of staff.

Happy Kathy, BMS 6

The brand new Royal Derby Hospital was officially opened by the Queen in June 2010 and as modern and as spacious as it is, no allowance had been made for the Cytology Department to almost treble in size! Where and how was this Department going to be accommodated? The anticipated influx of new staff had to be put somewhere! A period of disturbance and reorganisation was inevitable and the last 18 months have seen an ergonomic, environmental evolution with various rooms being extended, converted and redecorated; offices being vacated and re-occupied; and deliveries of shiny new equipment including furniture, computers and microscopes.

This has resulted in the provision of:

- 38 individual screening work-stations in 2 separate screening rooms (26 and 12 respectively).
- 3 offices for 9 Data Entry staff
- 1 office for 2 office administrators/PAs
- 1 large processing laboratory for 10 MLAs
- 1 specimen reception room
- 1 non-gynae prep laboratory
- 1 Multi-Header Microscope Room
- 1 Cytology Meeting/Teaching Room

An unavoidable disadvantage to the room conversions is that we are spread along 2 neighbouring corridors and being fragmented in this way means that *effective communication* is paramount.

As I have mentioned before, the resulting consolidation of cytology was not a situation welcomed by the staff concerned, especially for those having to endure long journeys to and from work, and in particular, for those who have to rely on public transport. Transferred staff were not only having to cope with longer days and troublesome commutes but also with problems associated when starting at any new place of work, eg. where to park the car; which bus to catch; the most effective route through the hospital; different microscopes to get used to, as well as adjusting to different computer systems; getting to know new work colleagues; getting paid correctly and on time — the list goes on and on. Not to mention the added pressure of maintaining a 7-day turn-around-time (TAT).

Not everyone who moved over to Derby stayed. A Band 7 BMS left for career advancement; another Band 7 relocated to the East Coast; one BMS Band 6 took early retirement; while another Band 6 left to spend more time with her family and new grandchild and a Cytoscreener left to become a Locum screener. More recently, the Department sadly said goodbye to one of its Advance Practioners who was made redundant as a direct result of a recent organisational change.

The longer journey times, coupled with the stresses and strains of the transfer must have not only, had an impact on an individual's working day but also have had a knock-on effect with their home life such as arrangements for child-care. Management acknowledged this and adopted a flexible approach to altered working patterns to allow individuals to condense their hours into longer days and thus enabling a shorter working week for some and therefore, less time spent travelling. This arrangement seems to work well for a lot of the part-time staff.

Lynn's precise personalisation of her work space

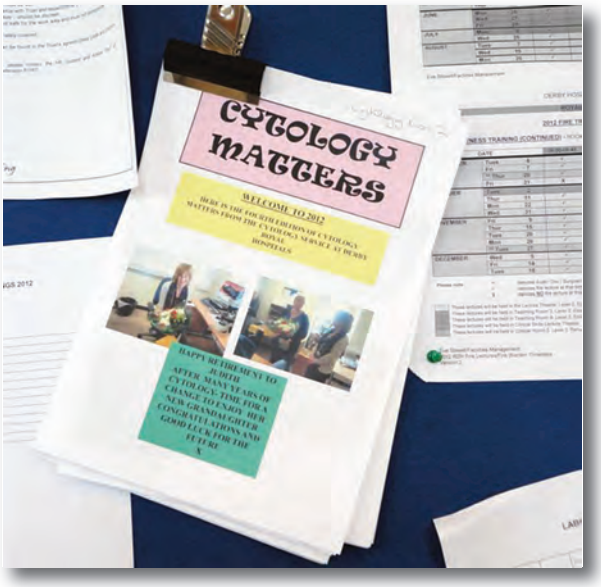
Unsurprisingly, it was not an easy transition and it proved to be disruptive for everyone and inevitably morale was affected. The laboratory dynamics had changed. There were increased staff absences from the lab due to compulsory Hospital Trust inductions, mandatory training as well as honouring transferred staffs' annual leave together with the usual annual leave commitments — the result was the gradual increase of the in-lab TAT — at its worst it rose to 16 days. In an attempt to resolve this, 'overtime' became the norm at weekends but eventually many stressed staff felt unable to continue with their commitment to 'over-time'. Consequently, Locum screeners were employed, and the increase in screening capacity resulted in sustained productivity and this went a long way to ease the immediate pressure during the settling-in phase. Needless to say a long period of adjustment was required in order to establish new and effective ways of working together as one team.

Syeria & Jane busy booking in

The scale of the department coupled with the dispersal of staff across 2 corridors of Pathology is a potential obstacle and it pays to offset this with good communication.

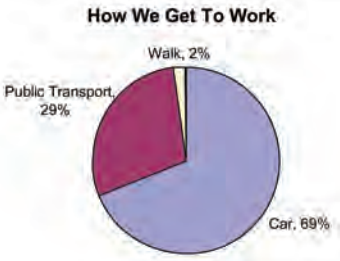
Regular meetings (huddles) for each of the areas within the Department as well as monthly Departmental Meetings are essential for highlighting and resolving issues. Everyone is encouraged to participate and all ideas and issues are listened to and acted upon effectively and quickly, enabling us to continually improve our method of working and deliver a quality service.

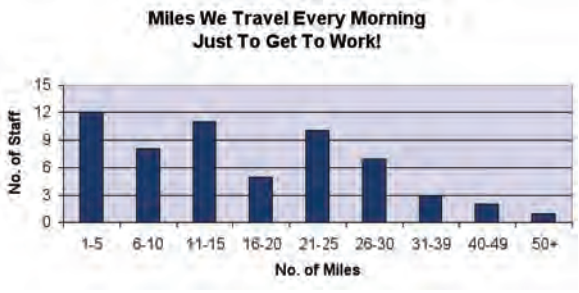
2012 has now seen things settle down with a newly established hierarchy; new friendships have formed; work-stations have been personalised; familiarisation has emerged; personal routines have surfaced and smiling faces are everywhere you look. Our in-lab TAT is now averaging at 3 days — Phew! We have been reliably informed by our Locum screeners that we are a very friendly, happy Team (and they should know). We are a sociable group with our very own staff newsletter 'Cytology Matters' which is published quarterly and we have a varied social calendar and have recently enjoyed — evening meals out, curry nights, and Ladies Race Nights at Uttoxeter Racecourse. Forthcoming events we have subscribed to include a Motown evening, a Ghost Walk, a trip to the theatre, a spa weekend at Hoar Cross Hall, and not forgetting the obligatory Christmas Meal & Disco — as you can see, there is something for everyone!



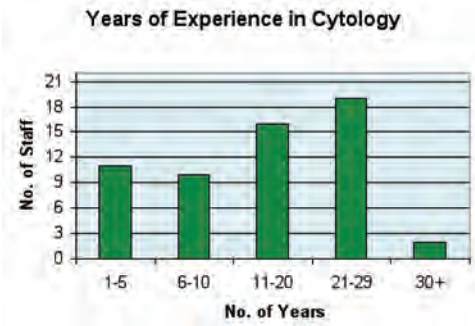
How many Labs have their own Newsletters?

And now for some statistics… Closer examination of our large Department has revealed some interesting facts:



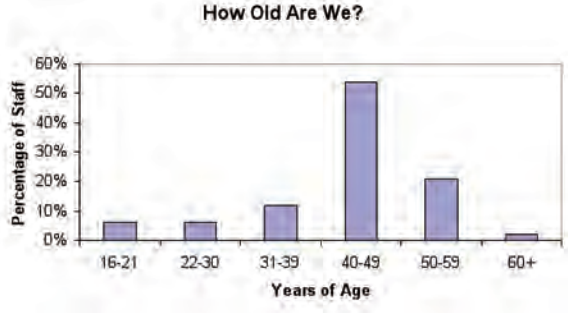


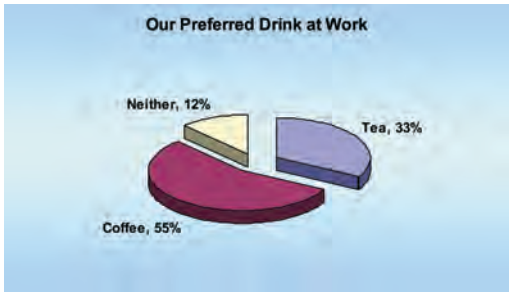
As a department we travel 802 miles every morning in order to get to work. I wonder how long it will be before the Government make enquiries about the carbon footprint involved with each sample reported, especially when you factor in how many miles the collected samples will have travelled to reach the lab…

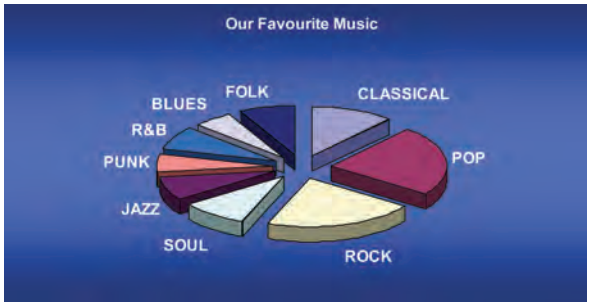


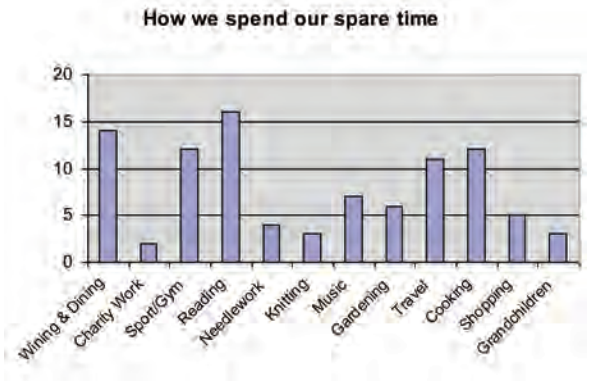
We have a total of 715 years of working within a Cytology Department with a collective total of 618 years of screening experience which means as a Department we have screened almost 4 million samples during our careers!

And what is it about this big dynamic Team that makes us tick? After further scrutinisation I have discovered the following:









And what can we conclude from these statistics? In the main, we are a very experienced bunch of middle-aged NHS employees who love our cars and caffeine. We have low-maintenance pets and love spending time in the UK just as much as lazing on a hot sunny beach abroad. We are a pretty cultured lot who enjoy reading and classical music but we also enjoy our sport and keep-fit regimes and have a passion for food as well as having an ear for some up-beat sounds.

I think this is a fair assessment of the cheerful, robust and dynamic team at Derby — but don't take my word for it — come and see for yourself!

BAC Annual Scientific and General Meeting

17 September 2012 : The BAC AGM was held at Keele as part of the very successful BAC ASM. The proposed changes were passed by a well attended meeting, with over 70 members present. Updates were given on areas of BAC work, and ideas for the future were also aired. Feedback from the ASM itself will be given when all the delegate forms are collated. Many thanks to all those who attended, and made for a very enthusiastic, and informative meeting. Look out for details of our meetings for 2013 which will be announced soon!

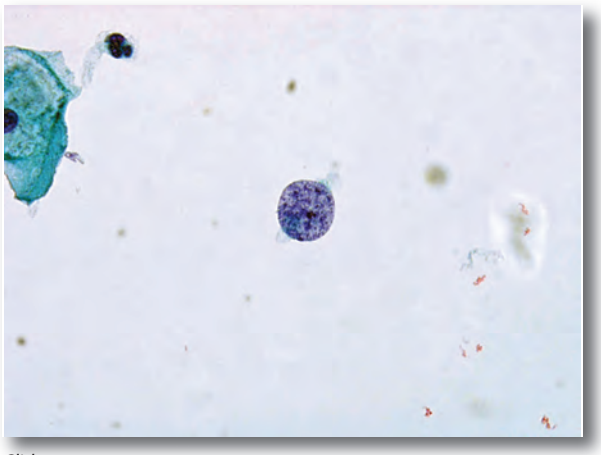
The abstracts and talk outlines from the ASM are available at the following link:

http://onlinelibrary.wiley.com/doi/10.1111/cyt.2012.23.issue-s2/issuetoc

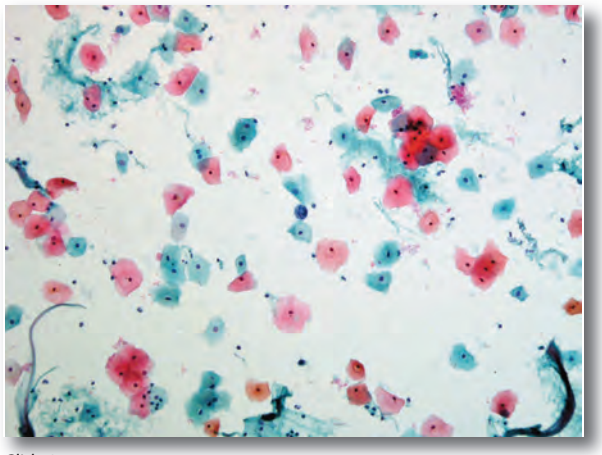
Quick Quizzes

Sue Mehew, Cytology Laboratory and Scottish Training School

QUIZ 1. Clinical Details: Age 23; Routine sample (ThinPrep); LMP day 22
Clinical information: PCB & IMB, bleeding after smear, erosion noted



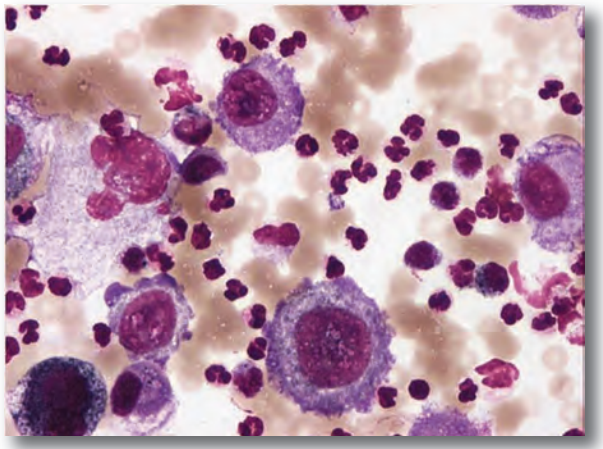
Slide 1.



Slide 2.

Dr Diane Hemming, Dr Paul Cross, Consultant Cellular Pathologists Queen Elizabeth Hospital, Gateshead

QUIZ 2. A 66 year old male presented with bowel obstruction and ascites. Ultrasound showed multiple masses in keeping with metastases in the liver and around the stomach. Previous history of malignancy (type uncertain). Ascitic tap performed. The ascites was cellular, and contained many cells as shown in the four pictures below. What is the diagnosis?



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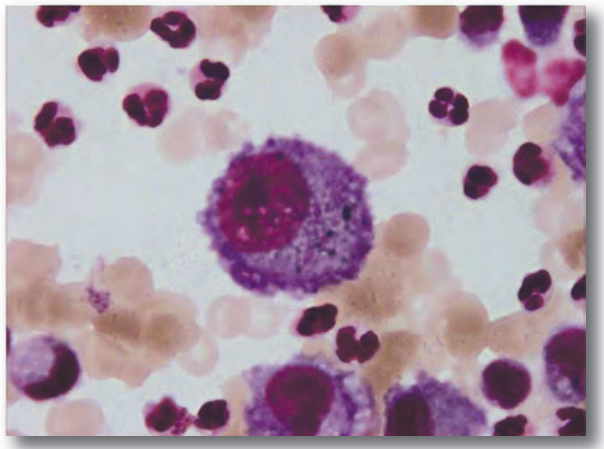

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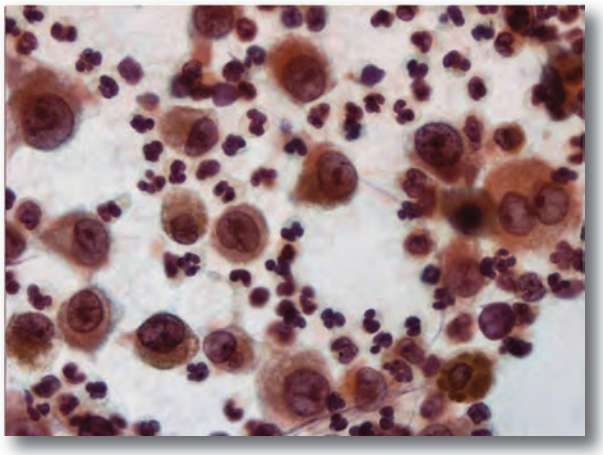

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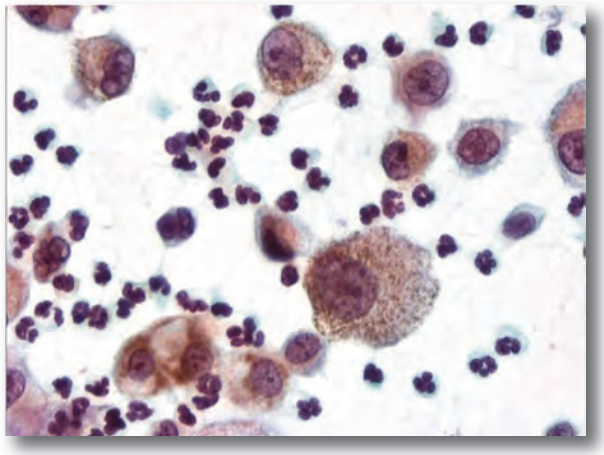


Slide 4.

Answers on page 30

Cytology Horoscopes

for October to December 2012

Libra
22 September – 22 October

Mercury maintains you should be cautious with decisions made at work – don't dismiss that crowded group. Your career will take a backseat during October but this suits you fine allowing you time for your other commitments. The New Moon on 15th October will prove significant – sit back and enjoy some new attention!

Scorpio
23 October – 21 November

Luck is all around you around the Full Moon at the end of September taking you in a new direction at the start of October. It is time for you to focus on your talents stop self-doubting. Say what you see. The New Moon on 13th November means your Birthday wishes will come true… and you will now begin to enjoy a voyage of self-discovery.

Sagittarius
22 November – 20 December

The Full Moon on 28th November means it is a good time to evaluate important relationships in your life. Don't be complacent about the background debris – keep an open-mind. The New Moon on 13th December will give you the confidence to make some necessary changes to help you achieve your work-life balance at long last.

Capricorn
21 December – 18 January

Your financial situation is about to improve and huge Planetary events will bring healing to your home – however, you will continue to feel torn between the demands of your domestic life and travelling to work. November will prove to be a life-altering month for you and changes will continue to unfold at work over the next few months. Remembering pit-falls will prove significant!

Aquarius
19 January – 17 February

Being assertive in October will help you earn respect from your peers. Don't be afraid to speak out – others may learn from your interpretation of that glandular architecture. The Full Moon on 28th November helps you with an important decision, if you are negotiating a contract you can rely on celestial support. Surprisingly, December will prove to be an amazing time to go travelling.

Pisces
18 February – 19 March

The influence of Jupiter means lots of support for your career will be forthcoming from someone who has been dismissive about it in the past. Your hectic work schedules need to slow down. Be aware of increased tension at work around 15th October, don't get distracted, stay focussed and you will reap the benefits.

Aries
20 March – 19 April

The Full Moon at the beginning of October means it is a good time to start planning that special event. You will have to prioritise your work deadlines very carefully during November, some of your decisions will not be popular – take advantage of the New Moon on 13th December and deflect confrontation from a drama-prone colleague.

Taurus
20 April – 20 May

Venus and Jupiter means a combination of love and money will come to fruition in November giving you extra confidence to make some big changes. Keep a look out for those small single cells, all is not what it seems… Your ability to keep a cool head will be rewarded by a grateful employer very soon.

Gemini
21 May – 20 June

Embrace being out of your comfort zone during October and November and life will change for the better at work. Don't feel excluded, you are not the only one who takes the moderate path. The Planets' influence means a new direction but only if you really want it to happen. Adopt a practical approach to a long-standing issue at work and you will reap the rewards.

Cancer
21 June – 21 July

Your financial situation is about to improve, especially before the end of December. However, your desire to achieve the perfect work-life balance will not be feasible until next year, so be patient. Find a middle ground between what you desire and reality – The New Moon on 15th October will help you with this. Look out for unexpected severe changes at the beginning of November.

Leo
22 July – 22 August

The stars are transforming the way you approach your career problem and you will no longer feel torn between the demands of work and home. Your natural mediation skills will come to the fore during October and someone will show their appreciation in an astonishing way! At the beginning of December consider using more magnification, maybe they are not reactive groups…

Virgo
23 August – 21 September

If you want to revamp your career options then take advantage of the Full Moon on 28th November. Tensions between duty and freedom will reach its peak around the New Moon on 13th December and Planetary influences will help you breakdown some communication barriers at work around this time. Be aware of some occasional mild changes, blink and you may miss them!

Quiz 1 results

Cytology reported as severe dyskaryosis.

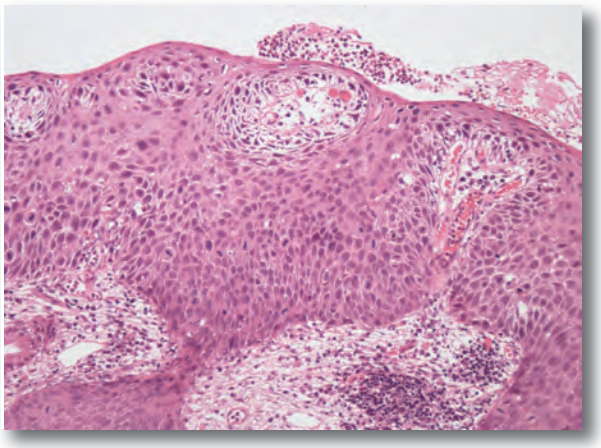
Colposcopic opinion

CIN 3

Histology – LLETZ

CIN2 in one out of seven blocks

CYTOLOGY CROSSWORD – ANSWERS



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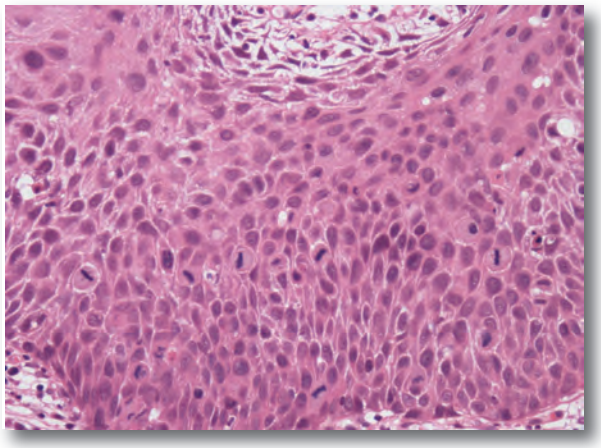
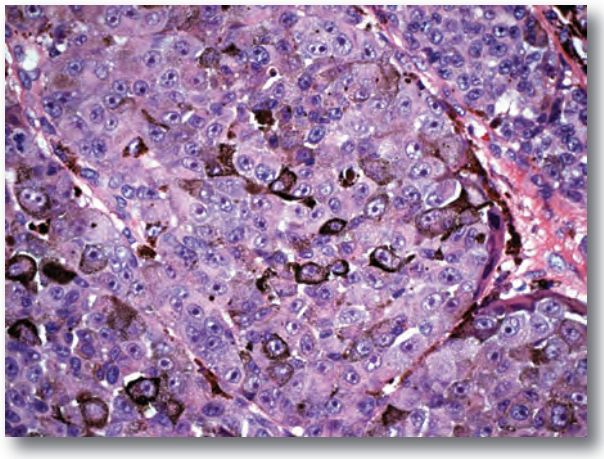


Slide 2.

Answer to Quick Quiz 2

The ascitic fluid contained plentiful single malignant cells, with pleomorphic nuclei and prominent nucleoli with generous cytoplasm. Some cells contained pigment. The previous history on searching was of a malignant melanoma of the chest, diagnosed some 2 years earlier. The cells in the fluid are fully in keeping with spread from this. The diagnosis may not be difficult in the presence of the correct history and of malignant cells with pigment, as in this case. Remember that melanin on MGG preparations stains navy blue but is brown with PAP. The differential diagnosis will include mesothelioma and metastatic adenocarcinoma. However, often there is no such history and malignant melanomas can often be amelanotic. Always consider this diagnosis in any malignant process with cells such as this – it can often be overlooked on histology also so beware! Malignant melanomas are cytokeratin negative and vimentin positive, and are usually S100, HMB45 and melan A positive on Immunohistochemistry (which can be done on a cytology clot if enough cells are present or on a cytology preparation). The older cytologists may remember that melanin (if present) can be stained for - the pigment is Masson Fontana positive, and removed by bleach which differentiates it from haemosiderin and lipofuscin, but few (if any!) labs may feel confident to do this stain these days.



Histology image

The histology image shows a malignant melanoma with an appearance very similar to the cytology case, and with prominent pigment in this particular case.

Reference : Page 181-183
Diagnostic Cytopathology, Gray and McKee, Churchill Livingstone

London Regional Cytology Training Centre

The North West London Hospitals NHS
NHS Trust

2012/13 COURSES

All course information and online booking form can be found on our website
www.lrctc.org.uk

Pre-Registration Gynaecological Courses

INTRODUCTORY COURSE IN GYNAECOLOGICAL CYTOLOGY (Thinprep®)

- *1st – 26th October 2012*
- *25th February – 22nd March 2013*
- *30th September – 25th October 2013*

Course fee:
- Contracted London regional students: No charge
- All other students: £1100

FOLLOW UP COURSE (Thinprep®)

- *7th – 11th January 2013*
- *29th July – 2nd August 2013*

Course fee:
- Those who attended the Introductory Course at LRCTC: No charge
- Other participants: £400

PRE – EXAM COURSE (Thinprep®)

- *3rd – 7th December 2012*
- *13th – 17th May 2013*
- *2nd – 6th December 2013*

Course fee:
- Contracted London regional students: Free
- Non-Contracted students: £400

Medical Practitioners Courses

PATHOLOGISTS COURSE – GYNAE

This two day course covers gynaecological cytology.

- *20th – 21st + 22nd (Optional Mock Exam) February 2013*

Course fee: - £200 Mock exam - +£50

PATHOLOGISTS COURSE – NON GYNAE

This four day course covers non-gynaecological cytology.

- *4th – 7th + 8th (Optional Mock Exam) February 2013*
- *9th – 12th + 13th (Optional Mock Exam) September 2013*

Course fee: - £ 400 Mock exam - +£50

Please indicate on the online booking form if you wish to attend the mock exam.

MEDIC'S 1-DAY UPDATE COURSE

A refresher course for consultant pathologists/AP's.

- *22nd November 2012*
- *24th May 2013*
- *26th September 2013*
- *21st November 2013*

Course fee
– Contracted London regional participants: Free
- Non-Contracted participants: £150

Post Registration Courses

BMS/CYTOSCREENER UPDATE COURSE

- *13th – 15th November 2012*
- *26th – 28th November 2012*
- *12th – 14th December 2012*
- *14th – 16th January 2013*
- *11th – 13th February 2013*
- *17th – 19th April 2013*
- *21st – 23rd May 2013*
- *10th – 12th June 2013*
- *18th – 20th September 2013*
- *13th – 15th November 2013*
- *25th – 27th November 2013*
- *11th – 13th December 2013*

Course fee:
- Contracted London regional participants: Free
- Non-Contracted participants: £350

Introductory Non-Gynae Courses

RESPIRATORY CYTOLOGY COURSE

- *18th – 19th June 2013*

SEROUS FLUID CYTOLOGY COURSE

- *5th – 6th September 2013*

URINE CYTOLOGY COURSE

- *19th – 20th November 2013*

Course Fees
- Contracted London regional participants: Free
- Non-Contracted participants: £200

Medical Laboratory Aides (MLA's) Courses

INTRODUCTORY MLA COURSE

This is an Introductory course designed to cover topics such as overview of the NHSCSP, terminology, role of an MLA and audit.

- *1st November 2012*
- *24th April 2013*
- *1st November 2013*

Course Fee
- Contracted London regional participants: Free
- Non-Contracted participants: £150

Book online at www.lrctc.org.uk

All courses above are CME, IBMS CPD and NAC CEC accredited. Course dates may be subjected to change.
Further details/information can be obtained by contacting 0208 869 5270 or emailing nwlh-tr.lrctcbooking@nhs.net or by visiting our website.

Central Manchester University Hospitals NHS
NHS Foundation Trust
Directorate of Laboratory Medicine

THE NORTHWEST CYTOLOGY TRAINING CENTRE
COURSES Autumn 2012 – Spring 2013

Website: http://www.cmft.nhs.uk/info-for-health-professionals/laboratory-medicine/north-west-cytology-training-centre.aspx

LBC Update Course In Gynae. Cytology For BMSs/Cytoscreeners (Surepath)

1 day courses (£100 per day)

1st October 2012	Cervical Glandular
14th November 2012	Squamous/Pitfalls
10th December 2012	Non Cervical Glandular

3 day update (£350)

20th – 22nd February 2013
Please see website for more dates in the near future

FRCPath COURSES

NON- GYNAECOLOGICAL CYTOLOGY revision course

£500
3rd – 7th September 2012

4th – 8th March 2013

FRCPath Mock Exam course

£400
17th – 20th September 2012

11th – 14th March 2013

For information, please contact:
Administrator: Miss Jen Bradburn
0161 276 8804
Email: jennifer.bradburn@cmft.nhs.uk

Director
Dr Mina Desai CBE
Consultant Cytopathologist/Director
Email: mina.desai@cmft.nhs.uk

Non Gynae Beginners Guides (BMS/Screeners)

£100 per day

16th October 2012 – Urinary Tract

27th November 2012– Serous Fluids
Please see website for more dates in the near future

Examination practice for the Advanced Specialist Diploma in Cervical Cytopathology

Dates To be Confirmed
£250
Please contact the centre if you have any particular requirements

Mandatory Courses Are Free Of Charge To North West Region Technical Staff.

Please note that all Gynae Courses are based on Surepath Morphology

A 20% Discount Is Available For All Fee Paying Courses For NW Regional Staff

The training centre is happy to discuss any other training needs you may have.

Manager:
Mrs Jenny Davies
Tel: 0161 276 5114
Email: jenny.davies@cmft.nhs.uk

Birmingham Women's NHS
NHS Foundation Trust

BIRMINGHAM CYTOLOGY TRAINING CENTRE

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

INTRODUCTORY COURSES FOR CITY & GUILDS DIPLOMA IN CERVICAL CYTOLOGY

24 September-5 October & 15-26 October 2012; February 2013 *tbc*

This course provides students with a theoretical and practical introduction to cervical cytology. A five-day Follow-on Course is offered free of charge to all those attending our Introductory Course.

FOLLOW-ON COURSES FOR CITY & GUILDS DIPLOMA IN CERVICAL CYTOLOGY

5-9 November 2012; 4-8 March 2013

The aims of this course are to revise the topics taught on the Introductory Course, consolidate skills and identify problem areas.

PRE-EXAMINATION COURSES FOR THE CITY & GUILDS DIPLOMA IN CERVICAL CYTOLOGY

2-4 January 2013; 13-15 May 2013 *tbc*

A 3-day course for those preparing to take the City and Guilds Diploma in Cervical Cytology.

UPDATE COURSES IN GYNAECOLOGICAL CYTOLOGY (ThinPrep & SurePath)

29 November 2012 (FULLY BOOKED); 29 January 2013; 28 February 2013; 1 May 2013 (Checkers' Update); 11, 12 & 13 September 2013

Topics include: Endometrial cells in LBC, Atrophic Changes, HCCGs, Invasive SCC, BNC, Endocervical dyskaryosis

BIRMINGHAM HISTOPATHOLOGY COURSE

10-21 June 2013

The programme 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.

NEW for 2013—optional Saturday morning for personal review of workshop slides

GYNAECOLOGICAL CYTOLOGY FOR TRAINEE PATHOLOGISTS (StRS)

4-5 February 2013; 2-3 September 2013

The programme for this course is a combination of lectures workshops and multiheader sessions. This course includes a mock exam and is particularly suitable as revision for the FRCPath Part 2 exam

NON-GYNAECOLOGICAL CYTOLOGY FOR TRAINEE PATHOLOGISTS (StRS)

6-9 February 2013; 4-7 September 2013

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

NEW for 2013— optional Saturday morning for personal review of workshop slides

INTRODUCTORY COURSE FOR ST1s

3-7 December 2012

Gynaecological and Non-Gynaecological Cytology including Autopsy element

LBC Conversion Courses, Ad hoc workshops and Off Site workshops can be arranged on request—please contact BCTC

Please see our website for further details and for reservations please contact Louise Bradley or Amanda Lugg

Birmingham Cytology Training Centre
Birmingham Women's Hospital
Birmingham B15 2TG
Phone: 0121 627 2721
Fax: 0121 627 2624
Email: Louise.Bradley@bwhct.nhs.uk or Amanda.Lugg@bwhct.nhs.uk
Website: http://www.bwhct.nhs.uk/professionals/ctc-training-centre.htm

CEC IBMS RCPath CPD accredited courses

NHS Lothian

Scottish Cytology Training School

Programme 2013/14

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

Training School Manager
Judith Bingham
Tel: 0131 242 7149
Email:
j.bingham@luht.scot.nhs.uk

Training School Manager
Sue Mehew
Tel: 0131 242 7149
Email:
Sue.Mehew@luht.scot.nhs.uk

Training School Director
Dr Edward Duvall

Application forms available on request from:

Mrs Linda A Cooper
Training School Administrator
Pathology Department
Edinburgh Royal Infirmary
51 Little France Crescent
Edinburgh
EH16 4SA
(Available mornings Mon–Thurs)

Tel: 0131 242 7135
Fax: 0131 242 7169
email: Linda.Cooper@luht.scot.nhs.uk

NHSCSP Accredited Training Centre

SCOTTISH CYTOLOGY TRAINING SCHOOL

Introductory Course

18th February – 15th March 2013
23rd September – 18th October 2013
17th February – 14th March 2014
£1000

Introductory Course Part 2

12 – 16th November 2012
11–15th November 2013

Update Course

26–27th November 2012
6–7th December 2012
7–8th February 2013
15 –16th April 2013
6–7th June 2013
14th June 2013
2nd – 4th September 2013 (for medical staff)
4–5th November 2013
5–6th December 2013
3rd – 4th February 2014
£100 per day

Hosting Exam

Examination to be held in Edinburgh
28, 29th October 2013
Applications to Examination Office, Liverpool.

Pre-Exam Course

16–18th September 2013 (for Oct Exam)

£250

Non-Gynae Workshops

9th May 2013
24th October 2013
£100

Trainee Colposcopists

2013 tbc
£200

Non-NHS Labs – price on application
All courses are in Liquid Based Cytology (Thin Prep)
Courses are CPD accredited

East Pennine Cytology Training Centre

EPCTC NHS

Overall Winner 2010

Achieving Excellence in Learning, Teaching & Development

Training Centre Manager:

Mr N Dudding
0114 226 8691
Nick.dudding@sth.nhs.uk

Website: www.cytologytraining.co.uk

Administration:

Mrs K Hawke
0113 246 6330
Kathryn.hawke@nhs.net

One-Day Masterclasses

Challenging masterclass aimed at practicing consultants or trainees wishing to refresh or extend their knowledge.

"Cytology of the Salivary Gland and Lymph Node"

Date: 7th May 2013

Course Fee: * £120 each

Cytopathology in the FRCPath Examination
A Tutorial for Trainees in Cellular Pathology

This one day tutorial that would be ideal for any trainees in Cellular Pathology, but in particular those approaching the FRCPath Part 2 Examination. Experienced educators, including past and current RCPath examiners in cytology and histopathology, will offer guidance on training and the examination.

1st March 2013

Course Fee*: £120

Three-Day Update Course for AP/Consultant BMSs

Includes sessions on cervical histopathology, recent developments in colposcopy, HPV triage and test of cure, the use (or not) of BNC HG and a whole session on the NHSCSP cancer audit. Suitable for Thinprep® or Surepath™ users

20th – 22nd November 2013

Course Fee* : £15 / £230

Mock Exam Course for the Advanced Specialist Diploma in Cervical Cytopathology

A two-day course ideal for anyone intending to sit the Advanced Diploma exam. Practice at both written and practical elements and a full mock exam.

29th & 30th April 2013

Course Fee*: £200

One - Day Update specifically for Checkers & Experienced BMS staff

A One-day course aimed specifically at those intending to, or already acting as Checkers. Includes a session on basic histopathology and microscopy sessions on what can be called negative and what cant!

31th January 2013

Course Fee*: £15 / £120 per day

Participants from the North East, Yorkshire and East Midlands will incur £15 administration fee only on all courses above except those marked * where full fee applies. All prices are subject to change. Further information and application forms are available from our Administration Team: Kathryn.hawke@nhs.net

East Pennine Cytology Training Centre

EPCTC NHS

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0114 2712538
Nick.dudding@sth.nhs.uk

Website: www.cytologytraining.co.uk

Administration:

Mrs K Hawke
0113 246 6330
Kathryn.hawke@nhs.net

One-Day Update Courses in ThinPrep® Cytology

Venue: Westbrook House, Newmarket

Borderline High-Grade Lesions and the use of HPV Triage and Test of Cure

This one day course covers the difficult area of borderline changes and also the use of the category of borderline high grade.

29th November 2012

Aspect of ?Invasive Cytology and Histology

A full day session is dedicated to both the cytology and histology of squamous cell carcinoma of the cervix and "aggressive" CIN3.

28th March 2013

Course Fee: · £120 each

Update Courses in Non-Gynae Cytology

A series of three /four one day courses ideal for anyone intending sit the IBMS diploma, but also suitable for anyone seeking an update in non-gynae cytology. Day four includes a full mock exam

23rd – 26th April 2013

Course Fee*: £230 / £345

One-Day Non-Gynaecological Cytology Courses

Aimed at anyone undertaking their Specialist Portfolio, but also suitable for anyone requiring an introduction to non-gynae cytology. These courses will cover specimen preparation, urine, respiratory and effusion cytology.

5th & 6th March
17th & 18th September 2013
Course Fee*: £95 per day

One-Day Update Course for Medics

Pitfalls & Problems in Cervical Cytology – Glandular Lesions

This workshop covers the many challenging and interesting cytological presentations associated with glandular lesions in particular endocervical abnormalities. The day includes discussions on current issues in cervical screening including automation, HPV testing and new technologies and recent developments with the NHSCSP invasive cancer audits and other issues relevant to the NHSCSP.

14th May 2013

Course Fee: · £95

Participants from the North East, Yorkshire and Trent Regions will incur £15 administration fee only on all courses above except those marked · where full fee applies. All prices are subject to change. Further information and application forms are available from our Administration Team: Kathryn.hawke@nhs.net

South West Regional

CYTOLOGY training centre

2013 Course Schedule

Date	Gynae Courses	Fee*
25 Feb-22 March 30 Sept-25 October	**Introductory in Gynae Cytology**	NHS £1000 Other £1200
22-24 April 9-11 September 25-27 November	**Prep for C&G Diploma in Cervical Cytology**	NHS £250 Other £300
4-6 Dec 2012 16-18 April 11-13 June 3-5 September 3-5 December	**Update in Cervical Cytology for Technical Staff**	NHS £300 Other £350
24 September	**Update for Cytology Checkers**	£100
21 May 12 November	**Update in Cervical Cytology for Pathologists & Consultant BMS's & Holders of the Advanced Specialist Diploma in Cervical Cytology**	£100
6 June	**Gynae Histology for Technical Staff**	£100
22-24 January 25-27 June	**Gynae for Trainee Pathologists**	£300
30 April-1 May	**Gynae Pathology for Trainee Colposcopists**	£200
11-12 February 17-18 June 16-17 September	**Cervical Sample Taker Training**	£250

Date	Non-Gynae Courses	Fee*
7 November	**FNA Cytology**	£100
21 November	**Urinary Tract Cytology**	£100
20 June	**Respiratory Cytology**	£100
16 May	**Serous Fluid Cytology**	£100
5-8 February 2-5 July	**Non-Gynae for Trainee Pathologists**	£400

PLEASE NOTE THAT NO FEE IS APPLICABLE FOR NHS STAFF BASED IN THE SOUTH WEST REGION

For further course details & application form please visit our website: www.cytology-training.co.uk

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BRISTOL BS10 5NB
Phone: 0117 323 5649
Fax: 0117 323 5640
E-mail: SWRCTC@nbt.nhs.uk

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Course Administrator

North Bristol NHS NHS Trust

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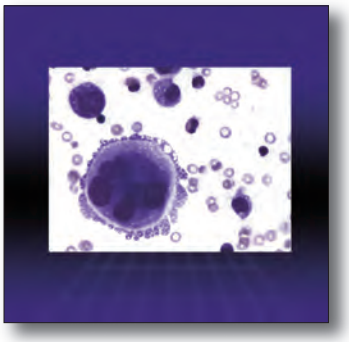

Website now available: www.britishcytology.org.uk