EQA review session Nov 2012 minutes

The review session for EQA 22 was held on 7th November 2012 in Sheffield.

23 Consultant members and 4 trainees attended the review session. 105 responses were received, the vast majority answering all 18 cases.

Items discussed ahead of the scoring of the 18 cases were

- need for participants to submit suitable cases. The present set of 18 cases was put together from a selection of only 21 and those not included were often duplicates. Despite this, consensus was achieved on all but 1 case.
- Likely changes are moving to a software based system of administration for sending out messages, CPD certificates, invoicing, members to update details and also submission of responses. Urology EQA have developed what looks like a very good system with a Sheffield based company and I will arrange a meeting one this circulation is over.
- I have done some calculations as to how much per year it costs to run EQA and it is a little in excess of £15 pa, therefore the present situation were BSOMP members have EQA membership included is not cost effective. If we move to a software based management system this alone will cost >£15 pa. It will be necessary to move to a single invoicing system in 2013 (invoice to Trusts not individuals) which hopefully can be less than the present £100 currently billed to Trusts for non BSOMP members
- Some minor changes to response form for EQA 23 to simplify it a little and to limit the number of differential diagnoses that can be offered. Also to get rid of the working diagnosis category and to have 2 categories – definitive, a single answer confident to sign out on the basis of the 1 H&E section examined. Second category, favoured or differential diagnosis, either a single diagnosis but with a requirement for more work up to confirm or a maximum of 3 differentials, in order of preference, with work up to explain how a final diagnosis will be reached.
- Survey monkey questionnaire will be sent out in the new year to gauge thoughts on some changes to the scheme although we may be restricted in some areas, for example number of cases, by RCPath standards.

Discussion of cases and allocation of points

1. Vast majority thought this was an inverted duct papilloma, score 2. An answer of any of the other benign papillomatous lesions or benign cystadenoma = 1. Diagnosis of malignancy score 0 as does necrotizing sialometaplasia
2. Nasopalatine / incisive canal cyst as definitive, working or included in differential =2. Fissural non-odontogenic cyst = 1. Globus maxillary cyst = 0 as is a response of glandular odontogenic cyst and antral cyst. Discretion for 1 point if good work up. Periapical cyst scores 1.

3. Langerhan's cell histiocytosis as definitive, working or differential diagnosis and / or mention of histiocytic proliferation and inclusion of CD1a / langerin in IHC panel = 2. No mention of LCH or relevant IHC = 0
4. Educational case as no consensus between cystic lesion and benign neoplasm. Some at the meeting suggested there might be some heterogeneity in sections since theirs appeared more proliferative than the image taken from my section.
5. Vast majority of respondents gave a diagnosis of angioleiomyoma with some slight variation in terminology, score 2. Leiomyoma was given as a diagnosis by 1 person, those at the meeting suggested score but on reviewing their response sheet they had mentioned angioleiomyoma but didn't think that there were enough vessels so I have awarded 2 points. . Angiomyolipoma was mentioned several times, agreed score 1 as this is a distinct lesion with rather different pathological features and with HMB45/melan A positivity. One person gave this diagnosis but thought it not to be the same entity as the HMB45+ renal lesion.
6. All score 2 with diagnosis of lipoma / lipoma with entrapped salivary gland or sialolipoma / lipoadenoma. Hamartoma scores 1 as out of consensus.
7. Discussion at the review session about the lack of minor salivary glands in the gingiva and therefore highly unlikely to be a primary salivary gland malignancy. Anyone mentioning metastatic disease scores 2, those not considering metastasis score 0 but discretion used for a working diagnosis without metastasis mentioned. Most thought likely lower GI tract primary rather than liver primary.
8. At the review session, it was decided that those stating mucoepidermoid carcinoma in the diagnosis would gain 2 points and those not considering this possibility would score 0, again discretion for working / differential diagnoses applied.
9. All diagnoses of pilomatrixoma score 2. All other benign calcified lesion diagnoses score 1.
10. All those who mention melanoma in definitive, working or differential diagnosis score 2. Those who favour SCC but include melanocytic markers in IHC panel score 1. Malignant tumour without consideration of melanoma score 0. One person mentioned metastatic melanoma, 2 points as impossible to know if every section contained the junctional component.
11. Response of pleomorphic adenoma or myoepithelioma = 2. Benign soft tissue tumour such as schwannoma scores 1. Malignant diagnosis of either carcinoma or sarcoma scores 0. Discretion used when work up provided.
12. All score 2, granulomatous inflammation, not all slides appear to have shown caseation / necrosis.
13. Vast majority thought low or intermediate grade mucoepidermoid carcinoma, score 2. Some thought ex PA or Warthin's. High grade adenocarcinoma ex Warthin's scores 1, Warthin's scores 0. MEC as part of differential score 2 unless stated high grade, score 1.
14. All score 2 as everyone mentioned chondrodermatitis nodularis helicis.

15. Score 2 for reactive lymphoid hyperplasia. Score 1 for amyloid as working diagnosis as presumably negative Congo red would lead to re thinking the case.
16. Jugulotympanic paraganglioma = 2. Neuroendocrine neoplasm scores 1. Neuroendocrine carcinoma, neuroblastoma, medulloblastoma and small cell carcinoma score 0. Referral to colleague with incorrect diagnosis can gain 1 mark.
17. Keloid / hypertrophic scar scores 2, solitary fibrous tumour as working, use discretion depending on work up. Amyloid papule v elastotic nodule = 1 since had specified specials.
18. Any mention of metastasis score 2, no mention of possibility of metastasis = 0. Score 1 for referral as "don't do thyroids" although this technically is not a thyroid lesion!

A few notes
As mentioned above, many of the cases in this circulation could only be given a working or differential diagnosis and participants are encouraged to use these options, and also the official response form. Several of those with *** next to their score did not use the form and submitted a list of answers which I had to assume to be definitive unless otherwise stated and I feel that these participants lost points by doing this.

Please send in cases for EQA 23, the more I have to chose from the better and I will aim to send out a set including a majority of cases that can be diagnosed on the single H&E provided, mixed with a smaller number of cases that are a little more challenging, hence providing more educational value, but on which participants should be able to gain full marks by using the favoured / differential category.

To date just over half of Trust invoices have been paid. Last year not all invoices were paid. If we move to a software based system there will be a cost per participant associated with this and I will have to get much more strict with chasing payments. Other schemes have similar issues of non payment and some withhold CPD certificates from participants whose Trusts do not pay, which I also propose to trial.

The next circulation will start late Jan / early Feb with a likely deadline for submission immediately after Easter and with the review session to be held on 24th April 2013 in Newcastle as part of the annual BSOMP meeting.

Gillian Hall
November 2013