NATIONAL HEAD AND NECK HISTOPATHOLOGY EQA SCHEME

Circulation 16 (Autumn 2009)
Notes of the Review Session held at the School of Clinical Dentistry, Sheffield, Wednesday 14th October 2009

PRESENT: Dr. AW Barrett (Chair)
Professors PM Farthing, PR Morgan, EW Odell, P Sloan, PM Speight; Drs. G Hall, AS High, KD Hunter, M Fernando, SS Napier, M Pring, IA Robinson, KA Shah, RD Start, JL Stone, S Thavaraj, A Triantafyllou, HK Williams, JA Woolgar (total 20)
Trainees: Drs. T Bates, A Betts, P Chengot, RC Hall, AV Jones, SJ Payyappilly, T Soland, K Suchak, A Torres, S White (total 10)
Apologies: Professors W Binnie, CD Franklin, KA MacLennan, Drs. R Allibone, P Brown, K Denton, T Helliwell, CH Kendall, K Piper, CM Robinson, G Smith.

Matters Arising

1. Three participants triggered the first action point following EQA 15 (Spring 2009). Two of these, having exceeded the allowed number of zero scores in EQA 14, had not returned responses to EQA 15. The third registered three zeros in EQA 14 and a further three in EQA 15.
2. All participants would be asked to sign an updated Acceptance Form as a condition of participation in EQA 17 (Spring 2010). New participation codes will be issued once the signed Form is received.
3. Dr. Barrett had received another letter from a participating consultant expressing concern about the Scheme, specifically with regard to the content (thought to be unrepresentative of routine Head & Neck caseload), the high number of cases scored and the means by which poor performance is detected. Since its inception as a specialist oral pathology scheme in the early 1990's, the balance of participation has gradually, but recently rapidly, tilted towards consultants who report Head & Neck, but who are not necessarily (and would not regard themselves as) specialists. Dr. Barrett expressed his view that some changes in the scheme are probably inevitable to reflect this altered participation and prevent a high level of persistent poor performance. To this end he would canvas the views of participants, and the Chairs of the RCPath Steering Committee and NQAAP.
4. For circulation 16, participants were asked to specifically request slide boxes (the number of potential participants now being well in excess of the 50 boxes available), or use the Aperio web-based "virtual microscopy" system hosted by the University of Leeds. Boxes were distributed to 34 centres.
5. Participants were asked to specify which method they had used to assess the 18 cases: of the 56 who did so, 44 had used glass slides only, 5 the Aperio system only and 7 a mixture of both.
6. There were a total of 67 respondents. The answers of the first 50 received comprised the basis for the discussion of each case, but all are included in the table of personal performance scores.

Circulation 16 – scoring of responses for personal performance analysis

Cases 1-6 (number of respondents = 39)

Case 1 Local diagnosis = haemangioma (Julia Woolgar)
2 points (all respondents): a definitive or working diagnosis of haemangioma or benign vascular anomaly. No differential diagnoses were submitted.

Case 2: Local diagnosis = non-specific ulcer, exclude monoclonal gammopathy (Gordon MacDonald)
2 (38 respondents): a working or differential diagnosis of a reactive process or potential malignancy, with appropriate work-up.
1 (one): a definitive diagnosis of erosive lichen planus with no further investigations requested.

Case 3: Local diagnosis = odontogenic myxoma (Bill Barrett)
2 (all): a definitive, working or differential diagnosis of (odontogenic) myxoma.

Case 4: Local diagnosis = mucous extravasation cyst (Eddy Odell)
2 (all): a definitive or working diagnosis of mucous extravasation cyst/mucocoele. No other diagnosis, and no differential diagnoses, were submitted.

Case 5: Local diagnosis = adenoid cystic carcinoma (Ken MacLennan)
2 (37): a definitive, working or differential diagnosis of adenoid cystic carcinoma.

0 (2): a definitive diagnosis of polymorphous low grade adenocarcinoma. Given the textbook microscopic appearances of the case, the potentially serious clinical consequences of under-treatment and the fact that this diagnosis is markedly out of consensus, it was decided to award this diagnosis zero (rather than 1).

Case 6: Local diagnosis = fibrous polyp showing myxoid degeneration (Ken MacLennan)
2 (all): all proferred definitive, working and differential diagnoses were regarded as acceptable. It was pointed out that oral focal mucinosis could be polypoid, and the working diagnosis of odontogenic myxoma submitted by one respondent would have been corrected by the additional investigations intimated.

Cases 7-12 (number of respondents = 50)

Case 7: Local diagnosis = reactive lymph nodes (Ken MacLennan)
2 (46): a definitive, working or differential diagnosis of reactive/dermatopathic lymphadenopathy, a working or differential diagnoses of lymphoma or metastasis with appropriate work-up. The latter two were justified on the basis that some sections contained strikingly pleomorphic cells in some of the sinuses.
1 (3): a differential diagnosis which specified Castleman's disease, granulomatous lymphadenitis or sinus histiocytosis with massive lymphadenopathy.
0 (1): a definitive diagnosis of angiolymphoid hyperplasia with eosinophilia with no further work-up.

Case 8: Local diagnosis = squamous cell carcinoma (Ken MacLennan)
2 (all): a definitive, working or differential diagnosis which included squamous cell carcinoma. The one outlying response, a first differential diagnosis of "reactive lymphoid tissue (infectious mononucleosis?)", would have been corrected by the additional investigations itemised. The significance of adding the descriptor "basaloid" to squamous cell carcinoma was briefly discussed, as basaloid tumours might be more radiosensitive. However, this term is apparently inappropriate where HPV has been detected.

Case 9: Local diagnosis = salivary duct carcinoma (Ivan Robinson)
2 (45): a definitive, working or differential diagnosis which included salivary duct (adeno)carcinoma. This case was thought to be a good example, which demonstrated the hallmark microscopic features, but a working diagnosis of high grade mucoepidermoid carcinoma, high grade adenocarcinoma NOS, or a first choice differential diagnosis of acinic cell carcinoma with high grade neoplasm(s) listed were also considered sufficient on the grounds the high grade nature of the tumour was recognised.
1 (3): definitive diagnoses, with no further work-up, of mucoepidermoid carcinoma or carcinoma with Kuttner's tumour (both of which it was felt failed to emphasise the high grade nature of the tumour); a first choice differential diagnosis of acinic cell carcinoma without a high grade neoplasm also considered.
0 (2): definitive diagnoses, with no further work-up, of "chronic sialadenitis and carcinoma *in situ* in ducts with extension"; necrotising sialometaplasia.

Case 10: Local diagnosis = primary squamous cell carcinoma/small lymphocytic lymphoma (Ivan Robinson)
2 (32): a definitive, working or differential diagnosis which included both pathological processes.
1 (18): a definitive, working or differential diagnosis which included (metastatic) carcinoma, but which did not mention CLL or small cell lymphoma. This was justified on the basis that the leukaemic/lymphomatous element was relatively biologically insignificant compared to the carcinoma.

Case 11: Local diagnosis = spindle cell carcinoma (Eddy Odell)
There was an approximate 50:50 split between those respondents who thought this was a reactive process, and those who regarded it as malignant. Cytokeratin staining at the time was positive, consistent with a carcinoma. Given the array of diagnoses, this case was therefore classed as "educational" and not scored for personal performance purposes.

Case 12: Local diagnosis = acinic cell carcinoma (Paul Brown)

2 (45): a definitive or working diagnosis of acinic cell carcinoma.
1 (3): a working diagnosis of carcinoma ex-pleomorphic adenoma.
0 (2): definitive diagnoses of "acinic cell tumour" (a long obsolete and potentially misleading term) and adnexal carcinoma with no further work-up.

Cases 13-18 (number of respondents =40)

Case 13: Local diagnosis = Burkitt's lymphoma (c-myc translocation confirmed) (Ivan Robinson)

2 (all): a definitive, working or differential diagnosis of lymphoma, the majority of respondents (30) opting for Burkitt's lymphoma (the supplied immunoprofile supporting this diagnosis).

Case 14: Local diagnosis = metastatic colonic carcinoma (Charles Kendall)

2 (38): a working or differential diagnosis of metastatic carcinoma (no definitive diagnoses of metastasis were submitted).
1 (2): a definitive diagnosis of (papillary) adenocarcinoma with no mention of the possibility of a metastasis, and no further work-up.

Case 15: Local diagnosis = squamous cell carcinoma with idiopathic cystic chondromalacia (Simon Rose)
2 (39): a definitive, working or differential diagnosis which included squamous cell carcinoma, with or without mention of the cartilaginous changes (which were regarded to be of interest, but of no clinical significance).
1 (1): a definitive diagnosis of trichilemmal carcinoma with no further work-up.

Case 16: Local diagnosis = embryonal rhabdomyosarcoma (Eddy Odell)

2 (38): a working or differential diagnosis of a sarcoma of some sort (36 respondents) or other soft tissue tumour (2) with appropriate work-up.
1 (1): a definitive diagnosis of embryonal rhabdomyosarcoma, with no apparent confirmatory work-up.
0 (1): a definitive diagnosis of juvenile angiofibroma, with no apparent work-up or consideration that this was a malignant process.

Case 17: Local diagnosis = nasopharyngeal angiofibroma (Ken MacLennan)

2 (35): a definitive, working or differential diagnosis of angiofibroma (23), or other benign entity (14) with appropriate work-up. The presence of bone was noted to be unusual in nasopharyngeal angiofibroma, and although the other features were generally typical it was commented that the vascular pattern was not as florid as is often the case, and that the pattern of ossification was typical of that seen in some ossifying fibromas.
1 (5); a definitive diagnosis of myxoma or juvenile aggressive ossifying fibroma, with no further work-up, or a working or differential diagnosis of malignancy but with appropriate work-up.

Case 18: Local diagnosis = follicular/cystic papillary carcinoma (Ken MacLennan)
As with case 11, there was an approximate 50:50 split between those respondents who thought this was a reactive process, and those who regarded it as malignant. Thus this case was also classed as “educational” and not scored for personal performance purposes.

Date of next meeting: April 29th 2010 @ 13.30, Robens Suite, Guy’s Tower (floor 29), London (final session of annual BSOMP conference)

A.W. Barrett
2/11/2009