Minutes of review session held at Royal College of Physicians – Head and neck EQA circulation 21

Present: U Earl, A Betts, T Helliwell, A Chambers, B Conn, K Sisson, S Lan, Z Zaini, B Ayaz, N Bshassi, M Pring, P Sloan, M Toner, K Allan, Y Teo, P Matthews, S Napier, K Maclennan, B Barrett, W Binnie, P DaForno, C Kendall, P Farthing, A High, E D Daledtei, J Van der Waal, T Soeland, L Kroona, P Lindberg, S Ng, D Milne, T Peizer, S Thavaraj, R Hall, E O'Regan, M Calaminici, T Palmer, J Potts, A Jones, K Hunter, M Robinson, J Weir, C McCarthy, D Brierly, S Ali Khurram, D Ioana Ion, I van der Waal, G Pitiyage, K Moutasim, H Cottom, B Almeida, I Robinson, M Reed, P Vickers, M Khan, E Odell, T Bates, K Suchak, R Agarwal, S White

The meeting began with a thank you to the outgoing organiser Bill Barrett to acknowledge the huge amount of time and work he has given to the scheme over the last 3 years. Bill also kindly put together the cases for circulation 21 to make my job as incoming organiser a little easier.

Participants who attended the meeting were invited to vote on scores for answers deemed out of consensus and brief notes are included below.

In total, there were 100 respondents for circulation 21, 71 completing all 18 cases, 20 cases 7-18 and 9 cases 1-12. The schedule of responses previously includes 99 responses; one was received too late for inclusion but was received before the schedule was circulated.

The present response form makes assessment of such a large number of cases an arduous task. Whilst it is do-able, if numbers continue to increase, it may become too much work for a single organiser. Over the next few months, I am going to look at alternative ways of collecting the data, likely to be in excel or access formats. Keeping the options of definitive and working / differential diagnosis will continue as previous questionnaires have indicated that the members like that feature of this scheme. Having a format that requires you to given additional information if you chose a non-definitive diagnosis option would be helpful to the organiser as there are still numerous people who use this category yet provide no supporting information on what they will do next. The response format for EQA22 will remain the same but will almost certainly change beyond this.

Those attending the meeting were strongly encouraged to submit cases for inclusion. Whilst cases that are straightforward and represent common diagnoses are needed, submission of more difficult and interesting / unusual cases is also encouraged. Given that we have the categories of working and differential diagnosis, it is still possible to gain full marks on these more difficult complex cases if worked up correctly and these types of cases are of more educational value. I will endeavour as organiser and with the help of the working group, to ensure that there is a fair mix of cases.

Case 1

All respondents gave papillary endothelial hyperplasia as diagnosis +/- pre-exisitng benign vascular lesion. All score 2. Local diagnosis was papillary endothelial hyperplasia possibly arising in a haemangioma.

Case 2

Definitive, working or differential favouring canalicular adenoma, basal cell adenoma or hybrid of the two score 2. Definitve diagnosis of PLGA score 0. Working diagnosis of low grade malignant with work up and including showing to colleague score 1. Working diagnosis of low grade malignant but with a work up not deemed to get to the correct diagnosis score 0. Discussion deemed that further levels and immunos would not likely differentiate. Radiology would almost certainly not be performed pre-op for such a lesion. Other benign (PSA / myoepithelioma) score 1 if given as definitive or working. A small number gave a long list of differentials including benign and malignant, some but not all outlining work up. These score 1 unless strongly favouring the consensus and local diagnosis as those present at the meeting thought that features were typical enough for accurate diagnosis.

Case 3

All score 2 as granular cell tumour offered as definitve or working diagnosis from all respondents. Some thought likely secondary candidal infection.

The local diagnosis was of granular cell tumour with pseudoepitheliomatous hyperplasia and with secondary candidosis.

Case 4

Definitive diagnosis of neurofibroma (consensus answer) score 2, definitive of schwammona or neuroma or mucosal neuroma score 1. Working or differential of benign peripheral nerve sheath tumour favouring or slanting towards neurofibroma score 2. If strongly favouring mucosal neuroma or schwannoma score 1. Discretion used when scoring if appropriate work up and consideration of multiple lesions / NF.

Local diagnosis was neurofibroma.

Discussion regarding how precise a diagnosis needs to be made in this case, ie plexiform neurofibroma which would suggest neurofibromatosis type 1. Respondents advised to use the further investigation section to comment on important clinical connotations of the offered diagnosis. Points were not lost in this case for not mentioning NF1 but it is worth mentioning important clinical associations in the additional information section for such cases.

Case 5

Consensus diagnosis was lichenoid type inflammatory pattern, many wanted PAS as suspicion of secondary candida. Vast majority who mentioned presence of atypia though this was reactive and commented upon it. All respondents giving diagnosis of lichen planus / lichenoid reaction / lichenoid mucositis score 2.

Definitive diagnosis of dysplasia score 0.

Working / differential of dysplasia but with consideration of reactive / inflammatory condition and with work up score 2. Working / differential of candidosis as main disease process but with work up, clinical correlation and comment to see any residual lesion after antifungals also score 2.

Some comments regarding debris on the slide. The local diagnosis was chronic hyperplastic candidosis with mild to moderate dysplasia.

Case 6

Consensus answer of well diff / verrucous type squamous cell carcinoma. Submitting pathologist requested breakdown of WDSCC v verrucous SCC which I will carry out before the next review session.

A very small number of out of consensus responses. Definitive of verrous hyperplasia with moderate dysplasia scores 0. Working diagnosis of verruca vulgaris with levels and DPAS scores 0. Viral wart as a differential but consideration of SCC requesting levels scores 1. Differential of SCC in situ in a condyloma vs condyloma with moderate dysplasia scores 1as there was a consideration of stromal invasion in the further investigations.

Case 7

Sebaceous lymphadenoma scores 2 as definitive, working or favoured differential diagnosis. Sebaceous adenoma scores 1 as not fully correct and virtually all recognised the lymphoid element. Warthins with metaplasia and FNA changes as definitive scores 0. Lymphoepithelial cysts, branchial cyst, mucoepidermoid carcinoma all score 0 unless sebaceous lymphadenoma also in differential and work up adequate.

Sclerosing polycystic adenosis with second opinion score 1.

Case 8

Most thought dermatofibroma (some mentioned cellular / aneurysmal / pigmented variants) and score 2. Many gave spindle cell differential which included dermatofibroma also score 2.

Malignant melanoma as a definitive =0.

Other benign working and differential diagnoses with good IHC work up that did not include dermatofibroma score 1 as negative IHC results would lead to reconsideration. Many also were to discuss with skin / soft tissue pathologists. One respondent giving metastatic melanoma as favoured differential and not considering dermatofibroma scores 0 as well out of consensus.

Case 9

The case with the most consensus.....all score 2! Local diagnosis Molluscum Contagiosum.

Case 10

Consensus was medullary carcinoma of thyroid metastatic to lymph node as definitive or working. Some considered paraganglioma in the differential in addition and all score 2.

Epithelioid haemangioendothelioma as a working diagnosis with IHC for vascular markers was voted as scoring 0 as well out of consensus. Metastatic carcinoma not specified v carcinoma ex pleomorphic adenoma v myeloma with IHC but not including markers of medullary carcinoma scores 0. Metastatic carcinoma with amyloid with IHC including calcitonin / CEA to score 2 but without specific immunos scores 1.

Local diagnosis was metastatic medullary carcinoma of thyroid.

Case 11

All diagnosed as adenoid cystic carcinoma as definitive or working and score 2. Adenoid cystic carcinoma was the local diagnosis.

Case 12

Diagnosis of toxoplasmosis (definitive or working) or granulomatous inflammation differential including toxo to score 2. Granulomatous inflammation not including toxoplasmosis score 1.

Favouring a diagnosis of lymphoma but with referral / second opinion score 1.

Definitive diagnosis of Rosai Dorfman disease score 0.

Working diagnosis of Langerhans' cell histiocytosis with IHC (CD1a and langerin) to score 1.

The local diagnosis was of reactive lymphoid hyperplasia with features consistent with toxoplasmosis.

Case 13

Basal cell adenocarcinoma as definitve, working or favoured differential score 2.

Basal cell adenoma as definitive or working score 0.

Basal cell carcinoma, PLGA and adenoid cystic as definitive all 0.

High grade adenoid cystic as working with no supporting information 0.

A small number of respondents gave a long list of differentials and if this included basal cell adenocarcinoma at the top / towards the top of the list with appropriate work up score 2. One participant had the consensus diagnosis 5th on the list and scores 1. Basal cell adenoma v cylindroma score 0.

Local diagnosis basal cell adenocarcinoma.

Case 14

Vast majority of respondents regarded this as an acinic cell carcinoma. This answer as definitive, working or high in the list of differentials score 2. Oncocytic carcinoma was mentioned by many in the differential and where included alongside acinic cell, scores 2. Respondents only going along the lines of oncocytic hyperplasia , adenoma or carcinoma or a metastasis score 1. Mammary analogue

secretory carcinoma as a definitive scores 1 as clearly out of consensus. Local diagnosis acinic cell carcinoma.

Case 15

All respondents score 2. Two mentioned this as a metastasis rather than recurrent primary but those present at the review session voted to score this 2. The local diagnosis was of malignant melanoma.

Case 16

This case generated a very wide range of responses, all benign ranging from a simple cyst through hyperplasia of various elements, hamartoma / choristoma, sialolipoma and all score 2. There was one response of viral change and dysplasia which was clearly out of consensus and the group decided to score this 0.

Case 17

All respondents favoured a diagnosis of Hashimoto's / autoimmune / lymphocytic thyroiditis and all score2.

Case 18

This case generated considerable discussion. 17 thought there was no carcinoma and 56 thought that there was. Some thought the changes mimicked carcinoma and a few though it was indeterminate for malignancy. Those present at the meeting voted to regard this as a non-scoring educational case.

The local diagnosis was of changes due to carbimazole effect but given that a large mumber of respondents though that there was malignancy, the submitting pathologist is to seek a further review.

Next review session will be held in Sheffield, likely early November but date TBC asap.

Gillian Hall

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Please note difficulty in allocating points ie case 7 diff met mec v sebaceouls lymphadenoma in that order with no work up