NATIONAL HEAD AND NECK HISTOPATHOLOGY EQA SCHEME

Circulation 18 (Spring 2010)
Notes of the Review Session held in the School of Clinical Dentistry, University of Sheffield
Wednesday 13th October 2010

PRESENT: Dr. AW Barrett (Chair)
Professors PM Farthing, PR Morgan, EW Odell, K Piper, P Sloan, N Thakker; Drs. U Earl, M Fernando, G Hall, T Helliwell, AS High, KD Hunter, K MacLennan, SS Napier, TJ Palmer, AJ Potts, M Pring, M Reed, IA Robinson, KA Shah, RD Start, A Triantafyllou, HK Williams (total 24)
Trainees: Drs. A Betts, P Chengot, RC Hall, AV Jones, A Torres (total 5)
Visitors: Dr. M. Nyagam
Apologies: Professors GT Craig, CD Franklin PM Speight, GJ Thomas, DM Walker; Drs. M Calaminici, S Di Palma, J James, CH Kendall, CM Robinson, DSC Rose, G Smith, S Thavaraj, J Williams, JA Woolgar
Quorum: 20 (25% of the total number of respondents – SOP 8)

Matters Arising

1. 96 re- and newly registered individuals were eligible to return EQA 18 following the "amnesty" and "stock take" at the end of 2009/beginning of 2010.
2. 80 had made returns for circulation 18. The answers of the first 78 received comprised the basis for the discussion of each case at the review session, but all are included in the table of personal performance scores.
3. All boxes were distributed for circulation 18. Participants from four centres had been asked to share a box with a geographically adjacent centre. At least one had experienced problems accessing or retrieving slides (N.B. it has since become apparent that some participants are requesting slide boxes, but not then making a return).
4. Participants had again been asked to specify which method they had used to assess the 18 cases, 73/80 had done so. All had used glass slides, but nine (12%) had also used the Aperio web-based "virtual microscopy" system hosted by the University of Leeds. None had used only the virtual microscope.
5. Participants were:
    a. reminded of the importance of using the correct participant code, and asked not to assume their new code was their old one + 100;
    b. asked, if e-mailing their responses, to send them in one attachment, not 12 or 18.

    A postal only return was being considered for the next circulation (EQA 19), although it had been suggested that distributing an 18 page response form (rather than a single page form which participants copied 12 or 18 times) might avoid the problem outlined in 5b above.
6. Participants were reminded of the importance of confidentiality, and advised:
    a. not to e-mail responses to the Scheme Organiser;
    b. to avoid entering "this is my case" or similar on the response form;
    c. to consider submitting a typed response if they have easily identifiable handwriting.
7. Following ongoing discussion about the inclusion of thyroids in the Scheme, a short questionnaire will be circulated shortly via e-mail. An option to reply anonymously would be available.
8. Several participants are submitting diagnoses unsupported by further investigations in the working or differential diagnosis sections. These will in future be regarded as definitive diagnoses.
9. Following the "amnesty" (see above), eight participants have not submitted responses to either EQA 17 or 18 and are thus in breach of SOP 11 (which states that the minimum acceptable level of participation in the Scheme is two out of three consecutive circulations). The reason for this is known in one case. The other seven will receive "letters of enquiry". Several other participants, who did not return EQA 18, are obliged to make returns for EQA 19.
10. As this is the second circulation since the "amnesty", it has not yet been possible for a first action point to be triggered. Three participants (120, 172 and 193) had registered substandard performances in EQA 17. 120 and 172 had achieved satisfactory scores in EQA 18 (193 did not submit).
11. Prior to beginning the scoring for each case, participants were reminded of the criteria for awarding the scores of 0, 1 and 2 (see SOP 8).
12. Electronic voting was again used. Votes were not taken on the consensus diagnosis. Technical problems prevented votes for all cases - verbal consensus (with or without a show of hands) was taken when allocating scores where electronic voting was not possible.

Scoring of responses for personal performance analysis

Cases 1-6 (number of respondents = 55)

Case 1 Local diagnosis = severe chronic sialadenitis with acinar atrophy and fibrosis (Julia Woolgar)
2 points (45 respondents): those who submitted a definitive, working or differential diagnosis of/which included sialolipoma/lipoadenoma.

1 point (9): a definitive, working or differential diagnosis of/which included sialadenitis (6) or hamartoma (3).
0 (1): a definitive diagnosis of retention mucocoele*. Result of vote:

	% in favour of score of 0	% in favour of score of 1	% in favour of score of 2
Chronic sialadenitis	18	59	23
Retention mucocoele	86	14	0
Hamartoma	43	43	14

*Organiser's comment: currently, the scoring system (SOP 8) does not discriminate between a wrong answer which is of no clinical consequence, and one that is; the fact that a harmless, but nevertheless clearly wrong response scores the same as a potentially calamitous misdiagnosis is a frequent point of contentious discussion in review sessions, even after 20 years of running the Scheme.

Case 2: Local diagnosis = traumatised benign vascular anomaly such as a haemangioma (Bill Barrett)
2 (47): a definitive, working or first differential diagnosis of/which included a benign vascular anomaly or haemangioma.
1 (8): a working or first differential diagnosis of Kaposi's sarcoma in which appropriate work-up would have led to an appropriate diagnosis (7); a definitive diagnosis of mild epithelial dysplasia/capillary haemangioma (1). Result of vote:

	0	1	2
Mild epithelial dysplasia/capillary haemangioma	24	62	14
Kaposi's sarcoma (appropriate work-up)	31	63	6

Case 3: Local diagnosis = adenomatoid odontogenic tumour (Bill Barrett)
2 (50): a definitive, working or first differential diagnosis which included adenomatoid odontogenic tumour.
1 (2): a first differential diagnosis of hybrid adenomatoid odontogenic tumour/calcifying epithelial odontogenic tumour; a first differential diagnosis of calcifying epithelial odontogenic tumour where a further opinion was sought*.
0 (3): a definitive diagnosis of calcifying epithelial odontogenic tumour*. Result of vote:

	0	1	2
Hybrid (AOT/CEOT)	19	57	24
Calcifying epithelial odontogenic tumour (opinion sought)	29	62	10
Calcifying epithelial odontogenic tumour (no opinion sought)	100	0	0

*Organiser's comment: SOP 7 states that requests for second opinions should not be included in more than 20% of a participant's responses in any one circulation (i.e. three for 12 responses, four for 18). The fact that misdiagnoses may score 1 merely by specifying that a further opinion would be sought is also a source of irritation to some participants. However, the current *modus operandi* of the Scheme is to attempt, however clumsily and artificially, to mimmick the histopathological diagnostic process; second opinions, whether they be formal referrals to another centre or a brief discussion in a colleague's office, are clearly a part of this.

Case 4: Local diagnosis = pemphigus vulgaris (subject to confirmatory immunofluorescence) (Murray Walker)
2 points (55): all submitted a definitive or working diagnosis of pemphigus.

Case 5: Local diagnosis = metastatic renal cell carcinoma (Bill Barrett)
2 points (55): all submitted a definitive or working diagnosis of metastatic renal cell carcinoma.

Case 6: Local diagnosis = central giant cell lesion (central giant cell granuloma); hyperparathyroidism should be excluded (Murray Walker)
2 (55): all agreed this was a giant cell lesion, but there was no consensus as to whether consideration of hyperparathyroidism should be a requisite for two points, or that there was sufficient evidence in the sections supplied to have enabled a peripheral lesion and a giant cell tumour of bone to be excluded. No vote was taken.

Cases 7-12 (number of respondents = 78)

Case 7: Local diagnosis = basal cell adenoma, tubular variant (Gordon MacDonald)
Only seven respondents (9%) had proposed a definitive, working or first differential diagnosis of a benign tumour, but there was a considerable range of proposed adenocarcinomas. Given the array of diagnoses, no consensus was possible and so the case was excluded for personal performance assessment.

Case 8: Local diagnosis = lymphoplasmacytic lymphoma (lamda restricted) with amyloid deposits (Ivan Robinson)
2 (70): a working or differential diagnosis of amyloid with/without lymphoma, with appropriate work-up to exclude lymphoma.

1 (5): a definitive or working diagnosis of amyloid with no mention of lymphoma (2); a working diagnosis of proteinaceous lymphadenopathy with appropriate stains (1); a first differential diagnosis of granulomatous lymphadenitis with appropriate stains (1); a first differential diagnosis of tuberculosis with appropriate stains (1).
0 (3): a working diagnosis of granulomatous inflammation, no appropriate stains sought (1); a first differential diagnosis of tuberculosis with no appropriate stains sought (1); a first differential diagnosis of fibrotic lymph node with no appropriate stains sought (1). Technical problems prevented an electronic vote and these scores were agreed verbally.

Case 9: Local diagnosis = Warthin's tumour (Eddy Odell)
2 (68): a definitive, working or first choice differential diagnosis of Warthin's tumour.
1 (8): a definitive, working or first choice differential diagnosis of a benign oncocytic tumour, but not Warthin's.
0 (2): first choice differential diagnoses which were malignant. Result of vote:

	0	1	2
Benign oncocytic lesion, but Warthin's tumour not considered	Vote	not	taken*
Malignant first differential, benign entities considered	55	40	5
Malignant first differential, benign entities not considered	95	5	0

*There was verbal agreement that this should score 1.

Case 10: Local diagnosis = metastatic medullary carcinoma of thyroid (Peter Morgan)
2 (70): a definitive, working or first differential diagnosis of medullary carcinoma.
1 (6): a working diagnosis of paraganglioma with appropriate immunohistochemistry.
0 (2): a definitive diagnosis of paraganglioma (1); a differential diagnosis of epithelial-myoepithelial carcinoma where a thyroid metastasis was not considered (1). Result of vote:

	0	1	2
Paraganglioma (appropriate work-up)	19	62	19
Paraganglioma (no or inappropriate work-up)	91	9	0
Epithelial-myoepithelial carcinoma (thyroid metastasis not considered)	95	5	0

Case 11: Local diagnosis = extranodal marginal zone lymphoma with clonal light chain restriction and immunoglobulin gene rearrangement (Ken MacLennan)
2 (71): a definitive, working or differential diagnosis of lymphoepithelial sialadenitis/Sjogren's with lymphoma (or with lymphoma work-up).
0 (7): a definitive or working diagnosis where lymphoma was stated to be absent, or not considered (6). "Mikulicz disease", a term used by one respondent, was regarded as obsolete. Result of vote:

	0	1	2
"Mikulicz disease"	100	0	0
Lymphoepithelial sialadenitis/Sjogren's, no lymphoma (or not considered)	74	26	0

Case 12: Local diagnosis = cylindroma with perineural infiltration (Ken MacLennan)
2 (72): a definitive, working or first differential diagnosis of cylindroma.
1 (4): a working diagnosis of malignant cylindroma (2) or adenoid cystic carcinoma (2) where a further opinion was sought.
0 (2): a definitive diagnosis of adenoid cystic carcinoma (1); a working diagnosis of basal cell adenocarcinoma where no further opinion was sought (1). Result of vote:

	0	1	2
Adenoid cystic carcinoma (expert opinion sought)	30	57	13
Adenoid cystic carcinoma (no expert opinion sought)	95	5	0
Malignant cylindroma (expert opinion sought)	24	62	14
Basal cell adenocarcinoma (no expert opinion sought)	100	0	0

Cases 13-18 (number of respondents =69)

Case 13: Local diagnosis = thyroglossal duct remnant with florid periductal cholesterol granuloma formation (Simon Rose)
2 points (68): a definitive, working or first differential diagnosis of thyroglossal duct cyst with/without cholesterol granuloma.
0 (1): a definitive diagnosis of cholesterol granuloma. No electronic vote was taken; these scores were agreed by a show of hands.

Case 14: Local diagnosis = benign chondroma (Charles Kendall)
2 (63): a definitive, working or differential diagnosis of chondroma, choristoma or chondro-/chondroid lipoma.
1 (5): a working or first differential diagnosis of low grade chondrosarcoma where a further opinion was sought (2); a first differential diagnosis of chondroid metaplasia (not otherwise specified) (2); a first differential diagnosis of spindle cell lipoma with appropriate immunohistochemistry (1).
0 (1): a first differential diagnosis of recurrent low grade chondrosarcoma. Result of vote:

	0	1	2
Chondroid metaplasia not otherwise specified (opinion sought)	13	50	38
Spindle cell lipoma with chondroid metaplasia (appropriate markers)	29	65	6
Low grade chondrosarcoma (opinion sought)	19	75	6
Recurrent low grade chondrosarcoma (no opinion sought)	94	6	0

Case 15: Local diagnosis = respiratory epithelial adenomatoid hamartoma against a background of inflammatory nasal polyposis (Seamus Napier)
2 (68): a definitive, working or differential diagnosis of respiratory epithelial adenomatoid (READ) hamartoma and/or inflammatory polyp.
0 (1): a definitive diagnosis of low grade adenocarcinoma. Result of vote:

	0	1	2
Inflammatory/allergic polyp (READ not mentioned)	Vote	voided*	
Inflammatory/allergic polyp with adenomatoid hyperplasia	Vote	voided*	
Low grade adenocarcinoma	100	0	0

*Discussion between the votes on these two diagnoses influenced the second vote. Given that READ, despite the term, is merely a variant of inflammatory nasal polyp the votes were voided and all responses of READ and/or inflammatory polyp awarded two points.

Case 16: Local diagnosis = haemangiopericytoma (Malee Fernando)
2 (64): a definitive, working or differential diagnosis of sinonasal haemangiopericytoma/glomangiopericytoma.
1 (4): a working or first differential diagnosis of sinonasal glomus tumour (2), glomangioma (1) or paraganglioma (1).
0 (1): a first differential diagnosis of clear cell neoplasm, borderline benign/malignant. Result of vote:

	0	1	2
(Sinonasal) glomus tumour	14	50	36
Glomangioma	7	64	29
Paraganglioma	14	64	21
Clear cell neoplasm, borderline benign/malignant	75	25	0

Case 17: Local diagnosis = pT3 pN1b oncocytic thyroid psammomacarcinoma (Ivan Robinson)
2 (63): a definitive, working or differential diagnosis of papillary carcinoma.
1(4): a definitive diagnosis of oncocytic psammomacarcinoma (1); a working diagnosis of metastatic carcinoma where there was work-up likely to identify papillary carcinoma (2); a working or differential diagnosis of thyroiditis where papillary carcinoma was not considered/declared absent, but where a further opinion was sought (1).
0 (2): a definitive diagnosis of “chronic thyroiditis, probable variant of Hashimoto’s thyroiditis” (1); a differential diagnosis where papillary carcinoma was not considered/declared absent (1). Technical problems prevented an electronic vote and these scores were agreed verbally.

Case 18: Local diagnosis = papillary carcinoma of thyroid (Ivan Robinson)
2 points (69): all submitted a definitive or working diagnosis of papillary carcinoma.

Date of next meeting: Friday May 6th 2011 @ 13.30, University of Sheffield Dental School.

A.W. Barrett
Scheme Organiser