# SCAN

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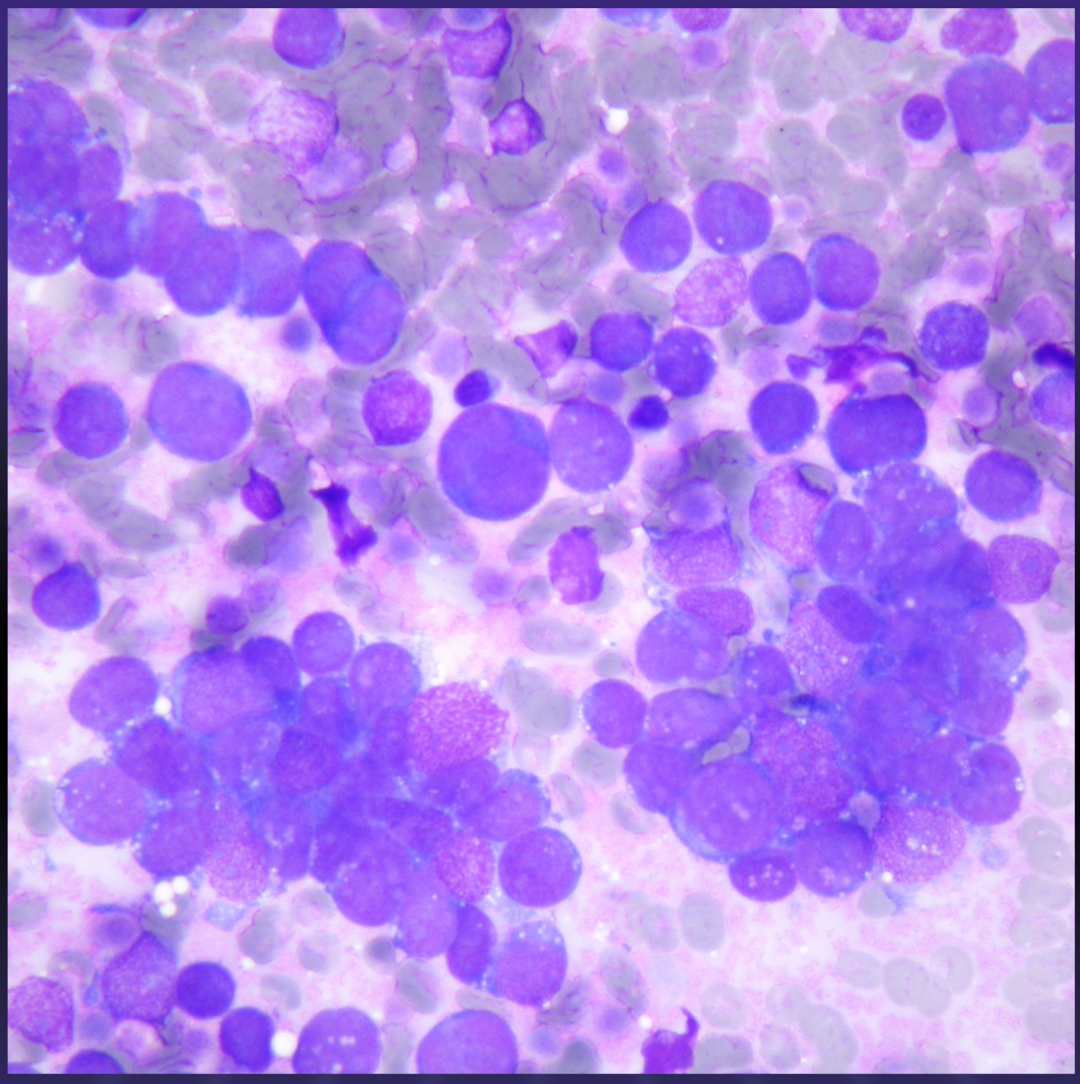

BAC British Association for Cytopathology

# BAC Executive Committee

**President**

**Dr Paul Cross** Consultant Cellular Pathologist, Queen Elizabeth Hospital, Gateshead Health NHS Foundation Trust, Tyne and Wear, NE9 6SX
Tel: 0191 445 6551
Email: paul.cross1@nhs.net

**Chair**

**Alison Cropper** Cytology Department, 5th Floor, Derby Hospitals NHS Foundation Trust, Royal Derby Hospital, Uttoxeter Road, Derby DE22 3NE
Tel: 01332 789327
Email: alison.cropper@derbyhospitals.nhs.uk

**Honorary Secretary**

**Sue Mehew** Consultant Healthcare Scientist in Cytology, Cytology Laboratory, Pathology Department, Royal Infirmary of Edinburgh, 51 Little France Crescent, Edinburgh. EH16 4SA.
Tel: 0131 2427149
E-mail: sue.mehew@luht.scot.nhs.uk

**Treasurer**

**Kay Ellis** ABMSP/Cytology Manager and HBPC, Cytology Department, Floor E, Royal Hallamshire Hospital, Glossop Road, Sheffield S10 2JF
Tel: 0114 271 3697
Email: kay.ellis@sth.nhs.uk

**Membership**

**Dr Louise Smart** Department of Pathology, Laboratory Link Building, Foresterhill, Aberdeen. AB25 2ZD
Tel: 01224 552836 Work Fax 01224 663002
Email: louise.smart@nhs.net

**Meetings Sub Committee Chair**

**Alison Malkin** Lecturer in Biomedical Science (Cytology and Cellular Pathology), School of Biological Science, Dublin Institute of Technology, Kevin Street, Dublin 8, Ireland
Tel. 00 353 1 4022835
Email: alison.malkin@dit.ie

**CEC**

**Helen Burrell** Consultant Biomedical Scientist & Manager, South West Regional Cytology Training Centre, Lime Walk Building, Southmead Hospital, Bristol BS10 5NB
Tel: 0117 323 2704
Email: Helen.Burrell@nbt.nhs.uk

**Members**

**Dr Ash Chandra MD FRCPath DipRCPath (Cytol)** Consultant Pathologist, Cellular Pathology, 2nd floor North wing, St. Thomas' Hospital, London SE1 7EH
Tel: 0207 188 2946 Fax: +44 207 188 2948
Email: Ashish.Chandra@gstt.nhs.uk

**Hedley Glencross** Advanced Specialist Biomedical Scientist, Cytology Department, Queen Alexandra Hospital, Southwick Hill Road, Portsmouth PO6 3LY
Tel: 023 9228 6700
Email: hedley.glencross@porthosp.nhs.uk

**Dr Anthony Maddox** Department of Cytology, Watford General Hospital, Vicarage Road, Watford, WD18 0HB
Tel: 01923 217349
Email: anthony.maddox@whht.nhs.uk

**Dr. Yurina Miki** Consultant Histopathologist
Cellular Pathology, 2nd floor, North wing, St. Thomas' Hospital, Westminster Bridge Road, London, SE1 7EH
Tel: 020 7188 7188 ext. 56514
Email: yurina.miki@nhs.net | yurina.miki@gstt.nhs.uk

**Eva Halloran** Consultant Biomedical Scientist
Cytopathology, St Thomas' Hospital, Westminster Bridge Road, London, SE1 7EH
Email: eva.halloran@nhs.net
Tel: 0207188 8188 ext 54635

**Allan Wilson** Lead Biomedical Scientist in Cellular Pathology and Advanced Practitioner in Cervical Cytology, Pathology Department, Monklands Hospital, Monkscourt Avenue, Airdrie. ML6 0JS
Tel: 01236 712087
Email: Allan.Wilson@lanarkshire.scot.nhs.uk

***please see inside back cover for co-opted members***

# Editorial

## Sharon Roberts-Gant

Just when we thought things couldn't get any more challenging, following all the changes in cervical cytology, along comes a pandemic. This situation has precipitated the move of *SCAN* from print to online, *SCAN* will remain in this format for all future editions.

Even in these difficult times we have several articles to share with you. Part 3 of A World Tour is with us, focussing this time on the IAC Yokohama System for reporting Breast FNAB. There are reports from the Primary HPV laboratory meeting held on 5th December 2019 and the BSCCP Annual Scientific Meeting held last May. We have a question and answer session from the new IBMS President – Allan Wilson (great to see a cytologist in the role).

I bet you didn't know that *SCAN* is not alone … see article for explanation!

Now that we have moved to a digital format we are not restricted to balancing the number of pages to a multiple of four (or trying to) to make printing cheaper so if you have anything you want to share with the cytology community please send it to me.

I hope that you and your families keep well and safe during this pandemic, this is going to be a difficult time for many.

*Sharon*

Editor: Sharon Roberts-Gant

Copy date for October 2020: 10th August 2020.

**Correction from the last issue of SCAN:**

Correction to the authors of the article entitled:

'Paris, Milan, Yokohama... A World Tour of Recently Published Reporting Systems in Cytopathology: Part 2'

Authors: Maria Buttice, Specialist Registrar in Histopathology, Guy's and St Thomas' NHS Foundation Trust.
Yurina Miki, Consultant Histopathologist, Guy's and St Thomas' NHS Foundation Trust.

**INFORMATION FOR CONTRIBUTORS**
**Articles for inclusion in SCAN can be emailed to the editor if less than 5MB 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 Piece

## Paul Cross

I must start this piece by congratulating Allan Wilson in his new role as President of the IBMS. Allan is well known for his many years of dedication and hard work in cytology, nationally and internationally, and his work with the BAC as Chair, President and Exec member. He will I am sure face many challenges and I wish him luck. There are many issues facing the IBMS and its members, as there are to staff across Pathology and the wider NHS, but I am sure Allan will tackle them with his usual level headedness, borne of years of experience and knowledge of Pathology. Whilst Allan has a background in cellular pathology and cytology in particular, I am sure cytology will get no special treatment as compared to the rest of the issues in his in tray, unless we can make a sound and reasoned argument. The IBMS is in safe hands with his stewardship.

The dust is sort of settling now in England after the major upheavals of the pHPV implementation. The service is working, samples are being processed and reported, results issued and lab moves largely, if not fully, completed. The staff repercussions are also largely known or being finalised. Many good staff will be unable to relocate even if they wished to. Many will leave the service, taking their vast experience and skills with them. The loss of this wealth of knowledge and experience cannot be underestimated. Those staff that have been able to stay within the service are now, in many instances, dealing with a very different programme to the one they were used to. We will all muddle through, as we always tend to. I must pay tribute to all staff who have or who are still working the CSP, not only in England but across the UK. Their hard work, dedication and skill have made the UK CSP the best in the world. Our job now is to carry on this work and ensure that this is maintained.

One major reason for the existence of the BAC is education, we run one day tutorials, scientific meetings and input to sessions internationally. We offer bursaries to help members attend meetings. We have Cytopathology as our flag ship journal, contributing to the science of cytology. We take this aspect of our reason to exist seriously. Whilst our membership numbers may fall, largely as a result of the national CSP changes, this does not mean that we will cease to deliver educational resources. This will reflect the changing areas of cytology, both scientifically and clinically. It must also reflect what our membership needs and wants. Once again, we have several meetings organised, as shown on the website and in this edition of SCAN. Please do look to attend, and let others know of our meetings. Members get reduced rates for attendance at BAC

***Alison Cropper, Allan Wilson, Paul Cross***
***Presidents – Future, Past and Present***

organised meetings, and new members can also get a good deal if they join. Spread the word to your colleagues who may not be members.

We will be having some changes in the Executive this year, as some members stand down after their term of office, whilst others may stand again. I must thank all Exec members for their hard work. I must especially thank Yurina Miki who is standing down from the Exec later this year for all hard work in helping move us into the social media age. As one of our chief Twitterers she has helped promote and expand awareness of us and what we do. While we have done much as a body there is still much more to do. Please do consider standing for the Exec. Don't be shy or reticent. If you work in cytology, believe in cytology, then think about standing. I am sure any Exec member will be happy to give more insight about what we do and the level of commitment. It is above and beyond the day job, but anything worth doing requires effort.

This edition of SCAN once again highlights various aspects of the BAC, and its members. It reflects the range of work we are doing, and how we are looking to promote, develop and advance cytology. Many things we do take a long time to come to fruition, or even at times be visible. It's not for want of trying. Rome wasn't built in a day, and never was that more apt than in the NHS. The pace of change can be slow, agonisingly slow at times. This is one of my biggest professional frustrations. We hear a lot about innovation, change and empowerment. It seems sadly lacking often. I will be completing my term of office as President later this year, and will be standing down from the Exec. I have enjoyed by time on the Exec immensely. I have been able to meet and work with some amazing and talented people. However, we need new blood, new ideas and new energies. I look forward to seeing how the BAC develops and moves forward. This is not my last SCAN, as I will help with the Autumn edition, but I will be passing the Presidency over to Alison Cropper as incoming President. The BAC is safe in her hands.

# Chairman's Column

## Alison Cropper

Storms Ciara and Dennis have just passed over the UK and left in their trails many unhappy communities and some displaced people feeling rather battered, bruised and angry – sound familiar?! Likening this to what has just happened to the wider cytology community I know there are many colleagues out there who feel just that way – that they have been uprooted and dropped into new places of work, or have chosen to stay put but in other roles, or chosen to leave for non-NHS employment, or have just decided to retire from work altogether. Individuals have made their own choices according to their own personal circumstances, but they have been enforced choices and not ones made of their own accord.

NHS England / Improvement had 2 targets – one that HPV primary screening be fully implemented in England by 31/12/19 – tick; the other that consolidation onto 8 sites be complete by 31/3/20 – will be another tick. But in the fallout from this we have lost a tremendous amount of knowledge, skills and experience in the cervical screening programme, not just in England but across the UK, and this is not, nor should be, under estimated. The years of dedication to the programme from so many is so very much appreciated by the BAC, we cannot say this enough or any more sincerely.

On a brighter, more positive note, I was recently honoured to have been invited by the IBMS to the inauguration of their new President, Mr Alan Wilson, a past President of BAC and still an executive member. During his acceptance speech Alan paid tribute to cytology staff across the UK and acknowledged the unprecedented changes that we are going through, and also described his vision for his term of office and what he hopes to achieve – to continue the expansion of roles and breaking barriers across Pathology – something that cytology has been at the forefront of for some years now. This is something that BAC look forward to working with IBMS and RCPath on, and in that respect the future is most definitely bright!

If you are reading this then you are probably still involved in cytology in some way, even if the focus of your role has changed , but we appreciate that our membership is more than likely to reduce in the coming months and years , and this is where BAC are keen to evolve and respond to our members' changing needs. As Paul has described in his President's Piece, one of the major aims of BAC is to provide education, and this will continue to grow with a wide range of educational activities being organised and supported by BAC, but


should you have any requests for specific activities or events that you would like BAC to consider organising then please do let us know -

email@britishcytology.og.uk

One aspect of change for BAC is looking at our means of communication – we recently topped the 1,000 followers mark of Twitter, largely due to the tremendous efforts of Dr Yurina Miki and Christian Burt. If you don't yet follow us on Twitter please do so @britishcytology, and Tweet away! In the not too distant future we are going to be looking at both our journals, Cytopathology and SCAN, to evaluate the most appropriate format for these going forwards, considering whether on-line only would be the most cost effective and tree saving medium for us – again, if you have any comments about this please do let us know.

We are also looking at improving the way in which we hold elections, which until now has been by snail mail or e-mailing ballot papers to and from our members. On-line voting systems are currently being appraised and we hope to have one in place soon, ready for the nominations and voting for executive members to be held this autumn. We are hoping this will make the process much easier and less time consuming, which given the low response 3 years ago, is clearly much needed!

Speaking of which, there will be at least 2 vacancies on the executive this year and we really would like to see some new faces come forward. If you are passionate about all things Cytology and feel you can contribute to the work of your association then please do stand for election, or nominate someone else you think would be great on the team – with their consent and willingness obviously!

BAC is the voice of cytology not only in the UK but across the globe – if you want your voice to be part of that please consider joining the executive. So often I hear – 'why don't BAC do this, or that' and 'why didn't BAC comment on such an article' – if you're one of those people, don't just sit back ask those questions, join the executive and help turn words into actions! We'd love to have you on board:

# Paris, Milan, Yokohama… A World Tour of Recently Published Reporting Systems in Cytopathology: Part 3

**Dr Claire Farrell (Specialist Registrar in Histopathology) and Dr Yurina Miki (Consultant Histopathologist), Guy's and St Thomas' NHS Foundation Trust**

## Introduction

So far in this world tour of cytopathology reporting systems, we have visited France for 'The Paris System for Reporting Urinary Cytology' and Italy for 'The Milan System for Reporting Salivary Gland Cytopathology'. Japan is the last stop in this 3-part review, with a summary of the newly proposed 'International Academy of Cytology (IAC) Yokohama System for Reporting Breast Fine-Needle Aspiration Biopsy Cytopathology'.

## The IAC Yokohama System for Reporting Breast Fine-Needle Aspiration Biopsy Cytopathology

Breast fine-needle aspiration biopsy (FNAB) is a rapid, cost-effective and accurate technique, which carries a minimal risk of complications; in the diagnosis of breast cancer, it has a 90-95% sensitivity with a positive predictive value (PPV) approaching 100%.[1,2] However, there is international variability in the application and use of breast FNAB, particularly due to changes in breast cancer screening programs and the preferential use of core-needle biopsy (CNB). Nonetheless, the two techniques should be regarded as complementary and an integral part of the 'triple assessment', which includes clinical examination, imaging and biopsy. Through the creation of a standardised reporting system, the fundamental aims of the IAC Yokohama System are to establish best practice guidelines for the appropriate use of FNAB in diagnosing breast lesions and to improve the accuracy and consistency of breast cytopathology reporting.[2]

The system was conceived at the 2016 International Congress of Cytology meeting in Yokohama by a group of cytopathologists, radiologists, surgeons and oncologists with experience in the management of breast lesions.[3] Following input from their peers via a 2018 international survey, the first draft was edited and took form as a practical, applicable and evidence-based set of guidelines.

The IAC Yokohama System stratifies breast FNAB samples into five diagnostic categories according to their associated risk of malignancy (ROM): 1) 'Insufficient/inadequate', 2) 'Benign', 3) 'Atypical', 4) 'Suspicious of Malignancy' and 5) 'Malignant'.2 Two recent studies have shown a ROM for each of the diagnostic categories as follows: 2.6-4.8% ('Insufficient/inadequate'), 1.4-2.3% ('Benign'), 13-15.7% ('Atypical'), 84.6-97.1% ('Suspicious of Malignancy') and 99-100% ('Malignant').[4,5] Each of these categories will be reviewed in turn, from the diagnostic criteria to the suggested management.

### *Insufficient/inadequate*

The IAC Yokohama System recommends that assessment of adequacy is considered pragmatically in the context of the clinical and imaging findings. Epithelial cellularity may be thought of as an important criterion for adequacy, but epithelial cells may not be required for the diagnosis of certain breast lesions if the cytological findings correlate with clinical and imaging findings; for example, the presence of pus that would be consistent with an abscess, or the finding of proteinaceous fluid (with or without histiocytes) that would be consistent with cyst contents.[2] However, if the cytological findings do not explain the clinical or imaging findings, then the report should state that the material may not be representative of the targeted breast lesion; in these instances, repeat sampling (either FNAB or CNB) is recommended.[2]

In other situations, epithelial cells are crucial for diagnosis. This applies if a solid lesion has been palpated or seen on imaging, in which case the presence of seven tissue fragments each containing at least twenty epithelial cells is considered adequate.[6,7] The exception to this rule is the finding of atypical features or necrosis; these cases should be placed in the 'atypical' category, regardless of cellularity.[7] The 'insufficient/inadequate' category also includes poorly prepared direct smears with artefacts (e.g. crush artefact, slow air-drying or poor alcohol fixation) that consequently preclude a cytomorphological diagnosis.[2]

The management of breast lesions in this category depends on the nature of their inadequacy. If it is due to technical issues, then the system recommends repeating the FNAB to a maximum of three passes.[8]

If the sample is considered insufficient to explain the clinical or imaging findings, the recommendation is to repeat the FNAB or proceed to CNB.[2]

### *Benign*

The IAC Yokohama System defines a 'benign' breast FNAB sample as one with unequivocally benign cytological features, whether or not they are diagnostic of a specific entity. They further qualify benign cytological features as "a pattern of predominantly large cohesive three-dimensional tissue fragments and flat mono-layered sheets consisting of evenly spaced, ductal epithelial cells with myoepithelial cells creating a 'bimodal' pattern, as well as, 'bare bipolar nuclei' representing stripped myoepithelial nuclei, in the background" (Figure 1).[7]

The most commonly diagnosed lesions in this category include[2]:

- Acute mastitis
- Breast abscess
- Granulomatous mastitis
- Foreign body reactions
- Fat necrosis
- Cysts with apocrine sheets and proteinaceous fluid
- Material "consistent with cyst contents" without epithelial cells (provided that clinical and imaging findings are corroborative and that the cyst has been completely drained with no palpable residual lesion)
- Fibrocystic change
- Lactational change
- Normal breast
- Usual epithelial hyperplasia
- Fibroadenoma
- Intraductal papilloma
- Gynaecomastia
- Intramammary lymph nodes

In general, a 'benign' diagnosis that correlates with the suspected clinical and imaging findings does not require a further biopsy; however, if there is a discrepancy, then repeat FNAB or CNB is recommended.[2] Subsequent follow-up depends on the nature of the lesion and institutional practices, with the patient usually returning for routine mammographic screening in 12-24 months.[2]

### *Atypical*

The 'atypical' category is perhaps the most difficult to strictly define, as illustrated by the wide range of ROM in the literature.[2] A breast FNAB sample should be placed in this category when the features are predominantly those of a benign process, but certain additional features are present that are not commonly seen in benign lesions and may be seen in malignant lesions.[2]

These features include[7]:

- High cellularity
- Complex cribriform or micropapillary architecture
- Prominent dispersal of single intact cells
- Nuclear enlargement and pleomorphism
- Necrosis or mucin

The system recommends a description of the specific features prompting the 'atypical' diagnosis. The report should include a differential diagnosis and the cytopathologist's favoured diagnosis.

Some breast lesions that display atypical features cannot be definitively placed in the 'malignant' category due to overlapping features with certain 'benign' diagnoses. For example, intraductal papillomas may be indistinguishable from papillary carcinomas on cytology alone. The 'atypical' category is therefore perfectly appropriate for cases such as these, as it will prompt a subsequent CNB or excision biopsy and conclusive diagnosis on histology.

Designation into the 'atypical' category may also result from factors such as poor FNAB technique, poor smear preparation or inexperience of the cytopathologist.[9,10] In cases where the 'atypical' diagnosis is thought to be related to a technical issue, a repeat breast FNAB is recommended. However, if good quality material is available and there are atypical features, then CNB is considered mandatory, particularly if the clinical or imaging findings are indeterminate or suspicious.[2]

### *Suspicious of Malignancy*

The 'suspicious of malignancy' category also has a rather variable ROM in the literature.[2] A breast FNAB is considered 'suspicious' when it shows cytological features that are frequently seen in malignant lesions, but is lacking in sufficient quality or quantity to make a definitive diagnosis of malignancy.[2] The type of malignancy suspected should be stated wherever possible. This category is important as it maintains the high PPV of the 'malignant' category, while preserving the sensitivity of breast FNAB by preventing under-calling of lesions such as low-grade DCIS.[2]

Any breast FNAB samples that are designated into this category mandates either CNB or surgical excision biopsy.[2] If the breast FNAB has been performed at rapid on-site evaluation (ROSE), this can be achieved immediately by CNB. However, in some instances, such as cases of suspected lymphoma, this course of action would not be suitable; in such cases, sending material for flow cytometry and/or cell block preparation for immunohistochemistry would be the most appropriate subsequent step.

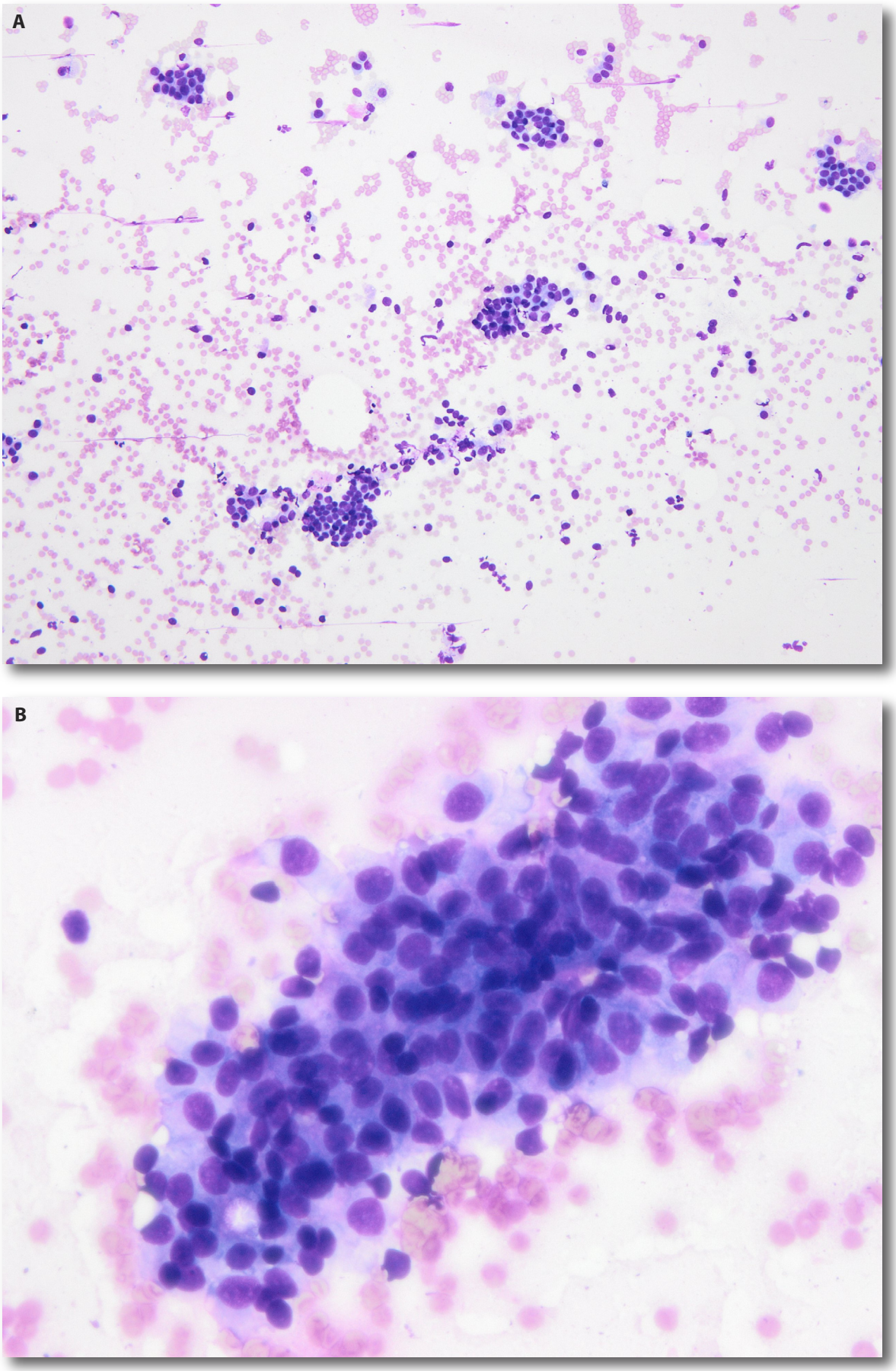


*Figure 1. Breast FNAB sample with cytological features fulfilling diagnostic category of 'Benign'. (A) The aspirate shows cohesive groups of ductal epithelial cells with associated myoepithelial cells, along with dispersed bare nuclei in the background (direct smear, Hemacolor stain, 100x magnification). (B) Note the dual population of ductal epithelial cells and myoepithelial cells at high magnification (direct smear, Hemacolor stain, 400x magnification).*

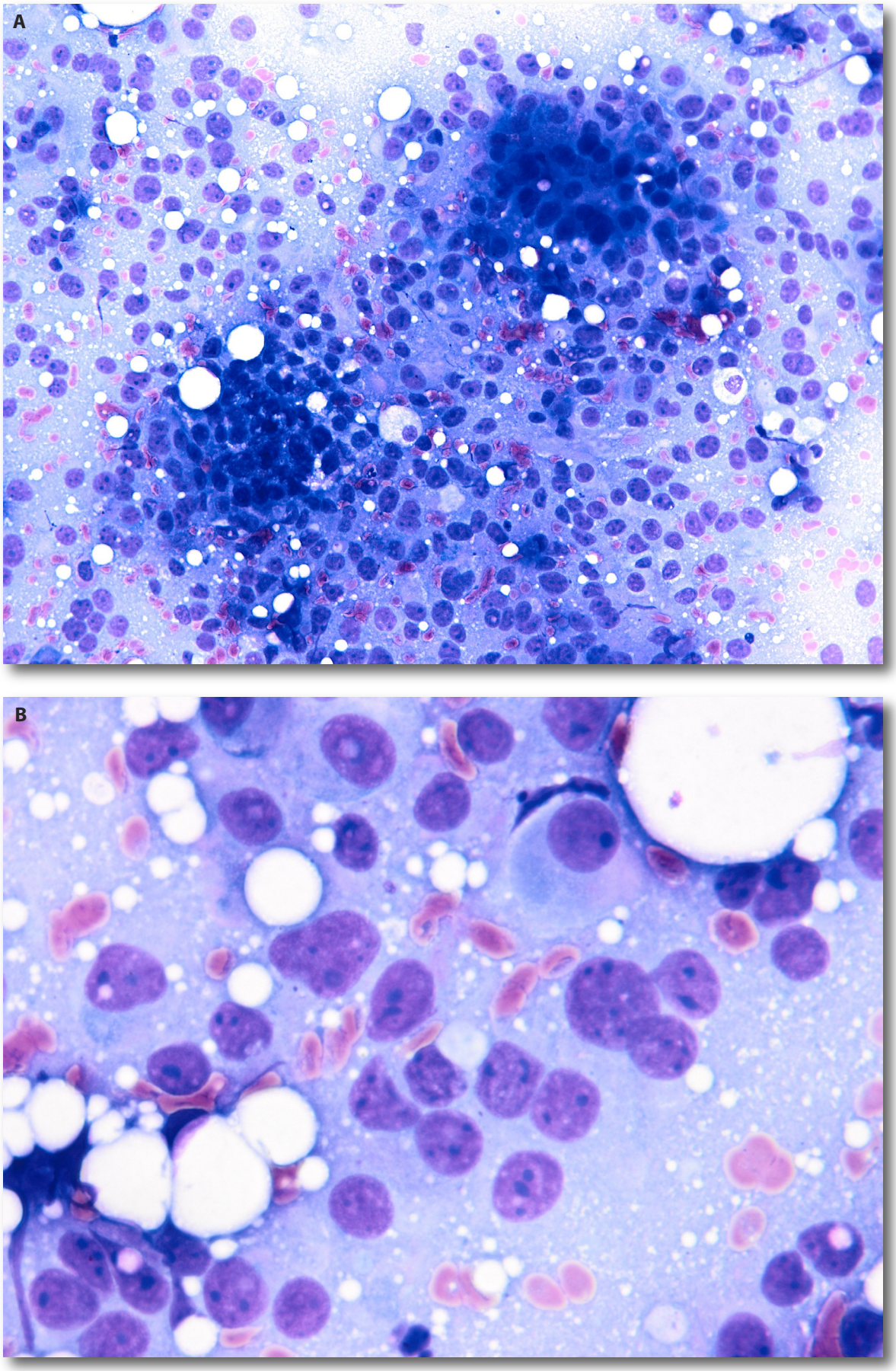


*Figure 2. Breast FNAB sample with cytological features fulfilling diagnostic category of 'Malignant'. (A) The aspirate is of high cellularity and shows disorganised sheets of tumour cells with prominent dissociation (direct smear, Hemacolor stain, 200x magnification). (B) The tumour cells show nuclear enlargement and pleomorphism, many with prominent nucleoli (direct smear, Hemacolor stain, 600x magnification).*

### *Malignant*

The 'malignant' category has the highest ROM[4,5], which ideally should be 100%. A 'malignant' diagnosis is reserved for cases that have unequivocally malignant cytological findings, with no inconsistent features to suggest an alternate diagnosis.[2]

The key features quoted by the system include (Figure 2)[7]:

- High cellularity
- Prominent dispersal of single cells
- Nuclear crowding and overlapping
- Nuclear enlargement and pleomorphism
- Anisonucleosis
- Nuclear hyperchromasia
- Prominent nucleoli

The IAC Yokohama System acknowledges that no specific feature alone is pathognomonic of a malignant process, and the key to diagnosis is the constellation of findings.

As with any cytological diagnosis, a breast FNAB sample classified into the 'malignant' category should be correlated with the clinical and imaging findings. If all are concordant, the next step may be CNB or definitive surgical excision depending on local practice (however, most centres in well-resourced countries would require CNB before proceeding to definitive treatment).[2] If, however, the breast FNAB diagnosis is inconsistent with the clinical and imaging findings, then CNB or excision biopsy is imperative to reach an accurate diagnosis.

## Conclusion

The IAC Yokohama System was developed to improve the accuracy and consistency of breast cytopathology reporting through defining five diagnostic categories for breast FNAB samples, each associated with a specified ROM and management recommendations. The system also emphasises the importance of the FNAB technique and the preparation of high-quality direct smears in diagnostic interpretation. Although the use of breast FNAB has been largely superseded by CNB in most medically well-resourced countries, it remains of clinical value particularly in the context of ROSE, which has the advantages of providing an immediate assessment of adequacy, allowing the cytopathologist an opportunity to convey a provisional diagnosis to the clinical team, and facilitating efficient management planning. In the UK, the use of the Breast Screening Programme (BSP) diagnostic categories of C1-C5 is recommended when reporting breast FNAB samples, but the IAC Yokohama System closely mirrors this five-tiered reporting system. The new proposed system is by no means a replacement of the UK BSP guidelines, but it equally provides a reproducible global guide for the reporting of breast FNAB samples, providing a means of auditing practice for quality assurance and ultimately improving patient care pathways.

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# We are not alone...

## Paul Cross

I've read SCAN for many years, and always assumed that we were the only magazine called this. However, I was wrong! My first introduction to this was while waiting for a plane and idling time flicking through the magazines that were around. One caught my eye. SCAN, but not our one! This SCAN was one promoting Scandinavian lifestyle -it's title is obvious really when you know this! This Scan Magazine is "a unique English-language showcase for Brand Scandinavia and appeals to all those who have a relationship with or a connection to Scandinavia – be it through family, business, tourism, migration or investment." It appears to have been published for 11 years.


This promoted me to do a search for other such named journals. Another is the Savannah College of Art and Design (SCAD), Atlanta, USA, and its magazine, SCAN. Founded in 2008, this SCAN is "an award-winning quarterly print magazine showcasing the SCAD Atlanta community from the student perspective. Ten years, thirty issues and more than 200 awards later, SCAN is going strong. A typical issue of SCAN includes the work of approximately 35 students. From planning to printing, every bit of every issue — staff photos, tables of contents, sets for fashion shoots, makeup, illustrations — is completed by a team of dedicated students."


Our SCAN has been published since the early 1990s, being the long running journal of the National Association of Cytologists (NAC). When the NAC and BSCC joined together to become the BAC, we continued with SCAN as our members magazine. Other magazines exists with SCAN or Scan as part of their title, but I can only find two so far which are just called SCAN. On that basis we appear to have the longest running SCAN title I can find. If you know better, or come across another SCAN magazine out there let us know!

# Primary HPV laboratory meeting

## 5th December 2019

There have been huge changes in the delivery and provision of the cervical screening programmes in recent months. The new model has been implemented as best as possible by the laboratories, but this has been with varying degrees of help, guidance or success. It is a great credit to the laboratories in England, Wales and Scotland that they have been able to implement and deliver pHPV screening within their respective screening programmes. The organisational, technical, and human issues around this cannot be underestimated. Implementation of this change of screening delivery has led to a major reconfiguration of laboratories, and will mean only 11 laboratories (8 England, 2 Scotland and 1 Wales) will be delivering pHPV cervical screening after March 2020. The provision in Northern Ireland has yet to be decided. Some of the laboratories have shared experiences and approaches, but this been informally and ad hoc. Several laboratories highlighted difficulties to the BAC, and working with the RCPath and IBMS, a meeting was organised to try and assist the laboratories. This was held at the IBMS offices on 5th December 2019. All the pHPV laboratory providers in England were invited to attend, as was representation from pHPV labs in Wales and Scotland, and observers from Northern Ireland. The laboratories were asked to give a presentation on the day. It allowed discussion around the issues raised. Six of the eight English laboratories were able to attend, but with all eight contributing presentations.

It was apparent that there were many issues that laboratories had faced in looking to deliver this new service and this has led to many innovative and novel approaches. This is a testament to the staff in the laboratories as to their ingenuity and commitment to delivering a quality cervical screening service. The issues faced in each of the mainland UK countries were similar, but were modified by the systems in which they work. As such, some issues appeared country specific, whilst others appeared more generic. The presentations were well received, and allowed for open, honest and on occasion frank discussions.

Whilst many issues have been solved, many are as still very much work in progress. Generic issues raised, in no particular order, were: work flow, IT,

staff and HR issues, QA monitoring, servicing MDTs, service resilience, staff training, legacy data issues, local engagement and call/recall issues. Many of these are complex and interdependent, and many aspects are outside of the direct control of the laboratories themselves. Much detail behind these headline topics were discussed, and recorded.

The meeting concluded with an agreement to share ideas, and where possible solutions, between laboratories more in the future. No future meeting was planned, and any need to do so would depend on forward movement on resolving issues, ideally through formal structures, and any new problems that may be encountered. The outcomes have been shared with PHE and NHSE in England, and are able to be shared by the laboratories elsewhere in the UK as they see fit. The issues have been acknowledged by PHE in England, and the English laboratories, as well as all three professional bodies, are looking forward to working with them to help address them.

So, was it worth it? Those present on the day felt it had been a useful, being able to meet each other and knowing they were not alone. Some ideas were shared on the day, others afterwards. Why re-invent the wheel if you can avoid it? While most people knew each other, the situations that they find themselves in now are vastly different to previous. The meeting may not have solved everyone's problems, but it did allow agreement on the major ones that need addressing. Time will tell if it was a success.

# British Society for Colposcopy and Cervical Pathology Annual Scientific Meeting, Bournemouth 8-10th May 2019

**Nichole Villeneuve, Consultant Biomedical Scientist, Severn Pathology, North Bristol NHS Trust**

Attending the BSCCP 2019 Annual Scientific Meeting was a professional first for me and I would like to thank the BAC for sponsoring my attendance from their bursary fund. The meeting was held at the Bournemouth International Centre (BIC) in May. The BIC is conveniently situated directly adjacent to the beautiful Bournemouth beach and is only a short walking distance from the Bournemouth Pavilion, Pier Approach and the promenade. The weather was favourably warm and sunny during the week of the conference. Attendees were able to enjoy the great outdoors, in addition to an excellent scientific meeting. The white sands and blue seas enticed some delegates to enjoy a refreshing paddle along the seashore before and after the lectures, each day.

Speakers and delegates from the UK, Europe, North America, Asia and the Middle East were in attendance.

The theme of last year's meeting was the 'Introduction of HPV Screening and the Enlarging Area of Non-cervical HPV Disease'. There was a full programme over three days, with a variety of informative and engaging plenary sessions and proffered papers.

The meeting commenced on Wednesday afternoon with a 'Colposcopy Trainer's Seminar'. As I work in cytology and not in colposcopy, I did not attend this session, but I would like to thank my former colleague - nurse colposcopist and colposcopy trainer Rajvinder Dhillon for providing me with a summary of the session, which Raj found useful. The first speakers delivered an interesting, interactive session on 'Advanced Communication Skills'. Case studies on 'breaking bad news' and 'informed consent and the assessment of capacity' were presented.

The training seminar included a talk on vaginal and vulval disease. Vulval intraepithelial neoplasia (VIN) is a multi-focal disease. An important reminder was highlighted during the talk - that vaginal intraepithelial neoplasia (VAIN) should be considered in cases where there is high grade cytology and no cervical abnormality colposcopically.

Upon completion of training to become a colposcopist, an exit exam is undertaken, which is known as the colposcopy OCSE (objective structured clinical examination). The OSCE consists of 8 different stations, 3 that have written questions and 5 interactive stations. An informative presentation was delivered based on the feedback from the most recent (OSCE) results. The lead trainers who assess trainee logbooks gave suggestions to trainers on topics which trainees are required to answer. Discussions on digital e-learning, and simulation training were also demonstrated.

The welcome reception and trade exhibition opening were held Wednesday evening in the conference centre where drinks and canapes were served. The commercial stands were very

***Bournemouth beach***

***Rajvinder Dhillon, Nurse Colposcopist***

accessible and well attended. Seeing new kit and commercial ideas, and networking with our amiable trade representative colleagues is always useful. Collecting relevant literature, pens, 'post-it' notes and small models of rubber cervices was a highlight for many delegates. Hot food was served for lunches, with a variety of options provided. Poster presentations were displayed in the hall for delegates to read during lunchtimes and breaks.

After spending time speaking with representatives from Jo's Cervical Cancer Trust, I decided to join their panel of healthcare professionals who volunteer for their 'Ask the Expert' support service for women with questions and concerns. This is one of their most popular support services which offers women, and sometimes their friends, families or partners, the opportunity to put their questions to a panel of qualified experts. As a panel member for the service you receive, on average, about one question a week to respond to. The questions cover a variety of topics and you are sent queries which are appropriate to your area of expertise. I have been a panellist now for eight months and have found it to be very rewarding. I would recommend that any cervical screening professionals who can afford to devote some time to this worthy cause, consider doing so and contact Jo's Trust for further information.

The scientific programme on Thursday, May 9th began with a talk on the regulation of cervical metaplasia and the particular vulnerability of the cervical transformation zone to HPV driven neoplasia, given by Professor John Doorbar from the University of Cambridge. He explained how genetic and molecular changes resulting from HPV infections can lead to marked differences between cells. He also talked about the use of biomarkers for the stratification of cervical neoplasia and questioned whether many types of cervical cancer with different rates of progression exist. These talks were followed by a stimulating panel discussion.

A proffered paper session followed where the use of HPV DNA methylation in cervical intraepithelial neoplasia was highlighted as a promising molecular marker for the triage of HPV positive women in screening, with the caveat that further evaluation of this approach is warranted. A study on improving the uptake of cervical screening in and around pregnancy was also presented, which highlighted the fact that pregnant and recently post-natal women have multiple contacts with health professionals which provides useful opportunities to promote cervical screening.

The plenary session began with an interesting keynote address by Professor Douglas Lowy from the American National Cancer Institute on the latest evidence and future developments of HPV vaccines. Professor Maggie Cruickshank from the University of Aberdeen presented an informative update on outcomes of the Scottish HPV vaccination programme, which has shown that routine immunisation with the bivalent HPV vaccine is highly effective against high grade cervical disease.

After lunch and further opportunities to visit the trade stands and view posters, the recipient of the BSCCP Founders Medal (and inventor of the Swede Score), Dr Björn Strander from the Regional Cancer Centre West Sweden, gave his perspective on the continuing challenges of delivering effective cervical screening programmes, based on his experience of the Swedish national cervical screening programme. His focus on maintaining

***Rajvinder Dhillon, Nurse Colposcopist and Nichole Villeneuve, Consultant Biomedical Scientist***

effectiveness through participation in screening and quality assurance measures were resonant with the screening programmes in the UK.

The next proffered paper session included presentations by speakers from China, Sweden and the UK on a range of subjects: the use of p16/Ki-67 dual-stained cytology for detection and post-treat surveillance of high-grade CIN/VAIN; the risk of developing vaginal cancer in women who have had a hysterectomy for CIN or cervical cancer; and a genome-wide association study on cervical intraepithelial neoplasia and cervical cancer. Work based on samples from the UK Biobank showed genetic variants significantly associated with CIN3 and cervical cancer, and genetic factors were identified which may affect the susceptibility to developing CIN3 and cervical cancer through altered immune responses. Plans are in place to undertake work to further classify any novel causal variants which may explain the estimated genetic susceptibility to cervical cancer.
Thursday afternoon's scientific programme included a session on colposcopy MDTs and a presentation which highlighted the patient's perspective and experience of 'cervical cell changes' in screening results.

Following a full day of informative scientific presentations and discussions, delegates had a short while to get ready for an evening of socialising at the conference dinner, which was held in the Bournemouth Pavilion Ballroom. Dinner and dancing continued until midnight.

Friday morning's session began with talks on the global neglect of gynaecological disease and on worldwide initiatives for the prevention of cervical cancer. These were followed by the final proferred paper session, which included informative updates from the English screening programme pilot evaluation on primary cervical screening with high-risk HPV testing and the performance of HPV primary early adopters in the Welsh screening programme. Further talks on HPV primary screening were presented from an epidemiological viewpoint and from the laboratory perspective, including practical aspects of implementation.

New and relevant topics in screening quality assurance were presented from the perspective of Public Health England, which included challenges in rolling out HPV primary screening, findings and recommendations from QA visits, national colposcopy data analyses and details of a new individual colposcopist data tool which will be rolled out by SQAS in the near future.

The focus of the talks then returned to HPV, but from a non-cervical perspective, with presentations on HPV related disease of the head and neck, anus and vulva. Then an international perspective was given on colposcopic terminology of disease of the cervix and lower female genital tract.

On the final afternoon of the meeting, findings from audits undertaken in two different colposcopy services in England were presented - one on the conservative management of CIN2 and one on outcomes following the conservative management of stage IA cervical cancer. Results from both audits supported the use of these approaches in appropriate clinical settings. An assessment of a new colposcopy simulator developed in Singapore, which can be used to support colposcopist's training was presented. Talks were also given on trials examining both prophylactic and therapeutic uses of HPV vaccines and an update on the response to the LACC (Laparoscopic Approach to Cervical Cancer) trial.
The meeting was brought to a close following the presentation of prizes, and refreshments were provided for delegates as they prepared to depart the BIC after three days of useful learning and enjoyable networking with colleagues. The next BSCCP Annual Scientific Meeting is being held in Edinburgh at the International Conference Centre, 27-29th May, 2020. I would recommend you save the date in your diaries and attend if you have the opportunity.

## Membership Details

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

***Email: mail@britishcytology.org.uk***

**Christian Burt**
**BAC Administrator**
**Institute of Biomedical Science**
**12 Coldbath Square**
**LONDON EC1R 5HL**

# Q & A Session with Allan Wilson, new President of the IBMS, longstanding BAC Executive member and lifelong cytologist

Question: What does the IBMS president do?
Answer: My main role is to provide leadership to Council. We have agreed a clear strategy to promote our profession and one of my key roles is to promote the strategy and lead council in achieving our strategic objectives. I also promote the profession in the public arena and represent the Institute at external meetings. The President must also introduce new initiatives and champion change and challenge the status quo. My background in cytology has prepared me well for this!

I think one of my key roles that I really enjoy and am easing myself into during my first few months as president is to ensure that the Institute is positioned to influence stakeholders effectively and be the principal spokesperson and leading public face of the Institute. I have been meeting with the leaders and key decision makers within related professional bodies, regulators, government bodies and other stakeholders to establish a relationship and develop opportunities for our profession. My role as President is unpaid and is a voluntary position.

My role in communications to Institute members is very important to enhance the reputation of the Institute with all its members and to lead the communication of the strategy to the membership. I would also like to think that I can persuade lapsed members to re-join the Institute and to encourage non-members to join our professional body.

I chair the quarterly Council meetings and ensure openness and transparency in its dealings, by encouraging open, informed and respectful debate amongst Council members and ensuring Council is collectively accountable for its decisions. I have been a member of the Institute Council for six years and have learned from the previous Presidents how to manage such a large and diverse group. I enjoy chairing meetings and relish the challenge that this brings. I will also chair the Institute's Congress Committee.

Communication with the IBMS executive and in particular the Chief Executive is vital to the success of my presidency and I am in regular contact with Jill Rodney. The Institute president must also maintain and develop relationships with all members of the Institute and I have already scheduled visits to the UK devolved nations and major regions.

Question: What does the IBMS council do?
Answer: The IBMS Council members take ultimate responsibility for the governance of the Institute but governance is not a role for council members alone but reflects the way in which council work with the Chief Executive, Institute staff, with members and with stakeholders to ensure the effective running of the Institute.

The governance arrangements within the Institute provide for a clear separation of the function of the Council, as the governing body, and the function of Institute staff. Council is responsible for setting the strategic direction and agreeing and monitoring progress against the corporate objectives of the Institute. Management is charged with implementing the strategy and achieving the objectives it is set. Council does not get involved in operational matters. Council, collectively, are responsible for determining, approving and monitoring the effectiveness of the overall strategy of the Institute. Council ensures the governance and decision-making structures of the Institute are appropriate and function effectively. This includes setting the framework for the financial strategy, approving the annual budget, monitoring performance against the budget and approving the annual accounts taking decisions regarding strategic priorities according to their importance to the Institute, to the profession and available resources.

Question: How long is your term of office as president?
Answer: I had one year as president elect in 2019, I serve for two years as President then one year as past president then I stand down from council – I will then think about retirement!

Question: How do fit the role of President in with your day job?
Answer: This is a challenge. I had to think about this long and hard before I decided to stand for President. I am well aware that I have multiple roles and could not hope to keep all the balls in the air and take on the presidency. I have stopped carrying out UKAS assessments and my term as Scottish Pathology Network (SPAN) manager comes to an end on 31st March 2020. This should free up time within my professional life to do justice to the role of Institute President. However, much of the preparation and reading of papers is carried out in my own time and I was well aware of this commitment before I stood for the presidency.

Question: How long have you been working in cytology?
Answer: I started in the laboratories at the tender age of 17 in the cytology department of Glasgow Royal Infirmary under the careful tutelage of Gordon Campbell and Helena Hughes two masters of the art and craft of cytology. I learned so much in those early formative years that I am eternally grateful to Helena and Gordon for their patience and commitment to training. Our next step was somewhat unconventional when we made the momentous decision to head to Dunedin in New Zealand in 1983 at the tender age of 24, Ann, my wife, was only 23. We had been married less than 6 months.

At that time and arguably still New Zealand had a reputation of "making giants of moderate men". I would like to think that even at the tender age of 24 I was more than a moderate man but there is no doubt that I had opportunities in Dunedin that I would not have had in the UK. By the age of 25 I was managing a busy cytology and histopathology lab with a drop in one-stop FNA clinic before the concept even existed in the UK. By the age of 26 I was writing national exam papers and presenting at international meetings.

Our antipodean adventure provided easy access to employment back in the UK. There were not many 27-year olds who could claim the technical, clinical and managerial CV that I had when we returned to Scotland in late 1986. My CV alone led to job offers but given our long absence from family and friends we were keen to return to Scotland. I was one of a team of eight new staff that were appointed to a newly reconfigured cytology service in Edinburgh led by a young and enthusiastic consultant Phemie McGoogan who not only challenged the status quo but threw the rule book over her shoulder and embraced change. This melting pot of new and relatively young staff mixed with an established older cytology team and young consultants provided a fertile ground for research and challenging the norm. This was undoubtedly one of the most enjoyable periods of my career. I learned as much about what to do as I did about what not to do!

Based on my CV I was fortunate enough to have choices for my next step and I am grateful for the guidance at this stage in my career of my long-term mentor Gordon Campbell and my friend and colleague Jocelyn Imrie. My final career destination is Monklands Hospital in Airdrie, where I have been since 1988 when I joined NHS Lanarkshire just after the birth of our first son Mark. I found an organisation that allowed me to grow and presented me with a continuous stream of fresh challenges. Some of which, as I am sure some of my colleagues, and Ann will testify that I should have probably have refused. Saying no to opportunities, irrespective of timing or workload, has never been one of my strengths and this weakness has on occasion impacted on my family and my colleagues.

Question: So, how has it been so far?
Answer: Fascinating! I have really enjoyed myself so far, it has been hard work but I have met some key people and started to sow the seeds of what I would like to achieve from my presidency. I have chaired my first Council meeting which seemed to go well. I am managing to keep up with the reading and paperwork so far and I am trying to develop a routine to ensure I maintain a balance between my day job, home life and IBMS business. Professional body politics is always a tricky area and has to be managed carefully, I have always been a good negotiator, now I am learning diplomacy!

Question: What made you stand to be IBMS President
Answer: I get bored very easily and really enjoy challenging myself. I truly believe that I can achieve real change within our professional body and advance opportunities for all biomedical scientists. I suppose this is also a bit of a "swan song" for me, I will seriously consider retirement, or at least semi-retirement after my term as President. I turned 60 last year and have three grandchildren!

Question: Does your cytology background help?
Answer: Cytology is a little different from the other lab disciplines; the considerable overlap between the respective cytoscreener, biomedical scientist and medically qualified roles, the common binding of the cervical screening programme and the strong regional and national cytology bodies provided a discipline specific multi-professional focus that is not present in other disciplines. I firmly believe that my development has been strongly influenced by the wider cytology community and our common objectives. Cytology also opened international doors and I am proud to have presented across the globe on cytology issues and to have delivered the European cytology exam with Paul in many European cities.

I learned a lot from my time on the cytology professional bodies, not just professionally but about inter-professional politics and relationships. This was a positive experience and demonstrated to me that irrespective of our academic and professional backgrounds we could and did work well together to deliver common objectives and the success of the UK cervical screening programmes is heavily dependent on the commitment of biomedical scientists and medical consultants working in labs across the UK. The formation of the BAC provided me with my first taste of leadership of a national professional body when I became the first Chair of the BAC and then the President.

Question: What are you planning to achieve as IBMS president?
Answer: In a few words, I would like to unleash the potential of biomedical scientists, an untapped and unrealized resource and in doing so relieve the pressure on the medically qualified consultants and clinical scientists struggling to deliver the pathology service across the UK. We wish to share the service delivery burden equitably and reduce the pressure on all staff groups.

Biomedical Scientists training in areas of expert practice across the country are often not utilised while other staff groups are struggling to meet clinical demands leading to backlogs in histopathology and inability to meet clinical requirements in infection control in microbiology and a collective stress and frustration. How many of us have colleagues either on or recovering after stress related sick leave. I know this is not just a pathology phenomenon but we can so much more to relieve the stress and pressure in our collective working lives.

We have limited medical and clinical scientist resources in many laboratory specialisms and service demands are stretching this limited and increasingly rare resource to breaking point.

The solution is in our collective hands: unleash the potential of the biomedical scientists and the support workers. The tasks that can be carried out by biomedical scientists and support workers have largely been identified but we need to go further. We need to embed this practice into our pathways in a sustainable manner and remove the numerous professional barriers to enhancing service delivery to the benefit of patient care.

This needs to be coupled with a mammoth effort to raise the profile of what we do. For too long biomedical scientists have been invisible to the general public and to other healthcare professionals. The public and our fellow professionals need to understand what we do and our vital place in the patient pathways.

Why are biomedical scientists still struggling to demonstrate what they can achieve through advanced practice when many other professional groups (nurses, pharmacy, radiographers) have numerous opportunities and in some cases are being pulled into advanced roles created to release pressure on limited medical resources?

We continue to apply expensive sticking plasters such as pricey and backlog companies to an ailing service staffed by stressed staff while a significant element of the solution is staring us in the face. We need to unleash the potential of highly trained biomedical scientists and support workers who are already on the pathway to advanced practice and can provide a relatively rapid solution to prevent us breaking the scarce resource we have. We need to nurture that resource. Not push it to breaking point. Long term academic training programmes have their place but the service needs vocational training in highly pressured specialties. This is the Institutes field of expertise. We have a strong track record of delivering courses and qualifications precisely to the point they are required. We do this with our members and the executive and in cooperation with other professional bodies such as the Royal College of Pathologists. The conjoint board structure we have in place in cellular pathology is one of our strengths and I would like to see this model across all laboratory disciplines where there are opportunities for advanced practice and service improvement.

As an advanced practitioner of some 20 years standing it is gratifying to see the progress that we have made recently particularly with histopathology reporting but equally frustrating to see the opportunities that have been missed or have yet to be explored. Having worked in the NHS for more than 40 years and seen many opportunities arise due to crisis it would be gratifying for once to plan proactively rather than wait for the crisis to envelop us in true NHS style.

Question: Does this impact on your role on the BAC executive?
Answer: I did consider my role on the BAC executive when I decided to stand for the presidency but on balance decided that it would be beneficial for me to maintain strong links with the BAC and feedback issues to IBMS Council at this time of tremendous change within our specialty. The main issue is going to be finding the time to attend executive meetings and if proves to be a struggle I will stand down and allow someone else who can do the position on the executive justice take my place.

Question: Who has been most influential in your career?
Answer: I am the product of many cytologists from across the world I would like to mention my local team who have been with me for decades at Monklands, in particular Jocelyn Imrie, Lynn Govan, Janice Black and Lynne Patterson they have been key to my professional life and have supported me over the years with advice and constructive criticism. I have had the pleasure and honour of working with all three cytology professional bodies, the NAC, BSCC and obviously the BAC, I would like to specifically mention Mina Desai, Nick Dudding, Paul Cross and Alison Cropper for their help and support over the years.

I have also been fortunate to work and travel overseas and to work with highly skilled cytologists including Norman Fitzgerald in New Zealand, Phemie McGoogan in Edinburgh and most importantly my cytology mentors in my home town of Glasgow, Gordon Campbell and Helena Hughes. These generous and influential colleagues have shaped me over the years.

My parents were powerful role models for me who shaped my personal and professional life. I am one of eight children born in a tenement flat in the north side of Glasgow, it was my parents' determination to defy the odds and raise eight children in the face of considerable adversity. It would have undoubtedly been easier to go with the flow but they refused to conform and raised eight normal (at least by Scottish standards) professionals. Our close family gatherings now number more than 50!

Most importantly I would not be where I am without the long term and continuous love and support of my wife Ann and my three sons, Mark, Michael and Calum who have never failed to support every step on the path towards presidency of the Institute.

# Meetings diary

## POSTPONED BAC Spring Tutorial

30th March 2020

Guy's Hospital, London

Due to COVID-19 the BAC 2020 Spring Tutorial on the theme of ultrasound examination by pathologists together with interpretation of FNA material was postponed.

The BAC proposes moving the tutorial programme to become part of the two-day BAC Annual Scientific Meeting (ASM) on 2 - 3 October 2020 in Nottingham

The programme would be suitable for cytopathologists and biomedical scientists, both experienced and in training.

## BAC Annual Scientific Meeting 2020

2 - 3 October 2020

Double Tree Hilton Hotel, Nottingham

The Annual Scientific Meeting (ASM) of the BAC will include themes of Diagnostic Cytology, Molecular Cytology and Digital Cytopathology.

The BAC AGM will be held during this event. Further information will be posted on the BAC website in the coming months.

www.britishcytology.org.uk/go/cytology-events~21

## 43rd European Congress of Cytology Wroclaw, Poland

4 - 7 October 2020.

The ECC 2020 promises a varied scientific programme on all things cytology and the BAC are happy to announce that we will hosting our companion meeting on Weds 7th October.

Details of the programme are available on the following link: https://cytology2020.eu/scientific-programme

# CEC: Journal Based Learning

## The colour of urine: then and now – a comprehensive review of the literature with emphasis on intracytoplasmic pigments encountered in urinary cytology

**McIntire, P.J. et al. Journal of the American Society of Cytopathology 2020:9 p 9-19**

1. Prior to microscopy and development of chemistry, how did practitioners interpret the various colours of urine? (2 marks)

2. Give 2 medical conditions that can cause black colouration of urine (2 marks)

3. Which pigment may be seen in urine from patients with chronic haematuria and describe its cytological appearance? (4 marks)

4. Which special stain can be used to identify the pigment names in Q3? (1 mark)

5. Give reasons for pathological accumulation of lipofuscin within the urothelium of the bladder (2 marks)

6. Why is the pigment visible in all layers of the urothelium from basal to superficial? (1 mark)

7. Describe the cytological appearance of lipofuscin pigment in urothelial cells (2 marks)

8. Why is metastatic melanoma detected only rarely by urinary cytology? (1 mark)

9. Describe the cytological appearance of pigmented cells from a metastatic melanoma in a urine sample (2 marks)

10. Give examples of 3 foods that can affect the colour of urine samples (3 marks

Name…… CEC Number……

Enjoy ☺ Please send or email your completed JBL to:

Helen.burrell@nbt.nhs.uk

**Helen Burrell (BAC CEC Officer)**
Consultant BMS & Manager
Cytology Training Centre
Pathology Sciences Building
Southmead Hospital
Bristol BS10 5NB

# SOUTH WEST REGIONAL CYTOLOGY TRAINING CENTRE BRISTOL

## 2020 Course Schedule

**Whilst COVID-19 restrictions are in place please contact the Centre for updates**

| Date | Gynae Courses | Fee |
|---|---|---|
| 8-19 June<br>6-17 July | Introductory in Gynae Cytology – Part 1<br>Introductory in Gynae Cytology – Part 2 | NHS £1000<br>Other £1200 |
| 5 March<br>6 May<br>24 June<br>2 September<br>14 October<br>2 December | One Day Update in Cervical Cytology | £100 |
| 3 June<br>25 November | Update in Cervical Cytology for Pathologists & Consultant BMS's & Holders of the Advanced Specialist Diploma in Cervical Cytology | £100 |
| tbc | Cervical Histology for Technical Staff | £100 |
| 21-22 May | Gynae Pathology for Trainee Colposcopists | £200 |
| 11-12 May<br>21-22 September<br>2-3 November | Cervical Sample Taker Training | £300 |

| Date | Non-Gynae Courses | Fee |
|---|---|---|
| 19 March | Serous Fluid Cytology | £100 |
| tbc | Respiratory Cytology | £100 |
| 11 November | FNA Cytology | £100 |
| 1 April | Urinary Tract Cytology | £100 |
| 9-12 March<br>14-17 September | Non-Gynae for Trainee Pathologists | £400 |

South West Regional Cytology Training Centre

Department of Cellular Pathology
Pathology Sciences Building
Southmead Hospital
Bristol BS10 5NB

Tel: 0117 414 9808

Email: SWRCTC@nbt.nhs.uk

www.cytology-training.co.uk

**Whilst COVID-19 restrictions are in place please email the centre or look at the website for updates**

NHS Lothian

# Scottish Cytology Training School

## Programme 2020-2021

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


**Training School Director**
**Sue Mehew**
Tel: 0131 242 7149
Email: sue.mehew@nhslothian.scot.nhs.uk


**Application forms available on request from:**
scts@nhslothian.scot.nhs.uk

**NHSCSP Accredited Training Centre**

**Courses held at:**

**Cytology Training School, Queen Elizabeth University Hospital (QEUH) Glasgow**

*Non-NHS Labs – price on application*
*All courses are Liquid Based Cytology (ThinPrep)*
*Courses are CPD accredited*

## Introductory Course Part 1

**February 22nd – March 20th 2021**

## Introductory Course Part 2

**16th - 20th November 2020**
**15th – 19th November 2021**

## Update Courses

**4th– 5th November 2020**
**3rd - 4th February 2021**
***£100 per day***

## Update Workshops – BMS Medical/Consultant Staff

**26th November 2020 (TBC)**
***£100***

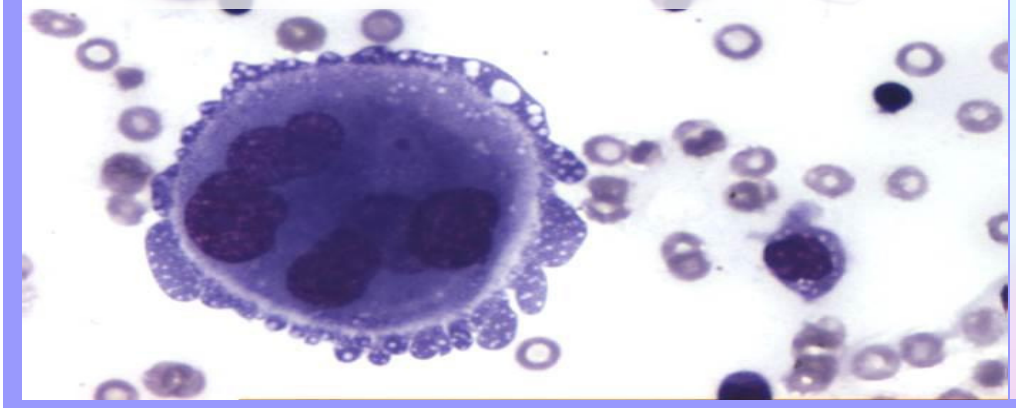
## ST1 Intro to Cervical Cytology

**7th - 11th September 2020**
***£1000***

**Whilst COVID-19 restrictions are in place please email the centre or look at the website for updates**

# NEPSEC North of England Pathology and Screening E

## Non Gynaecological Cytology



## Training Opp 2020/2


### Courses in Expert Practice Diagnostic Cytology

These courses cover serous fluids, urine and respiratory cytology and are ideal for anyone wishing to further their experience or workings toward the IBMS DEP

**17th, 18th, 19th & 20th November 2020**

### Exam Practice for the IBMS Diploma of Extended Practice in Non-Gynaecological Cytology

Ideal for anyone taking the IBMS Diploma of Extended Practice in Non-gynaecological Cytology

**30th April – 1st May 2020 Postponed New Dates to be announced**

### Exam Practice for the IBMS Advanced Specialist Diploma in Non-Gynaecological Cytology

Ideal for anyone taking the IBMS Advanced Specialist Diploma in Non-gynaecological Cytology

**Spring 2021 Dates TBC**

### Three Day Update Course in ( Consultant Biomedical Scient

It includes elements of Gynae Hi and MDT cases amongst other t

**4th – 6th November 2020**

### Your Role as a Cervical Scree

This course is developed in asso AMG to guide both experienced the role and covers many differe CSPL may encounter.

**10th & 11th June 2020 – Postpon announced**

### Breaking Bad News A one-day communication sk

A one-day communication skills communication challenges, facil associated theory.

**12th June 2020 – Postponed Ne**

The above courses will be running, however due to the current situation around C **www.nepsec.org.uk** or contact our admin team fo

ducation Centre

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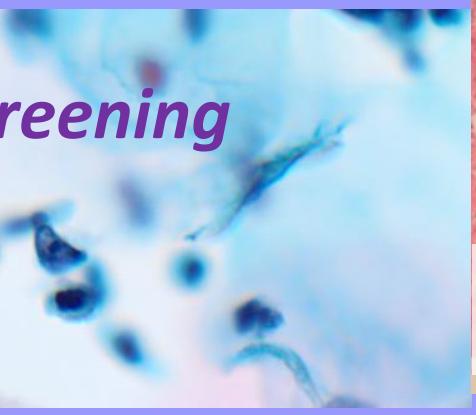

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## Histopathology

### BMS Reporting in Histopathology

### Stage A & C GI & Gynae Exam Preparation Day

These days are specifically for those working towards Stage A or C part of the BMS reporting qualification

**Stage A – 1st February 2021; Stage C – 2021 Date TBC**

### Tissue Recognition, Section Quality and Clinical Consequences

This course is aimed at BMSs preparing for their specialist portfolios and involved in preparation of routine histological sections, also useful for support staff involved in section preparation and quality control

**1st March 2021**

### A Course for the Expert Role in Specimen Dissection

This course is suitable for BMSs who intend to train as Histological tissue specimen dissectors, in particular those undertaking the RCPath/IBMS Diploma. It covers all the mandatory elements and a selection of specialist modules

**Commencing November 2020**

COVID-19 outbreak some dates maybe subject to change. Please visit our website
or up to date information **sht-tr.nepsec@nhs.net**

London Regional Cytology Training Centre

NHS
London North West University Healthcare
NHS Trust

# 2020 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®)

- ***28th September – 23rd October***

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

### FOLLOW UP COURSE (Thinprep®)

- ***1st – 5th June***

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

### PRE – EXAM COURSE (Thinprep®)

- ***17th – 21st August***

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

## Medical Laboratory Assistant (MLA) 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.

- ***22nd April***
- ***2nd December***

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

## Post Registration Courses

### BMS/CYTOSCREENER UPDATE COURSE

- ***18th – 20th May***
- ***6th – 8th July***
- ***23rd – 25th November***

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

## Non-Gynaecological Courses

### URINE CYTOLOGY COURSE

- ***13th – 14th May***

### RESPIRATORY CYTOLOGY COURSE

- ***28th – 29th April***

### SEROUS FLUID CYTOLOGY COURSE

- ***16th – 17th June***

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

## Medical Practitioner Courses

### MEDIC'S 1-DAY UPDATE COURSE

A refresher course for Consultant staff: pathologists & AP's

- ***3rd April***
- ***18th September***

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

We can also offer bespoke courses to meet your training requirements
Please check our web-site for further details
More information and advice can be obtained by contacting **0208 869 5270**

**Whilst COVID-19 restrictions are in place please email the centre or look at the website for updates**

# Co-opted members:

**SCAN Editor**

**Sharon Roberts-Gant** Cellular Pathology, The John Radcliffe Hospital, Headley Way, Oxford, OX3 9DU
Tel: 01865 220494
E-mail: sharon.roberts-gant@ouh.nhs.uk

**Cytopathology Editor**

**Professor Michael Sheaff** Consultant Histopathologist, Barts Health NHS Trust, 80 Newark Street, London E1 2ES
Email: Michael.Sheaff@bartshealth.nhs.uk

**BAC Administrator**

**Christian Burt** BAC Administrator, Institute of Biomedical Science, 12 Coldbath Square, London, EC1R 5HL
Tel: 0207278 6907 or 0207713 0214 extension 141. Work Fax 0207 837 9658
Email: christianburt@ibms.org

**IBMS Representative**

**Kirstie Rice**
Email: kirstie.rice@nhs.net

**Miscellaneous**

**Cytopathology Journal**
Publisher: Hollings, Danielle — Oxford
Email: dhollings@wiley.com
Administrator: Tom Broomfield.
Email: tbroomfield@wiley.com

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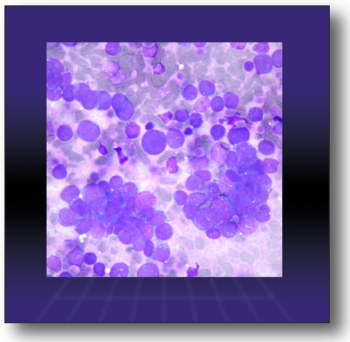
Material for publication should be sent direct to the Editor; all other correspondence with the Association should be addressed to the Secretary.

***Front Cover image:***
*Metastatic small cell carcinoma.*
*The editor is indebted to Dr Ketan A. Shah, John Radcliffe Hospital, Oxford University Hospitals NHS Foundation Trust.*



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