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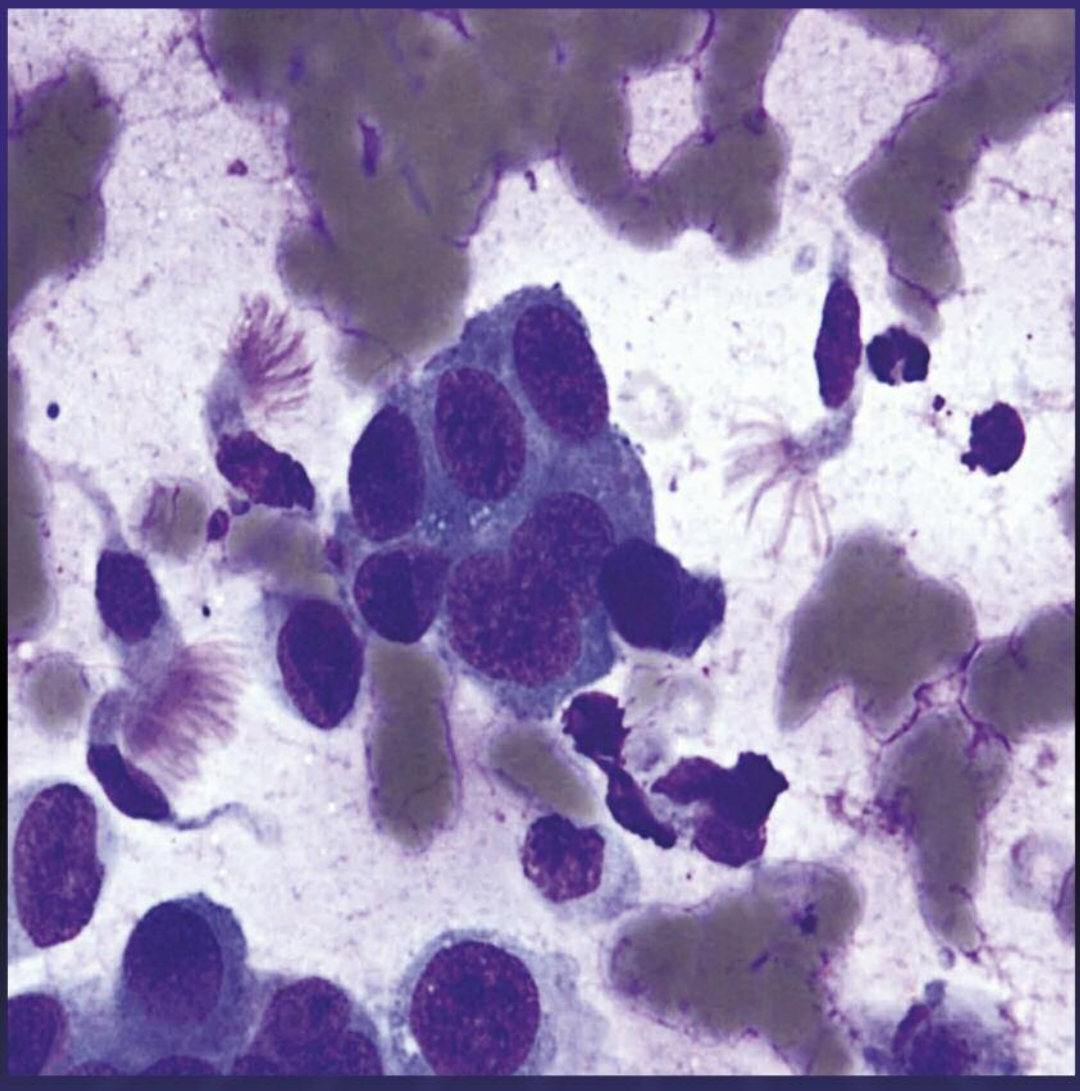

BAC British Association for Cytopathology

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please see inside back cover for co-opted members

Editorial

Sharon Roberts-Gant

As we send this Issue to print its two weeks to British Summer time – longer daylight hours are definitely something to celebrate!

We have a positive educational vibe in this Issue, with a review of Cytology reporting systems, a shared experience of a BMS supported service – EBUS ROSE and an educational case as well as the promotion of several upcoming educational events.

Robert Music shares the important work of Jo's Trust with us and Donna Morrison reports on the IAC Tutorial 2018.

The arrival of this Issue is likely to coincide with the English Cervical Cytology tender outcome. As someone from a laboratory that has not bid for the service I'm aware of the worry and stress for people working in the service who know their working lives will change and that the work they have done for years will no longer be there, something that our Scottish and Welsh colleagues have already experienced. I know that we are striving for a different cytology service with more non-medical responsibility in diagnostic cytology, I believe that these changes will encourage a stronger diagnostic cytology career pathway and open up new opportunities. As Alison says in her column, we must ensure that the changes to the cervical programme provide the best possible service for the women of the UK. I am sure that as cytologists we will continue to provide the highest quality UK cervical screening service that we can deliver.

Thank you to all of the contributors in this edition.

Sharon

Editor: Sharon Roberts-Gant

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INFORMATION FOR CONTRIBUTORS
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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

Icebergs, they say, are one eighth above water and seven eighths below. Often what the BAC and the Executive do is like this. We share what and when we can. However, despite this, it may often seem that we are up to nothing. This is frustrating for everyone. We have been and are very active across many fronts, and across all aspects of cytology.

There is currently much ado around the cervical screening programmes and the move to implementation of primary HPV. As I write this the tendering process in England has just closed and we await with interest the outcome which is anticipated in early April. Until the puff of white smoke emanates from NHSE we will not know the shape of the English CSP for the near future. We have been working with colleagues at the RCPath and IBMS in raising the concerns of members and the profession about aspects of these changes. We have inputted into the consultation by the National Screening Committee about potential changes to cervical screening intervals and follow up with the move to primary HPV. This consultation also proposed the use of self sampling within the CSPs, a move that many are advocating potentially not only for hard to reach women but perhaps more widely within the programmes. Whilst these have yet to be deliberated upon, the future CSPs will look very different to the one we work in now. The move to less laboratories across the UK, and the changes to the algorithms that we use, will be profound.

The recent meeting held last November in Nottingham showed a huge need by members, and non-members, for a chance to talk about the cervical screening programme changes and how it affects them professionally and personally. Working with professional bodies and unions produced a busy interactive meeting with many questions asked, and some, but not all, answered. Unfortunately I couldn't attend it, but the feedback I have heard, and articles in this edition of SCAN, highlight the mood and atmosphere from it.

Working together is better than working alone and against each other. Our joint working with the RCPath and IBMS will hopefully bring greater clarity on areas such as clinical responsibility in cytology laboratories, better guidance on cytology in general and the reporting systems used, and greater use of precious skills across the cytology workforce, to name but three. The recognition by the RCPath that those with the ASD in cervical cytology can apply for Associate Status with the RCPath is a great recognition for those with this qualification, and the role they undertake. These are all important changes. Change does take time, and whilst glacial on occasions, it can and does happen.

Whilst much of what I have mentioned above seems political, we do not forget our educational remit. Following on from the highly successful Nottingham one day meeting and the three day IAC meeting co-hosted with the RCPath at the new college building, we are at it again. Mention is made of these elsewhere, but the desire for cytology education and sharing is ingrained in us all. I must thank the very active meetings group, and in particular Alison Malkin and Ash Chandra for all their input.

I cannot let the opportunity pass without congratulating Allan Wilson on his election as incoming President of the IBMS. Allan has so many hats that I lose track, but this is yet another one he can wear with pride. Allan has given so many hours over many many years to help develop, promote and champion cytology. His new role will of course cover all aspects of biomedical science, but i am sure that cytology cannot do anything but benefit from his new role.

I feel I must also mention that I have recently retired, at the ripe young age of 60, prior to a return to work but with less hours. It is a day that I never thought would happen to me, but happen it has. Whilst I may be officially working less, I am still very committed to cellular pathology and cytopathology. Perhaps I will have more time to devout to this in my dotage, as long as I can input constructively and it is still felt to be of use. When I get the tap on the shoulder I will know it is time to walk away - but not just yet I hope.

Chairman's Column

Alison Cropper

Well, that was a year that was, wasn't it?! 2018 I'm talking about. The whole year felt like we were forever playing 'one step forward, two steps back', and as I'm sure you can guess, I'm talking about the national roll out of HPV primary screening - what else?!

I happened to be looking at old copies of Scan recently and came across the Chairman's column written by Allan Wilson in the April 2012 edition. Writing as the first chairman of the BAC, Allan commented that following his attendance at his first Cytopathology editorial board meeting it was clear to him that our (UK) cervical screening programme was the envy of Europe but that we were lagging behind in the clinical application of non-gynaecological cytology. He went on to state that two of the main aims of the newly formed BAC would be:

- To protect the Cervical Screening Programme(s) to ensure that we meet clinical standards in the face of an uncertain future and decisions in neighbouring countries to move to HPV primary screening
- To develop non-gynaecological cytology to match and even exceed what has been achieved in other countries, and to do this we must learn from the UK labs that offer best practice in this area and also look to other countries who have used molecular technologies to integrate non-gynaecological cytology into a modern healthcare service.

Seven years on, would you say that BAC has achieved these aims? We have certainly tried our utmost to, and will continue to do so, but I'm not sure the answer is a resounding yes quite yet.

Regarding non-gynaecological cytology I think it's a very slow process which has probably been somewhat overshadowed by the on-going issues with cervical cytology and HPV implementation, but I can assure you that BAC are steadily but surely pursuing this aim and the educational events we have planned in the near future reflect the efforts that are being made by executive colleagues such as Ash Chandra, Tony Maddox, Yurina Miki and Miguel Perez-Machado to highlight and achieve this. Speaking of which I have to mention that Miguel has unfortunately resigned his position on the executive, but I would like to take this opportunity to thank him for his valuable contributions over the time he was in post, not least in setting up the BAC Twitter account along with Yurina and Christian Burt, which is increasing in followers on a daily basis - please do follow us if you haven't already done so! Join us at @britishcytology

In terms of HPV primary screening it has been a long, drawn-out and tumultuous journey which some could say was nearly over but others would say is only just starting. Back in 2012 Allan was talking about the profound impact it might have on the UK programmes, and that was even before the six Sentinel sites commenced primary screening in 2013. The report of the pilot results has only just been published in the BMJ (January 2019) but in the meantime the UK National Screening Committee made a recommendation in 2016 that HPV primary screening be implemented into the programme, which was very quickly backed up by a ministerial announcement that HPV primary would be rolled-out across England by 2019.

And then it would appear nothing....for a long time. But as Paul has already said in his President's piece, BAC were beavering away in the background for a couple of years, banging on doors, trying to get a seat round several tables and continually stressing the importance that whatever the changes were going to be, we (the programme) must get them right to ensure the safe continuity of our world class service. And so to 2018 – following the stakeholder engagement events in the spring there was a 'period of reflection' in which no progress seemed to be made at all, but then it all happened with a bang! Within a matter of weeks last autumn we were told that the procurement process would commence in England to award a maximum of 9 contracts to provide the HPV primary screening service, and that tender process duly commenced shortly afterwards, with a very short closing date. BAC joined forces with our colleagues at IBMS and RCPath to express our concerns with the process and timescale but to no avail.

So, we are where we are. By the time this edition of SCAN is published we may well know the outcome of the tender process in England. There will be winners and losers; there will be risks and uncertainty for both. We know that this is already the state of play in Scotland, and it hasn't been pain free in Wales either, where they are now up and running. We know that several Trusts in England did not bid, and the dedicated workforces in those labs will undoubtedly be going through the greatest change process that has ever happened to them, as will many more

colleagues in April and beyond. I do not believe there will be any individual in cytology that is untouched by this, and the face of cervical cytology as we know it will be changed forever.

Is this protecting our screening programme? We must ensure that it is. It is about providing the best possible service we can for the women of the UK, and we must accept the end of something to build something new; so for those who will remain in the cervical screening programmes it is up to you, and BAC will be there to support in any which way we can, to ensure that the UK continues to provide a cervical screening programme that is the envy of the rest of the world.

Paris, Milan, Yokohama… A World Tour of Recently Published Reporting Systems in Cytopathology: Part 1

Yurina Miki

Introduction

'Clinicians are from Mars and pathologists are from Venus'.[1] Almost 20 years have passed since the article from Powsner et al. was published, yet the core message still remains true today – that, despite the comprehensiveness of a pathology report, it may be understood by the clinician in a completely different way to what was intended by the pathologist. Sound familiar? All too often, we use terms such as 'suspicious' or 'atypical' without truly appreciating the degree of confusion it may create for the clinician regarding the clinical significance and implications of a diagnosis. It, therefore, comes as no surprise that there has been a collective effort to develop standardised reporting systems based on evidence and consensus international expert opinion. Over the last 6 years, diagnostic reporting systems in the field of cytopathology have been published, including 'The Paris System for Reporting Urinary Cytology'[2] and 'The Milan System for Reporting Salivary Gland Cytopathology'[3]; others, such as a standardised reporting system for breast cytopathology ('International Academy of Cytology Yokohama standardized reporting system')[4,5], are underway. These guidelines aim to standardise the language of cytopathology reporting and provide clinically meaningful diagnostic categories that ultimately helps guide patient management.

In the current and following few issues of SCAN, we present a series of educational articles of these recently published reporting systems, summarising key points of each diagnostic category and providing a practical approach to utilising these systems in routine practice. We begin our world tour in France, starting with a closer look at 'The Paris System for Reporting Urinary Cytology'.

The Paris System for Reporting Urinary Cytology

Work on a standardised reporting system for urinary cytology began at the 18th International Congress of Cytology in Paris in May 2013, with support from both the American Society of Cytopathology (ASC) and the International Academy of Cytology (IAC).[6,7] During the congress, The Paris System Working Group was formed, which consisted of 49 members from 10 different countries and included cytopathologists, surgical pathologists and urologists.[2] They met on numerous occasions to appraise the current literature and discuss the challenges of urinary cytology; the fundamental goal was to create a practical reporting system that reflected the current understanding of the pathogenesis of urothelial neoplasia and could be universally adopted and understood by pathologists and clinicians alike. The efforts and hard work of The Paris System Working Group culminated in the publication of 'The Paris System for Reporting Urinary Cytology' in late December 2015.[2]

One of the main principles of TPS is that it focuses on the strength of urinary cytology, which is the detection of high-grade urothelial carcinoma (HGUC).[2,6,7] Over the years, several studies have shown urinary cytology to be a valuable test with a high specificity (> 90%) and relatively good sensitivity (ranging from 50-85%) for detecting HGUC.[2] These neoplasms are associated with a poor prognosis, including a 60% mortality rate as well as potential for metastases and recurrence.[7,8] In contrast, urinary cytology has a poor specificity and sensitivity in detecting low-grade urothelial neoplasms.[2,6,7] Fortunately, low-grade urothelial neoplasms have a low risk of progression and are

readily identifiable on cystoscopy/ureteroscopy.[7] As a result, from a clinical perspective, urologists place a far greater emphasis on the use of urinary cytology as an initial diagnostic test in identifying the cohort of patients with a potentially life-threatening urothelial malignancy – i.e. HGUC. TPS follows this principle and thus concentrates on the diagnosis of HGUC.

There are 7 diagnostic categories of TPS (summarised in Table 1).[2] Each of these categories will be reviewed in turn, with a focus on the defining cytomorphological criteria and the clinical implications of each category.

1	Non-diagnostic or Unsatisfactory
2	Negative for High-Grade Urothelial Carcinoma (NHGUC)
3	Atypical Urothelial Cells (AUC)
4	Suspicious for High-Grade Urothelial Carcinoma (SHGUC)
5	High-Grade Urothelial Carcinoma (HGUC)
6	Low-Grade Urothelial Neoplasia (LGUN)
7	Other Malignancies, Primary and Metastatic, and Miscellaneous Lesions

Table 1. Diagnostic categories of The Paris System for Reporting Urinary Cytology

Non-diagnostic / Unsatisfactory

TPS takes a rather practical stance when it comes to defining adequacy – the authors quote an adequate urine specimen as the "usefulness of the specimen to diagnose or broach the suspicion of urothelial carcinoma"[2]. As such, TPS outlines a practical algorithm to systematically determine the adequacy of a urine specimen, which takes into consideration four variables, including cytomorphological findings, collection type, cellularity and volume.[2] According to the algorithm, cytomorphological findings are considered first; if the specimen contains abnormal cells (i.e. cells that are "atypical, suspicious, or malignant" – definitions to follow as each TPS diagnostic category is reviewed), then the specimen is considered adequate regardless of the collection type, cellularity or volume. Otherwise, if no abnormal cells are present, then the remaining three variables are subsequently considered. However, TPS does not provide specific values (e.g. number of urothelial cells or volume of urine submitted that defines an adequate sample) as studies examining adequacy with quantitative data are limited. Nonetheless, two recent studies have examined adequacy for voided urine and bladder washing specimens. In the study by VandenBussche et al., voided urine specimens with a volume of 30 ml or greater was found to increase specimen adequacy.[9] Furthermore, in the study by Prather et al., which examined cellularity adequacy criteria for bladder washing specimens processed using the ThinPrep® method, a minimum value of at least 2 well-visualised, well-preserved urothelial cells per high power field (HPF) in 10 consecutive fields (20 urothelial cells per 10 HPFs) increased the sensitivity of detecting HGUC.[10] TPS encourages further research into this area such that evidence-based guidelines on adequacy values for volume and cellularity in the context of the collection type can be established.

Negative for High-Grade Urothelial Carcinoma (NHGUC)

The name of the diagnostic category says it all – this TPS category is reserved for urine specimens that do not contain HGUC cells or any cells with features concerning for HGUC (as defined by the criteria below).[2,6] As a result, this category is not only reserved for those urine specimens that solely contain normal cellular constituents (e.g. superficial, intermediate and basal urothelial cells), but is also used to categorise cases containing urothelial cells with cytomorphological changes that have resulted from a known cause that is not associated with malignancy. Examples of the latter include changes related to instrumentation, lithiasis, infectious processes (e.g. polyomavirus infection) or treatment effect (e.g. Bacillus Calmette-Guerin (BCG) instillation, pelvic irradiation, chemotherapy or urinary diversion specimens post-cystectomy).[2,7] By ensuring that such cases are classified into the 'NHGUC' diagnostic category (and are not carelessly labelled

as 'atypical'), the 'Atypical Urothelial Cells (AUC)' diagnostic category becomes more clinically meaningful. This is completely in line with the key principle of TPS, which is to identify cases that are at risk of HGUC.

One important point to note is that the 'NGHUC' diagnostic category does not exclude a diagnosis of low-grade urothelial neoplasia (LGUN).[2,6] If a urine specimen shows features suggesting LGUN (but cannot be definitively categorised in the 'LGUN' diagnostic category), the sample may still be placed in the 'NGHUC' diagnostic category; however, the additional possibility of LGUN should be noted. Such cases require careful clinicopathological correlation, particularly with the cystoscopic/ureteroscopic findings.

Table 2 summarises the inclusion criteria for designation into the 'NGHUC' diagnostic category.[2]

Benign/reactive urothelial cells, squamous cells, glandular cells
Benign urothelial tissue fragments or clusters (seen in instrumented and non-instrumented urine specimens)
Unexpected normal cells (e.g. seminal vesicle cells; cells from the female genital tract)
Cytological changes related to a known non-neoplastic cause: • Urinary bladder and renal calculi • Viral cytopathic effect: polyomavirus (BK virus) infection • Post-treatment effect: Bacillus Calmette-Guerin (BCG) instillation; radiotherapy for other malignancies (e.g. pelvic irradiation); chemotherapy that may affect urothelium (e.g. cyclophosphamide) • Urinary diversion specimens post-cystectomy

Table 2. Cellular elements and cytological changes falling into the 'Negative for High-Grade Urothelial Carcinoma' diagnostic category.

Atypical Urothelial Cells (AUC)

No matter what organ system, the diagnosis of 'atypia' perhaps causes the most consternation and confusion as the true clinical significance (i.e. likelihood of underlying malignancy) of such a diagnosis is unclear. Indeed, there is wide interobserver and intraobserver variability in how 'atypia' is defined in urinary cytology and, as a result, the reporting rates of 'atypia' vary from 2% to 31% among various institutions.[11–17] In keeping with the core principle of TPS, the 'AUC' diagnostic category is used to "capture the cases worrisome for HGUC that fall short of the 'suspicious for high-grade urothelial carcinoma' (SHGUC) category"; it is *not* to be used to classify cases that show reactive changes related to a known specific cause, such as polyomavirus infection, treatment effect, etc. (as discussed above).[2] To this end, the 'AUC' diagnostic category is defined by certain cytomorphological criteria with the hope of making this a more objective, reproducible and clinically meaningful category.

According to TPS, the 'AUC' diagnostic category is reserved for urothelial cells that fulfil the major (required) criterion and one of the three minor criteria2:

- Major criterion (required):
  - Non-superficial and non-degenerated urothelial cells with an increased nuclear to cytoplasmic (N/C) ratio (> 0.5)

- Minor criteria (one required):
  - Nuclear hyperchromasia
  - Irregular nuclear membranes
  - Irregular, coarse, clumped chromatin

Suspicious for High-Grade Urothelial Carcinoma (SHGUC)

The 'SHGUC' diagnostic category is used to classify cases that contain urothelial cells exhibiting severe atypia (beyond that defined in the 'AUC' diagnostic category), but falling short of a definitive diagnosis of HGUC, either quantitatively (i.e. there is a suboptimal number of urothelial cells meeting criteria for the 'HGUC' diagnostic category) or qualitatively (i.e. not all the cytomorphological criteria of the 'HGUC' diagnostic category is met).[2,6] A diagnosis of 'SHGUC' has important clinical implications; patients with such a diagnosis will be actively managed by clinicians, receiving thorough evaluation with cystoscopy and biopsy as well as close follow-up.

According to TPS, the 'SHGUC' diagnostic category is reserved for urothelial cells that fulfil the major (required) criteria and one of the two minor criteria2:

- Major criteria (required):
  - o Non-superficial and non-degenerated urothelial cells with an increased nuclear to cytoplasmic (N/C) ratio (at least 0.5-0.7) *and* moderate to severe nuclear hyperchromasia

- Minor criteria (one required):
  - o Marked irregular nuclear membranes
  - o Irregular, coarse, clumped chromatin

High-Grade Urothelial Carcinoma (HGUC)

Following on from the 'AUC' and 'SHGUC' diagnostic categories, in order to fulfil a diagnosis of HGUC, all of the above cytomorphological criteria must be present.2 By having strict criteria for the 'HGUC' diagnostic category, it ensures that urinary cytology remains a highly specific and sensitive initial test for the detection of HGUC.

According to TPS, the 'HGUC' diagnostic category is reserved for urothelial cells that fulfil all of the criteria below (Figure 1)[2]:

- Increased nuclear to cytoplasmic (N/C) ratio (> 0.7)
- Moderate to severe nuclear hyperchromasia
- Marked irregular nuclear membranes
- Irregular, coarse, clumped chromatin

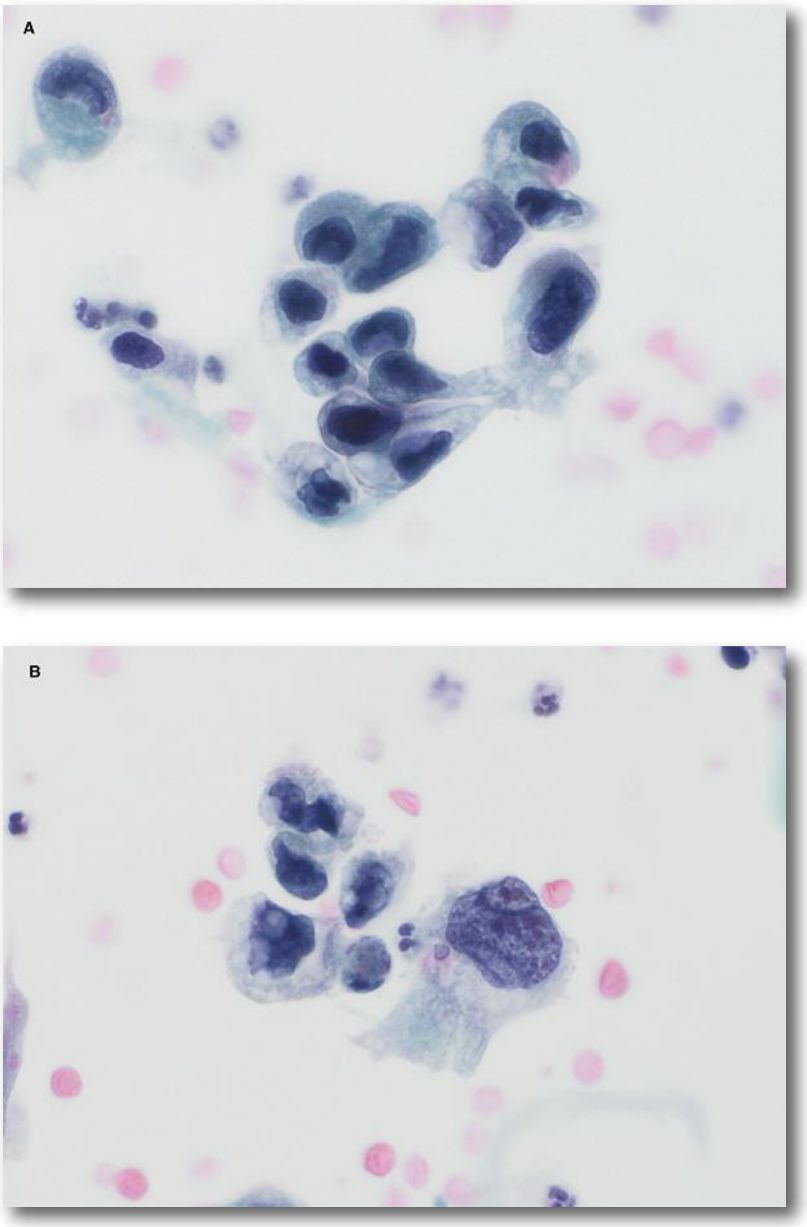

Figure 1 (A) and (B). High-grade urothelial carcinoma (voided urine, cytospin, Papanicolaou stain, magnification 400x).
The voided urine specimen had numerous urothelial cells with increased N/C ratio (> 0.7), nuclear hyperchromasia, irregular nuclear membranes and coarse chromatin

Furthermore, TPS recommends that all of these cytomorphological features be present in at least 5-10 urothelial cells.[2,6] However, the clinical context and the collection type needs to be taken into consideration. For example, for instrumented specimens (which, by nature, are more cellular than voided urine specimens), TPS recommends that at least 10 abnormal cells fulfilling the above criteria are required before it can be placed in the 'HGUC' diagnostic category.[2,6] In addition, lesions in the upper urinary tract may not always be amenable to biopsy (although visible on imaging or ureteroscopy); as a result, a nephroureterectomy may be performed based on the cytological diagnosis without obtaining histological confirmation. Therefore, a higher threshold should be reserved for diagnosing HGUC in upper urinary tract specimens in comparison to lower urinary tract specimens.[6] In contrast, in voided urine specimens and/or in the context of a previous clinical history of HGUC, as little as five abnormal cells meeting the above cytomorphological criteria can qualify for a diagnosis of HGUC.[2,6]

Low-Grade Urothelial Neoplasia (LGUN)

A cytological diagnosis of 'LGUN' encompasses the following histological entities as described in the 2016 WHO classification system: urothelial papilloma, inverted urothelial papilloma, papillary urothelial neoplasm of low malignant potential (PUNLMP) and non-invasive low-grade papillary urothelial carcinoma.[18] Urinary cytology cannot unequivocally distinguish between these entities; therefore, rather than attempting to diagnose each of these entities on urinary cytology, they have been grouped together under the diagnostic category of 'LGUN'.[2]

A number of studies have examined the cytomorphological criteria associated with LGUN[19–22]; however, there is low interobserver agreement and considerable variability in the reported sensitivity.[2,23] Therefore, according to TPS, a diagnosis of 'LGUN' can be made with confidence (in either voided urine or instrumented specimens) when "three-dimensional cellular papillary clusters with fibrovascular cores" are present.[2] The presence of fibrovascular cores is a rare finding in urine specimens and the diagnostic category of 'LGUN' should be used sparingly.

Other Malignancies, Primary and Metastatic, and Miscellaneous Lesions

The final diagnostic category of TPS is reserved for non-urothelial tumours arising in the urinary tract, including both primary and secondary malignancies.[2,6,7] Primary malignancies of the urinary bladder which are not urothelial in origin are rare, accounting for less than 5% of all bladder tumours.2 These include squamous cell carcinomas, adenocarcinomas, small cell carcinomas, and other rare tumours (such as sarcomas and haematological malignancies).2 Secondary malignancies of the urinary bladder constitute directly invasive tumours from adjacent organs (e.g. colorectum, prostate or female genital tract) or distant metastases.[2,6,7] The diagnosis of these non-urothelial malignancies requires immunocytochemistry as well as careful correlation with the clinical history and radiological findings; an accurate diagnosis is crucial for the appropriate management and accurate prognostication of these tumours.

Conclusion

More than 50 years have passed since Dr. George Papanicolaou first began his work on the cytological analysis of urine sediments to diagnose urinary tract malignancies.[24] Since then, many reporting systems for urinary cytology have been published, each one providing an updated approach as our understanding of urothelial neoplasia and histological terminology have evolved.[25] However, there has not been widespread acceptance and use of any particular reporting system, resulting in inconsistent and variable reporting of urinary cytology specimens. In this context, TPS has been critical in standardising the reporting of urinary cytology and, since its publication, many institutions have implemented TPS into their clinical practice. Subsequent studies examining the diagnostic performance of TPS have been promising[26], but continued investigation is required in order to determine the relative risk of malignancy of each diagnostic category and define its impact on patient management.

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New co-opted BAC executive member – Eva Halloran

The BAC executive are pleased to welcome Eva Halloran as a co-opted executive member.

Eva is a Consultant Biomedical Scientist currently employed by Viapath, working at ST Thomas' Hospital in London, and she has many years' experience in both Cytology and Histology with a variety of previous posts across England.

Eva is also the scientific Professional & Clinical Advisor (PCA) for London SQAS.
As a member of both NAC and BSCC prior to BAC, Eva says she is looking forward to working as an executive member in these 'interesting and challenging times for all cytopathology professionals'.

What does Jo's Trust do?

Robert Music, CEO of Jo's Cervical Cancer Trust

It's an interesting time to be working in the cervical screening programme. On the one hand, we are at a record low in attendance with over 1.2 million women not taking up their invitation in 2017/18. Sadly, we are also seeing rates of cervical cancer going up.

However, on the other hand, we are seeing substantial advancements within the programme which will benefit the millions who take up their invite each year.

All of us working in screening have a shared goal of reducing the impacts of cervical cancer. At Jo's our vision, which we are sure you share with us, is a future where cervical cancer is a thing of the past. On the way to achieving this, seeing fewer lives lost to the disease and the lessening of the far-reaching consequences of treatment is what keeps us motivated. Every day, we hear stories of young women losing their fertility, women living with pain and those faced with debilitating conditions including changes to bowel and bladder function, not to mention the family members and friends of those who have sadly lost a loved one to the disease.

While cervical screening cannot prevent every single case of cervical cancer, we know it prevents thousands each year. Screening is the best protection that we have against the disease and, if used to its full potential, it's estimated by Public Health England that screening could prevent 83% cases of the disease. Recent modelling by King's College London suggests that screening in England has prevented around 65,000 cancers between 1988 and 2013. In 2013 alone, there were nearly 5,000 fewer cervical cancers than there would have been had there been no screening programme. We should all feel really proud of this figure.

At Jo's Cervical Cancer Trust we're working hard to increase participation in our fantastic programme. We're also there to support those who are working tirelessly to deliver it. With the move to human papillomavirus (HPV) primary screening over the next 12 months in England and Scotland, this is a period of adjustment and upheaval. Competing priorities and resources remain a challenge. In England especially, there are ongoing challenges to the roll out of this test, even though once it is in place it will be a far more effective test. Yet improvements to our programme only benefit those who participate in it.

You'll be familiar with our campaigns that span social media and the press. We are sure you curse us when January comes around each year with Cervical Cancer Prevention Week and our #SmearForSmear campaign producing extra workload, but we hope you forgive us too! However what we do goes much further than online campaigns. Here's some more about what we do and why we do it.

We share best practice, ideas and guidance to reduce barriers to screening. This includes detailed case studies from GP surgeries, local authorities and Clinical Commissioning Groups (CCGs) and insight from our Spotlight reports collating work happening at a local level. Our outreach team works with GP practices and in communities to develop interventions to improve understanding of cervical health and tackle declining screening attendance. We provide free, peer-reviewed resources spanning all aspects of HPV, cervical screening and cervical cancer. They include posters, factsheets and an easy read guide for those with learning difficulties.

We publish regular blogs and articles which provide tips and information about specific barriers to cervical screening, in a series called 'Let's talk about it…' which includes posts about accessing screening after female genital mutilation (FGM) and what to do if you find smear tests painful. We have best practice guidance for nurses and GPs for before and after screening to ensure the experience is as comfortable as possible for women. We also offer information about cervical screening for survivors of sexual violence, for who the test is often incredibly difficult.

We provide free online, phone and face-to-face support for anyone who needs us, including women or patients who are confused, anxious or are dealing with a diagnosis. We know that the experience of cervical cancer can be an isolating one, so we run information and support days where people who have been through a diagnosis have the chance to connect with each other. These days are very popular and include workshops and talks about aspects of life after cervical cancer such as sex and intimacy post-treatment.

On a policy side, we are constantly championing improvements in cervical cancer treatment and support, as well as those within cervical screening. This includes pushing for self-sampling to be adopted by the programmes, tackling the declining provision of screening through sexual health services (where a higher percentage of abnormal results are actually detected) and highlighting areas in which the programme needs significant investment and overhauling.

In England, this concerns our outdated IT system which we are sure many of you are familiar with as it can make your job more difficult than necessary. The recent report by the National Audit Office was welcomed by us, as it highlighted serious concerns that we have held for a long time in England. It showed that cervical is the most underachieving of all the screening programmes in regards to coverage, which is both frustrating and concerning. Not only is the optimum target not being reached, it is not even achieving the lower threshold target of 75% and has not for the past 6 years.

As the report says, the programme is supported by an ancient IT infrastructure with multiple systems and multiple providers across multiple locations. This means it is far more complex than the other three screening programmes. This presents opportunity for errors in data transfer, plus the risk from operating on such outdated technology. Furthermore, it is impeding positive change and progress, such as the possibility of self-sampling. We are concerned that one of the biggest changes to the programme in years – HPV primary testing – is going to be rolled out on an IT system that is not fit for purpose. We will have to make do with the resources we have and try to make the switch as smooth as possible.

Issues with capacity, with outdated IT and with complexity in programme governance must be addressed. It is women who end up being affected and that is simply not fair. Along with many others, we look forward to reading and responding to the recommendations of the review being conducted by Professor Sir Mike Richards.

It is often easy to talk about the problems that affect the cervical screening programme. However, we should all be very proud of it too. We deserve to take time to reflect and look at what we achieve.

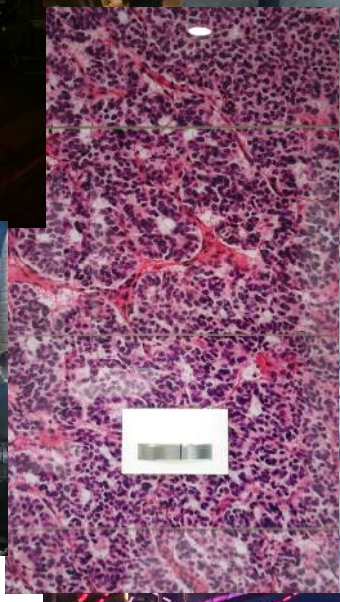
Across the UK we have a fantastic, hardworking and passionate workforce and a programme that prevents thousands of cancer diagnoses every year. I want to thank the cytology community for the work that you do. Your professionalism and dedication, despite challenges and potentially uncertainty is unwavering and it is a pleasure to work with and support you.

IAC Tutorial 2018

Donna Morrison,
Specialist Biomedical Scientist, Aberdeen Royal Infirmary

In October last year I received the BAC e-mail about the International Academy of Cytology (IAC) tutorial being held in London early December 2018. Not being familiar with the IAC I was intrigued to find out more about the organisation and the tutorial. The two and a half day programme comprising a broad range of topics covering cervical, urine, serous, head & neck, pancreatic and EBUS cytology very much appealed to me as I am working towards my IBMS Higher Specialist Diploma. With the tutorial being in the UK and hosted by the BAC this was too good an opportunity to miss! On that note, I would like to thank the BAC for awarding me a BAC Bursary enabling me to attend the IAC tutorial. Just one of the fantastic benefits of being a member!

On day one I was eager both to attend the event and to see the new Royal College of Pathologists on Alie St, London. The tutorial was one of the first meetings to be held here. What a lovely new building! I was met with a light and airy foyer and a spacious and comfortable conference room, with a social area right outside for lunch breaks and networking. However, one of the main talking points was the toilet cubicles with some rather impressive wall decor!



As I previously mentioned, the tutorial covered a wide range of cytology, predominantly diagnostic cytology. It was very well structured with lectures being followed by case presentations. The lecture content was made available to delegates before the event. I found this very helpful as I was able to concentrate on the lectures and take any extra notes I needed. This was also a helpful aid for reflecting back and consolidating my learning as there was a wealth of in-depth educational material delivered in the two and a half days.

Presentations included an overview of the Paris and Milan reporting systems for urine and salivary gland cytology which brought me up to date with terminology and definitions. Dr Ashish Chandra gave a talk on the proposed diagnostic categories for developing an international system for reporting serous fluids. A survey of current practice has been completed, the results of which support the need for a terminology system. There will also be guidance on specimen adequacy assessment by means of sample volume and cellularity, the most up to date methods of serous fluid preparation

and ancillary testing, in addition to the diagnostic categories to be used to report this challenging specimen type. Serous fluids are a staple in the workload of any cytology laboratory so I look forward to hearing more about this system and its development this year.

The lecture on ancillary testing of effusion and FNA samples by Professor Fernando Schmitt stood out as there was a particular focus on molecular testing and how different cytological preparations lend themselves to this. With molecular testing becoming increasingly integral to tumour diagnosis and management, cytology samples are proving invaluable in many cases. Prof. Schmitt stressed how small biopsies and cytology samples should be utilised for diagnostic purposes morphologically but also managed to provide ample material for molecular studies. This is an area where Rapid On-Site Evaluation (ROSE) can be helpful in ensuring sufficient sample acquisition and appropriate triage.

Course Director, Professor Syed Ali and Dr Miguel Perez-Machado covered pancreatic cytology. This is a difficult area in cytology with a variety of of benign and malignant lesions that can present; this topic was of particular interest to me as we are looking to develop our EUS-FNA service here in Aberdeen.

An "Unknown Case" session followed each lecture where the speakers presented interesting and unusual cases and, of course, the dreaded diagnostic pitfalls! Slides were clear, easily visualised and well projected on screen. The sessions were interactive, with open discussion and audience participation encouraged, which made them both educational and entertaining.

With all this intense learning during the day my brain was in need of a rest in the evening! Being in London in December, my colleague Louise Smart and I were never going to be short of something to do, and a little trip to the Winter Wonderland in Hyde Park was just what we needed. Bratwurst, mulled wine and live music made for a very different but enjoyable Tuesday evening.

Overall the speakers, content and structure of the tutorial was excellent, a worthwhile use of study leave and I would recommend it to others. Medical Trainees and Biomedical Scientists with an interest in diagnostic cytology would find the tutorial very useful. So if you ever get the opportunity to attend one of the IAC tutorials, you should definitely go!

Educational Case

Paul Cross

An 89 year old man presented with shortness of breath, and investigations identified bilateral lung masses on a CT scan. Some bowel thickening was also noted. The medical history revealed a history of previous bowel surgery for colonic cancer and some cardiac problems. He was a lifelong smoker. Clinical diagnosis: two separate lung primary tumours vs metastatic bowel cancer. Specimen was from a bronchial brushing and washing from the right upper lobe, submitted as Thinprep samples with clot.

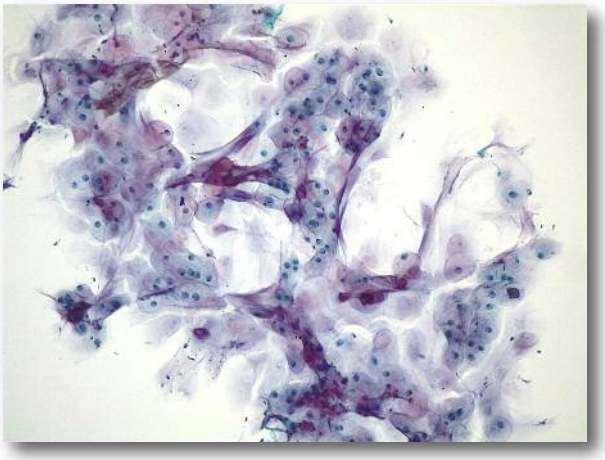


Figure 1- PAP Thinprep x 10

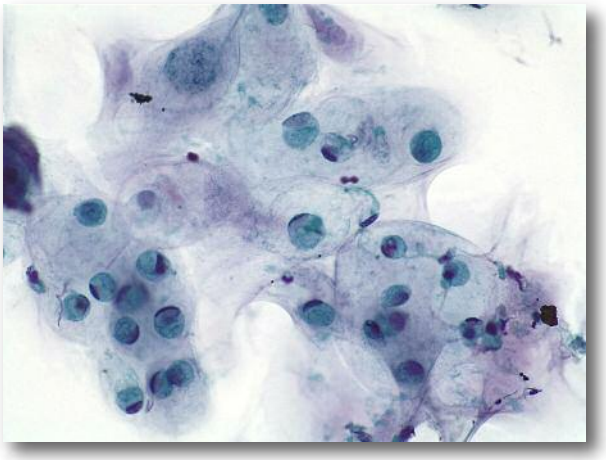


Figure 2 - PAP Thinprep x 40

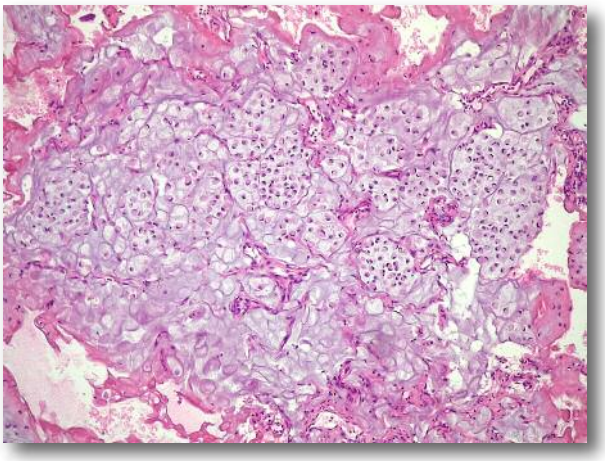


Figure 3 - Clot sample H+E x 10

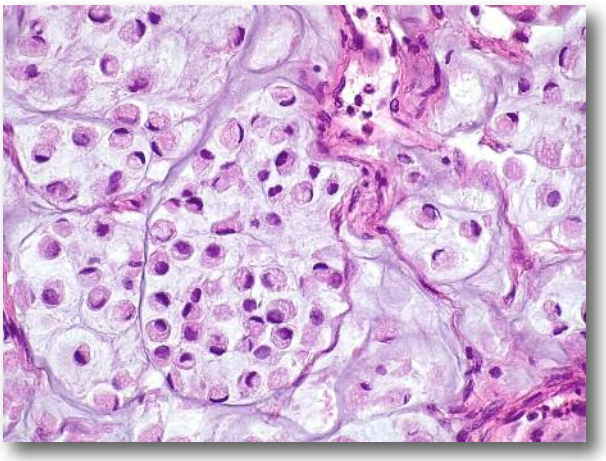


Figure 4 - H+E of clot x 40

Q1 Describe what the samples show.

Q2 What cell types are present?

Q3 What is your diagnosis?

Q4 How can you potentially prove your diagnosis?

Answers

A1. The samples show plentiful mucoid material in the background, with scattered cells. The cells generally have eccentric or peripherally displaced nuclei with vacuolated or bubbly/foamy cytoplasm. Many have a signet-ring appearance. The nuclear chromatin is focally clumped with variable hyerpchromasia. No mitotic activity is noted. Similar cells and background material are very evident in the clot preparation.

A2. The cells seen are epithelial, and represent adenocarcinoma cells. The overall features are in keeping with a mucinous adenocarcinoma with signet ring forms present.

A3. Signet ring/mucinous adenocarcinoma. This could represent a tumour from several sites, but given the history, it is most likely from the known colonic adenocarcinoma.

A4. Immunohistochemistry can be of use, especially given that many atypical cells are present in the clot preparation. The panel used showed the cells to be cytokeratin 20 positive and CDX2 positive. They were negative for cytokeratin 7and TTF1.

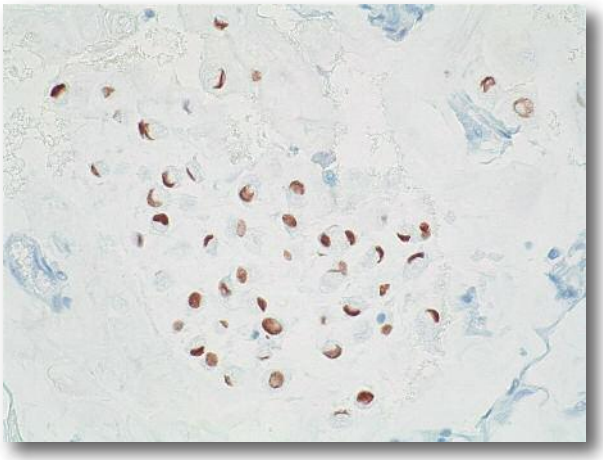


Figure 5 – CDX2 positive nuclear staining on clot preparation x40

Discussion

The differential diagnosis of a lung mass/masses invariably centers around a possible primary vs a secondary tumour. Other clinical information may help in deciding this, but the ability of cytology to potentially definitively answer this is of great clinical value. In this case the cytological appearances can seem very bland, with the cells present being mistaken for macrophages. However, the nuclear appearances are very different. The background mucinous material can also often be overlooked, and if so then the correct diagnosis may not be made. Always look at the background, if present, and this must be interpreted within the context of the overall diagnosis. In this case the plentiful mucinous material with the presence of atypical cells, is diagnostic of a mucinous adenocarcinoma. This can arise in many body sites, especially breast, lung, pancreas and colon as the commonest, but the clinical details are obviously suggestive in this case. The presence of signet ring cells (adenocarcinoma cells with a high content of cytoplasmic mucin that causes displacement and indenting of the nucleus to the periphery) is common in such tumours, but can be found in many mucin producing adenocarcinomas. In this particular case IHC on the clot, which contained plentiful cells, showed the cells to be positive as described. This profile is typical of a colonic adenocarcinoma (CK20 +ve/CK7 –ve/CDX2 +ve) (Figure 5). The majority of lung adenocarcinomas would be CK7+ve/TTF1+ve. If in any doubt, then a macrophage marker, such as CD63, can be of use and if positive with no cytokeratin staining (with a pan-cytokeratin such as MNF116 or AE1/3) can prove macrophage cell lineage. The final diagnosis is of a mucinous adenocarcinoma, in keeping with metastases from a colonic primary tumour.

CEC: Journal Based Learning

Understanding Men's Perceptions of Human Papillomavirus and Cervical Cancer Screening in Kampala, Uganda

Moses, Erin Pedersen, Heather N. , et al Journal of global oncology (issue 4 pages 1-9) November 2018

1. Give 4 factors that influence the success of cervical cancer screening programmes in sub-Saharan Africa (4 marks)

2. Give 2 reasons why HPV testing might offer an effective alternative to cytology screening in such areas (2 marks)

3. WHO has recently called for an increase in male involvement in the prevention of cervical cancer in low to middle income countries; why is this? (1 mark)

4. What is ASPIRE? (1 mark)

5. What were the key aims of this study? (1 marks)

6. Briefly describe how the study was carried out (3 marks)

7. What percentage of men had knowledge of (a) cervical cancer and (b) HPV at the beginning of the study? (1 mark)

8. Were the men supportive of their wives having cervical screening? (1 mark)

9. What misconceptions regarding HPV remained even after this session? (3 marks)

10. 100% of men in this study said they would want their daughters to be vaccinated against HPV. Discuss the significance of this finding (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

Please remember to make a copy of everything before it is sent — there have been one or two losses in the post. Thank you

EBUS ROSE – A BMS supported service

Meera Mylvaganam, Advanced Biomedical Scientist, South West London Pathology.

Dr Caitlin Beggan, Consultant Pathologist, Clinical Lead in Non-gyane Cytology, South West London Pathology.

Endobronchial Ultrasound (EBUS) guided fine needle aspiration (FNA) is a Biomedical Scientist supported service provided by St Georges Hospital, London supplied by South West London Pathology (SWLP). I have attended EBUS clinics to give rapid onsite evaluation (ROSE) since 2015 and with the support of consultant colleagues coupled with establishing good relationships with the lung team; this is a very successful clinic. Attending EBUS ROSE is an aspect of job role that I thoroughly enjoy and one that gives me great job satisfaction. I also like to pre-screen these cases and construct a report which is reviewed by the reporting consultant which allows me to look at the entire patient history to that point and have a greater understanding of the patient pathway.

EBUS ROSE is a well-established procedure where conditions such as carcinoma, lymphoma, TB and sarcoidosis can be diagnosed on the procurement of these minimally invasive samples. The BMS role at EBUS ROSE is to ensure adequate sampling and triaging of samples. Collecting further sample for ancillary testing is even more significant in the current era of personalized medicine where molecular pathology forms an essential part of the diagnostic pathway and testing for specific mutations can provide targeted treatment options in patients with lung cancer. I have recently embarked on the IBMS certificate of expert practice (CEP) in Molecular Pathology which emphasizes the importance of molecular pathology for targeted treatment in patients with cancer and is a very interesting field.

At our trust, we guide the respiratory physicians in terms of accuracy of needle placement and until diagnostic material has been confirmed; we prepare 1 wet fixed and 1 air dried slide from each pass and place the remaining sample from each pass into formalin. Once adequacy has been achieved, further passes are collected into formalin to increase the yield of tissue available for ancillary testing. Samples can also be triaged into balanced Hanks solution if microbiology or flow cytometry tests are required.

At specimen preparation, if any clots are visible macroscopically; these will be processed separately into cassettes and the remaining formalin deposit is processed as an agar cell block.

The primary purpose of ROSE in EBUS is to confirm specimen adequacy and to triage the sample appropriately. A decision on specimen adequacy is dependent on the clinical differential diagnosis and clinical and radiologic features of the case must be taken into consideration. In most cases the respiratory physician aims to sample a lymph node, and confirming the presence of nodal tissue is essential. However in some scenarios it may be appropriate that only lesion tissue is aspirated. It is vital that there is accurate clinical correlation in the EBUS clinic and therefore effective communication with the lung physicians and an understanding of the clinical context of each individual case is essential.

As other BMS staff became interested in attending EBUS ROSE, it posed the question as to how we could deliver initial training and how we could document on-going competency. EBUS ROSE clinics are our best opportunity to ensure that we get a good sample. An inexperienced BMS at ROSE may be overwhelmed by the fast paced clinic and raise the risk of the procedure being stopped on false confirmation of adequacy. Our aim is to provide a high quality reproducible and consistent service to the patient.

With this in mind, I contacted Allan Wilson, Lead Biomedical Scientist in Cellular Pathology and an Executive member of the British Association of Cytology who kindly shared his experience of implementing and documenting training for EBUS ROSE. With his pearls of wisdom and experience I was able to implement a successful training protocol for a BMS attending EBUS at St Georges Hospital.

Rapid Romanowsky staining setup for EBUS ROSE

Our in house training protocol comprises three stages covering at least 30 EBUS cases.

- Stage 1 is where the trainee ROSE BMS attends the clinic and observes at least 5 cases.
- Stage 2 incorporates at least 15 cases where the trainee ROSE BMS will prepare the slides, stain the slides and let the trainer know if they think the sample is adequate. The trainer will assess the slide for adequacy and convey this to the lung team.
- Stage 3 incorporates a further 15 cases where the trainee ROSE BMS will prepare the slides, stain the slides, assess the slide for adequacy and confidently convey this information to the lung team. The trainer will observe and only be present if the trainee requires assistance.
- Overall training and sign off will be carried out by the clinical lead in Non Gynecological cytology. If it is felt that competency has not been achieved then the trainee BMS will continue to attend these clinics with a trained BMS and reflect with consultant pathologist.

The training process also includes reflection of cases, review of discrepant cases with reporting pathologists and attending Lung MDT meetings so that the trainee understands the entire patient pathway. Once the initial training is complete and signed off by the trainer and a consultant pathologist, the newly trained ROSE BMS will be on the rota to independently attend EBUS clinics.

It is also important to complete an on-going audit of attendance by the trained ROSE BMS. On-going competency is recorded by documenting an audit of each case attendance. This will record the initial adequacy assessment by ROSE BMS (diagnostic/not diagnostic) and correlation with final report (see table 1). Any discrepant cases must be discussed with the reporting consultant pathologist and reflective learning implemented. The final report may not always reflect what is in the direct slides as the diagnostic material may be present in the cell block, and this will be evident on reflection of the case with the reporting pathologist. On a yearly basis, there are also competency based questions to answer and examination audits to ensure that procedures are followed.

Date	Lab no.	Site	No. of passes	No of slides	Initial adequacy assessment by BMS Diagnostic / Not Diagnostic at clinic	Additional passes requested Y/N	Ancillary tests eg flow? Cell block?	Consultant report	Diagnostic/ not diagnostic on the direct MGG preparations	Final outcome/ histology	Reviewed with Consultant
04/08/18	Nxx/18	4L	2	2 MGG	diagnostic for malignancy	Yes	Cell Block	pooly diff AdenoCa	Yes	Adeno CA	Yes

Table 1 – An example of the table used to audit BMS attending EBUS ROSE at St Georges Hospital – London

Dr Caitlin Beggan

I joined the consultant staff in the Cellular Pathology department in 2016 and from the outset was keen to participate in all aspects of cytopathology reporting. Our non gynae cytology service is a busy one with consultant support across a number of clinics. In 2015 consultant pathologists were supporting multiple head and neck ultrasound clinics, head and neck outpatient clinic, skin cancer outpatient clinic, CT guided lung FNA lists and EBUS FNA lists. This varied from rapid on site assessment with triage of samples to actual hands on performing of the FNA.

As reporting demands within the department increased, particularly with the establishment of South West London Pathology (SWLP), it was clear that the consultant body could not continue to support this intensity of clinic work, going forward.

From December 2015, to alleviate the time pressures on consultant staff, our BMS colleagues have attended the EBUS clinics ensuring material is appropriately triaged and samples are adequately spread.

In the absence of a nationally accepted training protocol for BMS training in ROSE we designed an in-house training that met the needs of our department. This facilitated a period of observership, shadowed attendance and feedback for individuals. This training protocol provided BMS staff with a level of confidence in their abilities and also provided consultant staff with assurance that there was consistency in the quality and training for BMS staff. Standard operating procedures (SOP) were also drafted to ensure there was consistency with regards to the number and type of slides prepared in clinic and the ways in which samples were triaged. As with all new initiatives there have been amendments to protocols, particularly with emerging emphasis on molecular testing in cases of lung cancer. With this in mind we now collect the majority of the sample into formalin to maximise material available for molecular testing.

The rollout of this service change has been a great success providing a positive benefit in both the pathology department and the endoscopy suite. Our respiratory colleague feedback is excellent. They are happy with the professionalism shown by our biomedical staff and also are happy with the level of certainty shown when asserting that a sample is representative and of good quality. From a departmental perspective the change in practice is invaluable. BMS attendance has facilitated consultants in reporting a greater number of cytology cases per week. Our EBUS clinics are held on a Friday afternoon and we consultants can sleep easy at the weekend knowing our EBUS samples have been triaged appropriately!

BAC session as part of the overall meeting, full details of the meeting can be found at:

See:https://cytologyasc.eventsair.com/QuickEventWebsitePortal/icc2019/home

British Association of Cytopathology (BAC) Companion Meeting

Monday, May 6, 2019
2:00 PM - 3:45 PM
Cockle Bay Room 2

Primary HPV Screening in the UK

Dr John Smith
Royal Hallamshire Hospital

Expansion of Roles for Scientists in Cytopathology

Mr Allan Wilson
Lead Biomedical Scientist in Cellular Pathology and Advanced Practitioner in Cervical Cytology
Pathology Dept, Monklands Hospital

Digital Technology: Its Advantages in the New Era

Dr Roberto Dina
Pathologist/Medical Doctor, Imperial College NHS Trust

RCPath Tissue Pathways for Diagnostic Cytopathology Specimens

Dr Ashish Chandra
Pathologist/Medical Doctor, Guy's and St Thomas' NHS Foundation Trust

BAC British Association for Cytopathology

BAC Spring Tutorial 2019

29 March 2019

HODGKIN BUILDING, GUY'S HOSPITAL, LONDON

See: http://www.britishcytology.org.uk/go/cytology-events~14

The BAC are delighted to host the 2019 Spring Tutorial on the theme of
Practical application of reporting terminologies in diagnostic cytopathology

This meeting always proves **extremely popular** and is a mixture of lectures and a full microscopy workshop in the afternoon. Places are limited to 80 delegates, with BAC and RCPath members able to register at a discounted rate.**The event has been CPD approved by the RCPath for 6 credits and CPD listed by the IBMS.**

Please note - for non-members who register you can also join the BAC free of charge as this is included within the registration fee. Simply download the Membership Form and send with the registration form for the event. This membership will run until 1st October 2019 where you can then complete and return a direct debit mandate for the £30 annual fees for non-medical staff/junior consultants and £125 for medical members.

Initial Programme:

0900-0955:	Registration and coffee
0955-1000:	Welcome
1000-1040:	**The Paris system for reporting urinary tract cytopathology** Dr Yurina Miki, Guy's & St Thomas' NHSfT
1040-1120:	**The Milan system for reporting salivary gland cytopathology** Dr Ashish Chandra, Guy's & St Thomas' NHSfT
1120-1200:	**RCPath terminology for reporting thyroid cytology** Dr David Poller, Queen Alexandra Hospital
1200-1300:	Finger buffet lunch
1300-1700:	**Microscopy workshop** covering thyroid, salivary gland and urinary tract cytology cases with tutors

BAC sessions as part of the overall cytology sessions, full details of the whole meeting can be found at:

https://congress.ibms.org/home/

CYTOPATHOLOGY 22nd September 2019

Cytopathology Session 1

Sponsored by: Olympus

1:00PM - 5:00PM

Cytopathology Microscopy Workshop

Dr Behdad Shambayati, Surrey Pathology Services Ashford and St Peter's NHS Foundation Trust & John Crossley, Leeds Teaching Hospitals NHS Trust

1:00PM - 5:00PM

CYTOPATHOLOGY 23rd September 2019

Cytopathology Session 1

Sponsored by: British Association of Cytopathology

9:00AM - 10:00AM

A four nation's perspective on HPV primary screening

Wales: Louise Dunk, Public Health Wales. Scotland: Allan Wilson, Monklands Hospital, Lanarkshire. Northern Ireland: Jackie Jamison, Antrim Hospital. England: Helen Burrell, Southmead Hospital, North Bristol Trust

9:00AM - 10:00AM

Cytopathology Session 2

Chairman:*Dr Behdad Shambayti*
Sponsored by: British Association of Cytopathology
10:30AM - 12:00PM

HPV implementation - international perspective

Jesper Bonde, Copenhagen, Amager og Hvidore Hospital, Denmark

10:30AM - 11:15AM

Experiences and outcomes from introducing HPV primary screening into a large NHSCSP laboratory

Stephen Burrows, Manchester University NHSFT

11:15AM - 12:00PM

Cytopathology Lunchtime Session

Sponsored by: British Association of Cytopathology
12:45PM - 1:45PM

British Association of Cytopathology Annual General Meeting

BAC AGM

12:45PM - 1:45PM

CYTOPATHOLOGY 24th September 2019

Cytopathology Session 1

Chairman:*Dr Behdad Shambayti*
Sponsored by: British Association of Cytopathology
9:00AM - 10:00AM

Digital cytology

TBC

9:00AM - 9:30AM

Introduction and development of a digital non-gynaecological diagnostic cytology interpretative scheme

Chantell Hodgson, UK NEQAS CPT

9:30AM - 10:00AM

Cytopathology Session 2

Sponsored by: British Association of Cytopathology

10:30AM - 12:00PM

ASD in Non-Gynaecological Cytology - a candidate's perspective

Tracey Stevenson, Royal Devon & Exeter NHS Foundation and Nadira Narine, Manchester University NHS Foundation Trust

10:30AM - 11:00AM

ASD Histology Reporting from a cytopathology candidate's perspective

Gary Player, Queen Elizabeth Hospital, Gateshead

11:00AM - 10:09AM

Bronchoalveolar lavage in interstitial lung disease illustrated by cases

Huzaifa Adamali and Dr Nidhi Bhatt, Southmead Hospital, North Bristol Trust

11:30AM - 12:00PM

Cytopathology Session 3

Sponsored by: British Association of Cytopathology

2:00PM - 3:30PM

Current status of molecular in cytopathology

Robbie Wilson, Antrim Hospital, Northern Ireland

2:00PM - 2:30PM

Let's start small: training in molecular cytology

Perry Maxwell, Queen's University Belfast

2:30PM - 3:00PM

EBUS ROSE

Dr Anthony Maddox, West Hertfordshire Hospitals NHS Trust

3:00PM - 3:30PM

Cytopathology Session 4

Sponsored by: British Association of Cytopathology

4:00PM - 5:00PM

Salivary gland cytopathology

Dr Cynthia van der Horst, NHS Greater Glasgow & Clyde

4:00PM - 4:30PM

Cell blocks: head and neck cytopathology

Dr Ivan Robinson, Derby Hospitals

4:30PM - 5:00PM

CYTOPATHOLOGY 25th September 2019

Cytopathology Session 1

Sponsored by: British Association of Cytopathology

8:15AM - 10:00AM

Interactive discussion: The ups and downs of HPV primary rollout- what have we learned so far?

Allan Wilson, Monklands Hospital

8:15AM - 9:00AM

Recruitment of women for cervical screening

Jesper Bonde, Hvidore Hospital, Copenhagen

9:00AM - 9:30AM

HPV: The patient experience

Hannah Dwyer, Jo's Trust

9:30AM - 10:00AM

Cytopathology Session 2

Sponsored by: British Association of Cytopathology

10:30AM - 12:00PM

HPV Vaccination Programme

Dr Kevin Pollock, Glasgow Caledonian University

10:30AM - 11:00AM

The Ripple Effect: colposcopy and primary care services following HPV primary rollout

Dr Julia Palmer, Sheffield Teaching Hospitals

11:00AM - 11:15AM

Who needs colposcopy with HPV Primary?

Rajvinder Dhillon, Gloucestershire Royal Hospital

11:15AM - 11:30AM

Future of the National Cervical Screening Programme

Ruth Stubbs,PHE Screening

11:30AM - 12:00PM

Cytopathology Session 3

Sponsored by: British Association of Cytopathology

2:00PM - 3:30PM

Sperm morphology

Dr Matt Tomlinson, University of Nottingham

2:00PM - 2:30PM

Attaining ISO15189 for andrology

Stephanie Brooks, The Hewitt Fertility Centre, Liverpool Women's Hospital

2:30PM - 3:00PM

Andrology QC and MOU

Steve Harbottle, Cambridge IVF, Addenbrooke's Hospital

3:00PM - 3:30PM

42nd
European Congress of Cytology

16-19 June 2019 • Malmömässan, Malmö, Sweden

BAC session as part of the overall meeting, full details of the meeting can be found at:
See: http://cytology2019.com/preliminary-programme/

Sunday 16th June 2019

16.00 – 18.00

Companion Meeting BAC

British Association for Cytopathology

Cytopathology in the UK: Bridging the gap

Chairs:
Alison Malkin, *TU Dublin – School of Biological and Health Sciences, College of Sciences & Health. Dublin, UK*
Alison Cropper, *The Royal Derby Hospital. Derby, UK*

Speakers:

Primary HPV screening in the UK
Alison Cropper, *The Royal Derby Hospital. Derby UK*

Expansion of roles for scientists in cytopathology
Allan Wilson, *NHS Lanarkshire, UK*

Digital technology: its advantages in the new era
Roberto Dina, *Cellular Pathology -Imperial College London. London, UK*

RCPath tissue pathways for diagnostic cytopathology specimens
Paul Cross, *Queen Elizabth Hospital, Gateshead, UK*

Membership Details

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

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BAC Administrator
Institute of Biomedical Science
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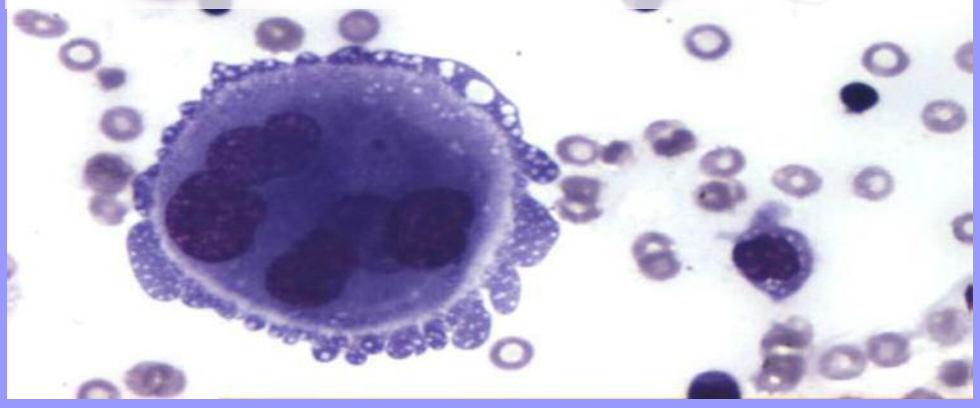
NEPSEC North of England Pathology and Screening E

Non Gynaecological Cytology



Training Opp 2018/

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

19th, 20th, 21st & 22nd November 2019

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

16th – 17th May 2019

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

2nd & 3rd May 2019

Three Day Update Course in
Consultant Biomedical Scient

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

6th – 8th November 2019

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.

5th & 6th June 2019

Breaking Bad News
A one-day communication sk

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

7th June 2019

For further information contact our Admin Team: sht-tr.nepsec@nhs.n

ducation Centre

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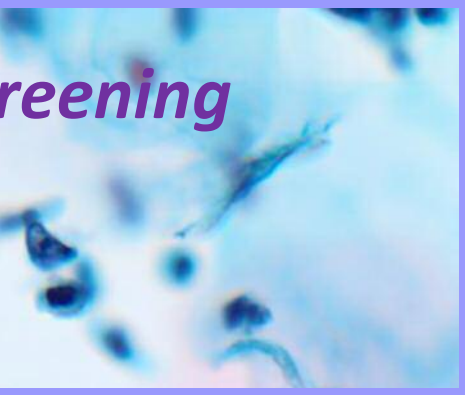

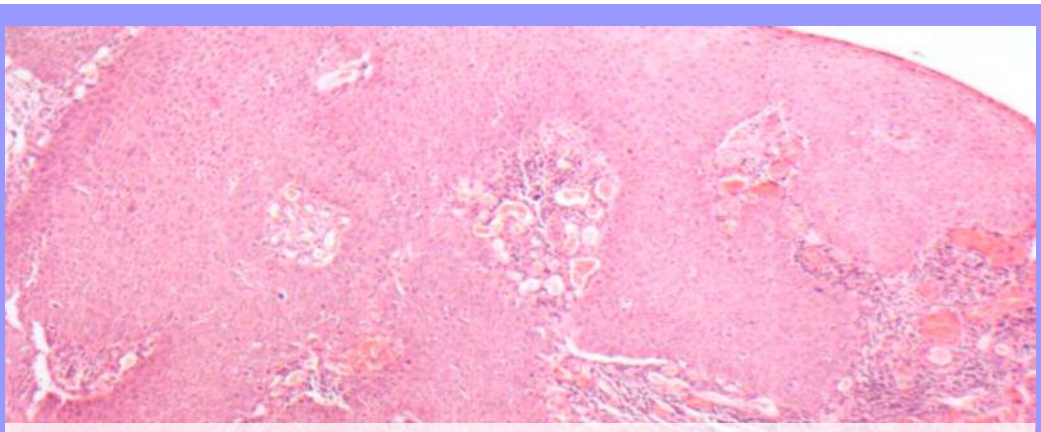

Histopathology

Cervical Cytology for tists

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kills course

course to explore itative skills and

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 – 29th April 2019

Stage C – 19th August 2019

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 including:

Gastrointestinal and Hepaobiliary; Gynaecology; Breast; Skin; Osteoarticular and Soft Tissues; Genito-Urinary; Exam and Portfolio; Endocrine & Head and Neck

Specialist module sessions are scheduled throughout 2019.

et Tel: 0113 2466330 www.nepsec.org.uk

SOUTH WEST REGIONAL CYTOLOGY TRAINING CENTRE

BRISTOL

2019 Course Schedule

Date	Gynae Courses	Fee
10-21 June 15-26 July	**Introductory in Gynae Cytology – Part 1** **Introductory in Gynae Cytology – Part 2**	NHS £1000 Other £1200
6 March 2 May 25 June 4 September 17 October 3 December	**One Day Update in Cervical Cytology**	£100
6 June 27 November	**Update in Cervical Cytology for Pathologists & Consultant BMS's & Holders of the Advanced Specialist Diploma in Cervical Cytology**	£100
tba	**Cervical Histology for Technical Staff**	£100
21-22 May	**Gynae Pathology for Trainee Colposcopists**	£200
13-14 May 16-17 September 4-5 November	**Cervical Sample Taker Training**	£300

Date	Non-Gynae Courses	Fee
19 March	**Serous Fluid Cytology**	£100
6 February	**Respiratory Cytology**	£100
12 November	**FNA Cytology**	£100
3 April	**Urinary Tract Cytology**	£100
11-14 March 9-12 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

London **R**egional **C**ytology **T**raining **C**entre

London North West Healthcare NHS
NHS Trust

2019 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®)

- *30th September – 25th October*

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

FOLLOW UP COURSE (Thinprep®)

- *8th – 12th July*

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

PRE – EXAM COURSE (Thinprep®)

- *8th – 12th April*
- *5th – 9th August*

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

Post Registration Courses

BMS/CYTOSCREENER UPDATE COURSE

- *19th – 21st March*
- *14th – 16th May*
- *16th – 18th July*
- *17th – 19th September*
- *26th – 28th November*

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

Medical Practitioner Courses

PATHOLOGISTS COURSE – NON GYNAE

This four day course covers non-gynaecological cytology.

- *11th – 14th + 15th (Optional Mock Exam) March*
- *9th – 12th + 13th (Optional Mock Exam) September*

Course fee: - £ 400 Mock exam - +£50

Please indicate on the online booking form if you wish to attend the mock exam.

MEDIC'S 1-DAY UPDATE COURSE

A refresher course for consultant pathologists/AP's

- *22nd May*
- *30th October*

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

Non-Gynaecological Courses

SEROUS FLUID CYTOLOGY COURSE

- *8th – 9th May*

RESPIRATORY CYTOLOGY COURSE

- *19th – 20th June*

URINE CYTOLOGY COURSE

- *24th – 25th July*

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

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.

- *17th April*
- *4th December*

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

Book online at www.lrctc.org.uk

All courses above are CME and/or IBMS CPD accredited.

Further details/information can be obtained by contacting **0208 869 5270**

Scottish Cytology Training School

Programme 2019-2020

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

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Royal Infirmary of Edinburgh
51 Little France Crescent
Edinburgh EH16 4SA

Tel: 0131 242 7135
Email: scts@nhslothian.scot.nhs.uk

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

NHSCSP Accredited Training Centre

Courses held at
The Bioquarter, Royal Infirmary of Edinburgh,
1st Floor, Building 9, Edinburgh Bioquarter,
9 Little France Road, Edinburgh. EH16 4UX

Unless states (QEUH) Glasgow

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

Introductory Course
18th February – 15th March 2019
2nd – 27th September 2019
£1000

Introductory Course Part 2
18th November – 22nd November 2019

Update Course
19th March – 20th March 2019
5th June – 6th June 2019 (QEUH)
6th November – 7th November 2019 (QEUH)
4th December – 5th December 2019
5th February – 6th February 2020
£100 per day

Pre-Exam Course
21st August – 23rd August 2019
(for October Exam)
£250

Workshops – BMS Medical/Consultant Staff
26th November 2019
£100

ST1 Intro to Cervical Cytology
2nd September – 6th September 2019

Course for Colposcopists
8th & 9th May 2019
£100 per day

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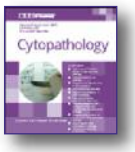

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Administrator: Tom Broomfield.
Email: tbroomfield@wiley.com

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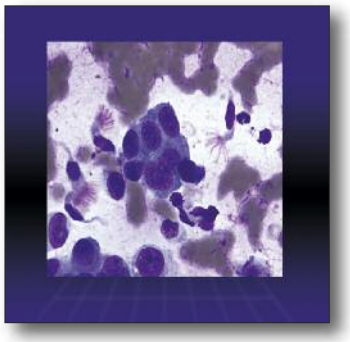
Material for publication should be sent direct to the Editor; all other correspondence with the Association should be addressed to the Secretary.

Front Cover image:
Whole slide scanned image using Olympus scanner of a respiratory direct smear with MGG, showing both benign and malignant non-small cell carcinoma cells x 40. The editor is indebted to Dr Paul Cross, Queen Elizabeth Hospital, Gateshead Health NHS Foundation Trust.



BAC British Association for Cytopathology

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