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South East England General Histopathology EQA Scheme

Case Discussion Round p

Wednesday 11th August 2021

THANK YOU FOR WAITING

The meeting will start at 12:30pm

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Meeting Etiquette

1 

If your camera is on, everyone can see you

2 

Mute your mic if you're not speaking

3 

Use the "raise hand" Or "chat" feature to raise questions or share ideas

4 

Wait for the Chair person to call on you before you unmute your mic

6 

Remember… Everyone can see your chat comments

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Agenda

1. **Welcome & Introduction of Scheme Staff**

2. **Meeting Terms of Reference**

3. **Case and Preliminary Score Review**
   a) Case 817 – 826
   b) Educational Cases – 827- 828

4. **Questions / comments**

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2. Meeting Terms of Reference

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- This pilot meeting will be held between the end of case consultation and results being issued.
- The purpose of this meeting is an educational exercise, an opportunity to explain the reasons behind scoring and merging or why cases were excluded.
- For clarity, this is not an opportunity to alter merging decisions, as participants have that opportunity during the “Case Consultation” period.
- An additional CPD point will be awarded to those who attend, and added to the annual certificate.
- This is a pilot meeting and will be the subject of a participant survey. We welcome any feedback – good or bad – you may have about today.

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3. Round p Review

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Case Consultation

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- **151 responses received for round p**
- **87 responses received for consultation – 57.62% QUORATE**

- **Basic Rules regarding Case Consultation and Merging Diagnostic categories:**
  - If you are exempt from a category, your consultation response to that case is also not counted
  - Each case must have received a consultation response from at least 50% of those that answered it
  - For a merge to be automatically accepted, more than 50% of consultation respondents must agree
  - Between 40-50% agreement, the merge will be accepted only with the agreement of the Organiser (i.e. clinically valid).
  - The consensus CAN be over-ridden if there are clinically valid reasons for doing so. These are recorded, and reviewed at the AMR. You will see an example of this today

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Case 817 – Miscellaneous

Specimen: Lump from finger

Submitted Diagnosis: Glomus Tumour

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Clinical	Macro	Immuno	Image link	Preliminary Results	Final Merge Results
F48. Probable neuroma ulnar border of distal phalanx left ring finger	**Pale Tissue 4mm**	**SMA+ Desmin+ CD34+ S100 - Melan A- MNF-116 -**	***Click here to view digital image***	1. Glomus Tumour 9.77 2. Angioleiomyoma 0.02 3. Myopericytoma / Perivascular myoid tumour 0.16 4. Epithelioid leiomyoma 0.02 5. Glomangiopericytoma 0.03	We will be merging diagnoses 1 and 5 48.28% agreement from 87 responses

General Comments from participants during case consultation:

- All benign however with no impact on clinical management/prognosis, 2+3 can also be given some points
- Does Glomangiopericytoma occur outside nasal cavity?
- None of these diagnoses are malignant and none would alter clinical management
- The immunohistochemistry is typical for this entity
- Are of same spectrum

Case 818 – Respiratory

Specimen: Pleural Biopsy

Submitted Diagnosis: Metastatic adenocarcinoma c/w colorectal origin

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Clinical	Macro	Immuno	Image link	Preliminary Results	Final Merge Results
M63. Large L sided pleural effusion with nodular macroscopic appearance of pleura, likely malignancy. PMH bowel cancer 2017.	**Multiple pieces of cream fibrous tissue 25x20mm in aggregate**	**CK20 + CDX2 + BER-EP4 +** **CK7 - Calretinin -**	***Click here to view digital image***	1. Metastatic colorectal Adenocarcinoma 9.71 2. Metastatic Adenocarcinoma NOS 0.28 3. Pulmonary enteric adenocarcinoma 0.01	No merging 56.1% agreement from 82 responses

General Comments:

- The IHC profile should give an indication of the primary site
- Difficult to say. Might merge all
- Response 2 is not necessarily incorrect but there is sufficient information to be more specific
- Specific management issues with all three diagnoses
- This is metastatic disease NOT a variant of primary pulmonary adenocarcinoma
- The immuno profile is typical for metastatic colorectal carcinoma; especially with the history of previous bowel cancer
- Same entity
- Clinical history provided, hence merge none.

Case 819 – Lymphoreticular

Specimen: Supraclavicular LN

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Submitted Diagnosis: Post-transplant lymphoproliferative disorder (EBV+ Classical Hodgkins lymphoma)

Clinical	Macro	Immuno	Image link	Preliminary Results	Final Merge Results
M76. Previous renal transplant recipient 1996. Now has palpable lymphadenopathy in right supraclavicular region. ? lymphoma.	**Two firm cream nodules, 16 x 16 x 10 mm and 6 x 6 x 4 mm**	**Large cells CD30 + CD15 + MUM1 + PAX5 + EBER ISH +** **CD20 - CD79a - CD2 – CD3 - ALK1 – EMA -**	***Click here to view digital image***	1. Hodgkin's Lymphoma NOS 2.62 (neither classic-MC or transplant mentioned) 2. Classical /MC Hodgkin's Lymphoma 5.74 (transplant not mentioned) 3. PTLD – Classical Hodgkin's Lymphoma 1.26 4. PTLD Only 0.09 5. Hodgkin's Lymphoma- like PTLD 0.07 6. Hodgkin's Lymphoma 0.15 Lymphocyte predominant. Nodular 7. B Cell Lymphoma 0.07	We will be merging 1, 2, 3, 5 61.25% agreement in 80 responses Note: participants thought the mention of HL was important there 4 was therefore not included

General Comments:

- Good case. Important to recognise PTLD
- Classical Hodgkin lymphoma identified
- Difficult to suggest merges due to crossover (particularly in 3)
- Transplant was a long time ago, so unsure how relevant
- This is classical Hodgkin Lymphoma, probably mixed cellularity, up to the clinicians whether or not it is transplant related
- The diagnosis is essentially the same
- Same lymphoma
- As this is general scheme the case would likely to be referred to a specialist, hence any Hodgkin containing Dx seems to me OK

Case 820 – Breast

Specimen: Breast tissue

Submitted diagnosis: Paget's disease

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Clinical	Macro	Immuno	Image link	Preliminary Results		Final Merge Results
F64. Eczematous rash nipple	**Nipple wide excision**	**Intraepi-thelial cells are Her-2 positive**	***Click here to view digital image***	1. Paget's disease of the nipple 2. Lentigo maligna 3. Bowen's disease	9.98 0.01 0.01	No merges. 100% agreement by 80 participants

General Comments:

- All 3 require immuno and need to be considered, cannot be merged
- Nice case
- Her-2 not positive in lentigo maligna and Bowens disease
- All different entities
- Immuno stain was provided.

Case 821 – Endocrine

Specimen: Total thyroidectomy

Submitted Diagnosis: Papillary carcinoma of thyroid.

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Clinical	Macro	Immuno	Image link	Preliminary Results	Final Merge Results
F84. Total thyroidectomy and level 6 dissection on left side.	**Left lobe, lobulated tissue 55x25x20mm, on section it has a partly firm white cut surface, the rest showing gelatinous appearance. The firm area measures approx. 30 x 22 x 15mm.**	**N/A**	***Click here to view digital image***	1. Papillary Carcinoma 8.44 2. Papillary Cell Carcinoma (tall cell variant) 1.16 3. Follicular variant papillary Thyroid ca (Encapsulated) 0.34 4. Diffuse sclerosing variant of papillary thyroid carcinoma 0.06	1, 2, 3, 4 will be merged 43.53% agreement from 85 responses

General Comments:

- Am not convinced about the features for variants 3,4
- All papillary thyroid carcinoma
- Diagnosis 3 is more indolent and would probably be managed differently
- Similar diagnosis with same prognosis and treatment
- Same entity
- Tall cell variant has poorer prognosis.
- 3 has rather strict criteria and I would be reluctant to make a dg on the basis of a single slide

Case 822 – Gynae

Specimen: Endometrium

Submitted Diagnosis: Normal menstrual endometrium

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Clinical	Macro	Immuno	Image link	Preliminary Results	Final Merge Results
F49. Irregular PV bleeding	**Multiple pale and tan coloured friable pieces of tissue and blood clot measuring 30mm in aggregate.**	**N/A**	***Click here to view digital image***	1. Menstrual endometrium 9.19 2. Endometrial hyperplasia 0.07 3. Hormonal Disorder with irregular shedding 0.17 4. Endometrial stromal & glandular breakdown 0.11 5. (Treat as) Atypical endometrial hyperplasia 0.13 6. Dysfunctional uterine Bleeding 0.18 7. Low grade stromal sarcoma 0.01 8. Proliferative endometrium 0.07 9. Poorly differentiated Endometrial carcinoma 0.07	We will merge 1 & 4 64.29% agreement from 84 responses

General Comments:

- Very good case.
- 3, 5 – clinical diagnoses, not enough history here so can only be suggested
- 6 is not a pathological diagnosis
- Not suitable for scoring
- Rather worrying range of answers here. I think a benign biopsy and calling atypical / malignant is an overcall, Also Number 6 is not even a pathological diagnosis!
- The other diagnoses are either incorrect or clinical diagnoses which are impossible to make with the clinical details supplied!

Case 823 – GU

Specimen: Renal mass

Submitted Diagnosis: Papillary RCC (type I)

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Clinical	Macro	Immuno	Image link	Preliminary Results	Final Merge Results
M72. Left renal mass partial nephrectomy	**Subcapsular cystic lesion weighing 25 grams and measuring 40 x 30 x 35 mm, contains cloudy fluid. Thickness of wall 4mm, with tan necrotic material to the internal surface.**	**CK7 +** **MCK +** **EMA +** **AMACR +** **PAX8 +** **CD10 +** (focal) **RCC+** (patchy/weak) **vimentin +** **CD117 -**	***Click here to view digital image***	1. Papillary RCC 5.63 2. Clear cell papillary RCC 0.67 3. Clear cell RCC 0.83 4. RCC 0.36 5. Papillary RCC Type I 2.22 6. Papillary RCC Cystic variant 0.08 7. Papillary RCC Type II 0.21	Merge 1, 2, 5, 6, 7 Consensus (56.79% of 81 participants) was to merge 1, 5, 6, 7. However, Diagnosis 2 is also a form of papillary carcinoma and should therefore be included **CLINICAL OVER-RIDE**

General Comments:

- Diagnosis of renal cell carcinoma
- Again crossover (option 2), so merges difficult
- A bit difficult to categorize on single slide
- This is papillary renal cell carcinoma. I don't think clear cell/conventional renal cell carcinoma is correct
- Same entity with same prognosis. Clear cell carcinoma is CD10 strongly positive and CK7 negative
- All can have similar histology and IHC.

Case 824 – GI

Specimen: Stomach

Submitted Diagnosis: Schwannoma

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Clinical	Macro	Immuno	Image link	Preliminary Results	Final Merge Results
M69. Wedge excision of a proximal gastric GISTM72. Left renal mass partial nephrectomy	**Wedge of stomach. 50x30x30mm. Margin inked blue. Slicing shows a cream submucosal nodule, 27x25x25mm, lying 7mm from the stapled resection margin.**	**Lesional cells S100 +** **CD117 +** (Patchy background) **DOG-1 -** **CD34 –** **SMA -** **DESMIN –** **Ki67<1%**	***Click here to view digital image***	1. Schwannoma 9.51 2. Hyalinised neurofibroma 0.13 3. GIST 0.28 4. Neurofibroma 0.07 5. Neuroma 0.01	Merge 2 & 4 as clinically valid. This are both "incorrect" diagnoses so participants answering this will be penalised, but not as much as if un-merged. 40.23% agreement from 87 responses

General Comments:

- Nice case, the IHC would seem to make GIST less likely as a diagnosis
- The morphology and immunophenotype is typical for schwannoma. Neurofibroma has genetic implications i.e. neurofibromatosis
- All benign entities, but different
- Classical histology with supportive immunostains.

Case 825 – Skin

Specimen: Skin

Submitted Diagnosis: Merkel cell carcinoma

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Clinical	Macro	Immuno	Image link	Preliminary Results		Final Merge Results
M88. Left shin ? SCC	**Fleshy fragments 18 x 10 x 6 mm**	**CK20 + Cam5.2 + CD56 +** **CK7 –** **TTF1 -**	***Click here to view digital image***	1. Merkel cell tumour / carcinoma 2. Cutaneous neuroendocrine carcinoma	9.90 0.10	Merge all 72.09% agreement from 86 participants

General Comments:

- Eponyms
- 1 is the eponym of 2!
- The same entity x 2
- Though Merkel cell nomenclature should be preferred.

Case 826 – GU

Specimen: Orchidectomy

Submitted Diagnosis: Organising Haematoma

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Clinical	Macro	Immuno	Image link	Preliminary Results	Final Merge Results
M46. Right testicular tumour. Tumour markers normal.	**Radical orchidectomy with testis 50 x 35 x 25mm. Slicing shows a well-defined subcapsular of 12mm with an off white and red cut surface.**	**Perls stain +++**	***Click here to view digital image***	1. Organising Haematoma 8.30 2. Organising haemorrhagic cyst 0.07 3. Testicular infarct, +/- torsion 0.96 4. Haematocele 0.07 5. Adenomatoid tumour 0.15 6. Scar & Haemorrhage 0.14 7. Malakoplakia 0.07 8. Biopsy site with Macrophages & iron 0.06 9. Seminoma / regressed germ cell tumour / choriocarcinoma 0.10 10. Haemangioma & organising haemorrhage 0.08	Clinical over-ride A complex case with many suggestions. The consensus suggested merging 1, 2, 6. However it is clinically relevant to merge 1, 2, 3, 4 & 6. The addition of 10 is not supported by participants and contains a different diagnosis

General Comments:

- Needs a history and clinical path correlation
- Not the other diagnoses; two of which are neoplastic
- Wide range of responses which includes benign and malignant diagnosis
- Disregard from scoring.
- Similar histology

Case 827 – Skin (EDUCATIONAL)

Specimen: Skin

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Clinical	Macro	Immuno	Image link	Suggested Diagnosis (Top 10)	Submitted Diagnosis
M73. Skin lesion below left ear face.	**Piece of tissue measuring 11x6x4mm.**	**N/A**	***Click here to view digital image***	Trichofolliculoma x49 Fibrofolliculoma x42 Benign adnexal tumour x6 Trichoblastoma x5 Trichoepithelioma x4 Folliculosebaceous cystic hamartoma x4 Trichodiscoma/fibrofolliculoma x3 Trichodiscoma x 3 Branchial cleft cyst x 3 Dermoid cyst x3	**Fibrofolliculoma**

Case 828 – Breast (EDUCATIONAL)

Specimen: Breast Tissue

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Clinical	Macro	Immuno	Image link	Suggested Diagnosis (Top 10)	Submitted Diagnosis
F51. Left breast G2 IDC. WLE & SN Bx	**Sentinel node left axilla 1.5g. No macroscopic abnormality**	**S100 +** **No clinical history of melanoma.**	***Click here to view digital image***	Dermatopathic lymphadenopathy x15 Capsular naevus cells x13 SUBCAPSULAR NAEVUS x 9 Dermatopathic lymphadenitis x6 Benign Capsular Naevus x 6 Benign naevus cells in nodal capsule x 5 Naevus cell inclusion x 5 Benign naevus inclusion x 5 NAEVUS CELLS x4 Benign naevus cell aggregates x4	**Intracapsular Benign Naevocytes**

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4. Questions
Comments
Suggestions
Feedback

Thank you for attending. This presentation can be found on the EQA website from next week.

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