

**NOTES OF THE SCOTTISH GASTROINTESTINAL PATHOLOGY GROUP MEETING
HELD ON TUESDAY 12TH SEPTEMBER 2006 AT 1 PM
IN MEETING ROOM 4, PERTH ROYAL INFIRMARY**

Present: *M Balsitis(MB), F Carey(FC), I Brown(IB), F Duthie(FD),
G Murray(GM), B Langdale-Brown(BLB), A Lessells(AL),
R Campbell(RC), R Howatson(RH), A Riley(AR),
C Harper(CH), S Walsh(SW)*

1. INTRODUCTION

Action

Introductions were made. MB made a general introduction to the Scottish Gastrointestinal Pathology Group.

2. SCOTTISH GASTROINTESTINAL PATHOLOGY GROUP – MEMBERSHIP AND REMIT

MB summarised the background of the Scottish Gastrointestinal Pathology Group; this evolved following discussion with FC in 2005 with the initial aim of disseminating information relevant to the Scottish Bowel Screening Programme. This coincided with the development of the Scottish Pathology Network (SPAN) and the GI path group was set up with a view to being a subgroup of SPAN. FC summarised the background to SPAN. As is the case for SPAN in general and other SPAN subgroups, the presence of a group with particular gastrointestinal pathology interest allows for improved communication between pathologists and also between this group and others wishing to communicate with pathologists.

Those present agreed that the activities should be widened beyond preparation for bowel screening and should include an educational meeting such as a yearly meeting with presentations and discussion of previously circulated interesting cases. FC suggested that it may be useful to link with the Scottish Society of Gastroenterology and hold our annual meeting to coincide with their meeting(s). The British Society of Gastroenterology (BSG) Pathology subgroup was mentioned, as well as its EQA scheme. The path subgroup of the BSG is an active group with several educational activities occurring at the annual BSG meeting. It was thought not to be appropriate for this Scottish group to attempt to set up a separate EQA scheme.

FC

The main aims of the group therefore would be

- To improve communication between pathologists on matters relating to gastrointestinal pathology
- To provide gastrointestinal pathology education within the group.

Membership – a formal membership list was not drawn up. Meetings would be open to all Scottish pathologists. It was acknowledged that many pathologists with a gastrointestinal interest were unable to attend today's meeting.

Communication/organisation

- MB will continue as chairperson
- Communication, other than at meetings, will be by email
- Annual meeting, preferably September or late October

MB

- MB will organise 2007 meeting, thereafter responsibility for organisation should rotate around members of the group with a GI interest.

3. SCOTTISH BOWEL SCREENING PROGRAMME

a. *General Update on Programme*

MB tabled documents indicating the organisational structure of the screening programme and the pilot bowel screening pathways. Although the order of roll-out to all NHS Boards has been drafted, this order has not yet been confirmed.

b. *Aspects of Data Collection/Pathology Reporting*

Discussion took place around data items required for the bowel screening programme key performance indicators, the biopsy dataset proforma devised for FC for use in the pilot and problems relating to issuing of proforma reports by individual departments. In view of the variable use of datasets etc. across departments and variable reporting styles it was indicated that in pathology reports for screening specimens the main diagnosis should be indicated in such a way that facilitates recording of the main diagnosis by non-medical audit/clerical staff. FC would discuss computer problems at the next Bowel Screening Programme Board Meeting and request assistance for departments to enable the use of software to allow proforma style reports to be issued.

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FC

The pathology report should include usual patient demographic details and the date of receipt of the specimen and the date of issuing/authorisation of the report. It was acknowledged that pathology reports may include the date of typing however authorisation may be some time after that date. It was indicated that screening specimens should be separately identifiable for example by a stamp or sticker applied to the request form at colonoscopy. Some of those present indicated that colonoscopy electronically generated reports are currently supplied with pathology requests. It was indicated that the collection of data relating to turnaround time and diagnosis should be by audit/clerical staff and not by pathologists.

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HIGH RISK ADENOMA PATIENTS

In order to confirm the adenoma category "high risk adenoma" it is necessary to confirm the number and size of adenomas. It was agreed that the size of a polyp should be recorded as the size of the formalin fixed specimen.

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GRADING OF DYSPLASIA

Those present agreed unanimously that a two-tier grading system of dysplasia should be applied to the colon and rectum (i.e. high grade and low grade). Some departments were already using a two-tier system.

POLYP CANCERS

FC highlighted the difficulty with some polypoid lesions detected by screening and suggested that a mechanism be devised for rapid circulation/2nd opinion on difficult cases. Several suggestions were put forward but no decision made.

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4. NHSQIS BOWEL SCREENING DRAFT STANDARDS - HISTOPATHOLOGY

MB discussed the background to the QIS standards and the recent meetings to discuss the standards.

Standard 6d.1 – It was suggested that this should be shortened.

MB

Standard 6d.2 – It should be clarified that the time referred to here is the time to the date of signing/authorisation. In keeping with suggested changes to the remainder of the document the five working days should be changed to seven days.

Standard 6d.3 – There was some discussion around the criteria relating to CPA accreditation however the majority opinion was that this should remain as it stands.

RH also indicated that Standard 6d.2 (colonoscopy standard) referring to results of colonoscopy should be clarified to indicate that this is the result of the macroscopic colonoscopic findings, not including pathology.

5. OTHER COLORECTAL PATHOLOGY ITEMS

a. HNPCC

SW indicated that immunohistochemical staining and genetic analysis of tumours and patients' blood samples is being undertaken in Dundee. This is being provided for cases coming from all across Scotland and therefore if our local geneticists request HNPCC analysis on tumours, a tumour block should be submitted to Shaun Walsh in Dundee who will cut the appropriate sections for immunohistochemical staining and return the block to the department of origin as soon as possible. A copy of the report will also be sent to the pathologist.

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b. Paediatric Gastrointestinal Group

SW indicated that this group was soon to meet in Crieff. There was some discussion around paediatric gastrointestinal pathology and issues around referring cases for a second opinion. It was indicated that in Glasgow and Edinburgh members of the group were aware that paediatric gastrointestinal pathology reporting was being undertaken by Drs A Howatson and M Evans respectively.

c. RCPATH Guidelines and Minimum Dataset for CRC

FC indicated that he had been informed that the new version would soon be available. AL provided some information from a paper in his possession which included RCPATH guidelines 2006 in the reference list, which appeared to suggest that at least a draft of this document was now available. AL highlighted some points, including recording of tumour perforation and lymph node retrieval from a recent paper by Drs Neil Shepherd and Lin-Marie Ludeman. (Current Diagnostic Pathology 2006 12(3); 220-230.)

Further items discussed included nodal metastases. In breast cancer pathology the TNM 6 classification is applied and therefore descriptions of isolated tumour cells (ITC) and micrometastases may be included in reports. It was generally felt that any tumour cells identifiable on an H&E section should be regarded as a metastasis for the purpose of the pN stage however this is not covered in the current RCPATH guidelines. With regard to lymph node handling, members of the group reported differing practice with regard to processing of lymph nodes in entirety versus sampling large lymph nodes. FC indicated that there was currently a member of staff in his department who could possibly undertake a small survey looking at practice in this area. The current RCPATH guidelines do not suggest any particular approach to lymph node sampling. These difficult areas highlighted should be assessed by members of the group when the draft of the new

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dataset/guidelines is available from the college for comments.

d. Post-chemoradiotherapy Reporting

There was some discussion around grading of tumour response, the significance of mucin pools without carcinoma cells and the importance of including the 'y' prefix for post chemoradiotherapy pTNM staging. The majority of the group interpreted mucin pools without residual carcinoma cells as not representing viable tumour but possibly representing a site previously occupied by tumour.

e. Rectal Carcinoma – Stage pT3 versus pT4

The differing approaches of surgeons, pathologists and radiologists was briefly discussed.

6. ANY OTHER COMPETENT BUSINESS

It was indicated that the next British Society of Gastroenterology meeting would be in Glasgow in March 2007 and that the next Pathological Society meeting would be in Glasgow in the summer of 2007 and this meeting would include a gastrointestinal pathology component.

7. SUMMARY OF AGREED ACTIONS AND FOLLOW-UP

See 'action' points above

8. DATE AND TIME OF NEXT MEETING

The next meeting will be held in September/October 2007. Date and venue to be confirmed.

(Post meeting note – FC has contacted the President of the SSG to re linking with that group)