EQA 23 review session - minutes of meeting held on 24 April 2013 at the Vermont Hotel, Newcastle.

Ahead of scoring the cases, GH informed members in attendance of proposed changes to the scheme.

GH has been in discussions with a software company who already have quite extensive experience in designing and hosting websites for technical EQA schemes and also one interpretative EQA scheme (urology).

Given increasing membership and the fact that we are still administering the scheme by simple word / excel documents with occasional errors in transcription of emails addresses having led to mis-communication of information to some members, we need a more robust administration system. The software company KPMD based in Sheffield can provide a website for this. Online submission of responses will hopefully eliminate human error from the organization of the scheme and avoid the "reply to all" email disclosure of one members responses which happened this time.

The response form will remain in its present form for the time being and once we have adjusted to the new online system, I will see if the software developers are able to develop with us a new form, which may perform some of the analysis automatically.

I discussed at the previous meeting and also with members of BSOMP council yesterday, that the £15 BSOMP membership fee no longer covers the cost of EQA in its present form and once we have to pay a fee per person to the software company, we would be running at a considerable loss.

The proposal is therefore that all participants will be invoiced to their TRUSTS (and not to individuals) for £100 pp. At present I only recover 60% of the £100 invoices sent out to participating Trusts and the web based system will I hope help in continually chasing unpaid invoices. If recovery can be increased, the £100 cost may be reduced in future years as it is not the purpose of the scheme to generate income but we must be able to cover costs incurred.

Second, I discussed the scores of one participant who in

Circulation 21	3 0's
	1 1
	score 27 (lowest recorded score)
Circulation 22	4 0's
	1 1
	score 24 (second lowest recorded score)

to determine if a first action point should be triggered and there was universal agreement that these scores fulfill the criteria for first action point.

There were no other participants with low scores from the last 2 circulations warranting further discussion.

Finally, there is still no clear consensus on how to proceed with circulation 23 given the disclosure of results mid way through receipt of answers. The schedule has been broken into pre email and post email responses as have the scores. The vast majority of emails and verbal communications have been in favour of allocating CPD points for participation in this circulation but with no actions taken against those with low scores as doubt will remain about the impact of the disclosure of results and the unfairness of only flagging those with low scores who got their entries in early.

I will issue all scores in the usual way and we can discuss this matter alongside the scores at the next meeting to see how best to proceed.

Scoring of cases

1. Unanimous answer of granular cell tumour, all score 2.
2. Debate as to whether odontome and ameloblastic fibro-odontoma do constitute polar ends of a spectrum or not. I proposed that both should score 2 as otherwise, we would not have consensus.
   Odonto-ameloblastoma, ameloblastoma scored 0, even with a second opinion as it was thought that in a specialist EQA scheme that the 2 lesions are sufficiently distinct to be distinguished and have quite differinf behaviours. Ameloblastic fibroma scored 1.
3. 90% consensus for adenomatoid odontogenic tumour. Calcifying cystic odontogenic tumour, calcifying odontogenic tumour, pleomorphic adenoma, ameloblastoma and polymorphous low grade adenocarcinoma, all score 0. Thought to be a very typical example and marked behavioral differences compared to ameloblastoma in particular.
4. 2 points for noting and mentioning the epithelial component and designating as Juxtaoral organ of Chievitz / benign epithelial rests (89% saw the epithelial element). 1 point for designating as benign but missing the deep epithelial component.
5. Quite a variety of responses but 70% overall mentioned the possibility of odontogenic fibroma (more in the second post email batch of responses). This case was included in cases 1-6, oral pathology section and members in attendance thought diagnosable as odontogenic fibroma and wished to score the case. Score 2 for odontogenic fibroma as definitive or working or in differential. Score 1 for other benign odontogenic lesions, score 0 for only malignant suggestions.
6. All bar one participant gave viral lesion / herpes as definitive, working or differential and score 2. Pemphigus vulgaris as definitive = 0.
7. Schwannoma / neurilemmoma mentioned by all bar one participants, score 2. Carotid body tumour v pleomorphic adenoma scores 0 as well out of consensus.
8. Basal cell adenocarcinoma and epithelial myoepithelial carcinoma both score 0. Tubular adenoma = 2. Monomorphic PA v epi-myoepithelial

carcinoma =1. 97% of participants basal cell adenoma so a strong consensus for this benign diagnosis, score 2.

9. Strong consensus for angiolymphoid hyperplasia with eosinophilia and / or epithelioid haemangioma = 2. Kimura's disease, haemangioendothelioma v myopericytoma v Kaposi's and Kimura's v LCH v Kaposi's score 0 or 1 depending on work up.
10. No consensus between benign and malignant lesion and scored E educational case.
11. HIV / benign LEL / +/- check for lymphoma =2. Diagnosis of lymphoma without consideration of this benign entity which is well described in HIV + patients score 0. Mucoepidermoid carcinoma and lymphoepithelial carcinoma =0. 94% of respondents were aware of lymphoepithelial lesions in HIV and responded as such.
12. Strong consensus for toxoplasmosis = 2. Reactive lymph node without mentioning granulomas =1. Follicular lymphoma =0 as even with IHC, is well out of consensus. Same for metastatic lymphoepithelial carcinoma =0. HIV with referral =1
13. All but 1 participant mentioning myoepithelioma / cellular PA, both score 2. Solitary fibrous tumour v melanoma v carcinoma =0.
14. Adenoma of middle ear no IHC = 0. Adenoma of middle ear with IHC inc keratins, neuroendocrine markers and S100 = 2 as would get diagnosis Meningioma EMA vimentin only and no IHC for paraganglioma =0 Haemangiopericytoma as definitive =0
15. Sinonasal carcinoma = 1 as not specific enough (covers wide range of squamous and non squamous tumours). Nasopharyngeal carcinoma voted as 0 since it suggests a tumour at a different head and neck site, which is treated by different modalities. SCC moderate / poorly differentiated ex Schneiderian papilloma =2. Adenocarcinoma ex Schneiderian papilloma scores 1 as out of consensus but IHC panel did include p63.
16. Some debate as to whether participants should gain points for 2 points for definitive diagnosis as HL but difficult to argue against this as it is the consensus answer. All mentioned HL so all score 2.
17. All but one participant responded with acinic cell carcinoma =2. Acinic cell tumour scores 1 as inaccurate and not in keeping with WHO 2005 classification.
18. 97% of participants mentioned parathyroid carcinoma = 2. Parathyroid adenoma with no consideration of carcinoma =0. Parathyroid lesion / neoplasm v medullary ca requiring further info = 1 as consideration of malignancy.

Comments

Reminder to participants that options of submitting responses for 1-12 or 7-18 exist. In particular, quite a few 0's awarded for the odontogenic tumours and the option exists to not respond to these if they are not part of your normal reporting practice.

The next review session will take place on the 6th November in London (see attached flyer) alongside a 1 day educational meeting. Members may of course attend the EQA section of the day only without payment but attendance at the full day session carries a fee.

I will aim to get the next set of slides ready for early August and slide boxes are available on request as usual. Once the 50 boxes are gone, I will arrange to share the box with your closest centre. This time we were 2 boxes short requiring these centres to share. We are not yet at a stage where we need to have a formal cell system where centres have the box for a set amount of time and then have to pass it on.

You will receive some email communication over the coming weeks regarding how to register on the website as I would hope to have all registrants on that database by the initiation of the next circulation. In order that we don't miss anyone, I will also send an email to initiate as well but it will be much easier to manage if everyone is on the one system.

Gillian Hall
May 2013