Minutes of the review session held on 6 November, Royal College of Pathologists, London
Head and neck EQA 24

Case 1
In order to achieve consensus, we would have to accept ossifying / mineralizing / calcifying fibrous epulis, fibrous epulis with metaplastic ossification / calcification / mineralization and also peripheral ossifying fibroma as answers. Some don't like the latter as a diagnosis as it implies a neoplastic process but it is a term used in some textbooks (mostly American). Therefore all accepted, score 2.

Fibrous epulis with no mention of the mineralization also voted to score 2.

Giant cell lesion / pyogenic granuloma voted as 1.

Fibro-osseous lesion voted as 0, GH to check work up on those offered as working / differentials.

Case 2
Basal cell adenoma scores 2
Salivary duct papilloma scores 1
PLGA scores 0
Canalicular adenoma as definitive, working or in differential = 2.

Local diagnosis canalicular adenoma

Case 3
Some discussion as to those who did not offer any diagnosis.
Reminder from GH that participants can opt out of cases 1-6 or 13-18 and submit 12 rather than 18 answers to allow more specialized oral pathology cases to be included, to include teeth which were not infrequently included in past circulations.
It is not however possible to just opt out of 1 case
At present, we do not ask for participants to declare in advance as to whether they will do 12 or 18 but is an area that some suggested should be looked at and some favour an upfront declaration.

Dentinogenesis imperfecta as definitive, working or differential = 2
GH to check those with morphological descriptions / work up
The participants voted for 0 points where no answer was offered at all.

Local diagnosis dentinogenesis imperfecta.

Case 4

Solitary fibrous tumour scores 2 (definitive, working or in differential)

Participants voted for 1 for haemangiopericytoma as IHC provided should allow for diagnosis
Kaposi sarcoma as a definitive =0

Case 5

Two participants missed the granular cell component and score 0
Granular cell tumour +/- candida = 2

Local diagnosis Granular cell tumour with florid candidosis.

Case 6

No consensus with more favouring keratocystic odontogenic tumour rather than ameloblastoma. The local diagnosis was ameloblastoma but made with examination of more sections.

Educational case.

Case 7

Oncocytoma / oncoctytic adenoma arising in the background of multifocal oncocytic hyperplasia = 2
Those not mentioning the background changes lose a point, score =1. This was thought relevant since recurrent / persistent nodules would be expected in the setting of multifocal disease and if not highlighted, could lead the clinicians to be misled into thinking they were dealing with a more aggressive disease and result in further surgery.
Acinic cell ca v renal cell ca = 0 as is acinic cell carcinoma as a definitive.

Case 8

Merkel cell carcinoma as definitive, working or in differential, or a differential including neuroendocrine markers and CK20 scores 2

A differential with IHC panel that does not cover neuroendocrine differentiation/ CK20 scores 0. There was a very strong consensus towards a neuroendocrine malignancy.

For those present during the morning session, Dr Ffolkes drew attention to the fact that the RCPath minimum dataset does include information as to the recommended minimum IHC panel when diagnosing this entity.

There was some discussion around Merkel cell carcinoma as a definitive diagnosis without IHC. We have had similar discussions in previous circulations. Members are encouraged to use the working diagnosis section where in real life they would carry out extra work. The EQA response form does not recapitulate a

real life pathology report and so it is difficult to mark down those who give a definitive.

Local diagnosis Merkel cell carcinoma

Case 9

Almost unanimously a chordoma =2
Mucoepidermoid v epithelial myoepithelial carcinoma =0

Local diagnosis chordoma.

Case 10

Myoepithelioma, schwannoma and malignant melanoma as definitive = 0.

Benign myofibroblastic / nodular fasciitis as definitive, working or differential = 2

Benign spindle cell not mentioning nodular fasciitis / myofibroblastic, GH to check work up, likely 1 point if no IHC to cover myofibroblastic lesions.

Clear cell carcinoma v epithelial myoepithelial carcinoma v myoepithelial carcinoma, to check work up but likely 0 as all differentials malignant, this is benign and strong consensus towards nodular fasciitis.

Local diagnosis nodular fasciitis.

Case 11

Lymphangioma / cystic hygroma =2

Haemangioma / hamartoma = 1

Thymic lesions = 0 (check work up)

Lipomatous lesions = 0 (check work up)

Local diagnosis lymphangioma.

Case 12

No consensus as to whether this was a myoepithelioma or pleomorphic adenoma but both acceptable for 2 points.

Myoepithelial carcinoma as definitive = 0

Local diagnosis myoepithelioma.

Case 13

All participants regarded this is adenocarcinoma (various descriptive types: mucinous, signet ring, high grade, ITAC)

Most considered both primary and metastatic disease as possibilities

Some thought this was definitely metastatic and there were some that stated very clearly that this was not the primary site raising the possibility that some are unaware of the entity ITAC.

The clinical history provided was of disseminated disease.

IHC may be helpful in differentiating primary from metastatic disease if there is some CK7 positivity along with positivity for CK20 and CDX2. MDT discussion and further clinical history regarding risk factors would also help. The EQA response form does ask for a diagnosis, not necessarily a discussion of precise origin, which would be dealt with in the MDT.

All score 2 but as an educational note, those who thought that this was not an ENT malignancy should be alerted to the existence of intestinal type adenocarcinoma of nasal cavity / paranasal sinuses.

Local diagnosis was of primary intestinal type adenocarcinoma and the patient had known occupational exposure (woodworker).

Case 14

Ossifying fibroma and juvenile / aggressive / psammomatoid ossifying fibroma accepted for 2 points

Fibrous dysplasia and osteoblastoma as definitive = 0.

Working / differential diagnosis of benign lesions such as fibrous dysplasia, osteoid osteoma, osteoblastoma, cemento-osseous dysplasia score 1, GH to check work-up.

Case 15

All but one participant suggested angiofibroma as definitive / differential / working, score 2.

Haemangioendothelioma as working voted to score 0 as out of consensus.

Local diagnosis: juvenile angiofibroma.

Case 16

Fungus ball / mycetoma =2
I did not pay attention to the name of the species as this was very variable!

Allergic fungal sinusitis as definitive = 1

Adenoma of the middle ear as definitive = 0

REAH, seromucinous hamartoma v inflammatory polyps and rhinoscleroma v plasma cell dyscrasia = 0.

Local diagnosis: Mycetoma

Case 17

Strong consensus for inverted schneiderian papilloma without dysplasia or malignancy.

Those with possible / mild / low grade dysplasia score 2

Those with high grade dysplasia score 0 (GH to check work up if working diagnosis)

Those thinking there was carcinoma score 0

Local diagnosis was inverted Schneiderian papilloma

Case 18

All score 2, diagnosis of paraganglioma also the local diagnosis.

Also discussed

EQA 23: incident of one participant sharing answers via a reply to all email. I have discussed with with BSOMP council and also the RCPath steering committee. The decision is that it is not possible to fairly flag anyone with a low score as the possibility exists that the accidental sharing of answers has affected the consensus. There were quite a few less 0's in the group that came post email. Low scores from EQA 24 will be compared to EQA 22 scores. There were no objections to this at todays meeting.

Website: will be pushing to ensure that everyone registers and ensures all relevant contact info up to date. Aiming to run EQA 25 online but will also send out information via the email list. It will be possible and preferable to submit your answers online.

Invoices: will be sent out late 2013, please pass onto lab manager and try to get these paid asap.

Please consider sending in a suitable case: 50 H&Es or send a block to me. There will be a page on the website where the clinical info can be submitted.

Date of next review meeting: 14 May 2014 in Manchester. Further info to follow. Aiming for a 1 hour educational session ahead of the main review session and have provisionally confirmed a speaker.

Gillian Hall
November 2013