**FRCPath CYTOLOGY**

- Old Curriculum – 8 diagnostic cytology cases, 8 cervical cytology cases. Marked separately.
- New curriculum – 8 diagnostic cytology cases only. Option of CHCCT.
- All sections marked out of 40 with pass mark of 20.
- Candidate unlikely to pass with two major errors in any section.
Need 12 sets of equivalent slides (120 candidates Spring 2013)

Limits the cases that can be selected

- Effusion cytology good
- Bronchoscopy possible with LBC
- FNAs with fluid – cystic neck lumps
- Common conditions – breast carcinoma or fibroadenoma
- Cases are not usually equivocal
EQUIVOCAL CASES

- There are few equivocal cases that lend themselves to the examination setting
  - Thyroid – Thy 3f
  - Breast – Papillary lesions, Cellular fibroadenomas
- With these exceptions, most cases are clear cut examples, either benign or malignant
Most cases have two slides (Pap and Giemsa)
Provided with relevant details, age, gender and brief description of presentation
Expected to provide a short description, diagnosis. Differential or further investigations should only be stated if necessary to make the diagnosis.
Closed marking scheme

- Educationally dubious but it "works"
- Applies to all sections of the exam
  - Surgical
  - Long cases
  - Macro
  - Frozens
  - Cytology
MARKING

- Most cases marked out of 5
- Minimum score even if wrong benign v malignant is 1
- Maximum score is 3.5 (rare in Cytopathology), or 3. Occasional cases the max score is 2.5, usually gynae cytology
- Marking scheme agreed in advance but may be modified on day
MARKING

- All cases marked by two examiners
- Where they give different marks, they discuss answer and agree a mark
- If a candidate is overall borderline 18.5, 19.0, 19.5 then the paper is marked by two more examiners
- If at any stage a candidate scores 20, they have passed
- Some candidates may be marked by two more examiners – a total of 6 examiners
MARKING

- If on marking, a particular case or a particular slide appears to be causing problems, the slide is reviewed by the examiners and if necessary marking adjustments are made.
- Diagnostic material will be present on both air dried and wet fixed slides where they are provided.
HYPOTHETICAL MARKING SCHEME

- Gynae with severe dyskaryosis
  - Severe dyskaryosis – 3
  - Moderate or invasive 2.5
  - CGIN – 2.0
  - Mild/borderline 1.5
  - Negative 1

- 0.5 marks may be deducted if management code is inappropriate for the answer – moderate, repeat 6 months would score 2.0
HYPOTHETICAL MARKING SCHEME

- Non-gynae case – negative fluid
  - Negative – 3.0
  - Atypia – 2.5
  - Suspicious – 2.0 or 1.5 depending on exactly what is said – suspicious but immuno that might give the correct answer – 2.0
  - Malignant – 1.0
EXAMINER DISLIKES - CYTOLOGY

- Endless immuno where not indicated
- MDT discussion advised – the purpose of the MDT is NOT to make the diagnosis
- Over complicating simple cases
- Not using reporting categories – C1, Thy1 etc
EXAMINER LIKES - CYTOLOGY

- Short legible well reasoned answers
- Specific recommendations about further investigation
  - Eg – negative bronchial washings with a history strongly indicative of lung cancer – suggest percutaneous needle biopsy
THE CLINICAL CONTEXT

- Breast Cytology
- Default position is not to remove lumps unless indicated therefore it is important to identify the abnormal areas and select those for surgery
- Adverse impact of false positive is greatest so avoid at all costs
- Triple approach means that false negative is rarely a problem
THE CLINICAL CONTEXT

- Thyroid Cytology
- The default position for a dominant nodule is to remove all dominant nodules
- It is therefore important to be confident in your Thy 2 diagnoses
- If Thy 2 then patient may elect not to have surgery
THE CLINICAL CONTEXT

- Lymph nodes
- If you receive a sample from a node that looks reactive but there is no immuno, then it is fine to say “No high grade lymphoma, no metastatic tumour but cannot exclude a low grade lymphoma”
- For staging FNAs, fine to call negative
THE CLINICAL CONTEXT

- Salivary Gland Lesions
- Reactive/inflammatory
- Tumours

- Tumours – specific easily recognised entities – PSA, Warthin’s, most adenoid cystics
- Tumours – high grade malignancy, should suggest primary or metastatic
THE CLINICAL CONTEXT

- Salivary Gland Tumours
  - For tumours that are not high grade and not one of the easily recognised varieties, may suggest that it is a tumour either benign or low grade malignant but would depend on histological assessment
THE CLINICAL CONTEXT

- Cystic lesions Head and Neck Region
  - For even the most bland squamous lined lesion in the Head and Neck Region it is recommended that in patients over 40 you make a statement that although this looks bland, it is not possible to completely exclude a well differentiated squamous carcinoma
  - However if MR/PET and endoscopy are negative, it is highly unlikely to be malignant.
PASSING THE EXAM

- There are no tricks
- Cases are usually either benign or malignant but if you are not sure then use atypia or suspicious
- Call it as you see it
- Give specific clinical guidance where appropriate
PASSING THE EXAM

- Best preparation is to report cases as they come in to the lab and see a range of negatives.
- Preparation for the exam should not consist of review of teaching slide sets
- The best discriminating cases are almost always fluids. The exam may include up to three fluids. An area of pathology where biopsy is not possible and hence cytology very important.
GENERAL COMMENTS

- The cytology cases are not intended to be tricky
- Treat the cytology cases like a normal day’s work
- Diagnostic material will be present on all slides. If you depend primarily on Giemsa slides for fluid/FNA diagnosis, look at those first.
- Don’t second guess yourself just because it is an exam. First instincts are usually correct.
CHCCT

- Twenty single slide cases
- Four longer cases with multiple slides or statistical questions
- No viva
- Pass rate on average just over 60%