ORIGINAL ARTICLE

The national head and neck histopathology external quality assurance scheme: evolution, design, and analysis of 11 circulations from 1999 to 2005

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The background and design of a specialised head and neck histopathology external quality assurance (assessment) scheme with optional oral and ENT arms is described. Participation (submission of response forms) exceeded 85% in eight of 11 slide circulations. In 60% of the 168 circulated cases, up to 33% (and in occasional cases, up to 56%) of respondents gave incomplete or wrong responses owing to a lack of awareness of specific diagnostic entities or to the misinterpretation of specific histological features. In all, there were 118 wrong responses, of which 58% could be considered “potentially serious”. The scheme incorporates several design features which optimise the educational value. The stringent marking of cases, and the flagging of performances showing “a meaningful deviation in standard” based on the decision of peer members rather than a rigid numerical formula, encourages high standards.

Although external quality assurance/assessment (EQA) is fundamental to quantitative pathology such as clinical chemistry and haematology,¹ there were initial concerns about the value and design of EQA schemes in interpretive histopathology.^{2–5} However, in recent years, these have been largely overcome,⁶ and membership of at least one EQA scheme is now considered a prerequisite for independent reporting in histopathology.⁷ In addition to the regional and local general histopathology EQA schemes, national specialised EQA schemes such as the renal, liver, and paediatric schemes are now well established with full CPA (UK) Ltd accreditation.⁶ The National Head and Neck Histopathology EQA Scheme (HNS) developed gradually from the Oral Pathology EQA Scheme by way of the Oral and Maxillofacial EQA Scheme, and the HNS was launched in January 2002 with twice yearly circulations of 18 cases. Currently, the HNS has a membership of more than 50 pathologists. The present report describes the development of the HNS and its unique design features, together with an analysis of 11 circulations from 1999 to 2005. The main aims of the report are to identify the profile of cases and their suitability, to detail the levels of participation, and to outline the performance of participants.

METHODS

Background and evolution of the HNS

The Oral Pathology EQA Scheme developed from the Oral Pathology slide club and began operating as a pilot scheme in 1993. The dual aims were education and quality assurance (including the detection of substandard performance) in line with the recommendations of the Royal College of Pathologists.^{8,9} The membership consisted of 22 oral pathologists and one ENT/general pathologist. Two circulations of 12 cases were sent out each year and members' responses were discussed at a review session. I took over as scheme organiser in 1996, and gradually developed standard operating procedures (SOPs) and the scoring system for personal performance analysis (PPA). The scheme's name was changed to “The Oral and Maxillofacial Pathology EQA Scheme” (OMFS) in January 1999 to reflect the changing workload of oral pathologists. The current scoring system and SOPs for identifying and dealing with a persistent

substandard performance were established by the second circulation of the OMFS (July 1999). Increasing numbers of ENT/general pathologists either joined the OMFS or expressed an interest in joining, and the scheme was modified to accommodate them. This modified scheme—the HNS—was launched in 2002. The number of cases per circulation was increased to 18 and these were organised into three distinct groups. Cases 1–6 are oral lesions (odontogenic, oral mucosal, jaw bone, and so on). Cases 13–18 are ENT lesions (for example, paranasal sinuses, larynx), and cases 7–12 cover the common territory (such as salivary glands, facial skin, cervical lymph nodes). Each member enters responses to the common group together with responses for either the oral group, the ENT group, or both oral and ENT groups. All members benefit from seeing the complete set of 18 cases and partaking in the discussions at the review sessions.

Standard operating procedures of the HNS

SOPs pertaining to the present report are outlined. Further details are available on the website of the British Society for Oral and Maxillofacial Pathology (bsomp.org), sponsors of HNS.

- SOP 1: Maintenance of SOPs.
- SOP 2: Scheme membership. HNS is available to independent reporting pathologists specialising in oral and maxillofacial or ENT histopathology. Trainees can attend the review sessions.
- SOP 3: Enrolment of new members.
- SOP 4: Obtaining case material. Cases for circulation are submitted by the membership using a proforma. The submitting pathologist's diagnosis is not revealed until the review session. The case must reflect routine practice and a single haematoxylin and eosin (HE) stained section must be representative of the pathological process and permit diagnosis (or at least formulation of a differential

Abbreviations: EQA, external quality assurance/assessment; HNS, Head and Neck Histopathology EQA Scheme; NQAAP, National Quality Assurance Advisory Panel; OMFS, Oral and Maxillofacial Pathology EQA Scheme; PPA, personal performance analysis; RCP, Royal College of Pathologists; SOPs, standard operating procedures

Table 1 An example of how each case is presented in the Schedule of Responses

Female, 66 years. Incidental finding of "leaf fibroma" noted when patient attended for new dentures.		
Total responses:	31	
Definitive diagnosis:	8	
	Leaf fibroma (denture induced FEP) (with florid epithelial hyperplasia)	6
	Necrotising sialometaplasia	1
	Squamous odontogenic tumour	1
Working diagnosis:	18	
	Leaf fibroma with pseudoepitheliomatous hyperplasia/squamous metaplasia	11
	Peripheral squamous odontogenic tumour	4
	Necrotising sialometaplasia, polypoid / atypical	2
	Very well differentiated mucoepidermoid carcinoma	1
Require:	Further levels	8
	PAS/PASD	8
	Discuss with pathology colleagues	3
	Further clinical information	6
	Radiographs	4
Differential diagnosis:	5	
First choice:	Leaf fibroma with hyperplastic and metaplastic salivary ducts	2
	Epithelial hamartoma	1
	Low grade mucoepidermoid carcinoma	1
	Peripheral squamous odontogenic tumour	1
Lists also included:	Peripheral Pindborg tumour, peripheral odontogenic fibroma, odontogenic gingival hamartoma, early necrotising sialo-metaplasia, floridly hyperplastic retrocuspid papillae, denture hyperplasia plus MEC	

diagnosis). Currently, 45 sections of each case are required. On receipt, the organiser checks suitability and logs the case. The organiser with the help of a selection panel of two oral and two ENT members assembles a circulation of 18 cases ensuring a well balanced mix of pathological and tissue categories, degree of difficulty, and so on.

- SOP 5: Initiating a circulation. A set of paperwork (case summary list, response forms and return envelope, time scale of circulation, details of review session) is sent to each member and a box of 18 slides is sent to the senior pathologist at each hospital.
- SOP 6: Confidentiality. Each member has a confidential code number known only to the scheme secretary. Any confidential communication from the organiser to a member is passed to the secretary in a sealed envelope bearing only the relevant code number.
- SOP 7: Submission, receipt, and analysis of responses. Discussion of cases before the review session is prohibited but access to textbooks and journals is allowed. Members complete the response forms as they feel appropriate for each case—in most cases by listing the salient histological features and giving a single "definitive" diagnosis. In other cases, a "working" diagnosis or limited "differential" diagnosis (in order of preference) may be offered if supplemented by an indication of the further investigations necessary to reach a definitive diagnosis. Members are expected to study all 18 cases. They may choose to submit responses for 12 cases (either six oral or six ENT plus the six common cases) or for all 18 cases. After the closing date, the organiser prepares a schedule of responses summarising the submitted diagnoses for each case (see table 1 for an example).
- SOP 8: The members' open meeting and review session. The organiser distributes the schedule of responses which forms the basis of the discussion and mark allocation for PPA. Each case is discussed in turn while the salient features are displayed on a projecting microscope. The submitting pathologist reveals their diagnosis and presents any relevant follow up information. Cases deemed appropriate for PPA are allocated marks: 2 for responses that are judged complete and correct; 1 for responses that are judged incomplete or deficient; and 0 for responses judged to be wrong. The "correct" diagnosis is the consensus majority opinion of members at the review session provided at least 25% of respondents are present.
- SOP 9: Feedback to members. After the review session, the organiser marks the response forms according to the decisions made at the meeting and enters the marks against the relevant code number in a table which thus provides both a personal report and the results of other members for comparison. The table is circulated together with notes on each of the 18 cases, detailing the discussion, decision process, and consensus diagnosis.
- SOP 10: Persistent substandard performance, remedial action, and non-participation. Any member with a 0 or 1 score should review the slide in the light of comments made at the review session. The score table allows an individual member to be alerted in confidence to substantial deviation from their peers. The score table is reviewed at the following review session and members decide which (if any) of the bottom ranked scores represents a meaningful deviation in standard by considering the number and nature of incorrect and incomplete responses. The organiser sends a "Dear Colleague" letter to any participant whose performance is flagged as substandard in two of three circulations (first action point). The letter warns the participant that a similar ranking in two of the next three circulations will trigger the second action point—an investigation by the Chairman of RCPATH National Quality Assurance Advisory Panel (NQAAP). Failure to participate in the any of the next three circulations (without valid documentary evidence) leads to automatic flagging. Failure to reach the minimum acceptable level of participation (two of three consecutive circulations on a rolling basis) prompts a "letter of inquiry".
- SOP 11: Communications and complaints.

- SOP 12: Oversight. The organiser is supported by a deputy organiser and a BSOMP EQA subcommittee. The HNS is scrutinised by RCPATH steering committee for Interpretive EQA, NQAAP, and CPA (UK) Ltd.
- SOP 13: Managerial accountability.
- SOP 14: Finance. The cost of running HNS and its supervision is covered by the BSOMP membership fee.
- SOP 15: Accounting.
- SOP 16: Staffing.
- SOP 17: Training.

Material forming the present report

Circulations 2 to 6 of OMFS—circulations following the adoption of the current scoring system and SOPs for identifying a substandard performance—and six circulations of the HNS form the basis of the present report. Hence, in all, 168 cases were available (60 in the OMFS and 108 in the HNS).

RESULTS

Submission of cases

The 168 cases were submitted by 34 pathologists. Each of these submitted between one and 31 cases (median 3, mean 4.9). Fifteen of the 34 pathologists (44%) had submitted a single case, while three (9%) had submitted in total 68 (40%) of the 168 cases. One pathologist has submitted to all 11 circulations and two pathologists have submitted to nine circulations. In all, nine pathologists have submitted to four or more circulations but the majority of the 34 pathologists (56%) have submitted to only one or two circulations.

Participation rates

The numbers of members, respondents, and review session attendees in each of the 11 circulations are shown in fig 1. The current membership of 50 includes 25 oral pathologists and 25 ENT/general pathologists. Response rates range from 68% to 96% with response rates greater than 85% in eight of the 11 circulations. The membership and response rate increased suddenly with the launch of the HNS in 2002 and a small gradual increase has been maintained. In contrast, apart from the first HNS circulation, attendance at the review session has remained more or less constant. As shown in fig 1, attendance rates ranged from 63% to 80% in the OMFS while attendance rates of only 44% to 56% have been achieved in the last five HNS circulations.

The number of respondents entering the oral arm, the ENT arm, and both oral and ENT arms in each of the six circulations since the launch of the HNS in 2002 is shown in

Figure 1 The number of members, respondents and attendees (y axis) in each of the 11 circulations (x axis).

Figure 2 The number of respondents (y axis) entering the oral arm, the ENT arm and both the oral and ENT arms in six circulations of the HNS (x axis) since 2002.

fig 2. No members entered both arms in HNS1. There has been a gradual increase with each successive circulation and in HNS6, 42% of respondent entered both arms. The number of respondents entering the oral arm has gradually decreased, while the number entering the ENT arm has remained almost constant since HNS2.

Scoring of cases

In 68 (40%) of the 168 cases, all respondents scored 2 marks. In 23 cases (14%), at least one respondent scored 0. In 35 cases (21%), at least one respondent scored 1 mark. In 33 cases (20%), there was at least one 0 and at least one 1. The remaining nine cases (5%) were graded E and excluded from PPA scoring. The reason for exclusion is shown in table 2.

In the 56 cases with scores of 0 or 0 and 1, the number of 0 scores per case ranged from 1 to 8 (median 2, mean 2.1). In 50 of the 56 cases (89%), there were between one and three scores of 0 per case (less than 10% of total responses). At the top of the range, 28% of respondents scored 0 (7 of 25 respondents in one case (complete correct diagnosis: ameloblastic carcinoma)) and 8 of 29 respondents in a further case (complete correct diagnosis: pleomorphic adenoma with squamous metaplasia)).

In the 68 cases with scores of 1 or 0 and 1, the number of 1 scores per case ranged from 1 to 24 (median 2, mean 2.6). In 53 of the 68 cases (78%), there were between one and three scores of 1 per case (less than 10% of total responses). At the top of the range, 53–54% of respondents scored 1 (22 of 41 respondents in one case (sequestra with *Actinomyces* and *Aspergillus*) and 24 of 45 respondents in a further case (chronic sclerosing sialadenitis with sialoliths)).

In the 33 cases with a mixture of 0 and 1 scores, the number of 0/1 scores per case ranged from 2 to 23 (median 4, mean 5.2). In 31 of the 33 cases (94%), there were between two and nine 0/1 scores per case (less than 33% of total responses). At the top of the range, 55–56% of respondents scored 0 or 1 (16 of 29 respondents in one case (pleomorphic adenoma with squamous metaplasia), and 23 out of 41 respondents in a further case (sequestra with *Actinomyces* and *Aspergillus*)).

When the responses to all 11 circulations are considered, there were in all 118 scores of 0, and 69 of these (58%) were potentially serious (misdiagnosing a benign lesion for a malignant lesion and vice versa, or giving an incorrect diagnosis that would affect the management). Examples included a diagnosis of desmoplastic melanoma when the correct diagnosis was dermal melanocytic naevus with neurotisation, and ameloblastic odontoma when the correct diagnosis was a complex odontome.

Scoring of participants

The total PPA scores of respondents in each of the 11 circulations are shown in fig 3. Figure 3A shows the scores in the five OMFS circulations. Panels B, C, and D in fig 3 show

Table 2 The submitting pathologist's diagnosis and reason for exclusion from personal performance scoring in cases graded E

Submitting pathologist's diagnosis	Reason for exclusion
Glandular odontogenic cyst	No consensus: split between mucous metaplasia in a residual dental cyst and mucoepidermoid carcinoma
Moderate squamous epithelial dysplasia	No consensus: split in interpretation of "keratin granuloma" within submucosa
Ameloblastoma with ghost cell formation	No consensus: a range of odontogenic neoplasms including odontogenic carcinoma
Glandular odontogenic cyst	No consensus: split between nasopalatine duct cyst and glandular odontogenic cyst
Acinic cell carcinoma	Incomplete clinical information. Possible metastasis from carcinoma of prostate.
No evidence of neoplasia	Deemed "educational" following a discussion of reactions to fine needle aspiration biopsy of lymph nodes
Metastatic oncocyctic papillary thyroid carcinoma	Deemed too difficult
Nodular fasciitis	No consensus other than "myofibroblasts" present
Inflammatory nasal polyps	No consensus: some members diagnosed dysplasia

the scores of respondents entering the oral arm, the ENT arm, and both oral and ENT arms, respectively, in the six HNS circulations. One case was deemed E in circulations OMF 1, 2, and 5 and circulation HNS4; two cases were deemed E in circulation HNS5; and three cases were deemed E in circulation HNS3 with a consequent reduction in the maximum possible scores.

The scores of 18 in OMS2, 15 in OMF5, 26 in HNS3 (two respondents), 17 in HNS4 (two respondents), and 18 and 24 in HNS5 were flagged as meaningful deviations in standard. In circulations OMS3, OMS4, HNS1, HNS2, the lowest scores were discussed and it was decided that they did not signify a meaningful deviation in standard and hence no respondents were flagged. The scores for HNS6 will be discussed at the next review session. To date, no respondent has been flagged in two of three consecutive circulations and hence no action points have been triggered.

Resignations and non-participation

There have been five resignations owing to retirements. All five were oral pathologists and have been replaced by newly qualified oral pathologists. Two ENT/general pathologists have resigned because of changes in their job plans—they no longer report diagnostic head and neck histopathology.

"Letters of inquiry" have been sent to 13 members. Ten replied with apologies and assurances that they would respond to future circulations. The majority of these cited "pressure of work" as the major reason for their non-participation. The other three inactive members failed to make contact before the deadline and hence their membership was cancelled.

DISCUSSION

Although the HNS is a small specialised EQA scheme specifically designed to suit the needs of oral and ENT pathologists, its concept and design, and many of the challenges it faces, are common to most interpretive EQA schemes. Hence, analysis of the first 11 circulations provides data of potential interest to general pathologists and to the bodies responsible for oversight of interpretive EQA schemes. The prime purpose of the HNS is educational, reflecting its origin in the oral pathology slide club. The unique design of separate oral and ENT arms allows all members to benefit from seeing a wider range of cases without the pressure of submitting diagnoses for lesions that they may only rarely encounter in their routine workload. Exposure of ENT pathologists to the range of rare odontogenic tumours is a good example. The schedule of responses provides details of "further investigations" which provide a useful update and peer comparison. The discussions at the review session allow further exchange of ideas and dispersal of new knowledge. Several members are highly respected authors in specific

diagnostic categories and their contributions at the review session greatly enhance the educational value of the discussion. References that are cited at the review session and specific diagnostic tips are outlined in the notes of the review session, which thus provide a valuable resource for both attendees and non-attendees. The offset of these design details is the time involved in analysing the response forms and preparing the schedule of responses and notes on the review session. The interpretive nature of the scheme and free text answers means that each response has to be analysed by the organiser, interpreted, and collated.

As detailed in the results section, only 34 pathologists have contributed to the circulated slides to date, and the majority of these have contributed several cases. Some pathologists have contributed unsuitable material. SOP 4 details that CPA (UK) Ltd accreditation of the submitting pathologist's laboratory is expected and participation in an approved technical EQA scheme is the minimum acceptable evidence of technical standards. Nevertheless, some cases have been rejected on technical grounds. The major reason for rejection, however, is the diagnostic difficulty. Despite guidance, some pathologists submit "one-off" lesions that may result in an interesting discussion but no consensus opinion on scoring for PPA. Other members have been tardy in submitting even one case, despite frequent reminders. Staff shortages and heavy technical workload are the most frequently cited explanations. As organiser I am under pressure to assemble well balanced circulations within a strict time scale and I adopt a flexible attitude to the expectation that members should submit one case a year. I tend to compensate by approaching reliable members who thus may submit several cases per circulation. It could be argued that submitting pathologists have an unfair advantage in knowing the diagnosis of their own cases but this does not invalidate their responses as the "correct" diagnosis is normally the consensus view, which may not necessarily tally with the submitting pathologist's diagnosis.

The background of the HNS means that oral pathologists accounted for over 95% of the membership in the early years. The number of oral pathologists has remained steady, and new members are nearly all ENT pathologists. ENT pathologists now account for 50% of members. A large percentage of oral pathologists attend the review sessions and regard these as invaluable continuing professional development (CPD) events. Only a small percentage of ENT pathologists are regular attendees and hence, as seen in fig 1, the attendance rate has remained more or less constant despite the rise in membership. Nevertheless, sufficient members have always been present for the meeting to be quorate. Poor attendance at review sessions has been noted by the organisers of other histopathology EQA schemes and is regularly discussed at the annual meeting of scheme

Figure 3 The total personal performance scores of respondents. The scores of respondents in the five circulations of the OMFS are shown in (A). The scores of respondents entering the oral arm, the ENT arm, and both the oral and ENT arms in six circulations of the HNS are shown in (B), (C), and (D), respectively. Flagged scores are in bold. HNS, Head and Neck Histopathology EQA Scheme; OMFS, Oral and Maxillofacial Pathology EQA Scheme.

organisers and the Chairs of the RCPATH NQAAP and Steering Committee for Interpretive EQA Schemes. One of the HNS review sessions is held during the annual scientific meeting of the BSOMP. Arranging a scientific programme that is attractive to ENT pathologists may encourage their attendance. Varying the timing, day, and venue of the second

review session, or a single annual review session where both circulations are discussed, are other simple suggestions that may be worth trying. A single annual review session has the major drawback of possible delay in identifying a substandard performance and prevents poor performers from taking remedial action before the following circulation.

Participation rates of both oral and ENT members are high, and most members respond to every circulation. There has been a gradual trend for oral pathologists to submit responses for all 18 cases and this accounts for the decrease in oral arm respondents since HNS2 (fig 2). Figure 2 shows also that the majority of new members are entering both oral and ENT arms. The trend for oral pathologists to enter both arms probably reflects increased confidence in their diagnostic expertise following the exposure to the ENT cases in earlier circulations, and also changing workloads and the need to meet obligations to enter relevant EQA schemes.

There is no accepted definition of an ideal EQA case. The present report shows that in 40% of the cases, all respondents scored 2 marks. It could be argued that perfect scores should be achieved in nearly all cases with only an occasional award of 0 or 1. On the other hand, cases with perfect scores generate little discussion at the review session and hence it could be argued that these have limited educational value. This is one of the fundamental difficulties of using an EQA scheme for both education and quality assurance. Selection of more challenging cases stimulates an educationally valuable discussion but often results in a lack of consensus, forcing a designation of E and thus rendering the case unsuitable for performance scoring. Members of the HNS adopt a flexible approach and on occasions cases are scored even if less than 50% of respondents have given what is deemed the complete correct diagnosis. The case of pleomorphic adenoma with squamous metaplasia mentioned in the results is a good example. Twenty eight per cent of respondents scored 0 because they diagnosed mucoepidermoid carcinoma, and a further 28% scored 1. A respected authority on salivary tumours was at the review session and led an informative discussion, including tips on why the tumour was not a mucoepidermoid carcinoma, and hence it was decided that the case was valuable for EQA purposes despite the lack of a clear consensus in the written returns.

There has been a tendency to assign an increased proportion of 0 and 1 scores in recent circulations (fig 3). There are several possible explanations, including more diverse background and experience of members—such as the infrequent exposure to odontogenic lesions and more newly qualified members; more difficult cases; and a more stringent application of the scoring criteria. It is important to remember that as a specialist EQA scheme, we expect members to be fully familiar with the full range of lesions covered in the relevant WHO international histological classifications, and also to be aware of recently described diagnostic entities. Hence the circulated cases may include examples of lesions that general pathologists may refer for a second opinion. The unique design of opting to enter either the oral or the ENT arm was developed to prevent a watering down of the specialist nature of the scheme. Members are required to respond to all 12, or if they opt to enter both the oral and ENT arms, all 18 cases, in each circulation. They may indicate on the response form (under the banner “further investigations”) that they would wish to discuss the case with an expert/colleague, and members at the review session will decide whether the referral was appropriate and take this into account when allocating scores. Failure to appreciate fully the expected level of specialist knowledge and expertise probably explains many of the 1 scores. For example, failure to recognise the “mural plaques” in a developmental lateral periodontal cyst was deemed an incomplete answer and

scored a mark of 1. Members at the review session decide what constitutes the complete correct response for each case, and listening to the discussion and accepting the consensus view ensures that the allocated marks accurately reflect the standard of the peer group. In a specialised scheme run on the lines of the HNS, an ideal case (that is, one that balances the two roles of education and maintenance of standards) is perhaps one in which 10% of the responses score 0/1.

Although participation in an EQA scheme is considered compulsory for independent reporting, its role in identifying a substandard performance is uncertain and the imperfections and shortfalls have been discussed at length.^{6,7,10-15} The findings in the present report show that scores of 0 or 1 are commonplace (fig 3). In some cases, sporadic errors occurred because the respondent was unaware of the specific diagnostic entity. The misdiagnosis of a calcifying odontogenic cyst as a unicystic ameloblastoma is a typical example. Other errors appear to be caused by misinterpretation of specific histological features. The misdiagnosis of a fibrolipoma as a well differentiated liposarcoma probably reflects misinterpretation. The HNS accommodates these sporadic lapses unless the respondent has several "lapses" within a single slide circulation. The SOPs define a substandard performance as a meaningful deviation in standard when the lowest ranked scores are examined rather than the more usual criterion of rigidly flagging the bottom ranked 2.5%.^{6,7} Our approach copes better with the relatively small number of respondents in each arm, and allows a more subjective consideration of the nature of the errors, the degree of difficulty of the cases, and the performance of other low scorers. No member has been flagged in two of three circulations. Hence it could be argued that the scheme does achieve its second purpose of maintaining standards. It appears that flagged members take remedial action and that this is successful.⁶ It should be remembered also that a single low score may reflect rushed or careless submissions,¹² and following flagging, the pathologist makes more effort to return accurate responses.⁶ The longitudinal performance of respondents in the 11 circulations will be considered further in a separate report.

Confidentiality is an important aspect of interpretive EQA schemes.^{6,10} The unique code number known only to the member and the scheme secretary, and the "double envelope" technique, work well and only one member has been issued with a new code number after inadvertently revealing the original. Most members talk freely at the review sessions and openly discuss their diagnoses and thought processes. Given the pace and clamour of the discussion, it would be almost impossible for the organiser or another member to recall who said what or to successfully work out a member's code number, even if they had the will to try. The atmosphere during the discussion of cases is generally friendly and the good will of members has been maintained throughout the evolution of the scheme and development of the SOPs. The spirit of peer review can be maintained if an effort is made to listen to all members who are trying to contribute to the discussion, and by voting with a show of hands when necessary.

BSOMP sponsorship of the HNS offers several advantages. It provides an additional tier of management and support, and maintains goodwill and a sense of ownership. The most important advantage, however, is the financial support. The annual subscription to the BSOMP includes membership of the HNS and hence the scheme organiser does not have the burden of issuing invoices and collecting subscriptions as this is all done by the BSOMP treasurer. Part of the cost of the HNS is spread among the members, as each member is expected to submit cases regularly and thus the cost of labour and consumables is picked up by the submitting pathologist's

Take home message

In a specialised head and neck histopathology external quality assurance scheme, stringent marking of cases and flagging of deviant performances based on the decision of peer members rather than on a rigid numerical formula encourages high standards.

Trust, leaving the BSOMP to finance running and oversight costs. No charge is made for the organiser's time; in my own case I am a university employee with an honorary Trust contract and both the university and the Trust accept the role of organiser as part of my agreed job plan.

In summary, the experiences of the HNS show that participation in an interpretive histopathology scheme is an important part of histopathology practice, offering invaluable educational experiences and an excellent opportunity to compare ones own knowledge and diagnostic expertise with a wide peer group. To gain maximum benefits, members must attend and participate in the review sessions. The time and effort of the organiser and staff, and other members, should not be underestimated.⁶ In addition to the "routine" of preparing and analysing the two slide circulations each year, there are additional demands such as CPA accreditation inspections and preparation of annual reports to the various overseeing bodies and tiers of management. One of the new challenges facing the HNS is the ability to cope with an increasing membership. Expansion of pathology workload, increased specialisation with general pathology departments, and the RCPATH policy of encouraging membership of multiple EQA schemes⁶ are likely to lead to a continued gradual increase in applications to join the scheme. The current need for 45 stained sections for each case already limits the availability and selection of small oral and nasal mucosal lesions. Wider sharing of slide boxes and the use of electronic images could offer a partial solution but the problems of an increased workload for the organiser and staff would remain. Furthermore, the schedule of responses would become unwieldy. A change in the format of the response sheet with abolition of free text, and electronic capture and analysis of data, may become necessary, and such possibilities will need to be discussed at future review sessions. If there is strong support among members for maintaining the present format, then ultimately it may be necessary to split the scheme (possibly on a regional basis) into two or more smaller ones.

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ECHO.....

More endoscopists improve outcome for upper GI cancer

Please visit the *Quality and Safety in Health Care* website [www.qshc.com] for a link to the full text of this article.

More endoscopists may be the answer to better outcomes for upper gastrointestinal (GI) cancer, as recent improvement seems to owe more to the introduction of nurse endoscopists than the UK government's two week wait scheme for a specialist consultation, according to doctors in one cancer unit.

True enough, the odds of curative resection increased significantly (odds ratio 1.48) in their unit in the two years after the scheme was introduced compared with the two years before, and curative resections for early (stage 1 and 2) cancers rose from 47 to 58. But only two patients (5%) of 38 diagnosed with the cancer out of 623 referred under the scheme had early stage disease compared with 56 (27%) outside it. Furthermore, just over a third of patients with early stage cancer had symptoms consistent with the referral criteria in the scheme, but only two of them were referred under it.

When the scheme was implemented at Norfolk and Norwich University Hospital, in September 2000, it coincided with appointment of two full time nurse endoscopists, which reduced routine waiting times for endoscopy—and probably accounted for the improvement.

Under the scheme guidelines for urgent referrals for upper GI cancer were issued to general practitioners to ensure timely specialist evaluation. Detecting the cancer early is key to curative treatment, but symptoms can be unreliable. This may be why reducing times for routine endoscopy may be the best option.

The UK government has been under pressure to improve its poor record on upper GI cancer outcome in western Europe.

▲ Spahos T, *et al.* *Postgraduate Medical Journal* 2005;**81**:728–730.