Approach to the cytology exam

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FRCPath Cytology course
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- Course format
- Handbook
- Slide collection boxes
- Broken slides

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Cytology exam advice

- Low power scan – quick answer
- Look at lots (and lots) of cytology cases
- Current & historic cases
- Look at lots of examples of each entity, cytology can be highly variable
- Even when doing histology pay attention to the cytomorphology

Marking

Exam is marked out of 40

In reality the maximum achievable is 28

Pass mark is 20

Serious errors (1.0) are a problem

3.5 is maximum achievable for more complicated cases

Not all cases are scored equally

Maximising your marks

- **DESCRIPTION** = 1 mark so be BRIEF eg cellular sample with….

- **DIAGNOSIS** = 1.5 if fully correct

2.5 puts you on course for a baseline pass with no room for error
Give one diagnosis! Eg. atypical cells present.
Differential lies between….
Only give a differential if you need to

Other 1.0 marks for:

- **PLAN**

1. Make a cell block
2. Immunohistochemistry table
   - Know immunos for met adeno in pleural & ascitic fluid for males & females
   - Know meso versus adeno versus reactive mesos immuno panel
3. Clinical / radiological correlation and discuss at MDT with details!!

- **COMMENT**

Write 2 or 3 points demonstrating clinically relevant background knowledge eg
Aetiological factors, genetic associations, other things to consider….

THIS WILL GET YOU THE EXTRA MARKS!

General advice

- Do not guess – in the patient's interest and your own, if you genuinely can't decide, consider calling it atypical explain the issue and how you would achieve a diagnosis
- Mentally prepare yourself - how you will avoid mid-exam panic and meltdown. Visualise this.
- Use your time wisely – write short descriptions
- Present your scripts as **clearly and neatly** as possible.
- Consider using a highlighter pen

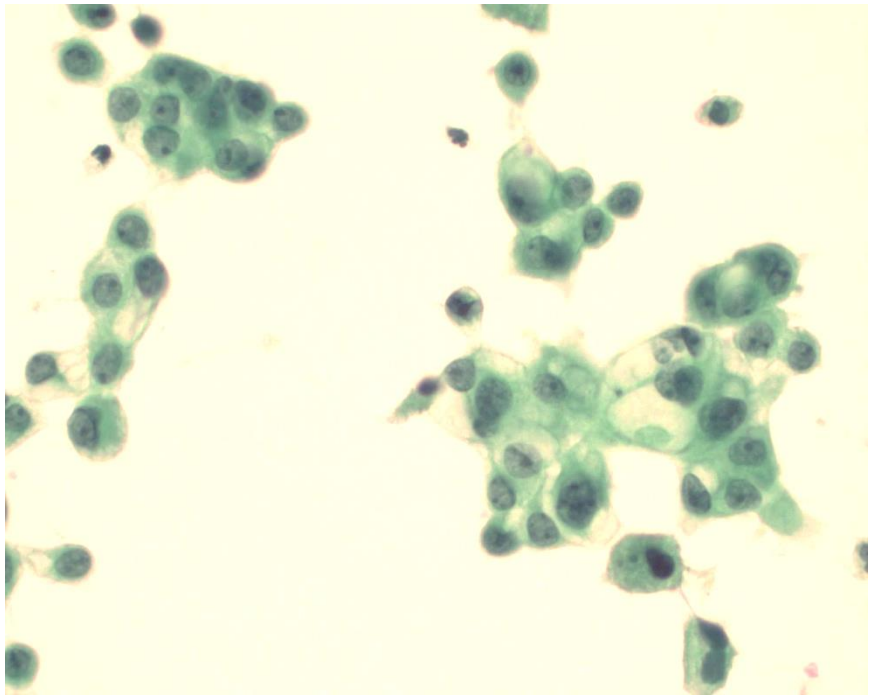
Becareful

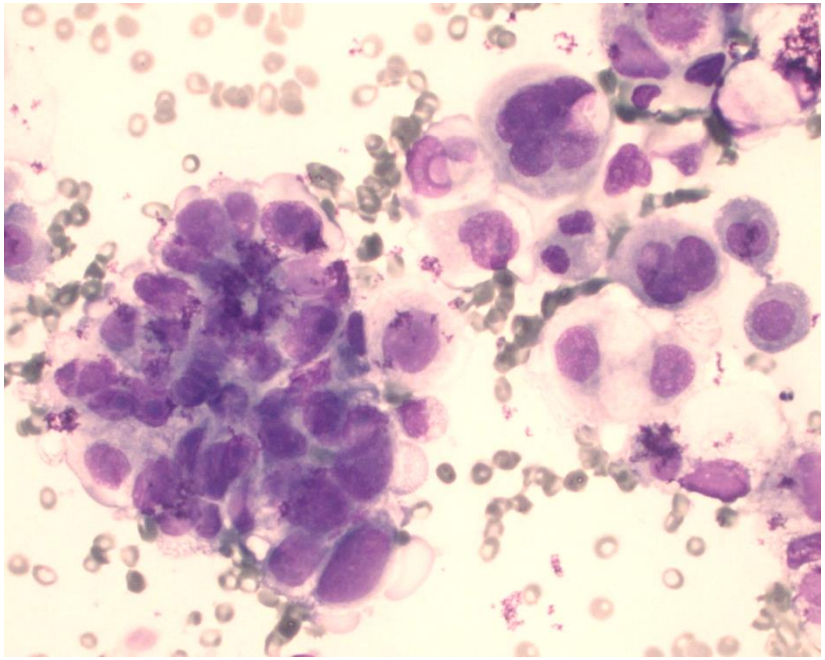
- Histories may be helpful or misleading. Make sure the history ties in with the findings
- Eg. Patient with known benign breast lump has metastatic adeno on pleural fluid – consider review of the histology to confirm it was benign. Consider other primary sites
- Patients with gastric cancer post chemotherapy with SOB - Consider metastases or infection esp. opportunistic infections
- Cystoscopy NAD with urothelial carcinoma – suggest checking upper tracts

Example 1

Female 68yr Ascites

- Ascitic fluid





Example 1

Description

Cellular sample containing groups of malignant epithelial cells showing nuclear pleomorphism with increased nuclear: cytoplasmic ratios, coarse chromatin, irregular membranes and cytoplasmic vacuolation.

Diagnosis

Metastatic adenocarcinoma

Plan

1. Make a cell block
2. Immunohistochemistry is required to suggest the primary site: eg

	CK7	CK20	CDX2	ER	WT1	PAX8	CA19.9	CEA	TTF1
Gynae	+	-	-	+	+ (serous)	+	+/-	-	-
UGI / HPB	+	+	-/+	-	-	-	+	+	-
LGI	-	+	+	-	-	-	+/-	+	-
Breast	+	-	-	+/-	-	-	-	-	-
lung	+	-	-	-	-	-	+/-	-	+

Comment

Correlation with imaging studies and clinical history is essential to guide management

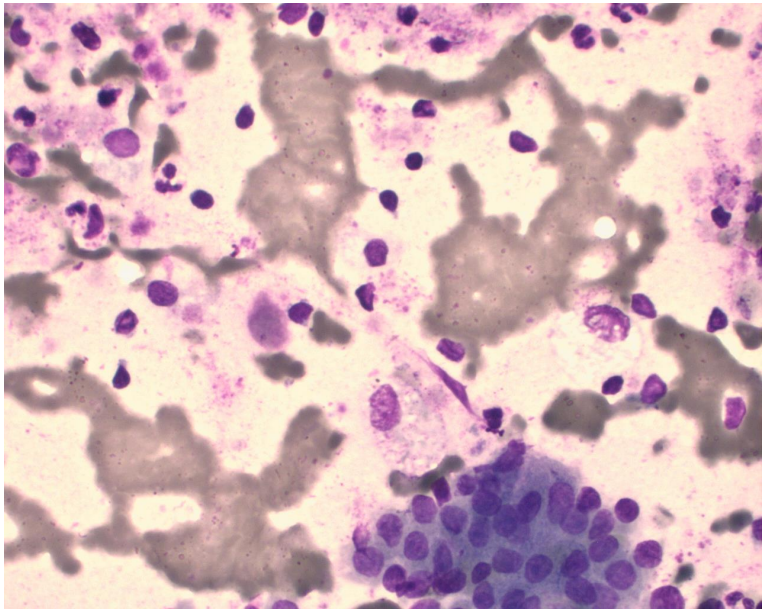
Is there a known primary tumour?

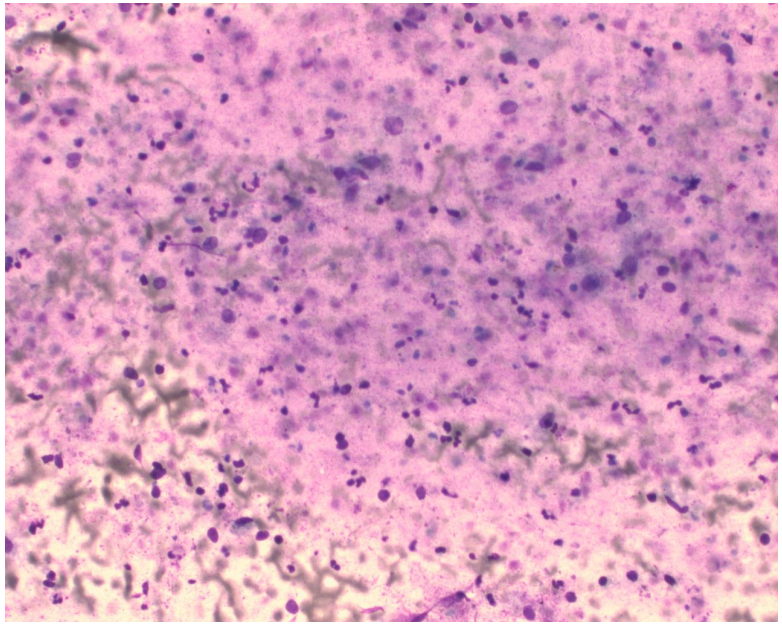
Discuss at the relevant MDT

Example 2

Female 70 Yr. Parotid nodule

FNA Parotid





Case 5

Description

The aspirate contains numerous sheets of benign oncocytic epithelial cells in a background containing lymphocytes and degenerate cell debris.

Diagnosis

Warthin's tumour

Comments

Warthin's tumour has a preponderance for older male smokers.

It can be multifocal and occasionally bilateral.

Presentation may be with a very rapidly enlarging mass.

In the presence of a clear FNA diagnosis and radiological correlation, clinical follow up rather than surgery may be discussed with the patient.