ASSOCIATION OF BREAST PATHOLOGY

NCCBP

Updated guidance for breast pathology staff in the COVID 19 pandemic, November 2020

Pathology specimen handling and reporting

We previously recommended (March 2020) that surgical specimens should not be submitted fresh and sliced or biobanked during the COVID 19 pandemic. This enveloped RNA virus is rendered inert by formalin fixation but, if slicing of unfixed samples is undertaken from patients of unknown COVID status, it remains the advice that this should be carried out in a Microbiological Safety Cabinet (MSC) and the specimen then fixed overnight.

It is now, however, the case that patients undergoing breast surgery have had negative tests for COVID 19 in the majority of units and have self-isolated prior to their surgery. It is important that this information is provided on the surgical request form. If the surgical specimen is from a patient with a negative COVID test, surgical specimens can be handled as prior to the COVID outbreak.

It remains the situation, as per 2016 RCPath breast guidelines, that optimal fixation should be attained in order for assessment of routine prognostic factors. If this remains problematic, procedures put in place because of the pandemic, for example, incision of large specimens from the posterior aspect by the surgeon in theatre, may have proven helpful and should thus be continued. This advice remains appropriate for patients with unknown COVID status.

Once a surgical specimen has been sliced and appropriately fixed, it should be cut up and reported as per 2016 RCPath breast guidelines.

All smaller (e.g. core or VAB) biopsies, can be treated as per RCPath non-operative guidance (also 2016) if received in fixative, as this will render the virus inert in the same way it does for other viruses (such as other coronaviruses, Hepatitis and HIV).

Reporting

It is clear that a range of approaches has been applied in pathology departments since March 2020 and work practices have not returned to previous patterns. In some departments, when specialist breast pathologists have not been available, non-breast specialist pathologists (who may, for example, not be routinely be participating in the Breast EQA scheme) are assisting / have assisted with service delivery. As previously recommended, review of such cases, particularly if difficult, is advised. Fewer laboratory staff are present, due to both the need for distancing in the histopathology department and self-isolating if required. In some units pathologists are still working from home, at least some of the time.

Operations on cancer patients, including oncoplastic procedures and immediate breast reconstructions are being performed in all UK regions but, in some hospitals, particularly with additional waves of the virus, surgical workload remains affected. However, the national breast screening programme has re-started and the breast EQA circulation has now returned, albeit in digital format. Whilst several successful breast conferences have been held virtually, fulfilling the QA requirements for breast screening pathology has been problematic for many. It is recognised by the breast screening QA team and the NCCBP that not all of the breast screening pathology QA requirements may be met at present; for example, the targets for numbers of breast cases reported by an individual.

Previous guidance noted that risk for patients with ER positive / HER2 negative tumours can be further stratified by molecular tests. In some centres, Ki67 assessment was preferred. Some patients have been treated with bridging endocrine therapy (or indeed longer term primary endocrine therapy). It is important to note that if molecular assays are subsequently requested, if these have not been performed prior to treatment, they should be performed on the core biopsy and not on the surgical specimen. If comparison of Ki67 frequency is requested on core biopsy and surgical excision, the option of both being examined contemporaneously and by the same methodology / pathologist should be considered.

MDT Meetings (MDTMs)

In many centres MDTMs have changed significantly, being attended remotely by a range of participants, including breast pathologists in some. There are challenges associated with this, such as difficulties in undertaking histological slide review (unless slides are digitalised). However, this is likely to continue and, at present, the number of staff attending MDTMs in person should be limited with appropriate wearing of masks and social distancing. MDTMs should still aim to be quorate. It remains essential to document and record patient management. Any patient plan in variance with “normal circumstances” should be recorded so that there is a mechanism for identifying in the future where treatment plans have deviated from standard of care and to ensure that these do not miss more appropriate treatment in due course.

Whilst it is welcome that many clinical trials have now recommenced recruitment, and research programmes have restarted, individual departments and hospitals will need to decide when it is appropriate to participate in research activities and clinical audits (previous guidance was to suspend these); ideally this should be as soon as possible.