Journal-based learning (JBL) exercises are a regular feature of CPD coverage in The Biomedical Scientist. You may complete as many JBL exercises as you wish and you are not restricted by specialty.

JOURNAL-BASED LEARNING EXERCISES

Each article’s contents should be read, researched and understood, and you should then come to a decision on each question. The pass mark is 17 out of 20 questions answered correctly. JBL exercises may be completed at any time until the published deadline. Please select your choice of correct answers and complete the exercises online at: ibms.org/go/practice-development/cpd/jbl

DEADLINE WEDNESDAY 2 AUGUST 2017


01 The BAC code of practice guidance will only be useful for NHS cytology laboratories.
02 Consultant pathologists working in the CSP do not need any experience of the programme and will not require any training.
03 A lead biomedical scientist within cervical cytology must be actively involved in cervical cytology, usually as a checker or consultant biomedical scientist.
04 It is recommended that the work of tumour agency staff for screening is double-screened for at least one week by checker staff.
05 All hospital trusts in England providing any element of the NHSCSP must have a formally appointed hospital-based programme coordinator.
06 Hospital-based programme coordinators must have a basic understanding of the NHSCSP.
07 Cases referred by the primary screener as high-grade dyskaryosis and considered negative or inadequate by the checker must be passed to a second checker or more senior staff for review before reporting as such.
08 Checkers also participating in primary screening should screen a minimum of 750 slides per annum.
09 Checking of cervical screening samples can only be carried out for a maximum of five hours per day.
10 All samples awaiting transportation or in transit must be refrigerated.
11 Where any discrepancy is noted between the vial and the request form, the sample should be destroyed.
12 Staining QC checks should be carried out daily and also for each new batch of stain by appropriately trained screening staff.
13 Non-microscopic duties can act as breaks from microscopy.
14 A recently published study on LBC adequacy concluded that SurePath slides require a minimum average cell count (MACC) of 15,000 and for ThinPrep 5000 to achieve a balance between sensitivity and adequacy rates.
15 Where the Hologic ThinPrep Imaging System is used the primary screener will examine 22 fields of view and if any potential abnormality is found a full manual screen of the whole sample must be performed.
16 Where rapid prescreening is used the laboratory must ensure that any abnormal samples are removed from the primary screening workload.
17 Split or multisite working may require the use of video conferencing but at least some of the MDTMs should involve direct face-to-face contact in order to help maintain and develop professional working relationships among members.
18 Mandatory NHSCSP performance measures are inadequate/rates, PPV and referral value, with the satisfactory performance range being the 10th–90th percentile.
19 TPV, APV and PPV/APV plot diagram, mean CIN score and HPV-positive rate for BNC/low-grade samples may be useful parameters for assessing laboratory performance.

REFLECTIVE LEARNING

01 Discuss how the BAC code of practice is applied within your laboratory. What approach would you take to implement the changes?
02 Critically evaluate how your laboratory complies with Standard 4 – ’Screening and reporting of cervical cytology’.
03 Suggest and justify a diagnostic repertoire of two to three assays to maximise detection of hereditary spherocytosis without access to a flow cytometer.
04 With reference to assay design and pathophysiology, describe why the EMA-binding test may have greater sensitivity to hereditary spherocytosis than the other assays described in this paper.