The British Division of the International Academy of Pathology
www.bdiap.org

The BDIAP Newsletter 50th Anniversary Issue

JANUARY 2012

BDIAP PRESIDENT
PROFESSOR NEIL A SHEPHERD

Inside this Issue

2011 has been a special year for the BDIAP. It has been our 50th Anniversary. The Division was initiated back in 1961 by Dr George Cunningham. His profound influence on the Society, in its early days, is, of course, celebrated in the naming of a BDIAP Medal, acknowledging those who make a substantial contribution to the BDIAP. This year, as seen elsewhere in this Newsletter, the Cunningham Medal was awarded to Ms Elizabeth Whelan, who has made such a huge contribution, over many years, to that very important organ of the BDIAP, its journal *Histopathology*.

Through the years there has been a procession of high profile Presidents of the BDIAP. One sneak at the Presidential chain of office (and I do, quite often) identifies the calibre of these Presidents, which humbles me a lot. As I said on the day of the 50th Anniversary celebration, it reads like a "Who's who" and it makes me feel a bit like a "Who's he?". Be that as it may, it has been a pleasure to serve at the time of this important 50th anniversary milestone in the history of the Division and to be closely involved in formulating its future, especially through the recent Away Day of the Council.

So, we duly celebrated the 50th Anniversary with a half day meeting at the Royal College in November, linked to our standard London Autumn meeting, on Infectious pathology, the next day. We had five excellent talks from the godfathers (and one godmother) of the Society.

Presentation of Cunningham and President's Medals at The Infectious Diseases Meeting London, November 2011

Professor Chris Elston gave a comprehensive account of the history of the BDIAP and Professor Mike Wells of its journal, *Histopathology*. Professor Kristin Henry described the international challenges in pathology and Professor Sir James Underwood the professional challenges facing pathologists. Finally, the outgoing College President, Professor Peter Furness, a former Divisional Editor of the BDIAP, talked about the future of diagnostic pathology in the next fifty years. It was an excellent meeting and entirely appropriate to celebrate this important landmark for the BDIAP.

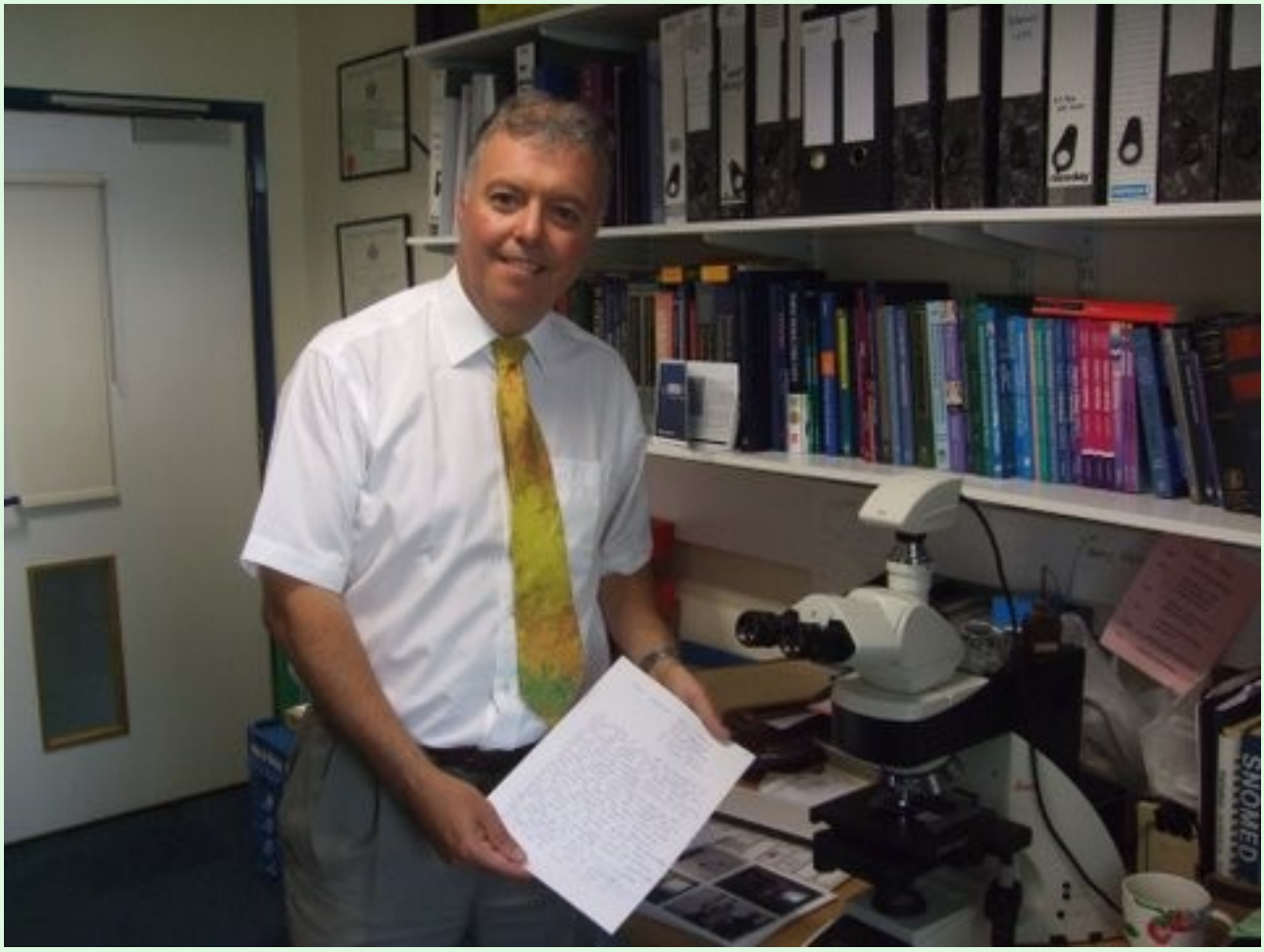
So what else has been happening this year? Well, we have had excellent educational meetings, especially our joint meeting with the Pathological Society, Ghent Pathology 2011 in May, organised with aplomb by the indefatigable Professor Claude Cuvelier, the IAP's European Vice President and former President of our Division. Our charitable activities within our member countries and elsewhere continued unabated. In October of this year, Council undertook its second ever Away Day. This meeting, and our subsequent AGM, ratified the establishment of a further Subcommittee, the International Subcommittee, to deal with our international affairs. It is really excellent news that Dr Alec Howat, our former Treasurer, has agreed to chair this committee and its workings are now established. As part of the Away Day, we agreed the following initiatives: increased educational activity in our member countries; augmented administrative support; increased co-operation with other IAP Divisions, particularly in Europe and further co-operation and collaboration with sister societies, especially the Pathological Society. The Away Day also established the principles that we should have increased democratisation of the Society and Council and that we should have increased representation from UK-based members on Council. Finally, the institution of the Cunningham Lecture, at our joint meetings with the Pathological Society, has produced confusion with the Cunningham Medal. For these reasons and to acknowledge the huge contribution that she has made to the BDIAP, over many years, and her current IAP Presidency, Council has agreed to rename the George Cunningham Lecture the "Kristin Henry Lecture". These initiatives have subsequently been ratified by the AGM of the BDIAP in November.

Council is very proud of its charitable pathological educational activities outside its four member countries. The four British Schools of Pathology, the Arab, Bosnian, Sri Lankan and East African, continue to provide excellent pathological education in those parts of the world. I would like to make particular mention of the Bosnian British School of Pathology. This was instituted through the vitality and foresight of Mr Michael Franey, Professor Bryan Warren and Dr Semir Vranic. Mike runs a charity called "Acorn Aid", particularly concentrating on providing various forms of charitable support to Bosnia. Of great help in the earlier days of this endeavour was Nermin Durakovic, Mike's friend and translator. Nermin had lived through the dark days of the 1990s war in Bosnia and it was a numbing experience to hear him tell of his stories of the war. Sadly, Nermin died of cancer at a very young age two years ago. BDIAP Council has agreed to perpetuate his memory in the form of a bursary for Bosnian Pathology trainees to attend meetings and train elsewhere. It was a real privilege for me to receive a hand-written letter from Nermin's sister, representing his whole family, thanking the BDIAP for honouring her brother's memory in this way.

Finally, some congratulations are in order. Professor Geraint Williams, my predecessor as President, was presented with the OBE (the Order of the British Empire rather than the Order of the Bowel Experts) by the Princess Royal in Windsor Castle last month. That month, Professor Mike Wells, our President-Elect, was made Vice-President of the Royal College of Pathologists. Early in the year, our Meetings Secretary, Ian Roberts, became Professor of Pathology at the University of Oxford. I have already mentioned the awarding of the BDIAP's Cunningham Medal to Elizabeth Whelan. It was also a great pleasure, last month, to present the President's Medal to Professor Sebastian Lucas, an old friend, for his role in promoting pathological education in our member countries. Congratulations to all of them!

Left: Professor Geraint Williams OBE

Right: BDIAP President elect Professor Michael Wells



Our President receiving the humbling hand-written thank-you letter from Nermin Durakovic's sister indicating how grateful his family are for the establishment of the Nermin Durakovic Bursary.

MESSAGE FROM THE IAP PRESIDENT, PROFESSOR KRISTIN HENRY

Having been Chairman of the IAP Education Committee for the past 10 years, it is now a great honour to be appointed IAP President representing the 55 IAP Divisions worldwide. As President, I sincerely hope that over the 2 years I will do justice to this role, not just by supporting our many Divisions and building on existing educational programmes, but also in driving forwards with new educational initiatives aimed especially at those IAP Divisions representing underserved Countries

My tenure as President commenced on December 1st 2010 after the October XXVIII International Congress in Sao Paulo. The Congress was hugely successful and I would like to thank Marcello Franco and his team for organising such a successful meeting at every level. They deserve the highest praise and this has been reflected in the many letters of congratulation sent to Dr. Franco. Altogether there were 2347 participants. 1826 were registrants from 72 countries and of these 384 were residents/Postgraduate students with 65 of the young pathologists and trainees awarded bursaries - 57 of which were IAP Bursaries.

It seems appropriate at this point to briefly outline the work of the IAP Education Committee of which I am very proud to have been the Chair and to have had the support of the Education Committee Members who between them provide global representation.

Over the past 10 years, the Education Committee has supported 35 Scientific Meetings worldwide. Countries perceived as especially deserving have been located in Africa, Eastern Europe, the Asio-Pacific regions, South America and some other Spanish speaking countries areas. Amongst recent notable meetings have been the First International Scientific meetings of the Cuban, Romanian, Russian and Ukrainian Divisions, the 4th Asio-Pacific IAP Congress held in Beijing - the first international pathology meeting to be held in central China- and the 6th Asio-Pacific IAP (APIAP) Congress in Kochi India.

An important aspect of the Education Committee is the selection of applicants for IAP Bursary awards. These Bursary awards are made possible by the generous donations to the IAP from some of the larger IAP Divisions. The Bursaries are aimed primarily at young/Trainee Pathologists to assist them in attending the IAP International Congresses and strict guidelines are set out in applying for them. It is most gratifying to receive the reports from these young pathologists stating how much they enjoyed the experience. One particular aspect appreciated is the opportunity to meet senior colleagues and speakers and to exchange ideas with other participants.

The increasing demands made on the Education Committee for educational financial support has been recognised in that the biennial allocation has been significantly increased. Even so, other means of increasing the funds available continue to be actively explored.
The recent donation of $3000 from the Indian IAP Division made specifically towards educational activities was most gratefully received and it is hoped this will serve as an incentive to other Divisions to do likewise. Also gratefully received was the substantial donation from the Hellenic IAP Division of a share of profits from the 2008 Athens Congress towards educational support for underserved countries. Support for underserved Divisions is an important aim of the IAP. They lack many educational facilities and are very short of pathologists.

The IAP promotes and assists in the interaction between different Divisions of the IAP. One especially pleasing aspect is the fruitful collaboration between different IAP Divisions in supporting educational programmes. In the forefront of such educational collaborative activity has been that between the British and French IAP Divisions and the Arab Division; the British and South African Divisions and USCAP with the East African and West African Divisions, the educational programmes set up for the Asio-Pacific countries led by the Australian, Japanese and Hong Kong Divisions and the 'Transfer of Technology in Pathology' Meetings set up by the Hungarian Division aimed at pathologists from Central and Eastern Europe. Inter-action with other Pathology Societies may also prove beneficial such as that with the European Society of Pathology (ESP). A joint ESP/IAP symposium is conducted every two years during the European Congress of Pathology.

Another important outcome of successful collaboration between different IAP Divisions has been the setting up of joint Schools of Pathology targeted at trainee pathologists, as exemplified by the Arab British School of Pathology now in its 10th year. Also welcomed is the setting up of the International Junior Academy of Pathology set up by the German Division aimed at trainee pathologists not just from Germany but from other European countries. All these Schools underpin the IAP mission of disseminating knowledge and high standards of pathology practice. It is hoped that other Divisions will likewise form interactive links between themselves leading to educational programmes and new Schools of Pathology.

It should not be forgotten that there are also countries desperately in need of educational assistance which have not formed an IAP Division. These will be encouraged to form their own Divisions or to make links with larger, stronger Divisions. Three newly formed IAP Divisions are the Baltic, Mexican and Panamanian Divisions.
With regard to new educational initiatives, I have set up a Working Party to look an novel ways of building on and developing educational support for those Divisions most in need.

The areas which will be actively explored include;

i. An ‘outreach’ programme of visiting Ambassadors/Lecturers to countries with poor educational facilities and resources. These Lecturers will be drawn from those willing to travel to conduct workshops, seminars or other educational activities as requested by the country visited,

ii. The provision of teaching materials (CDs/DVDs) including the availability and easy access to Divisional Meeting course material.

iii. The setting up a Senior Pathologists Bursary Fund enabling pathologists with limited financial support to attend international congresses.

iv. Interaction with other Pathology Societies beneficial in terms of devising joint educational programmes as with the ESP and Central IAP.

In conclusion, it is my pleasure to welcome Dr. HK Ng as the new Chairman of the Education Committee who took over this role following the 2011 San Antonio Education Committee Meeting
I also salute the outgoing President Dr. Florabel Mullick and thank her for her hard work in setting up a Task Force; the Way Ahead. This Committee Chaired by Dr. Mullick conducted several valuable surveys directed at exploring the needs of the different Divisions and has identified certain problems in the organisation of the IAP which, you have my assurance, will be addressed.

Professor Henry talking at the BDIAP 50th Anniversary meeting in November 2011 on ‘International challenges in Pathology’

Professor Henry stressed that among the most important challenges are those imposed by travel restrictions due to cost; central IAP had limited funds to allocate to the Education Committee. Restriction in travel also resulted from ethnic and gender problems and in obtaining visas. Then there was increasing constraints in time available to engage in educational programmes - both on the part of teachers and participants. Language also could present problems. She then considered the solutions, many of which have been covered in her ‘Message from the President’
In summary she emphasised that the success and strengths of the IAP are dependent upon its 55 Divisions and that it was the educational endeavours and collaboration between the Divisions which were of prime importance in the delivery of effective international pathology education.

Kristin Henry
President, International Academy of Pathology

PRESENTATION OF THE BDIAP CUNNINGHAM AND PRESIDENT'S MEDALS AT THE DINNER DURING THE MEETING ON "INFECTIOUS DISEASES PATHOLOGY", NOVEMBER 2011

THE CUNNINGHAM MEDAL

Presented by the President to Ms Elizabeth Whelan, Associate Editorial Director of Histopathology, the journal of the BDIAP, in recognition of her service to the BDIAP

THE PRESIDENT'S MEDAL

Presented to Professor Sebastian Lucas for his long and distinguished service to education in Pathology

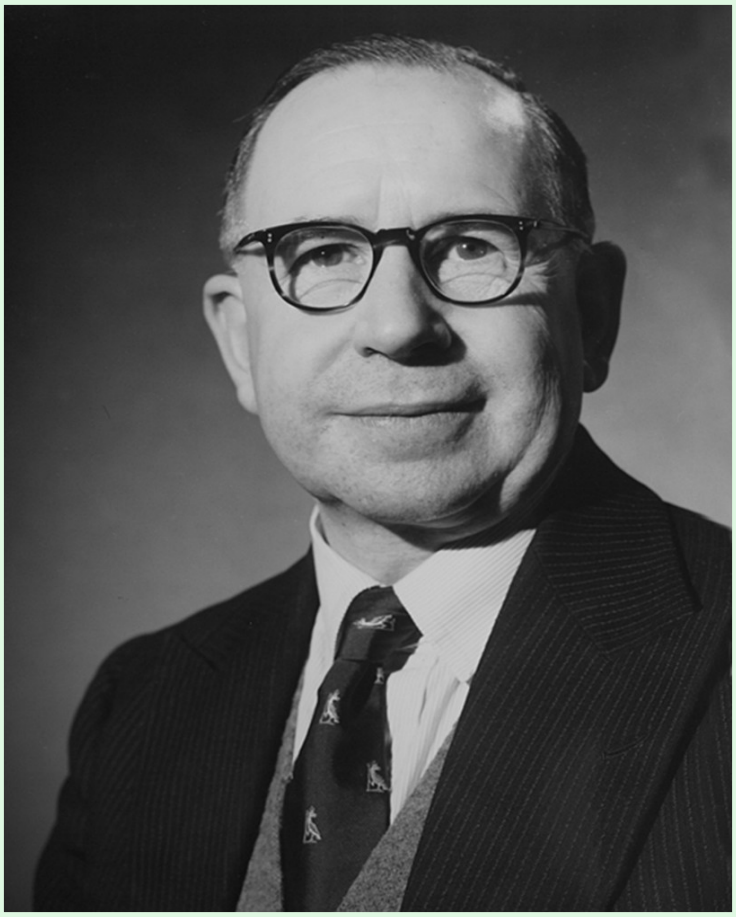
A History of the British Division of the International Academy of Pathology 1961-2011

Professor Christopher W Elston

The British Division (BDIAP) is an integral part of a world-wide organisation, the International Academy of Pathology (IAP), devoted to postgraduate education in Diagnostic Histopathology. The IAP was founded in 1906 as the International Association of Medical Museums (IAMM) with a structure based on a central committee and regional sections. The first international meeting was held in London in 1913 at the Royal College of Surgeons. The two World Wars so disrupted communications that the next international meeting was not held until 1960. In the meantime sectional societies continued to meet but with poor attendances and in 1955 it was decided to wind the IAMM up. However, a group of enthusiastic North American pathologists intervened and renamed the society as the IAP. Membership improved and in 1960 a second international meeting was held at the Royal College of Surgeons. This was organised by Professor George Cunningham (Fig 1) an important figure in British pathology at this time.

Buoyed by the success of this meeting, he and a group of like-minded colleagues formed the BDIAP. The first meeting of Council was held in October 1960 with Professor Vic Harrison as President, George Cunningham as Treasurer and Dr David Pratt as Secretary. The first Scientific meeting, on skin pathology, was not held until February 1961, hence the celebration this year of our 50th Anniversary. The initial membership of the society was 60 and with steady growth it has now reached nearly 1400. Colleagues from Belgium, Eire and Holland attended meetings from the outset and BDIAP has evolved into a regional society with representation on Council from each member country.

Scientific meetings were initially annual, and then from 1963 have been held twice yearly. It was decreed at the outset that meetings would follow the format adopted by the IAP at its foundation: i.e. a long course and slide seminar devoted to a single organ or system with programmes based on invited speakers; meetings were to last for a day or a day and a half with, importantly, a social programme. This is very much the system used today. The first overseas meeting was held in Utrecht in 1967, followed by Ghent in 1969; they are now held every 2 years in rotation between the associate countries. In 1999, after protracted negotiations, the Councils of the BDIAP and the Pathological Society agreed to hold a joint meeting biennially starting with Liverpool in 2001. Since 2005 there has been a BDIAP keynote Lecture dedicated to the memory of George Cunningham.



(Fig 1)
Professor George Cunningham

The BDIAP Council comprises the President, Secretary, Treasurer, Meetings Secretary, Divisional Editor and elected Councillors. Lists of the Officers who have served the society since 1961 may be found on the website. As the BDIAP has grown, two Away Days have been held in recent years to review its

structure and activities, in Nottingham in 2006 and Broadway (Cotswolds, not New York!) in 2011.
In 1975 the BDIAP was approached by Blackwell Scientific Publications with a proposal for a new journal devoted to papers on diagnostic histopathology. After considerable debate Council agreed and Roger Cotton was appointed as the founding Editor. 'Histopathology' has been an outstanding success since the first volume appeared in 1977 and the income earned from the journal has contributed substantially to the healthy financial position of the society; the capital account now stands at over £2 million.

As a registered charity the BDIAP has an obligation to donate to deserving causes. In addition to support for 4 Schools of Pathology (Arab, Bosnian, East African and Sri Lankan) the society provides funding for a number of African initiatives, including 'safaris' to East Africa and technical workshops.

The Division awards 2 medals for outstanding achievement. The Cunningham Medal is awarded to an individual, usually but not necessarily a member, for services to the Division: the President's Medal is given to a member who has made a significant contribution to Pathology education; the recipients of both medals may be viewed on the BDIAP website.

(Fig. 2) BDIAP International Presidents
Left: Professor Roger Cotton 1982-1983
Right: Professor Kristin Henry 2011-2012

No history of the BDIAP would be complete without mention of our two International Presidents (Fig 2); the late Roger Cotton served between 1982 and 1983 and Kristin Henry is the current incumbent (2011-2012). Both have brought great credit to the Division.

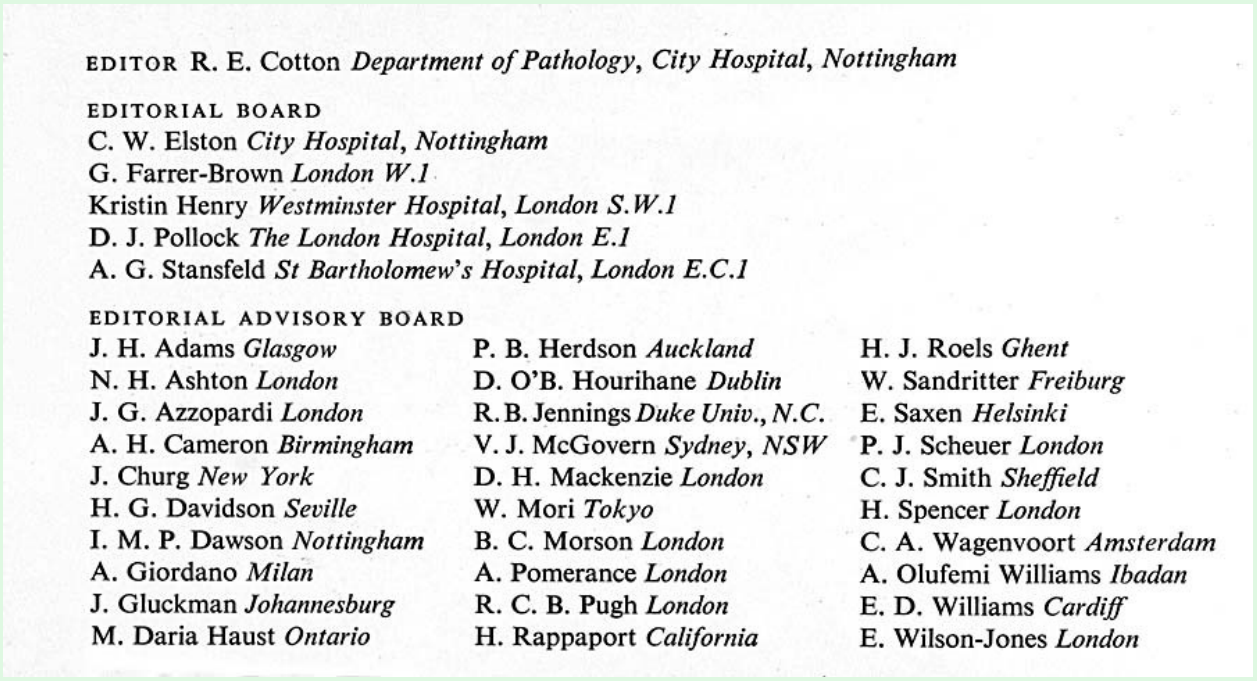
I would like to finish this account with some food for thought by returning to our roots in the IAP and its predecessor the IAMM. There is documentary evidence that a British Section of the IAMM existed from as early as 1931 until 1949. To date no definite connection has been found between the British Section and the BDIAP (e.g. George Cunningham having been a member of both organisations) but if such a link were to be found we could be in the curious position of celebrating our 50th anniversary in 2011 and the Centenary only 20 years later in 2031!

CW Elston

Histopathology – past, present and future
Professor Michael Wells
Editor of *Histopathology* 2003-2012

The birth of *Histopathology*

In the 1970s, Dr Geoffrey Farrer-Brown edited *"International Pathology"* the international news bulletin of the International Academy of Pathology (IAP) which, in those days, invited original papers. In 1976, Blackwell Publishing approached the British Division of the IAP (BDIAP) about the possibility of launching a journal with an emphasis on diagnostic histopathology. The BDIAP council under its President, Dr Alfred Stansfeld, was undecided and a subcommittee was formed with a membership of Trevor Betteridge, Geoffrey Farrer-Brown, David Pratt and Alfred Stansfeld. The decision was made to proceed, encouraged by Blackwell's promise to underwrite any losses. *Histopathology* was launched in January 1977 as a bimonthly journal.
"When the first discussions took place between the council of the BDIAP (under the Presidency of Dr A G Stansfeld) and Blackwell Scientific Publications, Roger Cotton seemed unsure of the need for another journal of Histopathology. However, following further deliberations both here and in the United States he became convinced that the time was opportune for such a publication. Indeed he became so enthusiastic about the venture that he was readily identified by Council as the person best suited to be its founder editor, a decision welcomed by Blackwell" (Pratt & MacSween, January 1985).
The words of Roger Cotton in his first editorial seem just as apposite today:
"Some may argue that significant advances in morphological aspects of disease are now slight. A moment's thought, however, regarding the improved diagnostic, prognostic and potentially therapeutic information available from the introduction of new techniques in the utilization of an increasing range of variably sophisticated methods of assessment, should soon reject such a view."
Below is a facsimile of the inside front cover of the first issue in January 1977, showing the members of the Editorial Board and Editorial Advisory Board.



EDITOR R. E. Cotton *Department of Pathology, City Hospital, Nottingham*

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G. Farrer-Brown *London W.1*
Kristin Henry *Westminster Hospital, London S.W.1*
D. J. Pollock *The London Hospital, London E.1*
A. G. Stansfeld *St Bartholomew's Hospital, London E.C.1*

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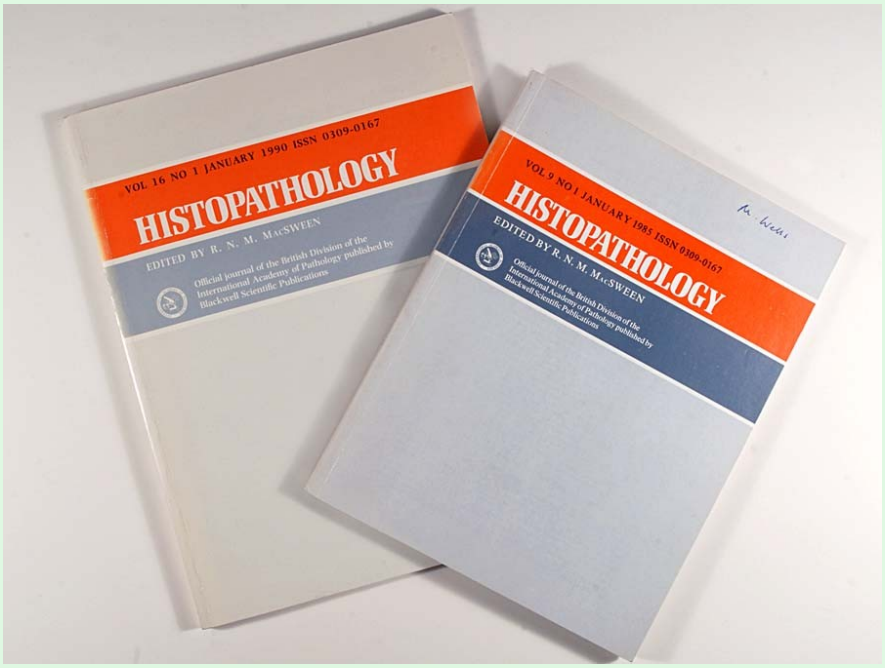
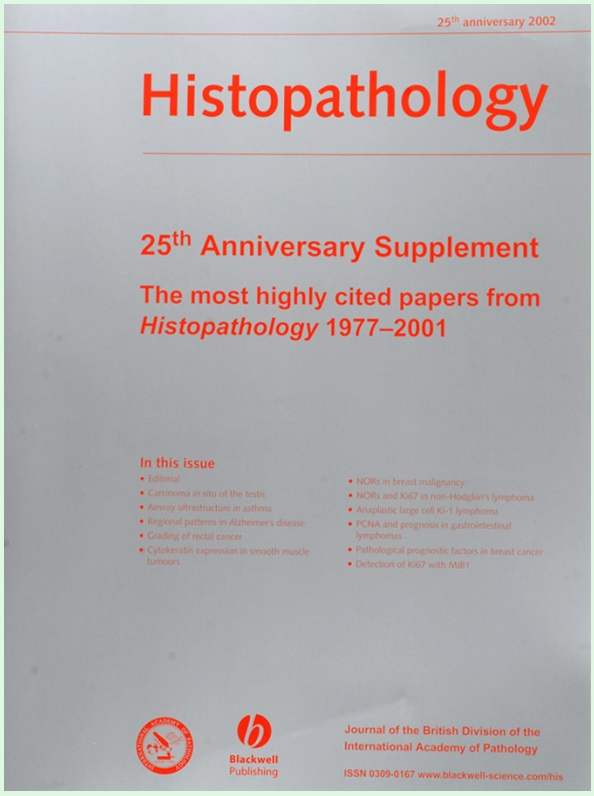
The first issue contained a review on chronic hepatitis by Peter Scheuer and five original papers, all of which were by British authors, including John Azzopardi, Harold Fox, John Tighe and Kristin Henry, who 34 years on is, of course, the current President of the IAP.
Histopathology was a financial success from its inception and no "bail-out" from Blackwell was ever necessary. Meanwhile, the Pathological Society of Great Britain and Ireland responded to the success of *Histopathology* by trying to appeal to the more diagnostically oriented pathology fraternity.

The society's journal *Investigative and Cell Pathology* (1978-1980) became *Diagnostic Histopathology* (1981-1983). Despite its title, it continued, bizarrely, to publish experimental pathology papers. *Diagnostic Histopathology* did not flourish and within two years was subsumed into the *Journal of Pathology*.

Coming of age

Roddy MacSween became Editor in 1985 and remains the longest serving editor of the journal, demitting office in 1996. *Histopathology* became a monthly journal. Roddy recalls that *"the editorial lunches were delightful affairs and acted as great bonding sessions".* Harold Fox regularly complained about the quality of the crisps. Under Roddy's stewardship, the journal flourished and in 1990 there was an increase in the size of the journal from A5 to sub-A4. The only serious mishap appears to have been, on one occasion, the contamination of a complete print run by a host of mosquitoes that adhered to the paper.





The Underwood years

James Underwood became Editor in July 1996 and remained Editor until December 2002; Simon Cross was Assistant Editor. Under James's editorship, case reports were published only as correspondence, a review article was published in each issue and Lesson of the month, Commentaries and "From this month's *Histopathology*" became regular features. James made the editorial board more international, introduced a breakfast meeting at the annual United States & Canadian Academy of Pathology meeting and created a computerised database.
In 2002, a special 25th anniversary issue was produced, containing the most cited papers from 1977 to 2001 and included papers by John Crocker, Kevin Gatter, Peter Hall (3 papers!), Andy Hamby, Jeremy Jass, David Levison, Basil Morson, Neil Shepherd and the seminal 1991 paper on the grading of breast cancer by Elston & Ellis.

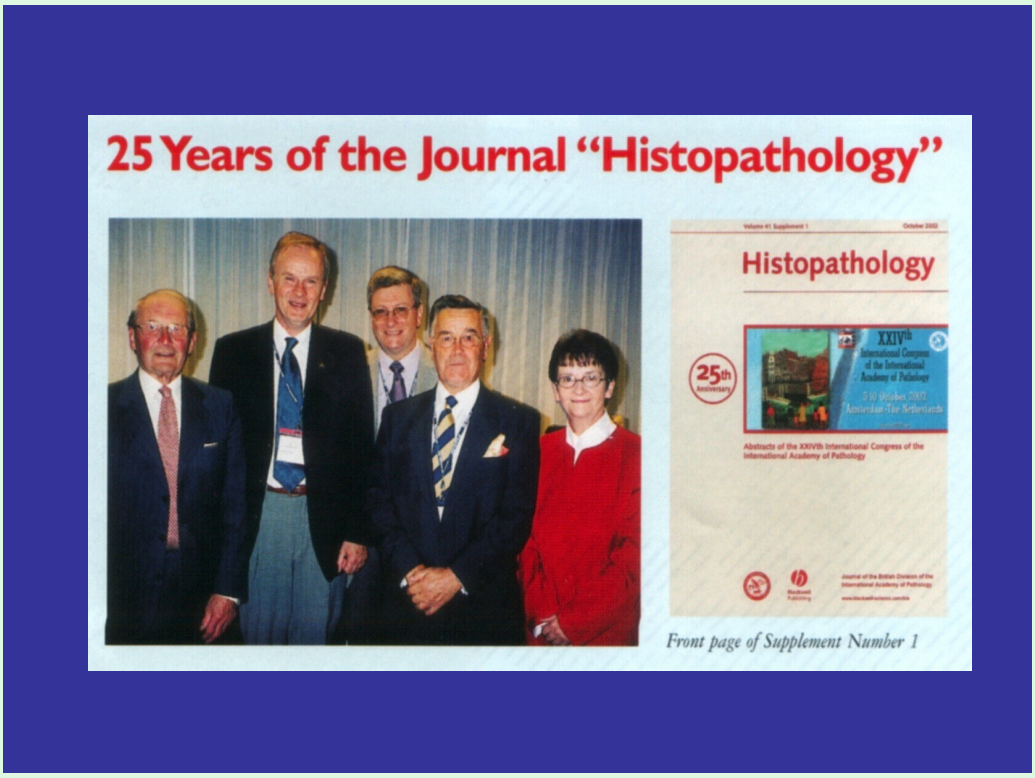
Our times

I was privileged to be appointed Editor of *Histopathology* by the council of the BDIAP, with effect from January 2003, following James's election to the Presidency of the Royal College of Pathologists. I introduced the annual review issue, the Roger Cotton prize for *Histopathology*, launched the *Histopathology* reception at USCAP (subsequently the *Histopathology* and *Journal of Pathology* joint reception) and appointed 11 associate editors. *Histopathology* became "electronic" (using Manuscript Central) in 2004 and, in 2008 & 2010, the IAP congress abstracts were published as a supplement to the journal.

The annual review issues have had some very distinguished pathologists as Guest Editor:

- 2006 - Soft tissue tumours - Chris Fletcher
- 2007 - Gastrointesinal pathology – Jeremy Jass
- 2008 – Breast pathology – Sarah Pinder
- 2009 – Thoracic pathology – Andrew Nicholson
- 2010 – Dermatopathology – Eduardo Calonje
- 2011 – Haematopathology – Andrew Jack

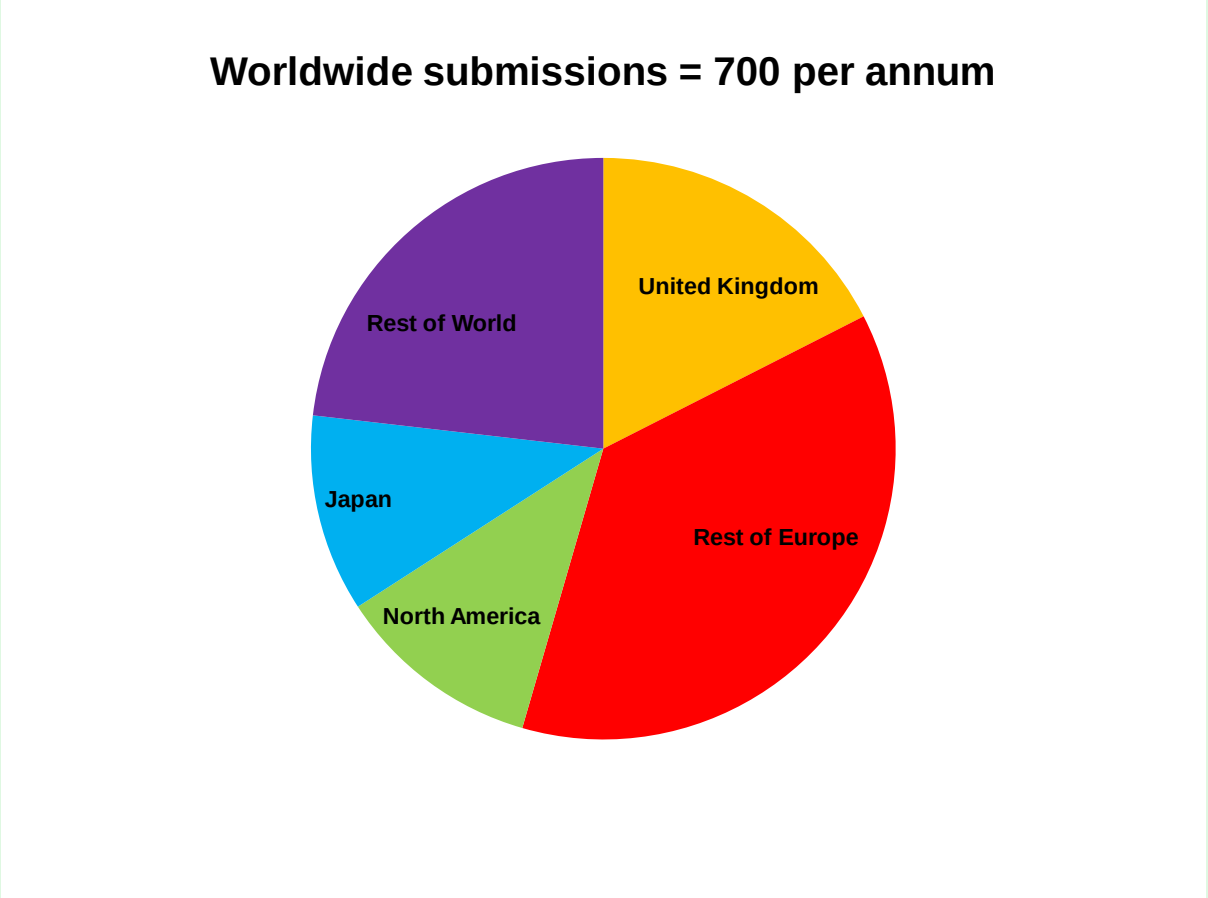
The annual meetings of the judging panel for the Roger Cotton prize have been intellectually stimulating and enjoyable affairs chaired in succession by Roddy, James and Claude Cuvelier.

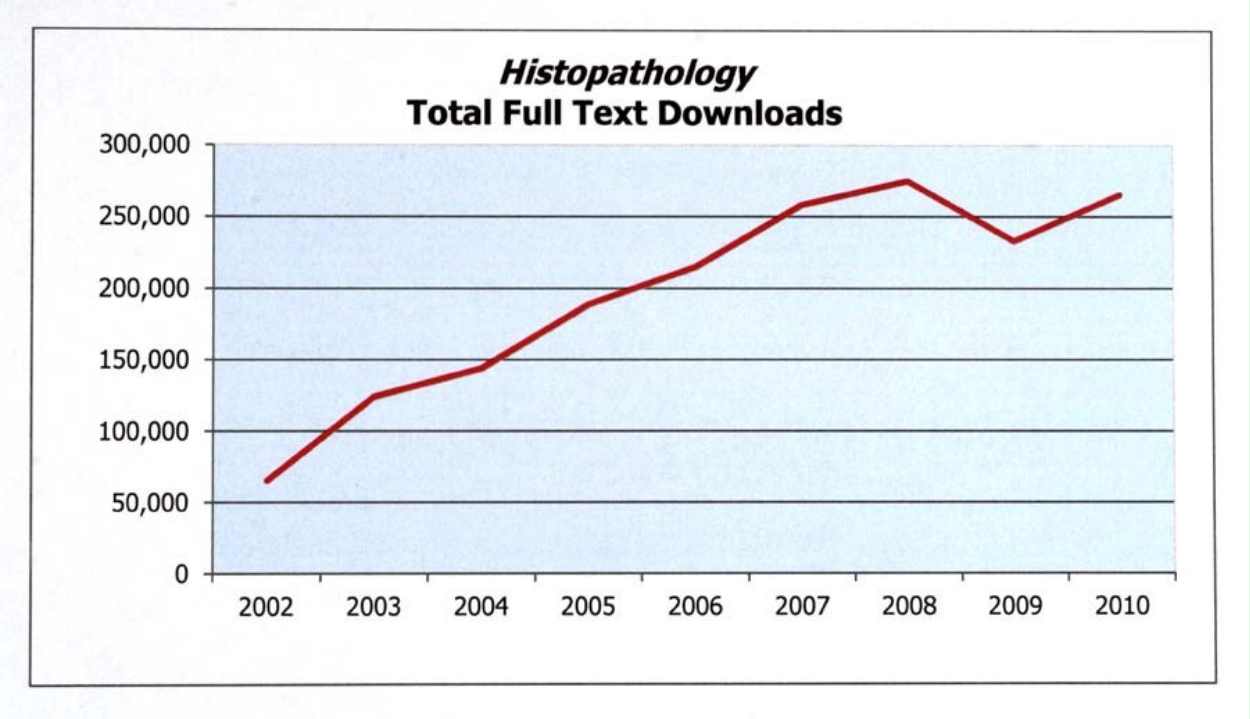


The four editors of *Histopathology* (Roger Cotton, James Underwood, Mike Wells and Roddy MacSween) with Elizabeth Whelan, IAP congress Amsterdam 2002

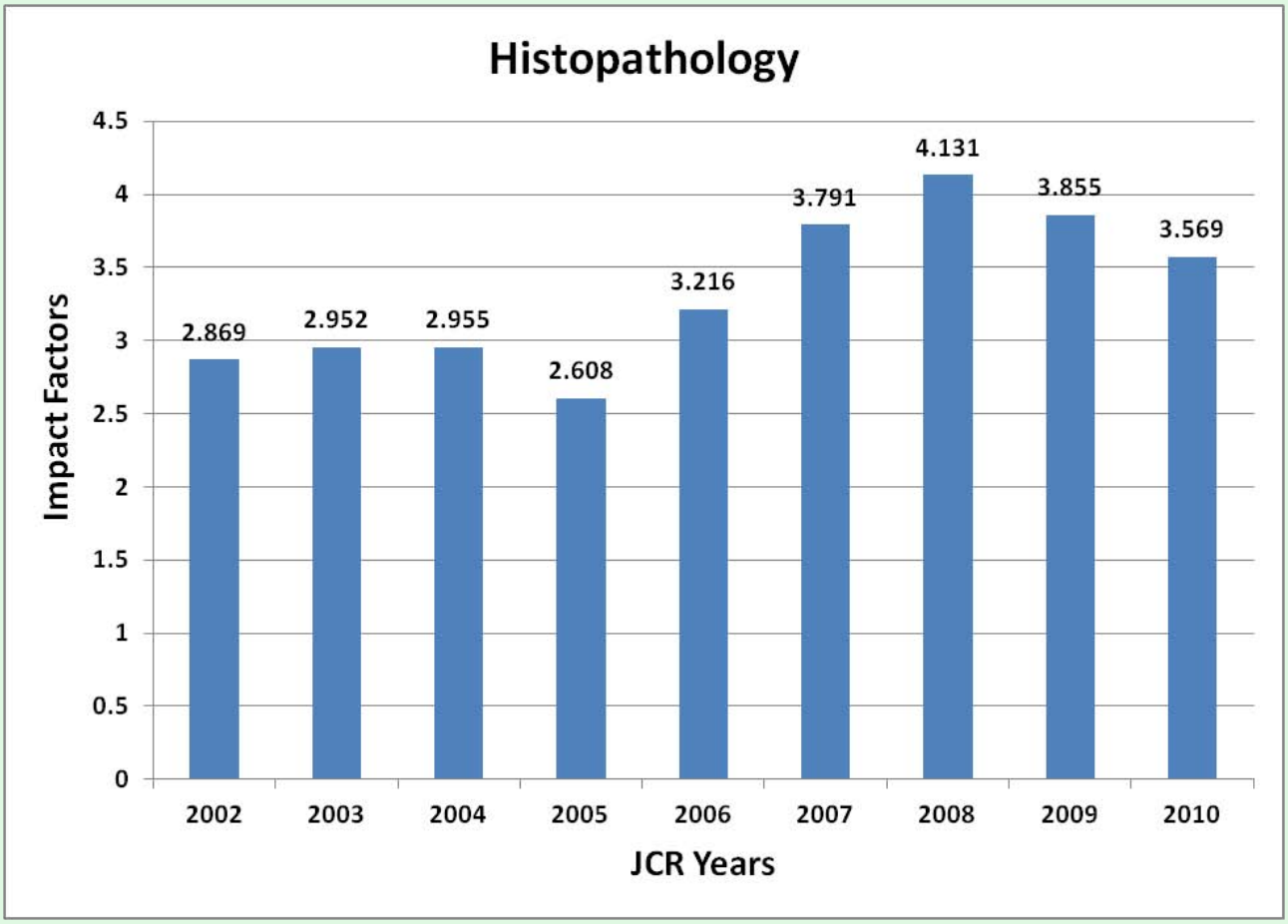
The journal and its three surviving editors were awarded gold medals at the 100th anniversary of the IAP in Montreal in 2006.

In recent years there has been a substantial increase in the number of annual submissions which are truly international and a massive increase in the number of electronic downloads.





There has been a substantial increase in impact factor in recent years.



Thankfully, in my time as Editor, there has been only one paper (a review article) that came under suspicion when it became known that one of the co-authors had been responsible for the publication of a fraudulent paper in another journal. However, a thorough investigation reassured us that there had been no impropriety, at least in so far as the review article was concerned.

The future

On Maundy Thursday 2010, the officers of the European Society of Pathology (ESP) held a meeting in London with the officers of the Pathological Society at 2 Carlton House Terrace, followed by a dinner at Rowley's on Jermyn Street. I was President of the ESP and Alastair Burt was the Treasurer of the Pathological Society. As we walked across St James's Park to return to our hotel, a discussion ensued between Alastair and myself, which (to cut a long story short) culminated in his appointment as only the fifth editor of *Histopathology* in thirty-five years.

Alastair's vision is for *Histopathology* to become the premier international peer reviewed journal for diagnostic/prognostic pathology and tissue based stratified medicine with an impact factor of > 5, its main competitors being the *American Journal of Surgical Pathology* and *Modern Pathology*. Alastair expresses his aims for the journal in his inaugural editorial.

Professor Alastair Burt

Concluding remarks

James Underwood has expressed in appropriate terms, on behalf of the three surviving past editors, the contribution that Elizabeth Whelan of Blackwell (latterly Wiley Blackwell) has made to the success of *Histopathology* over many years: *"The success Histopathology experienced during my time as Editor would not have been possible without Elizabeth Whelan. Her support for me as Editor and her interest in Histopathology was well beyond what I had expected."* It was very appropriate that Elizabeth was awarded the Cunningham medal of the BDIAP at its annual dinner in November 2011.

Michael Wells, January 2012

The editors of *Histopathology* with Elizabeth Whelan (centre)
From left to right Professor Sir James Underwood, Professor Alastair Burt (form January 2012), Professor Michael Wells and Professor Sir Roddy McSween

PROFESSIONAL CHALLENGES FOR PATHOLOGISTS

Professor Sir James Underwood
Emeritus Professor of Pathology
University of Sheffield

Advances in medical science, coupled with progress in clinical practice and changes in public attitudes, oblige pathology specialties to constantly evolve and develop so that they can continually best serve patients. Therein lie the challenges.

Matching the size and profile of the histopathology workforce to the increasing volume and complexity of the workload is still among the greatest challenges. Although consultant pathologists increased by c. 800% between 1939 and 1960, far exceeding the rise in physicians and surgeons (figure 1), some smaller hospitals continued to be staffed by general pathologists responsible for more than one specialty. Until the late 1970s, a few departments were staffed by just one histopathologist, thus providing a vulnerable service.

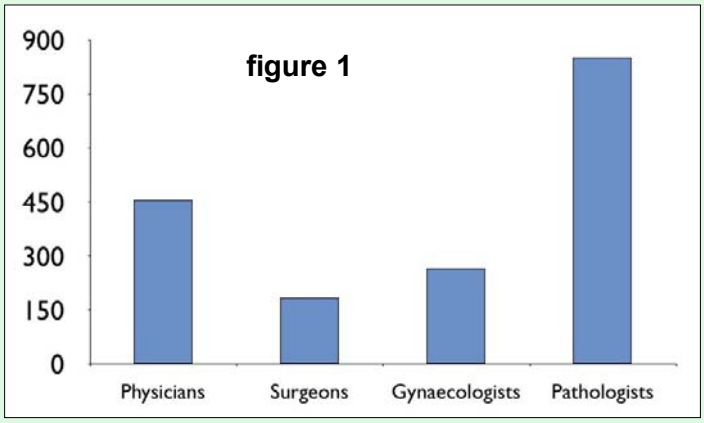


Figure 1. Increase (%) in consultants between 1939 and1960. (Based on data in WD Foster's *Pathology as a Profession in Great Britain*, RCPath.)

Unfilled histopathology consultant posts were uncommon until the late 1990s (figure 2). Subsequently, vacant posts increased dramatically because of a decision in the early 1990s by the Joint Planning Advisory Group (JPAC) responsible for specialty workforce planning. Mistakenly fearing a gross excess of trained candidates for consultant posts, JPAC axed 50% of senior registrar posts and halted recruitment to the remainder. Consequently, many histopathology SHOs were unable to progress and by 2004 over 200 consultant posts could not be filled. The Specialty Workforce Advisory Group (SWAG) — JPAC's successor — lifted the recruitment moratorium and approved a substantial increase in training posts. The subsequent creation of Histopathology Training Schools was a significant achievement. However, a predicted excess of trained candidates for histopathology consultant vacancies after 2013 is evidence that workforce planning is probably the most difficult challenge facing any specialty.

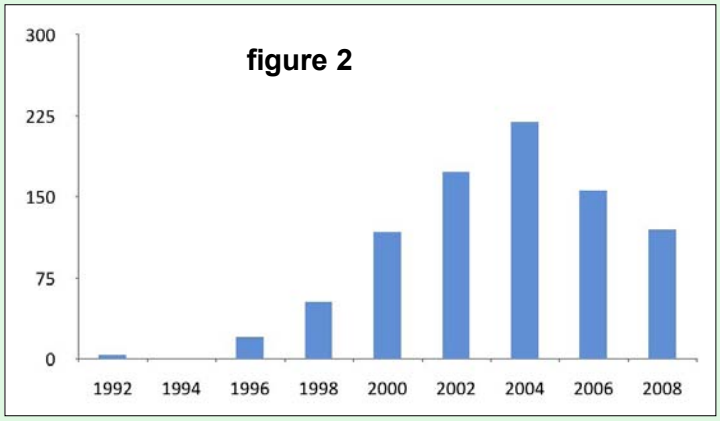


Figure 2. Histopathology vacancies in the UK. The rise reaching a peak in 2004 was largely attributable to JPAC's decision during the early 1990s to cut senior registrar posts by 50%.

Relying on overseas medical graduates to fill many training posts in the UK has averted a dire workforce situation, although regrettably this has deprived the countries in which they graduated whose need for histopathologists may be even greater. Their recruitment has compensated for a marked decline in UK medical graduates choosing a career in histopathology. This has been attributed to reduced exposure to pathology in the undergraduate curriculum. Some medical educationists seemingly do not appreciate sufficiently the fundamental importance of pathological knowledge and understanding for safe and effective medical practice.

Contrasting with the expansion of the NHS histopathology workforce, the declining status of academic pathology in the UK is now critical. Between 2000 and 2010, there was a c. 60% reduction in the number of

clinical academic staff in histopathology, a cut far greater that in any other academic specialty (figure 3). This reflects university staffing policies favouring research assessment (based largely on cost rather than on value) and a view that "pathology is *just* a technique" with a responsive rather than leading role in advancing knowledge.

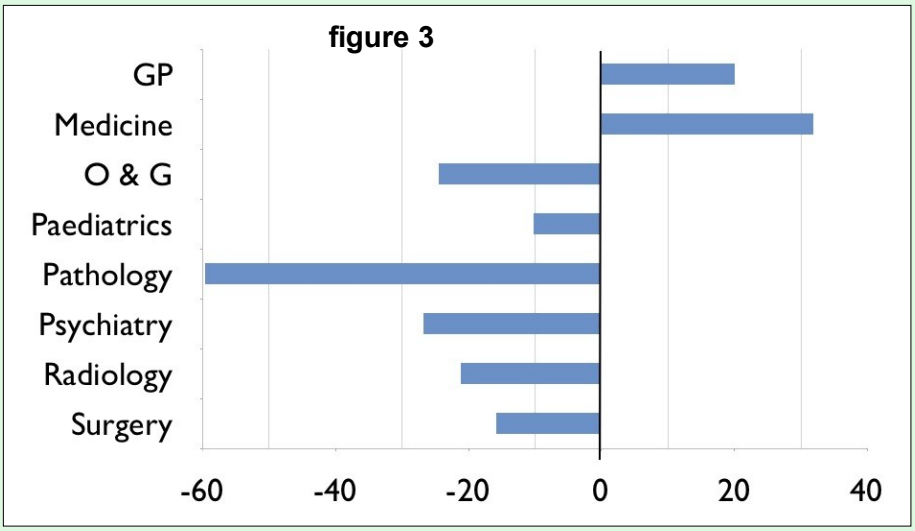


Figure 3. The decline of academic pathology: clinical academic staff 2000–2010 (FTE %). (Data from the Medical Schools Council.)

Significant advances have been made in three aspects of workload handling. First, there has been increased delegation of work to appropriately trained non-medical personnel (e.g. biomedical scientists) in cytology and in specimen dissection and sampling. Second, the Royal College of Pathologists produced evidence-based guidance on reducing workloads by eliminating biopsies, etc, of limited or no clinical value. Third, pathology networks, increasingly promoted in successive reports on NHS pathology (most recently those from Lord Carter's group), encourage collaborative links between departments in neighbouring hospitals. Greater specialisation and the collective expertise of the larger group of consultants can only benefit patients.

Error-free histopathology is a laudable aim but probably unachievable. All errors are regrettable, particularly from the patient's perspective, but in histopathology they are considerably less frequent than, for example, in radiology, prescribing and death certification. Unfortunately, errors in histopathology can become exploited when good working relationships break down between individual consultants or neighbouring departments. Therefore, just as important as the frequency of errors, is the response of individual histopathologists and their colleagues. Sometimes concerns about the reliability of a histopathology service are investigated by retrospective review of usually many thousands of previously reported cases. In my opinion, such investigations are rarely conclusive unless the results are substantially deviant from accepted standards. Far better to focus in depth and detail on the processes used for maintaining high standards, for handling individual errors when they occur, and for minimising the risk of recurrence.

Autopsy work is increasingly contentious for histopathologists. Coronial autopsies were at the focus of the Brodrick Report (1971), but many of its recommendations had little prospect of implementation. The proposal to bring coroners autopsies (other than forensic cases) into the NHS, thus depriving histopathologists of their fees for this work, was doomed to fail for obvious reasons. The recommendation that the government should earmark funding for university departments of forensic pathology may have been feasible, if affordable, at the time; but now most universities have removed this important subspecialty from their portfolios in the wake of research assessment exercises, deeming it to be "unproductive".

For many, our darkest days were during the "organ retention scandal". The public vilification of paediatric pathologists was intolerable, particularly when directed at those who had recognised the looming problem and led the way towards its resolution. Many histopathologists, including myself initially, didn't appreciate fully the symbolic significance of organs and tissues particularly for bereaved parents, some of whom were deprived of the opportunity to altruistically donate them for research and education. The Human Tissue (Scotland) Act 2006 is, in my opinion, a more proportionate response to the "organ retention scandal" than is the Human Tissue Act 2004 applying elsewhere in the UK. The Scottish legislation also extends directly to autopsies required by law, whereas elsewhere in the UK the relationship between the Human Tissue Act 2004 and the relevant Coroners Rules is still problematic.

Professionalism in pathology becomes most evident not when all is well, but when working to resolve the challenges faced by the specialty.

THE FUTURE OF PATHOLOGY: THE NEXT 50 YEARS

This is an edited transcript of an invited lecture, given by Professor Peter Furness, at a meeting to celebrate the 50th anniversary of the founding of the British Division of the International Academy of Pathology.

I approach this subject with some trepidation, because predictions of the future are usually wrong, and this is a topic that generates strong emotions amongst my colleagues. I take some comfort from the fact that, as I have been asked to predict 50 years hence, no-one will be able to prove me wrong until we are all past caring. However, having just had the privilege of spending three years as President of the College I have had considerable opportunity to observe the direction of travel of the whole of medicine, and pathology as a part of that whole. I hope that as a result my predictions will be of some value.

I propose to start, in order to encourage rational analysis rather than emotional reaction, by asking, in the context of the whole of our society, what attributes of a profession justify high social esteem, respect – and a high income? That sounds like a self-centred question, but when considering 50 years hence it is not; it is the question that will determine whether pathology in the future recruits the most able individuals to the ranks of its practitioners.

The emphasis in NHS staff recruitment and training, and in our own College curricula, is on 'knowledge and skills'. I am not convinced that these are the attributes that justify society's respect.

'Knowledge' can be understood in different ways; but if it is interpreted as 'information' it has never been cheaper than it is today. If you name a disease, or a symptom, I can use the Internet to deliver in seconds more information on that subject most pathologists know after a lifetime of study. Of course, one can argue that to turn information into knowledge demands the application of judgement and experience, to work out what information is relevant and what is reliable. I will return to that point. But information, once in the public domain, is now remarkably cheap.

Skills are much valued by our profession. But observation of wider society suggests that pure technical skill is also a very cheap commodity.

To take an example entirely outside medicine, consider the artist Tom Keating[1]. His paintings did not sell for much. He resented the fact that the art world did not value his skills. So he sought revenge by 'faking' paintings by famous artists. His technical skill was so great that he produced hundreds of paintings, in a wide variety of styles, that the experts failed to distinguish from the real thing. Yet his fakes, once identified, were worth very little. He had demonstrated technical skill equivalent to the old masters; but society did not value it. The reasons are complex, but it is probably relevant that he had produced nothing new. Unlike the original artists, he was not innovative.

Moving closer to medicine, as a PhD student long ago I had to learn how to transplant rat kidneys. That demands quite fine microsurgery. But the most competent teacher I had was not a consultant vascular surgeon; he was a technician, aged about 21, who for the previous three years had done nothing but transplant rat kidneys, all day and every day. He was technically brilliant at it. If I was a rat and I needed a kidney transplant I'd go to him. But – crucially – if I was a rat wondering whether or not I needed a kidney transplant, or which rat would be the best donor, he would be the last person I would consult. This relates to the old physician's tease about surgical skills. "Any surgeon knows how to operate; a good surgeon knows *when* to operate; a really good surgeon knows when *not* to operate."

This leads me to the proposal that what society really values in a profession is not knowledge or

skills, but good judgement. The ability to make difficult decisions, on important matters, in the face of limited information. I do not have time here to provide an exhaustive support for that view, but please consider how it applies to social groups that enjoy high esteem. Consider judges, top business managers, entrepreneurs, politicians, even bankers and financial investors. It also applies to creative artists; creativity and innovation are of course essential, but the successful innovator needs to judge which innovations are worth pursuing and which are not.
Good judgement is obviously expected from doctors, who have to help their patients to good decisions despite uncertain diagnosis and unpredictable treatments. Applying this to pathologists, getting the histological diagnosis right in the face of limited information demands good judgement. The right diagnosis is especially important in respect of cancer. So we pass the test. At present. Will we continue to do so for 50 years?

It is an unfortunate truth that any process that demands good judgement will occasionally be supplied with poor judgement, with disastrous results. Good judgement, as I have argued above, also tends to be expensive. Consequently, throughout society we can find attempts to minimise reliance on good judgement. Often – and certainly throughout medicine – this takes the form of developing ever more sophisticated guidance protocols, standard procedures and tick-boxes. There is no doubt that this approach has improved patient care, so we cannot argue against it. It does not actually remove the need for good judgement in difficult cases; but it risks giving the illusion of replacing professional judgement with a simple, reliable mechanical process. Our College datasets[2] have undoubtedly improved the quality of cancer reporting. But too often, when supervising a trainee, I have asked for something to be added to the pathology report, only to be told 'But it's not in the College dataset'. If our own trainees do not recognise the need to think as doctors, but instead they try to imitate data generation machines, what hope is there that the public will understand the value of our good judgement?

The quality of judgement can usually be improved if the scope of the topic is restricted; so the importance of good judgement has also helped to drive the trend towards increasing professional specialisation. I recently attended a GMC meeting on postgraduate training. An orthopaedic hand surgeon quipped that he was not all that specialised; he could operate on either left or right hands. He stopped laughing when he was asked, if he only operates on hands, why he needed to have undergone a full medical and surgical training in order to offer a safe service? In terms of technical skill, as I have argued above, he could produce no defence.
Now transfer that question to pathology, and consider our trend towards specialisation. My own practice has contracted over the years to renal, urological and gastrointestinal pathology. Reporting renal biopsies often demands that I consider the whole patient, understand renal medicine and make difficult judgements. But not so when I am presented with a large pile of needle biopsies of prostate. Identifying cancer in such biopsies takes skill, there is no doubt. But in difficult cases my judgement is supported by immunohistochemistry. It takes great diligence; but the output, realistically, is little more than 'neoplasm or no neoplasm'. Do I really need my years of medical training when I am just reporting prostate biopsies? I think not. If you doubt me, remember the rat transplant technician. And what of all those duodenal biopsies to exclude coeliac disease?
Bear in mind the country's current financial problems and the Health Secretary's insistence on the NHS using 'any qualified provider'. How qualified? How cheaply qualified? My prediction for rather less than 50 years hence is that there will still be high-status doctors making difficult judgements about patient diagnosis and management. But many routine surgical procedures will be delivered – with better outcomes and much more cheaply – by surgery technicians who do the same operation day after day. Pathology laboratories will have high-status pathologists making difficult decisions in unusual cases – but most prostate biopsies will be reported by people who are trained just to report prostate biopsies. As is already the case for cervical cytology. I will also predict that there will be pressure to take that process further than is safe, in order to cut costs. So we will need to have our arguments and evidence ready to protect standards of patient care where it is necessary. In doing so, we must not over-state our case, or our credibility will be lost and with it we will lose the argument. If we over-state the case, we demonstrate a lack of good judgement; if my ar-

gument is correct, that will be severely to our disadvantage.

But fifty years is a long time. Perhaps I am wrong. I now turn to the crucial question of how we will deliver that particularly high-stakes decision, the diagnosis of cancer.
In 2010, the prestigious Harveian Oration of the Royal College of Physicians of London was given by Sir John Bell. The full text is available on the Royal College of Physicians website and I recommend it to you.[3] The core of his argument was that improved understanding of the human genome is beginning to bear fruit in respect of understanding how disease is caused. He included all disease, not just conditions conventionally regarded as 'inherited'. He emphatically included cancer, a disease caused by acquired abnormalities in the genome. He went on to argue that, with improved understanding of the underlying mechanisms (and thus improved understanding of prognosis and response to treatment), will come the need for a complete revision of how diseases are classified. The new classification will be based on the underlying mechanism, not the morphology. An illustrative quotation:

> *"One of the most exciting outcomes of these studies is that it creates a framework of linking causality with disease definition and moves away from a disease taxonomy which has been unrelated to the events associated with pathogenesis."*
> *"This rapid progress is already creating a new diagnostic framework for cancer that is creating widespread redefinition of the disease."*

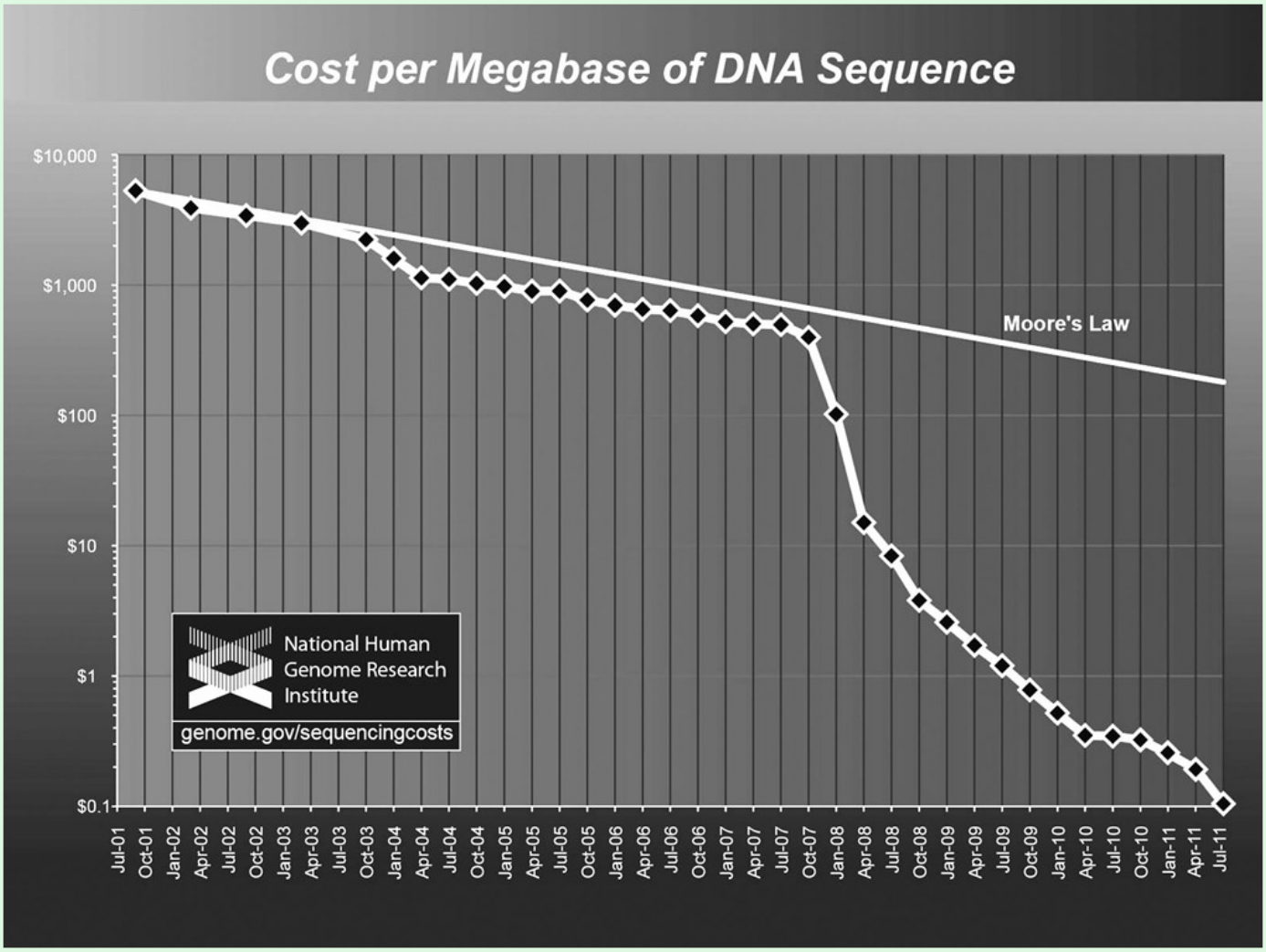


Figure 1.
The rate of decline of the cost of DNA sequencing over the last ten years. Downloaded with permission from http://www.genome.gov/sequencingcosts/

To put it bluntly; why look at surrogate markers, such as the architecture of the tissue, or the shape of the nucleus, if you can interrogate directly the changes in the genome that actually define all the characteristics of the tumour?

The main change that justifies this bold prediction is illustrated in Figure 1. This shows the rate of decline in the cost of sequencing DNA. This graph is regularly updated by the Sanger Institute. Note that the vertical axis has a logarithmic scale. We are all familiar with Moore's law, the hitherto-impressive rate at which the cost of computing has declined in recent years. That trend is illustrated by the gently sloping line at the top. The cost of sequencing nucleic acids was falling at a similar rate until mid-2007, at which point the Sanger Institute introduced so-called 'next generation' sequencing technology. The fall in cost was dramatic; estimated in July 2011 as one ten thousandth of the cost in early 2007. A further fall can be confidently predicted as so-called 'next -next-generation' sequencing becomes available. This technique involves single nucleic acid molecules being drawn through pores in particles that report the sequence as it passes through; rather like an artificial ribosome, but generating sequence data rather than protein. It works, and the technology has huge financial backing. Unless the world sees total economic meltdown, it will happen. So it is only a matter of time before the cost of sequencing a whole human genome falls below £100. Current estimates are between three and five years – certainly a lot less than 50 years.

That will have rapid consequences for some of the investigations of which we are currently so proud. If you are considering investigating a tumour using PCR, FISH, or CGH, why bother if you can sequence the genome for the same cost?
We may see that change in five years, but other changes in practice will take longer. In 2010 we saw the publication in Nature of the compete genome of a small cell carcinoma.[4] 22,810 mutations were documented. Most are surely random changes, irrelevant to tumour behaviour, but which ones? Multiply that by thousands of cancer genomes, all of them different, and ask how the changes in DNA sequence will be translated into a classification of disease, into predictions of prognosis and behaviour, into predictions about response to therapy. The magnitude of the bioinformatics problem becomes clearer. As the cost of sequencing plummets, the growing challenge is in analysing the huge volume of sequence data. But with time, it will be solved; the computer algorithms to extract clinically significant information will become gradually more sophisticated. A huge international collaboration has already started, currently planning the sequencing of 18,000 tumour genomes, covering 50 tumour types.[5]

I have heard pathologists claim that the study of morphology is the underpinning on which the development of cancer genomics will be built. I believe that is correct; but I am not sure that the architectural analogy is quite right. If we say "The study of morphology is the *scaffolding* on which the development of cancer genomics will be built", the changed word highlights the fact that once a new structure is sufficiently sound, the scaffolding can be taken away and the structure will stand alone. Sir John Bell's argument is that ultimately, genomics (supported by bioinformatics) will tell us all we need to know about the nature and behaviour of a neoplasm. The morphology of the tumour is merely another consequence of the genomic changes that actually drive tumour behaviour. Why study a surrogate marker of the genomic changes if we can read the genome itself?

Of course, many objections can be raised. For example:

- *The sequence is not everything. What about DNA methylation and other aspects of transcription control?* This is indeed important. But there is no doubt that changes such as methylation will also be increasingly amenable to analysis.
- *What about genetic heterogeneity within one tumour?* That too will be important, but that is not a novel problem; that's why we already sample multiple sites in a tumour for histological assessment. In due course genomics will be able to do the same.
- *You're ignoring RNA and proteomics.* Not entirely; RNA is also amenable to the new

sequencing strategies and proteomics is getting more sophisticated. They may be of value in cancer diagnostics, and they will certainly be of value in non-neoplastic disease. But in cancer, changes in RNA and protein are driven by changes in the genome. RNA and protein are far less stable molecules than DNA, so it seems logical at the moment to concentrate on the DNA.

- *What about tiny samples, or those containing just a few malignant cells?* That would currently be challenging; but it is important to recognise that the new techniques involve massive oversampling. Short segments of DNA are sequenced many times and the sequences are 'stitched together' by a computer, by mapping them against the known human genome. So by adjusting the level of oversampling it will be possible to detect abnormal sequences even if they are present only in a small proportion of cells.
- *It's not going to be ethically acceptable to sequence the whole genome because you don't know what unwanted information might be generated.* This argument is flawed. It misses the distinction between the sequencing and the analysis of the sequence. Sequencing the genome merely converts information in one form (DNA) into another (digits in a computer's memory). Neither represents information of any meaning to a human until the sequence is analysed and compared with other, known sequence changes. So the nature of the analysis needs ethical control. To claim that it's unethical to sequence the genome because you might, without consent, find a susceptibility to Huntingdon's chorea, is analogous to saying you can't take a blood sample because you might test it for HIV without consent.

The death of the H&E section has often been predicted in the past, and the obituaries have always been premature. But it would be illogical to infer that the H&E section is therefore immortal. If the developments I have describe do come to pass – and please remember that I have been asked to consider 50 years hence – we are considering a situation where histopathologists are responsible for making sure the right bits of tissue go into the sequencing process. Histopathologists will probably also be needed to make sure that the radiologists have assessed tumour stage correctly. But that is hardly enough to justify the highest respect of society.
The nucleic acid sequences generated will be analysed by computer algorithms that gradually increase in sophistication. Who will develop those algorithms? The results of the sequence analysis, at least initially, will be complex, uncertain and will demand human interpretation and judgement, fitting the computer readouts to other things that are known about the patient and the tumour. That is the sort of work that demands respect and high professional status. Who will do that work?

The situation is therefore in many ways similar to the mid nineteenth century, when Rudolf Virchow started to apply the new tool of tissue microscopy to the diagnosis of disease. The diagnostic project that he initiated has been developed and refined over the subsequent century and a half. But if Rudolf Virchow was a young man today, what would he be doing? Would he dismiss these new techniques, to concentrate of further refining the interpretation of the H&E section? I think not.

I recently met a trainee pathologist who is undertaking a PhD in cancer genomics. "How is it", she asked me with indignation, "that while I was training to diagnose cancer in the hospital laboratories I was never even aware of the existence of online databases of mutations in cancer such as CoSMiC?"[6]

How indeed? I hope I have made the case that the pathology trainees of today will see their work revolutionised within their lifetimes, and if they do not learn how to take part they will be sidelined. This is recognised by those responsible for training – to some extent. Molecular pathology, as practised now, has been introduced into the curriculum. But when I have pressed for more, for teaching our trainees about the techniques of the future, I have too often been met with the response that 'we can't put that in the curriculum because we can't deliver it'. That's tantamount to saying that we can't prepare our trainees for the future. In that attitude, I believe, lies the decline of our profession. Recently, in an attempt to break this argument, I have been involved in a plan to establish a short residential course on cancer genomics for histopathology trainees. This has been warmly welcomed. But

I was profoundly depressed when one Fellow of the College who is heavily involved in training said to me in an email: "As for recruitment, I hope that you are right; however from bitter experience, the great majority of trainees are just not interested in the subject".
If that is true, then whatever our success as trainers, as educators we have failed a generation of trainees. If that is true and if that attitude is not reversed, I fear there is no hope for our profession.

I will not end on such a gloomy note. I will discuss a possible cause and a possible solution. To do so I will start with a question. Is our attitude to research part of the problem?

I believe that involvement in research is essential for a good training in pathology, but emphatically ***not*** because consultant pathologists need to undertake research. It is essential because of its side-effects. Research proves to the trainee that our practice as diagnosticians moves on, and that keeping oneself at the cutting edge of medical knowledge, even in a small area, is hard but necessary work. Without recognising that, a worker will stagnate and the service will stagnate. Research also demands good judgement, problem-solving and self-motivation. These are surely attributes that distinguish a respected professional from the rest. These attributes will not be not taught if all we teach is 'knowledge and skills'.
We have all heard evidence that the level of research activity in histopathology in the UK has declined. I have heard it alleged that, because ours is a shortage specialty, our trainees know that they can obtain a permanent post if they pass the examinations, without having to do research; so they don't do any. This is not a valid explanation. Haematology is also a shortage specialty, but haematologists do not regard themselves as as properly trained unless they have undertaken at least some research work.

The difference lies in the trainers.

In 1987 the Pathological Society of the United Kingdom and Ireland awarded its prestigious C L Oakley lecture to A K Foulis, on the basis of his research into the cause of diabetes, using pancreatic tissue from recently deceased diabetics.[7] The author had contacted pathologists throughout the UK asking for such rare tissue samples and his requests had been fulfilled in abundance. In contrast, in 2009 I was informed that an MRC-funded project into the identification of patients who would respond to specific forms of cancer chemotherapy was in danger of failing (Personal communication, Professor P Quirke). This project also needed archival tissue samples from pathologists around the UK. These samples had been removed from the living; consent and research ethics approval were in place, so the human tissue legislation posed no barrier. Despite this, the majority of pathologists were ignoring or refusing the requests. The excuses given by those who had the courtesy to reply were various, but they all displayed a reluctance to facilitate research. The reasons for this lamentable change in attitude are complex, uncertain and beyond my remit in this lecture. We all know that a change in attitude has happened. But I had not realised until quite recently the pernicious effect this shift in attitude has had on training, and hence on the future of our profession.

In the 1980s and 1990s I recall many debates about whether an academic had to be involved in research in order to be a good teacher. I do not recall a clear answer ever emerging, but despite this we have seen a growing separation between those who research and those who teach. In my own department, the door between the NHS service department and the University department, once always open, now has a security lock. It seems highly symbolic of the wrong road that we have taken. Trainers who specialise in training can teach knowledge and skills very successfully, of that I have no doubt. But that is not a complete education. To teach the next generation to probe, to challenge current orthodoxy and to see the way the future leads needs the input from those whose job demands that they spend every day doing exactly those things; that is to say, it needs the input of active researchers.

If this diagnosis, based as it is on incomplete information, is accepted, then I suggest the following potential remedies.

1. Our curricula and assessments should demand up to date genomics and bioinformatics, not at the level currently practised in our cash-strapped NHS laboratories but anticipating the needs that we can see approaching. When it is in the curriculum we can argue more effectively about how to deliver it.
2. Every diagnostic laboratory should obtain approval from the National Research Ethics Service (NRES) to function as a research tissue bank, thereby removing the need for further ethics approval before trainees can undertake small tissue-base research projects. We complain about the bureaucracy, but have we taken advantage of this method by which it can be reduced?
3. Research should be a mandatory part of the training of every cellular pathologist. Ideally to MD level. As with genomics, not having sufficient active researchers within our training departments should not be accepted as an excuse.
4. All curriculum and training programme development should involve – or better still be led by – academics with current research experience. Any trainer who regards training merely as a process whereby the trainer's knowledge and skills are cloned should be allowed no role in planning how training is delivered.

I hope you can prove me wrong. I will welcome disagreement from those who produce logic and evidence to prove me wrong, because I am profoundly saddened by my conclusions. But if you agree with me – even if only in part – and if you wish our profession to have a future, then I hope you too will stand up and argue for change.

References

[1] Tom Keating. Wikipedia entry: http://en.wikipedia.org/wiki/Tom_Keating Accessed December 2011.

[2] Royal College of Pathologists. Cancer datasets and tissue pathways. http://www.rcpath.org/index.asp?PageID=254 Accessed December 2011.

[3] Bell, J. Redefining Disease. The 2010 Harveian Oration. Royal College of Physicians of London, 2010. http://bookshop.rcplondon.ac.uk/contents/pub318-897c4992-b899-430b-a895-a46197957d9d.pdf Accessed December 2011.

[4] Pleasance ED, Stephens PJ, O'Meara S et al. A small-cell lung cancer genome with complex signatures of tobacco exposure. Nature, 2010; 463(7278):184-90.

[5] International Cancer Genome Consortium, http://www.icgc.org/ Accessed December 2011.

[6] Catalogue of Somatic Mutations in Cancer (COSMIC). At: http://www.sanger.ac.uk/genetics/CGP/cosmic/ Accessed December 2011.

[7] Foulis AK. C. L. Oakley lecture. The pathogenesis of beta cell destruction in type I (insulin-dependent) diabetes mellitus. J Pathol 1987;152:141-8

BDIAP SPONSORED EDUCATION FOR OVERSEAS PATHOLOGISTS IN TRAINING

From Dr Udovicic-Gagula, Sarajevo, Bosnia

I would like to thank the BDIAP for giving me the opportunity to visit the Royal Brompton Hospital for six weeks in London, and meet Professor Andrew G Nicholson and his colleagues. There I had a wonderful opportunity to visit their Department of Histopathology and learn mainly thoracic but also cardiac histopathology from exceptional specialists like Professor Nicholson, Dr Rice and Dr Sheppard.

During my attachment, I saw and learned many new things from thoracic histopathology especially from non-neoplastic lung pathology, and had the pleasure to meet other pathologists, both consultants and trainees, from their own and other departments. Also, I had the opportunity to visit Harefield Hospital, and see some cases of transplant pathology, which I had not seen before during my training.

For me this was a priceless experience which will be very useful in my further work and I hope also for my department as I continue my training.

Thank you for your generous support, which has enabled to me this unforgettable experience.

From Prof Andrew Nicholson, BDIAP Honorary General Secretary:

Dalma attended as the first sponsored overseas trainee to take advantage of this BDIAP initiative in our department. She has taken full advantage of the opportunity, shadowing our own trainees through the macroscopic and microscopic reporting of thoracic and cardiac pathology and, when not sitting in on our sign-out sessions, she has worked her way through our teaching collections during her tenure.

It was also pleasing to see how she has dealt with the language barriers, such that in the six weeks attending our department, she started producing separate written reports alongside our regional trainees in an effort to advance not only her pathology skills but also her skills in the English language.

As an initiative, logistical issues aside (ensuring visas and other approvals) I think that this way of providing education to overseas trainees has significant merit, and has proved a successful venture. Congratulations should go in particular to our Education Subcommittee for their hard work in making this happen.

Dr Udovicic-Gagula reporting at a multiheader microscope with Prof Nicholson and Dr Anna Green, Specialist Trainee.

THE 4th JUNIOR INTERNATIONAL ACADEMY OF PATHOLOGY

By BDIAP Bursary recipient, Dr Manisha Ram

The “International Junior Academy”, the 4th in this successful series of meetings, was held at Johannisberg, Geisenheim (Germany) between the 3rd and 6th of July 2011. This meeting, held annually, is primarily aimed at trainee pathologists from all over Europe, the format being that of a Summer School. The Tutors are generally world renowned experts in their fields. This year’s meeting was organised by Professor Martin Hansmann and Professor Kristin Henry and the topic was “mesenchymal tumours and malignant lymphomas”. There were eleven Tutors from Australia, Germany, India, Ireland, Italy, UK and USA. Every year, the BDIAP sponsors two trainees for this experience and this year, the lucky winners were Dr Paul Bennett, Histopathology SpR at Calderdale Royal Hospital, Halifax and myself. I was filled with both excitement and trepidation at the prospect of meeting world leaders in a field, which I had only just started to scratch the surface of.

Day 1

It started with a formal come together lunch, in which the Vice President of the German Division of the IAP, Prof. Martin-Leo Hansmann (*Johann Wolfgang Goethe University, Frankfurt am Main, Germany*) gave us a very warm welcome.

The opening lecture was by Prof. Jurgen Hescheler (*University of Cologne*, *Germany*), in which he spoke about “Pluripotent stem cells in research”. This was followed by an educational lecture on “Classification strategies of mesenchymal tumours” by Prof. Reinhard Buttner (*University Hospital Cologne*, *Germany*). Even though I was quite tired by this time, considering the 3am start of my day, I thoroughly enjoyed it. To ensure that it was not too busy on the first day, with all the attendees arriving on the same day, the organisers had included a social programme for the evening. It started with a relaxing walk through the vineyards, which were literally geometric orderly grids. The guide explaining the whole process of wine making: right soil, right time and right grape for the right wine! On our return to the hotel, we were welcomed to the most finely organised barbecue.

The unclouded sky was the deepest blue, the clear and clean peaceful air was

Left: delegates at the 4th Junior Academy walking through the vineyards

Right:
Martin Hansmann and Kristin Henry enjoying the wine tasting

exhilarating. We had enough time to get to know each other during the al fresco dining. Our group comprised 22 trainees from Finland, France, Germany, Ireland, Norway, Slovakia, Switzerland and UK.

Day 2

It started with an excellent continental-style breakfast. We were fortunate enough to be joined by the energetic and charming Prof. Mary Leader (*Beaumont Hospital, Dublin, Ireland*), who started the day with a very clear lecture on "Mesenchymal tumours". The next keynote lecture was "Dendritic cell associated diseases" by Prof. Kristin Henry (*President of the IAP, Imperial College London, UK*), who delivered a very well structured and interactive lecture. Then came "Demystifying the art of making histologic diagnosis" by Prof. Bharat N Nathwani (*Los Angeles, USA*), which was utterly mesmerising. He gave us a practical approach to lymph node pathology. We found it to be so educational, that I took charge of requesting him for an extra lecture, which he very kindly agreed to slot in during the next day's lunch break. Prof. Fabio Fachetti (*Servizio di Anatomia Patologica, Italy*) then gave a fantastic overview of "Histiocytic tumours". Then came time for the three course dinner, during which we had ample time to talk and connect with each other. This day was slightly busy and after dinner, it was time for Prof. Paul Waring (*University of Melbourne, Australia*) to tell us about "Next generation sequencing in malignant tumours". He spoke about the Cancer Genome Project, Clinical trials (the phases they go through) and '*designer drugs*'. We came to know about third generation sequencers, which target individual patient tumours: almost like *bespoke medicine*! He stressed that if we (Histopathologists) do not stand up and take charge of this rapidly expanding field of Genomics and Molecular Pathology, we will be left out and soon overtaken by Medical Physicists, Geneticists, and the like.

I went back to my bedroom, fully charged with ideas and thinking about Molecular Pathology and what I could do to secure my place in the future of the Molecular world. The dreams which followed in the night are quite obvious!

Day 3

This day was expected to be quite busy with lectures extending till quite late in the evening. The theme of the presentations was "Haematolymphoid tumours" with the first key note lecture "T-cell lymphomas of AILT type" by Prof. Ahmet Dogan (*Mayo Clinic, USA*). This was followed by "Extranodal follicular dendritic cell sarcoma-where lymph nodes and soft tissues meet" by Dr Anita Borges (*SL Raheja Hospital and Director of Piramal Diagnostic Services Ltd, Mumbai, India*). She is known to be an excellent speaker and she made it all seem so easy. Follicular dendritic cells were described as '*kissing cells*' (a description which will always help me in their recognition). The next lecture was by Prof. Mary Leader (*Beaumont Hospital, Dublin, Ireland*), who presented a

The Hotel in a beautiful setting

further extension of her previous “Mesenchymal tumours” lecture. She told us in detail about diagnosing some of the more difficult soft tissue tumours. Prof. Hansmann (*Johann Wolfgang Goethe University, Frankfurt am Main, Germany)* gave the next talk “Hodgkin lymphoma-a mesenchymal tumour?” He gave us an interesting insight into Hodgkin lymphoma. We were all very fortunate to have the legendary Prof. Stephano Pileri (*Universita di Bologna, Bologna, Italy*), who in spite of being quite ill till one day prior to the meeting made it to Johannisberg and talked about “New tools for the classification, prognosis and therapy of peripheral T-cell lymphomas” The day ended with wine tasting in the nearby gardens. Being the mother of a ten year old, I thought it would be wise to sacrifice this session for a quick trip into town in order to buy a gift for her. Although I made it in time for dinner, I missed the fun and relaxation associated with the wine tasting. But I was also slightly relaxed-having found my daughter’s perfect gift! Over dinner, Prof. Ahmet Dogan and I had a frank and slightly cathartic conversation about the current state of the Histopathology service and what the future holds.

Day 4

This was the last day and intentionally kept quite short, starting with a clearly outlined lecture on “Myelosarcoma” by Prof. Kristin Henry, followed by a highly interactive slide seminar by Profs. K Henry, A Borges and B Nathwani. The cases were very informative and interesting-why shouldn’t they have been? The presenters were the best in their fields and they made sure that each one of us engaged in the discussion. We all had such great fun. What a fabulous end to a great meeting!

In Summary

Paul and I had an excellent educational experience. I felt like a sponge, trying to soak as much as possible in these areas. It was truly an invaluable experience, worth all the adventure (perilous taxi journey, etc). The meeting comprised a packed programme of spoken seminars, lectures and a small collection of some interesting lymph node slides, which Prof. Hansmann had brought with him. The quality of presentations throughout the meeting was very high, with enthusiastic discussion between the speakers and the trainees. We were provided with hard copies of the lectures so that we could concentrate on the lectures, rather than make notes. The social events were very enjoyable (thanks to Martina Schmidt of the organisation team), which gave many of us our first experience of German hospitality, which truly is second to none. Johannisberg is a beautiful village on the banks of the river Rhine, amidst famous vineyards. I would truly recommend attending the next meeting which is planned to be in Dublin, Ireland between 1-4 July 2012, covering varied and interesting topics.

I would like to thank the BDIAP for granting me this bursary, making it possible for me to attend and learn from this excellent meeting. I would also like to thank the organisers and speakers. Dankeschön!

5th International Junior Academy Summer School
July 1 – 4, 2012, Dublin, Ireland

The German and British Divisions of the IAP welcome you to the 5th International Junior Academy Summer School, this year being held in the beautiful seaside location of Portmarnock, just outside Dublin.
This annual Summer School is aimed primarily at young pathologists. Selected topics will be discussed in depth by experts and participants are encouraged to fully participate in all the sessions and to meet and have discussions with the experts. The School also provides the unique opportunity for participants to meet with other young pathologists from many countries and to exchange ideas.
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For information on BDIAP Bursaries for this meeting, see www.bdiap.org

Asbestosis Research and the Work of Professor Matthew Stewart

Peter Johnston
Recipient of a BDIAP BSc Scholarship for an Intercalated degree in The History of Medicine, University of Leeds, 2010

The historic development of the Pathological sciences in Britain is an area which has received little attention, but which affords fascinating perspectives into the development of the modern discipline. As a medical student taking an Intercalated degree in the History of Medicine, I was well placed to carry out a research project in this area, and was fortunate enough to be supported in this by the generous BDIAP intercalated scholarship. My research centred on Professor Matthew Stewart, who was Professor of Pathology at the University of Leeds between 1918 and 1950. Of particular interest to me were Stewart's researches into the effects that inhaled asbestos dust had on the lungs of asbestos factory workers. As will be summarised in the following short article, early asbestosis research is a complex and sometimes controversial issue, and provides an intriguing insight into the work of an Academic Pathologist in the 1920s and 30s.

I was fortunate to be able to draw on a unique source for my research into the history of pathology: the Brotherton Library at Leeds was bequeathed the diaries of Professor Matthew Stewart. The diaries total one hundred and eighty volumes, and cover a period of almost sixty years. As a man distinguished in his field and long-time editor of the influential *Journal of Pathology and Bacteriology*, Stewart's diaries represented a matchless opportunity to reconstruct a personal history of an era of rapid development for the discipline of pathology. Yet there was a second and potentially even more interesting aspect to the project - Professor Stewart had an interest in the pathological changes produced by inhaled asbestos dust; this was at a time when recognition of asbestos' carcinogenic properties was decades in the future, and its potential to cause pulmonary damage of any kind was only just becoming appreciated. In 1929 Stewart was given a Medical Research Council grant to conduct a thorough investigation of asbestos' hazards, involving clinical, pathological and physiological research. Yet the work was never completed. In 1930, a landmark paper by Edward Merewether of the Home Office proved conclusively that asbestos workers exposed to dusts developed progressive pulmonary fibrosis, or 'asbestosis' as it became known, resulting in the 1931 Asbestos Industry Regulation. These introduced measures for the suppression of

The Institute of Pathology, Leeds.
The Algernon Firth Building was designed by John Clifford Procter and completed in 1933, when the pathology department, headed by Stewart moved in. There is a dedication to Professor Matthew Stewart in the foyer. The Old Medical School was opened in 1865 and Stewart was Dean of the medical school between 1941 and 1948.

dust in factories. This paper marked the end of any purposeful research into the links between asbestos and disease until the late 1940s, and the matter was supposed resolved. For the thousands of workers who went on to develop malignant mesothelioma or lung cancers the pause in asbestos research was to prove catastrophic. My project attempted to establish why it was that Stewart's researches – which had the potential to uncover the truly injurious effects of asbestos dusts - had been abandoned.

Asbestos and Health: Research in Great Britain

The recognition of asbestos' injurious effects on workers' lungs was confounded by long latency periods and, in the early 20th century, by the near ubiquity of tuberculosis infections in workers suffering serious pulmonary disease. The first case of pulmonary fibrosis to be linked to asbestos inhalation was reported to a Home Office Committee on Industrial disease in 1907, although reports by the Women's Factory Inspectorate had raised concerns as early as 1898. In 1924 a Pathologist from Wigan named Cooke claimed to have the "first [case of asbestos fibrosis] …to be definitely proved." Carrying out the autopsy of an asbestos factory worker, Cooke had observed particles of mineral matter resembling asbestos fibres, in addition to extensive fibrosis of the lung parenchyma. Such isolated cases drew little attention, especially as it could not be demonstrated that the presence of asbestos spicules was a sufficient cause of fibrosis. Further, conditions in British factories at this time were far from salubrious, and industrial diseases were rife: the health hazards posed by a relatively small asbestos industry were not a pressing priority.

In 1927 the term 'asbestosis' (referring to pneumoconiosis caused by the inhalation of asbestos dust) was used in two articles in the *British Medical Journal*. Naming the disease after asbestos was not, however, sufficient to convince the establishment that the asbestos industry was to blame, especially since the presence of tuberculous change in the lungs of deceased workers could be pointed to as a confounding factor. Some method of demonstrating the presence of asbestos bodies in the lungs of living asbestos workers was required, and this needed to be linked to a comprehensive study of the changes observed clinically. Stewart's published work shows that he had devised techniques for detecting asbestos bodies in the sputum of patients. This would have allowed the presence of bodies to be tied with the symptoms of pulmonary asbestosis in the living patient, and to track the progression of disease. It was this potential that attracted the interest of the Medical Research Council. In 1929 they invested funds in the department for research on asbestosis, to be carried out in conjunction with the physiology department.

Shortly afterwards, in 1930, the Home Office published the results of a cross sectional study of asbestos workers carried out by Edward Merewether. The paper was an exemplary piece of epidemiological research, and resoundingly established the link between inhaling asbestos dust and developing a serious fibrosis of the lungs. This led to the 1931 Asbestos industry Regulations, which stipulated measures for dust suppression in British asbestos factories. Whilst this was surely advantageous to asbestos workers in the immediate term, it had the effect of offering reassurance that the problem had been dealt with – reassurance that analysis of the findings shows to be false. Merewether's report found that workers employed in the dustiest processes of asbestos manufacture had an incidence of asbestosis approximately four times greater than that of those employed in the least dusty, so the rationale behind the 1931 regulations was to reduce these high levels of dust. Yet nothing in the report indicated that suppressive measures would prevent asbestosis – the evidence simply implied that incidence would be reduced. Implicit in the Home Office response was a curious value judgement intrinsic to an age of distinct class values: it was expected that there would be some health risk associated with factory work, and the 1931 regulations were seen to reduce that risk to an acceptable level.

The reasons that Stewarts' researches were not continued are many and various, and form the main subject of my dissertation. This article serves only as an introduction to the topic, and as an interesting illustration of how the development of science is a historically contingent process. I finish this article by illustrating this more specifically with a few speculations of my own.

In 1955 Georgina Bonser (a pathologist from Leeds University) studied the association between patients who had suffered asbestosis and cancer concurrently. This was achieved by re-examining a col-

lection of eighty post mortem specimens that had been obtained by Stewart at the time of his own asbestos research. 72 of these specimens were included in the final study and 18 cases of cancer were found: an incidence of approximately one in four. At this time evidence of asbestos' carcinogenic properties was accumulating – evidence that would eventually lead to recognition of the true hazards of the mineral. Matthew Stewart had access to these specimens a quarter of a century before the publication of this study, and almost twenty years before serious questions were posed about the link between asbestos exposure and cancers. The abandonment of Stewart's asbestos research therefore represents an opportunity missed – an opportunity which could have had a profound impact on the health of asbestos workers both in the UK and worldwide.

I would like to thank the BDIAP for providing the generous scholarship which supported me throughout my intercalated degree, and which made this research possible. I feel strongly that the history of medicine has much to offer medical practitioners, and that an appreciation of the contingencies of scientific progress is a useful perspective to hold in any branch of research. My own thinking has been broadened whilst undertaking this degree, something that I feel the benefit of now that I am studying medicine once again. I hope that this article has been of interest, and if BDIAP members would like to read my dissertation in full please contact me at: um07pij@leeds.ac.uk.

The Gilbert Scott Building was added to Leeds General Infirmary in 1868 - Stewart and the Pathology department undertook much of the LGI's pathology work, which was a large source of income for the department (Sir Gilbert Scott is also famed for having built St Pancras Station).

36th European Congress of Cytology Istanbul, Turkey - Silke Weischede

Dr Silke Weischede is an SpR in Histopathology at Dewsbury District Hospital and Junior BDIAP Councillor

Thanks to the generous ACP travel grant[1] I was able to go where most people dream of: The land of bazaars, myths and mosques, where East meets West and outstanding history.

Under the supervision of Dr Avril Cullen, Consultant Cytopathologist, I looked at the adequacy of EGFR mutation testing in non-small cell lung cancer on cytology specimens in the Leeds Teach-

ing Hospital Trust over a 7-month period. We found that 98% of our cytology cell block preparations produced satisfactory DNA amplification in all four mutation sites in the EGFR receptor (exons 18-21), 16% of which actually carried the mutation. In total 7% of the mutations identified were of clinical significance. In comparison, surgical specimens tested during the same time period showed a much lower amplification rate of 73%, with a failure rate of 5% and a clinically significant EGFR mutation rate of only 1.2%.[2] Discussed as possible explanations were sampling difficulties (anyone who has at least seen pictures of a bronchoscopy will understand), poor fixation of resection specimens and interference of non-malignant cells in surgical specimens. Our data were comparable to a study carried out by Smouse, Cibas *et al*[3], and also to a study recently published in a letter to Thorax by a group in Manchester, UK[4].

Silke and BDIAP European Vice President, Professor Claude Cuvelier

The 36th European Congress in Cytopathology was held in the Istanbul Military Museum in Harbiye, situated in the modern part of town. It addressed all of the important pillars of Cytopathology, and additionally paid attention to areas that are not much talked about elsewhere, e.g. Training in Cytopathology, Digital Cytopathology and even Veterinary and Forensic Cytopathology. Slide Seminars, for which the slides had been made available online beforehand, and workshops rounded the programme off nicely. The speakers, and the participants, came from all over the world. The atmosphere was fantastic and delegates enjoyed not only being part of the conference but also discussing methods and strategies used in other countries. Professor Pinar Firat, Scientific Secretary to the Organising Committee, worked tirelessly to ensure that the conference proceeded smoothly. Being very approachable, she sorted queries quickly and efficiently, and her warm and welcoming personality added to the conference's success.

I had the opportunity to hear excellent speakers from the UK in slide seminars. Dr Ashish Chandra discussed a difficult case of renal cell carcinoma metastatic to the pancreas and Dr Mina Desai chaired and contributed to the gynaecological cytology seminar. Dr Amanda Herbert and Dr Karin Denton were present in multiple symposia concerning *EU guidelines for cervical screening, Training in Cytopathology* and gave advice on *How to write a paper*. Dr Winifred Gray took part in the well-attended session "*Our mistakes in cytology*".

The companion of probably every histopathology trainee in the UK, Dr Edmund Cibas, enlightened the audience with his lecture *The Bethesda System for Reporting Thyroid Cytopathology in the United States*. Professor Syed Ali made the diagnosis of pancreatic and thyroid lesions seem entirely possible, as opposed to the usual terrifying experience that such specimens present in a normal trainee's life. Both speakers are faculty members of the renowned John Hopkins University Department of Pathology Division of Cytopathology in Boston, MA, USA.

Hagia Sophia (Ayasofya in Turkish), Istanbul

In addition to a well selected group of speakers, the attendees were notable too, including our very own Professor Claude Cuvelier! (above left)

As a detailed review of the excellent programme, the free papers and poster presentations would go beyond the scope of this article, I refer the inclined reader to the internet homepage of the conference *http://www.cytologyistanbul2011.com.*

The conference covered not only scientific topics, but also tried to bring Istanbul closer to the participants with social events including city tours, a Gala Dinner Bosphorous cruise and a beautiful concert evening with classical Turkish melodies translated into contemporary performance in the magnificent Hagia Irene in the courtyard of the Topkapi palace. The Hagia Irene is a former Eastern Orthodox Church that, in daytime, serves as a museum. It can usually only be visited with special permission, so we were fortunate to get a glimpse at it.

During its long history, Istanbul has served as the capital of the Roman Empire (330–395AD), the Eastern Roman (Byzantine) Empire (395–1204 and 1261–1453), the Latin Empire (1204–1261AD) and the Ottoman Empire (1453–1922AD). The city is huge with over 20 million inhabitants, and it is a mystery to me how all the tourists fit in as well. Armed with the *Turkish guide for English speakers*, which was helpfully included in our conference welcome pack, and no sense of direction I set off to explore some of the Old Town must-sees: The Blue Mosque, the Hagia Sophia, the Egyptian Bazaar (also known as Spice Bazaar) and the Basilica Cistern.

The Basilica Cistern is a wonderful, dreamlike place so named because, before serving as a reservoir for the city, a Basilica stood in its place. An underground cathedral-sized water-filled chamber the cistern provided a water filtration system for the Great Palace of Constantinople and other buildings on the First Hill, and continued to provide water to the Topkapi Palace after the Ottoman conquest in 1453 and into modern times. A forest of 336 marble columns in Ionic, Corinthian and Doric styles supports the ceiling. In the fairy-tale-like gloom it was often hard to tell where the water level was, so clear were the reflections of the columns. The head of the myth-enshrouded Medusa lies at the base of two pillars and these were definitely worth the visit. Luckily they didn't turn me into stone whilst looking at them, as suggested by the legend.

A bus ride down the Golden Horn took me away from the buzzing life of the Old Town, and I went on a little cable car ride to the famous Pierre Loti Café. It is situated on a hilltop overlooking the Golden Horn and vast parts of Istanbul, affording you a hint of the grandiosity and diversity of the city. The café was named after a French Naval officer who wrote under the pen name "Pierre Loti", and apparently loved to sit on this hilltop spending his time overlooking the city (and writing, of course!).

My expedition to the 36th European Congress of Cytology was a great experience – I learned a lot whilst preparing a concise talk for an international audience, met with like-minded people from around the world and, last but not least, had the privilege to catch a glimpse of one of the most historical places in the world – Istanbul is included in the UNESCO World Heritage List. I also learned that there is always time for a good Turkish coffee or tea.

For your Diary:
The 37th European Congress of Cytology is takes place in Dubrovnik, Croatia between 30th September and 3rd October 2012.

References:

[1]O O'Mahony. ACP Travel Grant: 6th joint meeting of the BDIAP and the Pathological Society of Great Britain and Ireland, Ghent, Belgium. 10 – 13th May 2011. *ACP news* 2011; Autumn: 27-29.

[2]Weischede S, Davidson L, Cullen A. Assessment of adequacy of cytology samples for EGFR mutation testing in the treatment of non-small cell lung cancer *Cytopathology* 2011; **22 Suppl 1**: Oct 2011

[3]Smouse J, Cibas E, *et al*. EGFR Mutations Are Detected Comparably in Cytologic and Surgical Pathology Specimens of non-small cell lung cancer. *Cancer Cytopathol* 2009; **117**: 67–72

[4]Thiryayi SA, Rana DN, Woodhead M. Utility of cytopathology in diagnosis and molecular testing of lung cancer. *Thorax (published online July 29, 2011)*

HIGHLIGHTS OF 2011
GHENT PATHOLOGY 10-13th May 2011

The British Division of the International Academy of Pathology

Divisional Editor: Stephen Wells

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The British Division of the International Academy of Pathology covers:

- The United Kingdom
- The Netherlands
- Belgium
- The Republic of Ireland.

Its aim is the advancement of pathology, through:

- Improvement of methods of teaching pathology
- Coordination of pathology with allied sciences and techniques
- Promotion of research in pathology and pathologic techniques
- Publication of reviews and the results of work in pathology and related fields
- Convocation of meetings and congresses for exchange of scientific information and ideas.

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FUTURE MEETINGS

5th Trainees Meeting on "The Autopsy"
Magdalen College, Oxford,
12th April 2012

105th BDIAP Symposium on Dermatopathology
Magdalen College, Oxford
13-14th April 2012

IAP International Congress,
Cape Town
30th September - 5th October

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Left: Business over a drink with senior BDIAP members, Welcome dinner with Professors Claude Cuvelier and Ian Ellis, BDIAP and Pathological Society Presidents, Professors Neil Shepherd and Andrew Wyllie, The Public Lecture "Old and New Challenges in Global Health" given by Prof. P Piot, London with Prof. Cuvelier, The Pathological Society 9th Doniach Lecture given by Prof. F. Bosman, Lausanne, with Prof. Wyllie.

Right: Conference dinner in the Augustine Monastry, Ghent, BDIAP Bursary recipients from Nigeria, BDIAP Hon. Secretary Prof. Andrew Nicholson in action, Prof. Shepherd, Prof. Alistair Burt (now Editor of Histopathology) and Dr Ray McMahon (BDIAP Treasurer), our delightful hosts in Ghent, Professor and Mrs Claude Cuvelier. Professor Cuvelier also gave the BDIAP George Cunningham Lecture.