
Point of view

Subspecialisation in histopathology: The Sri Lankan perspective

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Many changes have taken place in the practice of histopathology over the last few decades. The demands on histopathologists have increased with regard to the use of minimum data sets in reporting, demands for diagnostic accuracy in terms of treatment and prognostic information including immunohistochemistry and molecular biology.

The most important technological advances we have seen in the last 25 years have been the introduction of the flexible endoscope, biopsy needles and various forms of imaging techniques, all of which have increased the workload and demands on the pathologists (1). With this, therefore, has come a trend towards specialisation in histopathology.

Currently, a selected number of pathologists worldwide practice superspecialisation, where they work and report only in one specific anatomical site. Subspecialisation on the other hand implies the day to day reporting of a limited range of sites in teams. The pressure for subspecialization comes mainly from the perception that this would bring about high standards of diagnosis and reporting. There is a body of

evidence supporting this in the form of audits (2,3,4,5).

However, we need to take a few moments to ponder the relative merits and demerits of a specialist versus generalist pathologist in histopathology practice. In subspecialisation, the directed expertise will result in greater accuracy (2,3,4,5,6) with experts being probably quicker than generalists in signing out cases. This will lead to more timely and accurate reports.

The clinicians would be happier working with a single pathologist or a small group of pathologists with whom they have developed an understanding and rapport. Pathologists may also feel happier in that they are more confined to their “comfort zone”. This however begs the question: would subspecialisation lead to solitude and boredom in the long run? “Solitude is to the mind what diet is to the body, a necessity that proves fatal if suffered too long.”- Marquis de Vauvenargues, in Reflections and Maxims.

In training of postgraduates, subspecialisation may be considered a double edged sword (7). On the one hand there will be more knowledge and skill gained by working with a specialist and the enthusiasm of an expert may

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definitely rub off. On the other hand in subspecialty reporting, trainees would typically see how an expert approaches a case. Subconsciously, they will absorb the biases and diagnostic thresholds of this individual with regard to "gray zone" or borderline cases. They may be surprised to find, that these differ in the real 'world'.

Working with a generalist, a trainee is likely to see how different pathologists approach a problem. In the process they would internalise a limited but real range of thresholds and achieve a better understanding of these gray zone areas. There will also be a need to identify as many specialists to work with, if trainees are to cover most of the different areas in pathology and complex training rotations would then be required. Perhaps the biggest drawback of this system would be the inevitable inefficiency that occurs in smaller histopathology practices.

Once a subspecialty approach is adopted the pathologist will be only signing out cases from a few anatomic areas and they are bound to lose their skill and confidence in signing out anything else. Thus, there will be a need to cover for each subspecialty during vacation, illness etc. This can lead to an increased requirement of cadre positions. Administrative problems that can arise include on call scheduling and work load calculations. A system of weighting factors has been formulated to ensure that there is an equitable work load distribution among pathologist reporting different specimens of differing complexity (8,9).

In Sri Lanka at present we have approxi-

mately 84 histopathologists. In the Health Ministry, almost all pathologists practice single handed. There are only two centres ie: the National Hospital of Sri Lanka and the Cancer Institute Maharagama that boasts of two consultant histopathologists. To achieve a specialised service there must be a critical mass of pathologists. Numbers are imprecise but it has been suggested that a group of 15 – 20 pathologists are needed (1). Even though smaller practices worldwide have adopted systems of partial subspecialization with a commendable degree of success (10), we in Sri Lanka will not be able to do so for a long time to come. The University departments however can seriously consider some degree of subspecialisation as many have at least 4 senior lectures on their staff.

For Sri Lanka therefore the ideal would be for pathologists to develop areas of special interest whilst practicing as generalists. Hence, younger pathologists should be encouraged to develop such interests from the beginning as in the post MD overseas training period and continue to build on it. The college should encourage the government to consider providing short term fellowships for the pathologists in their areas of interest.

Establishment of expert panels to advice on difficult cases would also be another possibility, thereby building a strong referral system within the country. The college could initiate such a process by nominating its members to function in such panels. Yet another

option would be to centralise pathology services to some of the major hospitals so that a team of at least four pathologists could be appointed to a single center. This however requires a major overhaul in the estimated cadres and the current transfer system.

The result, we believe, would be the best of both worlds (ie: of specialist and generalist), especially in Sri Lanka, where pathologists will be able to retain their generalist skills whilst developing areas of specialist interest that would bring forth the necessary expertise and skill to improve the diagnostic accuracy required. It is after all “very much better to know something about everything than to know all about something” - Blasie Pascal, in *Pensees*

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