Guidance for breast pathology staff in the COVID 19 pandemic from the National Co-ordinating Committee for Breast Pathology (NCCBP) and the Association of Breast Pathology (ABP)

Individual Trust and other national guidance should be adhered to in the setting of the COVID-19 pandemic, but in views of questions raised, the NCCBP and ABP felt it appropriate to produce some guidance regarding breast pathology specimen handling, reporting and associated activities.
These may change as knowledge and experience are gained.

Breast pathology specimen handling

The disease caused by "severe acute respiratory syndrome coronavirus 2" SARS-CoV-2, (COVID-19) is caused by an enveloped RNA virus and as such it is rendered inert by formalin fixation.

Guidance for larger breast samples that benefit from opening or slicing to facilitate fixation:

- Biobanking of fresh breast specimens is not recommended;
- Specimens should ideally not be submitted fresh to the laboratory but should be placed in formalin as soon as possible;
- Ideally, for large, for example for mastectomy specimens, the surgeon should incise the tumour from the posterior aspect, up to but not through, the skin, then place swab or paper, or similar, in the incision and then place the whole specimen in sufficient formalin. [Without incision the histological grade and type and assessment of lympho-vascular invasion etc may not be accurately assessable, and cannot be retrieved]
- If the sample requires opening/slicing in the histology laboratory, this should be carried out in a Microbiological Safety Cabinet (MSC);
- Specimens should be fixed overnight;
- Once the sample is sliced and fixed, it can be handled as per RCPath guidelines;
- **All staff members must adhere to PPE requirements.**

- Smaller (e.g. core or VAB) biopsies, can be treated as normal if received in fixative, as this will render the virus inert in the same way it does for other viruses (such as other corona viruses, Hepatitis and HIV).

Breast Reporting
In the event of specialist breast pathologists being unavailable, non-breast specialist pathologists may be able to assist with service delivery; the need for this will clearly depend on local circumstances. It is recommended that these are reviewed by the breast pathologists on return to work.

The clinical teams should be informed that reports, including receptor, and other immunohistochemistry and molecular assays, may be delayed, depending on laboratory staffing levels and may be occasionally be reported by non-specialists to help triage patients.

The Association of Breast Surgery (ABS) has produced guidelines for patient management. The UK Breast Cancer Group (UKBCG) are similarly producing recommendations for oncologists. Oncotype Dx and other molecular and genomic tests on core biopsies may potentially prove helpful in distinguishing those patients, for example with ER positive and HER2 negative tumours for whom endocrine therapy is a safe (or conversely a sub-optimal) option, whilst surgical capacity is limited and to minimise administration of chemotherapy. Similarly, for patients with node positive disease molecular assays may provide reassurance of this approach and reduce chemotherapy given. Decisions need to be made in consultation with oncologists and surgeons in line with local Breast Unit protocols for patient management during the COVID-19 outbreak.

Interdepartmental cover should be considered. Digital pathology can be considered as an option to allow pathologists to report remotely (at home) if the service has access, and ideally validation.

MDT Meetings (MDTMs)
Local guidance should be adhered to. Ideally the number of staff attending Breast MDTMs should be reduced and limited to core members with appropriate social distancing. Videoconferencing is appropriate, if available. Breast MDTMs should still aim to be quorate during the pandemic. If non-quorate, it may be possible to gain specialist advice from other units where appropriate staff are available (e.g. if no on-site radiologists, then advice can be sought from other centres for particular cases).

It is likely that retrieving and reviewing slides, as per present ideal guidance, will not be possible. Local approval may be sought if there is a significant variation to existing practice.

Documentation
It will be essential to document and record patient management in detail. If the case is initially reported by a pathologist who does not meet QA standards and usually reports other specialities, this should be noted, and ideally the case reviewed in due course.

It is suggested that any patient whose plan is in variance with “normal circumstances” should be documented as such, to ensure appropriate data and follow up of breast cancer patients who have not been managed as per normal pathways, e.g. non-operative management of surgically fit patients with endocrine therapy. A mechanism for easily identifying in the future where treatment plans have deviated from the norm, and to ensure that these do not miss more appropriate treatment in due course, will be important.

Research activity and clinical audits in pathology departments may be suspended.