Letters

KU activity

We were interested to read the paper “KU activity: a method for calculating histopathologists’ workload” by Suvarna and Kay, and note that they invite comments following the application of their scheme by other departments.¹

Our department is a dedicated cytopathology laboratory which in 1997 reported 59 628 cervical smears and 10 437 non-gynaecological specimens. The department is staffed by 2.5 WTE consultant pathologists (0.5 WTE currently vacant). It is located in a large teaching hospital and has close association with the department of histopathology, from which junior pathologists rotate through cytology for training (two to four with us at any time). The consultant staff also have undergraduate and postgraduate teaching commitments.

Table 1 shows application of Suvarna and Kay's KU activity to our workload numbers. This gives a total annual score of 30 133 KU. With 2.5 WTE, this is 1205 KU per session; at our current level of 2.0 WTE this is 1507 per consultant session. Application of the Royal College of Pathologists and BSCC guidelines on consultant staffing and workload (25 000 gynaecological specimens and 3000 non-gynaecological per WTE DGH cytologist) suggests we require a staffing of approximately 2.8 WTE consultants with additional allowance for teaching commitments.²³

We would, however, like to raise a few points and propose modifications to Suvarna and Kay's scoring to be equally applicable to a cytology service:
- For cervical cytology we presume that a figure of 2 KU per specimen (reported by a pathologist) allows for time taken in slide reviews for cytological/histological correlation, clinicopathological conferences (CPCs), and staff training.
- The score of 1 KU per non-gynaecological specimen does not reflect the wide range of specimens and time taken in reporting. We agree that one KU is appropriate for many specimens, e.g. breast fluid (brushings, urine, sputum). A significant proportion of our workload is fine needle aspirations (FNA) received from many sites, but especially breast, of which approximately 50% are from the breast screening programme. The latter can be extremely time consuming to report, involving numerous slides (up to 20 per case). In our department 70–80% of all breast FNA undergo immediate reporting, with the final report being issued by a different consultant who also reviews the immediate result; this is an important quality control aspect but adds time to the reporting process. One-stop breast clinics tie a pathologist down for reporting purposes for the duration of the clinic. This is time consuming. We therefore propose that a more realistic score for FNA from the breast screening programme would be 3 KU per specimen, with FNA from other sites and symptomatic breast disease being scored at 2 KU. This scoring, as with the gynaecological specimens, also allows for additional time spent on cytological/histological correlation and attending CPCs. Application of this modified KU score to our workload is shown in table 1, giving a total annual of 33 443 KU, which equates to 1338 per consultant session at 2.5 WTE and 1672 per consultant session at 2.0 WTE. No wonder we sometimes feel that we are working hard!
- Suvarna and Kay give no KU allowance for pathologists taking their own FNA samples, which in some departments is a large time commitment.
- Suvarna and Kay suggest that in university departments KU activity could be applied to sessions of research, teaching, or management. Management is also a requirement in an NHS department. Taking the duty or the extra cases, as appropriate.

For example, a consultant pathologist would require a KU score of 30 133 to support a 30 hour working week, which would equate to 1272 KU per year. The KU activity is myopic in looking at the pre-existing workload and this could then be calculated in terms of the time taken for the duty or the extra cases, as appropriate.

We wholly expect that many will disagree with our KU ratings. Rather than each department setting its own figures we need a quorum of departments to evaluate this methodology and then to revise (if necessary) our figures. We therefore welcome Drs John- son and Wadehra’s views on cytology weightings, and state in our defence that the figures reflect the large number of Cytospin sample cases that we see.

We have made no calculation for tasks such as taking FNAs personally. Our experience is in that most of this time is spent getting the pathologist to the patient and back again with little time doing the aspiration. Rather than engender a discussion on the

<table>
<thead>
<tr>
<th>KU activity</th>
<th>Swarna and Kay KU weighting</th>
<th>KU score</th>
<th>Modified KU weighting</th>
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We read with interest the recent paper of Gala et al.1,2 Histopathology today is facing an increasing demand from all hospital disciplines. To stay competitive we will be able to maintain the professional and appropriately resourced delivery of histopathology into the next century.

S K SUVARNA
M S KAY
Northern General Hospital, Sheffield

We have used Bouin’s fixative for trephine biopsies during the last 10 years because of the beautiful morphology which is achievable, and we find that monoclonal antibody L26 gives consistent results.5,10

As Furness has intimated, looking at your own workload and that of others can produce feelings of “pride, guilt, satisfaction or indignation” and perhaps a few more besides! Histopathology today is facing an increasing demand from all hospital disciplines. To stay competitive we will be able to maintain the professional and appropriately resourced delivery of histopathology into the next century.

KU/session rate. For the occasional 0.5–1

By being frank about ourselves/our own workload and that of others can produce feelings of “pride, guilt, satisfaction or indignation” and perhaps a few more besides! Histopathology today is facing an increasing demand from all hospital disciplines. To stay competitive we will be able to maintain the professional and appropriately resourced delivery of histopathology into the next century.
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Revised January 1999
Bouin's fixed trephine biopsies.

G M Markey, H D Alexander and H Foster

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