605 Third Avenue, Floor 20-22
New York, NY 10158

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CAP Annual Meeting – A Review
Wednesday, October 14th 2020

The virtual version of the annual meeting of the College of American Pathology (CAP) has drawn to a close. The final day on October 14 included a full slate of events, including a wide range of tutorials. Below, we recap some sessions that caught Informa Pharma Intelligence's attention.

CAP opens dialogue on racism, responsibility, diversity

CAP pledged its commitment to diversity in its membership and organization, as well as more broadly for the specialty of pathology, during a mid-day session on Wednesday.

CAP leadership has been vocal about the need for actively working against racial injustice following the death of George Floyd in Minnesota in May. At the end of 2019, CAP launched a multifaceted Diversity, Equity, and Inclusion initiative that will include a review of representation and leadership roles within the organization.

Pathologists are examining themselves and their institutions like never before, said CAP President Dr. Patrick Godbey, during the Wednesday session, which focused on the power of diversity and inclusion. A new committee on minority affairs will be reporting directly to the CAP Board of Governors and starting in 2021, demographic data will be collected for the CAP membership, he noted.

"As physicians and as pathologists, we are committed to the best quality healthcare for everyone, but that can only happen when we are serious about diversity and inclusion in the specialty of pathology," Godbey said.

Godbey added that candid conversation about diversity and inclusion at CAP is welcome.

The session on Wednesday was led by Janet Stovall, an executive communicator who works with organizations in creating more diverse and inclusive environments. Stovall flagged the lack of representation of Black and Latinx healthcare professionals relative to the size of these minority populations.

Businesses and organizations realize that diversity is a strength and healthcare is no exception as patients stand to benefit. Involvement of professionals who are the same race as patients promises to help decrease the heart disease mortality gap between white and Black populations, boost the use of preventative care services, and to dramatically drive down infant mortality rates among minority mothers, Stovall noted.

Stovall clarified that it's not just about adding people of color to the workforce – increasing the headcounts – but ensuring that they also have a real voice that is heard and acted upon.

But Stovall added that while many businesses organizations see the value of having a diverse and inclusive workforce, she hasn't met many companies that are happy about their success on this front. The reason is that the business case has been inherently aspirational, focused on the desire to create a more diverse and inclusive workforce and faltering when practical obstacles arise, for example when diverse candidates cannot be found.

Organizations "must get past the idea that it will just happen" because it is the right thing to do, Stovall said.

Diversity and inclusion goals should be suitable for the organization and measurable, Stovall said. Staff should be incentivized to achieving an inclusive workplace culture and held accountable for group initiatives.

"One thing we know for sure is that what gets measured is what gets done," Stovall said. "We also know that what is incentivized is prioritized."

Stovall suggested that training staff to discover their own unconscious bias and transforming it into conscious inclusion is an important step for organizations to take. The biggest mistake organizations make is not knowing where they want to end up with diversity/inclusion efforts, whereas this should be outlined at the start.

"Get a vision, build a foundation and then start working toward a goal with metrics," Stovall advised.

Diversity is not about "counting the number of bodies" in the building. Organizations should be looking deeper and determining how long it takes people of color to advance to various positions, she suggested.

Stovall also sees a strong role for individuals in making change. CEOs, for example, can establish a culture that where microaggressions against minorities are not tolerated. White colleagues can act as allies for their minority colleagues and work to create a more inclusive culture, she suggested. Often people are unaware of their own microaggressions and benefit from an understanding approach.

"Is it really your problem to solve? You bet it is," Stovall said.

Pathologists get crash course in COVID autopsies

The COVID-19 pandemic has underscored the importance of strict safety protocols and sharing of knowledge across borders worldwide, pathologists said during a panel session on Wednesday.

The rate of autopsies in the U.S. has declined dramatically since the 1950s but the pandemic is shining a light on the value of postmortem examination to provide answers about the nature of a mysterious disease with multiorgan effects. But to do the job, pathologists working in autopsy suites first need to protect their own health.

Dr. Jonathan Thompson, a forensic pathologist at the Iowa Office of the State Medical Examiner, reviewed appropriate personal protective equipment (PPE) for personnel, proper engineering controls for air filtration, and appropriate workplace practices like handwashing and sanitation of the autopsy suite.

Thompson said that his office wanted to ensure the safety of everyone who would come in contact with decedents and implemented protocols for three phases: pre-autopsy, autopsy and post-autopsy. This

would include morgue attendants, funeral directors, autopsy physicians and technicians, and histotechnologists.

The PPE includes N95 respirator masks, but these only work if they are properly fitted. At the Iowa office, all staff involved in autopsy were refitted for each type of respirator mask available and were required to watch videos developed by the U.S. Centers for Disease Control and Prevention (CDC) about proper PPE use.

Dr. Alex Williamson, associate professor of pathology at Northwell Health in New York, has been on the frontline of the pandemic. With the number of cases in New York escalating, personnel depended on the CDC for regularly updated guidelines on handling COVID-19 specimens and conducting autopsies on infected patients. Williamson also described the creation in late March of a COVID Autopsy Listserve to enable sharing of best practices for pathology performance and caring for staff and decedents. The listserve now has more than 220 members.

“At the same time as we were learning about the disease through autopsy, many of us were also contributing to scientific efforts at our institutions and also in a collaborative network around the country and around the world,” Williamson said.

The ongoing development of shared, readily accessible databases of whole slide images from COVID-19 patients will further help pathologists help each other, the panelists said.

Time for high-sensitivity troponin to take the lead?

High-sensitivity troponin (hsTn) tests emerging in clinical practice are superior to traditional troponin measures and will allow earlier diagnosis of myocardial infarction (MI), an expert said during a Wednesday session titled *Hot issues in clinical chemistry and immunology.*

Traditional troponin assays long ago replaced previously available cardiac biomarker tests for the evaluation of suspected acute coronary syndrome. They served physicians and patients extremely well but have limitations, for example most do not detect troponin in healthy/normal populations and there are many causes of elevated troponin, including non-cardiovascular diseases, noted Dr. William Winter, professor of pathology and pediatrics at the University of Florida.

High-sensitivity tests were designed to detect lower levels of troponin, resulting in earlier detection of MI and greater certainty in ruling out MI.

The diagnosis of acute myocardial infarction has based on a rise or fall in Tn with at least one value greater than 99th percentile, plus other supportive findings such as symptoms compatible with ischemia and abnormal imaging.

The high-sensitivity tests are more precise and accurate, with a lower limit of detection to pick up lower concentrations of troponin and higher faith in getting a reliable measure, Winter said. High-sensitivity tests must detect troponin in at least 50% of the healthy/normal population.

With traditional tests, it could take 6 hours or more for the troponin elevation to be elevated enough to rule in MI, versus 3 hours with the high-sensitivity assays, Winter noted. It’s also faster to rule out MI.

For emergency rooms, this translates into faster patient management and more efficient utilization, and for the patient it may mean less irreparable cardiovascular damage, he said.

Furthermore, large studies have shown that the use of high-sensitivity tests enabled earlier diagnosis, but did not increase the total number of diagnoses of MI, Winter said. In the future, high-sensitivity tests have promise as a method for profiling patients for cardiac risk and serving as a screening test, he added.