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PARAFFINALIA

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Contents:

Editor: Elizabeth Baranyai

"The HGV aims to provide a dynamic continuing education program in which all persons with an interest in Histology and Histotechnology are freely invited to participate."

Committee Page:

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Please feel free to contact any of the committee members listed above with any comments or suggestions. Contributions are always welcome.

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Please email articles (preferably Microsoft Word format) for inclusion in the next edition to editor@hgv.org.au All items submitted for publication will then become the sole property of the Histology Group of Victoria Inc.

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PRESIDENT'S REPORT 2009-2010

As with recent years the financial year kicks off with the trivia night. The 2009 trivia night saw a return of the event from the eastern suburbs to a more central location at Hawthorn. It was no coincidence that the numbers attending reflected the location. The event was a tremendous success.

Our primary goal of providing ongoing Histology education was once again achieved. The committee ran four scientific meetings, and although there has been a trend to lower numbers attending this year, the highlight was the talk and tour through the Victorian Institute of Forensic Medicine.

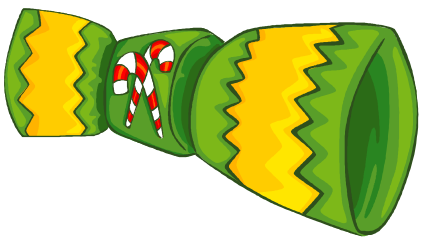
A lot of the committee's energy was placed in planning and staging the One Day Seminar and Workshops at St Vincent's Hospital in Melbourne in March. For many of the committee this was a new experience, but it was terrific to see that during the lead up to the event and then whilst the event took place that the committee gave so much to ensure we provided an event that was as professional as we hoped it could be. The attendance was great and the range and quality of the presentations extremely well received.

Two other projects for the year has seen the emergence of an online database of institution antibodies. The aim was to provide a local record of antibodies the individual institutions used as a reference for us all. To date five institutions have contributed to the venture, but others are more than welcome to contribute. This in no way commits institutions to providing a staining service, but rather provides a means of assistance in knowledge regarding specific antibodies.

Finally we have moved to sending out our newsletter electronically to those willing to receive it by email. This has been well received with almost a quarter of the membership now receiving the newsletter in this manner. This in turn is resulting in our advertisers submitting advertising electronically rather than physical inserts.

I would like to thank the committee for all their work throughout the year. There has been some significant "Changing or the guard" in recent times. Specifically I would like to congratulate Erin Little for his work in taking on the responsibility of maintaining the website, Elizabeth Baranyai for her work as newsletter editor and Alison Boyd for her work as our Trade Representative. I would also like to mention Judy Brincat and Maria Chavez who as Treasurer and Social Secretary put in a lot of dedicated hours to HGV success.

Adrian Warmington
President



WE NEED MORE TO GET GREENER!

22% of members now get their newsletter delivered electronically. Not only does this cut down on our paper usage, but also it preserves our funds, which are necessary in maintaining free membership to the HGV.

If you have work colleagues that may not have considered receiving their newsletter by email, mention it to them.

If you would like to join the members having consideration for the environment, then simply send us an email with the subject “GOING GREEN” from the email address that you wish to receive the newsletter to:

membership@hgv.org.au

VICTORIAN IMMUNOHISTOCHEMISTRY ANTIBODY DATABASE

Over the past 12 months the HGV has worked to get a list of antibodies on the website that institutions are currently using successfully. The HGV is simply providing information for everyone so that lines of professional communication are enhanced.

Provision of a list for the website, does not commit the institutions to undertaking stains for other institutions.

The aim is to enable all institutions to see what each other is doing so that

- You have a contact point for advise about staining techniques for specific antibodies.
- Enquire about the possibility of an institution undertaking a stain for your institution, which if agreed may incur a fee.

The HGV would like to see more institutions commit to providing lists of antibodies. If you would like to submit a list to us, please email secretary@hgv.or.au

To date we thank the following institutions for providing a list for everyone to reference

- Monash Medical Centre (Southern Cross Pathology)
- Peter MacCallum Cancer Centre
- St John of God Pathology - Geelong
- Royal Women's and Children's Hospitals
- AnatPath
- Healthscope Pathology (Gribbles)
- Cabrini Hospital

The database can be accessed at http://www.hgv.org.au/ihc_database.html

We hope to update the list on an annual basis.

Article Review

The Effect of Sampling Method on the Quality of Histologic Preparations in the Diagnosis of Melanoma: A Retrospective Study of 103 Melanomas Procured Via Shave, Punch, and Scalpel Excision.

Fraga G R, Warren N. 2010. The Effect of Sampling Method on the Quality of Histologic Preparations in the Diagnosis of Melanoma: A Retrospective Study of 103 Melanomas Procured Via Shave, Punch, and Scalpel Excision. J of Histotech, 33(2), pp65-70.

This article discusses the study conducted to compare the quality of histological preparations from Malignant Melanoma (MM). These MM's were obtained via three different methods of collection. Shave biopsies, punch biopsies and scalpel excisions.

Histopathologic analysis of Haematoxylin and Eosin (H&E) staining, immunohistochemical (IHC) preparations with the antibody MART-1 and the number of H&E slides requested per block were determined.

A total of 103 cases of newly diagnosed MM were analysed during the study period. 75 of these were shave biopsies (73%), 18 MM removed in scalpel excisions (17%) and 10 punch biopsied MM (10%). The majority of cases were received from dermatologists or dermatology based offices. It was found that shave biopsies were the preferred sample method.

All tissue was prefixed for a minimum of 6 hours with 10% neutral buffered zinc formalin. Tissue processing was performed on the Leica PELORIS, with varying programs selected for the three different biopsy types. The biopsies were sectioned at 4 microns and stained with a progressive H&E protocol. These were evaluated by a single observer. Six parameters were assessed, and for each parameter 0 or 1 was scored. '0' was given for a poor outcome and '1' for a good outcome. The number of H&E slides and ICH per paraffin block was also recorded.

IHC preparations were available on 27 of the cases. All were stained with MART-1 antibody utilising the BenchMark XT system. Four micrometer sections were pre-treated on line with ethylene diamine tetraacetic acid for 30 minutes and incubated with a monoclonal antibody to MART-1 for 32 minutes at ambient temperature. Positive reactions were visualized by use of the iVIEW DAB detection system. Three parameters for IHC quality were evaluated in each case, again by a single observer. A single point was graded for a "good" outcome.

In conclusion it was found that shaved MMs had significantly greater scores for overall histologic quality. These biopsies exhibited superior extracellular tissue preservation than the other collection methods. They were also found to have less chatter and better preservation of melanocytic cytoplasms. The mean score for MART-1 IHC quality was also better for shave MMs than either punched or scalpel excisions. The recording of slides per paraffin block was found to be negligible between the three collection methods.

It would appear that the smaller size and uniform tissue composition (shaves consist of approximately equal parts epidermis and dermis) might lead to improved fixation, microtomy and greater ease of perception of the pertinent elements being assessed in the tissue.

Kate Raven (St John of God Pathology Ballarat)

Meeting Reports:

THE IMMUNOHISTOCHEMISTRY FILES

Immunohistochemistry and Prostate Cancer – *Maria Sardellis (The Alfred Hospital)*

The immunohistochemistry department at the Alfred Hospital is involved in a prostate cancer research project which is led by the Cancer Epidemiology Centre of the Cancer Council of Victoria and is supervised by Associate Professor John Pedersen. The purpose of this project is to find prognostic markers for prostate cancer which are better than the current Gleason classification. Under the current Gleason classification, prostate cancers are scored based upon on the degree of loss of the normal glandular tissue structure. The higher the Gleason score, the more aggressive the tumour is likely to act and the worse the patient's prognosis is. Over 500 cases have already been assessed in this project. Histology specimens including prostate core biopsies and radical prostatectomy specimens have been evaluated from many Victorian diagnostic pathology laboratories. The IHC panel that is being used consists of five antibodies: pTEN, MUC1, Nkx3.1, ZAG and p53.

pTEN: Also known as MMAC or TEP1. It is a tumour suppressor gene located on chromosome 10. The pTEN protein regulates cell cycle, apoptosis and possibly cell adhesion. It is frequently mutated or deleted in both prostate cancer cell lines and primary prostate cancers. Several studies have found that the loss of pTEN expression correlates with an increased Gleason score and hence, advanced disease. Therefore, the loss of the pTEN protein may be considered as a potential marker of advanced prostate cancer. The staining pattern of pTEN is nuclear, with variable staining amongst tumour cells.

MUC1: Also known as Mucin 1 glycoprotein or episialin. It is a type 1 transmembrane glycoprotein. MUC1 expression can be heterogeneous in both normal and malignant human prostate epithelium. It is implicated in the progression of numerous types of cancers including breast, colon, lung, and gastric carcinoma, however, its role in prostate tumours has not yet been clarified. Few studies have suggested that MUC1 plays a role in the progression and metastasis of prostate cancer, yet there has been variability amongst these studies, most of them being limited by a small sample study size. MUC1 stains the cytoplasm of cells. Staining in normal prostate epithelium is variable. Some suggest that the staining pattern is restricted to the apical site of cells whereas its presence in tumour cell cytoplasm is greatly increased with staining showing a more diffuse pattern.

Nkx3.1: This protein is a product of a prostate specific regulatory gene, known as Nkx3.1 homeobox gene which is located on chromosome 8. In mouse models, Nkx3.1 has differentiating and growth suppressing effects. This has led to speculation that it may play a tumour suppressing function in human prostate. Hence, the loss of this protein's function results in a critical step in the initiation of prostate cancer. Several studies have indicated that normal prostate epithelial cells express Nkx3.1 and the expression decreases with disease severity. Loss of Nkx3.1 is associated with loss of pTEN function, this results in the activation of the Akt protein, which promotes cell growth and survival, and hence tumour growth. As Nkx3.1 is a prostate specific protein then the gene may have applications in prostate specific gene therapy; targeting this gene would minimize the toxicity of gene therapy to other organs. Nkx3.1 shows a nuclear staining pattern. Several studies have shown that non-malignant prostate epithelium stains uniformly positive, however, its staining pattern is heterogeneous in malignant prostate epithelium.

ZAG: Zinc-a-2-glycoprotein is a 41kDa glycoprotein secreted by a variety of normal epithelial cells including breast, prostate and liver cells. Due to its production by secretary epithelial cells, ZAG protein can be identified in human plasma and serum. ZAG production is associated with tumour differentiation status, with decreased or absent ZAG production in more poorly differentiated tumours. Tumours producing ZAG lead to an elevated serum ZAG in mice, so this protein may be a potential serum marker. ZAG stains the cytoplasm of prostate epithelium. It is present in normal epithelium and low grade tumours, with decreased staining seen in high grade tumours.

p53: The p53 gene is located on chromosome 17. In its normal state it acts as a tumour suppressor. Mutations in this gene can lead to p53 over expression. Abnormal accumulation of p53 protein in prostate has been identified primarily in poorly differentiated, metastatic and late clinical stage prostate cancers; hence, it is associated with poor patient prognosis. p53 exhibits a nuclear staining pattern with literature indicating that its presence

in normal prostate epithelium is variable, in comparison to tumour cells which show an increased staining pattern.

The Alfred is only part way through the initial stages of this research project yet there have already been some initial observations. Firstly, many of the studies that have been conducted on these antibodies so far have been done using tissue micro array (TMA) blocks only. Unlike various other tumours, prostate tumours are heterogeneous and therefore a small sample of tumour, as what is used in a TMA, may not adequately represent the entire tumour and hence lead to inaccurate results. Examining whole tissue sections, as is done in this study, rather than small areas in a TMA, will hopefully offer a more precise evaluation.

ZAG has been the most promising marker so far. ZAG positive tumours correlate with a lower grade malignancy and therefore a better patient prognosis. MUC1 has also shown to be of some value with results demonstrating increased staining in high grade tumours.

Reported by Michelle Zammit

Alfred Hospital

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CASES NEEDED FOR UNDERGRADUATE TEACHING

Royal Melbourne Institute of Technology (RMIT), the main provider of qualified medical scientists in Victoria, is seeking paraffin blocks for teaching Histology. They require both:

- One or two blocks from interesting cases
- As many blocks as possible from post-mortem cases

If you feel you are able to assist, please contact:

Dr Janine Danks
School of Medical Sciences
RMIT University
9925-7332
janine.danks@rmit.edu.au

Barrett's Oesophagus—The Importance of Ki67 & p53
by Alison Boyd St.V's

Alison was our second speaker. She began with an overview of the Ki67 and p53 antibodies and outlined the immunohistochemical staining methods used for each antibody.

For Ki67, they use a Dako antibody, MIB1 clone (Code M7240) on a Ventana BenchmarkXT machine. Heat retrieval is used and the antibody diluted to 1:100 for 32 minutes. Tonsil is used as a control which shows strong staining in the germinal centres.

This antibody is valuable for the demonstration of the Ki67 antigen in normal and neoplastic cells e.g. soft-tissue sarcoma, prostatic adenocarcinoma and breast carcinoma. Dianosis is aided by a panel of antibodies.

The Ki67 index is immunohistochemically quantified by determining the number of Ki67 positive cells among the total number of resting cells.

With p53 the same machine and retrieval are used. The antibody used is the Dako DO7 clone (Code M7001) at 1:500 dilution for 32 minutes.

p53 antibody labels both wild-type and mutant-type p53 protein, and both types were discussed in detail. It is a nuclear phosphoprotein, coded for by a tumour suppressor gene located on the short arm of chromosome 17. Over expression of p53 protein is associated with a poor prognosis in a variety of cancers. Again, dianosis is aided by a panel of antibodies.

She then went on to describe Barrett's oesophagus which results as a complication of gastro-oesophageal reflux disease (GORD), outlining the requirements for a diagnosis, the symptoms of the disease, and treatment options.

Barrett's Oesophagus is considered to be a pre-cancerous condition where the development of adenocarcinoma can be followed through various grades of epithelial dysplasia. Adenocarcinoma arising in Barrett's Oesophagus often manifest at an incurable stage so it is important to follow up and identify patients at high risk for developing carcinoma. Surveillance programs rely on histopathological assessments of oesophageal biopsies. Interpretation of changes in dysplasia are subjective and suffer from interobserver variation. Improvements in diagnostic accuracy occur when p53 and Ki67 immunohistochemistry are used.

p53 normally plays a role in cellular growth control. With mutant p53 protein, faulty DNA is allowed to replicate leading to malignant transformation. p53 detectable by immunohistochemistry suggests intranuclear accumulation of p53 with altered function due to mutation or complex formation. p53 expression correlates with prognosis in patients with dysplasia. p53 can also highlight zones not usually seen by light microscopy.

Ki67, a proliferation marker, is normally seen in the mucous neck region of gastric mucosa. In Barrett's Oesophagus, Ki67 is seen progressively closer to the luminal surface and at the surface proper in high grade dysplasia. Ki67's presence beyond the basal cell layer generally mirrors dysplasia.

Ki67 expression is significantly associated with p53 expression, tumour progression and patient prognosis.

Alison finished up by showing us some pictures of high and low grade dysplasia demonstrating Ki67 and p53 staining.

Reported by Elizabeth Baranyai
Cabrini Health.

P57Kip2

P57 is a cyclin-dependent kinase inhibitor (CK1), and also a cell cycle inhibitor and tumour suppressor gene located at chromosome 11p15.5. It is closely related to p21 and p27. It shows strong paternal genomic imprinting, and is only expressed from the maternally derived allele. P57 is most highly expressed in placenta, and is useful in diagnosing Gestational Trophoblastic Disease which refers to a wide range of proliferative disorders of the placenta.

In a normal pregnancy, the first cells to differentiate from the fertilised egg are called trophoblasts. These proliferate and form two layers cytotrophoblasts (inner layer) and syncytiotrophoblasts (outer layer). The layers grow to form tiny hair-like projections called villi, which have a cellular core of mesenchyme, and extend into the uterine wall. Other important structures include: villous mesenchyme; intervillous trophoblasts and decidua.

Specimens that may ultimately be assessed for p57 positivity are products of conception. At cut-up the specimen is weighed, a volume given and an over-all description is recorded including whether foetal parts are present or not. The specimen is submitted for routine paraffin processing, sections are cut and stained with H & E and examined by a pathologist. Gestational Trophoblastic Disease (GTD) includes Hydropic Abortion, Hydatidiform Mole, Invasive Mole, Choriocarcinoma and Placental Site Trophoblastic Tumour. Hydropic Abortion and Hydatidiform Mole are characterised by hydropic (swollen, oedematous) villi and can be difficult to differentiate from each other on H & E morphology alone.

Hydropic (or spontaneous) Abortion is non-molar and completely benign. It is caused by a “blighted” or defective ovum and does not go on to form GTD. There is no trophoblastic proliferation, but it can look very similar to Hydatidiform Mole (HM), from the Greek Hydatid- water-filled cysts and Mole – to burrow. HM is characterised by hydropic villi with varying degrees of trophoblastic proliferation, and is classified into two types: Partial Hydatidiform Mole (PHM) and Complete Mole (CM).

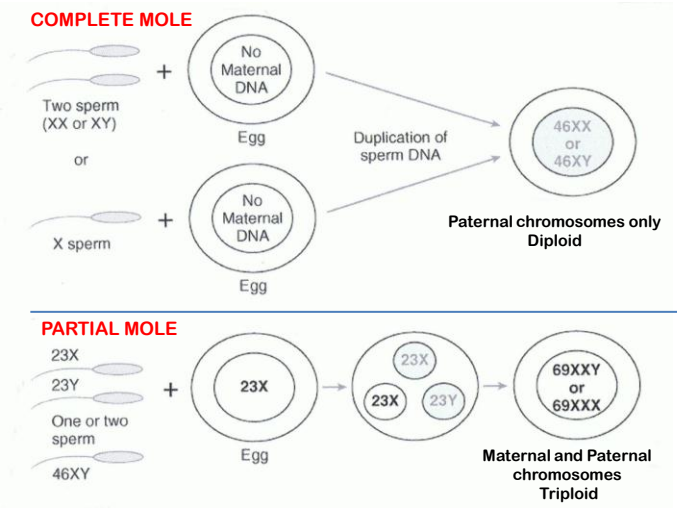
Hydatidiform Moles occur in 1:1,500 pregnancies.

- CHM >50% of molar gestations.
- PHM 25-40% of molar gestations.
- Asian populations have a higher frequency.
- Very young women and women over the age of 40 are affected.
- Diet lower in Vitamin A
- Blood Group A women paired with Group O men.
- Lower socio-economic status.

Hydatidiform moles are abnormally formed placentas with distinctive cytogenetic abnormalities. They arise as a result of the fertilisation of an abnormal ovum.

How Abnormal Gestations come about.

Cytogenetics



Complete moles result from the fertilisation by a single sperm of an egg that has lost its chromosomes, or the fertilisation of an "empty" egg by two sperm. Complete moles are of diploid karyotype but with both sets of chromosomes being of paternal origin.

Partial moles usually arise from two sperm fertilising an ovum with the correct maternal DNA, but the egg has a defective zona pellucidum, and a triploid karyotype results. The zona pellucidum is the thick homogeneous layer of glycoprotein and acid proteoglycans that surrounds the egg.

Macroscopically, Hydropic Abortion presents with a scant amount of tissue, far less than usual. Complete Hydatidiform Mole appears with uniformly large grape-like vesicles, absence of a foetus and an overly abundant volume of tissue. Partial Hydatidiform Mole presents with large grape-like vesicles mixed with normal-looking tissue, there is less abundant tissue than with CHM and there is a foetus present with developmental abnormalities.

Microscopically no single histological feature permits distinction between the three, overall classical features need to be observed.

Hydropic Abortions: the villi have more rounded edges, they are polar and there is no trophoblastic proliferation.

Partial Mole: foetal parts are commonly present; some villi are swollen and oedematous, some show only minor changes. The scalloped outlines of the villi appear leaf-like and there are trophoblastic inclusions.

Complete Mole: All or most of the villi are swollen and oedematous. There are no foetal parts, there is karyorrhexis and debris in the stroma, club-like projections and central degeneration with circumferential trophoblastic hyperplasia.

A significant proportion of CHMs will, if undetected and untreated, persist, recur or progress to choriocarcinoma. It is therefore important to be able to differentiate between the two. P57 can be helpful in this role.

Maternal and Paternal sets of chromosomes

Pregnancy Type	Maternal	Paternal	Genetics
Normal	Y	Y	Bi-parental Diploid
Hydropic non-molar	Y	Y	Diploid
Complete Molar	N	Y	Androgenic Diploid
Partial	Y	YY	Diandric Triploid

The gene encoding p57kip2 is strongly imprinted and expressed almost exclusively from the maternal chromosome. Therefore the CHM, which lacks any maternal chromosomes will not stain for p57, HA and PHM show positive staining.

P57 demonstrates nuclear staining in the cytotrophoblasts and villous stromal cells in normal placenta, hydropic abortions and partial moles. P57 staining is absent in the cells in CHM. Syncytiotrophoblasts are negative in all cases. The intervillous trophoblastic islands are positive in all cases and serve as a perfect internal control.

P57 is used to distinguish Complete Hydatidiform Mole from Partial Mole and Hydropic Abortion. Further tests may be required for more complicated cases. This involves ploidy studies to determine whether the population of villi are diploid or triploid.

Cathy Mostafa and Judy Brincat

Dorevitch Pathology

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DEMONSTRATORS REQURIED

Demonstrators are needed at RMIT for both semesters for Histopathology classes in 2011. 4-7 hours one day per week. Degree or diploma in Laboratory Medicine is necessary. No previous teaching experience is required but a good basic knowledge of Histopathology and relevant laboratory experience is essential.

Contact:

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RMIT University Bundoora, 3083.
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Under the Microscope

Reported by Maria Chavez

Hazel Chambers
Anatomical Pathology Scientist
The Royal Children's Hospital

1. **What was your first job?**
   I started working at McDonalds when I was 16 and remained there until I went on my uni placement. Working at Maccas taught me loads about team work and not taking life too seriously. The free meals were also a bonus! My first scientist job though, was at Aintree Hospital in Liverpool (UK).

2. **What attracted you to Histology?**
   I had the craziest teacher at uni. She brought histo to life for me. I also had a look around haemo and biochem aswell as histo during my uni placement, and knew instantly that histo was for me. The "hands on nature" of the work is what appealed to me most. The rest I guess is history.

3. **What is the worst decision you have ever made?**
   Can't really comment on that here sorry! But, not to give too much away, It involves expensive flights, long waits, thousands of miles, despair, tears, relief, chocolate (of course), retail therapy (naturally) and some girly nights in with a couple or three glasses of wine.

4. **What is the best decision you have ever made?**
   Since starting work at Anatpath I have settled into Australia really well. I love being one of the Anatpath angels ☺. I've also just started working at the Royal Children's which is fantastic. I'm really enjoying it and find the challenge exciting. So I guess the best decision I've ever made is Moving to Australia. Melbourne is the coolest city to live in. I love it!

5. **Who would you most like to have dinner with and why?**
   All of my friends from the UK. It would be lovely for us all to be together for a night to catch up and have a good laugh, but it would have to be in Melbourne. I know they would fall in love with the place and maybe start their own adventure down under.

6. **What music do you enjoy listening to?**
   I love a wide variety of music including some really good and (what others might think) really bad stuff! Cheesy power ballads from Heart and Meatloaf are what I'm listening to at the moment. They are a regular feature in my car, much to my husband's annoyance. I'm also going through a bit of a Pink Floyd phase (much to my husband's approval – not that I need it of course ha ha).

7. **What is your favourite stain?**
   There are so many! For a special stain though, I'm going with a Luxol Fast Blue/ H&E on a macro section of cerebellum. My Favourite immuno has to be MNF116. It wins hands down.

8. **What is your favourite food/Restaurant?**
   I really love sushi. There is a cute little Japanese restaurant just off Chapel Street in South Yarra which does yummy food. I am also partial to junk with a Zinger burger being my number one sin food.

9. **What are you reading at the moment?**
   Plenty of journal articles for my MSc about cancer cell behaviour and Targeted Antibody therapy for cancer. If I had a choice, I would re-read the whole Twilight saga again.

10. What is the best conference you have ever attended?

I would have to say the Adelaide Conference in 2009. The whole event was really well organised and the talks were great. Can't wait for the NHC 2011!

11. Are there any current projects you are working on at the moment?

I have recently started to do an Msc in Medical Science. It's by distance learning. I am thinking about a project for next year which would enable me to study paediatric tumours more in depth.

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6 Months in Bangladesh

After 5 years of working in Australia the lure of travel and working in a developing country finally became too much. We had heard bits and pieces about the Centre for the Rehabilitation of the Paralysed (CRP) in Bangladesh from various sources and knew that they were actively seeking Occupational Therapists and Speech and Language Therapists. My wife contacted them to see if they were interested in a Physiotherapist and a scientist guy… 6 months later we were on a plane bound for Dhaka.

The introduction to Bangladesh cannot help but be emphatic. We were picked up by a CRP driver and sped through the chaotic traffic, occasionally on the correct side of the road but rarely more than an inch from another road user. When we stopped for gas Sarah woke up (apparently even this rollercoaster couldn't keep her from her sleep) and decided to entertain a local starer by pulling a funny face. We quickly realised that this was not an effective way to diffuse interest in the strange foreigners as another 5 guys were called over to check us out.

As we arrived through the gates of CRP we were greeted by a beautifully serene oasis-like campus and quickly settled ourselves into our accommodation, which was significantly more comfortable than we had been preparing ourselves for.

CRP was founded by a British physio, Valerie Taylor, in 1979. Having been in Bangladesh for 10 years already (on and off to avoid some of the civil war in the early 70's) Valerie found that the services for spinal cord injured people were non-existent. She started out treating 4 patients with spinal cord injuries in an old cement warehouse in the grounds of a government hospital and has grown the centre into a nationally (and internationally) recognised rehab facility. CRP now provides rehabilitation services for almost 400 spinal in-patients, 2000 children with disabilities (predominantly cerebral palsy) and around 23000 out-patients every year, over 3 main sites. They also provide vocational training to almost 200 people with disabilities.

In 1992 the Bangladesh Health Professions Institute (BHPI) was established with the goal of producing highly skilled health care and rehabilitation professionals. BHPI now offers bachelor degrees in physiotherapy, occupational therapy and speech and language therapy and diplomas in nursing, laboratory science and radiography amongst others.

Our work at CRP was varied and we were encouraged to develop our own programs and ideas. However, we were both aware that we could not make any progress without the full participation of the local staff in the development and implementation of any projects. Therefore I spent most of the

first few weeks working to assist CRP's Research Associate (a recent physiotherapy graduate) to complete some research projects and to try to plan for the future of her department. During this period I spent time getting to know the staff in various departments and trying to ascertain where our efforts would be best directed. I was also roped in to giving a lecture on electronic search skills to the 3rd year OT students within about 2 days of arriving. Sarah began by spending some time in each physiotherapy department, providing clinical supervision as required. Later she developed more of a teaching role providing in-services and lectures to physiotherapy staff and students.

As we got more involved in life at CRP it became clear that a good area to focus some attention on was independent learning and evidence-based practice (EBP). We had been asked numerous times by different groups to teach electronic search skills and to review research proposals, so we got together with a number of the heads of departments and decided to develop an education program for EBP. With the help of one of Sarah's colleagues from Australia and some international contacts that I had made through other areas of work at CRP, we put together a one-day seminar for about 100 staff members and a further 3-day intensive course for the senior clinical and teaching staff.

In addition to this work I spent a significant portion of my time preparing a proposal to establish a Master's degree in Rehabilitation Science at BHPI. I collaborated with staff at CRP and BHPI to develop the concept and then negotiated with potential partners in the UK and Canada to further establish the details of the strategy for the project. Rather fortuitously we were invited to apply to a large donor fund in South Asia by the director of the fund (who was visiting CRP on a totally unrelated matter). As part of this process I was lucky enough to get the opportunity to present our case to Dr. Dipu Moni, the Bangladeshi Minister of Foreign Affairs to gain official support for the proposal. The staff at CRP took over responsibility for managing the project in conjunction with the partners in the UK and Canada and the application for funding is now well on the way to being approved.

I should finish by describing what, for me, is the defining feature of Bangladesh and CRP – the people – but I've already expanded the margins of this document a few times to squeeze my words in and would need several more pages to truly do them justice. So I will end with a quick story – a good friend of ours from CRP was taken critically ill with intestinal TB just before we were due to leave and whilst bedridden in hospital sent a message to us… to tell us that he was sorry that he couldn't come and see us off and hoped that we would forgive him for being rude!

Simon Davies.

Histology Group of Victoria Inc.
Org. No. A003523F
ABN 49 725 623 468

Future Events:

2011

12th - 14th March
Coonawarra Joint Meeting HGV/HGSA
Venue – Coonawarra, South Australia

5th May
HGV/ASC Scientific Meeting – Student Presentations
Venue – PeterMac

30th June
Scientific Meeting – Tissue Bank
Venue – PeterMac

29th July
Social Event – Trivia Night
Venue – TBA

15th September
Scientific Meeting – Further Education Possibilities for Histologists
Venue – PeterMac

4th – 6th November
National Histology Conference
Sydney

17th November
Scientific Meeting/AGM – Molecular Techniques (KRAS/BRAF)
Venue – PeterMac

Histology Group of Victoria Inc.
Org. No. A0035235F
ABN 49 725 623 468

Coonawarra Meeting March 12th -13th 2011

Speakers

Jean Mitchell	Skin Biopsies
Piero Nelva	New Lymphoma Markers
Julian Richardson	Development of pathology/histology during the American Civil war.
Elizabeth Baranyai	Our Experience with Stem Cell Treatment
John Stirling	Thoroughly modern electron microscopy and gruesome case studies
Kathy Cash	A case report of a Dysferlinopathy
Yvonne Ciuk	Neuropathology and Forensics in South Australia

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JOINT MEETING HGSA AND HGV
12th and 13th March 2011
COONAWARRA

For accommodation and special dietary requirements please contact

CHARDONNAY LODGE RESORT
Riddoch Highway, Coonawarra
T: 08 8736 3309 **F**: 08 8736 3383
E:enquiries@chardonnaylodge.com.au
chardonnaylodge.com.au

	Single	Double/Twin	Triple	Extra Adult	Extra Child
Studio	$118	$142	N/A	N/A	N/A
Standard	$128	$159	$188	$29	$18
Luxury	$138	$163	$192	$29	$18
Luxury Spa	$146	$173	$202	$29	$18
Superior Suite	$165	$192	$221	$29	$18
Apartment	N/A	$179	$208	$29	$18

REGISTRATION

Registration closes Friday 25th February, 2011

Name:.....

Business Name and Address:.....

.....

.....

Phone No:..... **Fax No:**.....

Email:.....

Name to appear on name tag:.....

FULL REGISTRATION (Includes morning teas, Saturday lunch and conference dinner)	**$140.00**	.....
SATURDAY REGISTRATION (Includes morning tea and lunch)	**$45.00**	.....
SUNDAY REGISTRATION (Includes morning tea)	**$30.00**	.....
WINERY TOUR SATURDAY AFTERNOON (Accompanying persons welcome)	**$10.00**	.....
Children under 18	**$5.00**	.....
CONFERENCE DINNER (Includes pre-dinner wine-tasting) (Accompanying persons welcome)	**$65.00**	.....
BARBEQUE SUNDAY LUNCH (Not included in any registrations above. Accompanying persons welcome)	**$24.00**	.....
LATE FEE (Registration after 20th January, 2011)	**$20.00**	.....
	TOTAL	.....
Signature:.....	**Date:**	.....

Please send completed registration form to:
Coonawarra Secretariat
Mark Bromley
Histology Department, Melbourne Pathology
103 Victoria Parade
Collingwood Vic 3066
mark.bromley@mps.com.au Phone: 03 9287 7806 Fax: 03 9287 7702

Payment options: Please indicate
Cheque/Money Order to Histology Group of Victoria Inc.
or
Direct Deposit Histology Group of Victoria Inc
Commonwealth Bank St Vincent's Hospital
BSB: 063 449 Account No: 1006 5881

Transaction details must include the delegate's name

HGV Xmas Party 2010

A small group gathered at Vivace restaurant Brighton for this year's HGV Christmas party. It was a lovely warm evening on Friday 3rd December, and although a small group, we could almost say there was at least one person from each major pathology group in Melbourne...and lets not forget the traveller from Ballarat. The restaurant was a good pick, excellent service, a separate room for pre dinner drinks..and plenty of drinks at that.

This year we were fortunate to have a speaker, Mrs Jenny Hamilton from Roche-Ventanna, who clearly provided the entertainment for the night, with a comedic/ educational presentation on her experience with the beautiful Tsavo elephants expedition. First course was served up and Jenny informed us of how this opportunity to go to Tsavo presented itself. Jenny is a volunteer of the Earthwatch Institute, an international non-profit organization that brings science to life for people concerned about the Earth's future. As a volunteer, you may have the opportunity to go on an expedition of your choice with the aim to help/ sustain the environment whilst also meeting some personal challenges...as Jenny did explain to us.

Now having read this far, you may be thinking Jenny is definitely one with nature, despite her high heel shoes and corporate role. Well, that wasn't so much the case in the beginning of her expedition. In the 8 days of this great adventure, Jenny was by far, out of her comfort zone, not much a camper let alone a wildlife ranger. She had many great stories to tell, including her frightening and exciting experience with the vast amount of African wildlife; coming face to face with Cobra snakes, avoiding the cheetahs on the way back to base camp (which meant singing loudly to avoid them), not having the comforts of a port a loo whilst out on research days and seeing a musth bull charge at a lady elephant prior to mating.

Jenny certainly made the evening, the presentation was most enjoyable and the photos superb. Those who attended learned a lot about the beautiful nature of these elephants, who live in familial groups and all exhibit a particular role in the hierarchy. Jenny's main role in her expedition was to count the number of elephants seen in each transect of the national park as well as identify if they were male or female...its not as obvious as you may think people. For those who have not been lucky enough to hear about Jenny's Tsavo elephants expedition I highly recommend you engage in conversation with her about it at future meetings because it is definitely worth listening to. A great night was had by all. Merry Christmas Folks.

Merry Xmas & Happy new Year