University College London Hospitals NHS Foundation Trust

PATIENT EXPERIENCE OF CORE BIOPSY PERFORMED BY EXPERIENCED RADIOLOGISTS FOR THE DIAGNOSIS OF LYMPHOPROLIFERATIVE DISEASE

Authors: Aoife Dervin, Max Brodermann, Oliver Cohen, Simon Morley, Ian Proctor, Neel Raja, Kirit M Ardeshna, William Townsend
University College London Hospitals NHS Foundation Trust, UK

Introduction

Lymph node excision has historically been preferred to core biopsy for diagnosing lymphoma, given reported higher diagnostic yield and concerns regarding insufficient histological material obtained with core biopsy.

Core biopsy is associated with lower morbidity and is more cost effective.

Advances in radiological and histological techniques to extract and process material have shown core biopsy to be a reliable primary diagnostic method for lymphoproliferative disease.

Methods

Data collection over a 6-month period.
Patients undergoing core biopsy were contacted and consented for participation in a telephone survey.

Data collected included: frequency and type of complications, severity and duration of discomfort, waiting time in the department pre- and post-biopsy and their overall impression of the service, graded poor to excellent.

Additional data collected included biopsy indication, final diagnosis, number of cores taken, size of the needle used, and biopsy site.

Aim

To investigate the patient experience of core biopsy and the self-reported complication rate in those who underwent core biopsy at our centre for the investigation of suspected new or relapsed lymphoma.

Results

Patients:
40 contacted, 4 declined to take part
Male to female ratio 1:1.4
Median age 53 (range 18-75 years)

Patient reported complications:
5 patients (13.9%) reported minor bleeding and bruising
Median discomfort of 1 (scale from 1-10)
No significant difference in discomfort based on needle gauge (p=0.329) or diagnosis (benign vs. malignant) (p=0.2997)

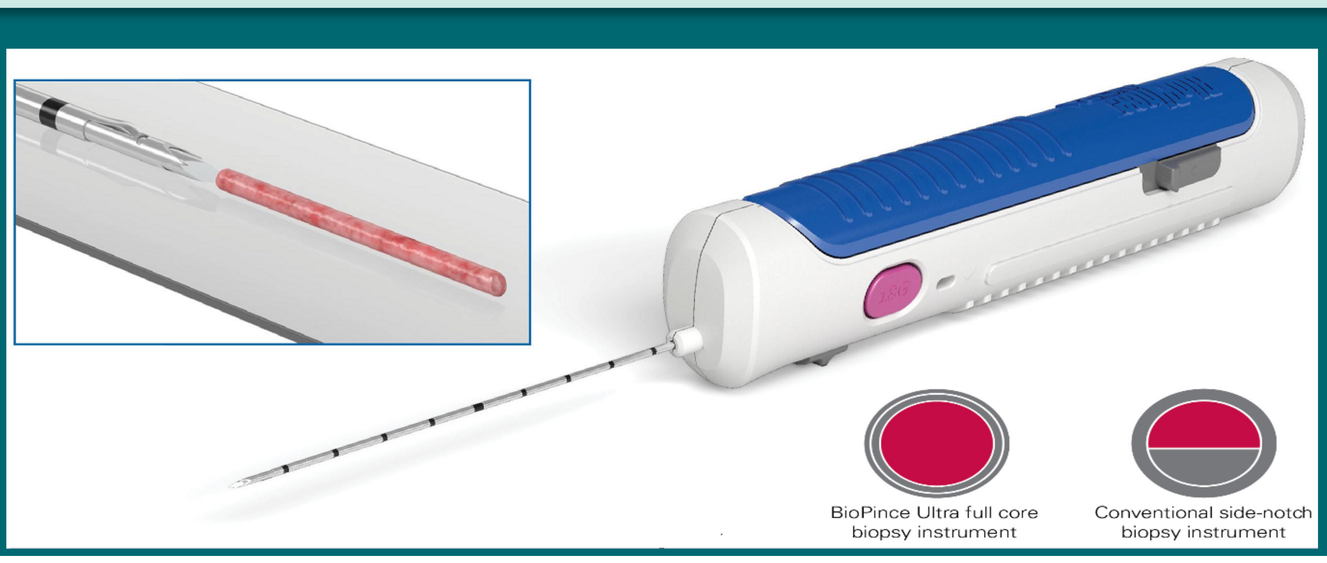
Time taken:
Mean waiting time was 24.3 minutes (range 0-180 minutes).
Observation time no longer than 20 minutes (range 0-20 minutes).

Biopsy:
Size of the needle used was either 16-gauge (41.2% of patients) or 18-gauge (58.8%).
Median of 3 cores obtained at biopsy
Biopsies sites were: 22 (61.1%) cervical, 4 (11.1%) axilla, 5 (13.9%) inguinal and 5 (13.9%) extra-nodal.
33 out of 36 biopsies were diagnostic (91.7%).
A repeat biopsy was required for 3 patients with non-diagnostic biopsies (8.3%).

Summary of larger study findings (analysis of 554 sequential biopsies):
Median 9 days from request to diagnosis
93.8% of biopsies were diagnostic
94.6% of biopsies confirming T-cell lymphoma were diagnostic
Additional tissue requested in 11.6% of cases

Overall Impression of Service

Final Diagnosis	n	%
Reactive	18	50
Lymphoma	12	33.3
Mature B cell neoplasm:		
DLBCL	3	8.3
Follicular lymphoma	0	0
CLL	1	2.8
Hodgkin's lymphoma	3	8.3
T-cell lymphoma	2	5.6
Other B lymphoma	3	8.3
Other malignancy	3	8.3
Inadequate	3	8.3



Conclusion

Core biopsy, when performed by experienced interventional radiologists and analysed by expert haemato-pathologists, is a fast and reliable method for diagnosing lymphoma, without the need for additional biopsy in most patients.

It is a well tolerated, quick procedure that can be performed in the outpatient setting, with few complications and high patient satisfaction.

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