

QML PATHOLOGY

newsletter February 2010

>>New Clinical Practice Guidelines for the Management of Melanoma, Basal Cell Carcinoma and Squamous Cell Carcinoma

Dr Elizabeth Munn MB BCh FRCPA, Consultant Dermatopathologist

In the last two years new guidelines for the management of Melanoma, Basal Cell Carcinoma and Squamous Cell Carcinoma tumours have been published (please see references). New recommendations and key points from these publications are summarised herein.

>> New Clinical Practice Guidelines for the Management of Melanoma, Basal Cell Carcinoma and Squamous Cell Carcinoma

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Melanoma

The clinical diagnosis of melanoma can be difficult as melanomas can be small, non-pigmented, scar-like and nodular, resembling basal cell carcinoma. It is important to biopsy lesions that the patient thinks have changed, even if they look benign.

The overall incidence rates have been fairly steady since 1997 except in males over 55, where the incidence continues to rise. Individuals at high risk of melanoma and their partner or carer should be taught to recognise suspicious lesions, and be checked six monthly by a physician, supported by dermoscopy and photography.

Sunburn should be avoided, but a total lack of sun exposure is not advised without Vitamin D supplementation. Measurement of Vitamin D is recommended in patients who avoid sun exposure.

Training and use of dermoscopy is recommended for clinicians routinely examining pigmented lesions. There are good studies showing improved diagnostic accuracy and better specificity using dermoscopy.

Biopsy

The optimal biopsy approach is complete excision with a 2 mm margin and upper subcutis. Orientation of the specimen is good practice.

Incisional, punch or shave biopsies are occasionally appropriate in some clinical circumstances, for example, large facial or acral lesions, or where suspicion

of melanoma is low. Partial biopsies may not be representative of the lesion and need to be interpreted in light of the clinical findings.

The most important factors in staging and prognosis are:

1. Breslow's thickness
2. Mitotic rate
3. Ulceration
4. Clark's level is important only in thin melanomas (<1 mm).

Excision margins for definitive treatment of primary melanoma

These are the margins measured clinically from the edge of the melanoma. The histological measurement will be up to 50% smaller as the skin contracts after removal and fixation in formalin causes further shrinkage.

1. (pTis) Melanoma in situ	5 mm
2. (pT1) Melanoma <1 mm	1 cm
3. (pT2) Melanoma 1-2 mm	1-2 cm
4. (pT3) Melanoma 2-4 mm	1-2 cm
5. (pT4) Melanoma >4 mm	2 cm

Further information on treatment of thick and disseminated melanoma, special types of melanoma, large congenital naevi, genetics of melanoma, adjuvant therapy, screening and psychosocial issues is available in the recent guidelines (see references).

Squamous Cell Carcinoma (SCC)

Solar keratosis, Bowenoid solar keratosis, intraepidermal squamous cell carcinoma (Bowen's disease) and invasive SCC may be regarded as a neoplastic continuum. All may regress.

Keratoacanthoma may represent a self-regressing SCC although its nature is uncertain. When regressing it has a characteristic architecture, but often it cannot be distinguished (especially in small biopsies) from well-differentiated SCC. The treatment of keratoacanthomas should be similar to SCC. Keratoses that recur after cryotherapy, enlarge or become tender or indurated, should be biopsied.

Immunosuppression (especially for organ transplantation) strongly predisposes to aggressive invasive SCC. Incompletely excised invasive SCC has a recurrence rate of >50% and should be re-excised or treated with radiotherapy.

SCCs of the scalp ear and vermillion (high-risk areas) have a higher recurrence and nodal metastasis rate (10-20%). Specialist referral may be appropriate.

Perineural spread and persistent or recurrent SCC have a poor prognosis and demand more aggressive treatment. Specialist referral is recommended.

The majority of favourable SCCs (<2 cm) can be excised under local anaesthetic with primary closure. Clinical margins of 4 mm are recommended. A histological margin of 1 mm or less mandates consideration of further therapy. Shave, punch or excision biopsy prior to definitive treatment may be appropriate. Cryotherapy, curettage and diathermy are suitable for many solar keratoses and Bowen's disease unless they are very large, recurrent or on high-risk areas.

Topical treatments for solar keratoses, intraepidermal SCC and superficial basal cell carcinoma are now available and are an effective alternative treatment, especially for difficult to excise lesions and lesions on the face. Both Imiquimod 5% cream and 3% Diclofenac gel can be used alone or in combination with cryotherapy. 5% 5-fluorouracil cream is less effective but also available.

Sun avoidance (with Vitamin D replacement if necessary) and continued follow up of patients with sun damaged skin or multiple tumours is recommended.

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Basal Cell Carcinoma (BCC)

The occurrence of BCC at younger ages than SCC, its relatively common occurrence on the trunk as well as the face and arms, and its probable origin in epidermal stem cells, suggests that BCC requires a lower threshold of total solar radiation before malignant transformation than is required for SCC.

Gorlin's syndrome should be suspected in patients with multiple BCCs occurring at a young age. Genetic testing may be appropriate.

Most basal cell carcinomas fall into four groups:

1. Nodular (showing solid, trichoblastic or follicular differentiation)
2. Superficial (multifocal superficial)
3. Infiltrative (showing fibrosing, morphoeic, or micronodular differentiation)
4. Mixed types (usually types 1 or 3 with a multifocal superficial component).

Tumours with an infiltrative component have the worst prognosis. They are most likely to recur, are the most difficult to completely excise, and tend to indicate which patients are likely to develop further BCCs. Stretching the skin over ill-defined BCCs may help to delineate the tumour more clearly.

Biopsy (punch, shave or excision) is appropriate before definitive surgery. The majority of clinically favourable BCCs (small, nodular lesions not on the central face or ears) can be excised with a clinical margin of 2-3 mm. An adequate microscopic clearance margin is 0.5 mm.

Infiltrative/aggressive tumours should have a clinical margin of 3-4 mm. Re-excision (or radiotherapy if re-excision is difficult) is recommended for any incompletely excised lesions. The re-excision specimen may be negative due to regression of the residual BCC, which is more common in nodular tumours. Specialist referral is recommended for recurrent tumours, large infiltrative tumours and some tumours of the head. Patient follow up is similar to SCC.

Further information on genetics, risk factors, metastatic tumour, radiotherapy and follow up are in reference 2 below.

Relevant clinical information on the pathology request form is very helpful to the Pathologist in all skin tumours, and consultation with the reporting Pathologist is welcomed by QML Pathologists and is advisable if there are any inconsistencies in the report or the clinico-pathological correlations.

References

1. Clinical Practice Guidelines for the Management of Melanoma in Australia and New Zealand, (2008) Approved by the Australian Government National Health and Medical Research Council and developed by the Australian Cancer Network Melanoma Guidelines Revision working party.
2. Clinical Practice Guide, basal cell carcinoma, squamous cell carcinoma (and related lesions) - a guide to clinical management in Australia (2008). Developed by the Australian Cancer Network with funding from the Australian Government.



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Consultant Dermatopathologist

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Graduating from The Queen's University of Belfast, Northern Ireland (1974), Dr Munn trained in general medicine in England until 1980. After training in anatomical pathology in Wellington, New Zealand, Dr Munn obtained her fellowship in pathology in 1986. From 1986-1996 she worked as a Consultant Pathologist in Timaru Hospital,

and in private pathology in Christchurch, New Zealand. During this time Dr Munn completed a skin pathology course in Philadelphia with Dr Bernie Ackerman before immigrating to Australia in 1997.

Dr Munn worked as a Dermatopathologist in Adelaide (1997-2000) and as a general and skin Pathologist in Toowoomba (2000-2007). In 2007 Dr Munn joined QML Pathology as a Consultant Dermatopathologist at the Redcliffe Laboratory.

Associations

Australasian Dermatopathology Society

Australian Medical Association

Royal College of Pathologists of Australasia

>> PSA Billing

In May 2009, Medicare Australia made new rulings about the ordering of PSA tests, the interpretation of which are somewhat complex.

The following descriptions may assist in the interpretation of these new rulings and provide guidance where the patient may be billed an out-of-pocket fee.

Schedule number 66655:

Prostate specific antigen - quantitation - 1 of this item in a 12 month period.

This is for screening purposes, for patients **without** prostatic disease.

Schedule number 66656:

Prostate specific antigen - quantitation in the monitoring of previously diagnosed prostatic disease - this can be performed multiple times in a 12 month period.

Written clinical notes on the request form advising prostatic disease are required.

QML Pathology is using the table (right) as valid clinical notes. Any other terminology is not considered valid.

Schedule number 66659:

Prostate specific antigen - quantitation of PSA and free-PSA in the follow up of a PSA result which lies above the age related median (ARM) but below the age related reference limit (upper limit of normal ULN) - 1 of this item in a 12 month period.

Clinical notes of Prostatic disease have no relevance with this schedule number.

Schedule number 66660:

Prostate specific antigen - quantitation of PSA and free-PSA in the follow up of a PSA result which lies above the age related reference limit (upper limit of normal ULN) but below a value of 10ug/L - 4 of this item in a 12 month period.

Clinical notes of Prostatic disease have no relevance with this schedule number.

If the patient does not qualify for any of the above schedule item numbers, a Medicare rebate is not allowed. QML Pathology will therefore bill the patient directly for these out-of-pocket fees.

Schedule number 66656

Clinical Notes

Cancer of the prostate (CaP)
Prostatectomy
Prostatic/Prostate adenocarcinoma
Prostatic/Prostate adenoma
Zoladex/Lucrin Depot/Androcur
Benign prostatic hypertrophy
BPH
Prostate Disease
Enlarged prostate
Nocturia
Prostamegaly
Prostatism
Prostatitis
Urinary Dribbling
TURP

Schedule number 66659

Patient Age	Age Related Median (ARM)	Upper Limit of Normal (ULN)
Below 50	1.0	2.5
50-59	1.0	3.5
60-69	1.2	4.5
Above 69	2.1	6.5

Schedule number 66660

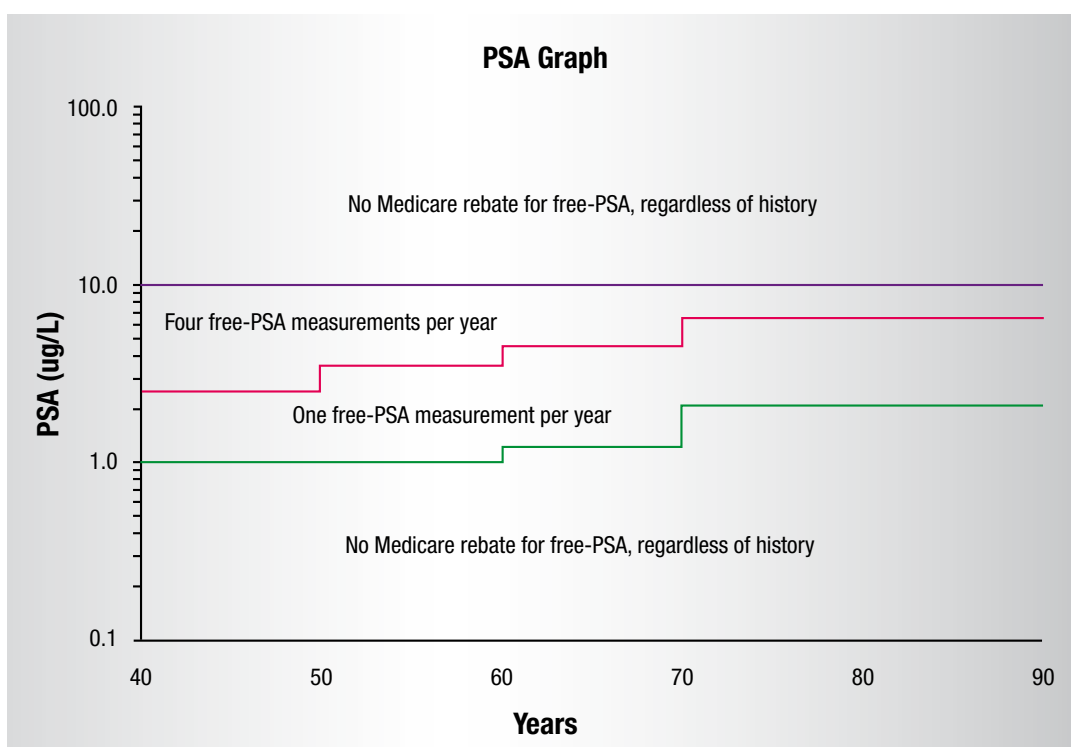
Patient Age	Upper Limit of Normal (ULN)	Medicare Determined Value
Below 50	2.5	10
50-59	3.5	10
60-69	4.5	10
Above 69	6.5	10

>> PSA Billing (Continued)

To assist General Practitioners who request PSA only, QML Pathology will add free-PSA tests to those with a high normal or frankly elevated PSA up to the limit of 9.9. These tests will be covered by the Medicare Schedule and the patient will generally not incur an out-of-pocket fee.

Examples

- A: Patient aged 65 years with PSA result 4.3 and no previous history.
QML Pathology will add a free-PSA, with rebate allowed and bill Medicare.
- B: Patient aged 65 years with PSA result 3.0 and previous result 3.0 in last 12 months.
*As Medicare rebate is not allowed, QML Pathology will **directly bill patient** as only allowed to screen once in a 12 month period.*
- C: Patient aged 65 years with PSA result 3.0, clinical note of prostatic enlargement and previous result 3.0 in last 12 months.
Medicare rebate is allowed as monitoring prostatic disease.
- D: Patient aged 65 years with PSA result of 3.0 and free-PSA requested.
Medicare rebate is allowed, as allowed one of such combination in a 12 month period.
- E: Patient aged 65 years with PSA result of 15.0 with free-PSA requested.
*QML Pathology will **directly bill patient** as Medicare will not pay for a combination with PSA higher than 10.0.*
- F: Patient aged 65 years with PSA result of 15.0 with free-PSA requested and clinical note of prostate cancer.
*QML Pathology will **directly bill patient** as Medicare will not pay for a combination with PSA higher than 10.0. Recognition of prostatic disease has no relevance in this example either.*



Infectious Diseases Report - Geographic Distribution - January 2010

ORGANISM	Regions (as per key below)															Total			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Jan	Dec	Nov	Oct
Adenovirus (not typed)		3	1		1		5		1	1	1					13	14	16	19
Adenovirus (typing pending)						1	3		1		2	1			2	10	8	16	12
Barmah Forest virus	5	2	1	1			3		3		2	2	1	1	2	23	21	13	15
Bordetella pertussis	4	29	18	4	1		24		19	4	47	31	12	8	14	215	233	219	201
Brucella species																0	0	0	2
Campylobacter jejuni																0	0	1	0
Chlamydia pneumoniae																0	0	0	0
Chlamydia trachomatis, not typed	73	88	38	22	1		84	1	56	27	173	52	20	31	16	682	560	644	614
Coxiella burnetii		1	1								1		1			4	2	3	4
Cryptococcus species			1								4			1		6	3	1	2
Cytomegalovirus (CMV)	2	8	5	1		1	13		2	5	19	8	3	3	1	71	61	67	49
Entamoeba histolytica																0	0	0	0
Enterovirus - not typed		1														1	2	3	1
Epstein-Barr virus (EBV)	2	24	6	3			23		18	2	41	14	4	8	3	148	117	203	179
Flavivirus unspecified	1						4				5	1		2	2	15	19	8	10
Hepatitis A virus							2									2	3	5	6
Hepatitis B virus	2	5	5				11		3	1	33	2		3	1	66	67	87	91
Hepatitis C virus	15	51	12	3	2		37		22	11	62	20	9	11	12	267	232	267	278
Hepatitis D virus																0	0	1	0
Hepatitis E virus											1					1	0	1	0
Herpes simplex Type 1	23	45	14	4	1		42	1	27	3	73	31	8	9	7	288	239	254	271
Herpes simplex Type 2	10	39	9	4	1		27		18	4	38	20	5	8	5	188	173	181	185
Herpes simplex virus - not typed																0	0	0	0
HIV-1		2					2		3		3					10	6	3	13
HTLV-1																0	0	0	1
Influenza A virus	1		1			1	1		2		2	2			1	11	12	21	22
Influenza B virus			1													1	0	0	11
Legionella pneumophila (all serogroups)																0	3	1	0
Legionella species			1						1		3					5	2	4	2
Leptospira species	2										1					3	0	1	1
Measles virus																0	0	0	0
Mumps virus																0	2	6	0
Mycoplasma pneumoniae		1	2				2		1		7	1		1		15	25	32	30
Neisseria gonorrhoeae	3	8	1				7		3		16			4		42	55	40	36
Parainfluenza virus Type 1											2					2	6	1	3
Parainfluenza virus Type 2			1						1		2	1				5	1	0	0
Parainfluenza virus Type 3									1			1			1	3	18	21	29
Parvovirus		2							1		1		1			5	7	19	21
Pneumocystis carinii																0	2		0
Respiratory Syncytial virus		7					1		3	3	4	4		1	1	24	22	15	18
Rickettsia - Spotted Fever Group											1					1	1	3	2
Ross River virus		1		2					1	3	1	4		3	1	16	13	49	64
Rubella virus																0	0	3	2
Salmonella paratyphi A																0	0	0	0
Salmonella paratyphi B																0	0	0	0
Salmonella typhi																0	0	0	0
Shigella dysenteriae																0	0	0	0
Shigella flexneri																0	0	0	0
Streptococcus Group A	3	11	3				11	1	13	2	14	3		4	2	67	54	68	78
Toxoplasma gondii																0	0	2	0
Treponema pallidum	15	6	3		1		19		6	7	35	7	2	13		114	129	117	131
Trichomonas vaginalis	6						1					1		5		13	14	27	13
Varicella Zoster virus	7	21	10				34		16	7	56	20	3	7	4	185	155	204	186
Yersinia enterocolitica																0	0	0	0
TOTAL	174	355	134	44	8	3	356	3	222	80	650	226	69	123	75	2522	2281	2627	2602

REGIONS

1 Cairns
2 Gold Coast/Northern Rivers
3 Ipswich

4 Mackay
5 Mount Isa
6 New England
7 North Brisbane Suburbs

8 Northern Territory
9 Redcliffe
10 Rockhampton
11 South Brisbane Suburbs

12 Sunshine Coast
13 Toowoomba
14 Townsville
15 Wide Bay/Burnett

Dec 2009 and further historical clinical data can be obtained by contacting your local Medical Liaison Officer

QML Pathology updates Feb 10

QML Pathology Bulk Bill all Pap Smears*

* Subject to Medicare eligibility and guidelines.

>> Pap Smear Campaign

Cervical cancer is one of the most preventable and curable of all cancers, yet approximately 36% of women aged 18-70 do not have regular pap smears, and 3 out of 4 women who develop cervical cancer have either never had a Pap smear or have not had one in the past 5 years¹.

As part of our ongoing commitment to women's health, from February to April 2010 QML Pathology is running a Pap smear campaign aimed at improving awareness amongst women of the importance of regular Pap smears in reducing the incidence of cervical cancer, and encouraging women 18 – 69 years to make a Pap smear appointment with their doctor. In particular the campaign will focus on those patients visiting QML Pathology collection centres, and those who rarely have or who have never had a Pap smear.

We also hope to dispel some common misconceptions, such as "I've had my cervical cancer vaccination, I don't need a Pap smear", or "I've been through menopause, I don't need a Pap smear". One of the key messages is that cervical cancer does not discriminate – it can affect your mother, your sister, your daughter, your friend, your wife or your grandmother. Now is the time to encourage friends and family to have a Pap smear.

As you all know GPs play a significant role in encouraging women to take the essential steps to prevent cervical cancer. Most women will have a Pap smear if their GP suggests it or if they receive a reminder notice from their surgery.

At QML Pathology we would like to assist with this process where possible. We will bulk bill all Pap smears that meet Medicare eligibility (patient's current Medicare number on the request form, the patient's signature on the assignment section of the request form, and D.B./B.B. indicated), and are able to provide Abnormal Follow up Lists and Pap Summary Reports to referring surgeries. These reports assist in identifying those patients who are due for routine

as well as early follow up smears, and give important feedback on the quality of Pap smear collection taking to our referrers. In addition we have a large number of resources that can be utilised by surgeries including posters and patient brochures, as well as information for doctors including our Women's Health Pack and reference material.

With your help we hope that the goals of our campaign will be achieved.

For further information, please contact Marketing on (07) 3121 4506 or Cytology on (07) 3121 4494.

References:

1 http://www.mariestopes.com.au/news1/media_releases/waging_a_smear_campaign_against_cervical_cancer/#_ftn2



Cervical Cancer Vaccines

To order or for more information, please contact QML Pathology Vaccines on (07) 3121 4523 or fax (07) 3121 4944.

Vaccine	Price (inc. GST)	Company
Gardasil	\$152.35	CSL
Cervarix	\$152.35	GSK

Key Messages for Women

- Cervical cancer is one of the most preventable and curable of all cancers.
- Early detection is the best prevention when it comes to cervical cancer.
- A Pap smear every two years can help prevent up to 90% of the most common type of cervical cancer.
- Regular Pap smears prevent more than 1,200 women from developing cervical cancer each year.



QML Pathology updates Feb 10

>> Doctor's Noticeboard

Dr Stirling Carlsen has joined Dr Wright-Smith, Dr Khatri, Dr Trim and Dr Meulet at The Cardiac Centre.

Dr Carlsen has recently completed a Fellowship in Clinical Echocardiography at the Flinders Medical Centre, Adelaide, and has additional special interests in the use of contrast echocardiography for better assessment of ejection fraction, wall motion abnormalities and LV thrombus in those with poor image quality and 3D TOE assessment of mitral valve pathology.

For appointments:

Southport

Phone: (07) 5591 6774

Pacific Private Clinic

Suite 5, Level 4

123 Nerang Street, Southport

Tugun

Phone: (07) 5598 0322

Fred McKay House

Suite 7a, Level 7

42 Inland Drive, Tugun

City Fertility Centre – Gold Coast has welcomed two new fertility specialists to the group. Dr Alwyn Dunn and Dr Penny Isherwood have recently joined CFC at Benowa, with IVF services offered out of Pindara Hospital. With extensive experience in Obstetrics and Gynaecology, they will be performing consultations and scans in their consulting rooms at Benowa Gardens Shopping Centre, and IVF procedures at Pindara Hospital.

Their rooms can be reached at:

(07) 5564 9359 for Dr Dunn and

(07) 5597 2660 for Dr Isherwood.

Clinical Director, Dr Andrew Davidson said that their experience will be a valuable addition. With services at Pindara, Robina and John Flynn Hospitals, City Fertility Clinic is the most accessible IVF clinic on the Gold Coast.

For further information or to request a free information pack, please phone Kassie on 1300 859 116.

Radiation Oncology Queensland (ROQ) offers a comprehensive range of specialist & general radiotherapy procedures to Southern & Western Queensland.

Equipped with the very latest technology, ROQ has grown rapidly since clinical inception in May 2007, and has recently opened a new clinic at Ipswich Towers Specialist Centre, Level 1, 15 Gordon St, Ipswich.

Contact Details:

280 North Street Toowoomba, Queensland 4350

Phone: (07) 4614 5855

Fax: (07) 4614 5843

Website: www.roq.net.au

Dr Greg Seeley and Assoc Prof Gordon Senator have moved to new consult rooms at John Flynn Hospital. Dr Seeley consults every Tuesday and Assoc Prof Senator every Friday from the QML Pathology Sessional Rooms, Level 1, Inland Drive, Tugun.

Full Time GP Needed

For Busy Family Practice - Mt Gravatt

- Non-Corporate
- Full time Registered Nurse
- No after hours
- Mixed billing
- Professional & friendly support staff
- Modern, computerised, accredited practice
- Excellent working environment.

Contact Carlos on **0433 126 448** or email wishart@internode.on.net.

WARFARIN DOSING OVER THE EASTER PERIOD

Over the Easter period, the Warfarin Care Clinic will be closed for the registering of new patients. The lines will be closed from 5.00pm, Wednesday 24/3/10 and will re-open at 7.00am, Tuesday 6/4/10.

During this time it is essential that any new patients on Warfarin are supplied with instructions and/or are referred to their local doctor for supervision. Patients who are currently monitored by QML Pathology and are being discharged from hospital will be accepted over this period.

QML Pathology updates Feb 10

>> Introducing our New Pathologists



Dr Bryan Knight

**BSc (Anatomy); MB,ChB;
MMed (Anatomical
Pathology); FIAC; ACAP; PhD.**

**Pathologist in Charge –
Cytology**

After graduating with his Bachelor of Science (Anatomy) in 1973 and a Bachelor of Medicine and Surgery in 1976 from the University of Rhodesia, Dr Bryan Knight continued with his studies and in 1985 completed a Master of Medicine (Anatomical Pathology) at the University of Cape Town. Dr Knight completed special training in gynaecologic and breast pathology at the University of Cape Town, and became a Fellow of the International Academy and Board of Cytology (FIAC) in 1997. He has been an Associate of the American College of Pathologists (ACAP) since 2003 and was granted his PhD at the University of Cape Town in 2004.

Dr Knight has been a Consulting Pathologist in private practice and at a variety of hospitals and universities from

1986 onwards in Cape Town, South Africa; Edmonton, Alberta and Vancouver, British Columbia in Canada. In 2007, he was appointed the Interim Director Laboratory Medicine and Pathology, Director Anatomical Pathology and Consulting Pathologist at the British Columbia Cancer Agency, Vancouver.

In 2009 Dr Knight joined QML Pathology as Pathologist in Charge of the Cytology Department.



Dr Shalinie Perera FRCPA

Dr Shalinie Perera obtained an MD in microbiology in 2001 and her FRCPA in 2008. Dr Perera worked as a Consultant Microbiologist from 2003 - 2008

at Sri Jayawardenapura General Hospital, Sri Lanka, and as a Registrar in Microbiology at PathWest Laboratory Medicine, Sir Charles Gairdner Hospital, WA from January 2007 to 2008. Dr Perera then worked at the Fremantle Hospital before joining QML Pathology in 2009.

>> Practice Incentives Program (PIP) - Cervical Screening Incentive

The PIP Cervical Screening Incentive aims to encourage practitioners to specifically examine under screened women who have not had a cervical smear in the last four years and to increase the overall screening rates of all women.

To be eligible for the PIP Cervical Screening Incentive, the practice must:

- participate in the PIP
- meet the requirements of each component of the Cervical Screening Incentive
- be signed on to the Cervical Screening Incentive for the practice to be eligible for outcomes payments
- ensure GPs are eligible for Service Incentive Payments.

The Cervical Screening Incentive consists of the components in the table below.

For further information about registering for the PIP Cervical Screening Incentive please contact Medicare on **13 21 50**.

QML Pathology and the PIP Cervical Screening Incentive

As part of our Pap Smear Campaign QML Pathology has compiled a list of patients who have attended your surgery and have no Pap smear recorded with QML Pathology for more than four years.

The report lists all patients meeting PIP criteria, including the date of their last smear recorded with QML Pathology. This list is available to assist you in your practice and to highlight the individuals who have not had recent smears.

Please note that it is possible that there may have been patient name changes, the patient has had a smear with another pathology provider, or the patient no longer attends your practice.

To obtain a list, please contact the Marketing Department on **info@qml.com.au** or **(07) 3121 4506**.

Component	Activity required for payment	Payment
Sign-on payment	One-off payment to PIP practices that engage with the state/territory Cervical Screening Registers.	\$0.25 per SWPE [†]
Outcomes payment	Payment to PIP practices where at least 50% of women aged between 20 and 69 years has been screened in the last 30 months	\$3 per eligible patient per year
Service incentive payment	Payment to practitioners working within a PIP practice for screening women between 20 and 69 years, who have not had a cervical smear within the last four years.	\$35 per patient

[†]Standardised Whole Patient Equivalent (SWPE) is used to measure practice size and includes a weighting factor for the age and gender of patients. The average load for a full time GP is 1,000 SWPEs per year.

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New Collection Centres

Aitkenvale

Aitkenvale Medical Centre
295 Ross River Rd

Phone: (07) 4728 5272

Opening Hours:

7.30am - 12.00pm, 1.00pm - 4.00pm (Mon-Fri)

8.00am - 12.00pm (Sat)

Broadbeach

Shop 369 (Giant Pharmacy)
Level 1, Pacific Fair Shopping Centre
20 Hooker Blvd

Phone: (07) 5504 7903

Opening Hours:

8.00am - 1.00pm (Mon-Fri)

Hyde Park

Oxford Street Specialist Medical Centre
16-18 Oxford St

Phone: (07) 4779 0158

Opening Hours:

8.00am - 12.00pm, 12.30pm - 4.00pm (Mon-Fri)

Kirwan

Kirwan Plaza, Unit 3
40-46 Thuringowa Dr

Phone: (07) 4773 6169

Opening Hours:

8.00am - 1.00pm, 2.00pm - 4.30pm (Mon-Fri)

8.00am - 12.00pm (Sat)

Rothwell

Unit T1.09, 757 Deception Bay Rd

Phone: (07) 3204 9633

Opening Hours:

8.30am - 12.00pm, 12.30pm - 4.30pm (Mon-Fri)

Strathpine

Shop 2, 130-134 Gympie Rd

Phone: (07) 3205 2453

Opening Hours:

9.00am - 2.00pm (Mon-Fri)

Townsville City

Urban Quarters-Townsville
Room 4, My Family Doctors
Stanley Street

Phone: (07) 4724 2794

Opening Hours:

8.00am - 11.30am, 12.00pm - 3.00pm (Mon-Fri)

Relocated Collection Centres

Goondiwindi

130 Marshall Street

Phone: (07) 4671 2222

Opening Hours:

7.00am - 3.00pm (Mon-Fri)



Flu season is here

Available to buy in boxes of 10 and single doses.
To order please contact QML Pathology Vaccines
on (07) 3121 4523 or Fax (07) 3121 4944

Amount	Price (ex. GST)
Less than 50	\$12.50ea
50 - 100	\$12.00ea
More than 100	\$11.80ea