but also as a major independent determinant of prognosis, second only in potency to apical lymph node involvement, among the range of pathology variables studied.⁵

Because of the difficulties inherent in creating a staging system which addresses all of the prognostically important aspects of tumour spread and is acceptable to all who have an interest in the subject, we now think that there is a case for a simple approach to staging with only three categories based on the presence or absence of lymph node metastases and the presence or absence of known residual tumour appropriately defined.⁶ Most would now accept that these two variables are likely to remain the most important stage related determinants of prognosis. We hold the view that further prognostic stratification using histological, clinical and other variables should be guided by the results of multivariate analyses performed separately for each of these three stages. The reasons for this approach are, firstly, that we have found that the importance of prognostic variables may be strongly influenced by stage⁷ and, secondly, it offers flexibility within a simple static staging system which can accommodate advances in our knowledge of prognostic variables.

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1 Shepherd NA, Baxter KJ, Love SB. Influence of local peritoneal involvement on pelvic recurrence and prognosis in rectal cancer. *J Clin Pathol* 1995;48:849-55.

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3 Davis NC, Newland RC. Terminology and classification of colorectal adenocarcinoma; the Australian clinico-pathological staging system. *Aust NZ J Surg* 1983;53:211-21.

4 Newland RC, Chapuis PH, Smyth EJ. The prognostic value of substaging colorectal carcinoma: a prospective study of 1117 cases with standardised pathology. *Cancer* 1987;60:852-7.

5 Newland RC, Dent OF, Lyttle MNB, Chapuis PH, Bokey EL. Pathologic determinants of survival associated with colorectal cancer with lymph node metastases: a multivariate analysis of 579 patients. *Cancer* 1994;73:2076-82.

6 Newland RC, Dent OF, Chapuis PH, Bokey EL. Clinicopathologically diagnosed residual tumour after resection for colorectal cancer: a 20 year prospective study. *Cancer* 1993;72:1536-42.

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Dr Shepherd comments:

I was delighted with the interest shown by the ACPS group in our paper on peritoneal involvement in rectal cancer. We have long felt the ACPS staging system to be among the more valuable of the staging systems in use for colorectal cancer in that it combines many of the most useful prognostic parameters with a Dukes-type staging system and it is a great shame that the system is not more widely promoted and used in the Northern hemisphere.¹

Perhaps I could respond to each of their comments in turn. Firstly, I would accept that both the Astler-Coller and ACPS

systems do have advantages over other systems in giving more weight to certain aspects of local spread independent of lymph node status. Nevertheless, in neither of these systems are the problems of a sequential system totally obviated. Astler-Coller C1 cases (lymph node metastases with local spread confined to the bowel wall) should be identified as a specific group as these tumours have a much better prognosis than Dukes C1 tumours in both rectal² and colonic³ cancer. I would also accede to the view that the ACPS system identifies that very important group of patients with mesorectal margin involvement in rectal cancer with a high likelihood of local recurrence and a poor prognosis.⁴⁻⁶ However, both of these patient groups are relatively small (in our own rectal cancer series of 334 patients Astler-Coller C1 cases account for only 3.9% of the total whilst patients with mesorectal margin involvement account for 10.8%). I believe that Newland and colleagues have to accept that there is a much larger group of patients with relatively extensive mesorectal spread but without spread to involve the mesorectal margin (in our own series 39.2%) in whom that spread (or perhaps other factors such as peritoneal involvement or extramural venous spread) may ultimately determine prognosis rather than the presence of an occasional lymph node metastasis and that such patients may not be identified accurately in either the Astler-Coller or ACPS systems.

Secondly, I fully accept that the ACPS classification does include serosal involvement (and this was clearly incorporated into our paper) and that the authors have shown its relatively strong independent prognostic influence in node positive cases. The ACPS group may be interested in our own data on colonic cancer (in a series of 643 patients) in which peritoneal involvement is the most powerful independent prognostic parameter over and above lymph node involvement and extent of local spread (manuscript recently submitted for publication). In our colonic cancer series, involvement of a free serosal surface occurs with much greater frequency than in the ACPS series (currently 55.8% of all colonic cancer cases). The difference between our figures and those of the ACPS may reflect the combination of colonic and rectal cancer in their study⁷ and perhaps the definition and means of identification of such involvement.

One conundrum of colorectal cancer prognostication, from which the ACPS series and classification is not immune, is the conjoining of colonic and rectal cancer in staging systems and prognostic assessment. For example, the prognostic influence of local spread in rectal cancer (particularly to the mesorectal resection margin) is very different from that of extramural spread in colonic cancer, particularly to the serosal surface. I have no problem with Newland *et al's* suggested approach to future prognostication but I would make an appeal for the separate prognostic analysis of rectal and colonic cancer or perhaps, more logically, separate analysis of cancer originating below and above the peritoneal reflection.

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3 Shepherd NA, Saraga EP, Love SB, Jass JR. Prognostic factors in colonic cancer. *Histopathology* 1989;14:613-20.

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5 Ng IO, Luk IS, Yuen ST, *et al*. Surgical lateral clearance in resected rectal carcinomas. A multivariate analysis of clinicopathologic features. *Cancer* 1993;71:1972-6.

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Book reviews

Cytodiagnostic urinalysis of renal and lower urinary tract disorders. Schumann GB, Schumann JL, Marcussen N. (Pp 200; £125.00.) Igaku-Shoin. 1995. ISBN 0-89640-243-6.

The authors of this textbook/colour atlas believe that cytodiagnostic urinalysis is a new, front line, cost effective, and non-invasive urine test that can detect urinary tract disorders accurately, especially renal diseases. I was intrigued to learn more about this useful new test. However, the authors have been performing cytodiagnostic urinalysis since the early 1980s, so it can hardly be described as new. Interestingly, nearly all the references are by one or more of the authors.

Cytodiagnostic urinalysis involves dipstick testing of a urine sample, a macroscopic description and a microscopic analysis of cytopspun, Papanicolaou stained sediment by a urinoscopist(!) including a quantitative assessment of white cells, erythrocytes, casts and renal epithelial cells and the detection of viral inclusions, other infections, crystals and malignant cells. A detailed proforma is completed, including a diagnostic summary.

It is, therefore, a complete urine test conducted in the cytology laboratory but it involves duplication of functions usually performed in separate settings—for example, dipstick testing, cell counts.

Cytodiagnostic urinalysis is extolled as an accurate means of diagnosing types of glomerular and renal tubular disease. However, in clinical practice urine cytology is used as an adjunct in the diagnosis of acute renal disease and is not a substitute for renal biopsy. Identifying dysmorphic erythrocytes and red blood cell casts is valuable for distinguishing glomerular bleeding from lower tract bleeding. This is perhaps best and most promptly performed by the nephrologist, using phase contrast microscopy, rather than by the laboratory. The authors believe that cytodiagnostic urinalysis is accurate and useful for diagnosing renal transplant rejection, yet the references given are from 1964 to 1977. Urine cytology has largely been superseded by fine needle aspiration or needle biopsy of the transplanted kidney and for monitoring, ultrasound or isotope scans are now widely used.

The greatest use for urine cytology is in the detection of malignant cells, yet there is just one brief chapter about cytodiagnostic urinalysis and urothelial neoplasia.

This book is clearly written and well illustrated, but it is uncritical and over

emphasises the use of urine cytology in clinical practice. I question the general applicability of cytodiagnostic urinalysis in pathology laboratories.

M BRETT

General Pathology. Walter JB, Talbot IC, eds. (Pp 750; £89.50.) Churchill Livingstone. 1996. ISBN 0443 042969.

The 7th edition of *General Pathology*, as with previous editions, attempts to "describe the fundamental process of pathology in relationship to the practice of medicine, particularly as it concerns the care of the patient". Many junior doctors have tended to view pathology as a hurdle to negotiate before graduation, only to realise when studying for postgraduate exams that pathology does not stop at medical school! An understanding of pathology informs clinical practice. *General Pathology* succeeds in being a very good review of the scientific basis of disease and emphasises its clinical importance.

The book covers all aspects of pathology from basic laboratory techniques and imaging, with up to date reviews of all the old favourites of pathologists such as tumours, inflammation and, of course, amyloidosis. There is very good coverage of oncogenesis and metastasis. The chapters on immunology have been completely updated and a whole chapter to the HLA system has been added. Overall, the text is very readable and most chapters do not assume a high level of prior knowledge.

Some areas could be expanded. Considering the importance of HIV, I felt this warranted more detailed coverage and was disappointed with the few paragraphs on prion disease in view of the theoretical potential threat of Mad Cow Disease! One further criticism is the paucity of diagrams. Though there are many plates of histology slides (all black and white), some sections were quite daunting due to the length of uninterrupted text. I felt some concepts would be easier to grasp with more diagrams to supplement the descriptions.

Overall, *General Pathology* is a good textbook of pathology suitable for medical students and candidates for postgraduate exams. The book is a comprehensive text for the pathology section of the current FRCS exam. However, in view of its length, cost, lack of diagrams, and colour I would not recommend it for an individual purchase but it is a valuable text for any medical library.

A WRAGG

Skin Cancer. 2nd edn. RM Mackie. (Pp 362; £75.00.) Martin Dunitz Publishers. 1996. ISBN 1-85317-203-0.

Finally, the UK Government has acknowledged the importance of cutaneous malignancies by setting a target in their Health of the Nation Document to halt the continuous annual increase in incidence by the year 2005. This second edition of *Skin Cancer*, first published seven years ago, goes a long way to update all medics in primary and secondary care faced with this problem. Rona Mackie is a world authority on the topic, especially in the field of cutaneous melanoma.

The author has tried to strike a balance between limiting the number of pages and providing a wide readership with enough illustrations, comprehensive text and key ref-

erences sensibly set out at the end of the book. With such a compact book of 362 pages there are bound to be omissions. She tries to cover both benign and malignant tumours and includes histiocytosis X, but not non-X-histiocytosis. Moreover, chapter 11 only outlines the topic of cutaneous lymphomas and the controversial "pseudolymphoma", a term which I understood most experts have done away with. Also, there is only a brief mention of the value of immunocytochemistry in differential diagnosis and no references to CD34 in identifying dermatofibrosarcoma. Overall, the book has tried to appeal to a wide readership at the expense of comprehensiveness. I was, however, surprised to see the number of typographical errors and poorly focused photomicrographs in what is a revised, updated book—for example, figs 12.3, 12.40, 12.48, 13.30, and especially 13.47. Presumably the publishers are at fault. In contrast, the clinical pictures are excellent.

I found much in this book to commend. The text is well written, appealing mainly to the physician, but skin pathologists would find the clinicopathological aspects valuable. I appreciated the chapter on malignant melanoma, especially the section on possible pitfalls in pathological reporting. I would, however, have liked to have seen more on this aspect and on horizontal and vertical phases of melanoma, a concept becoming more widely accepted.

R CERIO

Notices

The Leeds Course in Clinical Nutrition

September 3–6 1996

For further information, please contact: Mrs Hilary L Thackray, Department of Continuing Professional Education, Continuing Education Building, Springfield Mount, Leeds LS2 9NG. (Tel: 0113 233 3233; fax: 0113 233 3240.)

Australian Institute of Medical Scientists National Science Meeting

October 6–11 1996

On behalf of the Organising Committee, I extend a warm invitation to all Medical Scientists, Technical Officers and interested parties, to attend the above conference to be held at the Convention Centre in Adelaide, South Australia.

The Conference theme is Aboriginal Health and will cover this and many other related topics and scientific endeavours.

Persons interested in taking part in the scientific program by presenting a paper or poster should contact: Mr John Stirling, c/o Histopathology Department, Finders Medical Centre, Bedford Park, SA 5042.

For further information, please contact: SAPMEA Conventions, 80 Broughams Place, North Adelaide, SA 5006. (Tel: + 618 239 1515; fax: + 618 239 1566.)

Brian Matthews, Chairperson Organising Committee.

Dermatopathology for the general pathologist and dermatologist: diagnosis and broad review

September 25–27 1996

The Harvard Medical School Dermatopathology Residency Training Programme will present a postgraduate course in dermatopathology under the direction of Drs L M Duncan, R L Barnhill, T J Flotte, T J Harrist, and S R Tahan, to be held at the Copley Plaza Hotel, Boston, MA. Faculty include Drs W H Clark Jr, M C Mihm Jr and S L Moschella.

Participants will review practical dermatopathology with attention to broad certification and will learn to assess problems that arise in dermatopathology practice. The course is specifically aimed at practising pathologists and dermatopathologists as well as residents and fellows preparing for broad certification examinations. The Wednesday and Thursday lectures cover diagnostic criteria for specific orders organised by disease type. On Friday, the morning session will emphasise problem solving in dermatopathology consultations. Participants are invited to submit a case for the faculty to review prior to the course; all cases will be returned with a consultative note. On Friday afternoon, there will be a broad examination review session. A detailed syllabus consisting of lecture outline material and references will be provided.

The course has category 1 accreditation for 21 hours of CME credit by the American Medical Association. The fee for the course is \$500.00 (£333) (residents and fellows \$350.00 (£233)).

For further information, please contact: Department of Continuing Education, Harvard Medical School, 25 Shattuck Street, Boston, MA 02115, USA. (Tel: 617 432 1525; fax: 617 432 1562.)

Royal College of Physicians of Edinburgh

Consensus Conference on

Unrelated Donor Bone Marrow Transplantation

October 29 and 30 1996

Venue: Queen Mother Conference Centre, Royal College of Physicians The Conference will address the following issues, among others:

- The current status of blood or marrow transplants (BMT) from unrelated volunteer donors.
- The cost and the QALY; which patients will benefit most?
- Ethical care of the unrelated volunteer donor; how much can we expect?
- Alternative therapies; autografts and cytotoxic T cells.

For further information, please contact: Education, Audit and Research Department, Royal College of Physicians, 9 Queen Street, Edinburgh EH2 1JQ. (Tel: 0131 225 7324; fax: 0131 220 4393.)