relatively uncommon and so we chose to study centrolastic/centricytic follicular lymphoma. We accept Dr Crocker’s opinion that AgNOR counts may be useful in separating pure centrolastic lymphomas from reactive hyperplasia. We also agree that AgNOR counts reflect proliferative activity.1

Pathologists’ ability to estimate percentage of luminal occlusion in coronary artery disease

I was most interested to read the letter from Drs Champ and Coghill.1 In a small study, presented at the Pathological Society in London in January 1985,2 we wished to answer three questions:
1. How accurate are pathologists in estimating the percentage of luminal occlusion in a coronary vessel?
2. What is the extent of variation among different pathologists estimating the same vessel?
3. Does the use of a diagram proforma help in the naked eye assessment of coronary artery disease?

Twenty-five segments of coronary artery taken at necropsy were selected to provide a range of concentric and eccentric stenoses. These were shown to 15 trainee and consultant pathologists whose experience ranged from two months to over 30 years. No prior warning was given to the participants and each in turn was asked to estimate the percentage area of the lumen which was completely occluded by intimal proliferation (percentage estimate) and to grade this subjectively into mild/moderate/severe stenosis (subjective estimate). Having done this, diagram performances (figure) were then produced and the pathologist was asked to repeat the exercise. When all the results had been recorded, luminal occlusion was determined by planimetric methods on elastic van Giesen stained sections using a Kontron Videoplan computer (objective measurement). Each of the 25 coronary segments was then assigned to one of the following groups: mild (0 to 30% occlusion), moderate (31 to 69% occlusion), or severe (70 to 100% occlusion) stenosis on the basis of the objective measurements.

We then compared the percentage estimates and the subjective (mild/moderate/severe stenosis) estimates that had been made without the diagrams and with the diagrams to the objective measurements.

Not surprisingly, we found that the pathologists were most accurate in their estimations of coronary stenosis of less than 30% and greater than 70%.

The use of a diagram proforma improved the estimation of percentage of arterial occlusion, but the subjective estimate of arterial occlusion was not reproducible within this group of pathologists and was not improved by the use of the diagrams. This was because there was a wide range of values for luminal occlusion which different pathologists considered significant. Comparison of the percentage with the subjective estimates for each pathologist showed a range of 25% to 60% (mean 32%) occlusion for the lowest value in the moderate stenosis category. For the severe stenosis category from which the feed back at the present time is almost non-existent. Private pathology laboratories through the Independent Health Care Association should be far more aware of these responsibilities and be prepared to cooperate with national data collecting bodies, resisting the temptation to promote indiscriminate cervical screening.

Clinical pathology departments in the NHS have a proud record of providing a service and responsible advice to clinicians concerning the management of their patients. There is a danger that with the commercial factor ruling, laboratories will be established that will indulge only in remunerative pathology practice. There is no doubt that health service laboratories need to increase their efficiency, as we are continually being told in advance of April 1991. I would reverse the concerns of Dr Shanks expressed in her final sentence, however, and say that it would be a sad day if the lessons learnt in the NHS were ignored by the private sector rather than the other way around.

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Consequences of the provision of laboratory services of the National Health Service by commercial firms

I read this article by Shanks with great interest, and I would like to make some comments about it and about the general state of private pathology laboratories.

Many people may not know that J S Pathology is a public company quoted on the stock exchange and that Dr Shanks is the executive director. The laboratory is the largest in the United Kingdom and not attached to any regional or university department, and is about to move into purpose-buit premises in North London. The laboratory work is tailored to private medicine and has a low proportion of medical to non-medical staff, and the bulk of the work is biochemistry and haematology with some microbiology, rather a lot of cytology, and little histopathology.

Laboratories of this kind are almost invariably “demand led” whereby the tests are undertaken and interpreted by the clinicians who request them. With few pathologists available for advice, the consequences are that there is no control of the number and nature of the tests that are performed, in contrast to the NHS where pathologists are available for consultation concerning difficult clinical problems and will give advice on how the laboratory can help. Another result of the “tests on demand” approach is that aggressive drug companies will use these laboratories for promoting their products. The marketing of serum tumour markers is a good example of this.

With the advent of efficient cervical and breast screening programmes and the expansion of private medicine, the private sector must become responsible to those organisations concerned with quality assurance and conform to responsible reporting of tests undertaken so that meaningful national statistics can be compiled. Many people concerned with these projects consider the private sector the “soft option” from which the feed back at the present time is almost non-existent. Private pathology laboratories through the Independent Health Care Association should be far more aware of these responsibilities and be prepared to cooperate with national data collecting bodies, resisting the temptation to promote indiscriminate cervical screening.

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Proposed by Whitby et al.1 Discussions should take place between geographically related laboratories. These discussions should ensure that pathology services which are defined as non-core are provided in such a way as to maximise the use of local resources and to provide a professionally acceptable arrangement.

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Examination of faeces for bacterial pathogens

The ACP Broadsheet No 124 is a valuable summary of the subject,1 and I am particularly delighted to see a reference to Kohn’s two tube media which have been used in this laboratory for many years with great success and economy in time and, if properly used, materials. It is sad that this medium does not appear in a number of British textbooks and that one major British manufacturer has stopped supplying it. This is a retrograde step.

There is only one thing that concerns me and that is the inclusion of shigellas in the blanket recommendation (which otherwise is unexceptionable) that slide agglutination results should be confirmed by performing tube agglutinations. The late Patricia Carpenter maintained vigorously that it was not necessary to confirm slide agglutinations with shigellas by tube agglutinations. It may be argued that there are rare situations, such as with very uncommon Shigella boydii serotypes, when one might want to confirm the finding, and also it is wisely remarked in a recent edition of a standard British textbook that if there is doubt about a slide agglutination with Shigella, a confirmatory tube agglutination test should be performed. Both these latter points are, I am sure, valid, but a blanket recommendation that all Shigella slide agglutination results should be confirmed by performing tube agglutinations would, I think, surprise many workers, and it would be interesting to see if my views accord with those of others.

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Professor Wagenvoort and Dr Mooi have devoted their professional lives to the study of the histopathology of the pulmonary circulation. This splendid book represents a distillation of their researches. Open lung biopsy may be a rarity in some centres and when such a specimen arrives in the laboratory it is likely to cause difficulty. This volume provides ready help in such cases. There are 450 pages. New chapters dealing with how such material is to be obtained and processed. A straightforward description of the microanatomy of the normal pulmonary circulation precedes a series of exhaustive and well illustrated chapters on the pathology of the pulmonary vasculature in a comprehensive variety of congenital and acquired cardiopulmonary disorders. The sections on pleuropneumonic arteriopathy and on the subjective operability of congenital heart disease, the latter a special interest of Wagenvoort’s, are particularly good. Of greater value to the general histopathologist perhaps are the accounts of vasculopathies in primary lung disease and lung vessels in non-cardiac disorders. There are well chosen lists of references at the end of each chapter, though it is disappointing that the work of Ferrie and Lamb on the vexed question of measurement of medial hypertrophy and arterial contractance is not cited; only their paper on the effect of age and smoking on the pulmonary arterial intima receives mention. This book is well illustrated and indexed. It should be read and found a place in every diagnostic histopathology laboratory and hospital library.

M S DUNNILL

BOOK REVIEWS

Some new titles

The receipt of books is acknowledged, and this listing must be regarded as sufficient return for the courtesy of the sender. Books that appear to be of particular interest will be reviewed as space permits.


I was delighted to receive this book to review as I had previously discovered and bought volume I. This I had thoroughly enjoyed and can recommend to any pathologist interested in lung cancer. Volume I is almost entirely devoted to the pathological aspects of lung cancer; volume II only partly so. It is difficult to see why the subject matter has been separated into two volumes, for each is quite slim and together they would have made a text book of no more than 450 pages.

The book’s subtitle (The Evolution of Concepts) is a somewhat obscure way of saying that it is devoted to a historical survey of lung cancer, from its very beginnings to the present day. If you find history dull, these books are not for you, but I find it difficult to envisage how anyone could take an interest in the subject of lung cancer without knowing how our present day concepts have evolved. These books present a very scholarly historical survey of the subject and make fascinating reading. Illustrations include some interesting portraits of early workers, reproductions of original papers, and some of the early electron micrographs. I thoroughly recommend both volumes to anyone interested in lung cancer and believe that they represent important reading for any aspiring authors in this field. Volume I contains chapters on the history of lung cancer histopathology, selected histopathological studies, precursor lesions, the production of hormones by lung tumours, the neuroendocrine lung, pulmonary cytopathology, and a historical perspective of our understanding of the aetiology and development of lung cancer. Volume II contains such subjects as tumour registries, the development of the bronchoscope, a history of the roentgenology of lung cancer, radiotherapy from Roentgen to the present, historical facets of thoracic surgery, pulmonary function studies and chemotherapy. The final two chapters, entitled “Oncogenes” and “The biology of lung cancer,” are more likely to appeal to pathologists. Both volumes contain material of interest to the pathologist but this is particularly true of volume I.

B CORRIN


This book is concerned with the study of biopsy material derived from central nervous system, peripheral nerve, and muscle for the purpose of diagnosis. It describes how tissue can best be handled and what disease processes can be correctly diagnosed using established techniques. It is intended to be of service to neurologists, neuropathologists, neurosurgeons and pathologists.

There are four sections and two of them, concerning nerve biopsy and muscle biopsy, are straightforward and well illustrated accounts of well defined subjects. “Brain biopsy” is more difficult and controversial, embracing a varied assortment of neuropathological processes including neurodegenerative diseases of childhood, dementia of adult and late adult life, encephalitis, and so on. The authors wisely point out that other methods may be used in preference to brain...
Provision of laboratory services.

M J Galloway

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Updated information and services can be found at:
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