slightly pleomorphic mast cells, which made up 5% of all nucleated cells. However, focal mast cell infiltration was not found histologically, and malignant mastocytosis was thought unlikely. This reactive increase in mast cells was probably caused by the application of a particular haemopoietic growth factor (G-CSF) which would also strongly suggest a very close relation between mast cells and the myelomonocytic system.


5. HPV genotypes in cervical neoplasia in South Africa

Our recent publication on the prevalence of human papillomavirus (HPV) DNA in cervical intraepithelial neoplasia (CIN) using non-isotopic in situ hybridisation (ISH) in archival biopsy material from South Africa stated that there were no previously published data from that country.1 We have now become aware of a study from Cape Town on the prevalence of HPV DNA in CIN 3 using Southern analysis for HPV types 6, 11, 16, 18, 31, 33 and 35.2 There are several similarities in these independent studies using different molecular techniques (but the same probes) in patients from South Africa. Comparing our CIN 3 group from Durban with that from Cape Town, it is evident that there is a low prevalence of HPV 16 in Durban 15/55 (27%) and Cape Town 16/98 (16%) compared with Oxford patients 24/49 (49%). Furthermore, none of these groups showed any evidence of HPV 6, 11, or 31 in CIN cases. Excluding the unclassified group in Williamson's series, the prevalence of HPV 16, 18, and 31 in CIN 3 is less than 50% in Durban and Cape Town. The unclassified HPVs in the Cape Town series (36%), along with 59% of the Durban biopsy specimens of CIN 3 (with morphological evidence of wart virus infection) that did not contain HPV DNA by ISH, confirm our suspicion of a high prevalence of minor or unclassified HPV types in South Africa.


Reconstruction of fetuses after dissec-
tion

The paper by Gau, Napier, and Bhundia describes the use of the tissue adhesive Histoacryl Blue for the reconstruction of fetuses after dissection.1 In Huntingdon we use a similar technique to that described by ordinary Super glue (cyanoacrylate), which produces a very acceptable cosmetic result. Super glue is also very useful for closing small lacerations, particularly on the face or hands, which may be present in death associated with trauma, and also accidental cuts on visible areas of the neck which may occasionally occur in the course of necropsy. Persistent leakage of blood and fluid after removal of the calf muscles has also been remedied by running a line of superglue over the sutures.

The use of Super glue in this way is by no means new, in fact it is used by some anatomy departments to repair small nerves and vessels on demonstration specimens, which sometimes become severed by heavy handed protecrors or enthusiastic students. Super glue can be used by pathologists to reconstrucet organs after dissection, for use as teaching specimens. I understand that some undertakers even use Super glue on the eyelids of cadavers if they will not stay closed.

Although not subjected to such a rigorous study as that by Gau et al, in my experience ordinary Super glue produces good tissue adhesion, as anyone who has ever stuck their fingers together while attempting to repair some household ornament, or child's toy, will testify. The glue line has a slightly firmer consistency than the adjacent tissue, but the glue is colourless. Any excess dries to a crust, presumably the caugulum described in Gau's paper, most of which can be removed with forceps or a scalpel blade. Super glue is much cheaper and more readily available than the specialised surgical adhesive described.

Skin adnexal tumours

I must congratulate Dr Cotton on his paper which attempts to clear the minefield of skin adnexal tumours.1 In my experience these benign lesions cause great problems with classification, often requiring serious "bench testing" of such tumours of less than 3 mm.

Two points concern me. Dr Cotton states that "distant metastases have not been reported" for malignant pilomatrixomas. Two case reports of histologically confirmed metastatic pilomatrixomas do exist: Gould et al2 and Mir et al,3 both using the criteria of Lopransi and Mihm for diagnosis.4

He also states that Merkel cell carcinoma stains "with Cam 5.2 which oat cells do not". The product information sheet for Cam 5.2 contradicts this as both tumours can stain with Cam 5.2, usually with a paranuclear "dot" positivity.5

Correspondence

Department of Histopathology, Bury General Hospital, Walsmerley Road, Bury, Lancashire BL9 6DP


Dr Cotton comments:

I thank Dr Cross for his helpful comments. I have looked up the references to metastasis in malignant pilomatrixomas (or pilomatrical carcinomas) and there are about six cases that I can locate. My comment about metastasis not being reported referred to aggressive variants of pilomatrixomas rather than the frank carcinomas with pilomatrix differentiation. In the case reports that I have read some went from frank squamous carcinoma with pilomatrixal areas, some were carcinoma arising in pilomatrixoma, and two were possibly metastases arising from the cellular aggressive variants of pilomatrixoma. Dr Cross is, of course, right to comment that there are reports of malignant pilomatrixomas that have metastasised. I am still reluctant to believe that even cellular aggressive variants do so, although I agree that frank carcinomas do.

As to Dr Cross's comments regarding cytokeratin staining of Merkel cell versus oat cell tumours, there is some conflicting evidence. Dr Ross in Ackerman's Surgical Pathology refers only to keratin staining and does not mention CAM 5.2 as far as I can see. The reference that he quotes refers to a series of cytokeratin antibodies raised in the author's laboratories and which are not directly comparable with CAM 5.2 as far as I can ascertain. On the whole, the typical "ball in a fist" cytoplasmic dot positivity for CAM 5.2 is highly characteristic of Merkel cell tumours in my experience, and positivity in oat cell carcinomas is much less frequent and more diffuse when it occurs.
Skin adnexal tumours.

P Cross

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