Dr Ellison et al comment:

Dr Piette and colleagues make some valuable suggestions in their letter about our article. We were also keen to compare the presence of intratunical platelet deposition and titres of antiphospholipid antibodies in our series of patients. Three of the six had died before antiphospholipid antibodies were measured, however, and we could find no record of these tests in the case-notes of the other three. We were unable to trace any stored serum.

We would agree that a study of other vascular lesions in the antiphospholipid syndrome would be interesting. Though difficult to substantiate or to quantify, our impression was that intratunical platelet deposition was more readily found in the cerebral circulation of patients with the longest histories of neuropsychiatric symptoms and the most deformed, thickened, small vessels.

Carcinoid pattern in adrenal pheochromocytomas

In response to the paper by Harach and Bergholm, I would like to comment on a similar phenomenon that I have encountered in two adrenal pheochromocytomas.

One case was sporadic and the other associated with multiple endocrine neoplasia type IIa (MEN IIa). The carcinoid areas seen microscopically were reminiscent of the classic midgut pattern with packets of uniform cells. The tumour cells were smaller and less pleomorphic than the typical pheochromocytoma. The carcinoid foci were, however, minor histological components and both tumours had adjacent areas of typical pheochromocytoma. The medullary carcinoma of the patient with MEN IIa, interestingly, did not share this carcinoid phenotype. The question of metachronous metastatic adenocarcinoma has been described in these cases because of obvious areas of pheochromocytoma and the characteristic clinical scenario. At the same time, it must be remembered that metastatic medullary thyroid carcinoma within an adrenal pheochromocytoma has been described.1

Metastases aside, if one believes in the dispersed (diffuse) neuroendocrine system, it is not unexpected that overlaps in histological pattern will occur.

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Dr Slater comments: I appreciate Dr Benbow's interest in my audit of wording inaccuracies in relation to death certification. I fully support Dr Benbow's view that histopathologists should be sensitive to this issue and work hard to achieve this by personal communication with general practitioners and, when appropriate, by spending time with relatives of the deceased. We find this is preferable to the necessary limitation of providing information by a lengthy and somewhat "stark" and impersonal Death Certificate. I agree that the inclusion of a "mode of dying" in expert hands as Dr Benbow does does little harm. I am sure, however, that such a policy was adopted by inexperienced doctors then mode of dying would quickly become acknowledged as a definitive cause of death. Perhaps we should also not forget that we are not in fact naming the mode of death that we are certifying.

I am also appreciative of Dr Benbow's comprehensive list of references relating to the poor correlation between the clinical diagnosis of terminal malignancy and necropsy findings. This in itself proved an interesting audit and I was relieved that my own references were only 10% deficient. I was saddened to see that Dr Benbow expressed no personal opinion on the term carcinomatosis.

Further to Dr Slater's informative paper on audit of death certification we would like to add our experience in this field. Since 1990 we have audited the accuracy of death certification in this hospital by comparing the cause of death as found at post mortem (PCOD) with the presumed cause of death as written on the death certificate (PCOD). A post mortem examination is requested on all hospital deaths in this institution; the overall rate in three years is 24.2%, excluding coroner's cases, and only 8% are specially selected for post mortem examination. Accuracy of certification is scored 1–4: 1 = completely accurate; 2 = relatively accurate, the PCOD and COD match, but secondary causes are inaccurate caused by attempting to glean information from a somewhat "stark" and impersonal Death Certificate. Perhaps we should also not forget that we are not in fact naming the mode of death that we are certifying.
The rates have remained relatively constant over the three year period. Results of post mortem examinations are presented at clinicopathology audit meetings, which are held at two weekly intervals. As the junior medical staff turnover averages six months, however, it may be that the benefits are felt in other hospitals. Unlike Dr Slater, we have not found cases which should have been referred to the Coroner.

We would suggest that the accurate wording of death certificates is of paramount importance for statistical reasons.

Correspondence for statistical purposes is of importance.

ACP

Post mortem

Dr Forrest is to be congratulated on his ACP broadsheet concerning the usefulness of post mortem sampling for biochemistry and toxicology,1 a much neglected subject. There is one assay not mentioned among the generally useless enzyme determinations and that is the gamma glutamyl transpeptidase (γGT). Over many years I have found it to be a reliable additional investigation in those dying with indications of alcohol misuse. Where there is no active liver disease, a raised γGT result from a peripheral blood sample gives added confidence for chronic alcoholism to be included in the cause of death.

TO ASHWORTH

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This book aims to provide practice in pathology multiple choice questions (MCQs) for medical students.

An attractive feature is the good mixture of question styles. This helps relieve the monotony of reading through MCQs and gives excellent practice in exam technique. There is a good breadth of subjects, neatly divided into 25 sections. I found that the explanatory comments were written concisely and in an appropriate amount of detail. The answers to the MCQs, however, are printed in bold type in a column down the middle of the page between the questions and the explanations. It is frustrating to scan the MCQ answer boldly in front of you before you have a chance to cover it up. Perhaps in subsequent editions the answers could be on the following page.

This edition has occasional ambiguities, but they are relatively few. The format of the MCQPath primary exam has changed and does not include MCQs, so it seems curious that the back cover of this edition mentions its use in preparation for this exam.

This book is excellent value and I would recommend it for medical students who are preparing for pathology exams and who require practice in MCQ technique.

TF MILLARD


Measuring Alcohol Consumption is an excellent resource for all those interested, at either a research or clinical level, in alcohol consumption, use and misuse. Accurate assessments of alcohol use are vital in monitoring alcoholism treatment and prevention programmes and investigating the links between alcohol consumption, behavioural or medical problems. Ray Litten and John Allen have edited a multiauthored volume which is highly organised, cohesive, integrated and practical. It is divided into two main sections: the first dealing with psychosocial measures; and the second with biochemical measures of alcohol consumption.

The first chapter provides a good overview of self-report methods, and emphasises that verbal reports are neither valid nor reliable, but that the important issue is that certain conditions and procedures are more conducive to response accuracy and validity. The second chapter provides an excellent review of "computerised approaches to alcohol assessment", and the finding that the results of computerised testing are generally similar to those of personal or pencil-and-paper interviews.

Timeline Follow-Back (TLFB) is the best psychometrically evaluated and field-tested self-reported alcohol consumption instrument to date. Chapter 3 provides a description of the methods and a thorough discussion of its validity, and appropriate applications of this and other self-report measures in various research and clinical situations. A useful appendix provides instructions for administering TLFB which can be modified for different target groups or research projects. The final chapter of the section on psychosocial measures discusses the accuracy of subject and collateral accounts of drinking behaviour.

The second section reviews many new and complex biophysical indicators of alcohol consumption. An overview divides biological markers into several types: markers of predisposition to alcoholism (trait markers); markers of chronic or acute consumption (state markers); and markers of alcohol damage. Blood alcohol estimation for the measurement of alcohol consumption, two new markers of high alcohol consumption (carbohydrate-deficient transferrin and 5-hydroxytryptophol), and the usefulness of protein acetaldehyde adducts as state markers of consumption are all discussed. The last two chapters describe non-invasive methods for the measurement of transferinal ethanol as an assessment of ethanol availability. The technique is easy to use in an outpatient setting where patients are seen on a weekly basis and has a high degree of sensitivity and specificity. A wearable, electronic ethanol sensor/ recorder, an adaptation of the same chemical detection technology used in breath analysers, is also described. Unlike the dosimeter, it provides real-time rather than cumulative monitoring of alcohol use, and therefore gives accurate quantitative and temporal tracking of ethanol consumption over extended periods.

This superbly organised, thorough, and readable book is highly recommended for all those who need to assess alcohol intake.

CAROLINE C HORIZAW


The authors stated in the Preface that this volume was intended to be a single guide to the diagnosis and the pathology of non-neoplastic diseases encountered in diagnostic human ultrastructural pathology. It is a companion volume to the book Ultrastructural Appearances of Tumours prepared by the same authors.

This is a multiauthor work with uniformly high standards throughout, although the chapters range in the extent to which they cover aspects of the subject. As a whole the volume is best regarded as an atlas of high quality photomicrographs with a relatively brief, but extensively referenced, textual introduction to each chapter. The photomicrographs cover most of the commonly encountered entities and there is a generous selection of illustrations of the infrequent or rare lesions, but this cannot be regarded as comprehensive, given that the authors intended to cover the range of non-neoplastic diseases where electron microscopy can contribute to the diagnosis. There is a wide enough coverage, however, for the book to act as a valuable aide membre for an ultrastructural pathologist while pondering over a difficult specimen. This approach will be of little value to the histopathologist with occasional exposure to electron microscopy.
Relative friendly death certificates.

M M Walker and T Duffy

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