Measurement of medical staff overload

Dr Bignardi¹ is correct in his conclusion that it is crucial to ensure medical staff workload and requirements in microbiology departments. The current guidelines of the Royal College of Pathologists for consultant staffing suggest that for central laboratories in district general hospitals serving a population of approximately 250 000 there should be at least two consultant medical microbiologists.¹ A number of districts do not provide such staffing and cases need to be developed to persuade managers to provide appropriate cover. "Population served" is a crude measure of workload, even if referral patterns do not distort the picture. It is also clear that hospital bed numbers are not directly related to laboratory activity; indeed, hospitals reducing bed numbers has resulted in an increase in laboratory tests from outpatients, day cases, and GPs. Numbers of specimens and the number and nature of tests can be more closely related to laboratory activity and can be made more sophisticated by such systems as WELCAN, but these are not a measure of medical input; neither are they a measure of the quality of a microbiology service. Particular problems in measuring consultant microbiologist input are the contributions to core activities of the hospital(s) and clinics served—activities such as hospital infection control, policies for infection control, chemical disinfection—and the general provision of advice on the management of infected patients. The latter aspects depend to a large extent on the case mix profile of the units served: intensive care units, special care baby units and oncology wards make particularly heavy demands on medical microbiologists. Although these matters are generally clear in principle, the allocation of numbers and the interpretation of workload reports has proved to be very difficult. Some of the problems of consultant staffing levels have been discussed in a recent article in ACP News² and the Microbiology Society Advisory Committee of the Royal College of Pathologists is currently examining this subject. It will not be easy to produce a universally acceptable measure, but the problem must be addressed in order to try to achieve a composite workload definition that reflects the range of input required of a consultant microbiologist.


Necrotising granulomas of the uterine corpus

We read with interest the report by Drs Akosa and Boret of necrotising granulomas of the uterine corpus following Nd YAG laser ablation of the endometrium,¹ and noted their reference to the original report of peritoneal granulomas following laser ablation.²

We subsequently reported the histological findings from four hysterectomy specimens obtained for various indications following Nd YAG laser ablation.³ Our findings were essentially the same as those of Akosa and Boret, and we were able to demonstrate by energy dispersive x-ray analysis that the black foreign material within the necrotising granulomas consisted largely of aluminium oxide compatible with the known composition of the sapphire laser probe.

We also provided evidence to support the hypothesis that recurrent bleeding following laser ablation is due to impingement of functional endometrium from the tubal ostia and is unusual.¹ and we subsequently reported that Akosa and Boret made no comment on the histological appearances of the endometrium away from the obvious laser damage. Finally, Akosa and Boret refer to the technique as endometrial resection which is in our view not correct, as the use of the Nd YAG laser is a technique for endometrial ablation.

We are grateful to Dr Smith et al for their prompt comment on our short report. This was basically intended to increase awareness among histopathologists of what has become a diagnostic quandary in the absence of adequate clinical information and in view of the increasing use of minimal invasive surgical techniques.

We noted in our report that the abnormalities in the endometrium were either complete or focal, the latter the cause of subsequent bleeding. The residual endometrium, although not stated in our report, was not confined only to the cornu as in the case referred to in the paper by Baggish and Baltoyannis. If one assumes that in every case of endometrial ablation the entire endometrium is destroyed, the hypothesis of inspissation may be acceptable: in our experience this is not always the case.

Endometrial resection using laser and endometrial ablation have been and are used interchangeably. Our opening sentence, which is now under discussion, i.e. "Transcervical resection of the endometrium is a hysteroscopic method of endometrial ablation": this is self-explanatory.

Our literature search was confined to 1980 onwards, why the papers by Baggish and Baltoyannis and Lomano were not cited. As for the paper by Reid et al, we can only assume that at the time of our search it had not been indexed.

We have now read all these papers and they
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