work, because it allows antimicrobial sus-
cceptibilities (meronidazole, clarithromycin
to be determined, and we would not replace it
for a specific test that was not fully
specific as suggested by the correspondents.

1 Veendaal RA, Lischendal-Bernards AT, Peth
The influence of transport medium and transportation time on culture of
2 Petha AS, Endts HP, Offerhaus CJA, Hoogenboom-Verdegaal A, et al. Value of
serology (ELISA and Immunoblotting) for the diagnosis of campylobacter pylori infec-

Measurement of medical staff overload

Dr Bignardi1 is correct in his conclusion that it is difficult to ensure medical staff workload and requirements in microbiology departments. The current guidelines of the Royal College of Pathologists for consultant staff suggest that for central laboratories in district general hospitals serving a popu-
lation of approximately 250 000 there should be at least two consultant medical microbiologists.2 A number of districts do not provide such staffing and cases need to be developed to persuade managers to pro-
vide 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, several hospitals reducing bed numbers has resolved in an increase in lab-
atory 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 consult-
ant microbiologist input are the contribu-
tions to core activities of the hospital(s) and clinics served—activities such as hospital infection control, policies for infectious disease, chemical disinfection—and the general pro-
vision 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 of staff to reflect the workload has proved to be very difficult. Some of the problems of consultant staffing levels have been discussed in a recent article in ACP News3 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 univer-
sally acceptable measure, but the prob-
lens 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.1 We subsequently reviewed the histo-
logical findings from four hysterectomy specimens obtained for various indications following Nd YAG laser ablation. 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 inspreading of func-
tional endometrium from the tubal ostia and isthmus,6 and we did not disagree that Akosa and Boret made no comment on the histological appearances of the endo-
metrium 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.

JHF SMITH
A KENNEDY
F SHARP
Northern General Hospital,
NHS Trust, Hornsey Road,
Sheffield S5 7AU
PC REID
Luton and Dunstable Hospital
W THURRELL
University College Hospital,
London

Dr Akosa and Boret comment:
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 abnor-
malities in the endometrium were either complete or focal, the latter the cause of subsequent bleeding. The residual endo-
metrium, 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 inspreading may be acceptable; in our experi-
ence this is not always the case.

Endometrial resection using laser and endometrial ablation have been and are used interchangeably. Our opening sen-
tence, which is now under discussion, “Transcervical resection of the endo-
metrium is a hysteroscopic method of endo-
metrial 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

2 Baggish W, Reid PC, Kennedy A, Smith JHF. Necrotising granulomas of the peri-
3 Reid PC, Thurrell W, Smith JHF, Kennedy A, Sharp F. Nd YAG laser endometrial ablation: histological aspects of uterine heal-
4 Lomano JM, Photoacoagulation of the endo-

BF, Offerhaus CJA, Hoogenboom-Verdegaal A, et al. Value of

serology (ELISA and Immunoblotting) for the diagnosis of campylobacter pylori infec-

should be helpful in our review of the experience with endometrial ablation in Whips Cross Hospital.

**Multinucleated stromal giant cells in ulcerative colitis**

I read with interest the paper by Dr Pitt and colleagues on colonic multinucleate giant cells in ulcerative colitis. Unfortunately, however, the antibody panel used by the authors failed to investigate a possible origin from factor XIIIa (FXIIIa) positive collagen-associated dendritic cells. My own observations indicate that FXIIIa positive dendritic cells, initially described in the dermis as so-called "dermal dendrocytes", are present in abundance throughout the whole gastrointestinal tract (figure).3 Their function and relevance to disease remain obscure but, in part, appear to include a major role in immunocompetence and antigen presentation.4 The contribution of FXIIIa cells to the pathogenesis of gastrointestinal pathology warrants extensive investigation.

Paradoxically, however, although FXIIIa antibody studies are required in Dr Pitt’s case, the results may well be negative. The authors comment that the colonic giant cells resemble those in the lower female genital tract and my own observations in vulval disease indicate that such cells are FXIIIa negative. Like the authors, I suspect that their giant cells probably originate from indigenous stromal cells. Their hypothesis is, however, not proved until FXIIIa studies have been performed.

D SLATER
Department of Histopathology, Rotherham Hospitals NHS Trust, Moorgate Road, Rotherham S60 2UD


**Processing of uterine specimens**

The recent Association of Clinical Pathologists’ broadsheet, which deals with the processing of uterine specimens, advocates a more thorough sampling of the uterine corpus than current cut-up protocols.1 In most cases the latter recommended that a single histological block, including both endometrium and myometrium, should be taken from the anterior and posterior uterine wall.2 3 Silverberg4 recommends that an additional block should be taken from the posterior uterine serosa; although this specific recommendation is not included in many recent protocols designed for gynecological and obstetric specimens,1 3 I routinely take a block from this area as it is said to be a site of election for endometriosis. The block taken is confined to the superficial myometrium and serosa, around the posterior peritoneal reflection. It is less than 10 mm thick; it can thus be readily fitted into the cassette containing the block of cervix taken from the posterior lip.

I have found this an effective screening test for serosal endometriosis. In auditing 50 consecutive specimens of uterus and cervix which had been removed for a variety of benign conditions, foci of serosal endometriosis were identified in seven cases: in three cases there was associated adenomyosis; in two endometriosis was identified in the ovary; in one there was no evidence of endometriosis in either the ovaries or fallopian tubes; and in the final case the adnexae had been conserved.

The presence of either unexpected adenomyosis or adnexal endometriosis would normally prompt a more extensive search for endometriotic foci elsewhere in the specimen. In two of the cases above, however, the presence of endometriosis would have remained unsuspected had this screening procedure not been employed. Both patients were perimenopausal women who presented with menorrhagia. There was no macroscopic evidence of endometriosis or adenomyosis in either specimen.

Endometriosis is an important but readily treated source of morbidity in women, and may account for continued abdominal symptoms following hysterectomy. The technique described above offers the advantage of routinely examining a section from the posterior uterine peritoneum without the costs incurred in processing a separate additional histological block.

MK HEATLEY
Department of Histopathology, The Jessop Hospital for Women, Leegate Road, Sheffield S3 7RL


**Book reviews**

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This edition of Symmers’ systemic pathology is being published as a separate volume for each system. In the case of the cardiovascular system there are two volumes, of which this is the first. Reviewing it is rather like trying to assess the fit of a suit with the trousers missing.
Necrotising granulomas of the uterine corpus.

J H Smith, A Kennedy, F Sharp, P C Reid and W Thurrell

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