L26 (CD20) staining of Bouin fixed bone marrow biopsies

L26 (CD20) is one of the most useful markers in the diagnosis of lymphoid neoplasms, but when Gala et al tested a large panel of antibodies for use in Bouin fixed bone marrow, L26 was one of the few antibodies which failed to stain. Vassallo and Pinto now suggest that if Zenker solution is used instead of Bouin solution, satisfactory L26 staining may be obtained. However, Zenker has its own technical and safety disadvantages and we note that, in contrast to the findings of Gala et al., successful immunostaining of Bouin fixed material for L26 has previously been noted and we get consistent, strong immunostaining for L26. We have fixed marrow biopsies in Bouin fluid for many years because of its excellent morphology in haematoxylin and eosin (H&E) staining and for its ease of use. (Following three to six hours of fixation in Bouin, biopsies are decalci- cified overnight in 10% formic acid. A short daytime processing cycle allows H&E sections to be reviewed late on the day following biopsy.) For immunohistochemistry we use antigen retrieval in antigen unmasking solutions (Vector Laboratories) with pressure cooking for two minutes before applying L26 (Dako) followed by the avidin-biotin complex (Vector Laboratories) with pressure antigen retrieval in antigen unmasking solutions to be reviewed late on the day following biopsy. For immunohistochemistry we use antigen retrieval in antigen unmasking solutions (Vector Laboratories) with pressure cooking for two minutes before applying L26 (Dako) followed by the avidin-biotin complex (Vector Laboratories) with pressure antigen retrieval in antigen unmasking solutions to be reviewed late on the day following biopsy.

As in a previous issue of this journal,1 we presented a list of antibodies suitable for immunostaining of Bouin’s fixed, paraffin embedded bone marrow trephine biopsies. Very few data indeed report the reactivity of currently available antibodies on Bouin’s fixed bone marrow. Some of the antibodies assessed were inconsistently reactive (4K85/CD45RA, Ki-B3/CD35 or unreactive (CD 20/L26, LN1/CDw75, Bcl-1/PRAD1, rabbit-Ki-67). In a letter to the editor, Vassallo and Pinto commented on lack of reactivity of our L26 staining with Bouin’s fixed material.2 They pointed out the usefulness of L26 staining for differential diagnosis of reactive and neoplastic small cell lymphoid aggregates in bone marrow specimens, and stressed the satisfactory results that were obtained with their Zenker fixed material.3

Authors’ reply:

In a previous issue of this journal,1 we presented a list of antibodies suitable for immunostaining of Bouin’s fixed, paraffin embedded bone marrow trephine biopsies. Only a few data indeed report the reactivity of currently available antibodies on Bouin’s fixed bone marrow. Some of the antibodies assessed were inconsistently reactive (4K85/CD45RA, Ki-B3/CD35 or unreactive (CD 20/L26, LN1/CDw75, Bcl-1/PRAD1, rabbit-Ki-67). In a letter to the editor, Vassallo and Pinto commented on lack of reactivity of our L26 staining with Bouin’s fixed material. They pointed out the usefulness of L26 staining for differential diagnosis of reactive and neoplastic small cell lymphoid aggregates in bone marrow specimens, and stressed the satisfactory results that were obtained with their Zenker fixed material.3

The major difference between their method and our own method is that we previously reported and illustrated the strong reactivity of mast cells with antibody antitryptase (AA1).4 CD79A also appears immunoreactive in our hands after microwave heating. In this issue of the new data, we would like to update the current list of antibodies suitable for the immunostaining of Bouin’s fixed bone marrow trephine biopsies; this includes antibodies for immunotyping of haematological malignancies as well as solid tumors, as follows: CD4, CD8, CD15, prostate specific antigen (PSA, prediluted), cartilaginous embryonic antigen (CEA, prediluted), mouse antihuman oestrogen (MAE, prediluted), and cytokeratin (clone MNF116, prediluted), all from Dakopatts, Prosan, Belgium. Preliminary results with CD5 and CD1a also seem encouraging, but require confirmation on a larger series of clinical specimens. It should be borne in mind that prior microwave heating appears necessary for all these newly tested antibodies.

Figure 1 Immunoperoxidase staining of L26 (CD20) in Bouin fixed bone marrow infiltrated by hairy cell leukemia. The hairy cells show strong membrane staining and contrast with the unstained marrow trichrome.

Calcium oxalate (Weddellite) crystals within ductal carcinoma in situ

Following our short report of a rare example of calcium oxalate (Weddellite) crystals within an apocrine pattern ductal carcinoma in situ we have encountered a further case. A 54 year old woman had microcalcifications detected in her right breast on routine breast screening. Core biopsies taken under x ray guidance showed ductal carcinoma in situ, but only the calcifications seen in the biopsies after examination of multiple tissue sections were of calcium oxalate (Weddellite) crystals in the lumen of a duct involved by high grade solid pattern ductal carcinoma in situ. A subsequent x ray guided wide excision of the microcalcifications revealed extensive high grade solid and comedo pattern ductal carcinoma, associated with (predominantly) ordinary-type microcalcifications, but also with luminal Weddellite crystals. This contrasted with our previously reported case in which the ductal carcinoma in situ was of papillary type. As previously discussed, Weddellite-type microcalcifications are usually associated with benign breast disease—particularly with apocrine microcysts. Interestingly, the wide excision in this case also contained apocrine microcysts with Weddellite crystals, which were immediately adjacent to the Weddellite containing ductal carcinoma in situ (fig 1).

Ductal carcinoma in situ associated with Weddellite-type microcalcifications remains a rare finding. The coexistence of Weddellite crystals in apocrine microcysts (not present within previously reported cases and adjacent ductal carcinoma in situ in this case) lends further support to the “bystander” theory for this phenomenon; that is, that ductal carcinoma in situ may involve a previously benign duct containing Weddellite crystals associated with pre-existing benign changes.

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Figure 1 Weddellite crystals within high grade ductal carcinoma in situ, photographed under partially polarised light. Haematoxylin and eosin stain.

Book reviews


In this book the authors aim to provide “a single source for describing and illustrating normal cytology that may be seen in day to day practice.” Following introductory chapters covering the structure of the cell and cytological techniques, there are sections devoted to specific cell lines and individual organs. There is a section on gynaecological cytology, although the majority of the book is devoted to fine needle aspiration and exfoliative cytology from other organs.

Each section is arranged in a similar fashion, covering anatomy, histology, normal cytology, and potential pitfalls. This results in a pleasing uniformity that is often missing in multiauthor texts. The text, while brief, is clearly written and the sections in each chapter on potential pitfalls are particularly useful. The illustrations provide a good mix of Papanicolaou and Diff-Quik stained material, together with relevant haematoxylin and eosin stained histological sections. They are of generally good quality, although some of the photomicrographs of Diff-Quik stained material are a little dark, and in some sections there is quite marked variation in the photomicrograph background. These minor problems do not, however, detract from what is a high quality text.

This book would be of use to any practising cytotechnologist and would also be of benefit to trainees. As such, it would be an important addition to any cytotechnologist’s library.

NEIL ANDERSON


Virginia Woolf wrote, “for the desire to read, like all the other desires which distract our unhappy souls, is capable of analysis.” You may have noticed a few unhapy trainee souls around at the time of the MRCPath examination, so will the arrival of the fourth edition of Postgraduate Haematology bring a little light into their lives? The question of whether any book has a role for future trainees in the age of electronic publishing is certainly worthy of analysis. Remember when videos were going to sweep aside the cinema audience? The internet is unravelled for current information but only the most hardened of computer nerds could suggest that the internet will ultimately replace the textbook. The local trainees who have had a look at Postgraduate Haematology agree with my assessment that it is an excellent overview and very clearly laid out. Some of the tables will be familiar to those who have attended the Hammersmith course, but all the 41 authors are to be complimented on their presentation of tables and diagrams. The morphology slides are also particularly good.

The layout is clear with the diagrams and photomicrographs organised in the appropriate section of the text so that they can be easily referred to. I recall reading a review of the second edition which criticised a didactic style which was necessary to keep the size of the book down. The fourth edition is a much more expansive text to take in the wealth of recent developments (such as new chapters on haemopoiesis and stem cell transplantation), but it does present most sides of the major issues and the bibliography is commendably concise. I particularly enjoyed the chapters on aplasia, genetic disorders of haemoglobin, and the myeloproliferative disorders.

Inevitably there are criticisms but they really are minor issues. A textbook will find that its description of current trials (for example, CML IV) will be out of date by the time it is published. You could quibble about the balance in some areas but there is a wellcome overall balance between malignant and non-malignant haematology. Do you find it a challenge to remember CD numbers? I’m almost up to double figures but true enthusiasts can test themselves on seven pages of numbers, taking them up to CD166. The female trainees were not impressed that pregnancy is considered as a systemic disease, nor by the fact that the common haematological problems in pregnancy merit only one page, while the spleen has its own chapter. One could carp over other aspects but the most important point is that the fourth edition of this standard text book succeeds extremely well in providing a readable and visually attractive general overview of haematology. Clinical haematologists like myself attending the BSH or ASH meeting show a high incidence of narcolepsy during some of the presentations. This book will give us a good cutting edge introduction so that at least we can understand the titles of the presentations next time. It can be highly recommended to everyone who works in a haematology department and particularly its target audience of postgraduate students.

The past years have seen an explosion of knowledge and interest in the central position of adhesion molecules and their ligands in the processes of cellular recognition, activation, and migration. More recently studies of leukocyte migration have also highlighted the critical roles played by chemokines and cytokines in recruiting specific cells to defined microenvironments in both normal and pathological physiology. Our increased understanding of this intricate molecular interplay between several classes of receptors and their ligands inevitably brings with it a buzz of excitement about potential therapeutic interventions targeted at specific interactions. With this perspective in mind, I think that scientists will welcome this excellent new book of protocols designed to characterise adhesion molecules experimentally at both structural and functional levels. The book draws together a wide spectrum of analytical strategies written by experts and is highly accessible to both the beginner and the experienced scientist. Each chapter concisely defines a single key aspect of study which scientists from many disciplines could usefully adapt to their own specific needs. Key references included with each chapter provide additional interesting and useful information. I was particularly delighted with the “notes” at the end of every chapter which highlight potential pitfalls and provide the kind of empirical wisdom which only experience brings.

LYNN MORGAN


This is an exploration of the role of fatty acids in the skin, a much underevaluated area. The authors concentrate on describing biosynthetic pathways for ceramides in the skin, but principally on the role of arachidonic acid, eicosanoids, and leukotrienes in diseases of the skin. Topics reviewed include the role of eicosanoids in inflammation and its modulation as produced in the dermis and by keratinocytes, and also the role of these molecules in eczema and psoriasis. Brief sections describe basic analytical techniques and the effects of fatty acid compositions and their retinoid modulators in keratinocytes. The book is aimed at investigators and scientists looking for a review of data on the role of inflammatory mediators derived from fatty acids in dermatological diseases. It is a good summary of the field, clearly written to a high standard. Sometimes this may be a rational decision, but sometimes it may occur through isolation from wider contexts. The prime advantage of this book is that, in having such a wide range of approaches to microbialid applications, it enables a reader to make decisions and choose approaches within a broadly informed context.

P N HOFFMAN


This is a new edition of the standard UK text on killing microbes or preventing their growth. The first half of the book is devoted to chemical disinfection and covers all the relevant agents, how they work, what can interfere with successful disinfection, assessing activity, specific target organisms, and some applications in the wider field of healthcare. The rest of the book is split between preservation and sterilisation. It is the preservation sections that contain the most diversity in application, from familiar ground such as medicines and food to the preservation of wood, leather, and museum specimens. The sterilisation section covers sterilisation by heat, radiation, gases and filtration, the application of heat processes to both medical items and foods (the latter including substerilisation approaches), novel and experimental sterilisation technologies, reuse of disposables, and quality assurance. These are not fields where there have been major advances since the previous edition in 1992, but there have been shifts in perception. There is an important new chapter on the thorony topic of inactivating the agents of transmissible encephalopathies by physical and chemical methods. New space is also given to protozoa, listeria, and biofilms, and more detail on virucidal activity and rapid methods in microbialid assessments. In all, this edition has expanded by some 200 pages.

The book is not aimed at those primarily interested in infection control in healthcare. Its prime use lies in its multidisciplinary approach. There is always a danger that, as disciplines evolve, they will separate from each other and follow increasingly disparate standards. Sometimes this may be a rational decision, but sometimes it may occur through isolation from wider contexts. The prime advantage of this book is that, in having such a wide range of approaches to microbialid applications, it enables a reader to make decisions and choose approaches within a broadly informed context.

M M WALKER

The International Academy of Pathology Forthcoming meetings

Symposium on Infectious Diseases, Antwerp, Belgium, 19–20 May 2000


Further details from: British Division of the International Academy of Pathology (administrative secretary, Mrs C Harris), PO Box 73, Westbury on Trym, Bristol BS9 1RY; tel +44 (0)117 907 7940; fax +44 (0)117 907 7941; email: bdip@ cableinet.co.uk

Course on Pulmonary Pathology

London, 20–23 June 2000

This course is designed to provide histopathologists and cryopathologists with an opportunity to study diagnostic lung pathology in a comprehensive manner. It comprises lectures and practical microscopy sessions, the latter making up roughly half the time and consisting of an individual study of a unique collection of cases.

Further details and application forms from: Professor B Corrin, Brompton Hospital, London SW3 6NP; fax +44 20 7351 8293; email: b.corrin@ic.ac.uk

Correction

Lam KY. Oesophageal mesenchymal tumours: clinicopathological features and absence of Epstein-Barr virus, October issue (52:758–760).

There is an error in the legend to figure 1, which should read: “Coexisting carcinoma (arrows) noted in oesophageal leiomyoma.”

The reference to the figure in the text (Results, para 6, 3 lines from the end) should be moved to the end of the next sentence: “Coexisting squamous cell carcinoma of the oesophagus was found in 12 patients (fig 1).”
Instructions for Authors

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L26 (CD20) staining of Bouin fixed bone marrow biopsies.

D S O'Briain and C Murphy

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