Correspondence

Angiomyofibroblastoma of the vagina

Angiomyofibroblastoma is a rare, recently described, soft tissue tumour that occurs mainly, but not exclusively, in the vulval region of premenopausal women.1 We report a case arising in the vagina to draw the attention of pathologists to the fact that this rare neoplasm can occur outside the vulva.

A 54 year old woman, para 4+0, presented with a two year history of vaginal wall prolapse. Vaginal examination revealed a polypoid lesion on the anterior wall. Surgical removal and vaginal wall repair was performed.

The surgical specimen consisted of surface mucosa with an underlying well circumscribed, firm, homogenous, white coloured lesion measuring 2.5 cm in maximum diameter. Histology showed unremarkable surface squamous epithelium. Deep to this, a well circumscribed but unencapsulated lesion was present. This contained numerous randomly distributed blood vessels, most of which were thin walled and capillary-like (fig 1A), whereas others had thick muscular walls. The surrounding stroma contained spindle shaped cells, some with wavy nuclei (fig 1B), and others with a plasmacytoid or epithelioid appearance. Occasional multinucleate cells were present (fig 1B). There was little or no nuclear pleomorphism and mitotic figures were not identified. In some areas there was a tendency for concentration of the stromal cells around blood vessels, although this was not a prominent feature. The stroma contained collagen fibres and was focally oedematous with some extravasation of red blood cells. Immunohistochemical staining showed diffuse positivity of stromal cells for vimentin (Dako, Copenhagen, Denmark). There was focal strong staining for desmin (Dako) and occasional cells were weakly positive for α smooth muscle actin (Sigma, Poole, Dorset, UK). There was no staining of stromal cells for S-100 protein (Diagnostic Products Ltd, Abingdon, UK), AE1/AE3 (Dako), CD34 (Sertec, Oxford, UK), or factor VIII related antigen (Sigma, Ontario, Canada). Staining for α smooth muscle actin, CD34, and factor VIII highlighted the vascular channels. There was diffuse strong positivity of stromal cells for the oestrogen receptor (ER) (Dako) and progesterone receptor (PR) (Dako).

Within the vulva the chief differential diagnosis of angiomyofibroblastoma is likely to be aggressive angiomyxoma. Angiomyofibroblastoma is distinguished from aggressive angiomyxoma by its circumscribed border and higher cellularity, by the frequent presence of plump stromal cells, and by a lesser degree of stromal myxoid change. Angiomyofibroblastoma of the vulva is almost always a benign lesion which, unlike aggressive angiomyxoma, shows little or no tendency for local recurrence. However, a single case with sarcomatous transformation has been described.3

Since the original description, angiomyofibroblastoma has been described outside the vulva, in the female urethra and in the male genital tract, and there have been occasional reports of this neoplasm arising in the vagina.4 In a report of 12 angiomyofibroblastomas, three had a vaginal location.5 When situated within the vagina, the main differential diagnoses are likely to be a leiomysarcoma with prominent vascularity or an angiomyxoma. However, diffuse immunoreactivity with anti-α smooth muscle actin. Diffuse positivity for ER and PR was present and this has been described previously in vulval angiomyofibroblastoma.6 Although this raises the possibility that angiomyofibroblastoma is a hormonereponsive neoplasm, positivity for ER and PR might simply be a reflection of the presence of these receptors normally in the subepithelial stromal cells of the vulva and vagina. It is probable that angiomyfibroblastoma in this region is derived from mesenchymal cells in the subepithelial myoid stromal zone, which extends from the endocervix to the vulva.7 In a recent report this lesion has also been described in the fallopian tube.8

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Thrombophilia testing

In his recent leader, Dr Baglin gives an interesting overview of thrombophilia testing. However, his clinical practice of screening all unselected patients with an episode of venous thromboembolism is at odds with the British Committee for standards in haematology guidelines on the investigation of thrombophilia.9 According to these guidelines, the main indications for thrombophilia testing are patients with a venous thromboembolism before the age of 45 years, recurrent venous thrombosis or thrombophlebitis, thrombosis in an unusual site, or a first venous thromboembolism with a clear family history of venous thrombosis. Such restrictions on expensive and time consuming thrombophilia tests to patient groups more likely to have underlying thrombophilic defects are almost mandated by haematology departments working under the financial constraints of the present day national health service.

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A comparison of international normalised ratio (INR) measurement in hospital and general practice settings: evidence for lack of standardisation

Previous reports of discrepancies in international normalised ratio (INR) measurement between centres have focused on hospital based methodologies. However, his clinical practice of screening all unselected patients with an episode of venous thromboembolism is at odds with the British Committee for standards in haematology guidelines on the investigation of thrombophilia.9 According to these guidelines, the main indications for thrombophilia testing are patients with a venous thromboembolism before the age of 45 years, recurrent venous thrombosis or thrombophlebitis, thrombosis in an unusual site, or a first venous thromboembolism with a clear family history of venous thrombosis. Such restrictions on expensive and time consuming thrombophilia tests to patient groups more likely to have underlying thrombophilic defects are almost mandated by haematology departments working under the financial constraints of the present day national health service.

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method of INR testing, the result obtained was taken as the gold standard. Samples were sent to the laboratory using routine transport with no samples tested more than 12 hours after venesecision.

Fifty four separate venous samples from 26 patients were sent from the practice to the laboratories. The INR values obtained ranged from 1.0 to 6.1. Table 1 shows the mean difference in results from the various machines. There was a significant mean difference in the practice Thrombotrak results relative to the ACL and the KC-10 in both laboratories, but none between practice measurements and those obtained in laboratory 1 using the same technology. There were also significant differences between all hospital systems. Furthermore, there was a significant difference between ACL and KC-10 results from the same laboratory and between KC10 results from different laboratories.

Our results suggest that regular differences occur in INR measurements obtained on the same samples using different methodologies and draws attention to inherent problems associated with INR measurement in different settings. The clinical implication of these findings is that patients could receive different doses of warfarin depending upon which centre monitors their INR. Nevertheless, the best agreement to be found was between the practice derived INR and the laboratory derived INR using the same technology. This shows that the quality care INR estimations are as reliable as laboratory estimations using the same combination of reagents and technology. Therefore, it follows that as long as continuity of INR estimation by location and method is maintained for individual patients, the rate of unnecessary warfarin dose adjustments will be reduced.

Table 1  Mean difference (SEM) in INR between methods (n = 54)

<table>
<thead>
<tr>
<th></th>
<th>ACL Lab 1</th>
<th>KC-10 Lab 1</th>
<th>KC10 Lab 2</th>
<th>Thrombotrak</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACL: Lab 1</td>
<td>0.25 (0.04)**</td>
<td>0.50 (0.05)**</td>
<td>0.35 (0.06)**</td>
<td>-0.06 (0.04)</td>
</tr>
<tr>
<td>ACL: Lab 1</td>
<td>0.24 (0.03)**</td>
<td>0.11 (0.05)*</td>
<td>-0.13 (0.06)*</td>
<td>-0.65 (0.07)**</td>
</tr>
<tr>
<td>ACL: Lab 1</td>
<td>0.06 (0.02)</td>
<td>-0.13 (0.06)</td>
<td>-0.42 (0.07)**</td>
<td>-0.42 (0.07)**</td>
</tr>
</tbody>
</table>

*, p < 0.05; **, p < 0.001.

INR, international normalised ratio.

More fundamental questions are: What is the purpose of giant multiauthor texts like this, who needs them, when will they be used and how, and if they are required, what is the “pecking order” for choice of these? Very often better written, more detailed, and more up to date descriptions exist in specific texts. The constraints of producing a multi author work like this mean that the individual chapters are unlikely to rival the detail of the specialised book. However, I suspect most of us consult books like this on the areas in which we do not have specialised texts. Apart from this text, this market segment appears to include Ackerman’s Surgical Pathology edited by Rosai, Anderson’s Pathology edited by Damjanov and Linder, and Silverberg’s Principles and Practice of Surgical Pathology. Perhaps the Oxford Textbook of Pathology is not a direct competitor because its remit is so different. The choice of which of these books to consult is a personal matter, depending on preferred style and balance of writing. In my view, Ackerman is particularly commendable for Rosai’s masterful treatment of diagnost in surgical pathology, Silverberg is brief and to the point, yet quite detailed, and Anderson’s Pathology is good for clinicopathological correlations and the general context of disease. This text lies somewhere in the middle, meeting several of the purposes, but to my mind it is beaten for quality of histological description by the first two works, although still well worthwhile if funds allow its purchase.

T J STEPHENSON


The Atlas of Immunology aims to be “the most up to date and thoroughly illustrated treatise available”. Sadly the book does not achieve what it sets out to do. Many of the images by their nature attempt to illustrate clinical or laboratory situations and, particularly for these, the highest quality of image is required to enable the differentiation from other often subtly different conditions. Many clinical images are given simply as line drawings—for example, a malar rash in systemic lupus erythematosus, the hands in systemic sclerosis, or a baby with an intra-venous line (the image for severe combined immunodeficiency). A dermatology text would not accept line drawings of a malar rash and why should immunologists? It is as if a team of journalists have collected as many images as possible regardless of quality, content, or currency. All are printed in black and white, and the reproduction is often poor. No explanation is given to any figure, either in the text, or in the legends, which are all simple statements such as “release of sequestrated antigen”. For images such as indirect immunofluorescence of salivary gland duct showing the staining pattern of anti-salivary gland antibodies labelled simply as “Sjögren’s syndrome” this is especially uninformative. Even the accompanying text is now largely outdated.

This ambitious project was an opportunity for two distinguished authors to provide the reader with access to a lifetime’s experience in first class images, using each one as an explanation of a key immunological concept. Each would have a detailed explanation, describing the distinguishing features, and contrasting it with similar images. As a minimum it would

Book reviews
pathogenesis, and there are occasional errors, but the overall quality of the book is as high as ever.

Everyone working in a laboratory setting should have to read this book, especially those with little experience of working with viable organisms or clinical samples, such as those taking up genetic manipulation work. It remains thoroughly recommended.

C KIBBLER


In the past decade, proton pump inhibitors have dramatically changed the treatment of acid related disorders. They profoundly suppress gastric acid, without the development of tolerance or side effects, and are very commonly used. As such, this book edited by Dr Olbe is of interest to clinicians, physiologists, and pharmacists. The book is written by experts in the field and largely consists of two sections on pharmacology and clinical effects. The first section covers among others the mechanism of action and the consequences of acid inhibition in animals and humans. The second section focuses on the use of proton pump inhibitors for ulcer disease, Zollinger-Ellison syndrome, and gastroesophageal reflux disease. Thus, the book deals with many topics. Unfortunately, the subject index is limited, which hampers its use as a quick reference. Furthermore, several currently relevant issues are not, or only briefly, discussed. These include the new formulation of omeprazole in a multiple pellet solution, the use of intravenous formulations for upper gastrointestinal bleeding, the possibility of nocturnal acid breakthrough and fundic gland polyp formation during treatment, as well as that of rebound hypersecretion after the withdrawal of treatment. Finally, the topic of Helicobacter pylori and atrophic gastritis is discussed repeatedly, but only some of the arguments mentioned in the international literature are brought forward. Therefore, a second edition of the book would benefit from such updating for clinicians who are interested in the newest aspects of proton pump inhibitor treatment.

E J KUipers

Calendar of events

Full details of events to be included should be sent to Maggie Butler, Technical Editor JCP, The Cedars, 38 Queen Street, Castle Hal-ingham, Essex CO9 3HA, UK; email: maggiebutler@giltreee.prestel.co.uk

Applications and Techniques in Veterinary Pathology
5 October 2000, Royal College of Pathologists, London, UK
Further details: Maureen Russell, Scientific Meetings Officer, Royal College of Pathologists, 2 Carlton House Terrace, London SW1Y 5AF, UK. (Tel +44 (0)20 7451 6740; email www.rcpath.org)

New Millenium Bugs
18 October 2000, Royal College of Pathologists, London, UK
Further details: Maureen Russell, Scientific Meetings Officer, Royal College of Pathologists, 2 Carlton House Terrace, London SW1Y 5AF, UK. (Tel +44 (0)20 7451 6740; email www.rcpath.org)

Practical Adult Cardiovascular Pathology Course
6–8 November 2000, Royal Brompton Hospital, Imperial School of Medicine, National Heart and Lung Institute
Further details: Short Course Office, National Heart and Lung Institute, Dovehouse Street, London SW3 6LJ, UK. (Tel +44 (0)20 7235 1872; fax +44 (0)20 7235 8246; email shortcourse.NHLI@ICAC.UK)

Diagnosis and Gynaecological Pathology
13–15 January 2001, The Embassy Suites, Palm Desert, California, USA
Further details: Department of Continuing Education, Harvard Medical School, 25 Shattuck Street, Boston, MA 02115, USA. (Tel +1 617 432 1525; fax +1 617 432 1562; email hms-cme@hms.harvard.edu)

Urological Surgical Pathology for the Practising Pathologist
24–26 March 2001, Sanibel Harbour Resort and Spa, Fort Myers, Florida, USA
Further details: Department of Continuing Education, Harvard Medical School, 25 Shattuck Street, Boston, MA 02115, USA. (Tel +1 617 432 1525; fax +1 617 432 1562; email hms-cme@hms.harvard.edu)

6th European Forum on Quality Improvement in Health Care
29–31 March 2001, Bologna, Italy
Further details: BMA/BMJ Conference Unit, BMA House, Tavistock Square, London WC1H 9JR, UK. (Tel +44 (0)20 7385 6409; fax +44 (0)20 7385 8689; email Quality@bma.org.uk; website www.quality.bmjgp.com)
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158  Neuropathology 2000  WR TIMPERLEY
157  Guidelines for the laboratory handling of laryngectomy specimens 2000  TR HELLIWELL
156  Handling oesophageal biopsies and resection specimens and their reporting 2000  NBN IBRAHIM

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