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. 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, homogeneous, 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 multilaminate 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 smooth muscle actin (Sigma, Poole, Dorset, UK). There was no staining of stromal cells for S100 protein (Diagnostic Products Ltd, Abingdon, UK), AE1/AE3 (Dako), CD34 (Sertec, Oxford, UK), or factor VIII related antigen (Crovins, Ontario, Canada). Staining for o 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.1

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.2 In a report of 12 angiomyofibroblas-


Figure 1 (A) Numerous capillary-like vascular channels are present within the neoplasm. (B) The stroma contains spindle shaped cells with occasional multinucleate cells.

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.1 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 thromboembolitis, 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 mandatory in haematology departments working under the financial constraints of the present day national health service.

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1 Baglin T. Thrombophilia testing: what do we think the tests mean and what should we do with the results? J Clin Pathol 2000;53:626–9.

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.2–4 We previously have demonstrated differences in derived INR values for the same sample tested in primary care and in one of three different haematology laboratories.3,4 Hence this study is an extension of the previous one, investigating comparative results based on contemporaneous samples measured in one primary care centre and in two hospital laboratories using a variety of techniques.

Venous blood was drawn from patients in one primary care centre over a three month period. The sample was tested on site for INR estimation using the ACL/IL combination of thrombrotak NPT and Thrombotest reagent. The remainder of the venous sample was placed in a citrated collection bottle and sent to two reference laboratories routinely used by the general practitioners to measure INR values (laboratories 1 and 2). Laboratory 1 determined INR values using three separate methods: a Thrombotak using Thrombotest, an ACL machine using IL reagents, and a KC-10 machine using Manchester reagents. Laboratory 2 determined INR values using a KC-10 machine with Manchester reagent. Because laboratory 1 acts as the regional reference laboratory and uses the ACL/IL combination as its routine

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 venesection.

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 primary care 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 need for unnecessary warfarin dose adjustments will be reduced.

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<table>
<thead>
<tr>
<th>Method</th>
<th>ACL Lab 1</th>
<th>KC-10 Lab 1</th>
<th>KC10 Lab 2</th>
<th>Thrombotrak</th>
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<td>KC-10: Lab 2</td>
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<td>-0.42 (0.07)**</td>
<td></td>
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*, p < 0.05; **, p < 0.001.

INR, international normalised ratio.

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

More fundamental questions are: What is the purpose of giant multi-authored 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 of 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 Rosen’s masterful treatment of clinical diagnosis 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 very worthwhile if funds allow its purchase.

J T 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 clinical 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 intravenous 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 sequestered 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 outdatad.

This ambitious project was an opportunity for two distinguished authors to provide the reader with access to a lifetime’s experience. It is a 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 clinical 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 intravenous 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 sequestered 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 outdatad.

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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 Pat- hologists, 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 Pat- hologists, 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, Na- tional Heart and Lung Institute, Dovehouse Street, London SW3 6LY, UK. (Tel +44 (0)20 7351 8246; email: shortcourse@nhliic.ac.uk)

Practice Guidelines for Non-Hodgkin’s Lymphoma
21–22 November 2000, Royal College of Pathologists, London, UK
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Cytopathology Update: Making Cervical Cytopathology Work
7 December 2000, Royal College of Pathologists, London, UK
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Diagnostic 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)

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24–26 March 2001, Sanibel Harbour Resort and Spa, Fort Myers, Florida, USA
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