Aspergillus antigen testing in bone marrow transplant recipients

E C M Williamson, D A Oliver, E M Johnson, A B M Foot, D I Marks, D W Warnock

Abstract
Aims—To assess the clinical usefulness of a commercial aspergillus antigen enzyme linked immunosorbent assay (ELISA) in the diagnosis of invasive aspergillosis (IA) in bone marrow transplant recipients, and to compare it with a commercial latex agglutination (LA) test.

Methods—In total, 2026 serum samples from 104 bone marrow transplant recipients were tested. These comprised 67 sera from seven patients who had died with confirmed IA, 268 sera from nine patients who had died with suspected IA, and 1691 sera from 88 patients with no clinical, radiological, or microbiological signs of IA.

Results—The ELISA was more sensitive than the LA test. All patients who were ELISA positive were also LA positive, and a positive LA result never preceded a positive ELISA. Twelve of 16 patients with confirmed or suspected IA were ELISA positive on two or more occasions, compared with 10 of 15 who were LA positive. ELISA was positive before LA in five patients (range, 2–14 days), and became positive on the same day in the remainder. Aspergillus antigen was detected by ELISA a median of 15 days before death (range, 4–233). Clinical and/or radiological evidence of IA was noted in all patients, and a positive ELISA was never the sole criterion for introduction of antifungal treatment. Two samples (one from each of two patients without IA) gave false positive results.

Conclusions—The aspergillus ELISA is a specific indicator of invasive aspergillosis if the criterion of two positive samples is required to confirm the diagnosis. However, the test is insufficiently sensitive to diagnose aspergillosis before other symptoms or signs are apparent, and hence is unlikely to lead to earlier initiation of antifungal treatment. It is therefore unsuitable for screening of asymptomatic patients at risk of invasive aspergillosis, but does have a useful role in confirming the diagnosis in symptomatic patients.

Terminology:
Invasive aspergillosis (IA) is a common life threatening complication of allogeneic bone marrow transplantation (BMT), particularly in patients receiving grafts from unrelated donors. Patients at greatest risk of developing IA are those with delayed engraftment, and those with severe acute or chronic graft versus host disease (GVHD). In BMT recipients, IA is usually relentlessly progressive, with a mortality rate of more than 90% despite treatment. There is some evidence that the mortality rate can be lowered if an early diagnosis of IA can be made, and specific antifungal treatment given. This is difficult because of the absence of specific symptoms and because cultures of sputum and bronchoalveolar lavage (BAL) are seldom positive.

Aspergillus fumigatus, Sanofi Diagnostics Pasteur, Paris, France) uses a rat IgM monoclonal antibody EB-A2 to detect Aspergillus fumigatus GM. This test can detect 10–15 ng of GM/ml of serum. Previous evaluations of the LA test in patients with neutropenia have given variable results, with sensitivities ranging from less than 30% to 95%. Most studies have found the LA test to have a specificity of 90–100%. However, the test has been found to give positive results only during the later stages of the infection.

More recently, a commercial test has been developed using a double direct sandwich enzyme linked immunosorbent assay (ELISA) (Plateia Aspergillus, Sanofi Diagnostics Pasteur). This test also uses the rat monoclonal antibody EB-A2 to detect A fumigatus GM, but it has a 10 times lower limit of detection than the LA test. It has a sensitivity of 67–100% and a specificity of 81–99% when performed with serum samples from neutropenic patients receiving treatment for haematological malignancies. Previous evaluations of the ELISA have suggested that it might become positive at an early stage of infection in these patients, and GM has been detected in some neutropenic patients before symptoms and signs consistent with IA had become
Antigen testing for invasive aspergillosis

ELISA, enzyme linked immunosorbent assay; LA, latex agglutination; ND, not done; BAL, bronchoalveolar lavage.

Time refers to the number of days (D) before or after transplant. Aspergillosis was disseminated in all patients except patient 3 (lung only).

*Patient conditioned but not transplanted; dates taken from start of antifungal treatment.

### Methods

#### PATIENTS

Serum samples tested in this investigation were obtained from three groups of patients (n = 104) undergoing bone marrow transplantation at United Bristol Healthcare Trust, more than half of whom received grafts from unrelated donors. Most patients (69%) were children (age ≤ 17 years); ages of patients ranged from 3 months to 56 years, with a median of 12 years 5 months. The first group of 67 sera was obtained from seven patients who had died with confirmed IA (group I). All these individuals had histological evidence of disease, or had positive microscopy with branching septate hyphae seen in conjunction with positive culture of a respiratory tract or tissue sample. The second group of 268 sera was collected from nine patients who had died with suspected IA (group II). These individuals had two or more of the following features: new infiltrates on chest computed tomography (CT) scans or radiographs, positive bronchoalveolar lavage (BAL) culture, or respiratory symptoms including severe pleuritic chest pain. The third group consisted of 1691 sera from 88 patients with no clinical, radiological, or microbiological signs consistent with a diagnosis of IA (group III). All patients admitted for transplantation or management of late complications received antifungal prophylaxis with oral itraconazole capsules 2.5 mg/kg, replaced with intravenous amphotericin 0.5–1 mg/kg on alternate days when oral medication was not tolerated. The protocol for management of neutropenic fever was treatment with broad spectrum intravenous antibiotics, with the addition of intravenous amphotericin after 72 hours of refractory fever. Ninety eight patients, who were consecutive admissions to the unit over the 18 month period from November 1996 to April 1998, were evaluated prospectively. The LA test had been used prospectively on the unit before the introduction of the ELISA. All patients (n = 6) who were antigen positive by LA in the period March 1995 to October 1996 were re-evaluated by ELISA (patients 2, 4, and 5 in table 1 and patients 1, 3, and 5 in table 2). Clinical data including use of antifungal treatment and categorisation of patients into confirmed, suspected, or unlikely categories of invasive aspergillosis were assessed retrospectively, without reference to aspergillus antigen results.

#### ANTIGEN TESTING METHODS

Serum samples for prospective analysis were collected twice weekly and tested on the day of collection. Positive samples were frozen overnight and restested the next day. If the result of retesting was positive then the result was telephoned through to the requesting clinician. Sera from six patients evaluated initially by LA were collected twice weekly and tested after being frozen. These samples were tested retrospectively by ELISA after a maximum of two years storage at −20°C. Freezing does not

### Table 1

<table>
<thead>
<tr>
<th>Patient no.</th>
<th>Time of first sample</th>
<th>No. of samples tested</th>
<th>No. of samples positive</th>
<th>Time of first positive sample</th>
<th>Outcome</th>
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**Times** refer to the number of days (D) before or after transplant.

#### Table 2

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<th>No. of samples positive</th>
<th>Time of first positive sample</th>
<th>Outcome</th>
<th>Comment</th>
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</thead>
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**Time** refers to the number of days (D) before or after transplant.

ELISA, enzyme linked immunosorbent assay; LA, latex agglutination; ND, not done; BAL, bronchoalveolar lavage.

Antigen testing was disseminated in all patients except patient 3 (lung only).

*Patient conditioned but not transplanted; dates taken from start of antifungal treatment.

Aspergillus fumigatus

A. fumigatus

A. flavus

PM: Aspergillus fumigatus

PM: A. fumigatus and A. flaveus

PM: histology positive

PM: A. fumigatus

PM: A. fumigatus

Sputum: A. terreus

PM: A. fumigatus

PM: A. fumigatus

PM: A. fumigatus

No isolates

No isolates

Sputum: A. fumigatus

No isolates

No isolates

No isolates

No isolates

No isolates

BAL: A. fumigatus

No isolates

BAL: A. flaveus
Table 3 Clinical and laboratory findings in 16 patients with confirmed or suspected aspergillosis (groups I and II)

<table>
<thead>
<tr>
<th>Clinical group</th>
<th>Finding</th>
<th>No. (%) of evaluable patients</th>
<th>Time of first positive finding</th>
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<tr>
<td></td>
<td></td>
<td>No. of evaluable patients</td>
<td>No. (%) of evaluable patients positive</td>
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<td>Confirmed IA</td>
<td>Fever</td>
<td>7 6 (86)</td>
<td>25 8–52</td>
</tr>
<tr>
<td>(n = 9)</td>
<td>CT</td>
<td>1 1 (100)</td>
<td>10 –</td>
</tr>
<tr>
<td></td>
<td>CXR</td>
<td>7 7 (100)</td>
<td>12 4–52</td>
</tr>
<tr>
<td></td>
<td>ELISA</td>
<td>7 6 (86)</td>
<td>13 4–28</td>
</tr>
<tr>
<td></td>
<td>Culture*</td>
<td>7 1 (14)</td>
<td>8 –</td>
</tr>
<tr>
<td>Suspected IA</td>
<td>Fever</td>
<td>9 5 (56)</td>
<td>62 9–176</td>
</tr>
<tr>
<td>(n = 9)</td>
<td>CT</td>
<td>4 4 (100)</td>
<td>31 9–56</td>
</tr>
<tr>
<td></td>
<td>CXR</td>
<td>9 8 (89)</td>
<td>31 5–176</td>
</tr>
<tr>
<td></td>
<td>ELISA</td>
<td>9 6 (67)</td>
<td>23 6–233</td>
</tr>
<tr>
<td></td>
<td>Culture*</td>
<td>9 2 (22)</td>
<td>52 49–56</td>
</tr>
</tbody>
</table>

Time of first positive finding refers to number of days before death.

*Antemortem samples.

IA, invasive aspergillosis; CT, computerised tomographic scanning; CXR, chest radiograph; ELISA, enzyme linked immunosorbent assay.

Aspergillus antigen tests were performed on 1691 serum samples from 88 patients with no signs of invasive fungal infection (group III). Two samples (one from each of two patients) gave positive ELISA results. None of these 88 patients later developed IA. Antigen tests were performed on 335 serum samples from 16 patients with confirmed or suspected IA (groups I and II) (tables 1 and 2). All patients had pulmonary involvement; there were no cases of invasive fungal sinusitis. Seven of these patients developed IA as a late complication of transplantation (> 100 days after transplant), and only one of these late cases was neutropenic when IA developed.

Table 1 summarises the antigen test results for seven patients who died with confirmed IA (group I), five of whom died during their initial admission for transplantation and two of whom were readmitted at > 300 days for management of GVHD. In six cases both tests gave positive results, but 29 of the 60 samples from these patients gave positive results by ELISA compared with 20 samples tested by LA. Table 2 summarises the results of the two antigen detection methods in nine patients who had died with suspected IA (group II). None of these patients underwent postmortem examination. In six of these cases, the patient died more than 100 days after transplantation. Six of the nine patients gave positive results by ELISA, compared with four of eight by LA. In the four patients in whom both tests gave positive results, 52 of the 100 samples gave positive results by ELISA compared with 43 samples by LA.

In an attempt to assess the clinical usefulness of aspergillus antigen detection by ELISA, we evaluated the clinical records of the 16 BMT recipients with confirmed or suspected IA (groups I and II). Table 3 summarises the clinical, radiological, microbiological, and serological findings in these patients. In the seven patients with confirmed IA (group I), antigen was first detected a median of 13 days before death. Among the other findings in this group, chest radiological changes were noted in all seven patients a median of 12 days before death, but culture was positive in only one patient (eight days before death). In the four late cases of suspected IA (group II), antigen was detected in six patients, a median of 23 days before death, but culture was only positive in two patients, a median of 52 days before death. Chest radiological changes were detected in eight of these cases, a median of 31 days before death. CT scans were only performed in four of these nine patients, but changes were noted in all four cases, a median of 31 days before death. The reason for commencing antifungal treatment was assessed for all patients with confirmed or suspected IA who became ELISA positive (n = 12). Factors contributing to the introduction of treatment were neutropenic fever in five patients, respiratory symptoms in four, pulmonary radiological changes in five, and a positive antigen test in five. A positive ELISA was never the sole reason for institution of antifungal treatment. Two of six retrospectively evaluated patients were ELISA positive before becoming LA positive. Antigen testing did not contribute to the introduction of antifungal treatment in these patients.

Discussion

Invasive aspergillosis is an increasingly common complication of BMT. Patients who develop chronic GVHD are at particularly high...
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risk, and these patients represent a major diagnostic challenge because they are often not neutropenic and steroids used to treat GVHD may diminish the febrile response to an infectious process. The response of BMT recipients to antifungal treatment is poor, and death is common once aspergillosis infection is established. Early treatment may be associated with a better outcome, but early diagnosis is difficult to accomplish. Non-specific clinical and radiological findings, failure to culture the organism, and the lack of a detectable antibody response to infection have led to interest in the development of tests to detect aspergillus antigens in body fluids. Aspergillus GM, a major cell wall component, has been found to circulate in the blood of neutropenic patients with IA. However, concentrations fluctuate during the course of the infection because of antigen clearance by the Kupffer cells of the liver, and it has therefore been suggested that frequent sampling (at least weekly) of patients at risk of IA is necessary. This was the strategy used on our bone marrow transplant unit. All patients on the unit were receiving antifungal prophylaxis with eitheritraconazole capsules or alternate day amphotericin B, which was switched to empirical amphotericin B treatment in the presence of a neutropenic fever of 72 hours duration unresponsive to broad spectrum antibiotics. The effect that the administration of antifungal drugs might have on the release of GM antigen and consequent performance of the test is not known. However, such practice is common in many BMT units and would therefore reflect common clinical application of the test.

Our results are in agreement with those of others, who have demonstrated that the ELISA is more sensitive than the LA test for aspergillus antigen, leading to both an increased number of patients being found to be antigen positive, and earlier diagnosis in some patients. However, the ELISA does not appear to become positive sufficiently early to alter clinical management. Assessment of the clinical usefulness of a diagnostic test requires information on the timing of positive test results in relation to the onset of the disease, and information on whether the test alters management. The onset date of invasive aspergillosis is often difficult or impossible to define in a BMT recipient, because the initial symptoms and clinical signs of infection, such as cough and fever, are non-specific. There is an association between invasive fungal infection and viral infections, many of which present with pulmonary involvement, in BMT recipients, which further complicates diagnosis. Therefore, we have chosen to assess whether the ELISA alters clinical management because the dates of administration of antifungal drugs were obtainable for all patients. Although a positive ELISA was a factor in the introduction of antifungal treatment in five patients, it was never the sole reason for starting treatment. Furthermore, ELISA did not contribute to the management of most (11 of 16) patients with IA, either because ELISA was never positive (four of 16), or because a diagnosis had already been obtained by other means (seven of 16 patients).

Other strategies have been evaluated as an adjunct to diagnosing aspergillosis. Thoracic CT scans are more sensitive than plain chest radiographs, and might be useful in some patients if small nodules and/or small pleural based lesions with a surrounding low attenuation area, the “halo sign”, are present. Our study does not provide comprehensive data on the usefulness of CT in BMT recipients, because CT was usually only performed to provide further information on suspicious plain radiographs. Therefore, our data will tend to underestimate the usefulness of this procedure. However, CT scanning might not be achievable in all patients, because of problems of moving very unwell patients and of sedating young children.

Two patients with no other signs of IA gave positive ELISA results but only on one occasion. Advice contained in the ELISA kit suggests that tests should be repeated on a fresh specimen to confirm positive results so these patients would not meet that criterion and cannot be regarded as confirmed false positives.

In conclusion, although the Platelia aspergil-lus ELISA appears to be a relatively insensitive procedure, it is specific, non-invasive and, unlike CT scanning, can be repeated at frequent intervals and without removing patients from protective isolation. It is insuffi-ciently sensitive to be used for routine screening of asymptomatic patients considered at risk of invasive aspergillosis, but forms a valuable adjunct to diagnosis if there is clinical suspicion that invasive aspergillosis has developed. Because this test is insensitive, the negative predictive value is low; therefore, a negative result would not be an indication for withholding antifungal treatment. Our bone marrow transplantation unit has therefore abandoned twice weekly screening of patients, but the ELISA is still used if there is clinical suspicion of invasive aspergillosis. A combination of strategies is needed to diagnose IA. The combination of radiology and aspergil-lus ELISA might be useful, and possibly the polymerase chain reaction (PCR) will also have a role in diagnosis, although data comparing PCR and antigen testing are limited, because most studies have looked at late cases, positive by both methods. One retrospective study found PCR to be less sensitive than ELISA, and concluded that neither test anticipated the introduction of antifungal treatment. No current diagnostic test obviates the need for empirical antifungal treatment in BMT recipients.


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Bones, groans, moans . . . and salivary stones?

A 46 year old man was referred to hospital by his general practitioner with abnormal bone biochemistry. He had presented with poor appetite, fatigue, myalgia, and backache. Serum calcium, corrected for albumin, was 2.63 mmol/litre (reference range, 2.12–2.62), serum phosphate was 0.85 mmol/litre (normal range, 0.7–1.4), and alkaline phosphatase was 367 IU/litre (normal range, 80–280). There was no history of previous fractures or of renal calculi. The parathormone concentration was raised at 19 pmol/litre (normal range, 1.3–7.5) and the urinary calcium to creatinine ratio was 0.375 (normal range, 0.085–0.65). Bone densitometry provided a T-score of −2.4 (osteoporosis (T-score, −3.05). Ultrasound of his neck revealed a solid lesion of low echodensity at the lower pole of the right lobe of the thyroid gland, typical of a parathyroid adenoma. At surgery the lower right parathyroid gland was excised, and confirmed by histology to be an adenoma.

At outpatient one week before elective parathyroidectomy, the patient reported that he had passed a stone from a salivary gland. He had attended hospital as an emergency two months previously and had been diagnosed as having sialadenitis of the left gland. Subsequently, he had become exasperated with the pain and manually forced the calculus out of the duct. There was no history of chronic infection or of other pathology to explain the presence of the calculus. The calculus weighed 2 mg and consisted of calcium phosphate (59%) and calcium oxalate (41%).

Sialolithiasis has been reported in hyperparathyroidism secondary to chronic renal failure,1 but not previously in primary hyperparathyroidism. Salivary stone formation may be promoted by the combined effects of excessive calcium release into the acinar lumina resulting in calcium phosphate aggregates. Such calcium phosphate intermediates may transform into more stable hard deposits. Their saturation in solution varies widely, partly because of the variation in pH that occurs in saliva. As a result, some of these calcium phosphate aggregates may precipitate.

Why do salivary stones occur so much less frequently than urinary stones in hyperparathyroidism? Some ions in saliva and urine, such as citrate, inhibit the growth of precipitated crystals, whereas others, like calcium and phosphate, accelerate growth. The balance of these and other molecules might favour stone formation in urine but not in saliva. Certainly, mechanisms involved in explain urolithiasis in hyperparathyroidism include hypercalciuria, hyperphosphaturia, and hypocitraturia. However, salivary concentrations of calcium and phosphate are also raised in primary hyperparathyroidism; the comparative rarity of salivary stones in hyperparathyroidism probably owes more to specific salivary proteins that control mineralisation, such as statherin and proline rich protein.2 It is possible that when salivary stones develop in hyperparathyroidism, they arise via the mechanism outlined above, with alterations in the concentrations of calcium and phosphate playing a primary pathogenetic role. Such a putative similarity in the pathogenesis of these two conditions in nephrolithiasis would be consistent with the observed association between the two conditions. In one large series, six of 56 patients with sialolithiasis were reported to suffer from nephrolithiasis as well.3

It is impossible to estimate accurately the true extent of any putative link between hyperparathyroidism and sialolithiasis, precisely because such a link has not been widely recognised. Certainly, most patients with salivary stones are not investigated for abnormal bone biochemistry. The time honoured mnemonic has it that hyperparathyroidism and other hypercalcemic states were classically associated with “bones, stones, abdomininal moans, and psychic groans”. Although this full blown clinical presentation is rarely seen today, we suggest that it may include salivary stones as well as urinary stones.


A case of purple urine bag syndrome associated with *Providencia rettgeri*

We would like to report this interesting case of an elderly lady (85 years old) who has been passing violet coloured urine over the past four weeks. She is living in a nursing home and has a long term urinary catheter. There were no other symptoms but her general practitioner was worried about urine discoloration and sent three urine samples to the biochemistry department on three separate occasions to identify the cause of the violet colour. There was no history of intake of medication, food colouring, or foreign substances that may alter the urine colour. The urine sample was alkaline (pH 8.5) with a strong smell of ammonia. It was centrifuged and a precipitate of fine blue crystals was identified in the sediment. The supernatant was clear and purple coloured, and was negative for haemoglobin, myoglobin, and porphyrins. At this stage, the purple urine bag syndrome (PUBS) was suspected and an aliquot was sent to microbiology for culture. There was heavy growth of a coliform species identified as *Providencia rettgeri*, an ammonia producing bacterium, adding support to the diagnosis of PUBS. This interesting phenomenon in which the urinary catheter of some elderly patients develops intense purple colouration is thought to be caused by indirubin formation.4 Various observers stated that indigo producing bacteria, which possess indoxyl sulphatase activity, usually bring about the decomposition of urinary indoxyl sulphate to indigo and indirubin.5 Several bacterial species have been reported in association with PUBS including *Escherichia coli*, * Proteus mirabilis*, * Morganella morganii*, * Klebsiella pneumoniae*, and *Providencia stuartii*.6,7 *Providencia rettgeri* was isolated from our patient; to our knowledge this organism has not been reported previously in PUBS cases. Awareness and prompt identification of this syndrome by biochemistry and microbiology departments should avoid the commencement of unjustified unnecessary tests on such urine samples.

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Fetal legionella pneumonia after fludarabine treatment in chronic lymphocytic leukaemia

Treatment of chronic lymphocytic leukaemia (CLL) with nucleoside analogues may cause T cell dysfunction, thereby predisposing to opportunistic infections in addition to bacterial infections as a result of neutropenia and humoral immune dysfunction.8 The following case provides an example of fatal legioinella pneumonia arising in these circumstances.

A 62 year old male non-smoker had obtained a good partial response after completing four courses of fludarabine treatment for relapse of stage B CLL. He had been treated at diagnosis 2½ years ago with chlorambucil and epirubicin but had never received corticosteroids. His general health had been good and he had continued in full time employment throughout. He developed “flu-like” symptoms just prior to returning to the UK from holiday in Spain and was prescribed co-amoxiclav by his general practitioner immediately on arrival. The next day he was admitted to hospital under a general medical team with lobar pneumonia and commenced treatment with ceftazidime. Clarithromycin, ciprofloxacin, and rifampicin were added soon after *Legionella pneumophila* was suspected (and later confirmed) to be the usual organism, but he died two days later.

There are approximately 200 cases of legioinella pneumonia arising in these circumstances which have been reported, including 30 out of which have been fatal.9

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chronic pulmonary disease.1 Of the haematological diseases, the risk of legionella seems highest in hairy cell leukaemia, possibly because of impairment of monocyte function, and has been seen after treatment with 2-chloro-2-deoxyadenosine.2 Opportunistic infections after treatment with fludarabine are usually seen with advanced Rai stage, severe neutropenia, impaired renal function, or concomitant prednisolone treatment.3 Legionella is uncommon in CLL, although it has been described after treatment with fludarabine.4 Treatment with co-trimoxazole is recommended for prophylaxis against pneumocystis in patients receiving nucleoside analogues but use is unclear from its use in HIV infected patients whether this decreases the risk of legionella infection.5 With the increasing use of fludarabine as a first line treatment, the number of treated patients with CLL who are fit enough to consider travelling abroad will probably increase. Because patients may present for medical help to those unfamiliar with immunosuppression after treatment with nucleoside analogues, the carrying of an alert card specifying infective and transfusion risks seems warranted.

A HENDRICK
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Is it useful to test for antibodies to extractable nuclear antigens in the presence of a negative antinuclear antibody on HEP-2 cells? Antinuclear antibody (ANA) negative lupus has long been recognised as a distinct entity affecting a small number of patients with systemic lupus erythematosus (SLE).1 Initial estimates of the prevalence of this entity (5% of patients with lupus) were based upon studies using rodent tissues as substrate for antinuclear antibody testing. The increasing use of human epithelial cell lines (HEP-2 cells), which have greater sensitivity for extractable nuclear antigens (ENA), has meant that new patients with true ANA negative lupus are now rarely encountered. Many immunology laboratories are faced with a substantial number of requests for antibodies to ENA and double stranded DNA, even in patients with negative ANA, on the grounds that patients with ANA negative lupus might go undetected. Using HEP-2 cells, we have attempted to define the prevalence of ANA negative, anti-ENA positive disease in a series of consecutive, unselected serum samples.

Over a 12 month period, all laboratory requests for antibodies to ENA (antibodies to Sm, Ro, La, and ribonuclear protein) were scrutinised to determine the number of samples that had antibodies to ENA despite a negative ANA on HEP-2 cells. The notes of patients who were ANA negative, anti-ENA positive were examined to verify the clinical diagnosis. During the 12 month study period, 7077 HEP-2 ANA samples were processed and 468 patients had an ANA-ENA profile performed during the same period on a HEP-2 ANA. Of these 468 patients, nine were identified who were ANA negative, anti-ENA positive. Review of their clinical notes indicated that six of these nine patients had previously been ANA positive and were known to have lupus but were receiving immunosuppressive treatment. Only three patients were persistently ANA negative despite positive anti-Ro antibodies before treatment. Thus, the prevalence of anti-ENA positivity combined with a negative ANA was three out of 468 (0.6%). Because ANA negative lupus characteristically presents with cutaneous disease the clinical notes of 90 of the dermatology patients were reviewed. Only seven of these patients had confirmed lupus erythematosus. Only one patient from the dermatology group had ANA negative, anti-Ro positive lupus before the commencement of immunosuppressive treatment. The finding of a low prevalence of anti-ENA positivity in the presence of a negative ANA on HEP-2 cells is in keeping with other studies in the literature.

Manoussakis et al found that only 0.4% of 243 HEP-2 negative patients with systemic autoimmune disease had positive anti-ENA antibodies1 and Homburger,2 reporting on the experience of the Mayo Clinic immunopathology laboratory, stated that anti-ENA antibodies were unlikely to be positive in the presence of a negative ANA result on HEP-2 cells. However, neither of these studies included a clinical evaluation of the ANA negative, anti-ENA positive patients. We recognise that ANA negativity is subject to potential sources of bias. The failure to scrutinise patients’ notes on all ANA negative samples irrespective of anti-ENA antibody status might have resulted in some patients with strong clinical evidence of connective tissue disease being overlooked. We think it unlikely that this would have greatly changed our findings given the rarity of uniformly sero-negative lupus (ANA negative, anti-ENA negative, and anti-DNA negative) and the general acceptance that a repeatedly negative ANA effectively excludes systemic lupus. Second, if clinicians failed to request ANA along with ANA, it is possible that some cases of ANA negative, ENA positive disease would be missed.

Based on these findings and others in the literature3 we have modified our testing strategy for antibodies to ENA. All requests for anti-ENA antibodies are “gated” by performing an initial ANA screen on HEP-2 cells. Samples that are ANA negative do not proceed to further testing unless there are compelling clinical reasons to suggest lupus. In conjunction with clinical liaison this testing strategy allows streamlining in busy clinical laboratories.

K F THOMSON
A MURPHY
M J D GOODFIELD
S A MISBAH

Handling of renal biopsies: different approaches reflect a lack of evidence for what constitutes “best practice” We read ACP Best Practice No 160 “Renal biopsy specimens” with interest.1 Dr Furness rightly avoids providing a list of specific procedures to follow because, as he points out, “there is a need to assess each case on its merits, rather than following rigid rules”. It is clear from an audit of handling of renal biopsies in the UK, performed in 1999, that standard operative procedures varied widely, and that many laboratories fall short of “best practice”. A probable reason for this is that there is very little hard evidence to support any specific recommendations. In the UK audit, a questionnaire was sent to all members of the UK Renal Pathology Group and returns were received from 50% of the 54 laboratories represented. It is interesting to compare current practices with Dr Furness’s guidelines.

Dr Furness recommended that all specimens should be examined in the biopsy room for adequacy, using a dissecting microscope. However, in only 15% of units is this performed as routine. Failure to confirm the presence of renal cortex in the specimen would be expected to increase dramatically the proportion of inadequate biopsies. This was not the experience of those who Audit, however, where in 1994, as a result of staff shortages, the practice of sending an MLSO to attend every biopsy procedure was stopped.1 In Oxford, the histopathology laboratory is on a different site to the renal and transplant units; neither an MLSO nor a pathologist attends biopsies, as was once the case. Furthermore, what constitutes an adequate specimen is difficult to define and to some extent depends on the nature of the pathology. More tissue is required to detect focal than diffuse lesions.3 This has been demonstrated in renal allograft biopsies; in the validation study of the CCGTT classification of allograft pathology, those biopsies showing acute vascular rejection contained the diagnostic arteritic lesion in only one of two cores taken in 82% of cases.4 In the UK audit, it was found that the proportion of renal tissue routinely taken varied from one to four in different centres. Dr Furness recommends that division of the specimen should be done within minutes of the biopsy being taken, to avoid artefactual ultrastructural changes. Although subtle subcellular changes do develop if fixation is delayed, for routine diagnostic electron microscopy (EM) rapidity of fixation is much less crucial. Formaldehyde fixation alone may produce
perform EM in all cases.

There is also variation in the immunohistochemical techniques used when handling native renal biopsies. A frozen sample for immunofluorescence (IF) is taken routinely in 81% of laboratories, the remaining 19% rely entirely on immunoperoxidase (IP) stains performed on paraffin wax embedded sections. This, in part, reflects varying success in achieving reliable results with IP for immunoglobulins and complement. In the case of early transplant biopsies, only 30% of laboratories routinely take frozen tissue for IF. In those that do, it is often for research purposes rather than for patient management. Similarly, most laboratories (88%) routinely take tissue for EM from native renal biopsies. Because some of the most common renal diseases, such as thin membrane nephropathy, can only be diagnosed ultrastructurally, those laboratories that do not take tissue for EM are certainly falling short of “minimum adequate practice.” Although it may be “best practice” to perform EM in all cases, it is probably sufficient to store this tissue as a resin block and only perform EM if the light microscopy is non-diagnostic. In many instances, EM will not influence patient management and the “minimum adequate practice” would, therefore, be to consider each case on its own merits and perform further investigations only if necessary. At present, EM does not have a clearly defined role in the assessment of early transplant biopsies and the UK audit found that only 38% of laboratories routinely take tissue for EM from these specimens.

The choice of which special investigations are performed should, at least in part, be determined by our clinical colleagues. Nephrologists differ widely in how aggressive they are in investigating patients with asymptomatic renal disease, such as those presenting with microscopic haematuria detected at a routine health check. In some centres a biopsy will only be performed if it is likely to affect management of that patient; in others, biopsy practice is partly driven by research interests. Equally, the information required from the pathologist will depend on its potential clinical value. For example, providing a measure of the severity of chronic tubulo-interstitial injury in a patient with membranous nephropathy is of far more value to the nephrologist than knowing the glomerular disease stage, as defined by ultrastructural appearances.

In the UK audit, the number of paraffin wax sections routinely cut for native renal biopsies varied greatly—from two sections on two slides to 70 sections on 10 slides—again reflecting a lack of evidence base. In his article, Dr Furness indicated that the number of sections that should be cut and examined depends on the nature of the question. A renal biopsy standard operative procedure should, however, include examination of sufficient sections to enable the diagnosis of conditions in which the pathology is usually focal. In the case of primarily focal segmental glomerulosclerosis, this is considerably in excess of two. For renal transplant biopsies, the Banff classification recommends that at least three haematoxylin and cosin (H&E) and three periodic acid Schiff or methenamine silver stained sections should be examined. The rationale behind this is that the diagnostic lesions of acute rejection—tubulitis and arteritis—are often focal. A recent review of transplant biopsies in Manchester concluded that one third of diagnoses of acute vascular rejection would be missed if only one, rather than three, H&E sections were examined (GP McCarthy, ISD Roberts, 2000, unpublished data).

All laboratories that handle renal biopsies should review their standard procedures, particularly if they do not conform to Dr Furness’s guidelines or “usual practice”, as indicated by the UK Renal Pathology Group audit. As the diagnostic questions asked by nephrologists change and new techniques emerge, procedures will inevitably require updating, but we will need to provide the evidence that any changes introduced are of demonstrable benefit to patient management.

I am grateful for the opportunity to respond to the letter of Drs Roberts and Davies on the ACP Best Practice article “Renal biopsy specimens”, although they say very little with which I disagree. Most of their points of difference relate to “current practice” or “minimum adequate practice” rather than “best practice”. For example, the observation that electron microscopy (EM) can provide useful information even if fixation is delayed for a day or more is interesting and useful information. It supplements my observation that tissue from the paraffin wax block can be reprocessed for EM, but it does not alter the fact that best practice is to get the tissue fixed quickly!

The UK audit that they describe is a welcome update of a similar study that we performed in 1995, which influenced the development of the ACP guidelines. There is one small point where I think that Roberts and Davies misrepresent my suggestions. In their discussion of identifying and dividing the sample under a dissecting microscope, they imply that this has to be done by a pathologist or an MISO. We have found that nephrologists and radiologists can identify renal cortex and divide the biopsy appropriately with only minimal training. Again, rapid division is best practice; taking a bit longer is probably quite adequate in most circumstances, but (for example) in the future a delay will probably invalidate studies of gene expression.

Apart from these rather trivial quibbles I welcome Roberts and Davies’s contribution to the discussion.


In reply

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Book reviews


To my knowledge, this is the first comprehensive textbook dealing exclusively with the histological interpretation of needle core biopsy samples. To date, there have been one or two books edited by radiologists on needle core biopsy, which include chapters on histological interpretation. These by their nature have been restricted to basic principles.

The author of this book is of course well known to pathologists involved in breast disease reporting. He has numerous widely cited publications in peer review and in recent years has produced a major textbook on breast pathology based on his personal experience. Personally, I am a great admirer of his achievement, enthusiasm, and dedication to the field of breast pathology. For this reason, reading this book has been a pleasure. First, I would point out that this book although dealing principally with needle core biopsy interpretation is also a distilled version of Rosen’s textbook of breast pathology. Diagnostic entities are described in succinct detail and are well referenced.

The book includes 31 chapters, the first seven dealing with normal anatomy and benign conditions, including one chapter on major breast disorders, which form diagnostic groups that appear to be gaining prominence, particularly in the American literature. Rosen recognises that most adenomyoepitheliomas are variants of intraduct papilloma and closely related to ductal adenoma and pleomorphic adenoma.

There is a substantial chapter on ductal hyperplasia and intraduct carcinoma, which covers in detail the difficulties of distinguishing the microfocal changes present in core biopsy. By this chapter the author recognises that there are some challenging forms of atypical ductal proliferation that exhibit pronounced architectural and architectural disorganisation, but retain the focal characteristics of usual type hyperplasia, and comments that some pathologists would ignore these latter features and classify the lesions as intraduct carcinoma, whereas others would diagnose atypical hyperplasia. He introduces the concept of the “borderline” lesion. I found this concept useful because it emphasises the fact that a definitive classification of such lesions cannot always be achieved by needle core biopsy, and definitive resection may be required to establish the correct diagnosis, be it in situ carcinoma or atypical hyperplasia.

There are 12 chapters devoted to specific types of breast carcinoma including a chapter on rare special types. Lobular neoplasia, mesenchymal lymphoid, haemopoeitic tumours, and mastitis are dealt with in separate chapters. There is a useful chapter on the pathological effects of radiation and chemotheray and a short chapter dealing with the pathology associated with needle procedures. This chapter is controversial because it recognises that epithelial displacement can occur as part of the biopsy procedure. Such displaced cells may rest in the stroma or be found as carcinomatous lymphovascular emboli or groups of tumour cells in the subcapsular sinus lymph nodes. In cases of in situ carcinoma. The clinical relevance of such findings is uncertain and controversial. Dr. Rosen sticks his colours to the mast and states that he would regard these as evidence of invasive carcinoma and metastatic carcinoma, respectively.

The book concludes with three chapters on technical laboratory aspects, image guided techniques for needle core biopsy sampling, and the impact of needle core biopsies on the clinical management of breast disease. These are valuable chapters that I personally feel would have been better placed at the beginning rather than the end of the book. The chapter on pathological examination is succinct but I would give a critical analysis of the coverage for reporting core biopsies. Although specific diagnostic problems are covered in the various chapters on diagnostic entities, an overview on strategy and handling diagnostic problems, with guidance on reporting and avoidance of pitfalls would have been useful.

All of the chapters are well illustrated in colour, although the colour balance could have been improved.

Until relatively recently there has been few textbooks on breast pathology. This position has changed and we have several major textbooks from authorities. Does this book merit purchase for your reporting room? In my view there are two good reasons for considering the purchase of this book. First, the widespread option of needle core biopsy for diagnostic sampling of breast lesions is the door to a textbook, such as this, which considers many of the diagnostic problems that are now being encountered. Second, it serves as an updated and concise version of Rosen’s major textbook. Those of you reporting breast disease who have not purchased this textbook could “kill two birds with one stone” by acquiring a copy of this book. I will be placing my copy in our reporting room and suspect that it will spend more of its time open on the bench top rather than gathering dust on our library shelf.

I O ELLIS


In summary, methods of molecular biology are described related to gene isolation, characterisation, expression, and transfer, and (of course) cell death. In each chapter, the principle of the technique is explained (of course a basic knowledge of molecular biology is necessary). Subsequent materials and methods sections are described stepwise. Each chapter ends with notes that give extra clues for doing the experiments, and also functions as a troubleshooting. Also helpful are the illustrations of the outcome of the described experiments, when successful. In the last chapter, gene transfer protocols are described, according to recent developments in this field. Although all these methods can be used in pathological specimens, for general histopathology it is probably less suitable. Nevertheless, it is a very interesting book and I recommend it strongly for researchers, including pathologists, who are doing research in the field of vascular disease.

H W M NIJESSEN


I thoroughly enjoyed reading this compact, stimulating, and refreshingly thought provoking book. It really puts cancer into an evolutionary context. It was pitched just right for me; as for most doctors, even those involved with cancers and leukaemias, my knowledge of evolution, history, epidemiology, and molecular biology is very focused on and tends to be limited to what affects my daily practice. So, essentially, most of us are laymen.

It is the sort of book that will be enjoyed by scientists, doctors, and many of those whose primary interests lie in the arts and the humanities, not to mention pathologists too. This book, with its almost conversational tone, allows us all to follow the arguments in what are potentially impenetrable arenas with surprising ease. Some of that ease is probably an illusion, but a welcome one. One’s confidence in Mel Greaves to lead us through the jungle of cancer is probably as important as truly understanding the implications and fine detail of the paths and surrounding countryside through which he takes us. I must say, one can end up at a conclusion really believing one understands how one got there, only on reflection to realise that one might need to read the argument all over again. Perhaps I should replace all the “ones” with “I”! It’s a seductive story, and well told too—that’s what carried me along, rather than my own intrinsic abilities to understand. But I do confess I got almost as much pleasure rediscovering how I got to some of his destinations as I had when I first arrived.

M M REID

Full details of events to be included should be sent to Maggie Butler, Technical Editor, JCP, The Cedars, 36 Queen Street, Castle Hedingham, Essex CO9 3HA, UK; email: maggiebutler@pilottree.prestel.co.uk

Calendar of events

International Consultation on the Diagnosis of Noninvasive Urothelial Neoplasms

11–12 May 2001, University of Ancona School of Medicine, Torrette, Ancona, Italy

Further details: R Montironi, Ancona Italy (email: r.montironi@opas.unipa.it); M Bassi, Padua, Italy (email: bambossaid@bostwicklaboratories.com), P-F Bostwick, Richmond, VA, USA (email bostwick@bostwicklaboratories.com), P-F Bassi, Padua, Italy (email: bassi@ux1.unipd.it); M Droller, New York, USA (email: michael.droller@empilink.mssm.edu), or D Waters, Seattle, WA, USA (email: waters@vet.vet.purdue.edu)

Human Adverse Drug Reactions

30 May 2001, Royal College of Pathologists, London, UK

Further details: Michelle Casey, Academic Activities Coordinator, 27, Charter House, Old Street, London SW1Y 5AF, UK. (Tel: +44 020 327 580 00)

www.jclinpath.com
Recent Advances in Genetics
5 July 2001, Royal College of Pathologists, London, UK
Further details: Michelle Casey, Academic Activities Coordinator, 2 Carlton House Terrace, London SW1Y 5AF, UK. (Tel +44 020 7451 6700; fax +44 020 7451 6701; www.rcpath.org)

BSCC Annual Scientific Meeting
9–11 September 2001, Majestic Hotel, Harrogate, UK
Further details: BSCC Office, PO Box 352, Uxbridge UB10 9TX, UK. (Tel +44 01895 274020; fax +44 01895 274080; email lesley.couch@psilink.co.uk)

1st Asia Pacific Forum on Quality Improvement in Health Care
Three day conference
Wednesday 19 to Friday 21 September 2001
Sydney, Australia

We are delighted to announce this forthcoming conference in Sydney. Authors are invited to submit papers (call for papers closes on Friday 6 April), and delegate enquiries are welcome. The themes of the Forum are:

- Improving patient safety
- Leadership for improvement
- Consumers driving change
- Building capacity for change: measurement, education and human resources
- The context: incentives and barriers for change
- Improving health systems
- The evidence and scientific basis for quality improvement.

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For more information contact: quality@bma.org.uk or fax +44 (0)20 7383 6869

Correction


In table 1 the time of the first sample should have been at −11, −7, and −4 days in patients 1, 2, and 3, respectively; similarly, in table 2 the time of the first sample should have been at −12, −6, −4, and −1 days in patients 1, 2, 3, and 4, respectively. The authors apologise for this oversight.