Correspondence

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Accuracy and completeness of the documentation of blood culture results

Heard and colleagues’ raise the thorny issue of how important microbiological results and advice should be recorded in patients’ notes and by whom. Reported here is a prospective audit identifying how accurately this is done.

It was decided that the audit should concentrate on blood cultures yielding a clinically significant isolate, a finding that all members of staff should consider as important and worthy of prompt documentation.

This work was performed in a 1045 bed hospital where all Gram stain and culture results from clinically significant blood cultures are telephoned by a medical microbiologist to either the attending doctor or to qualified nursing staff on the ward. It is expected that the information and advice given over the telephone should be promptly documented in the patient’s notes and that nursing staff would contact the patient’s attending doctor. Where it is clear from nursing staff that the patient is still septic, not responding to empirical treatment, on inappropriate treatment, or when other medical action is necessary, the attending doctor is contacted directly.

Because of time constraints and the unavailability of personal visits to the ward the exception rather than the rule. In a minority of cases culture results are imparted to attending doctors face to face. Of the 61 blood cultures reviewed, four were ultimately considered as contaminants. The microbiology departmental clinical database was used to identify what information was imparted, to whom, and whether this occurred on a weekday or at the weekend. The patient’s notes were scrutinised more than 24 hours after contact was made. The required minimum entry in the notes was correct Gram or culture result. The accuracy of this and any other recorded information was noted. It was felt that if simple microbiological information concerning clinically significant pathogenic infections was not being documented then more complex clinical information was unlikely to have been recorded any more faithfully.

Of the 61 episodes reviewed, 16 (26%) were not recorded in the patient’s notes at all. One hundred and eleven individual contacts were made and 71 (64%) of these contacts were recorded in the patient’s notes. Not all of the 61 episodes necessarily had two contacts made, on 11 occasions the microbiologist wrote directly in the notes. It was of note that 60 of the 76 calls to doctors were documented in the patient record, whereas only 10 of the 34 calls to nurses were documented. There were marginally fewer documented calls at weekends (56% v 67% during weekdays) but this was largely because more weekend calls were made to nurses. In one instance it was unclear to who the telephone call was made.

The number of contacts documented is similar to previous studies that have looked at the accuracy of both telephone and face to face contacts. In similar studies 83% and 79% of clinically significant blood cultures had at least one entry in the patient’s notes.2 3 There seemed to be little difference if the result was reported over the telephone or face to face. An audit looking at day one results only reported a documentation rate of 54% but contaminated blood cultures, which may be less likely to be documented, were also considered.4

This audit shows that advice given by microbiologists to other members of staff is recorded in the notes on fewer than two thirds of occasions, although where recorded it is generally accurate. The finding that over one quarter of clinically significant bacteraemias were not noted at all is troubling. This audit was not designed to measure whether these omissions led to adverse outcomes, although one might expect this to be the case on occasion. At Derriford Hospital, computerised reports of all culture positive are issued. There is generally a lag of at least 48 hours between initial culture and the issue of the report and probably a further delay before the attending doctor looks at the report. In many cases, this leaves a window when the patient’s condition is at its most critical and where important microbiological advice is not readily available.

These data support the need for microbiologists to review all clinically significant bacteraemias and write in the patient notes. With all the other calls on the time of microbiologists, few departments can provide such a service. Without innovations such as electronic patient records or real increases in the numbers of medical microbiologists, the laudable advice of Heard and colleagues that “microbiologists should make relevant notes in patients’ records” is unlikely to be a realistic option in many hospitals in the UK.1

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References

Pelvic sarcoma arising from chronic osteomyelitis

Gulmann et al reported on a case of chronic osteomyelitis presenting as a chest mimicking a soft tissue sarcoma.5 They authors suggested that, although chronic osteomyelitis is a known cause of confusion with bone tumours, a definitive diagnosis is feasible by specific immunohistochemical staining.

However, the potential risk of transformation of chronic osteomyelitis into a malignant lesion is an unforgettable point both for the clinician and the pathologist.6 Two years ago we encountered a patient developing a rapidly aggressive sarcoma with an uncommon onset. He was a 23 year old man, with a 16 month history of chronic osteomyelitis of the left hip bone, referred to the urological department. Three years before, he had been involved in a road accident with a bilateral fracture of the thigh bone and left acetabulum. On admission to the ward the patient had fever, dysuria, and suprapubic pain. Physical examination demonstrated an osteocutaneous fistula with foul smelling drainage on the lateral aspect of the left hip bone. On standard computerised tomography a large and heterogeneous hypodense region was seen. Three months postoperatively, the patient died. Malignant lesions are rare complications of chronic osteomyelitis. As reported in a large series by McGrory et al,5 squamous cell carcinoma is by far the most common type of associated malignant disease, whereas sarcoma has been reported only rarely.7 The latency period between the onset of osteomyelitis and the development of neoplasia may be as short as one year, or it may be decades. In general, the neoplasia occurs in the osteomyelitic sinus or in a chronic draining fistula. The most frequent clinical findings of malignancy in chronic fusulating osteomyelitis are persistent foul discharge, pain, and bleeding.8 In this case, the osteocutaneous fistula was connected to the left iliac area where the sarcoma arose and spread to pelvic lymph nodes. In conclusion, even though chronic osteomyelitis may be a cause of difficult differential diagnosis with bone tumours, we would emphasise the need to maintain a high index of suspicion in a case of chronic osteomyelitis with an unusual presentation.

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Prepubertal testicular tumours in Kashmir: a histopathological report of 15 cases

Prepubertal testicular tumours are very rare and occur at an incidence of 0.5–2/100 000 children. Of all the paediatric malignancies they rank seventh in frequency and represent only 1% of all paediatric solid tumours.

We conducted a study to see the pattern of prepubertal testicular tumours in Kashmir. The material for our study was obtained from the files of the histopathology section of the department of pathology, Government Medical College, Srinagar, Kashmir, India. The records of all prepubertal testicular tumours reported from January 1984 to December 1998 were studied. Routine and special stains were applied on fresh sections from paraffin wax embedded blocks wherever required. Fifteen prepubertal testicular and paratesticular tumours were recorded in the 15 year period of our study. Germ cell tumours predominated: there were 12 germ cell tumours and only three non-germ cell tumours. There were 10 yolk sac tumours, two teratomas (mature), one non-Hodgkin’s lymphoma—Burkitt’s lymphoma and one non-germ cell tumour. There were applied on fresh sections from paraffin wax blocks. The youngest patient (10 months of age) had a yolk sac tumour and the oldest (14 years old) was a non-Hodgkin’s lymphoma—Burkitt’s lymphoma. The youngest patient was 10 months old and the oldest was 14 years old.

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The youngest patient (10 months of age) had a yolk sac tumour and the oldest (14 years old) had rhabdomyosarcoma. In two patients both testes were involved, with one of these two patients having bilateral undescended testes. Prepubertal testicular tumours most commonly occur within the first 4 years of life. Although the cut off age for our analysis was 14 years, most patients presented at or below the age of 4 years. The youngest patient (10 months of age) had a yolk sac tumour and the oldest (14 years old) had rhabdomyosarcoma. In two patients both testes were involved, with one of these two patients having bilateral undescended testes. Prepubertal testicular tumours most commonly occur within the first 4 years of life. Although the cut off age for our analysis was 14 years, most patients presented at or below the age of 4 years. The youngest patient (10 months of age) had a yolk sac tumour and the oldest (14 years old) had rhabdomyosarcoma. In two patients both testes were involved, with one of these two patients having bilateral undescended testes.

Reduced bone formation in UK Gulf War veterans: a bone histomorphometric study

We read the paper by Compston et al on bone loss in Gulf veterans’ with concern and interest. However, if taken to represent the problems of unwell Gulf veterans it is open to serious misinterpretation because of problems in design, factual accuracy, and certain conjectures.

The 17 cases are potential litigants who are highly unlikely to be representative of the Gulf veteran population. Apart from very brief sociodemographic details, smoking and alcohol consumption histories, no clinical information is given about the indications for bone biopsy except that 16 complained of unexplained arthralgia and other truncusoskeletal symptoms. The 13 controls were taken from a study, reported 20 years ago, involving bone biopsies on civilians undergoing minor surgery and are thus not a comparable group. Furthermore, investigators were not blind to case control status, allowing for observer bias. Therefore, no general conclusions about Gulf veterans’ morbidity can be inferred from this work.

The findings of reduced bone formation are said to be heterogeneous but bone histology was normal in six cases. No clinical histories suggesting bone disorder are reported and the presence of osteoporosis is denied. We agree that the clinical relevance of these findings is unclear, but would point out that bone loss occurs in several conditions in which reduced activity is a feature, including depressive illnesses and other multisymptom disorders, which are not uncommon in Gulf veterans. Exclusion of these and other conditions associated with bone loss are necessary steps before these findings are assessed with service in the Gulf.

The attribution of these findings to possible exposures in the Gulf deserves comment. Lifestyle changes are briefly discussed but no other possible clinical explanations are offered. Instead, the authors point to associations with very dubious exposures to organophosphate (OP), compounds such as pesticides and sarin. What exactly was the basis of the statement of obvious OP pesticide spraying and why was it accepted so uncritically? Sarin is an odourless, colourless vapour whose detection on military operations is only possible by either patients experiencing symptoms or special detection equipment. There was no confirmed offensive use during the Gulf conflict or subsequently. Given the toxicity of sarin and the fact that no deaths from or cases of OP poisoning were seen during the Gulf conflict the uncorrected acceptance of a statement of awareness of sarin exposure is irresponsible. To claim similarities with findings in agricultural workers with chronic OP exposure from sheep dipping is equally unjustified because any possible exposure histories would be quite dissimilar, usually involving several years of exposure. Immunisation history is a red herring. A search of MEDLINE reveals no evidence to connect osteoporotic conditions with immunisations. It is true that the reversible anticholinesterase pyridostigmine was used as a nerve agent pretreatment but doses were small. If this was a factor in the bone changes found would one not expect to see a similar picture in patients with myasthenia gravis? Clearly, there are many alternative explanations for the reported findings, which may or may not have clinical relevance at all.

(Then the authors are all employed by the Ministry of Defence. The views expressed are their own and do not represent those of the Ministry of Defence.)

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Corrections


Dr C Rubins address should have been Watford General Hospital not Watford Green Hospital.

Pathology of Vascular Skin Lesions: Clinico pathological Correlations


This book fulfills the goal set out in the foreword by the authors. Indeed, there is no

www.jclinpath.com
Diagnostic Cytopathology, 2nd edition


It is a daunting task to produce a contemporary and comprehensive textbook of cytopathology that adequately deals with the full expanse of the topic. This difficulty is compounded by the need to write a text that is not only appealing, but functional as a desktop reference for a diverse group of practitioners, from student cytotecnologists to expert cytopathologists. Yet, the second edition of Diagnostic Cytopathology manages to accomplish much of this task.

This single volume book is organised into a systems based review of general cytopathology. The second edition maintains its focus on cytopathology with minimal discussion of sampling and preparatory techniques. There is some attention paid to the impact on cytomorphology of exfoliative versus fine needle aspiration sampling; however, the effects of cytopreparation on the cytological features and interpretation are not frequently discussed. This is particularly evident in the differences in cytomorphology that occur as a result of liquid based preparations. The application of immunocytochemistry is covered in most sections, but again greater detail would be useful, and there is little discussion on the use of other ancillary studies. New technology is mentioned as overviews on liquid based processing, automated screening devices, and other modalities for screening for cervical cancer, in addition to newer sampling techniques, such as endoscopic ultrasonographically guided fine needle aspiration.

There is variability in the comprehensiveness of coverage of some topics, but particular strength is shown in the sections relating to the respiratory system, serous cavities, breast, and female genital tract. With some other chapters, the advanced reader may be left wanting for details when topics are rather briefly discussed. To compensate, the reader is at times directed to a chapter's bibliography for further information, and in general these bibliographies are reasonably comprehensive, although inclusion of more recent references is inconsistent. Novice readers, in particular, may appreciate the use of bulleted lists of the pertinent cytological features of the major entities, which have been offset from the text by coloured headings and are followed by a discussion of the diagnostic pitfalls, review of the differential diagnoses, and often with a suggested approach to the separation of entities under consideration. These discussions could have been aided by the inclusion of tables to contrast and compare differential diagnostic entities. In addition, allusions to the limitations of cytomorphology to separate some entities could have been more clearly stated.

The nomenclature and classification systems used in the book follow most standard classification systems in use, but there are some chapters in which the most recent classification system is not applied. Notable examples include the use of the 1973 World Health Organisation (WHO) classification for urothelial neoplasms rather than the 1998 WHO/International Society of Urological Pathology Consensus classification, and the use of the revised European–American classification of lymphoid neoplasms (REAL classification) rather than the 2001 WHO classification. The book does not address recent changes to histological classifications that have rendered definitive cytological diagnosis more difficult. This is illustrated by bronchioalveolar carcinoma, which by the 1999 WHO histological definition must be a non-invasive lesion. Because inaccessibility cannot be accurately assessed in exfoliative or fine needle aspiration specimens, a cytological diagnosis of bronchioalveolar carcinoma may not correlate with the ultimate histological classification of the excised lesion; a dilemma that is not addressed within the discussion of this entity.

The book is richly endowed with colour photomicrographs aptly demonstrating the pertinent cytological features of normal cellular constituents and pathological entities under discussion. The cytological images include air dried and alcohol fixed material with both May–Grünewald–Giemsa and Papanicolaou staining. Some illustrations of liquid based preparations are included, but most of the illustrations are of conventional cytological preparations. Occasional gross and histological photographs are used to good effect, and the focus, clarity, and colour balance of most illustrations are good to excellent.

Diagnostic Cytopathology demonstrates a number of strengths and is particularly useful as an introductory and general reference book. Further updating would be useful with regard to classification schemes and the impact of new technologies on cytological interpretation, but this does not detract from the wonderful illustrations and sound basis in cytomorphology with which the book is endowed.
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J Clin Pathol 2003 56: 558
doi: 10.1136/jcp.56.7.558

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