Appendix invaded by caecal adenocarcinoma. The mucosal hyperplasia, to the left, is restricted to the parts of the appendix not involved by the tumour. Haematoxylin and eosin $\times 12$

lium covering the tumour was either normal or flattened with a small area of ulceration, probably the result of invasion by tumour tissue from below. No dysplastic or neoplastic changes were seen in the appendiceal mucosa covering the tumour or anywhere else in the appendix.

On the other hand, severe hyperplasia was present in the appendiceal mucosa lining the rest of the appendiceal wall not involved by the tumour tissue (Figure). The distinction between atrophic and normal mucosa on the one hand and hyperplastic mucosa on the other was clearcut and matched perfectly the presence or absence of tumour tissue, respectively, in the appendiceal wall. The appearance suggests a direct relationship between the absence of tumour tissue in the wall and the occurrence of mucosal hyperplasia, perhaps as a compensatory phenomenon due to interference with mucosal function in the adjacent area invaded by or covering a tumour. Of course, we cannot exclude the possibility that the hyperplasia was present from the start and that the tumour has selectively invaded the non-hyperplastic areas; but this in itself would be interesting to investigate.

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Reference

- Isaacson P, Attwood P R A. Failure to demonstrate specificity of the morphological and histochemical changes in mucosa adjacent to colonic carcinoma (transitional mucosa). *J Clin Pathol* 1979;**32**:214-218.

Sense and safety in the laboratories

The excellent summary in the May issue prepared by the ACP Working Party is particularly valuable in terms of its commonsense approach and emphasis on the fact that no workplace can be rendered completely safe.

My early experience (1934-40) in charge of a clinical bacteriology laboratory and my subsequent experience (1940-78) directing naval and teaching hospital laboratory services in general made me continuously conscious of safety problems. The most difficult problem has been that of maintaining 'constant awareness of hazard' (as stated in the report) and of watching for potentially dangerous shortcuts personally devised by busy technicians. In the hospital laboratories from which I recently retired, this problem was gradually resolved over the last 10-12 years by designating and training a senior technician in each laboratory division as 'safety officer' who was given a certain

amount of time each week to look things over, to discuss techniques with individual technicians, and to report to the laboratory director. Needless to say, it is important to select a tactful person, not a drill-sergeant type for such a job.

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Further investigation of the specificity and sensitivity of ELISA for rubella antibody screening

We recently reported (*J Clin Pathol* 1979;**32**: 542) a comparison of haemagglutination-inhibition (HI), single radial haemolysis (SRH), and enzyme-linked immunosorbent assay (ELISA) for the detection of rubella antibody. In a series of 1000 sera we identified 14 sera that were ELISA positive but had no detectable rubella antibody by either HI or SRH. We interpreted this finding as indicating the incidence of false-positive results by ELISA. We have now tested these 14 sera at a single dilution (1 in 10) for rubella IgG antibody by immunofluorescence (IF) using coverslip cultures of BHK21 cells infected with Judith strain virus (Cradock-Watson *et al.* *Ann NY Acad Sci* 1975: