manifestation of CNS tumours were also present.³

Moreover, a personal unpublished case causes us great concern in using donors with a CNS tumour, as sources for organ transplantation. Briefly, in a 36-year-old male who was twice operated for a malignant cerebral astrocytoma, we discovered microscopic metastasis, in a rib sample, taken at random during necropsy. We detected glial fibrillary acidic protein in tumour cells using a technique that has already been published.⁵ This provided us with indisputable proof of their astrocytic origin. We must insist on the fact that this rib had a normal macroscopic appearance and that there were no previous clinical or radiological manifestations to draw our attention to a possible metastasis. It is difficult to know if this microscopic astrocytic spreading would have given way to an apparent costal metastasis, or would have remained in a "dormant metastasis" state.²

However, it seems to us, that whatever is possible for a rib is, unfortunately, also possible for a kidney. Therefore, even though to the best of our knowledge no primary CNS tumour has yet produced a metastasis in the recipient, it seems imperative to us to draw attention to such a possible outcome. In our opinion, using donors with CNS tumours as sources for organ transplantation, involves a risk to the recipient, of metastatic spread which cannot be completely eliminated.

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Classification of lymphoreticular malignancies

Trenchard *et al.*¹ report a patient with angioimmunoblastic lymphadenopathy and immunoblastic leukaemia, the latter defined on the basis of "numerous immunoblasts in the peripheral blood." Leukaemia is a malignant proliferation of haematopoietic cells; these authors present no evidence to support the thesis that their patient had a neoplastic proliferation of immunoblasts. They used surface immunoglobulin as a marker of B cells in the peripheral blood yet make no comment as to whether this was monotypic (as expected in a neoplastic population) or polytypic (as expected in a reactive process). If leukaemia is identified on the criteria given in this paper is infectious mononucleosis diagnosed as leukaemia in Cardiff? The understanding and classification of lymphoreticular malignancies is bedevilled by semantic confusion. The loose use of the terms "immunoblastic leukaemia" and "immunoblastic sarcoma" does nothing to help this problem.

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Drs Trenchard and Whittaker reply as follows:

The term "leukaemia" is always preceded by a clarifying term which takes the definition beyond the Greek implication of excess and/or abnormal "white cells in the blood." Certainly the terms "acute"

and "chronic" are well recognised as implying neoplastic monoclonal proliferations of haematopoietic cells. In other situations however, the initial term defines a cell type followed by the term "leukaemia" which indicates the unexpected pathological appearance of that cell type in the peripheral blood—that is, overspill. Examples include plasma-cell (not haematopoietic) leukaemia, mast-cell (probably not haematopoietic) leukaemia, and lymphosarcoma-cell (neoplastic but not haematopoietic) leukaemia. Semantic confusion can be minimised or avoided by careful definitions, and the "overspill" nature of the term "leukaemia" was clearly indicated by stating in the introduction to the paper that "less common clinical features of AIL may include the presence of numerous immunoblasts in the peripheral blood, which we define as immunoblastic leukaemia if the concentration exceeds $1.0 \times 10^9/l$." It is suggested that haematologists be allowed to continue using the term leukaemia in these ways, already historically established and totally in accordance with the real meaning of the word.

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Book reviews

Microbiology of Human Skin. Vol 2 series Major Problems in Dermatology. WC Noble. (Pp 433; illustrated; £25.00). Lloyd-Luke Ltd. 1981.

This book is one of a collection of monographs which deal with topics of current interest in dermatology. While the text has been enlarged the presentation of the book's contents is essentially unchanged from that of the first edition written by Drs Noble and Somerville.

The author again reviews in detail the physicochemical properties of the skin, the complex nature of its microbial populations, and their changing patterns in health and disease. The chapters covering taxonomy and methods of identification are mainly relevant to the specialist who