Letters to the Editor

Is it time to rethink "high risk" labelling?

In 1978 the "Howie" Code of Practice¹ for the prevention of infection in clinical laboratories and post mortem examination rooms recommended that specimens and request forms from patients known or thought to be suffering from infections with micro-organisms in Categories B1 and B2 should be marked, "danger of infection." In 1985 the Advisory Committee on Dangerous Pathogens (ACDP) in its interim guidelines² on acquired immune deficiency syndrome (AIDS) also recommended that specimens from patients with AIDS or PGL should be identified with a warning label or colour code in compliance with the containment measures laid down in the guidelines.

Both recommendations presupposed that such patients can be readily identified but do not take account of potential hazards, of whatever degree, from specimens not so readily identified. By implication specimens fall into two broad categories; high risk and others (presumably lower risk). We now know that in our population about 1 in 800 people are carriers of hepatitis B antigen. With HTLV-III virus the pool of infected persons is unknown, although there is evidence³ that there has been a five fold rise over a period of 26 months in the numbers of British homosexual and bisexual men attending a London clinic who have antibody to HTLV-III, with at least 2600 homosexuals in London already having been exposed to the virus; and most of these would have been symptomless. The potential numbers are clearly much greater if sexual contacts and children born to parents who are known risk factors—for example, bisexuals, haemophiliacs, or intravenous drug abusers and those with links with subSaharan Africa—are included.

Adherence to the view that certain specimens can be labelled high risk becomes irrational when presented with this situation. The rational response would be to abolish the current categorisation of specimens and to maintain scrupulous attention to good laboratory practice, not least of which would be the avoidance of self inoculation, rather than the adoption of containment measures, which seem to be irrelevant to the prevention of infections transmitted in blood or body fluids in clinical laboratories. The advent of HTLV-III virus infection into our community presents us with an opportunity to rethink our approach to the label-

ling and handling of specimens based on scientific sense rather than emotive nonsense. Any other course perpetuates the myth that safety in laboratories depends on a label.

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- ² DHSS. *Acquired immune deficiency syndrome (AIDS)—interim guidelines*. London: HMSO, 1984.
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Arteritis of the epididymis

I read with interest the paper by Womack and Ansell on arteritis of the epididymis.¹ The authors are, however, incorrect in asserting that this phenomenon has not been previously reported. Arteritis of the epididymis occurring as an isolated event has been described on at least two previous occasions,^{2,3} both in the American journal, *Urology*. It is most important in these cases that full screening for collagen disease is done and that the patients are adequately followed up, because lesions in both testis and epididymis are very common in the systematised form of polyarteritis nodosa. In 1960 Dahl *et al* reported gonadal disease in 38 of 44 men with systemic polyarteritis nodosa examined at necropsy.⁴ Epididymal lesions were present in 25 of the 37 patients in their series for whom epididymal sections were available for examination. Only two patients, however, had had epididymal signs on clinical examination. Scrotal tenderness, however, has been reported as the initial complaint in systemic polyarteritis nodosa.⁵

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- ² Roy JB, Hamblin DW, Brown CH. Periarteritis nodosa of the epididymis. *Urology* 1977;10:62.
- ³ McLean NR, Burnett RA. Polyarteritis nodosa of the epididymis. *Urology* 1983;21:70.

- ⁴ Dahl EV, Baggenstoss AH, De Weers JH. Testicular lesions of polyarteritis nodosa, with special reference to diagnosis. *Am J Med* 1960;28:222.
- ⁵ Valleteau de Molliac M. Circumstances of unusual discovery of polyarteritis nodosa. *Nouv Presse Med* 1977;6:4069.

Drs Womack and Ansell reply as follows:

We thank Dr Burnett for his interest and comments. We apologise for not having acknowledged two previous reports of granulomatous necrotising arteritis that were apparently confined to the epididymis.^{1,2}

Our discussion³ was primarily concerned with the possible mechanisms of aetiology and pathogenesis of isolated arteritis of the epididymis. This condition seems to be a clinicopathological entity distinct from polyarteritis. Although epididymal lesions are not uncommon in polyarteritis, once systemic disease has been excluded clinically it is reasonable to suppose that arteritis is confined to that site and that no further treatment is required.

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Fine needle aspiration cytology: experience with a cell block technique

We agree with the views of Dr Mutch¹ on the relative safety of fine needle aspiration of lung lesions. Surprisingly, therefore, the use of this technique remains confined to a limited number of centres in the United Kingdom. This may in part be explained by the lack of appropriately trained people to interpret this type of material. Tao *et al* argue that the conventional criteria of malignancy which are generally accepted by cytologists and histopathologists, may be inadequate when dealing with specimens of fine needle