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New method or new application of a method?

In a thorough evaluation of a morphometric technique for the assessment of pulmonary arteries Fernie and Lamb claim that the method they use entailing a computer assisted planimeter is new.¹

The concept of using the internal elastic lamina as a reference for the true size of an artery was pioneered in Britain by Cook and Yates in 1972.² Work, which extended this concept to evaluate the intima and also used computer assisted planimetry, was presented by myself at the summer meeting of the Pathological Society of Great Britain and Ireland in Edinburgh in 1983.³ A further detailed description of the method was presented at the winter meeting of the society in January 1984⁴ and was subsequently published in the *Journal of Clinical Pathology*.⁵

I would suggest that the paper of Fernie and Lamb represents the application of an established method to a specific problem. While the methodology may be new to the authors working on pulmonary vessels, its advantages and ease of use come as no surprise to those who have already used it to evaluate arteries in other sites.

When the authors presented their work at the Pathological Society summer meeting in 1984 I expressed this point of view and suggested to them that the method was not new. I feel that the word "new" when applied to a method should mean what it says.

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Drs Fernie and Lamb reply as follows:

We do not claim any originality with regard to the concept behind our measuring technique, which is the use of the length of the internal elastic lamina as an indicator of artery size. In the first¹ of our series of papers we refer to the work of Cook and Yates,² who pioneered this technique in Britain, following description of the technique by Furuyama.³

On the issue of computer assisted morphometry, such measuring techniques are new to those engaged in studies of the pulmonary vasculature as we pointed out to Dr Lowe when we presented our work at the summer meeting of the Pathological Society of Great Britain and Ireland in 1984.⁴ Furthermore, we consider that a measuring technique is incomplete if it is not applied to a range of subjects with a view to determining how the data should be analysed and how subjects should be compared. As such an approach has not been adopted in previous studies of the pulmonary vasculature we feel that our paper⁵ makes a new and useful contribution in this area.

Lastly, with regard to Dr Lowe's suggestion that "the paper of Fernie and Lamb represents the application of an established method to a specific problem" we would question whether such methods are truly established. It is interesting that our paper⁵ was rejected by a reputable British pathology Journal in July 1984 on the grounds that there were "queries concerning the fundamental validity of the technique."

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Fine needle aspiration of thyroid: confusion v. subsequent histology

The review article published in your January 1985 issue¹ has stimulated us to report some additional data of fine needle aspiration of thyroid performed in the department of pathology at Athens University.

During the past few years Greek physicians have increasingly accepted percutaneous, fine needle aspiration in the diagnosis of thyroid nodules. According to many authors, fine needle aspiration is the best procedure currently available for selecting and directing treatment for thyroid nodules.²⁻⁶ In our institution 320 thyroid nodules (1.5-4 cm in diameter) have been studied by fine needle aspiration since October 1984. Of these, 12 cases were identified as papillary carcinoma, seven as follicular tumours, two as medullary carcinoma, five as unclassified tumours, two as Hurthle cell tumours, one as lymphoma, and 17 as "suspected neoplasia." All of the above cases underwent operative treatment by means of the cytology; in addition, 35 patients were clinically selected for surgical biopsy of the nodule despite the fact that the cytological diagnosis of fine needle aspiration was negative.

The needling was performed with a 22 gauge needle and occasionally with a 27 gauge needle. When no adequate material had been obtained by the first needling, the procedure was repeated. Double sampling was also performed if the nodule was greater than 2.5 cm in diameter. The procedure was well accepted by most patients, and no appreciable complications or side effects were observed, as in other series.^{3,7} Miller, however, noted that an intranodular hematoma can occur, which may be palpated by the physician.

When we examined histologically the 55 surgical specimens of biopsied nodules most showed intranodular bleeding. In two of these cases it was so extensive that we could not precisely define the histological pattern of the lesion. Moreover, it was impossible to