results had absorbance values below 1.0. Thus, although raising the cut off point between positive and negative readings to a value of ≥ 1.0 provides a test which has an improved and acceptable specificity, it does, at the same time, produce one that has lamentable sensitivity. We sympathise with the desire and need to reduce false positive results in a population with a low chlamydial prevalence, but equally we cannot see that it is acceptable to analyse the results in such a way that sensitivity is so seriously jeopardised. Will our clinical colleagues be comforted by the knowledge that for every patient they can be assured has a chlamydial infection there are two who are also infected but go untreated because of a negative ELISA result? All of this indicates the urgent need for an ELISA which combines much greater specificity with sensitivity and not one that is made to have one of these attributes at the expense of the other.

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Reference

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Reporting colorectal cancer

Drs Jass and Morson argue persuasively the case for a new system for prognostic classification of colorectal cancer.¹ Having tried to follow their scheme, however, I find two difficulties and feel that comments on these might well be widely appreciated.

The authors seem not to have taken

account of the findings of tumour breaching the peritoneum or being present at or close to the surgically dissected surface of the specimen or to the cut end. I presume that if any such features are present, the scheme would be invalid.

There is ambiguity in the definition of "lymphocytic infiltrate" as a favourable prognostic factor. In their fig 1 (identical with that in the earlier paper by Jass *et al*)² the legend reads "Conspicuous peritumoural lymphocytic infiltrate." Their text refers to an "inflammatory infiltrate", with other cells present, and to a resemblance to the normal lamina propria. Jass *et al*³ also refer to these mixed cells being "scattered" rather than conspicuous.

A further problem arises from the patchy distribution of the inflammatory infiltrate. Jass advises assessment based on "the worst area"³ but as prognosis is better with many cells, does the "worst area" have most cells or fewest?

I think that clarification of the lymphocytic infiltrate criterion is needed and would be much appreciated by those who wish to adopt this new scheme.

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Drs Jass and Morson comment:

We are grateful to Dr Penman for highlighting two difficulties he has experienced with the new prognostic classification.

Invasion by tumour beyond the confines of the serosa and involvement of the deep

margin of surgical excision are likely to be associated with an adverse outcome. Regrettably, these variables have not been subjected to detailed study in the past and cases showing such features were not specifically excluded when the new classification was developed. The system was based on data derived from operative procedures that were considered by the surgeon to be curative. It is likely that some but not all specimens with serosal penetration by tumour or extensive spread to the deep excision margin would have been regarded as incurable. We would agree with Dr Penman that the system should not apply to growths extending to surgical margin. Spread beyond the serosa, however, does not necessarily identify an operation as non-curative. For example, if an adjacent organ is fixed to the point of penetration and has been removed with the main specimen en bloc, then the procedure would be regarded as curative. Under these circumstances we would see no great objection to applying the new system but would again emphasise the need to undertake detailed study of the prognostic importance of serosal disease in the future.

On the second point, there are always problems with applying subjective variables. On low power examination a conspicuous lymphocytic infiltrate manifests itself as cellular lamina or cap at the invading margin of the tumour. It is not necessary to identify enormous numbers of lymphocytes, but the term "scattered" was perhaps unfortunate. "Distributed" might have been better. The worst area is that in which the lamina is least developed and lymphocytes are fewest in number. When there is any doubt, cases should not be regarded as showing conspicuous lymphocytic infiltration. It is always important to attempt to preserve the purity and prognostic value of a variable, even if the size of the resulting group is small.

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Book reviews

Venous Thrombosis. Causation and Prediction. D Ogston. (Pp 242; £26.50.) John Wiley. 1987. ISBN 0 471 91558 0.

Professor Ogston's book is a timely addition to the literature in the area of venous thromboembolism. Recently considerable advances

have been made in the investigation of the pathogenesis of venous thrombosis, particularly in the recognition of familial deficiencies of natural anticoagulants such as protein C and protein S, and of abnormalities of the fibrinolytic system. These developments are of importance to all clinicians involved in the management of, and prophylaxis against, deep venous thrombosis, and they are exhaustively reviewed by

professor Ogston. The opening chapters on haemostatic and thrombotic mechanisms are rather scantily illustrated and it is doubtful whether the non-specialist reader would find them as useful as was intended. Most positive guidance, based on the author's experience, on the management of subjects with a congenital prothrombotic state and on screening for deficiencies could have been usefully included. In relation to the chapter

Book reviews

on lupus type anticoagulant, an area of considerable current research interest, it is surprising that no mention of anticardiolipin antibodies is made. As an otherwise comprehensive and up to date review of the subject, this volume can be highly recommended to clinicians and pathologists alike.

M GREAVES

Immunoperoxidase Techniques. A Practical Approach to Tumor Diagnosis. M Nadj, AR Morales. (Pp 196; \$116.) Raven Press. 1987. ISBN 0 89189 213 3.

This account falls into three main sections. There is a short introduction to immunoperoxidase techniques, including their history, comparisons of methods, a detailed description of the authors' chosen technique, and some of the pitfalls. There follow 30 chapters of one to three pages each, on individual antigens and their occurrence in benign and malignant tissue, with a final chapter outlining a systematic approach to tumor diagnosis. Lastly there are 43 colour plates with a total of 344 colour photomicrographs of stained tissues.

The authors are acknowledged experts and they approach their subject with enthusiasm. The book is attractively produced, and has a very personal flavour; less kindly, one could call it one sided. It is too brief and superficial to be a good reference work; and the short bibliographies after each chapter are heavily weighted towards older publications, with relatively little more recent than 1983. It is hard to see who ought to invest the large sum of \$116 for this book. A trainee histopathologist would enjoy browsing through it, and might be inspired to take up immunohistochemistry as a result; once he did so, he would set aside the book for meatier competitors.

NGP SLATER

Prostaglandins and Related Substances. A Practical Approach. Ed C Benedetto, RG McDonald-Gibson, S Nigam, TF Slater. (Pp 330; £18.) IRL Press. 1987. ISBN (soft-bound) 1 85221 031 1.

This book is one of a practical approach series published by IRL Press Limited and concerns the eicosanoids. These unsaturated, ubiquitous lipids are derived from ara-

chidonic and other fatty acid precursors by the cyclo-oxygenase or lipoxygenase pathways. The former gives rise to the prostaglandins, prostacyclins, and thromboxenes, while the latter lead to the formation of the leucotrienes and the lipoxines.

My first impression after reading the 330 page text was one of profound relief not to be directly involved in this complex area. The multiplicity of these frequently unstable compounds, which are present at extremely low concentrations and often have half lives measured in seconds, is further complicated by interconversions and difficulties in differentiating primary products from metabolites. Several chapters relate to the analytical techniques used, of which some, especially immunoassays, are prone to give erroneously high values.

This book is unsuitable for a general readership but at £18 may provide a useful summary for research workers actively involved, or about to be involved, in this field.

K LONDON

Cancer of the Liver, Esophagus, and Nasopharynx. Ed G Wagner, Y-H Zhang. (Pp 208; 46 figs.; soft cover DM 128.) Springer. 1987. ISBN 3 540 16967 9.

This Chinese-German symposium on cancer of the liver, oesophagus, and nasopharynx was held in Heidelberg in 1985. These cancers are responsible for 60% of all cancer deaths in China, and it has been suggested that selenium could be used as a chemopreventive agent. Liver cell cancer is linked to hepatitis B virus infection, alcoholic cirrhosis, consumption of house ditch and field well water, and aflatoxins. Cigarette smoking is regarded as a cofactor. Surgical resection of small cancers is accompanied by five year survival figures of 55–60%. Exogenous risk factors have been identified for carcinoma of the oesophagus in association with poor nutrition and familial aggregation. Nitrosamines are clearly implicated. Consumption of fruit and yellow/green vegetables lowers the risk. Chemopreventive agents have prevented severe dysplasia progressing to cancer over a seven year period in a limited study. The Curacao story of petrol contamination of water supplies combined with exposure to plant diterpine ester promoters is illuminating. Nasopharyngeal carcinomas with poorly differentiated patterns and lymphocytic infiltration have a strong association with Epstein-Barr virus. Antibody

detection has been used as a screening test. This publication will interest the cancer expert.

H THOMPSON

Atlas of Cardiovascular Pathology. Current Histopathology. Vol 12. EGJ Olsen. (Pp 131; £65.) MTP Press Limited. 1987. ISBN 0 8520 0866 X.

Despite its aim to serve as a day to day guide for practising histopathologists, this atlas would seem considerably more suited to the trainee junior pathologist. The initial chapter with accounts of the commoner necropsy techniques for examination of the heart, annotated macroscopic plates illustrating normal anatomy, and performance of sections in echocardiographic planes will be an invaluable aid to the novice at necropsy.

The remainder of the book amply covers the major pathologies of the cardiovascular system with well chosen and displayed macroscopic specimens, but it is rather disappointing to discover that the microscopic plates show considerable variation in quality.

Each chapter includes a clear text section which provides definitions and simple understandable descriptions of the conditions covered, most of which are illustrated. Line diagrams and electron micrographs feature where appropriate.

With few reservations this book would seem useful as a day to day guide to the cardiovascular system for the trainee pathologist.

TINA MATTHEWS

Colour Atlas of Pathology. L Giarelli, M Melato, G Antonutto. (Pp 721; £97.50.) The Butterworth Group. 1987. ISBN 0 407 00301 0.

The excellent reproduction of the colour photographs in this publication amply supports the authors' belief that imagery, especially at the macroscopic level, is a vital component in the teaching of pathology, especially during the early phases of medical training, and may also be helpful to clinicians particularly in the surgical field. Unlike other comparable atlases, many of the pictures approach actual size and with few exceptions achieve their intentions. The