histamine as well as other mediators released after antigenic stimulation of the mast cell could be implicated in the development of tissue damage in *H pylori* positive patients. We think that histamine released by these or by other mechanisms could also be involved in gastric acid hypersecretion in these patients.

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- 2 Queiroz DMM, Mendes EN, Rocha GA, et al. *Helicobacter pylori* and gastric histamine concentrations. *J Clin Pathol* 1991;44:612-3.
- 3 Smith JTL, Pounder RE, Nwokolo CU, et al. Inappropriate hypergastrinemia in asymptomatic healthy subjects infected with *Helicobacter pylori*. *Gut* 1990;31:522-5.
- 4 Aceti A, Celestino D, Caferro M, et al. Basophil-bound and serum immunoglobulin E directed against *Helicobacter pylori* in patients with chronic gastritis. *Gastroenterology* 1991;101:131-7.

Repair of fetal bodies after dissection

We have, for the past year, used a method similar to that described by Gau and her colleagues to repair both fresh and formalin fixed fetal bodies after dissection,¹ and occasionally to completely reconstruct early second trimester fetuses received in fragments after genetic termination of pregnancy by suction or other evacuation methods. We have found that large skin defects in the small fetus can be repaired using a patch of amnion attached with adhesive. Whether a single or double layered patch of amnion or a sheet of amniochorial membrane is used depends on the fetal skin colour, thickness, and texture in the region to be repaired. Moreover, we have found that colourless cyano acrylate adhesive, usually referred to as Super glue and commonly used to assemble plastic models and for domestic repairs, is entirely satisfactory and fully acceptable to funeral directors and parents. Even in single drop dispensing tubes this is between 10 and 20 times cheaper than surgical adhesive and is cheaper still in larger tubes.

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Experience of invasive aspergillosis in Hong Kong

We read with interest the article by Boon *et al*,¹ and would like to share our experience in Hong Kong.

We reviewed the records of the 2462 necropsies performed between 1987 and 1990 by the Department of Pathology, Queen Mary Hospital, Hong Kong. Using the same criteria as Boon *et al*,¹ 11 cases of invasive aspergillosis were identified (eight males and three females with a mean age of 46.4 years,

ranging from 12 to 81 years). Eight of these were considered to be high risk for aspergillosis: they had haematological malignancies (four with acute myeloid leukaemia, two with chronic myeloid leukaemia in blastic transformation, one with acute lymphoblastic leukaemia and one with polycythaemia rubra vera). One patient was receiving long term total parenteral nutrition after extensive gut surgery. Another was a 78 year old man with an incidental finding of a 1 cm hepatocellular carcinoma at necropsy. The last case was a 12 year old girl with apparent good health who suddenly developed bronchopneumonia and died four days later; necropsy showed invasive aspergillosis in both lungs. The commonest site of infection is the lung, evident in all our cases, and other sites include the liver, spleen, kidneys and the heart.

Invasive aspergillosis was not diagnosed until necropsy in all our 11 cases, although fungal infection was strongly suspected in three of them. Repeated cultures for aspergillus were negative and transbronchial biopsy specimens were taken in the three cases, but none was considered diagnostic of aspergillosis.

Boon *et al* commented that invasive aspergillosis is not exclusive to the classic "high risk" group and included three in their report.¹ There were also three such cases in our series, although two of the patients were debilitated by total parenteral nutrition or solid malignancy while the young girl was apparently healthy before death. Other authors have also reported similar experiences.^{2,3} While premortem diagnosis of invasive aspergillosis has been refined by new investigative techniques,⁴ it is still more often diagnosed at necropsy,¹ and we reaffirm the value of necropsy in clinical audit.⁵

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- 4 Rogers TR, Haynes KA, Barnes RA. Value of antigen detection in predicting invasive pulmonary aspergillosis. *Lancet* 1990;336:1210-3.
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Costing of pathology services in the United Kingdom National Health Service

Professor Dick's useful review ended with a strong recommendation to pathologists to ensure they have "efficient resource management systems".¹ I cannot think how pathologists in the United Kingdom at present could disagree, but have a question and a comment.

The question is "who pays?"—that is, for the testing, introduction, and regular use of an efficient system.

The comment is that it is now vital that we pathologists give the same care and attention to obtaining and checking financial data about our laboratories, as most of us have for many years, to information about the number and variety of tests carried out and the quality of our results. In this department, however, the staff are very hard pressed to keep up with what, until now, has been regarded as their regular duties as clinical biochemists to provide results and comments to clinical colleagues, and it is hard to find the resources (staff) to assess, introduce, and apply simple computer packages for ordering, stock control, and noting expenditure without which accurate and precise budget statements can neither be obtained nor those from management validated.

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BOOK REVIEWS

All titles reviewed here are available from the BMJ Bookshop, PO Box 295, London WC1H 9TE. Prices include postage in the United Kingdom and for members of the British Forces Overseas, but overseas customers should add 15% to the value of the order for postage and packing. Payment can be made by cheque in sterling drawn on a United Kingdom bank, or by credit card (Mastercard, Visa or American Express) stating card number, expiry date, and full name.

Surgical Pathology of the Female Reproductive System and Peritoneum. Ed SS Sternberg, SE Mills. (Pp 317; \$102.00). Raven Press. 1990. ISBN 0-88167-726-4.

This short book, extracted from *Diagnostic Surgical Pathology*, covers the whole female genital tract, placenta, gestational trophoblastic disease and peritoneum in only eight chapters. It is not as detailed as the major diagnostic gynaecological text books, but the chapters are authoritative and comprehensively referenced up to 1990. The text is clear with excellent monochrome and colour illustrations. Much of the content is familiar and represents a concise overview and updating of work presented in other textbooks. Hendrickson and Kempson's chapter on uterine pathology includes many of the charts and lists from their textbook. The three chapters which Young, Clement, and Scully have written on the ovary, fallopian tube, and peritoneum are excellent summaries and