Letters to the Editor

Postpartum lobular granulomatous mastitis

The paper by Fletcher *et al* in the issue of September 1982[1] rightly calls attention to a little recognised condition. However, their term "granulomatous mastitis" misleadingly lacks specificity. We should like to suggest that "postpartum lobular granulomatous mastitis" better describes the clinical context and morphology of the lesions. This would not imply any, as yet unknown aetiology, but would serve to separate the condition from the many other types of granulomatous mastitis. The lack of mention of the disease in many pathology textbooks probably reflects an underlying taxonomic confusion about granulomatous mastitides.

Postpartum lobular granulomatous mastitis is certainly an uncommon disease, although we have seen two examples in Bristol surgical biopsies in the space of two years, and four other cases by referral from the United Kingdom over the last 10 years.

Continental Europe has not, in fact, been spared the disease. A clear clinical description and well illustrated histological account of a German case is presented in Bässler's monograph.[2] We agree with Fletcher *et al*[1] that care must be taken to exclude demonstrable micro-organisms in tissue sections, and also regret the paucity of reported cultural studies in such cases. However, there is little documentation of sarcoidosis causing lobular lesions of the extent and distribution seen in postpartum granulomatous mastitis. The four most acceptable cases of mammary sarcoidosis with histological descriptions in the literature,[3-7] and two others that we ourselves have seen, generally showed scattered granulomas which bore no especial relation to the lobules. Dalmark's case,[8] a 28-year-old woman who had an excision biopsy eight months after childbirth, has often been cited as an example of mammary lobular sarcoidosis. The lack of extramammary lesions led Scadding[5] to reject the diagnosis of sarcoidosis. We feel, to judge from the case description and photomicrographs, that it probably was another, early European case of postpartum lobular granulomatous mastitis.

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The Howie code: is the price of safety too high?

As a microbiologist at present involved in consideration of the upgrading of postmortem rooms, I was interested to read Dr Cohen's article on the cost-effectiveness of the implementation of the Howie code.[1] His conclusions are particularly relevant in the light of the recent correspondence[2 3] regarding the requirements of the Code for the ventilation of postmortem rooms.

At this hospital, following a visit from the Health and Safety Inspector, we have received a report recommending 10, and preferably 15 changes of air hourly. Setting aside the question as to whether or not such ventilation is effective in reducing the risk of infection, it seemed sensible to try to assess the degree of exposure to infectious tuberculosis that our morbid anatomists and mortuary room attendants might expect, especially as the implementation of these recommendations has very considerable financial implications.

In 1980, the number of deaths from tuberculosis (all forms, and including late effects) was 903,[4] of which about half were due to pulmonary tuberculosis and one third due to late effects, if the trends indicated by previous years continue. The death rate has been falling slowly but steadily and can be expected to continue to fall, in view of the declining numbers of new cases and more effective treatment. Even if *all* these deaths were associated with infectious disease and *all* patients dying of tuberculosis came to necropsy, that would still be less than one infectious case annually in all the postmortem rooms in England and Wales. Where necropsy rooms serve hospitals where a higher incidence of tuberculosis might be expected, such as ID and Chest Units (and many morbid anatomists would be unwilling to carry out necropsies on known infectious cases of tuberculosis except for the most pressing reasons), the risk is still extremely small, and should be met by proper observance of safe and careful procedures rather than embarking on expensive schemes for which there is lack of proof of efficacy in the reduction of this risk. Indeed, with the small numbers of tuberculosis infections in laboratory staff reported by Professor Grist in 1979,[5] proper evaluation of such measures becomes impossible, and their adoption does not obviate the need to maintain vigilance and care in working practices.

In these days of financial stringency in the NHS, I agree wholeheartedly with Dr Cohen's conclusion that there is a need for the proper consideration of economic issues. Ideally this should be at the development stage of any regulatory code, but surely it is not too late even at this stage of implementation of the Howie code?

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Screening method for mucopolysaccharidoses

A screening method for mucopolysaccharidoses involves the precipitation of urinary mucopolysaccharides (glycosaminoglycans) with cetylpyridinium chloride (CPC) and quantification by measuring the absorbance of the suspended precipitate.[1]

The method refers to the precipitate formed during the test as being "insoluble". This is not the case and vigorous shaking or vortex mixing of the contents of the tube results in re-solution of the precipitate. The initial high absorbance values