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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References
[1] Fletcher A, Magrath IM, Riddell RH, Talbot IC. Granulomatous mastitis: a report of seven cases. *J Clin Pathol* 1982;**35**:941–5.
[2] Bässler R. Pathologie der Brustdrüse. In: Doerr W, Seifert G, Uehlinger E, eds. *Spezielle pathologische Anatomie.* Band 11. Berlin: Springer-Verlag:1978:271–3.
[3] Scott RB. The sarcoidosis of Boeck. *Br Med J* 1983;ii:777–81.
[4] Stallard HB, Tait CB. Boeck's sarcoidosis. *Lancet* 1939;i:440–2.
[5] Scadding JG. *Sarcoidosis*. London: Eyre & Spottiswoode, 1967:335–6.
[6] Haagensen CD. *Diseases of the breast*. 2nd ed. Philadelphia: WB Saunders, 1971:339–41.
[7] Rigden B. Sarcoid lesion in breast after probable sarcoidosis in lung. *Br Med J* 1978;ii:1533–4.
[8] Dalmark G. Lymphogranulomatose bénigne. Un cas avec des altérations mammaires comme seule symptôme. *Acta Chir Scand* 1942;86:169–78.

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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[1] Cohen DR. The Howie code: is the price of safety too high? *J Clin Pathol* 1982;**35**:1018–23.
[2] Fine W, Burgess EJ. Safety in the postmortem room. *Lancet* 1982;ii:447.
[3] Collin CH. Safety in the postmortem room. *Lancet* 1982;ii:719.
[4] *OPCS Monitor* 24 August, 1982.
[5] Grist NR. Hepatitis and other infections in clinical laboratory staff. *J Clin Pathol* 1981;**34**:655–8.

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

obtained with positive samples may be reduced to near reagent blank values in this way and false-negative results obtained. Careful mixing of the contents of the tube by gentle inversion two or three times after the addition of the CPC reagent and again immediately prior to reading the absorbance is essential to obtain consistent results.

This test can be used as the initial discriminatory procedure in the investigation of mucopolysaccharidoses and it is important that other users performing this test are made aware that the "insoluble" CPC—precipitable mucopolysaccharide can redissolve if not handled carefully.

This could also be a source of error in the quantitative hexuronic acid method[1] for estimating mucopolysaccharides, which also has an initial CPC precipitation step.

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Reference

[1] Pennock CA. A review and selection of simple laboratory methods used for the study of glycosaminoglycan excretion and the diagnosis of the mucopolysaccharidoses. *J Clin Pathol* 1976;**29**:111.

Book reviews

The Year Book of Pathology and Clinical Pathology. 1982. Ed Kenneth M Brinkhous. (Pp 475; illustrated; £34.) Year Book Medical Publishers Inc. 1982.

The Year Books are designed as a compact and efficient means of "keeping up with the literature". Over 250 articles are summarised with the additional comments of the editor putting them into perspective. The aim of the book is admirable and the product is fun to browse through, especially before the final MRC Path examination. Sadly, the price is prohibitive for a readable pocket book with built-in obsolescence. For anyone with an annual book-buying urge, the Recent Advances series gives more lasting value. A dip into the library or departmental copy of this Year Book is, however, both enjoyable and informative and may add a little gloss before that crucial viva.

S KNOWLES

Principles and Practice of Disinfection, Preservation and Sterilization. (Pp 653; illustrated; £32.) Blackwell Scientific Publications. 1982.

The editors are to be congratulated on the production of a book which is broad in concept, successful in execution, and brings together expertise from many areas.

In Part I "Disinfection" there are two excellent chapters on the use of disinfectants and antiseptics in hospitals in addition to a great deal of other useful information. Attention is paid to the principles involved so that the rational development of good practice is possible. The second part "Preservation" contains sections on the use of preservatives in food and in pharmaceuticals. However, for many of us heat sterilisation is still of paramount importance. It would have been useful if this topic could have been considered in more detail and particularly if more of the outstanding problems that are proving difficult today could have been covered. Nevertheless, a great deal of valuable information is included on a variety of sterilising procedures.

There is evidence throughout of an effective editorial policy and the bibliography is extensive and useful. E MARY COOKE

Laboratory Investigation of Rubella. Public Health Laboratory Service Monograph Series No. 16. Ed JR Pattison. (Pp 81; illustrated; paperback £4.) HMSO. 1982.

This long monograph is a clearly presented account of the current laboratory techniques for the diagnosis and screening of rubella.

Following a brief historical introduction chapters are devoted to the methods of rubella virus isolation; detection of IgG by haemagglutination inhibition, radial haemolysis, complement fixation, immunofluorescence, RIA and ELISA; detection of IgM and appendices containing recipes for various reagents and media.

The principles and recommended procedures for each test are described in detail sufficient to form the basis of laboratory method sheets. There are also valuable discussions on the clinical significance of each test and some guidelines for their reporting.

This monograph is thoroughly recommended for all clinical microbiology laboratories whether already providing a diagnostic service or only contemplating routine rubella screening. DV SEAL

Some new titles

Host Factors in Human Carcinogenesis. IARC Scientific Publications no 39. (Pp 581; illustrated; Sw fr 100.) World Health Organisation. 1982.

Corrections

In the paper by Jeffrey *et al*[1] in the January 1983 issue, on page 56, first column, lines 23–26, there is a typographical error. This was due to a machine error on the main typesetter The sentence should read: "Most authors agree that metastases are very uncommon in patients with primary melanomas less than 0·76 mm, provided that tumours showing extensive areas of regression are excluded."

Reference

[1] Jeffrey I, Royston P, Sowter C, *et al*. Prognostic value of tumour thickness in cutaneous malignant melanoma. *J Clin Pathol* 1983;**36**:51–6.

In the paper by Mehtar and Afshar[1] in the January 1983 issue, on page 97, Table 1, *H aphrophilus* should read *H parainfluenzae*.

Reference

[1] Mehtar S, Afshar SA. Biotyping of Haemophilus using API 10S—an epidemiological tool? *J Clin Pathol* 1983;**36**:96–9.

Notice

Symposia in Basic Science in Gastroenterology

The Fifth Symposium in this series entitled "Gastrointestinal secretion—mechanisms and disorders" organised by the Royal Postgraduate Medical School (RPMS) in collaboration with the Medical Department of Glaxo Group Research, will be held at the RPMS, London on 19 April 1983. The organisers are JM Polak, SR Bloom, NA Wright, AG Butler.

Subjects include:
Pharmacology of acid secretion
Alkaline and mucous secretion
Secretion of the alimentary tract
Bile secretion
Mechanisms of pancreatic secretion
Diseases of the pancreas
Ion transport and small intestinal secretion
Small intestinal secretion in disease

Invited speakers include:

JH Baron (UK)	M Case (UK)
A Garner (UK)	EP di Magno (US)
MJ Berridge (UK)	LA Turnberg (UK)
JL Boyer (US)	VS Chadwick (UK)

The cost including lunch, tea and coffee will be £10. For information, please write to: Dr AG Butler, Glaxo Group Research Ltd, Ware, Herts, SG12 0DJ.