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Letters to the Editor

Necrotising granulomata in prostatic resection specimens—a sequel to previous operation

We read with interest the article by Dr Lee and Dr Shepherd.¹ We have observed similar appearances in two patients, aged 61 and 62 years, who had second transurethral prostatectomies 22 and 25 days respectively after their first operations. There was no clinical evidence of preceding urinary infection or tuberculosis.

In both cases there were granulomata in the second specimen, whereas they were absent from the first, which showed only benign nodular hyperplasia. The giant cells, most of which were of the foreign body type and occasionally contained pigmented particles or fibrinoid material, were situated close to necrotic areas, and there was also an infiltrate of lymphocytes, plasma cells, neutrophils, and eosinophils; the last were numerous in one patient. There was frequent squamous metaplasia of prostatic ducts. We did not find distinctive linear and non-linear changes, as did Dr Lee and Dr Shepherd.

We agree that these lesions are induced by operative trauma. The squamous metaplasia may be the result of ischaemia, but the latter is probably not directly related to the granulomatous reaction since granuloma is not a feature of spontaneous prostatic infarction.

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Anti-DNA immunoassay

Concern recently expressed¹ about the quality of anti-DNA test kits is well founded. Single stranded reagents were present in all the samples of labelled native DNA from different commercial sources examined by Medoff.² Such defects increase binding values and decrease the specificity of the Farr test.

Since its introduction we have used routinely native ¹⁴C DNA from Amersham in routine immunoassays, though both the stability and the molecular weight distribution of this material are unspecified. Of the many batches purchased, one, specially treated to remove single stranded regions, gave generally lower serum binding values, with some close to zero. As most batches appear to be incompletely double stranded we have reluctantly adopted the Farr test for antibodies to ss-DNA, using heat treated material, despite its disadvantages. Though tests for antibody to native DNA may be valuable for prognosis and treatment, their diagnostic value is uncertain. Using phage derived native DNA Swaak *et al*³ found increased values were given by sera from patients who did not satisfy the diagnostic criteria for systemic lupus erythematosus.

The Crithidia luciliae immunofluorescence test is deservedly popular, but the problems of variation between observers and in the composition of the labelled antigen-serum remain. It may also detect anti-protein antibodies in some circumstances.⁴

The stimulation of antibody production to native DNA may no longer be considered unique to systemic lupus