Letters to the Editor

Table Identification of patients with overt and borderline hypothyroidism

<table>
<thead>
<tr>
<th>Case No</th>
<th>Age (y)</th>
<th>Sex</th>
<th>T4 (nmol/l)</th>
<th>TSH (mU/l)</th>
<th>AST (IU/l)</th>
<th>LDH (IU/l)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypothyroidism (n = 2):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>81</td>
<td>F</td>
<td>64</td>
<td>35-5</td>
<td>29</td>
<td>337</td>
</tr>
<tr>
<td>2</td>
<td>67</td>
<td>F</td>
<td>34</td>
<td>50+</td>
<td>33</td>
<td>428</td>
</tr>
<tr>
<td>Borderline hypothyroidism (n = 3): (T4 80 - 110 nmol/l; TSH greater than 6.5 mU/l)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a)</td>
<td>(b)</td>
<td>(c)</td>
<td>(b)</td>
<td>(a)</td>
<td>(a)</td>
<td>(a)</td>
</tr>
<tr>
<td>1</td>
<td>69</td>
<td>F</td>
<td>81</td>
<td>83</td>
<td>7.1</td>
<td>23</td>
</tr>
<tr>
<td>2</td>
<td>68</td>
<td>M</td>
<td>103</td>
<td>103</td>
<td>8.3</td>
<td>4.6</td>
</tr>
<tr>
<td>3</td>
<td>83</td>
<td>M</td>
<td>82</td>
<td>103</td>
<td>7.5</td>
<td>5.6</td>
</tr>
</tbody>
</table>

(a) = initial blood test results; (b) = repeat blood test result taken three to nine months later.

increased in 92 cases, AST activities alone were raised in 18, and in 16 both enzymes were high. Thyroid function testing consisted of initial duplicate analyses of serum T4 concentrations by radioimmunoassay using donkey anti-sheep antibodies (RAST Allergy Unit, Benenden Chest Hospital) and 12I (Amersham International) as a tracer. Eighty-one of 125 samples with T4 concentrations of less than 110 nmol/l (normal range 50–160) were then assayed for TSH (Serono Kit). Five of 125 patients (table) were found to have abnormal thyroid function tests. The two cases of frank primary hypothyroidism identified had been diagnosed by the admitting physicians and received treatment before the study results were available. All three borderline cases were asymptomatic for thyroid disease and on follow up showed no progression.

Matters arising

Use of necropsy in clinical audit

The views of Hunt on the necropsy in audit are somewhat surprising.1 Discrepancies between clinical and necropsy diagnoses have been found in several studies,2,4 and the discrepancies have been regarded as important by clinicians. These findings must not be ignored on the basis of an unjustified comparison with surgical operations. The rather confusing sentence, “It has never been claimed that in hospital medicine more than a few erroneous diagnoses could have been made correctly except by luck” is simply not true. This sentence seems to mean that hospital diagnosis is as good as it possibly can be and cannot be improved. There is a considerable body of evidence to suggest that this is not the case. 3

No comments are made about quality of necropsy and the need for audit of necropsies. There is considerable disquiet about the quality of some coroners’ necropsies on cot deaths, and the number done in a single morning by some pathologists suggests that the quality may not be high. Furthermore, not all coroners’ necropsies are performed by properly trained histopathologists. The views expressed by Dr Hunt seem remarkably complacent.

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References


Dr Hunt comments:

It is difficult to reduce a half hour presentation to 500 words, and it is a shame that Dr Bissett did not come to the meeting. I stick by my opinion that most misdiagnoses in modern hospitals follow careful consideration by a medical team and are seldom the result of negligence or lack of individual skill. I dread a return to my early days in pathology when we often were regarded as busybody corpse-cutters trying to teach clinicians their job and were not part of clinical pathology. It is up to clinicians to regulate their own specialty; it is up to us to provide a high quality necropsy service, which with present staffing levels would be impossible if there were to be a dramatic increase in necropsy numbers, the necessity for which I question. Professor Schonle, recently quoted to me Professor Hamperl’s autobiographical account (not available to us monoglot old tradition, “We tried to stop the surgeons sending specimens to us—it was interfering with the real work of the department”). And that was in my own lifetime.

The standard of necropsy was not mentioned in my presentation because it was not part of my brief. I share Dr Bissett’s disquiet, especially in view of my belief that coroners’ necropsies are a particularly important form of audit.

Clinical importance of squamous metaplasia in invasive transitional cell carcinoma of the bladder

Merely to set the record straight, Martin and colleagues state that with respect to squamous metaplasia an invasive transitional cell carcinoma of the bladder, “Its importance for prognosis is not known,” and, “It is only relatively recently that histopathologists have recognised that transitional cell carcinoma with squamous areas is an entity distinct from squamous cell...