Correspondence

(1) Serum calcium, phosphate, and albumin concentrations were not given. This is an omission on our part which we failed to note on proof reading before submitting the letter to you. Please accept our apologies. The results were as follows: serum calcium (uncorrected) 4.07 mmol/l; phosphate 1.36 mmol/l; albumin 22.0 g/l.

(2) The red blood cell count was correctly reported as 4.1 x 10^11/l and not 4.1 x 10^11/l. The white cell count was not included in the script, but was 10.9 x 10^9/l.

(3) Our paragraph states the diagnosis to be non-Hodgkin’s malignant lymphoma. The confusion over diagnosis arises because the title of the original letter by Wayne and Burch was “Hodgkin’s disease presenting with hypercalcaemia”, which was, therefore, logically used by the Journal as the heading for our letter.

Prognostic index for breast carcinoma: a 22% improvement in the prediction of outcome?

There is a significant arithmetical error in Baak et al’s data, leading them to conclude that, compared with using the presence of lymph node metastases as a classifying variable, their cell prognostic index was more effective in 22% of instances to predict the actual prognoses of their patients. The actual difference is 6.7%.

Baak's prognostic index predicts accurately the outcome in 139 out of 195 patients (73.3%) of cases; lymph node status alone predicts accurately in 126 out of 195 (64.6%) of cases. The difference between the effectiveness of the two methods is thus 6.7%. The discrepancy of 6.7% vs 22% is explained as follows:

Data from original paper

<table>
<thead>
<tr>
<th>Baak's prognostic index</th>
<th>Lymph node status</th>
<th>Distant recurrence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>&lt; 0.6</td>
<td>8</td>
<td>91</td>
</tr>
<tr>
<td>0.6</td>
<td>2</td>
<td>21</td>
</tr>
<tr>
<td>&gt; 0.6</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>37</td>
<td>158</td>
</tr>
</tbody>
</table>

21 + 7 = 28 cases where prediction by prognostic index is confirmed and prediction by lymph node status is contradicted.

2 + 13 = 15 cases where lymph node status correctly predicts outcome and the prediction by prognostic index is contradicted.

The number of cases where prognostic index and lymph node status indicate a different prognosis is indeed 23 + 20 = 43 cases (or 22%). The purpose of the comparison, however, is to prove the superiority of the prognostic index over the prediction by lymph node status alone: only an added 13 cases (28 – 15) or an added 6.7% are correctly predicted by the prognostic index, not 22%.

We applied Baak’s prognostic index to our own series of 75 patients with breast cancer with known 10 year follow up. We have been particularly careful to count mitoses per 10 high power fields (400 x magnification), as recommended by the authors. In our experience the dichotomised prognostic index did not improve correct predictions, compared with predictions derived from lymph node status alone. A comparison of the effect of lymph node status alone, vs Baak’s prognostic index, 10 year survival curves, showed both virtually to overlap with each other.

There are two possible explanations for our inability to reproduce Baak’s results. On the one hand, the observed improvement by the dichotomised prognostic index in the prospective study is minor (an increase of 6.7% in accuracy) and therefore difficult to detect with a study of only 75 patients. The other possible explanation is that additional variation has been introduced by our lack of experience with Baak’s techniques, a different population, different treatment protocols, and different follow up periods. Either possibility shows that the use of Baak’s prognostic index is not likely to have much impact in the ability to differentiate patients at greater risk.


This is the first in a series of books, the stated aims of which are to cover the biology of extracellular matrix components, their effects on gene expression, and their control by cytokines, and to bridge the gap between these basic biological aspects and their implications for disease processes. This first volume contains five chapters, devoted to immunomodulation of extracellular matrix, animal models of connective tissue disease, non-invasive assays of organ fibrosis, evaluation of hepatic fibrosis by molecular hybridisation, and clinicopathological analysis of pulmonary fibrosis. As is evident, these form a pretty varied group and are unlikely to be of equal interest to the different possible audiences. The text is generally well written (with few typographical errors) and the illustrations are of reasonable quality. Given the rapidly changing nature of this field, it is disappointing that references rarely go beyond mid 1987. Because of its heterogeneous content, this book is unlikely to appeal to anyone but the collagen “fetishist”.

Perhaps the editor should consider devoting future volumes to single subject areas, such as normal biology, fibrosis, desmoplasia, neo-plasia, and so on.

CDM FLETCHER


The book is divided into three: non-neoplastic conditions in seven chapters; thyroid tumours in nine; and special diagnostic techniques in three. In addition to detailed discussion of papillary and follicular lesions, medullary and anaplastic carcinoma and lymphomas, the material is specially organised for ease of reference. The chapter headings therefore include granulomas in the thyroid, lymphocytes in the thyroid, fibrosis,

The organisation of most pharmacology texts is based on organ systems, classes of drugs, or disease states. In this easily readable but detailed book a novel approach is taken. The biological, chemical, and molecular concepts which are the basis of pharmacology and thus underlie the principles of drug action are presented.

The opening chapters cover the molecular basis of drug specificity, and this is one of the few general pharmacology books to include information on the influence of chirality and stereoselectivity on the interaction between the drug molecule and its site of action. Many examples in which an unusual response to a drug may be precipitated by hereditary factors are given in the chapter on pharmacogenetics. This book also covers the areas of carcinogenesis, mutagenesis, and teratogenesis in addition to drug metabolism, allergy, resistance, tolerance, and physical dependence.

There have been tremendous advances in the understanding of drug action in the 16 years since the last edition of this textbook and, with the advent of new technology that knowledge is still evolving. My major criticism is that textbooks which include state-of-the-art research in a rapidly advancing area will quickly become out of date. It is to be hoped that we do not have to wait another 16 years for the next revision. There is a definite need for a frequently updated text of this kind available at a reasonable price.

In short, this is a book which will help not only the pharmacologist, but also the biological scientist, chemist, and clinician to understand the factors which regulate and determine drug action.

I LENNARD


The arrival of an "Aids to MRCPath" book has been long awaited by histopathology trainees such as myself for whom the final exam looms large on the horizon. Advanced Histopathology admirably fills this gap in the market. Contrary to what its title may suggest, this is not a conventional textbook of pathology; rather, it is a trainee's vade-mecum aimed specifically at how to pass the MRCPath.

The book is divided into sections covering all aspects of the examination including the written paper, post mortem, practical, and viva voce. The largest section of the book (242 pages) is devoted to the written exam. Papers have been reviewed back to 1969 and specimen answers are illustrated. About one quarter of the answers are in the form of essay plans, the remainder as explanatory paragraphs. The post mortem and practical sections are reviewed in slightly less detail, although this is inevitable given the variability of the exam from centre to centre.

The style of the book is informal rather than didactic and I found it very readable. One minor criticism is that for many candidates at this stage of their career, much of the information is superfluous; how many of us need to be reminded to take an extra pen to the exam in case the one we're using runs out? This aside, the book is helpful and informative and will, I believe, help most candidates optimise their approach to this formidable exam.

P DOMIZIO

NOTICES

Association of Clinical Pathologists
Junior Membership

Junior membership of the Association is available to medical practitioners who have been engaged in the practice of pathology for a period of less than four years. Junior members are able to remain in this category for a maximum of six years or on the attainment of consultant status. The annual subscription is £24 for those resident in the United Kingdom and £55 for those overseas. The annual subscription may be claimed against tax.

Junior members receive the Journal of Clinical Pathology each month. Other benefits are reduced registration fees to attend ACP scientific meetings, all the documents regularly sent to full members of the Association including ACP News, which has a regular column for juniors, and the twice yearly summary of pathology courses included in the ACP programme of postgraduate education. Junior members have their own representative body, the Junior Members’ Group, which has a direct input to Council.

For Junior Membership apply to: The Honorary Secretary, Association of Clinical Pathologists, School of Biological Sciences, Falmer, Brighton, BN1 9QG. (0273) 678435.

ACP Locum Bureau

The Association of Clinical Pathologists runs a locum bureau for consultant pathologists.

Applicants with the MRCPath who would like to do locums and anyone requiring a locum should contact The General Secretary, School of Biological Sciences, Falmer, Brighton, BN1 9QG. Tel and Fax: 0273 678435.

Corrections

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