

aluminium, plain vaccines should also be submitted for absorbent vaccines to prevent further immunisation reactions.

JS ROSS
NP SMITH
IR WHITE
*St John's Dermatology Centre,
St Thomas's Hospital,
Lambeth Palace Road,
London SE1*

- Hallam LA, Mackinlay GA, Wright AMA. Angiolymphoid hyperplasia with eosinophilia: possible aetiological role for immunisation. *J Clin Pathol* 1989;42:944-9.
- Fawcett HA, Smith NP. Injection-site granuloma due to aluminium. *Arch Dermatol* 1984;120:1318-22.
- Tosti A, Vincenzi C, Peluso AM. Accidental diagnosis of aluminium sensitivity with Finn Chambers. *Contact Dermatitis* 1990;48:48-9.
- Clemmensen O, Knudsen HE. Contact sensitivity to aluminium in a patient hypersensitized with aluminium precipitated grass pollen. *Contact Dermatitis* 1980;6:305-8.

Dr Hallam comments:

The histological changes described by Fawcett and Smith certainly seem to bear a striking resemblance to the appearances we described. We did not see clinically remarkable necrosis or vacuoles surrounded by multinucleated giant cells, however. It is also interesting that Fawcett and Smith note the resemblance between their cases and the lesions of angiolymphoid hyperplasia and related disorders, known as the "inflammatory angiomatoses" reported by Wilson.¹

We did not stain for aluminium or test for aluminium hypersensitivity in our cases, but agree this would be a worthwhile exercise.

- Wilson Jones E. Malignant vascular tumours. *Clin Exp Dermatol* 1976;1:287-310.

Locally organised medical audit in histopathology

We read the paper by Ramsay on local pathology audit with interest as this department has been engaged in the internal audit of necropsies and surgical pathology for over 18 months.¹ The necropsy audit has been invaluable in achieving greater uniformity in the standard and timeliness of our reports as well as providing data on clinicopathological discrepancies with which to stimulate clinicians' interest in the necropsy.

Our surgical pathology audit covers similar ground to that of Ramsay and makes use of the dedicated McDonnell-Douglas system described by others for timing the laboratory procedures.² Monthly discussions involving all the pathologists and representatives of the MLSO and clerical staff have been beneficial in harmonising our approach to diagnostic problems and appreciating others' difficulties. These meetings also serve as a focus to address current problems as well as those shown up by the retrospective audit. We rapidly abandoned anonymity in the review process, partly because cases were easily traceable through the computer, and also because it inhibited the discussion when the original pathologist was not able to justify his or her approach to a case.

Two problems have concerned us: firstly, maintaining enthusiasm for the audit process once it became "routine"; and secondly, we felt that we could not audit our overall performance without considering whether we provided the information that clinicians

required. Both problems have been resolved by inviting a surgeon or physician with a particular interest to a pathology audit meeting at which we discuss a group of cases selected on the basis of SNOMED codes to provide a range of specimen types and diagnoses. By a judicious choice of clinicians, these meetings have been of greatest value in modifying our practice to ensure that our reports are clinically useful. They also help clinicians to appreciate some of the problems of providing a service and give them a greater understanding of some of the subtleties of the wording of pathology reports.

Although a random audit of cases is still necessary to maintain the internal standards of a department, we would commend the use of periodic specialty based meetings, involving the interested clinicians, as a means of entering the "audit loop" for the clinically relevant performance of a department.

TR HELLIWELL
PA SMITH
*Department of Pathology,
Royal Liverpool University Hospital,
Liverpool L7 8XW*

- Ramsay AD. Locally organised medical audit histopathology. *J Clin Pathol* 1991;44:353-7.
- Zuk JA, Kenyon WE, Myscow MW. Audit in histopathology: description of an internal quality assessment scheme with analysis of preliminary results. *J Clin Pathol* 1991;44:10-16.

Dr Ramsay comments:

I thank Helliwell and Smith for their comments. Since first presenting the Southampton audit scheme at the Pathological Society meeting in Aberdeen in 1989,¹ it has been used as a basis for local audit in histopathology departments throughout Britain and on the continent, frequently with modifications to accommodate local circumstances. From their letter it seems clear that the University Department of Pathology at Liverpool has established a useful audit system that includes an assessment of their necropsy performance.

Like the authors, at Southampton we abandoned anonymity early in our program. Although the department was not computerised

at the time (late 1988), cases could still be readily traced, and individuals were often recognisable by their reporting style. We are also aware of the two problem areas detailed in the letter. The maintenance of enthusiasm for any regular task is always difficult. At Southampton we encountered this problem after 18 months of audit, and went through a period in 1990 when the system was in "abeyance", although we now manage to run it on a regular basis.

The clinical importance of the information provided by pathologists is an area where audit is difficult, but can be of vital importance. I am pleased that the clinicians in Liverpool are sufficiently "broad-minded" to attend pathology audit meetings, and feel that this cooperation should be encouraged. At Southampton we adopted a rather more formal approach to this problem and are in the process of writing up a study based around the clinicopathological meeting, an established forum for interaction between clinician and pathologist. Over a three month period 56 meetings covering eight specialties were attended, and all diagnostic amendments noted, together with information from the clinicians as to how these would affect patient management. The reasons for diagnostic change were also determined, and all clinicians were questioned about the role and value of specialist clinicopathological meetings. The study reviewed 416 cases, and found that 81% of the diagnoses were unchanged, 10% were refined, and 9% were changed. In only 4% of the cases, however, did the diagnostic change result in a significant (as defined by the clinician) change in patient management.

I therefore agree that a random audit is not the only means of assessing performance and that an input from the clinicians is valuable, particularly with regard to selected specialist cases.

- Ramsay AD, Gallagher PJ. Quality control of surgical pathology by peer review—the Southampton Experience. *J Pathol* 1989; 158:343A.

Declining necropsy rate

We read with interest the recent paper by Benbow on medical students' views on necropsies.¹ In common with many other hospitals around the world our own district general hospital has suffered a steady decline in the hospital necropsy rate,^{2,3} in our case from over 50% in 1960 to 10% in 1990 (excluding coroners' necropsies). In an attempt to address this we sent a questionnaire to 120 of our clinical colleagues to canvass their opinions on the current situation and the reasons behind it.

Replies were received from 37 consultant

and 43 junior clinical staff. It was interesting to compare the replies of consultant and junior respondents. When asked if the falling necropsy rate worried them, 79% of consultant but only 37% of junior clinical staff stated that they were concerned by it (table). Furthermore, most consultants (51%) felt that for patients dying in hospital a necropsy was desirable in most cases; most junior staff (64%) considered necropsy desirable in only a few cases.

When asked about reasons for the declining necropsy rate, decreased emphasis on necropsy in medical education was considered an important factor by the highest

Replies of consultant and junior clinical staff to necropsy questionnaire

	Consultant (%)	Junior (%)
Are you worried by the declining hospital necropsy rate?		
Yes	79	33
No	16	52
Don't know	5	15
For patients dying in hospital necropsy is desirable in:		
All cases	19	7
Most cases	51	29
A few cases	30	64
No cases	0	0