and deficiencies of cell mediated immunity are known to predispose to mucocutaneous candidiasis.[5] We believe that further study of the histology and immunological response of the vulvo-vaginal epithelium in diabetic patients infected with the organisms shown by Rowe *et al* may be useful.

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2 Catalan J, Bradley M, Gallwey J, Hawton K. Sexual dysfunction and psychiatric morbidity in patients attending a clinic for sexually transmitted diseases. *Br J Psychiatr* 1981;138:292–6.
3 Oates JK, Rowen D. Desquamative inflammatory vaginitis. A review. *Genitourin Med* 1990;66:275–9.
4 Sonnex C. Recurrent genital tract infection; A result of induced immunosuppression? *Genitourin Med* 1989;65:372–5.
5 Rowe BR, Logan MN, Farrell I, Barnett AH. Is candidiasis the true cause of vulvo-vaginal irritation in women with diabetes mellitus? *J Clin Pathol* 1990;43:644–5.

Dr Rowe et al comments:

We thank Drs Boag and Barton for their interest in our paper and answer their points as follows:

Swabs were taken by an experienced midwife (BRR) using a Cuscoe's speculum. We have been unable to find any standard nursing or medical text which advocates the taking of vaginal samples without a speculum and had assumed that this was implicit in the term "high vaginal swab".

A full drug and topical medication history (including the date when medication was last used) was taken from all 27 patients who went on to have further investigations (group 2). Only two of these patients had received antifungal treatment in the six weeks before the study. Boag and Barton's statement that, "one quarter of the patients had previously been prescribed antifungal medications," refers to the subjects who completed a questionnaire (group 1): these were not discussed further in our paper.

Examination for clinically important microbiological pathogens naturally included Gram stain and microscopy. A Papanicolaou smear was also performed. There were no cases in which microscopical examination showed candidal spores or hyphae with negative fungal cultures. Trichomonads were not seen and there were no reports of Trichomonas on the Pap smear, a common source of false positive results.[1] Gonorrhoea and chlamydia cultures were negative in all patients, consistent with the low prevalence of sexual activity. Amine tests were not performed, but *Gardnerella vaginalis* was specifically sought and cultured from two swabs. Vaginal pH rises in postmenopausal women, making interpretation of the pH test difficult.

We agree that chronic vulvovaginal pathology (of whatever aetiology) may cause sexual dysfunction and that it is essential to identify treatable problems. It is our policy to swab all patients complaining of vaginal irritation before treatment is started. Furthermore, we suggest that in non-insulin dependent diabetes organisms usually regarded as commensal should be considered potential pathogens.

BR ROWE
MN LOGAN
AH BARNETT
SC BAIN
I FARRELL

1 Eschenbach DA. Vaginal infection. *Clin Obstet Gynaecol* 1983;26:186–218.

BOOK REVIEWS

Testicular Tumors. RH Young, RE Scully. (Pp 240; $163.50.) Raven Press. 1990. ISBN 0 89189 295 8

The British and American classification of testicular tumours are both widely used internationally. Although the British system is superior, the WHO unfortunately adopted a slightly modified American classification. It is important that any textbook on testicular tumours gives a comparison of the British and WHO terminology.

Young and Scully are renowned experts in gonadal pathology and have produced a superbly illustrated account of testicular tumours containing more than 270 high quality colour macro- and microphotographs. It is well written, although not comprehensive, and covers prognosis, clinical aspects, and response to treatment. The importance of tumour markers and immunostaining are described.

This book illustrates the WHO classification extremely well, but makes no mention of the British classification and does not include the Royal Marsden staging method which is the most widely accepted. It adds very little to the official WHO publication. Pathologists and clinicians must be familiar with the British classification and this omission limits the value of the book to pathologists, at least in the United Kingdom.

KM GRIGOR

The Pathology of Organ Transplantation. Ed GE Sale. (Pp 327; 58.) Butterworths. 1990. ISBN 0 409 90133 4

This concise volume is a welcome addition for the practising pathologist concerned with transplantation, either working in a unit or through referral. Texts on transplantation are often limited to a specific organ, whereas in this publication skin, kidney, heart, heart-lung, pancreas, intestine, bone marrow and thymic and corneal transplantation are excellently discussed in separate chapters.

Acute rejection and long term changes are detailed. Immunological aspects are included and specific problems associated with a specific organ are also well described. Immunopathology is also described in an easily understandable way. Infections of transplant recipients are summarised. The final chapter addresses itself to fine needle aspiration in transplantation pathology.

The numerous illustrations are of the highest technical standard. Each chapter contains an extensive list of references. A comprehensive index is provided.

I can highly recommend this book, not only to pathologists, but also to those engaged in transplantation, either experimentally or surgically; all will derive much useful information.

EGJ OLSEN

NOTICES

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April 8–12, 1991

Harvard, Massachusetts, USA

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