the lymph node biopsy specimen showed large cell lymphoma and the bone marrow
biopsy specimen showed paratrabecular aggregates of small lymphoid cells.

1 Bruning RD, Bloomfield C, McKenna RW, Peterson L. Bilateral bone marrow
2 Collar BS, Chabner BA, Graimick HR. Frequencies and patterns of bone marrow

Rapid ELISA for detecting Epstein-
Barr virus infection

We read with interest the assessment of the rapid ELISA test (Monolert—Ortho: Diag-
nostic Systems, New Jersey, USA) for detecting Epstein-Barr virus infection cited in this
report and present a case of parvovirus infection which also gave a false positive result with this
test. A 12-year-old boy presented with sponta-
eneous bruising and had thrombocytopenia (platelets 20 × 10^9/L). A bone marrow
examination showed increased megakaryocytes, slight haemophagocytosis, and a total
absence of red cell precursors. A monospot test was positive and the rapid ELISA test
for EBV infection was positive for an acute infection. IgM antibody to parvovirus
was present in high titre (greater than 40 units). No EBV IgM antibody was detected, but
IgG antibody to EBNA was positive in low titre. Thus despite the positive monospot
and Monolert results, there was no serological evidence for an acute EBV infec-
tion.

Matheson et al found false positive results with adenovirus, cytomegalovirus, and Toxo-
plasma gondii infections. Our case suggests that EBV infection may also cross-react
and we agree that this test has limitations.

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1 Matheson BA, Chisholm SM, Ho-Yen DQ. Assessment of rapid ELISA test for detection

Cerebral aspergillosis

Boon et al have reported a seasonal variation in cerebral aspergillosis following liver trans-
plantation, with most cases undergoing postmortem examination between November and
April. The authors state that, "no environmental source was identified," and it was
suggested that the seasonal variation may simply reflect a higher concentration of spores
outside the summer months. The highest aspergillosis counts, however, are usually
found in the autumn; most of the cases after liver transplantation occurred between
December and March.

The possible role of hospital demolition and maintenance work in outbreaks of this
condition has been suggested in two recent papers—one of four patients on a single
intensive care unit and the other of three immunosuppressed patients on a medical
ward. We therefore wondered whether the apparent seasonal variation in liver transplan-
tation might be related to hospital building work and renovations occurring on a
"seasonal basis" rather than to external sources. This would have clear implications for
the risks of infection in immunosuppressed

patients and the planning of hospital
rebuidling. It would avoid restricting liver transplantation to the summer
months.

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1 Boon AP, Adams DH, Buckels J, McMaster P. Cerebral aspergillosis in liver transplantation.
3 Harvey IM, Leadbeatter S, Peters T, et al. An outbreak of disseminated aspergillosis
4 Dewhurst AG, Creed AJ, Khan SM, Pallett AP, Danzke JRE. Invasive aspergillosis
in immunosuppressed patients: potential hazard of hospital building work. Br Med J
1990;301:802-4.

Dr Boon comments:
Dr Clements et al have, quite correctly,
drawn attention to the possible role of hospi-
tal building and maintenance work in out-
breaks of aspergillosis. Despite the current
stringencies of NHS capital expenditure, such work still occasionally occurs, but was
not a factor in our series.1 In fact, two further cases of aspergillosis occurred in the liver unit
at the Queen Elizabeth Hospital in the sum-
mer of 1989. This prompted a thorough
investigation of possible sources of Asper-
gillus spores by our microbiologists. Heavy
contamination of air shafts leading to the liver
unit was discovered and the details of this
excellent piece of detective work have been
presented. (Elliot TSJ, Stone JW, Smith J.
Abstact presented at Pathological Society
of Great Britain and Ireland, January 1990.)
Clearly, where air contamination is very
heavy, Aspergillus spores will lead to infection
in susceptible patients, whatever the season.
This does not conflict with our observations,
which are consistent with a greater abun-
dance of A fumigatus spores in winter,1
wherever the organism might be lurking. One
could argue, perhaps, about definitions of
“autumn” or “winter,” but I suspect there
may be variations in the sporulation of A
fumigatus according to season, and I note
the North American source of the reference
quoted by Clements et al.3

As others have recently testified,4,5 asper-
gillus is an important cause of morbidity
and mortality in many groups of patients. It
would, however, be quite unrealistic to plan
hospital rebuilding and maintenance work so as to avoid contamination of specific
units at certain times of the year, as to restrict
liver transplantation (or treatment of haematological malignancies) to the summer
months! The correct approach must surely be
effective prophylaxis, avoidance of high dose
steroids except where absolutely essential,
early diagnosis, safer antifungal treatment
and most importantly, a high clinical index
of suspicion. I would also emphasise that
without more detailed study, the findings
such as ours4 the true extent of the problem
posed by Aspergillus would not be apparent.

1 Boon AP, Adams DH, Buckels J, McMaster P. Cerebral aspergillosis in liver transplanta-
4 Kelsey SM, Newland AC, Van der Walt J, Doran H. Pulmonary aspergillosis in patients
5 Shields ML, Joyner M, Lee R. Invasive asper-

BOOK REVIEWS

30540-97166-1

The stated aim of this textbook is to combine classic histological approaches to endocrine
pathology with recent developments in immunohistochemistry and molecular biology. In
attempting to achieve this, the author presents a single author textbook, covering the breadth
of the endocrine system, Dr Lloyd has set himself a formidable task. He admits that
Rat certain areas have not been covered.
The text is variable. For example, there is a useful short, but comprehensive, discussion
of the new classification of pituitary adenomas, based on immunohistochemistry and
electron microscopy. In contrast, the problematic area of diagnostic uncertainty in
adenocarcinomas is incompletely discussed and referenced. The book is extensively
illustrated. There are very elegant colour plates of immunocytochemistry and non-
sectional in situ hybridisation, but some of the black and white photomicrographs are
not as crisp as might be expected.

This volume must be compared with others based on a functional approach to the subject,
which incorporate more of the clinical and biochemical aspects of endocrine disease.
Perhaps to a greater extent than in any other area of pathology, histological diagnosis
cannot stand alone. I feel, therefore, that this textbook will not be seriously competitive.

AM MCBNOCIL

The Renal Biopsy: Major Problems in Pathology. Vol 8. 2nd ed. LJ Striker, JL
 Olson, GE Striker. (Pp 282; £40.) WB Saunders

The first edition of this text sits on my shelf but is rarely consulted, for useful information
is obtained more easily elsewhere. Two of the authors have changed and this is now
virtually a new work rather than just a new

J Clin Pathol: first published as 10.1136/jcp.44.4.351-a on 1 April 1991. Downloaded from
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