

CORRESPONDENCE

Ki-1 positive anaplastic large cell lymphoma of skin

Drs Banerjee, Heald, and Harris make an important contribution to our understanding of cutaneous Ki-1 positive anaplastic large cell lymphoma (ALCL).¹ Their comment that lymphomatoid papulosis (LYP), regressing atypical histiocytosis (RAH), and cutaneous Ki-1 positive ALCL, however, are the same disease under different names requires critical comment. They describe both LYP and RAH as diseases presenting with cutaneous lesions which regress and recur, and indeed most authorities would regard these clinical features as essential to their diagnosis. Accordingly, the authors' belief that cases 2, 8, 9, 11 and 12 could be regarded as examples of LYP or RAH is illogical; regression was absent in these cases.

LYP, following its original description by Macaulay, continues to defend successfully its position as a specific disease entity.² Macaulay's description of LYP representing a continuing self-healing eruption, clinically benign but histologically malignant, still cannot be bettered; although it is now acknowledged that other diseases (including RAH and some of Ki-1 positive ALCL) belong to this characteristic spectrum of "rhythmic paradoxical eruptions".² Macaulay's original patient with LYP remains alive and well 25 years after the initial diagnosis, and transformation to systemic lymphoma rarely occurs in more than 20% of patients. In view of these clinicopathological correlates and its wide acceptance to both dermatologists, it would be tragic to abandon LYP as a diagnostic label.

Furthermore, the authors comment that monoclonality in LYP only partially reflects the true situation. For example, some genotypic studies have only been able to show monoclonality in 53% of cases.³ Whether or not nonclonal cases of LYP represent malignant lymphoma, benign lymphoma, or a polyclonal lymphoproliferative disorder, has been discussed elsewhere.⁴ Because of this current uncertainty, however, it seems inappropriate to apply the encompassing term ALCL for LYP at this point.

The rearrangement of T cell receptor β and γ chains in the cases of RAH investigated to date is indicative of a monoclonal T cell lineage, and RAH seem to have a substantially higher risk than LYP for development of systemic lymphoma. Most cases of RAH seem to relate more to ALCL rather than LYP, and I am sympathetic to the implied views of Banerjee that the continued use of the term RAH serves little useful purpose. In view of its characteristic clinical feature of regression, however, the recent suggestion that RAH be renamed "regressing phase anaplastic lymphoma" seems sensible.⁵

There is undoubted clinical, histopathological, and immunohistochemical overlap between ALCL, LYP, and so-called RAH. To dismiss them as the same disease under different names, however, is clearly erroneous. Banerjee paraphrases Chan *et al* and Kaudewitz *et al* as sharing their opinion with regard to terminology. My own reading of the papers, however, is that Chan regards LYP as

"a form of cutaneous ALCL that shows a propensity to pursue peculiar clinical course". Likewise, Kaudewitz regards them as "variants of the same disease entity". Chan also concludes with the crucial comment that it is very important to convey biological meaning to the clinician. Ki-1 positivity in ALCL may (but not always) be a favourable diagnostic variable. With respect to LYP, however, use of the term ALCL would fall well short of Chan's requirement.

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- 1 Banerjee SS, Heald J, Harris M. Twelve cases of Ki-1 positive anaplastic large cell lymphoma of skin. *J Clin Pathol* 1991;44:119-25.
- 2 Macaulay WL. Lymphomatoid papulosis update. A historical perspective. *Arch Dermatol* 1989;125:1387-9.
- 3 Whittaker S, Smith N, Russell Jones E, Luzzatto L. Analysis of beta, gamma and delta TCR genes in lymphomatoid papulosis; cellular basis of 2 distinct histological subsets. *J Invest Dermatol* (in press).
- 4 Slater DN. Clonal dermatoses: a conceptual and diagnostic dilemma. *J Pathol* 1990;162:1-4.
- 5 Jaworsky C, Cirillo-Hyland V, Petrozzi JW, Lesser SR, Murphy CF. Regressing atypical histiocytosis. *Arch Dermatol* 1990;126:1609-16.

Dr Banerjee *et al* comment:

We are grateful for Dr Slater's interest in our paper. We agree that the interrelation between cutaneous Ki-1 positive anaplastic large cell lymphoma (ALCL), lymphomatoid papulosis (LYP), and regressing atypical histiocytosis (RAH) is confusing, not least semantically. Slater maintains that, "it would be tragic to abandon LYP as a diagnostic label," but as the morphological and immunohistochemical features of LYP remaining localised to skin and exhibiting regression are identical with cases of cutaneous ALCL that develop extracutaneous disease we suggest that the distinction is impractical. Furthermore, we have seen similar histological features in cases remaining localised to skin but which did not regress.

Dr Slater's plea for the retention of LYP as a diagnostic label is based on clinical grounds—that is, spontaneous regression—this phenomenon occurs occasionally in many tumours. Would Dr Slater recommend calling spontaneously regressing non-metastasising malignant melanoma by another name, perhaps melanocytic papulosis?

We do not agree that we have misrepresented the views of Chan *et al* and Kaudewitz *et al* to support our opinion that "... RAH, lymphomatoid papulosis, and cutaneous Ki-1 ALCL are the same disease under different names". To avoid misunderstanding we quote the relevant statements in full:

Chan *et al*: "The existing evidence therefore suggests that it (LYP) is a form of cutaneous anaplastic large cell lymphoma that has a propensity to pursue a peculiar clinical course".

Kaudewitz *et al*: "Morphologic and immunophenotypic identity of the atypical cells found in primary cutaneous ALC lymphoma, in regressing atypical histiocytosis (RAH) and in lymphomatoid papulosis (LYP) of

type A, together with the protracted clinical courses in all three conditions, suggests that primary cutaneous ALC lymphoma, RAH, and LYP type A represent clinical variants of the same lymphoma entity".

We agree with Chan *et al* that it is important to convey biological meaning to the clinician, but we submit that this is precisely what the confusion term lymphomatoid papulosis does not do. We prefer to label cutaneous tumours of this appearances and phenotype as Ki-1 ALCL, with an explanatory note about their likely behaviour.

Measurement techniques for melanoma: a statistical comparison

The main disadvantage of eyepiece gratules is that they get lost and tend not to be used. It would be unusual for there to be an eyepiece graticule permanently inserted into every microscope in a histopathology laboratory. Bernier scales^{1,2} are at least attached to the microscope, although some pathologists choose to avoid a mechanical stage, and not all trainees have a Vernier scale on their microscope.

By far the quickest method of measuring to within the limits of accuracy necessary for diagnostic histopathology was taught to me by Dr Keith Blenkinsopp, now of Watford Hospital. As a preliminary calibration he used either an accurate ruler, or the Vernier scale, to measure the width of field of vision with the lower power objectives ($\times 2.5$ and $\times 6.3$), and calculated the corresponding field widths of vision with the higher power objectives. The Vernier scale could be used to check the latter. This exercise generates a tabulated list to stick on the wall next to the microscope, showing field widths of vision for each objective.

The proportion of a field width occupied by a tumour is easily estimated to within 20% of a field width by eyeballing, thereby allowing instant measurements down to about 50 microns, which is well within the shrinkage and sampling error of histological preparations. The overwhelming advantage of this method is that it is quicker and easier than any other, and so it is more likely to be used.

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- 1 Calder CJ, Campbell AP, Plastow SR. Measurement techniques for melanoma: a statistical comparison. *J Clin Pathol* 1990;43:922-3.
- 2 Measurement techniques for melanoma. *J Clin Pathol* 1991;44:263.

Survey of GPs' attitudes to microbiology services

We were interested to read the article on user views by Pedler and Bint.¹ We, too, have carried out a survey of user views directed at general practitioners who generate 40% of our workload.

Individual GPs had expressed dissatisfaction with a number of areas of the service, including the level of chlamydia investiga-