The finding of an improved prognosis in gastric cancers expressing c-erbB-2 protein is also in contrast to most studies in breast cancer where expression has been associated with a shorter relapse time and survival. The functional role of c-erbB-2 protein in gastric carcinoma is unknown and overexpression only occurs in a proportion of tumours. It may be related to a specific mechanism of transformation occurring in better differentiated tumours, although further studies are needed to clarify this.


6 Jain S, Filipe IM, Gullick WJ, Lincham J. Does c-erbB-2 expression have prognostic significance in gastric carcinomas? J Pathol 1990;161:343A.


Histological audit of acute appendicitis

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Abstract

One hundred retrospective appendix specimens were examined in an attempt to study the degree of uniformity and clarity of reporting of this common surgical specimen. There was full agreement in 73 cases and some degree of discrepancy in 27 cases. It is suggested that greater clarity in reporting can be achieved with five reporting categories: (i) established acute inflammation; (ii) no evidence of acute inflammation ("normal"); (iii) features suggestive of early inflammation; (iv) peri-appendicitis; (v) other features, such as granulomata, Enterobius vermicularis, tumours, etc.

Some 70,000 appendectomies are performed each year in England and Wales for a clinical diagnosis of acute appendicitis. This makes the appendix one of the more commonly received specimens in a histology department. This ensures that histopathologists should see a regular number of these specimens a year, but does not guarantee that they agree on what they see, or on interpretation. With the current emphasis on medical audit, we felt that the routine reporting of these appendix specimens required a new look with two main aims: (i) can histopathologists report appendix specimens consistently? and (ii) if not, why not?

Methods

The surgical pathology files of our department were searched and 100 retrospective consecutive appendix histology slides and their reports were withdrawn. All the specimens were from the period January to September 1990. The initial slides had been reported by six different histologists during the study period, all post-MRCPath. The slides were reviewed blind by three consultant histopathologists with no macroscopic or clinical details. The issued reports and those of the reviewing pathologists were then compared and any differences noted.

Results

Of the 100 study appendices, 90 were removed for a clinical diagnosis of acute appendicitis, four for persistent right iliac fossa pain, and six as part of another procedure. The average number of pieces of tissue taken from each appendix was four (including the tip and proximal resection margin), with a range of two to 13. Of the 100 appendix specimens reviewed, there was complete agreement between the three reviewing pathologists and that of the initial issued report in 73 cases, with the agreed diagnoses being established acute inflammation in 56 cases; no evidence of acute inflammation in 13 cases; early inflammation in two cases; peri-appendicitis in two cases, and with one case also containing Enterobius vermicularis. In 27 cases
there was at least one disagreement among the pathologists (table 1). The patient population studied is shown in table 2. On review of the patient notes for all of these 100 cases, there was no difference in symptoms, hospital stay, or post-operative complications between the discrepant group of 27 cases and that of the agreed 73 cases. The histological report was issued within two days in most cases, but was slightly longer in 35 cases (three to four days), largely due to the taking of further material. There was no evidence that the speed of return of the histological report delayed or interfered with clinical action. The histological report was not present in five of the clinical notes.

Discussion
In this study of 100 consecutive resected appendices there was complete agreement on the histological features in 73 cases. In the other 27 cases there was some level of disagreement. These disagreements can be divided into two broad categories: (i) those not related to inflammation (cases 7, 9, 13, 16, 17, 18, 26, 27); and (ii) those related to minor degrees of inflammation (the remaining cases including cases 13 and 16). In 18 of these 27 cases the terms “normal”, “early”, “sub-acute” or “resolving” were used—that is, there was no definite evidence of any established acute inflammation. The terms “sub-acute” and “resolving” are difficult to define but seem to be interpretations of groups of luminal/intraglandular polymorphs or chronic inflammatory cells in the submucosa/muscularis, while “early” acute inflammation is interpreted by some in the presence of minor groups of mucosal/luminal polymorphs with or without mucosal ulceration. The last three terms are subjective interpretations of minor degrees of inflammation seen historically and can be confusing to both histologists and surgeons alike. This confusion can be avoided, and more uniformity and clarity achieved with five reporting categories: (i) established acute inflammation; (ii) no evidence of acute inflammation (“normal”); (iii) features suggestive of early inflammation, (iv) peri-appendicitis; (v) other features, such as granulomata, Enterobius vermicularis, tumours, etc.

These are defined as follows:
(i) mucosal ulceration, transmural polymorph infiltrate, often with mural necrosis and a serosal inflammatory response;
(ii) no evidence of any inflammation (no features of i, iii, or iv);
(iii) focal true mucosal ulceration with polymorphs;
(iv) serosal/peri-appendicular inflammation (usually with polymorphs) with no evidence of any appendiceal mucosal/submucosal inflammation;
(v) features as mentioned, with the non-carcinoid tumours being described as outlined by Williams and Whitehead.8

These distinct groups ought to remove the situation seen in this study where, with the previously used terms, the reviewing pathologist disagreed with their own initial interpretation in 15 cases. However, this was never enough to alter a case to, or from, a definite "acute" diagnosis. Those appendices which show no evidence of any acute inflammation fall into the "normal" category, in that no features are seen to account for the clinical symptoms. We are now using these five categories for reporting appendices, and they are preferred by our requesting surgeons.

These categories indicate clearly if there is an early or acute appendicitis, and that the clinical symptoms are due to the appendix. If there is peri-appendicitis then the cause for the peritonitis (pelvic inflammatory disease, perforated bowel, etc) must be sought. If the appendix exhibits no inflammation at all ("normal") then, again, the cause for the symptoms probably lies outside of the appendix, although Enterobius vermicularis could account for appendiceal related pain in the absence of histological inflammation. This study also highlights the difficulty in deciding exactly what constitutes an early true appendicitis as minor degrees of inflammation can be seen in appendices from patients with no clinical symptoms.45 At present, category iii has to be defined by focal true mucosal ulceration with polymorphs. We are currently undertaking a detailed histological study of appendices in an attempt to define features which can be used to diagnose such true early intrinsic appendiceal inflammation prior to mucosal ulceration, and this will be reported shortly.