

would appear that this proportion is not large, but clearly larger numbers need to be examined before an accurate estimate can be made.

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- 1 Wright C, Angus B, Nicholson S, *et al.* Expression of c-erbB2 oncoprotein: a prognostic indicator in human breast cancer. *Cancer Res* 1989;49:2087-90.
- 2 Wright C, Mellon K, Johnston P, *et al.* Expression of mutant p53, c-erbB2 and the epidermal growth factor in transitional cell carcinoma of the human urinary bladder. *Br J Cancer* 1991; 63:967-70.
- 3 Fox SB, Day CA, Rogers S. Lack of c-erbB2 oncoprotein expression in male breast carcinoma. *J Clin Pathol* 1991;44:960-1.

False positive reactions with rotavirus latex agglutination test

Bendall and Gray describe a false positive reaction with a rotavirus latex agglutination test ("RotaScreen", Mercia Diagnostics Ltd, Surrey) on a stool sample from a child with haemorrhagic colitis and haemolytic uraemic syndrome.¹ We describe a further two patients in which potential false positive reactions were obtained with this test.

Case 1

This 1200 g baby girl was the first of twins born at 29 weeks' gestation by caesarian section. She received artificial ventilation for two weeks for hyaline membrane disease and pulmonary interstitial emphysema. At 27 days of age she passed a loose stool which was sent for virological examination. The Rota-Screen latex agglutination test was performed according to the manufacturer's instructions and found to be positive. The stool was not tested for blood but on the following day there was a small amount of blood present in the nasogastric aspirate.

Case 2

This 560 g baby was born at 24 weeks' gestation and had a difficult neonatal course including a prolonged ventilatory requirement and sepsis. He was eventually weaned on to low flow oxygen and full nasogastric feeds. At 85 days of age he developed the signs and symptoms of bowel obstruction with constipation, abdominal distension, and hyperactive bowel sounds, bile stained vomit, and splinting of the diaphragm with increased oxygen requirements. The following day he passed a large blood-stained loose stool which was sent for virological examination. This was found to be rotavirus positive using the latex test.

When examined by negative staining electron microscopy no viruses were detected in either stool specimen.

In both these patients the initial rotavirus positive result caused considerable concern and influenced patient management. With case 1, transfer back to the referring hospital was delayed. With case 2, a diagnosis of necrotising enterocolitis had been made and metronidazole was started. The rotavirus latex result caused some uncertainty about the appropriate further management of the child. In addition, the possibility of cross-infection in the nursery was considered as these patients had been in the same room and gowning and gowning was instituted for routine care of both babies.

The signs and symptoms of infection in neonates are often non-specific, requiring laboratory tests to provide a definite diagnosis. The availability of tests for rotavirus

such as the latex agglutination test has permitted more widespread testing for this virus than when electron microscopy was the only available method. Our observations indicate that the results obtained with the latex test were probably false positive results. This supports the finding of Bendall and Gray, who describe a false positive reaction with a rotavirus latex agglutination test in a child with bloody diarrhoea. In our cases the sample from case 2 was clearly bloody. The stool from case 1 was not tested for blood but a nasogastric aspirate taken the following day contained a small amount of blood.

In view of these findings we feel that the results of latex tests for rotavirus should be interpreted with caution, especially if there is evidence of blood in the stool. It is our policy to use the latex test as an initial rapid screening test but to examine all stools electron microscopically as well. This permits the detection of both false negative as well as false positive latex agglutination results. Other viruses associated with diarrhoeal disease may also be detected.

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- 1 Bendall RP, Gray JJ. Haemorrhagic colitis and haemolytic-uraemic syndrome: False positive reaction with a rotavirus latex agglutination test. *J Clin Pathol* 1991;44:609-10.

Drs Bendall and Gray comment:

Brink *et al's* description of false positive reactions with the RotaScreen latex test when testing bloody stools agrees with our own findings. Since our original report we have tested further stools with this kit and found a false positive rate of 28% with bloody stools. There were no false positive results in non-bloody stools. We hope to publish the details of our study shortly.

We agree that the "RotaScreen" test is a sensitive test and well suited to screening for rotavirus infection, but the high incidence of false positive results mean that some other means should be used to confirm the diagnosis.

NOTICES

Preliminary announcement

British Lymphoma Pathology Group Tutorial

9-11 September 1992
Chilworth Manor Residential
Conference Centre, Chilworth,
Southampton

Topics will include: T cell lymphomas; New techniques in lymphoma diagnosis; the borderline between Hodgkin's and non-Hodgkin's lymphoma; MALT lymphomas; monocytoid B cell lymphomas; diagnostic pitfalls in lymphoma pathology

Course Fee £250.00

For further information please contact:
Dr A D Ramsay, BLPG Secretary,
Department of Histopathology,
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Tremona Road, Southampton SO9 4XY.
Tel: 0703-796447 Fax: 0703-705580

Postgraduate training programme in pathology (IAP, Austria)

The Austrian division of the International Academy of Pathology (IAP) in collaboration with the Royal College of Pathologists (London), offers postgraduate courses in English in anatomical pathology and its subspecialties. The courses are designed to supplement the training in the home country and may be tailored to the special needs of the individual physician. The courses are recognised for the Part I MRCPPath examination of the Royal College (Diploma in Pathology). The main thrust of the programme is directed towards hands-on experience in necropsy pathology in preparation for the Part I examinations. Preference will be given to physicians-in-training with considerable experience in surgical pathology from countries with limited access to autopsies.

A limited number of places for a complete specialty training programme in anatomical pathology and cytology for physicians with knowledge of English and German is available, leading to the Part I MRCPPath (Diploma) examination.

Training programmes in advanced techniques in diagnostic pathology, ultrastructure, and cell biology may be arranged on request for pathologists and their laboratory staff.

Direct enquiries to: AKH-Klinische Pathologie, W Dutz MD, FRCPath, FCAP Course Director, IAP Austria AKH, Währinger Gürtel 18-20 A-1090 Wien, Austria Fax: 0043-1-424302

Association of Clinical Pathologists

Junior Membership

Junior membership of the Association is available to medical practitioners who have been engaged in the practice of pathology for a period of less than four years. Junior members are able to remain in this category for a maximum of six years or on the attainment of consultant status. The annual subscription is £34 for those resident in the United Kingdom and £65 for those overseas. The annual subscription may be claimed against tax.

Junior members receive the *Journal of Clinical Pathology* each month. Other benefits are reduced registration fees to attend ACP scientific meetings, all the documents regularly sent to full members of the Association including *ACP News*, which has a regular column for juniors, and the twice yearly summary of pathology courses included in the ACP programme of postgraduate education. Junior members have their own representative body, the Junior Members' Group, which has a direct input to Council.

For Junior Membership apply to: The Honorary Secretary, Association of Clinical Pathologists, 221 Preston Road, Brighton BN1 6SA. (0273) 561188.