Dr Ellison et al comments:
Dr Piette and colleagues make some valuable suggestions in their letter about our article. We were also keen to compare the presence of intramural platelet deposition and titles of antiphospholipid antibodies in our series of patients. Three of the six had died before antiphospholipid antibodies were measured, however, and we could find no record of these tests in the case-notes of the other three. We were unable to trace any stored serum.

We would agree that a study of other vascular lesions, in the antiphospholipid syndrome would be interesting. Though difficult to substantiate or to quantify, our impression was that intraplastral platelet deposition was more readily found in the cerebral vasculature of patients with the longest histories of neuropsychiatric symptoms and the most deformed, thickened, small vessels.

Carcinoid pattern in adrenal phaeochromocytoma
In response to the paper by Harach and Bergholm,1 I would like to comment on a similar phenomenon that I have encountered in two adrenal phaeochromocytomas. Our cases were sporadic and the other was associated with multiple endocrine neoplasia type IIa (MEN IIa). The carcinoid areas seen microscopically were reminiscent of the classic midget pattern with packets of uniform cells. The tumour cells were smaller and less pleomorphic than the typical pleomorphic, polygonal chief cells of the usual phaeochromocytoma. These carcinoid foci were, however, minor histological components and both tumours had adjacent areas of typical phaeochromocytoma. The medullary carcinoma of the patient with MEN IIa, interestingly, did not share this carcinoid phenotype. The question of metastatic spread was unwarranted because of obvious areas of phaeochromocytoma and the characteristic clinical scenario. At the same time, it must be remembered that metastatic medullary thyroid carcinoma within an adrenal phaeochromocytoma has been described.1

Metastases aside, if one believes in the dispersed (diffuse) neuroendocrine system, it is not unexpected that overlaps in histological pattern will occur.2

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Relative friendly Death Certificates
I read Dr Slater's description of his audit of the wording of Death Certificates with interest, and I agree that many of the inaccuracies he identifies are reprehensible. I take a far less harsh view than he does about the commonest inaccuracy, however, which is to quote the mode of dying qualified by an underlying cause; an unqualified mode of death, on the other hand, is quite obviously silly. General practitioners may have to counsel a bereaved family when the only information they have about the death of their loved one is a Death Certificate, and I do not hesitate to include a mode of dying if I think that it will help with this counselling by clarifying the sequence of events. Why should we deny the bereaved knowledge of coronary atheroma?2 Be deemed wrong when "myocardial infarction due to coronary atheroma" can be accepted? When I carry out a necropsy, I like to think that I can derive the greatest benefit for all concerned, including relatives, clinicians, and epidemiologists. I don't think the Office of Population Censuses and Surveys has.any particular difficulty with a Death Certificate if I put in an extra line at the beginning which clarifies the mode of death, because it is the underlying cause of death which is selected.1 Excluding modes of death from Death Certificates is one counsel of perfection which I also cannot ignore.

While on the subject of counsels of perfection, Dr Slater might like to know that the literature contains many references3–11 about the poor correlation between the clinical and pathological diagnosis of terminal malignancy and necropsy findings. Most are much more informative than the one he cites.12

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Dr Slater comments:
I appreciate Dr Benbow's interest in my audit of wording inaccuracies in relation to death certification. I fully support Dr Benbow's view that histopathologists should be involved in the process to achieve this by personal communication with general practitioners and, when appropriate, by spending time with relatives of the deceased. We find this is preferable to the necessity of incomplete information to glean information from a somewhat "stark" and impersonal Death Certificate. I agree that the inclusion of a"mode of dying" in expert hands (such as Dr Benbow's) does little harm. I am sure, however, that if such a policy was adopted by inexperienced doctors then mode of dying would quickly become acknowledged as a definitive cause of death. Perhaps we should also forget that the PCOD and not mode of death that we are certifying.

I am also appreciative of Dr Benbow's comprehensive list of references relating to the poor correlation between the clinical diagnosis of terminal malignancy and necropsy findings. This in itself proved an interesting audit and I was relieved that my own references were only 10% deficient. I was saddened to see that Dr Benbow expressed no personal opinion on the term carcinomatosis.

Further to Dr Slater's informative paper on audit of death certification, I would like to add our experience in this field. Since 1990 we have audited the accuracy of death certification in this hospital by comparing the cause of death as found at post mortem (COD) with the presumed cause of death as written on the death certificate (PCOD). A post mortem examination is requested on all hospital deaths in this institution; the overall rate in three years is 24–2%, excluding coroners' cases, and 33% of these cases are specifically selected for post mortem examination. Accuracy of certification is scored 1–4: 1 = completely accurate; 2 = relatively accurate, the PCOD and COD match, but secondary causes are inaccurate; 3 = accepted as inaccurate: by accepting unacceptable inaccurate where the PCOD may be missed for the COD, and 4 = completely inaccurate. The results are shown in the table.

<table>
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<td>43 (43%)</td>
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<td>29 (38%)</td>
<td>9 (12%)</td>
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<tr>
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<td>18 (29%)</td>
<td>27 (43%)</td>
<td>6 (10%)</td>
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This book aims to provide practice in pathology multiple choice questions (MCQs) for medical students.

An attractive feature is the good mixture of question styles. This helps relieve the monotonous reading of through MCQs and gives excellent practice in exam technique. There is a good breadth of subjects, neatly divided into 25 sections. I found that the explanatory comments were written concisely and in an appropriate amount of detail. The answers to the MCQs, however, are printed in bold type in a column down the middle of the page between the questions and the explanations. It is frustrating to see the MCQ answer boldly in front of you before you have a chance to cover it up. Perhaps in subsequent editions the answers could be on the following page.

This section has occasional ambiguities, but they are relatively minor. The format of the MRCPath primary exam has changed and does not include MCQs, so it seems curious that the back cover of this edition mentions its use in preparation for this exam.

This book is excellent value and I would recommend it for medical students who are preparing for pathology exams and who require practice in MCQ technique.

TP MILLARD


Measuring Alcohol Consumption is an excellent resource for all those interested, at whatever research or clinical level, in alcohol use and misuse. Accurate assessments of alcohol use are vital in monitoring alcoholism treatment and prevention programmes and investigating the links between alcohol consumption and the diagnosis of medical problems.

Ray Litten and John Allen have edited a multi-authored volume which is highly organised, cohesive, integrated and practical. It is divided into two main sections: the first dealing with psychosocial measures; and the second with biochemical measures of alcohol consumption.

The first chapter provides a good overview of self-report methods, and emphasises that verbal reports are neither valid nor invalid, but that the important issue is that certain conditions and procedures are more conducive to response accuracy and validity. The second chapter provides an excellent review of "computerized approaches to alcohol assessment" and the finding that the results of computerised testing are generally similar to those of personal or pencil-and-paper interviews.

Timeline Follow-Back (TLFB) is the best psychometrically evaluated and field-tested self-reported alcohol consumption instrument to date. Chapter 3 provides a description of the methods and a thorough discussion of its validity, and appropriate applications of this and other self-report measures in various research and clinical situations. A useful appendix provides instructions for administering TLFB which can be modified for different target groups or research projects. The final chapter of the section on psychosocial measures discusses the accuracy of self and collateral accounts of drinking behaviour.

The second section reviews many new and complex biochemical indicators of alcohol consumption. An overview divides biological markers into several types: markers of predisposition to alcoholism (trait markers); markers of chronic or acute consumption (state markers); and markers of transient damage. Blood alcohol measurement is the estimation of alcohol consumption, but new markers of high alcohol consumption (carbohydrate-deficient transferrin and 5-hydroxytryptophol), and the usefulness of protein acetaldehyde adducts as state markers of consumption are all discussed. The last two chapters describe non-invasive methods for the measurement of transdermal ethanol as an assessment of ethanol intake and responses to various situations. Measurement is best easy to use in an outpatient setting where patients are seen on a weekly basis and has a high degree of sensitivity and specificity. A wearable, electronic ethanol sensor/recorder, and the use of biochemical detection technology used in breathalysers, is also described. Unlike the dosimeter, it provides real-time rather than cumulative monitoring of alcohol use, and therefore gives accurate quantitative and temporal tracking of ethanol consumption over extended periods.

This superbly organised, thorough, and readable book is highly recommended for all those who need to assess alcohol intake.

CAROLINE C HORIZW


The authors stated in the Preface that this volume was intended to be a single guide to the diagnosis of most non-neoplastic diseases encountered in diagnostic human ultrastructural pathology. It is a companion volume to the book Ultrastructural Appearance of Tumours prepared by the same authors.

This is a multi-author work with uniformly high standards throughout, although the chapters range in the extent to which they cover aspects of the subject. As a whole the volume is best regarded as an atlas of high quality photomicrographs with a relatively brief, but extensively referenced, textual introduction to each chapter. The photomicrographs cover most of the commonly encountered entities and there is a generous selection of illustrations of the infrequent or rare lesions, but this cannot be regarded as comprehensive, given that the authors intended to cover the range of non-neoplastic diseases where electron microscopy can contribute to the diagnosis. There is a wide enough coverage, however, for the book to act as a valuable aide memoria for an ultrastructural pathologist while pondering over a difficult specimen. This approach will be of little value to the histopathologist with occasional exposure to electron microscopy

Post mortem sampling for biochemistry and toxicology

Dr Forrest is to be congratulated on his ACP broadsheet concerning the usefulness of post mortem sampling for biochemistry and toxicology, a much neglected subject. There is one assay not mentioned among the generally useless enzyme determinations and that is the gamma glutamyl transpeptidase (γGT).

Over many years I have found it to be a reliable additional investigation in those dying with indications of alcohol misuse. Where there is no active liver disease, a raised γGT result from a peripheral blood sample gives added confidence for chronic alcoholism to be included in the cause of death.

TO ASHWORTH


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