Correspondence

The investigation of hypercalcaemia

The recent ACP Broadsheet by P L Selby and P H Adams is very helpful and we agree with its recommendations.[1] However, we feel that there is an important omission, namely that serum intact parathyroid hormone (PTH) concentrations are not invariably frankly raised in primary hyperparathyroidism but may be at the upper limits of the normal range. PTH concentrations in this range are also found in hypocalciuric hypercalcaemia (familial benign hypercalcaemia) which may lead to a misdiagnosis of hyperparathyroidism. Most kindreds have a history of (unnecessary) parathyroidectomy, often repeated.

We strongly recommend that an index of calcium excretion be measured in any patient with hypercalcaemia who is being considered for parathyroidectomy and, where calcium excretion is relatively low, family studies be undertaken to exclude this condition.

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1 Selby PL, Adams PH. ACP Broadsheet 144: The investigation of hypercalcaemia. *J Clin Pathol* 1994;47:579–84.

Dr Selby comments:

We thank Dr Gordon and colleagues for their comments on our Broadsheet on the investigation of hypercalcaemia. We entirely agree with the points that they raise regarding hypocalciuric hypercalcaemia in which, as we stated, parathyroidectomy is generally contraindicated. In our experience a substantial number of patients referred for assessment after failed parathyroidectomy have this condition. We would go even further than Dr Gordon in suggesting that the need for parathyroidectomy be questioned in anyone with inappropriately low urine calcium excretion. However, consideration of treatment lay outside the scope of our Broadsheet.

Quantitative audit of histopathology reports

I read the paper by Campbell and Griffith[1] and the subsequent comments by Coghill[2] with interest. Campbell and Griffith described a system of local reporting guidelines prepared in collaboration with clinical colleagues and used by pathologists in their department when preparing histology reports. Coghill,[2] on the other hand, describes a series of template reports to which measurements are added and from which words and phrases are deleted in order to generate a report. Although Coghill[2] comments that use of this system was followed by a 1·3 day reduction in mean reporting time, neither author comments on the proportion of cases in which their respective reporting systems were found to be suitable and the proportion in which the pathologist "exercised his option of adding to or deleting from the template".

In this department a less rigid reporting protocol has been adopted. Standard templates like those described by Coghill for commonly encountered specimens such as endometrium, uterus and cervix, conceptional products including voluntary terminations of pregnancy, cervical biopsy specimens, cone biopsy specimens, and diathermy loop excisions of cervix were prepared. Draft reports are compiled by the pathologist on a pro forma sheet attached to the request form and the final report is prepared by secretarial staff. A policy decision not to include "unusual" diagnoses in those templates, such as carcinomas occurring in specimens from an organ like uterus or cervix where malignant tumours are a comparative rarity, was made. In this situation an "individually hand crafted report" was encouraged using guidelines included in a departmental handbook.

From 1 August to 31 December 1993, 1825 specimens were processed in this department, of which 1403 were from those organs for which a standard protocol had been prepared. Of the 1043 specimens, 939 (67%) were reported using standard templates to which no additional information incorporated in free text was necessary. Conceptional products were least likely to require additional free text whilst specimens of uterus and cervix were most likely to necessitate such additional information (table).

This audit has enabled us to identify those pathologies not included in the original templates which were encountered with sufficient frequency to merit subsequent inclusion. Adapted templates or hand crafted reports using the information required in the departmental handbook were prepared in the remaining cases.

The use of these templates has increased the standard of reports by providing the pathologists with a checklist of points which require comment in every case. We have found that they speed the reporting process and because of their synoptic nature save time when, before the report is signed, the original is compared with the final typed version prepared by our secretarial staff.

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1 Campbell F, Griffith DFR. Quantitative audit of the contents of histopathology reports. *J Clin Pathol* 1994;47:360–1.
2 Coghill SB. Quantitative audit of the contents of histopathology reports. *J Clin Pathol* 1994;47:681.

Dr Coghill comments:

I am delighted but not surprised to hear that a centre of excellence such as a University Department in Sheffield uses standard template reports for their routine histopathological reporting. This is relatively common practice in the United States where laboratory computing is rather more advanced than elsewhere. Dr Heatley expresses interest in the proportion of our cases in which template reports are used. At the time of my audit and at present, all of our reports are entered by the pathologist. The Sheffield policy is to exclude the use of template reports for unusual conditions in favour of what I described as "hand crafted" reports. It is in the use of templates, carefully engineered, for the reporting of these cases that I am particularly enthusiastic.

When a case under consideration is not already included in our directory of reports, a new template is generated which is then used to report the current case and is added to the directory for future use. However, I have also prospectively added templates in a number sectors of histopathological practice such as dermatopathology, and bone and soft tissue pathology. The directory is managed on personal computers using file handling and indexing software. The contents of the templates are carefully engineered so that the correct one is selected by the retrieval software following the entry of key words describing the important features of any case. If the search terms used are imprecise, the system will offer a differential diagnosis that may then be refined manually by viewing on the screen or automatically by the addition of further terms. By including typical immunohistochemical profiles in the templates, quite complex diagnostic decisions can be assisted. The way in which the template is "engineered" ensures that it can be easily edited to resemble a "hand crafted" product. The templates also contain appropriate prognostic and other data as well as key references extracted from the recent literature. This adds value to the final report with no effort from the pathologist. The response from clinicians has been favourable.

Therefore, it is in the reporting of "unusual" cases that my "textpert" system comes into its own. With the assistance of other pathologists, more expert than myself, it is my hope that this directory of templates can be expanded to become a major resource for practising histopathologists and trainees. With the addition of explanatory hypertext, references and possibly digitised colour images, the final product could potentially replace the pathologist's textbooks, journals and reference slides. Through the economic and ecologically sound medium of electronic publishing, it is my hope that these efforts can be made available to a wide audience. If regular updates are mailed or distributed by a Wide

Reporting format for 1403 specimens received between 1 August and 31 December 1993

Nature of specimen	*Number received*	*Number without additional information*	*Percentage without additional information*
Products of conception	291	236	81
Cervical biopsy	196	142	72
Cone biopsy/DLE	118	77	65
Endometrial curettings	545	348	64
Uterus and cervix	253	136	54

DLE = diathermy loop excision.