work, because it allows antimicrobial sus-
ceptibilities (meronidazole, clarithromycin) to be
determined, and we would not replace it for a specific test that was not fully spec-
cific as suggested by the correspondents.


Measurement of medical staff overload

Dr Bignardi1 is correct in his conclusion that the number of consultant medical staff, workload and requirements in microbiology departments. The current guidelines of the Royal College of Pathologists for consultant staffing suggest that for central laboratories in district general hospitals serving a popula-
tion of approximately 250 000 there should be at least two consultant medical microbiologists.2 A number of districts do not provide such staffing and cases need to be developed to persuade managers to pro-
vide appropriate cover. “Population served” is a crude measure of workload, even if referral patterns do not distort the picture. It is also clear that hospital bed numbers are not directly related to laboratory activity; indeed, capital expenditure reducing bed numbers has resulted in an increase in labor-
atory tests from outpatients, day cases, and GPs. Numbers of specimens and the num-
ber and nature of tests can be more closely related to laboratory activity and can be made more sophisticated by such systems as WELCAN, but these are not a measure of medical input; neither are they a measure of the quality of a microbiology service. Particular problems in measuring consult-
tant microbiologist input are the contribu-
tions to core activities of the hospital(s) and clinics served—activities such as hospital infection control, policies for infection control, chemical disinfection—and the general pro-
vision of advice on the management of infected patients. The latter aspects depend to a large extent on the case mix profile of the units served: intensive care units, special care baby units and oncology wards make particularly heavy demands on medical microbiologists. Although these matters are generally clear in principle, the allocation of numbers of consultants to reflect the workload has proved to be very difficult. Some of the problems of consultant staffing levels have been discussed in a recent article in ACP News3 and the Microbiology Specialty Advisory Committee of the Royal College of Pathologists is currently examining this subject. It will not be easy to produce a uni-
versally acceptable measure, but the prob-
lems must be addressed in order to try to achieve a composite workload definition that reflects the range of input required of a consultant microbiologist.

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3 Workload figures: whose norms are they any-

Dr Bignardi comments:

I welcome the interest from the Microbiology Specialist Advisory Committee of the Royal College of Pathologists: eliciting such inter-
est was the main purpose of my report. In my opinion the current guidelines by the Royal College of Pathologists for consultant staffing in microbiology are so impractical that they cannot be implemented by the College itself. This is demonstrated by the fact that, during the course of my study, four job descriptions for single-handed consult-
ts were approved by the College despite the fact that the respective popula-
tions exceeded 250 000 (the College recommends two consultants for departments serving a population of approximately 250 000). According to my analysis, the case for a second full-time consultant microbiologist was very strong in two of these four hospitals.

One would hope that if a formula based on the weighted number of beds and speci-
mens (and perhaps on other factors) was sanctioned and policed by the College, at the least the worst cases of understaffing could be eliminated. Since writing my report I have noticed some important trends: the overall number of both consult-
tants and junior doctors in microbiology seems to be increasing. All pathology departments have been asked to take sub-
stantial cuts in their budget over the next years, and the NHS Management Executive has commissioned a strategic review of pathology services and has thrown the door open to more pathology privatisations.

Given the current political climate, I think it most important that we try to iden-
tify and quantify the minimum medical staff requirement for a good quality service in microbiology.

Necrotising granulomas of the uterine corpus

We read with interest the report by Drs Akosa and Boret of necrotising granulomas of the uterine corpus following Nd YAG laser ablation of the endometrium,1 and noted their reference to our original report on peritoneal granulomas following laser ablation.2

We subsequently reported the histo-
logical findings from four hysterectomy specimens obtained for various indications following Nd YAG laser ablation.3 Our findings were essentially the same as those of Akosa and Boret, and we were able to demonstrate by energy dispersive x-ray analysis that the black foreign material

within the necrotising granulomas consisted largely of aluminium oxide compatible with the known composition of the sapphire laser probe.

We also provided evidence to support the hypothesis that recurrent bleeding following laser ablation is due to inspreading of func-
tional endometrium from the tubal ostia and isthmus, and we strongly suspected that Akosa and Boret made no comment on the histological appearances of the endo-
metrium away from the obvious laser damage.

Finally, Akosa and Boret refer to the technique as endometrial resection which is in our view not correct, as the use of the Nd YAG laser is a technique for endometrial ablation.

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Drs Akosa and Boret comment:

We are grateful to Dr Smith et al for their prompt comment on our short report. This was basically intended to increase awareness among histopathologists of what has become a diagnostic quandary in the absence of adequate clinical information and in view of the increasing use of minimal invasive surgical techniques.

We noted in our report that the abnor-
malities in the endometrium were either complete or focal, the latter the cause of subsequent bleeding. The residual endo-
metrium, although not stated in our report, was not confined only to the cornu as in the case referred to in the paper by Baggish and Baltoyyannis. If one assumes that in every case of endometrial ablation the entire endometrium is destroyed, the hypothesis of inspreading may be acceptable: in our experi-
ence this is not always the case.

Endometrial resection using laser and endometrial ablation have been and are used interchangeably. Our opening sen-
tence which is now under discussion1 “Transcervical resection of the endo-
metrium is a hysterocscopic method of endo-
metrial ablation”: this is self-explanatory.

Our literature search was confined to 1990 onwards, which explains why the papers by Baggish and Baltoyyannis and Lomano were not cited. As for the paper by Reid et al, we can only assume that at the time of our search it had not been indexed.

We have now read all these papers and they