Figure 2 Case 3: (a) Borderline papillary serous cystadenoma of ovary; (b) papillary structure in inguinal lymph node with psammoma bodies-benign epithelial inclusions.

carcinoma, as emphasised by Fisher *et al.*¹ and that metastasis seemed plausible in this case in view of the extensive primary tumour and lymphatic invasion. In retrospect, the intracapsular location should have led to the exercise of caution. The case also shows the phenomenon of intranodal naevus cells as well as the more commonly recognised intracapsular location.

The second case raises the question of whether lymph nodes in cases of lobular carcinoma of the breast should be screened for metastatic disease using immunocytochemistry. Presence of single cell micrometastases has been shown to have prognostic value.^{2,3} Clearly the routine use of serial sectioning or immunocytochemistry to detect metastatic disease is impractical in ordinary practice but judicious use in individual cases can be very helpful. It is important to recognise that breast carcinomas may be S100 positive⁴ (as in case 1), and a matching of immunocytochemical profile between primary and secondary tumours is essential.

The third case is an example of a long recognised problem beautifully described and illustrated by Ehrmann *et al* and one which can be impossible to resolve on purely morphological grounds.⁵ Immunocytochemical profiles of ovarian carcinoma and epithelial inclusions would be expected to be similar but in this instance tumour positivity for CA125 provided some support for the morphological opinion that the lymph node inclusions were benign. CA125 has proved not to be specific for ovarian carcinoma. Mesothelial cells seem to require inflammatory cytokines for CA125 expression and this expression tends to be apical.⁶

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1 Fisher CJ, Hill S, Millis RR. Benign lymph node inclusions mimicking metastatic carcinoma. *J Clin Pathol* 1994;47:245-7.

2 International (Ludwig) Breast Cancer study

group. Prognostic importance of occult axillary lymph node micrometastases from breast cancer. *Lancet* 1990;335:1565-8.

3 Trojani M, de Mascarel I, Bonichon F, Coindre JM, Delsol G. Micrometastases to axillary lymph nodes from carcinoma of the breast: Detection by immunocytochemistry and prognostic significance. *Br J Cancer* 1987;55:303-6.

4 Dwaraknath S, Lee AKC, Delellis RA, Silverman ML, Frasca L, Wolfe HJ. S100 protein positivity in breast carcinomas. *Hum Pathol* 1987;18:1144-8.

5 Ehrmann RL, Federsneider JM, Knapp RC. Distinguishing lymph node metastases from benign glandular inclusions in low-grade ovarian carcinoma. *Am J Obstet Gynecol* 1980;136:737.

6 Zeilemaker AM, Verbrugh HA, Hoynck van Papendrecht AAGM, Leguit P. CA125 secretion by peritoneal mesothelial cells. *J Clin Pathol* 1994;47:263-5.

Dr Millis *et al* comment:

We are pleased that our paper stimulated Douglas-Jones to present three further cases where immunohistochemistry was helpful in resolving the nature of difficult intranodal lesions. It is interesting to note in his first case that numerous S100 positive cells scattered throughout the lymph node parenchyma were considered to be intranodal naevus cells. The possibility that these cells represent dendrocytes, which are known to stain strongly for S100 (and also, sometimes, but less consistently, for CAM 5.2) should also be considered.

In case 2 small deposits of metastatic lobular carcinoma were detected and, as stated, the presence of micrometastases has been shown in a few studies to be of prognostic value.^{1,2} However, there are many conflicting papers.^{3,4} Furthermore, one of the groups with a positive result¹ has subsequently reported that, in the case of lobular carcinoma, immunohistochemically detected micrometastases are of no relevance.⁵

Case 3 is particularly intriguing and it seems that here the diagnosis was based mainly on morphology. Quite rightly, little

weight was placed on the discrepant staining between the tumour and supposed nodal inclusion. Staining for CA125 can be very heterogeneous.

As emphasised by Douglas-Jones it is always important to use a panel of antibodies to evaluate an immunocytochemical profile when making a differential diagnosis.

- 1 Trojani M, de Mascarel I, Bonichon F, Coindre JM, Delsol G. Micrometastases to axillary lymph nodes from carcinoma of the breast: Detection by immunohistochemistry and prognostic significance. *Br J Cancer* 1987;55:303-6.
- 2 International (Ludwig) Breast Cancer Group. Prognostic importance of occult axillary lymph node micrometastases from breast cancer. *Lancet* 1990;335:1565-8.
- 3 Byrne J, Waldron R, McAviney D, Dervan P. The use of monoclonal antibodies for the histopathological detection of mammary axillary micrometastases. *Eur J Surg Oncol* 1987;13:409-11.
- 4 Galea MH, Athanassiou E, Bell J, Dilks B, Robertson JFR, Elston CW, *et al*. Occult regional lymph node metastases from breast carcinoma: immunohistochemical detection with antibodies CAM 5.2 and NCRC-11. *J Pathol* 1991;165:221-7.
- 5 de Mascarel I, Bonichon F, Coindre JM, Trojani M. Prognostic significance of breast cancer axillary lymph node micrometastases assessed by two special techniques: re-evaluation with longer follow-up. *Br J Cancer* 1992;66:523-7.

Book reviews

If you wish to order, or require further information regarding, the titles reviewed here, please write or telephone the BMJ Bookshop, PO Box 295, London WC1H 9TE Tel: 071 383 6244. Fax: 071 383 6662. Books are supplied post free in the UK and for British Forces Posted Overseas addresses. Overseas customers should add 15% for postage and packing. Payment can be made by cheque in sterling drawn on a UK bank, or by credit card (MasterCard, VISA, or American Express) stating card number, expiry date, and your full name. (The price and availability are occasionally subject to revision by the Publishers.)

Atlas of Medical Parasitology. 3rd edn. Vigar Zaman. (Pp 250; US\$ 120.00.) Singapore University Press (PTE) Ltd. 1992. ISBN 9971-69-161-2.

This atlas contains 520 illustrations, of which 286 are in colour. It is intended as a pictorial companion to standard text books. Layout is clear and consistent. The book is divided into three main sections, each section being subdivided into protozoa, cestodes, trematodes, nematodes, and (sections 2 and 3 only) ectoparasites. Section 1 comprises 23 life cycle drawings in colour, covering some of the important and common parasites. The full page drawings are clear and simple to follow. They are adequately annotated and accompanied by

brief descriptions of geographical distribution, morphology, and life cycle.

Section 2 contains over 250 colour photographs covering a wide range of parasite morphology, pathology (including stained sections), and clinical pictures with captions on the facing page. Although the overall quality of the photographs is excellent, I was disappointed to see a lack of size markers on all but a handful. In the clinical laboratory size is of vital importance for identifying ova and cysts.

The third section contains black and white electron micrographs, radiographs, and other illustrations, separated from the colour section for reasons of economy. This does not detract from the atlas in any way, and indeed some of the scanning electron microscopic images are quite breathtaking. I would, however, like to have seen some indication of size on the photographs.

This atlas has a spacious and orderly feel to it, and I am impressed by the overall quality. Clinical microbiologists, particularly those in training, will find it useful.

AJ HAY

Atlas of Ovarian Tumors. L. Deligdisch, A. Altchek, C.J. Cohen. (Pp 182; £94.) Igaku-Shoin. 1994. ISBN 0-89640-240-1.

This sumptuously produced atlas is subdivided into two main sections with three chapters devoted to "clinical aspects" and seven chapters allocated to "pathology". This strategy may be convenient in a multi-author text, but it has resulted in a clinical section which is pathologically naive and a pathological section impoverished by the paucity of clinicopathological correlation.

The wide-ranging introductory chapter, which covers epidemiology, genetics, molecular biology, early diagnosis, and screening for ovarian cancer, provides a useful overview of the subject, although the emphasis placed on ultrasonography is excessive. The two ensuing chapters, both rather lengthy and repetitive, are devoted to management of ovarian carcinoma and non-epithelial tumours, respectively.

The pathology section comprises four chapters devoted to primary epithelial neoplasms including a whole chapter on the interesting but controversial subject of ovarian intraepithelial neoplasia. Other chapters deal with sex cord-stromal tumours, germ cell tumours, and metastatic tumours. This section is well illustrated with adequate photomicrographs and gross photographs of excellent quality. However, many entities are skimpily and uncritically described with no attempt to evaluate the taxonomic over-enthusiasm displayed by recent authors in this field. On the other hand, many rare but well established entities are not included. An even more serious drawback for a book aimed at the practising histopathologist is the lack of consideration given to possible differential diagnoses.

In conclusion, this new atlas is unlikely to fulfil the need for a comprehensive, authoritative, and up to date reference text on ovarian neoplasms. It cannot be recommended as a bench book for the reporting room.

SM ISMAIL

Notices

Postgraduate course: Current concepts in surgical pathology

November 14-18 1994

Massachusetts General Hospital,
Harvard Medical School

This course is designed for pathologists at resident and practitioner levels. It will provide an in-depth review of diagnostic surgical pathology with emphasis on morphological features, newly recognised entities, and new techniques, presented by the faculty of the Department of Pathology, Massachusetts General Hospital. Instruction will be primarily by lecture, but will also include discussion periods. Each participant will receive a comprehensive course syllabus.

The course has category 1 accreditation for about 35 hours CME credit by the American Medical Association. The fee for the course is \$785.00 (residents and fellows \$575.00).

For further information contact: Department of Continuing Education, Harvard Medical School, 25 Shattuck Street, Boston, MA 02115 USA (Tel: 0101 (617) 432 1525).

Update on Cerebrovascular Pathology

Thursday 8 December 1994 (one-day) to be held at The Royal College of Pathologists, 2 Carlton House Terrace, London SW1Y 5AF.

The meeting is open to members and non-members of the College. Further details and application forms can be obtained from the Scientific Meetings Officer, RCPATH, 2 Carlton House Terrace, London SW1Y 5AF (Tel: 071 930 5862 ext: 24/26).

Cytopathology for histopathologists Northwick Park Hospital

30 January-3 February 1995

This is an intensive course in cytopathology suitable for candidates preparing for the MRCPATH examination in histopathology, and for established histopathologists requiring revision. It is given by the Department of Cellular Pathology, Northwick Park Hospital (Dr Elizabeth A Hudson) and the Department of Cytopathology, St Mary's Hospital Medical School, University of London (Professor Dulcie Coleman).

The programme will consist of lectures, microscopy sessions, and discussions. Topics will include cytopathology of the cervix, urine, the respiratory tract, serous effusions and fine needle aspiration cytology of breast and other sites. The course is limited to 30 participants. The course fee is £300 excluding accommodation.

Applications and enquiries should be made to: Dr Elizabeth Hudson, Department of Cellular Pathology, Northwick Park Hospital, Harrow, Middlesex HA1 3UJ (Tel: 081-869 3312).

Corrections

J Clin Pathol 1994;47:205-8; Tillyer *et al.* The title of the correspondence should read "zinc protoporphyrin assays in patients with α and β thalassaemia trait." The title at present implies that zinc assays were performed which was not the case.

In paragraph 2, the second sentence should read "... not only were the drugs causing substantial interference extremely unlikely in the outpatient and general practice population we studied, ...". Paragraph 3 second sentence should read "... Paul and Brumfitt's is 15 μ mol/mol haem lower."

DR ML TILLYER

Estimation of haemoglobin concentrations using spectrophotometric tests. *J Clin Pathol* 1994;47:681.

The name of the author was given incorrectly as J Larner rather than AJ Larner.

ANDREW J LARNER

J Clin Pathol 1993;46:1116-9. (Darjee R, Gibb AP. Serological Investigation into the association between *Streptococcus bovis* and colonic cancer.) The methods section refers to "NCTC10449 (*Enterococcus faecalis*), but this should read ATCC19433 (*Enterococcus faecalis*). NCTC10449 is in fact the reference number of the type strain of *S mutans*.

AP GIBB

Increased pentane and carbon disulfide in the breath of patients with schizophrenia *J Clin Pathol* 1993;46:861-4. The concentrations of pentane and carbon disulfide were reported incorrectly. All values of pentane should be multiplied $\times 50$; all values of carbon disulfide $\times 0.05$. The statistical analyses and conclusions of the paper are not affected by these corrections.

MICHAEL PHILLIPS

Chu CM, Liaw YF. Coexpression of intercellular adhesion molecules and class I major histocompatibility complex antigens on hepatocyte membrane in chronic viral hepatitis. *J Clin Pathol* 1993;46:1004-8. The correct version of fig 2D is reproduced below.

CHIA-MING CHU