One should not lose sight of the scale of the problem. We only found two cases in 1756 biopsy specimens where the diagnosis of papillary carcinoma led to resection of a thyroid nodule which was the palpable lesion. Any procedure that increases the chance of detecting clinically insignificant lesions—papillary microcarcinomas as well as the benign nodules which were the palpable lesion—should be carefully evaluated before being introduced into routine use. Multiple blind needle biopsies obviously increase the chance of detecting clinically insignificant lesions—papillary microcarcinomas may occur in as many as 34% of adult thyroid nodules.2 If these thyroid nodules were thoroughly examined histologically, it was estimated that about 300 microcarcinomas would have been found.3 The prevalence of thyroid cancer will increase still further with an increasing number of sections studied per gland.3 Not to mention the primary thyroid nodules where fine needle aspiration cytology, serum calcitonin levels or genetic studies helped to yield a diagnosis of an unsuspected medullary microcarcinoma where thyreoidectomy should be advocated.4

Leukaemia immunophenotyping: effect of antibody source and fluorochrome on antigen detection

We read with interest the recent publication by Howard et al5 in which the authors highlight discrepant findings of myeloid antigen expression in cases of childhood acute lymphoblastic leukaemia (ALL). They concluded that the detection of antigens CD13 and/or CD33 may be dependent upon both the commercial source of antibody and the type of fluorochrome used. We wish to add support to their conclusions by reporting results from the United Kingdom National External Quality Assurance Scheme (UK NEQAS) for leucocyte immunophenotyping, in addition to data from our own investigations.

Results from UK NEQAS surveys have frequently shown variability in antigen detection attributable, in part, to the use of different commercial monoclonal antibodies. In survey 95, for example (acute biphenotypic leukaemia), the following mean values for CD13 expression were obtained for each reagent: Becton Dickinson (LeuM7) 15% (n = 15), Dako conjugate 28% (n = 21), Coulter 48-25% (n = 8), Seralab 3% (n = 10), Ortho 0·5% (n = 2), and Serotec 89% (n = 1). In addition, the scheme has consistently shown statistically significant differences between samples analysed with fluorescein isothiocyanate (FITC) and phycoerythrin (PE) conjugated antibodies for the following antigens: CD3, CD5, CD13, CD14, CD19, and CD33. In survey 92, investigating CD13 detection in a case of acute myeloid leukaemia, eight of 13 laboratories using FITC conjugated antibodies obtained values less than 50% (overall mean 58%), of which three were negative results, as defined as less than 20%.2 In contrast, all 12 laboratories using PE conjugated antibodies obtained results greater than 50% (mean 77%). This variation may be as a result of PE having a higher quantum yield than FITC, thus potentially increasing sensitivity.

In a paper devoted to that of Howard and colleagues5 we have recently determined the expression of myeloid antigens in B cell chronic lymphocytic leukaemia (B-CLL). As with childhood ALL such "aberrant myeloid" expression has been reported to be of prognostic significance.3 To confirm these findings we examined 53 cases of B-CLL (stages 0 to IV), using Becton Dickinson PE conjugated anti-CD13 and anti-CD33 (clones L138 and P6-7, respectively), by whole blood lysis and triple colour staining. In 51 cases fewer than 4% of B cells expressed either CD13 or CD33 (6% in two cases) when compared with isotype matched controls. Mean fluorescence staining intensity (MFSI) for both CD13 and CD33 expression did not differ significantly from the negative controls. Previous studies, reporting positive myeloid antigen expression, predominantly used Coulter anti-CD13 (MY7) and anti-CD33 (MY9) thus raising the possibility that these discrepant findings may relate to antibody source. To confirm this hypothesis we re-examined 15 of the B-CLL cases with PE conjugated MY7 (CD13) and MY9 (CD33). Of these, nine expressed the CD33 antigen on 10-18% of the leukaemic B cells, with five cases being regarded as positive (20% expression); results in agreement with previous studies. The MFSI values showed a significant increase when compared with controls (p<0.001). No sample expressed CD13 on 20% of the leukaemic B cells (one had 12%) although the values were significantly raised when compared with those obtained using Becton Dickinson antibodies (p<0.001). We feel, therefore, that antibody source and also the fluorochrome used should be taken into account when comparing reports studying "aberrant" myeloid antigen expression.

Data from UK NEQAS, together with our own studies, fully support the concern raised by Howard and colleagues and raises several important issues. Firstly, which result is right? This question may only be answered if all commercially available reagents are standardized. Secondly, there is considerable consideration when collecting immunophenotypic data in multicentre trials, particularly if meaningful diagnostic and prognostic information is to be obtained. Finally, the development of a newer and more sensitive fluorochrome, coupled with multiparameter technology, will increase the dilemma as to what should be regarded as positive. The simplistic approach using an arbitrary cut off point, as suggested in the recent BSCH guidelines,6 will probably not be applicable in the future. Data analysis procedures which currently employ the placement of a cursor at the boundary of the negative population are likely to be inappropriate. More biologically relevant procedures, such as antigen density quantification using calibrated flow cytometers, may yield more meaningful data.6 Finally, despite the experience of a number of quality control schemes worldwide, there is no consensus as to the best antibody within a CD group for diagnostic use. Such evaluations would require the production of reference materials for which this is of great practical importance. Research in this area is currently under way,7 although the technical difficulties must not be underestimated.

Recurrent thrombotic occlusions of arteries and veins caused by intravascular metastatic adenocarcinoma

I refer to the case reported by Levi et al of a young woman with recurrent vascular occlusions found at necropsy to be caused by microscopic metastatic adenocarcinoma. They rightly suspected the presence of malignant disease during life, but despite wide-ranging invasive, radiological and laboratory investigations were unable to confirm their clinical suspicion. In their last sentence, the authors speculate that cytological examination of the blood using specific markers for malignant cells, might have detected the adenocarcinoma cells; this may have been so, but I wonder if they performed bone marrow trephine biopsy as it is not mentioned in their paper. Certainly, it is a worthwhile investigation in the type of case reported by Levi et al if performed might have resulted...