be restricted to hepatocytes in both normal and diseased liver. By immunohistochemistry, no consistent abnormalities in androgen receptor expression were observed in non-neoplastic chronic liver diseases. Interestingly, androgen receptor expression was observed in a significantly greater proportion of women.

Recently Negro et al. developed a non-radioisotopic in situ hybridisation assay specific for the human androgen receptor mRNA. Although no normal liver was examined, androgen receptor mRNA was detected in eight (42%) of 19 non-neoplastic liver specimens, a similar proportion to that found in this study. Androgen receptor mRNA was similarly restricted to hepatocytes, although the proportion of reactive hepatocytes found was noticeably less than in the present study and was never more than 10%. This difference most probably reflects a difference in sensitivity of the two techniques. Indeed, in a test set of frozen sections from five hepatocellular carcinomas (HCCs) stained with a different androgen receptor monoclonal antibody, Negro et al. were able to demonstrate androgen receptor protein in only one case, which also expressed androgen receptor mRNA. Two HCCs, strongly positive for the androgen receptor mRNA, were negative by immunohistochemistry and in the remaining two cases, neither androgen receptor protein nor its mRNA could be detected.

Several clinical and experimental observations suggest that drugs which inhibit the activity of sex steroids may control the growth and invasiveness of HCCs in selected patients. However, results of pilot clinical trials have been disappointing so far. One explanation for this may be the lack of accurate evaluation of hormonal status prior to any such treatment.

The present study has shown the potential of immunohistochemical techniques to demonstrate androgen receptor in liver tissue. We believe that further studies of androgen receptor expression in premalignant lesions, such as small cell dysplasia and atypical macro-regenerative nodules, and in hepatocellular carcinoma are now warranted.

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**AFP production by a hepatoid adenocarcinoma of the uterus**

Microscopic findings: a major medullary portion (A) and a minor tubular portion (B).

The uterus was diffusely enlarged by the extensive tumour invasion into the myometrium and the uterine cavity was filled with a necrotic, haemorrhagic mass. An extensive tumour embolus formation was seen in the right para-ovarian area.

Microscopically, the tumour was composed of a major medullary portion and a minor tubular adenocarcinoma which had invaded the myometrium, the myometrial lymphatics and blood vessels. Neoplastic cells in the medullary portion were polygonal with glycogen-rich cytoplasm. Vascular permeation by neoplastic cells was prominent. Extensive hepatoma-like features were observed (fig 1).

AFP expression was detected immunohistochemically in all endometrial adenocarcinoma cells and was particularly strong in the hepatoma-like cells. Formalin fixed, paraffin wax embedded tumour sections were stained by the peroxidase-antiperoxidase (PAP) method using rabbit antiserum directed against AFP, and rabbit antiserum and mouse monoclonal antibody directed against human carcino-embryonic antigen (CEA). Tumour cell cytoplasm was AFP positive (fig 2). In the hepatoma-like cells complex canalicular structures were seen which reacted with the polyclonal (but not the monoclonal) antibody directed against CEA. The necropsy revealed a widespread metastatic proliferation in the lungs.

**Case report**

A 62 year old Japanese woman was admitted to hospital in October 1993 with abnormal vaginal bleeding of one month’s duration. Her medical history included one spontaneous abortion and four full-term pregnancies. She had experienced menopause at the age of 48 years. On pelvic examination the uterus was enlarged but no adnexal masses were palpable. Biopsies of the endometrium were carried out and the histological diagnosis revealed poorly differentiated adenocarcinoma. A liver computed tomography scan was normal but a few metastatic nodules were found on a chest radiograph. Her serum AFP concentration was raised at 280-3 µg/ml. The patient underwent a total abdominal hysterectomy, bilateral salpingo-oophorectomy and liver biopsy in November 1993. On the sixth day after surgery, the patient's serum AFP concentration had fallen to 66-9 µg/ml. A course of combination chemotherapy was instituted 10 days after surgery, comprising intravenous cyclophosphamide (400 mg/m²/day) and doxorubicin hydrochloride (40 mg/m²/day) on day 1 and cisplatin (10 mg/m²/day) for seven consecutive days. This regimen was repeated every three weeks. While on chemotherapy the size and number of lung metastases increased as did her serum AFP concentration (to 935-0 µg/ml by the end of January 1994). The patient died on 15 February 1994. A complete necropsy was carried out.

**PATHOLOGY**

To our knowledge only seven AFP producing endometrial tumours have been reported in the literature, four of which were EST at extra-gonadal sites.1-4 Ohira et al5 suggested that these tumours might have derived from fetal cells remaining after spontaneous abortion. Other authors6-9 suggested that the germ cells from which the EST originated had erroneously mi-
Anti-GMI antibodies in polyneuropathies of unknown origin

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Abstract
This study was undertaken to determine whether anti-GMI titres are raised in polyneuropathies of unknown origin and whether determination of these titres is useful for diagnosing these conditions. The study population comprised 20 controls (aged 36–88 years), 12 patients with polyneuropathies of unknown origin (aged 31–81 years) and 15 patients with polyneuropathies of unknown origin (aged 40–77 years). Antibody levels were measured using a commercial GMI enzyme linked immunosorbent assay kit (Buehllman Laboratories). Mean anti-GMI IgG and IgM antibody titres were not raised in patients with polyneuropathies of unknown origin. Anti-GMI IgG antibody titres were raised in one and GMI IgM antibody titres in none of the patients with polyneuropathies of unknown origin. In conclusion, GMI antibody levels are rarely raised in polyneuropathies of unknown origin and probably play a minor role in the pathogenesis of these conditions. (J Clin Pathol 1996;49:422–425)

Keywords: ganglioside antibodies, polyneuropathies, motor neuron disease, neuroimmunology.