Correspondence

Macroscopic examination of prostate specimens

Continuing the debate between Drs Furness, Harnden and Parkinson,1 the philosophy behind examining all of the resected material from a TURP in a man under 60 years of age and extensively sampling specimens from older patients is twofold:

(1) To detect a carcinoma confined to the prostate in a patient young enough to benefit from a radical prostatectomy or radical radiotherapy.

(2) To detect carcinoma in older patients, who are not candidates for radical therapy, so that we don't look silly when they present symptomatically from their carcinoma shortly after their TURP.

The majority (70%) of prostatic carcinomas arise in the peripheral zone. Prostatic hyperplasia affects the transitional zone and periurethral tissue. TURP specimens consist of tissue from the transitional zone, urethra, periurethral area, bladder neck, and anterior fibromuscular stroma. TURP specimens do not usually contain material from the central or peripheral zones.

If the objective is to detect operable prostate cancer in "young" symptomatotic patients, I would suggest that the general practitioner be instructed to take a blood sample for estimation of the free-bound serum PSA ratio. The urologist in receipt of the result when seeing the patient in clinic can then perform a rectal ultrasound scan and biopsy. If carcinoma is confirmed and computed tomography scanning suggests disease confined to the prostate, the patient can proceed to radical prostatectomy.

If the PSA suggests carcinoma, but the biopsy specimens are negative, the pathologist can be alerted on the request form accompanying the TURP specimen and process all the material, as this may be one of the 30% of prostatic carcinomas that arise within the transitional zone. If there is no suggestion of carcinoma, the specimen can be processed as for specimens from older patients.

If the objective is not to look silly when missing extensive prostate cancer in TURP specimens, I would suggest examining half of any specimen regardless of its size. It does not make sense to examine larger specimens less thoroughly than small specimens. If a TURP specimen contains three carcinomatous chips, examination of 55% of the specimen gives a 90% probability of detecting one carcinomatous chip.1 Having detected one carcinomatous chip, the rest of the specimen can be processed, if this is going to generate any information that will alter the patient's management.

Before drawing up a sampling protocol it is necessary to know the treatment protocols of your local surgeon and oncologist. If they are seriously looking for T1 and T2 carcinomas in symptomatic patients, it would seem more productive to process with PSA measurements and biopsy than for pathologists to pore endlessly over trays of slides from TURPs which contain fibromuscular stroma, bladder neck tissue and periurethral tissue.

Assessment of renal biopsy specimens

We would like to make a few small comments on the paper by Furness and Boyd.1 We recently presented our experience in Preston with both immunofluorescence and immunoperoxidase techniques on renal biopsy specimens.2 Our results supported immunoperoxidase as the routine method for detection of immune complexes, with the caveat that immunofluorescence should also be used for cases of acute renal failure as demonstration of linear IgG by immunofluorescence in our hands is unreliable.

Assessment of renal biopsy specimens


Drs Harnden and Parkinson comment:
We thank Dr Fuller for her interest in our article. We were purposely not didactic in discussing the handling of TURP specimens. An approach was suggested but many justifiable alternatives exist. It is important that sampling policy is defined and agreed between pathologists and urologists, taking into account local practice. Dr Fuller states that TURP specimens do not usually sample the central or peripheral zone, but in our experience this is not always the case. It is not uncommon to see adipsis tissue and seminal vesicles in these specimens, which must imply that the peripheral zone has been sampled. An asymmetrical cavity involving the peripheral zone post-TURP is seen on transrectal ultrasound, in radical specimens and at postmortem examination. This technique will preferentially sample the periurethral areas, we suspect that the actual areas sampled will depend on the size of the prostate, patient tolerance and the surgical technique adopted. Some surgeons may simply remove enough tissue to relieve obstruction, whereas others may resect or much as possible to prevent "re-growth". In one of our practices (PH), the smaller specimens generally come from small areas and fragments of the peripheral zone are often present, hence the policy of processing all the tissue.

The ratio of alpha-1-antichymotrypsin bound PSA to free PSA does seem to offer promise in the clearer distinction between patients with carcinoma versus hyperplasia,1 but we await the prospective evaluation of this ratio. It has been suggested that the free-total PSA ratio be used to detect prostate carcinomas in the PSA range below 4.0 ng/ml but the best threshold remains to be established.1 Therefore reliance on this test to dictate complete processing of TURP specimens in men under 60 years of age may not be justified at present.

We note that Dr Fuller agrees with our view that sampling protocols critically depend on local practice and treatment policies. There is a lively debate concerning the most "efficient" or cost effective method of detecting and treating prostatic carcinoma and we await with interest the results of ongoing trials.

Microbiology user satisfaction survey

We were pleased to read the study carried out by Dr Morgan to ascertain the views of their laboratory users in Exeter. We performed an almost identical survey in May 1995. A carefully designed user-friendly questionnaire was administered to all the junior medical staff in our hospital who were members of clinical teams that use our services regularly. Staff in specialties that used our services infrequently, such as anaesthetics, radiology, psychiatry, and biochemistry, were not included. In total, 120 questionnaires were sent out. As in Dr Morgan’s study, our questionnaire sought views on turnaround times, quality of reports, accessibility to and quality of microbiological consultations during normal working hours and “on-call”, present and past, and user satisfaction with the service and lastly, the infection control service. Completed questionnaires were made anonymous to ensure genuine replies. The response rate was 54% and nearly all the questionnaires were suitable for analysis.

It was rewarding that the overall appreciation of the quality of microbiology laboratory services offered was good. This included the majority of staff being more than satisfied with the accessibility to and quality of consultations (81% and 87%, respectively), turnaround times for results (77%), the comprehensiveness of technical results (86%), and amount and quality of clinical guidance/interpretation (79% and 84%, respectively) contained in our laboratory reports. Both access to authorised results and the facility for requesting investigations via ward-based computer terminals (in that order of priority) were identified as areas for further development. A hospital-wide development of information technology has been in progress and will fulfil those needs in the very near future. It was important to be reminded that our constant clinical profile at ward level is much valued. The infection control service received a satisfactory score from the majority of its users.

We believe that this survey was a useful exercise in allowing us to establish a baseline from which changes can be made. It has enabled us to examine user needs closely, identify areas of work that are performed well, plan ahead to improve specific aspects of the service, and reassess our position in the near future. In the present market orientated health service environment, the beneficial effects of positive feedback on all laboratory staff from such a study in terms of boosting morale and encouragement should not be underestimated. Also, re-auditing after a period of time and implementing changes is very important if the full benefits from this exercise are to be enjoyed. We would recommend this practice to other laboratories.

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Dr Morgan comments:
I was glad to find that Drs Lee and Holliman found similar results in the audit that they did of the views of hospital doctors, and that microbiologists with a high clinical profile are in demand from clinicians. Despite being extremely active clinically at Exeter I was most surprised that even more clinical involvement was requested, a demand that resulted immediately in a microbiologist attending five designated ward rounds in three additional specialties per week.

The extra dimensions of quality that results from the 24 hour input of a medical microbiologist on site were regarded as essential by our customers. We are now capitalising upon this in competition with the private sector for our fund holding contracts.

Unlike Drs Lee and Holliman, however, I found that the fact that only 8.5% of respondents chose to remain anonymous was particularly helpful, allowing me to discuss controversial points raised directly and clear up some fundamental misconceptions. An example of the latter was the apparent omission of the laboratory to report locoten and sofradex sensitivities in isolates from ear swabs.

Infection control issues were addressed in my survey too and the survey was similarly highly rated by both hospital doctors and general practitioners.

Finally, as Drs Lee and Holliman noted, completion of the audit loop after improvements have been carried out is essential. Indeed, a follow up audit is in progress with an 83% response rate to date. A preliminary analysis shows the quality of service has indeed been recognised as “improved” by 89% of the respondents to date. Two, who felt that there was “no improvement”, had actually given us a score of 10 out of 10 (“could not be better”).

Such wonderfully positive feedback from customers can boost staff morale considerably and leaders do so.

Book reviews

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MCQ’s enable knowledge of a wide range of topics to be assessed consistently and rapidly. Many collections of MCQ’s have been published but those dealing with pathology usually cover only one of its disciplines. A valuable feature of this book, the authors of which are all connected with the Newcastle Medical School, is that it embraces topics from all the major pathology specialties.

This book should enable undergraduates to identify gaps in their knowledge and understanding of pathology, and to obtain practice at responding to MCQ’s. Being clinically orientated, it could also be useful to postgraduate students studying for the MRCP and FRCS. The first 76 pages contain 300 questions, each consisting of a stem and four possible answers of which are either true or false. They are arranged in groups of 75 in sections devoted to medical microbiology, histopathology, clinical biochemistry, and haematology. Virology questions are included in the microbiology section and are followed with clinical photographs, x-ray films, photomicrographs, electron microcopy, and plates. There are many excellent photographs, notably the photo- and electron micrographs. The illustrations of agar plates and microbiology marks that have not been removed prior to photography and this detracts from the overall impression of the book.

The problem orientated approach will appeal in the light of the changes occurring in...