Correspondence

Phraseology in quality assurance reports

The study by Attanoos *et al*[1] highlights a problem that we have considered for many months. We represent the three Toxoplasma Reference Laboratories for the UK and produce the teaching sheets for the UK National External Quality Assurance Scheme (UK NEQAS) for toxoplasma serology. However, it has become apparent that the phraseology used by each laboratory is different, often being influenced by local factors and experience. For example, one laboratory feels that as "infection" may be asymptomatic and does not equate with "disease", the term "exposure to infection" may be preferred. Although many people may be "exposed" to infection, not all will become infected; therefore, it can be argued that such phraseology does not convey current disease to the physician. The objective is to ensure good communication to the user, but this may result in ambiguity if literal interpretation is applied.[2]

Our problem was similar to that of Attanoos *et al* in that the interpretation of results does depend on good clinical information. Whilst in UK NEQAS it is possible to provide such information, in clinical practice it is often lacking; phraseology needs to be robust enough to apply to both situations. Furthermore, with UK NEQAS, the end-users are microbiologists who should have common phraseology, and therefore it would be undesirable to establish a UK NEQAS phraseology that is very different to that which is in current usage by other medical practitioners. In addition, there is a risk of reinterpretation of results generated in Reference Laboratories before dispatch to a third party—for example, clinicians or general practitioners.

We accept that our users prefer definitive statements such as "diagnostic of", but recognise that some may not appreciate the difference between "latent, past" and "current, active" infection. Both these latter terms are consistent with "diagnostic of toxoplasma infection". In order to be more helpful, a two-stage report has been developed: the first part states whether toxoplasma infection has occurred or not, while the second relates to the likelihood of toxoplasma infection being significantly associated with the current clinical condition.

Attanoos *et al* rightly emphasise the legal aspects of reports and that good communication between user and pathologist is important for the best interpretation of the results. Communication is often informal and may be easier in a smaller hospital rather than in a larger one or where off-site laboratories are used. Many laboratories that use UK NEQAS are unduly preoccupied with achieving the correct result and their resultant "score" rather than the significance/interpretation of a result in a clinical context. UK NEQAS can perhaps attempt to remedy this by encouraging uniformity in phraseology, hence aiding interpretation. One way forward may be to adopt wording which reflects the degree of certainty, similar to that used in the National Breast Screening Programme.[3] Thus, at the end of the report, there could be a scale (albeit arbitrary), perhaps from 1 to 5, of probability of disease due to toxoplasma infection, where 5 = diagnostic, 4 = significant, 3 = suggestive, 2 = unlikely, and 1 = very unlikely. For all reports, however, clarity and unambiguity must be the objectives.

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1 Attanoos RL, Bull AD, Douglas-Jones AG, Aigelstone LJ, Semararo D. Phraseology in pathology reports. A comparative study of the interpretation among pathologists and surgeons. *J Clin Pathol* 1996;**49**:79–81.
2 Editorial. English as she is wrote. *Lancet* 1996; **346**:1045.
3 Department of Health and Royal College of Pathologists Working Group. Pathology Reporting in Breast Cancer Screening Draft Guidelines. London: Royal College of Pathologists, 1989.

Dr Attanoos comments:

I thank Drs Ho-Yen, Holliman and Joynson for their constructive comments relating to our earlier paper. I was interested to read the problems of phraseology in a different pathological discipline. The authors highlight the ambiguities of variable phraseology in relation to toxoplasma infection and have advocated a possible scoring system similar to that used in the National Breast Screening Programme. As we highlighted in our paper, such a system has too many limitations for use in the reporting of histological specimens. Variation in specimen preparation, specimen size, as well as the morphological features expressed, and the experience of the pathologist are all factors that can produce variations in report phraseology. The confidence to produce the ideal, definitive report for clinicians may be decreasing as many pathologists are now wary of litigation. There seems to be no simple means of reducing ambiguity in reporting without reducing the number of terms used. Unfortunately, this will restrict free text style reporting and may introduce further semantic complications. Computer generated template reports may offer some help for the future.

Phraseology in quality assurance reports

The report by Attanoos *et al*[1] was a useful survey highlighting actual and potential communication problems between pathologists and surgeons.

I would take issue with one point. The authors state that "characteristic of" is a "...semantically definitive term which should only be used to communicate total certainty in diagnosis". This is incorrect. A biopsy specimen of an inflammatory dermatosis—for example, can be characteristic of a given clinico-pathological entity without being in any way specific to that entity. I was surprised that 11 pathologists thought that the words "characteristic of" did imply total certainty in diagnosis.

In my own practice I quite commonly use a form of words such as "characteristic of but in no way specific for" to describe appearances in situations such as inflammatory dermatoses where I wish to convey the meaning that the microscopic appearance is what is found in the majority of biopsy specimens of a given condition, but that the same appearance can also be seen in a minority of cases of other conditions.

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1 Attanoos RL, Bull AD, Douglas-Jones AG, Aigelstone LJ, Semararo D. Phraseology in pathology reports. A comparative study of the interpretation among pathologists and surgeons. *J Clin Pathol* 1996;**49**:79–81.

Dr Attanoos comments:

We thank Dr Simpson for his interest in our recent article. In the Methods section of our paper, we clearly state that the designation of phraseological terms to either a "definitive" or "non-definitive" category was established by use of the concise Oxford Dictionary of Current English. It would seem, therefore, that Dr Simpson's definitions are at variance with those of the aforementioned dictionary. In response to one point, we believe that the sentence "characteristic of but in no way specific for" could be misleading and that the phrase "not specific for but consistent with" would be less ambiguous as there is no confusion of definitive and non-definitive terms within the same sentence.

βhCG as a prognostic marker in prostatic adenocarcinoma

I was interested by the recent paper from Sheaff *et al* on βhCG staining in adenocarcinoma of the prostate.[1] However, I was worried by the lack of support provided in the paper for one of the main points made—that is, that staining for βhCG identifies a group of patients with poor prognosis irrespective of histological grade. This assertion is made twice in the Abstract, it is repeated in the Results and in the Discussion and is crucial to the thrust of the paper. Yet, it seems to be based on a χ^2 test of just 12 positive cases, with a p value of 0.13. We are given no information on the distribution of Gleason grading within this group. If, as the literature would lead us to expect, the majority of prostatic adenocarcinomas are poorly differentiated, one is led to question the power of such a test with such a small group. Do the authors really have grounds to say "there was no correlation between Gleason score and prognosis in this group of patients"? On the data given, this looks like a misuse of conventional 5% confidence limits for rejecting the null hypothesis; in fact, they seems to have grounds for saying there is a correlation, but only if one accepts a p = 0.13 confidence. Surely, they should have said that by this approach a correlation could not be proven—a very different statement to an assertion that a correlation does not exist. Better still would be to test whether βhCG