

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.

D O HO-YEN

Scottish Toxoplasma Reference Laboratory,
Raigmore Hospital NHS Trust,
Inverness IV2 3UJ

R E HOLLIMAN

PHLS Toxoplasma Reference Unit,
St George's Hospital,
London SW17 0QT

D H M JOYNSON

PHLS Toxoplasma Reference Unit,
Singleton Hospital,
Swansea SA2 8QA

- 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.

C G B SIMPSON

Bronglais General Hospital,
Aberystwyth,
Dyfed SY23 1ER

- 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 seem 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

staining had prognostic significance that was independent of Gleason grade, using all the cases studied.

PETER FURNESS
Department of Pathology,
Leicester General Hospital NHS Trust,
Gwendolen Road,
Leicester LE5 4PW

1 Sheaff MT, Martin JE, Badenoch DF, Baithun SI. β hCG as a prognostic marker in adenocarcinoma of the prostate. *J Clin Pathol* 1996; 49:329-32.

Drs Sheaff, Martin and Baithun comment:

We appreciate the interest shown by Dr Furness in our paper. We feel, however, that table 1 may resolve any misunderstandings that may have arisen with regard to Gleason scoring/grading, β hCG expression and prognosis. In fact table 1 clearly states the distribution of Gleason grade allocations within the β hCG positive group, and it is evident that despite small numbers of cases, even the better differentiated groups had poor clinical outcome and not all metastases or deaths that occurred in this study were in the high grade group. We did perform statistics on the 80 patients as a whole (data not originally presented) and found that β hCG expression and prognosis were closely linked ($p < 0.002$). This supports our statement, namely that β hCG expression identifies a group of patients with poor prognosis irrespective of histological grade. This does not mean that β hCG expression is entirely independent of histological grading (Gleason grading in particular) or that the latter is not clinically useful, but simply suggests that β hCG expression may give valuable additional information when assessing treatment options with regard to further management.

Current guidelines for sampling the cervix in hysterectomy specimens are appropriate

Guidelines for sampling the cervix in a hysterectomy specimen removed for non-malignant conditions recommend two midline blocks, one taken from the anterior lip and another from the posterior lip.¹⁻³ The purpose of examining these random histological sections is to detect previously unsuspected cervical intraepithelial neoplasia (CIN). In a study examining 100 cervical cone biopsy specimens, taken as part of treatment of CIN, Heatley identified CIN at either the anterior or posterior midline positions (12 and 6 o'clock) in 94% of cases, with a higher grade of CIN and at a higher frequency than from lateral aspects.⁴

In contrast to Heatley, we assessed the guidelines by examining actual hysterectomy specimens. The hysterectomies had been performed for non-malignant conditions at two centres between February and November 1995. Cervical cytology screening was routine (at two yearly intervals, or more frequently as required) at the Adelaide Women's and Children's Hospital (WCH) but was not at the Universiti Kebangsaan Malaysia (UKM), Kuala Lumpur. Blocks of the cervix were taken from the 12, 3, 6, and 9 o'clock positions. We identified CIN in one of 72 cases from WCH and three of 40 cases from UKM. CIN was high grade in three cases and low grade in one and was found in the anterior or posterior blocks exclusively in three

cases or in either midline block with involvement in a lateral block in one case, but none was found in a lateral block exclusively.

Our study was discontinued at this point as these results verify the findings of Heatley and the current guidelines for sampling of the cervix in hysterectomy specimens.

M M MAYERS
T Y KHONG
Department of Histopathology,
Women's and Children's Hospital,
North Adelaide 5006, Australia

H ABDUL RAHMAN
Department of Pathology,
Universiti Kebangsaan Malaysia,
Kuala Lumpur, Malaysia

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- Robboy SJ, Kraus FT, Kurman RJ. Gross description, processing and reporting of gynecologic and obstetric specimens. In: Kurman RJ, ed. *Blaustein's pathology of the female genital tract*. 3rd edn. Berlin: Springer Verlag, 1987:925-40.
- Scurry J, Patel K, Wells M. ACP Broadsheet 138: Gross examination of uterine specimens. *J Clin Pathol* 1993;46:388-93.
- Heatley M. Distribution of cervical intraepithelial neoplasia: are hysterectomy specimens sampled appropriately? *J Clin Pathol* 1995;48:323-4.

Dr Heatley comments:

Drs Mayers, Rahman and Khong are to be congratulated for undertaking this study, in two centres in presumably different populations, which confirms the validity of sampling the uterine cervix at the 6 and 12 o'clock positions in hysterectomy specimens. Their results also highlight the continued validity of cervical screening given the lower incidence of CIN lesions in the screened compared with the unscreened population.

Specificity of plasma cell antibody VS38

In their paper on VS38 staining in melanocytic lesions, Shanks and Banerjee¹ mention positive staining in a single case of clear cell sarcoma of soft tissue. We have also noted positivity in a wide range of melanocytic lesions with this antibody and have noted strong positivity in a further case of clear cell sarcoma occurring in the vicinity of the ankle joint.

This latter finding is not unexpected as these tumours are regarded as soft part melanomas. However, the situation may be different with other antibodies showing unexpected positivity in malignant melanoma. Although the KP-1 antibody also stains many melanomas, we were previously unable to demonstrate corresponding positivity in any of seven clear cell sarcomas.²

We have also noted striking positivity with VS38 in benign schwannoma and would certainly agree that, as with KP-1, VS38 is best used as part of an antibody panel.

K AL-JANABI
M CASSIDY
Department of Histopathology,
Huddersfield Royal Infirmary,
Huddersfield HD3 3EA

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Confidentially, death and the doctor

The recent article by James and Leadbeatter¹ raises issues which extend beyond the narrowly medical.

The Tasmanian Court of Appeal in "Pawsey" held by majority that a patient ceases to be a patient at the moment of death. Although this is a Commonwealth case and arose out of Australian Health Insurance Legislation, the Court did not specifically limit its views of the patient/death issue to the context of that legislation.

Despite views to the contrary, and indeed UK legislation, "Pawsey" may provide a nice point for further argument. In any event, the trial judge's reasons and those of the appeal judges make for a very stimulating read.

J M N HILTON
Director,
NSW Institute of Forensic Medicine,
42-50 Parramatta Road,
PO Box 90,
Glebe, NSW 2037,
Australia

- James DS, Leadbeatter S. Confidentially, death and the doctor. *J Clin Pathol* 1996;49:1-4.

Peritoneal involvement by rectal cancer

Several points emerge from the paper by Shepherd *et al*¹ which deserve comment. The first is the observation that the staging system described by Astler-Coller² and the Australian Clinico-Pathological Staging (ACPS) system³ suffer because of their sequential nature as they do not address the possible prognostic influence of local spread beyond the bowel wall in cases where there is lymph node involvement. This is not strictly correct. The most significant contribution made by the Astler-Coller system was to emphasise the importance of direct spread of tumour in cases with lymph node metastases by subclassifying them into stages C1 and C2 according to the presence of spread beyond the muscularis propria. Furthermore, when tumour is demonstrated histologically in a surgical line of resection (in practice almost always the circumferential line) the ACPS system classifies the tumour as stage D irrespective of the lymph node status. Thus, local spread may displace lymph node metastases as a determinant of stage in this system.

The second point is that the authors state that there has been little attention to the prognostic importance of peritoneal involvement in colorectal cancer. In the clinico-pathological staging system used in the on-going prospective study of colorectal cancer at Concord Hospital, which began in 1971, provision is made for separately classifying stage B tumours in which there is direct spread to involve a free serosal surface.⁴ Our experience has been that this substage includes only a small proportion of stage B tumours (6%) but is associated with a significantly poorer survival. In a subsequent analysis on patients with stage C tumours, free serosal surface involvement emerged not only as a comparatively common finding (17%)