Correspondence

Childhood non-Hodgkin's lymphomas in the United Kingdom

In their recent article on childhood non-Hodgkin's lymphomas, Wright *et al*[1] rightly highlight an area of confusion that affects many paediatric oncologists, and some pathologists and haematologists. Within the non-Hodgkin's lymphomas they suggest that there is a need for classification systems to make a clear distinction between Burkitt's and "B lymphoblastic" lymphomas. Even haematologists, let alone clinicians, can be confused by the latter term. When most haematologists use the term "B cell" to describe leukaemia they imply surface immunoglobulin expression, not merely the presence of CD19, 20, and 79a. In other words, B cell acute lymphoblastic leukaemia (ALL), (rather than B cell lymphoblastic lymphoma as suggested in the discussion), the disease we call "ALL-L3", is defined, together with the cytological features and cytogenetic abnormalities, by the presence of strongly expressed, clonal surface membrane immunoglobulin.

I suggest two steps that could be remove some of this confusion. First, the REAL classification[2] recognises an entity "precursor B lymphoblastic lymphoma"; the cell involved is as indistinguishable from that of precursor B-ALL as is that of precursor T lymphoblastic lymphoma from precursor T-ALL, but clearly different from the cell of Burkitt's lymphoma. So an appropriate classification already exists—we should now use it. Second, widespread adoption of formal investigations by flow cytometry of suspensions of disaggregated lymphoma cells for the presence or absence of surface immunoglobulin would allow use of the term "B cell" to have the same meaning to histopathologists, haematologists, and paediatric oncologists. The REAL classification points this out. Such a practice would also allow use of an expanded panel of highly informative antibodies that approached what is now routine in the diagnosis of ALL.

The relatively small and cohesive group of pathologists, haematologists, and clinicians involved in diagnosing, staging, and treating childhood lymphoma would seem an ideal group to grasp this nettle, turn over a new leaf, and reduce the risk of camouflaging quite distinct and eminently recognisable forms of non-Hodgkin's lymphoma. Our example might even have an impact on adult practice.

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1 Wright DH, McKeever P. Carter R. Childhood non-Hodgkin's lymphomas in the United Kingdom: findings in the UK Children's Cancer Study Group. *J Clin Pathol* 1997;**50**:128–34.
2 Harris NL, Jaffe ES, Stein H. Banks PM, Chan JKC, Cleary ML, *et al*. A revised European–American classification of lymphoid neoplasms: a proposal from the International Lymphoma Study Group. *Blood* 1994;**84**: 1361–92.

Alanine aminotransferase assay to detect anti-HCV positive subjects in non-selected populations

Screening of asymptomatic subjects at high risk for hepatitis C has been debated recently.[1,2] The questionable point is how to screen people. A study from north east England has shown that only 13 (12.5%) of 104 patients positive for hepatitis C virus infection had abnormally high serum alanine aminotransferase (ALT) concentrations.[3] In the past few months, our group performed a seroepidemiological survey in a non-selected population from an urban area in southern Italy. Fourteen hundred subjects were recruited among the list of residents using a systematic simple random sampling procedure and 1352 (96.6%) accepted to enter into the study. The overall prevalence of anti-HCV enzyme immunoassay positive (RIBA confirmed) was 12.6% (170 of 1352). Hepatitis C virus RNA has been detected by polymerase chain reaction in 144 of the 170 (84.7%) RIBA confirmed anti-HCV positive subjects. ALT serum concentrations were above the reference value (≤ 40 UI/L) only in seven of the 170 (4.1%) anti-HCV positive subjects. These data provide further evidence that ALT serum assay cannot be considered a useful screening test to detect anti-HCV positive subjects in a non-selected population. ALT assay, although rapid and inexpensive, could miss a number of anti-HCV infected patients.

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1 Seymour CA. Screening asymptomatic people at high risk for hepatitis C. The case for. *BMJ* 1996;**312**:1347–8.
2 Allison MC, Mills PR. Screening asymptomatic people at high risk for hepatitis C. The case against. *BMJ* 1996;**312**:1349–50.
3 Watson JP, Brind AM, Chapman CE, Bates CL, Gould FK, Johnson JJ, *et al*. Hepatitis C virus: epidemiology and genotypes in the North East England. *Gut* 1996;**38**:269–76.

Book reviews

Understanding Accreditation in Laboratory Medicine. Burnett D. ACB Publications Committee. 1996. ISBN 0 9024 2920 5.

It is my impression that, at the outset, the concept of laboratory accreditation in the United Kingdom was given a mixed reception, partly regarded as a potentially bureaucratic nightmare, involving a great deal of work and offering questionable benefits. However, talking to laboratory professionals who have embraced and achieved accreditation for their laboratory, one hears a very different story—and not merely because of the success of achieving accreditation. I am sure this change reflects initial ignorance, which has been replaced by an understanding and appreciation of the benefits of accreditation. This book, written by David Burnett, one of the leaders in the development of laboratory medicine accreditation, provides a valuable guide to the principles and practice of accreditation that should dispel the ignorance. In fact, it provides a great deal more in that it sets out the guiding principles of good laboratory management.

In his preface, the author explains that the documentation that illustrates points made in the book comes from a fictional laboratory as having "a clarity of structure beyond belief"; perhaps this is a modest and polite statement reflecting on what the author believes should exist, but has never found! However, it is clear that the subject has been well researched, with evidence produced from relevant sources worldwide, distilled in the light of the author's obvious practical experience to provide a benchmark for good laboratory practice. The book is therefore of value, not only for the laboratory professional embarking on achieving accreditation, but also for the professional aspiring to a managerial position.

After an introduction to accreditation providing a valuable glossary of terms, the bulk of the book is set out in a style that leads the reader through preparation for accreditation. Thus, there are chapters that set out the standard of performance required of an organisation competent to deliver a service. While much of the discussion is about documentation, the author makes it clear that it is not the documentation per se that will ensure accreditation, but the correct use of the procedures described in the documentation; there is little point in having a standard operating procedure if nobody uses it. This is why, in my view, the book is a useful guide to laboratory management rather than simply a "manual for getting accredited". In places, the style in the book can be quite provocative, and I appreciate the fact that the author has not led the reader through what to do to gain accreditation. Thus the sequence of chapters follows logically through policies and procedures in relation to organisation and management, staffing, facilities and equipment, health and safety, operating process activities, quality assurance, and evaluation. The final chapter deals with the process of the inspection itself, giving some valuable tips to those about to be inspected.

The book is extremely well referenced with relevant official documentation vital for any laboratory director or manager to be aware of. Furthermore, the text is well illustrated with useful examples of documentation. Thus while the book might be perceived, and indeed to a degree could be used, as a manual for accreditation, that would detract from its true worth. This is a book that every laboratory professional aspiring to any managerial position should read; it provides valuable guidance and stimulus to an aspect of good laboratory practice where the training is not particularly good.

C P PRICE

Cancer Medicine, 4th edn, 2 volumes. Holland JF, Bast RC Jr, Morton DI, Frei E III, Kufe DW, Weichselbaum RR, eds. (£195.00.) Williams and Wilkins. 1996. ISBN 0 683 04095 2.

"Cancer Medicine" is a very American book with only 12 of the 346 contributors