

aluminium, plain vaccines should also be submitted for absorbent vaccines to prevent further immunisation reactions.

JS ROSS  
NP SMITH  
IR WHITE  
St John's Dermatology Centre,  
St Thomas's Hospital,  
Lambeth Palace Road,  
London SE1

- Hallam LA, Mackinlay GA, Wright AMA. Angiolymphoid hyperplasia with eosinophilia: possible aetiological role for immunisation. *J Clin Pathol* 1989;42:944-9.
- Fawcett HA, Smith NP. Injection-site granuloma due to aluminium. *Arch Dermatol* 1984;120:1318-22.
- Tosti A, Vincenzi C, Peluso AM. Accidental diagnosis of aluminium sensitivity with Finn Chambers. *Contact Dermatitis* 1990;48:48-9.
- Clemmensen O, Knudsen HE. Contact sensitivity to aluminium in a patient hypersensitized with aluminium precipitated grass pollen. *Contact Dermatitis* 1980;6:305-8.

#### Dr Hallam comments:

The histological changes described by Fawcett and Smith certainly seem to bear a striking resemblance to the appearances we described. We did not see clinically remarkable necrosis or vacuoles surrounded by multinucleated giant cells, however. It is also interesting that Fawcett and Smith note the resemblance between their cases and the lesions of angiolymphoid hyperplasia and related disorders, known as the "inflammatory angiomatoses" reported by Wilson.<sup>1</sup>

We did not stain for aluminium or test for aluminium hypersensitivity in our cases, but agree this would be a worthwhile exercise.

- Wilson Jones E. Malignant vascular tumours. *Clin Exp Dermatol* 1976;1:287-310.

#### Locally organised medical audit in histopathology

We read the paper by Ramsay on local pathology audit with interest as this department has been engaged in the internal audit of necropsies and surgical pathology for over 18 months.<sup>1</sup> The necropsy audit has been invaluable in achieving greater uniformity in the standard and timeliness of our reports as well as providing data on clinicopathological discrepancies with which to stimulate clinicians' interest in the necropsy.

Our surgical pathology audit covers similar ground to that of Ramsay and makes use of the dedicated McDonnell-Douglas system described by others for timing the laboratory procedures.<sup>2</sup> Monthly discussions involving all the pathologists and representatives of the MLSO and clerical staff have been beneficial in harmonising our approach to diagnostic problems and appreciating others' difficulties. These meetings also serve as a focus to address current problems as well as those shown up by the retrospective audit. We rapidly abandoned anonymity in the review process, partly because cases were easily traceable through the computer, and also because it inhibited the discussion when the original pathologist was not able to justify his or her approach to a case.

Two problems have concerned us: firstly, maintaining enthusiasm for the audit process once it became "routine"; and secondly, we felt that we could not audit our overall performance without considering whether we provided the information that clinicians

required. Both problems have been resolved by inviting a surgeon or physician with a particular interest to a pathology audit meeting at which we discuss a group of cases selected on the basis of SNOMED codes to provide a range of specimen types and diagnoses. By a judicious choice of clinicians, these meetings have been of greatest value in modifying our practice to ensure that our reports are clinically useful. They also help clinicians to appreciate some of the problems of providing a service and give them a greater understanding of some of the subtleties of the wording of pathology reports.

Although a random audit of cases is still necessary to maintain the internal standards of a department, we would commend the use of periodic specialty based meetings, involving the interested clinicians, as a means of entering the "audit loop" for the clinically relevant performance of a department.

TR HELLIWELL  
PA SMITH  
Department of Pathology,  
Royal Liverpool University Hospital,  
Liverpool L7 8XW

- Ramsay AD. Locally organised medical audit histopathology. *J Clin Pathol* 1991;44:353-7.
- Zuk JA, Kenyon WE, Myscow MW. Audit in histopathology: description of an internal quality assessment scheme with analysis of preliminary results. *J Clin Pathol* 1991;44:10-16.

#### Dr Ramsay comments:

I thank Helliwell and Smith for their comments. Since first presenting the Southampton audit scheme at the Pathological Society meeting in Aberdeen in 1989,<sup>1</sup> it has been used as a basis for local audit in histopathology departments throughout Britain and on the continent, frequently with modifications to accommodate local circumstances. From their letter it seems clear that the University Department of Pathology at Liverpool has established a useful audit system that includes an assessment of their necropsy performance.

Like the authors, at Southampton we abandoned anonymity early in our program. Although the department was not computerised

at the time (late 1988), cases could still be readily traced, and individuals were often recognisable by their reporting style. We are also aware of the two problem areas detailed in the letter. The maintenance of enthusiasm for any regular task is always difficult. At Southampton we encountered this problem after 18 months of audit, and went through a period in 1990 when the system was in "abeyance", although we now manage to run it on a regular basis.

The clinical importance of the information provided by pathologists is an area where audit is difficult, but can be of vital importance. I am pleased that the clinicians in Liverpool are sufficiently "broad-minded" to attend pathology audit meetings, and feel that this cooperation should be encouraged. At Southampton we adopted a rather more formal approach to this problem and are in the process of writing up a study based around the clinicopathological meeting, an established forum for interaction between clinician and pathologist. Over a three month period 56 meetings covering eight specialties were attended, and all diagnostic amendments noted, together with information from the clinicians as to how these would affect patient management. The reasons for diagnostic change were also determined, and all clinicians were questioned about the role and value of specialist clinicopathological meetings. The study reviewed 416 cases, and found that 81% of the diagnoses were unchanged, 10% were refined, and 9% were changed. In only 4% of the cases, however, did the diagnostic change result in a significant (as defined by the clinician) change in patient management.

I therefore agree that a random audit is not the only means of assessing performance and that an input from the clinicians is valuable, particularly with regard to selected specialist cases.

- Ramsay AD, Gallagher PJ. Quality control of surgical pathology by peer review—the Southampton Experience. *J Pathol* 1989;158:343A.

#### Declining necropsy rate

We read with interest the recent paper by Benbow on medical students' views on necropsies.<sup>1</sup> In common with many other hospitals around the world our own district general hospital has suffered a steady decline in the hospital necropsy rate,<sup>2,3</sup> in our case from over 50% in 1960 to 10% in 1990 (excluding coroners' necropsies). In an attempt to address this we sent a questionnaire to 120 of our clinical colleagues to canvass their opinions on the current situation and the reasons behind it.

Replies were received from 37 consultant

and 43 junior clinical staff. It was interesting to compare the replies of consultant and junior respondents. When asked if the falling necropsy rate worried them, 79% of consultant but only 37% of junior clinical staff stated that they were concerned by it (table). Furthermore, most consultants (51%) felt that for patients dying in hospital a necropsy was desirable in most cases; most junior staff (64%) considered necropsy desirable in only a few cases.

When asked about reasons for the declining necropsy rate, decreased emphasis on necropsy in medical education was considered an important factor by the highest

#### Replies of consultant and junior clinical staff to necropsy questionnaire

	Consultant (%)	Junior (%)
Are you worried by the declining hospital necropsy rate?		
Yes	79	33
No	16	52
Don't know	5	15
For patients dying in hospital necropsy is desirable in:		
All cases	19	7
Most cases	51	29
A few cases	30	64
No cases	0	0

percentage of all respondents (64%). Predictably, despite continuing evidence to the contrary,<sup>1,2</sup> advances in antemortem diagnostic techniques offsetting the need for necropsy were considered important by 54% of all respondents. Failure of junior doctors to ask for relatives' consent and an increased reluctance on their part to give consent were considered important by 53% and 52%, respectively. Failure of pathologists to communicate their findings and increased aesthetic or emotional objections of clinicians to necropsy were considered important by only 18% and 16% of respondents, respectively.

We feel that the somewhat negative attitude to the necropsy expressed by junior clinical staff in our survey and the acknowledgement that medical education is lacking in this area are important, as it is frequently the most junior of doctors who are called on to ask a relative's consent for necropsy. We agree with the conclusions of Benbow that more care, effort, and sensitivity must be shown in the training of future doctors with regard to the necropsy.<sup>1</sup> Only then, perhaps, may the current unacceptable decline in the hospital necropsy rate be halted.

AP GILES  
R DOSHI  
GG MENON  
MK KHAN

Departments of Histopathology and Neuropathology,  
Brook General Hospital,  
Shooters Hill, London SE18 4LW

- 1 Benbow EW. Medical students' views on necropsies. *J Clin Pathol* 1990;43:969-76.
- 2 Cameron HM. Future of the hospital autopsy. *Br J Hosp Med* 1988;40:335.
- 3 Frederici HHR. Reflections on the postmortem audit. *JAMA* 1988;260:3461-5.
- 4 Goldman L, Sayon R, Robbins S, Conn LH, Bettmann M, Weisberg M. The value of the autopsy in three medical eras. *N Engl J Med* 1983;308:1000-5.
- 5 Stevanovic G, Tucakovic G, Dotlic R, Kanjuh V. Correlation of clinical diagnoses with autopsy findings. *Hum Pathol* 1986;17:1225-30.

with information that cannot always be worked out from first principles.

AJ HOWIE  
SJ LEE  
Department of Pathology,  
University of Birmingham,  
Birmingham B15 2TT

- 1 Virchow-Robin space. *Webster's Medical Desk Dictionary*. Springfield, Massachusetts: Merriam-Webster, 1986:759.
- 2 Major RH. *Classic descriptions of disease with biographical sketches of the authors*. Springfield, Illinois: Thomas, 1932:469-71.

*Dr Paola Domizio, who contributed the series on eponyms that is currently running in the Journal as space permits, comments:*

I sympathise with Drs Howie and Lee that there is no guidance on how to pronounce eponymous terms. I wish it were possible. There are two difficulties. One is that usually when a person's name is given to a condition he or she is dead, and records may not survive of precisely how the name was pronounced. The other is that English freely assimilates foreign words and phrases and gives its own flavour to them. We do not speak of the Vulfian duct or the Artoose reaction, and we would probably not be able to do justice to shigellosis in the way that Shiga would have pronounced it.

To try to answer the specific question, our German senior house officer says Verchoff (the *ch* as in loch), Springer Verlag in London, who act for Virchow's Archiv in Berlin say Vershow (rhyme with cow), and the managing editor in London, Professor Colin Berry, says Verkow (again, rhyme with cow). I telephoned Berlin on the number given in the current international periodicals directory, and got a night-club.

*Contributions to this and related series are welcomed. Please send your contributions to Dr Domizio at St Bartholomew's Hospital, London EC1A 7BE, or to the Editorial Office.*

molecular pathology, telepathology, the interface between research, teaching and diagnostic pathology, and laboratory accreditation. Pathologists and others with an interest in pathology, its development, management and involvement in patient management are advised to read this valuable seminar report. Pathologists will take heart that Dr Metters, deputy Chief Medical Officer, Department of Health, who discussed the future of pathology in England and Wales, is quoted as saying, "The trend for pathologists to take on a greater clinical workload should be encouraged. The risk, if it is not, will be the tendency to see the laboratory simply as a factory, to produce test results. That would be very retrograde".

In an important final paragraph Dr Metters reasons as follows: "To conclude on a note of optimism: although at present the consequences of the White Paper for pathology may not be clear, speculation about the future is not necessary as pathology has a fundamental part to play in the diagnostic services of the NHS. If the diagnostic service is not right, the therapy won't be either. So whatever happens as a result of the White Paper fundamental importance must be attached to maintaining the quality of the pathology service and its vital contribution to diagnosis and treatment. Whilst pressures on staffing and cost efficiency may be on the increase, it remains essential that pathology services continue to provide an effective, on the spot, 24 hour service for all NHS hospitals, whether they are directly managed by Health Authorities or run by self governing trusts". Pathologists will wholeheartedly agree with Dr Metters' sentiments.

C ROBERTS

## Eponyms in pathology

We are impressed by the series on eponyms in pathology. For extra finesse, another detail could be added, namely a note on the pronunciation of names.

An example of why this is necessary is given by the surname of the great Rudolf Ludwig Karl Virchow. Medical students and doctors have a variety of ways of pronouncing his name, often along the lines of *verr-chow*, to rhyme with per-plough, with the *ch* pronounced as in chew, or *verr-koff*, among several others.

Of 14 medical dictionaries and other works of reference in the Barnes Medical Library, University of Birmingham, all of which mention Virchow, only four gave a pronunciation: one said *feer-show*, one said *verr-ko*, one said *fir-ko*, and one, *Webster's Medical Dictionary*,<sup>1</sup> said *fir-cho*, with the major stress on the first syllable, the *i* as in hit, the *ch* as in German ich or Scottish loch, and the *o* as in go. According to RH Major,<sup>2</sup> Virchow himself regarded the appropriate pronunciation as *fir-cho*.

It can be argued that there is no correct way to pronounce a name, but it is interesting, if nothing else, to find out how a person pronounced their own name. Your series could take the opportunity to educate pathologists

## BOOK REVIEWS

All titles reviewed here are available from the BMJ Bookshop, PO Box 295, London WC1H 9TE. Prices include postage in the United Kingdom and for members of the British Forces Overseas, but overseas customers should add £2 per item for postage and packing. Payment can be made by cheque in sterling drawn on a United Kingdom bank, or by credit card (Mastercard, Visa or American Express) stating card number, expiry date, and your full name.

**Medicine and Management: Proceedings of the 9th Trent Region Seminar on Pathology.** Ed J Pemberton. (Pp 64; soft cover, no price given). Trent RHA. 1990. ISBN 0951-1957-86.

The subjects dealt with at this seminar held by the Trent regional health authority included laboratories and management,

**Manual of Laboratory Immunology.** 2nd ed. LE Miller, HR Ludke, JE Peacock, RH Tomar. (Pp 427; £25.56.) Lea & Febiger. 1991. ISBN 0-8121-1319-5

This is the second edition of what, the authors claim, is a procedural manual of humoral and cellular immunology intended for a range of laboratory professionals. It starts with a commendably short and concise introduction to immunology with two sound chapters on specimen handling and the principles of serological methods.

The chapter on lymphocyte assessment occurs early, but it is not particularly easy to follow, nor can one easily discern the practical procedures required. It does not start by discussing the sample collection and handling (non-refrigeration, time from venesection to testing, etc.). It gives the uses of the techniques and discusses the principles, and at the end provides the practical instructions.

The section on immunoglobulins is disappointing and does not discuss the relative merits of radial diffusion and other automated fluid phase techniques widely used today. The characterisation of paraproteins is covered by immunoelectrophoresis and immunofixation, but there is no discussion of Bence Jones protein detection or paraprotein quantitation and its problems. Likewise, the section on complement is disappointing. While it goes into some detail of the complement pathways and the various complement deficiencies, it does not indicate the problems of quantitation of individual components, which ones