pericryptal granulomas. There are thus reasonable grounds for supposing that this patient had been suffering from Crohn's disease from the outset. In this case at least a warning to the surgeons that ileoanal pouch construction might have unwelcome consequences would have been entirely justified.

The received wisdom is that the presence of a pericryptal granuloma regardless of the context in which it arises is a diagnostic pitfall; but perhaps as the above case illustrates, the pitfall may be the other way round.

Colorectal cancer reporting

The article by Shepherd and Quirke[1] is timely and publication coincided with the completion of our own colorectal cancer reporting sheet (fig 1). This was designed for in-house use to supplement a laboratory protocol for handling and reporting colorectal malignancy resection specimens and to improve the accuracy and consistency of reporting. The top part of the sheet is filled in by the surgeon in the operating theatre and the specimens are handled according to ACP guidelines.[2] Together with the separate free text histology report, the sheet will be filed in the patient's clinical case notes and will be the source of the histopathological data that will be used, eventually, in the multidisciplinary database that we hope to have available for colorectal cancer patients in this unit.

The general layout of our form owes much to the "Sloane" forms for the reporting of breast screening histopathology and we are pleased to see that Professor Sloane is to chair the forthcoming Royal College of Pathologists' working party. However, unlike breast screening, reduction of mortality and morbidity from colorectal cancer is not a *Health of the Nation* target. For colorectal cancer this cancer unit is going to need at least one clerk to help gather and correlate data from several different sources including outpatients, radiology, operating theatres, histopathology, and oncology. The clinical audit committee at the Peterborough Hospitals NHS Trust has decided that cancer database entry is not an appropriate use of clinical audit facilitator time or audit funds. The decision was based on the fact that the clinical audit department is unlikely to be able to cope with the vast amount of data that will need to be collected for multiple cancers from several locations across a trust that is split between two sites. The department will continue to support data analysis and audit project presentation. We are exploring other means of collecting the data.

Any recommendations of the proposed Royal College of Pathologists working party must give consideration to a coordinated and multidisciplinary approach to the diagnosis and treatment of this important neoplasm and to the provision of software packages and support staffing.

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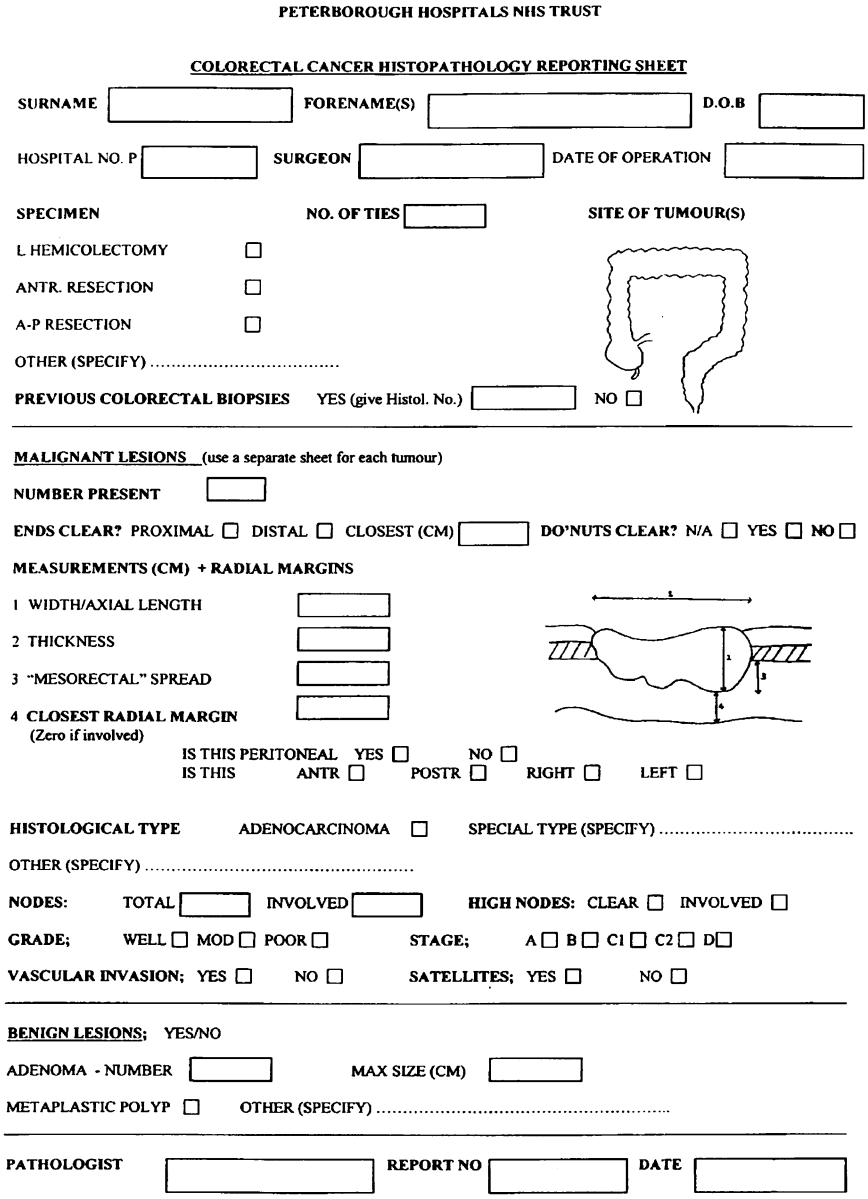
1 Shepherd NA, Quirke P. Colorectal cancer reporting: are we failing the patient? *J Clin Pathol* 1997;50:266–7.
2 Sheffield JP, Talbot IC. ACP Broadsheet 132. Gross examination of the large intestine. *J Clin Pathol* 1992;45:751–5.


PETERBOROUGH HOSPITALS NHS TRUST

COLORECTAL CANCER HISTOPATHOLOGY REPORTING SHEET

SURNAME FORENAME(S) D.O.B

HOSPITAL NO. P SURGEON DATE OF OPERATION

SPECIMEN NO. OF TIES SITE OF TUMOUR(S)

L HEMICOLECTOMY ☐
ANTR. RESECTION ☐
A-P RESECTION ☐
OTHER (SPECIFY) .....

PREVIOUS COLORECTAL BIOPSIES YES (give Histol. No.) NO ☐

MALIGNANT LESIONS (use a separate sheet for each tumour)

NUMBER PRESENT

ENDS CLEAR? PROXIMAL ☐ DISTAL ☐ CLOSEST (CM) DO'NUTS CLEAR? N/A ☐ YES ☐ NO ☐

MEASUREMENTS (CM) + RADIAL MARGINS

1 WIDTH/AXIAL LENGTH
2 THICKNESS
3 "MESORECTAL" SPREAD
4 CLOSEST RADIAL MARGIN (Zero if involved)

IS THIS PERITONEAL YES ☐ NO ☐
IS THIS ANTR ☐ POSTR ☐ RIGHT ☐ LEFT ☐

HISTOLOGICAL TYPE ADENOCARCINOMA ☐ SPECIAL TYPE (SPECIFY) .....

OTHER (SPECIFY) .....

NODES: TOTAL INVOLVED HIGH NODES: CLEAR ☐ INVOLVED ☐

GRADE; WELL ☐ MOD ☐ POOR ☐ STAGE; A ☐ B ☐ C1 ☐ C2 ☐ D ☐

VASCULAR INVASION; YES ☐ NO ☐ SATELLITES; YES ☐ NO ☐

BENIGN LESIONS; YES/NO

ADENOMA - NUMBER MAX SIZE (CM)

METAPLASTIC POLYP ☐ OTHER (SPECIFY) .....

PATHOLOGIST REPORT NO DATE

Figure 1 Colorectal cancer reporting sheet from the Peterborough Hospitals NHS Trust.

Dr Shepherd and Professor Quirke comment:
We welcome Womack *et al*'s adoption of a proforma and congratulate them on its design. We would, however, like to avoid a plethora of forms emerging. We are currently aware of a number of forms, all of which are slightly different with more in the pipeline. The value of Professor Sloane's breast cancer form is its national use and apparent acceptability; this will allow comparison of the quality of surgical reporting, the type and quality of treatment, and patient outcome on a national level. We have been involved in the generation of the UKCCCR Colorectal Cancer Subcommittee forms[1] and the pathology form of the Royal College of Surgeons Colorectal Cancer Guidelines[2]: we are now convinced that what is required is a basic minimum dataset of information on colorectal cancer that will be collected throughout the United Kingdom. The current Joint National Guidelines (fig 1) have been extensively discussed and approved by the Royal College of Pathologists, the Royal College of Surgeons (England), the Scottish Intercollegiate Guidelines Network, the Welsh CROPS Project, the Association of Clinical Pathologists, the Association of Coloproctology, and the Pathology Committee of the British Society of Gastroenterology. It has also been discussed extensively among British gastrointestinal pathologists. Professor Geraint Williams and Professor Ian Talbot have also played a major part in developing the proforma, as did Dr Judy Wyatt and Dr Michael Dixon in developing the Yorkshire proforma.

The major difference between the Joint National Guidelines and the Peterborough proforma is that the Joint National Guidelines have included TNM staging alongside Dukes's. We believe this is important as many international trials report their data in the context of TNM staging. This is most relevant in respect of stage pT1 for local excision studies and stage pT4 for adjuvant therapy studies. Subdividing nodal involvement into pN1 (1–3 nodes) and pN2 (4 or more nodes) is also important as this may

Joint National Guidelines Minimum Data Set
Colorectal Cancer Histopathology Report

Patient Name:..... Date of Birth:.....

Hospital:..... Hospital No:.....

Histology No:..... Surgeon:.....

Gross Description

Site of Tumour.....

Maximum tumour diameter .....cm

Distance of tumour to nearer margin (cut end).....cm

	Yes	No
Presence of tumour perforation (pT4)	☐	☐

For rectal tumours

Tumour is: Above ☐ At ☐ Below ☐ the peritoneal reflection

Distance from pectinate line.....cm

Histology

Type

	Yes	No
Adenocarcinoma (to include mucinous and signet ring adenocarcinomas)	☐	☐

If No, Other.....

Differentiation by predominant area

Poor ☐ Other ☐

Local Invasion

Submucosa (pT1)	☐
Muscularis propria (pT2)	☐
Beyond Muscularis propria (pT3)	☐
Tumour cells have breached the peritoneal surface or invaded adjacent organs (pT4)	☐

Margins

Tumour involvement	N/A	Yes	No
doughnut	☐	☐	☐
margin (cut end)	☐	☐	☐
circumferential margin	☐	☐	☐

Histological measurement

from tumour to circumferential margin ..... mm

Metastatic Spread

No of lymph nodes examined.....

No of positive lymph nodes.....

(pN1 1-3 nodes, pN2 4+ nodes involved)

	Yes	No
pN3 nodes positive along named artery	☐	☐
Apical node positive (Dukes C2 and pN3)	☐	☐
Extramural vascular invasion	☐	☐

Background Abnormalities

	Yes	No
Adenoma(s)	☐	☐
Synchronous carcinoma(s) Complete a separate form for each cancer	☐	☐
Ulcerative colitis	☐	☐
Crohn's	☐	☐
Familial adenomatous polyposis	☐	☐

Other Comments.....

.....

Pathological Staging

	Yes	No
Complete resection at all margins	☐	☐

TNM

T ☐ N ☐ M ☐

Dukes

Dukes A	☐	(Growth limited to wall, nodes negative)
Dukes B	☐	(Growth beyond M. propria, nodes negative)
Dukes C1	☐	(Nodes positive and apical node negative)
Dukes C2	☐	(Apical node positive)

	Yes	No
Histologically confirmed liver metastases	☐	☐

Signature.....

Date.....

Approved by the Royal Colleges of Pathologists and Surgeons (England), Associations of Coloproctology and Clinical Pathologists, the Pathology Section of the British Society of Gastroenterology, SIGN/SCTN and CROPS

Figure 1 Colorectal cancer reporting form of the Joint National Guidelines.

identify good and bad Dukes's C stages for more aggressive treatment. The precursor of the Joint National Guidelines form has been in use within the Yorkshire Region for the past year with the majority of hospitals returning data on 100% of all the registered colorectal cancers to the Yorkshire Registry, proving that all hospitals are capable of completing the form within current resources.

With respect to the multidisciplinary approach, these forms have received the backing of the relevant national clinical bodies that include surgeons, radiotherapists, and clinical oncologists. Recent discussions have taken place about the possibility of developing a national minimum dataset for surgeons as well as for radiotherapists and clinical oncologists, and we hope to develop this work further. One possible version of a clinical form is published as Appendix 1 in the UKCCCR handbook.

We agree that it is essential that proformas are adaptable to computerisation. The Welsh CROPS project is currently entering the Joint National Guidelines onto computers in Wales in association with Telepath. It may be possible to see whether this feature can be made available to Telepath users elsewhere in the United Kingdom. The easiest method would be for it to be part of the standard software offered by computer companies.

With respect to audit, we envisage that cancer registries will be collecting the data from the pathology forms to enable analysis of patient outcome according to the pathological features. We hope ultimately that the clinical and treatment minimum datasets will also be collected by cancer registries to provide a true picture of the presentation, treatment, and outcome of patients with colorectal cancer. We feel it is important that the Royal College of Pathologists is a part of this process and would commend to our colleagues the adoption of the Joint National Guidelines Minimum Dataset Colorectal Cancer Histopathology Reports, copies of which will be made available to pathologists by the Royal College of Pathologists in late Autumn 1997.

Quality reporting of colorectal cancer is very important and is to be highlighted in advice to purchasers in the near future.[3]

1 *Handbook for the clinicopathological assessment and staging of colorectal cancer.* Oates GD, Finan PJ, Marks CJ, Bartram CI, Reznek RH, Shepherd NA, *et al* on behalf of the UKCCCR Colorectal Cancer Subcommittee. 2nd edn, 1997:Appendix 1. [Copies of this can be obtained from the UKCCCR Secretariat.]

2 *Guidelines for the management of colorectal cancer.* London: The Royal College of Surgeons of England and the Association of Coloproctology of Great Britain and Ireland, 1996.

3 Haward RA. Improving outcomes in colorectal cancer. *Guidance for purchasers.* London: Department of Health. [In press.]

Book reviews

Pathology of Lymph Nodes. Contemporary Issues in Surgical Pathology. Weiss LM, ed. (Pp 453; £75.00.) Churchill Livingstone. 1996. ISBN 0 4430 7620 0.

In few other areas of pathology is the impact of evolving technology more evident than in diseases of the lymphoreticular system, a perception that receives particular emphasis in this latest volume in the *Contemporary Issues* series. The advancing role of what is described as molecular haematology is comprehensively and for the most part lucidly explored without in any way evading the complexities. The other key issue is classification, and the philosophy underlining the emergence of the REAL classification is objectively analysed even though it is obvious that few American pathologists are prepared to go further than cautious acceptance. The section relating to reactive lymphadenopathies is to be particularly commended; it is very well presented and includes excellent discussion of more recently described entities. The continuing re-assessment of Hodgkin's disease is well documented, and compared with other lymphomas there is even the possibility that light is beginning to appear at the end of this particular tunnel.

The real challenge to the REAL classification is the categorisation of the T cell lymphomas as is evident from the stimulating section on this topic. It is becoming obvious that, with a combination of molecular immunocytochemical and morphological features, the delineation of new entities may well be going beyond the resources of most histopathology laboratories, and will inevitably lead to a greater centralisation of diagnostic facilities. Fortunately, T cell tumours are still rare in most countries, and the position with regard to the more common B cell tumours, particularly in extranodal sites, has been clarified. The admirably presented section