preferred decentralised testing in primary care through off-site patient sampling. We are therefore in agreement that patients prefer to attend their local community practice for the purpose of anticoagulant control rather than a hospital based clinic. It is the delivery of service that is different. In the case of my own practice this is through off-site sampling, whereby a blood sample is sent to the central laboratory and the central laboratory takes responsibility for dosing, scheduling of the next test, and overseeing the service. This does retain central expert control. Dr Fitzmaurice and colleagues prefer to provide the service by near-patient testing with the development of expertise in general practice. Both approaches are workable, enable anticoagulant care to be provided through the community, andoffer opportunities for improvements in quality.

My evidence to support the statement that patients prefer to attend their general practice surgery is given in the reference in the editorial.[1] In a questionnaire survey of patients who had been exposed to both the hospital based clinic service and the decentralised service, 99% of patients preferred the latter.

As so many of the population are now receiving anticoagulant care, and there is an ever increasing demand on health care resources, it is essential that providers of anticoagulant services develop delivery of care in a flexible and pragmatic way in order to continue to provide ever improving care to an ever increasing number of patients.

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1 Baglin T, Lefort W, Luddington R, *et al.* Decentralised anticoagulant care: near-patient sampling, dosing or testing? [Abstract] *Br J Haematol* 1996;**95**(suppl 1):A115.

Fine needle aspiration and the diagnosis of non-Hodgkin's lymphoma

I agree wholeheartedly with many of the sentiments expressed by Jeffers *et al* in their recent publication on the value of fine needle aspiration (FNA) of nodes and the ancillary investigations which can be undertaken on such material in the diagnosis of lymphoma.[1] However, I would like to express a word of caution. Lymphoblastic lymphomas were conspicuously absent from their series. If, perchance, the cytological preparations from an aspirate are not convincing it may be misleading to rely too heavily on the immunophenotype in making a diagnosis of precursor T or B lymphoblastic lymphoma. That situation becomes analogous to making a diagnosis of acute leukaemia based on immunophenotype without cytology; well known pitfalls await those who regularly tread that path. There is often little about the immunophenotype, even using the rather expanded panel of antibodies necessary when investigating lymphoblasts, which could be considered pathognomonic, and neither form of lymphoblastic lymphoma expresses surface immunoglobulin to indicate clonality. Such cases will more usually arise in children and young adults but can also occur in older patients. I would not be comfortable about initiating treatment, which in many cases might be identical to treatment for acute lymphoblastic leukaemia (especially in the case of precursor T lymphoblastic lymphoma), without histological as well as supportive immunophenotypic (or even cytogenetic) data if the cytological preparations were not completely convincing. I hasten to add that Jeffers *et al* have by no means advocated universal replacement of excision biopsy of nodes with FNA nor even that this approach could obviate the need for formal histological examination in any newly presenting cases of lymphoblastic lymphoma; I merely note the absence of data on lymphoblastic lymphoma.

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1 Jeffers MD, Milton J, Herriot R, *et al.* Fine needle aspiration cytology in the investigation of non-Hodgkin's lymphoma. *J Clin Pathol* 1998;**51**:189–96.

Author's response:

Dr Reid is correct to point out the absence of data on lymphoblastic lymphoma in our series; this was simply owing to the absence of any such cases during the study period.

I note the caution which Reid raises regarding the excessive dependence upon immunophenotyping which may lead to pitfalls in treatment, but I would reiterate that our aim in this study was to investigate the role of immunophenotyping as an ancillary method in the initial investigation of lymphadenopathy. If, as Reid suggests, "the cytologic preparations from an aspirate are not convincing" it would, in our view, be entirely inappropriate to start any form of management on the basis of the immunophenotype alone, apart from recommendations that open biopsy be carried out. In the article we stressed the importance of interpretation of ancillary techniques in conjunction with cytomorphology and clinical information (a "triple test" as applied to lymph node fine needle aspiration!") and I would emphasise that our philosophy in using immunophenotyping in this way is to facilitate patient investigation in the setting of an initial presentation and to facilitate patient management in the setting of the recurrence or suspected recurrence of a known lymphoproliferative disorder.

I am gratified by Reid's agreement with many of our sentiments in terms of the use of cytology in the diagnosis of lymphoma.

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BOOK REVIEW

An Illustrated Guide to Bone Marrow Diagnosis. K Gatter and D Brown. (£65.00.) Blackwell Science, 1997. ISBN 0 632 04234 6.

In their preface, the authors state that they have tried to write a book for the busy pathologist who wishes to find on one page a description and illustration of most common bone marrow diseases seen in marrow trephines. Have they succeeded? On balance I think that they have. There are a lot of plus points. The book is beautifully produced and a pleasure to handle. Photomicrographs are generally of a high quality and are well organised on the page. Most bone marrow disorders are well dealt with and I particularly liked the approach to the diagnosis and classification of lymphomas which is a headache for many pathologists and haematologists. There is also some useful clinical information for those not well versed in haematological disorders.

The title is a little unhelpful: this is a book on bone marrow trephine histology—there is virtually no coverage of bone marrow aspirates. A few diseases get brusque treatment. Aplastic anaemia may be a rare disorder but the trephine histology is crucial in diagnosis and it seems a shame to relegate it to a few paragraphs at the end of a chapter on anaemia. Perhaps the least successful aspect of the book is the referencing. Although some chapters are well referenced, others attract only the occasional obscure reference or even none at all.

This is a user friendly book which is well written and comprehensively illustrated. It should provide a useful reference for histopathologists and haematologists who have to extract diagnoses from bone marrow trephine specimens.

MARTIN HOWARD

NOTICE

First announcement

Focus on: Autologous Blood Progenitor Cells

Ravenna, Italy, 12–13 November 1998

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