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Book Reviews

Leukaemia and Lymphoma: Reviews 1

Edited by A. Polliack. Harwood Academic Publishers, 1992. ISBN 3 7186 5251 X. £36.00, $68.00.

I MUST ADMIT that when I initially opened this first edition of collected reviews from the new journal *Leukaemia and Lymphoma* that I doubted that repeating the publication of the two invited reviews in each issue within a single review volume would be of any value. *Leukaemia and Lymphoma* after all has an established place in most medical libraries and it should be possible for a potential reader to find the reviews relatively easily. However, on reading these excellent short reviews I became convinced that their publication in a single volume was most worthwhile. The original journals do not come to hand easily and this collection of articles provides a relatively up-to-date convenient source of information on important current topics in leukaemia and lymphoma for the postgraduate student of haematology and medical oncology. The reviews are well written and cover a wide range of topics within the fields of molecular diagnosis, cytogenetic studies, the biology of haematological malignancy and modern management procedures, including the role of peripheral blood progenitor cell rescue, new biological and chemical agent therapies and there are special reviews on gut and peripheral T-cell lymphomas. I found these reviews informative and a useful reference source. I recommend this collection of short reviews to medical libraries who do not have *Leukaemia and Lymphoma* on their shelves and to serious postgraduate students of haemato-oncology.

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Histopathology of Non-Hodgkin's Lymphomas

By K. Lennert and A. C. Feller. Berlin, Springer, 1992, 2nd revised edition. 312 pp. ISBN 3 540 51270 5. DM 248.00.

THERE CAN be no doubt that Professor Karl Lennert has made major contributions to the study of lymphoma and fundamentally changed the manner in which pathologists think of lymph node classification. *Histopathology of Non-Hodgkin's Lymphomas* written in collaboration with Professor A. C. Feller is a second edition of their handbook directed at "pathologists in everyday diagnostics". However, the problem with this text is that one needs to know the diagnosis more or less before knowing where to look. Nearly all comparable diagnostic textbooks fail to appreciate that most "pathologists in everyday diagnostics" are relieved simply to diagnose non-Hodgkin lymphoma. Their ability to sub-classify reliably is distinctly wobbly (but not necessarily much worse than the experts—more of this later!). In fact this book is written for the specialist, and as such it is full of good things to stimulate, provoke, annoy or even outrage. This is the true value of the Kiel as opposed to any other classification that it challenges pathologists to think. Indeed the majority of the first two chapters consists of a vigorous rebuttal of opposition to the Kiel classification.

So why should we all learn and utilise the Kiel classification? A constant argument used by Professor Lennert is that the reluctant among us are basically too lazy to study the literature, prepare high quality slides or attend appropriate workshops. In some of this, particularly the poor quality of much material, he is absolutely right. But do the experts all agree? My major problem with the Kiel classification is that virtually every tumour must be related to a particular lymphoid cell type or stage of development. Large B-cell non-Hodgkin lymphomas are centroblastic or immunoblastic with four sub-types for the former and three for the latter. This distinction has been repeatedly challenged provoking always a robust reply from Professor Lennert. However, he himself has a tendency to move the goal posts. For example, immunoblastic lymphoma is called the most common large cell lymphoma in Stansfeld's original *Lymph Node Biopsy Interpretation* textbook as it is in *The Oxford Textbook of Pathology* by Professor Isaacson. However, in the current text being reviewed, centroblastic lymphoma outnumbers immunoblastic lymphoma by three times. There is no explanation in the current text for this but in the new edition of Stansfeld all becomes clear. The majority of previous immunoblastic lymphomas have now become centroblastic lymphomas. This is because the new definition of centroblastic non-Hodgkin lymphoma "contains at most 90% immunoblasts". No wonder the borderline is unclear and the diagnosis may seem arbitrary. One wonders whether such chopping and changing of imprecise categories does not make a nonsense of the whole concept of looking for seven different sub-types of B-cell large cell non-Hodgkin lymphoma or insisting that every lymphoma cell has a normal counterpart. Why not utilise a less arguable category such as large cell lymphoma of B-cell type until some evidence is brought to demonstrate that clearly recognisable sub-types have some prognostic or clinical value?

The foregoing illustrates my contention that this book is much better suited to a specialist pathologist than an everyday diagnostician. There are plenty of stimulating inconsistencies and unsubstantiated statements such as the following. The section on T zone lymphoma argues that it is difficult and sometimes impossible to distinguish T zone lymphoma from pleomorphic small cell T cell lymphoma. A few pages further it is emphasised that pleomorphic small cell T cell lymphoma must be differentiated first of all from T zone lymphoma. No good evidence is given to substantiate this distinction. The survival tables contain relatively small numbers of cases so that it is debatable whether the difference between T zone and pleomorphic small cell survival is significant. Another example concerns lymphoblastic lymphomas. In the section on T-cell lymphoblastic lymphomas it is pointed out that the most important distinction is that between T lymphoblastic lymphoma and B-cell lymphoblastic lymphoma although no reason is given for this distinction.

So finally what is my recommendation for the book-buying pathologist? If one wants a bench book for diagnostic lymphoma

work then texts such as that by Stansfeld or Jaffe are probably preferable. They are more clear-cut and cover a wider field including Hodgkin's disease and reactive lymphadenopathy. If one is more interested in the background to the diagnostic arguments about non-Hodgkin lymphoma and to have an understanding of lymphoma classification then this book is required reading.

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News

QUALITY CONTROL

EVALUATION OF quality in health care has received enormous attention over the past few years and traditional quality control (QC) has concentrated on physicians performance. Recently, however, the study of procedures and outcomes has also become subject to QC and improvement [1, 2]. The application of industrial quality management science has been advocated, using the principles of recognition, analysis and elimination of variation [3].

The EORTC Genitourinary (GU) Group began working on QC in 1987 and because multicentre clinical trials involve many different procedures, the first priority was to obtain baseline information about the centres and their infrastructure, individual members and their co-workers, trial procedures and the attitude and education of the participating clinicians.

In 1987 the EORTC GU Group established a committee for QC to evaluate the quality of the work of the group and its members as well as to formulate instructions on maintainance and improvement of QC.

It was decided that an attempt should be made to site-visit the majority of institutions in which members of the group were practising. Checklists were drawn up for the visitors as a reminder of their task. After a test-visit to one institution, the procedures and the checklists were finalised (Appendix). At every site-visit the urologist (member of the GU Group) was interviewed (checklist 1), the institution was inspected and other specialists (pathologist, radiologist, pharmacist, oncologist, the medical superintendent etc.) were also interviewed (checklist 2). Finally, examples of trial patient files were examined (checklist 3). At the end of each site-visit a final interview with the GU Group member was held in which shortcomings and interpretation errors, if any, were discussed and advice for improvement given. The final evaluation by the QC committee (QCC) was provided subsequently.

A total of 35 institutions were visited which represents 70% of the institutions that currently participate in the GU Group trials. Unfortunately, in five instances the checklists were incomplete, so that only figures for 30 institutions are available. The complete tables are part of the final report produced by the QCC for the GU Group (1991).

The size of urological departments varied from 10 to 120 beds indicating that some members of the group are working in isolation, with partners or in large (university) clinics with a staff of consultants and residents. Accordingly, the time involved with EORTC matters ranged from 5 to 100%. It was clear that solo workers have to do most of the administration themselves while in larger clinics (14 out of 30) data managers are generally available.

Twenty-five institutions had ethical committees, although these were not always consulted about EORTC trials. Two-thirds of the institutions have an oncology department. In 25 centres residents in urology were involved in EORTC trials. 378 patient files were examined and the contents compared with the data forms from the EORTC Data Centre. A total of 163 transcription errors and 78 interpretation errors were encountered.

The following definition of quality was adopted: 'Quality is the degree of excellence with which the group is able to perform clinical trials concerning significant and scientifically relevant problems in urological oncology and to present their results in a reasonably short period of time'.

To comply with these criteria the group must have:

1. Well-designed protocols.
2. Reliable data from members and their institutions.
3. Excellent data management and follow-up.
4. Control and analysis by the Data Centre and its statisticians.
5. Publications in top class journals and presentations in high level meetings throughout the world.

The QCC came to the conclusion that the quality of the GU Group in general could be considered as good although a number of features needed improving and reevaluation at certain intervals would be necessary. The group has worked with a range of good protocols and in particular the standardised phase II protocols are satisfactory. However, phase III protocols in general needed improvement, innovation and simplification. Too much data was requested that was never analysed and did not contribute to the final outcome. There was no doubt about the reliability of data but some members could have performed much better if administrative help had been available to them. The great variability in handling cytotoxic drugs encountered is still of great concern. There is still a need for oncologists and pharmacists to come to a consensus and uniformity in this respect.

The work of the Data Centre may be threatened by economic restraints. This means that relations with the pharmaceutical industry must be improved to encourage sponsorship that does not influence the independence of the group in conceiving and developing protocols and the presentation of trial results.

The authors and the following are members of the Quality Control Committee of the EORTC Genitourinary Group: Ph. Smith, J. W. Hoekstra, M. Brausi, F. Keuppens, P. Fernandez, W. Jones, J.C. Carneiro de Moura and P. de Mulder.