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Letters to the Editor

All nasal polyps need histological examination: an audit-based appraisal of clinical practice
J Laryngol Otol 2000;**114**:755–9

Dear Sir,

I have been reading this important paper[1] with nostalgic interest remembering the reluctance I have encountered when trying to convince my surgical colleagues of the importance of consistent and not selective histopathological examination of all specimens surgically removed including clinically trivial nasal and aural polyps; vocal cord lesions have been regarded with greater suspicion.[2,3] I applaud the authors with whose conclusions I agree.

The present rush for compensation seems to make comparisons of the relevant financial costs look attractive. That has not taken into account the staffing difficulties and overall shortage of qualified personnel in histopathology. Up-to-date techniques have added to the cost of these investigations and such august bodies as the Royal College of Pathologists has hinted in its Annual Report year 1999–2000 under the title 'Workforce', to look at ''areas where work can be declined''.[4] This suggestion seems to be supported by a histopathologist writing in the current issue of *ACP-NEWS* that certain specimens ''having a low strike-rate for unexpected abnormalities'', and here he includes nasal polyps, need not be examined. However he warns the histopathologist not to be selective on his own but only in agreement with the clinician, medical manager and chief executive IN WRITING, that the investigation was urgent; routine or only if resources permit.[5]

Another timely warning is contained in the excellent analysis of the *Future medicolegal and ethical aspects of ORL-NHS* (valid in my opinion for medical practice of any kind): that ''Litigation may also be possible when particular tests, perhaps expensive or new technology, have not been performed''.[6]

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References

1 Damantopoulos I, Jones NS, Lowe J. All nasal polyps need histological examination *J Laryngol Otol* 2000;**114**:755–9
2 Friedmann I. In Friedmann I, Osborn DAO eds. *Granulomas and Neoplasms of the Nose and Paranasal Sinuses.* Edinburgh: Churchill Livingstone, 1982
3 Friedmann I. In Friedmann I, Bennett MH, Piris J, eds. *Nose, Throat and Ears. Systemic Pathology.* (W St Clair-Symmers) Vol. 1. Edinburgh: Churchill Livingstone, 1986
4 Annual Report for 1999–2000 Royal College of Pathologists *Workforce.* p18
5 Christie J. How to survive the histopathology manpower crisis *ACP-News* Autumn 2000; p8
6 Cherry J, Weir R. Medicolegal and ethical aspects of ORL-NHS in the new millennium. *J Laryngol Otol* 2000;**114**:737–40

Author's reply

We were delighted to read Professor Friedmann's letter. It was heartening to have such an eminent and experienced Histopathologist backing our findings with his lifetime's experience. Otorhinolaryngologists might do well to show his letter and the article to their Histopathologists in order to help their patients as well as to reduce litigation against them. We would like to thank Professor Friedmann for his comments.

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Brown tumour of hyperparathyroidism in the mandible associated with parathyroid adenoma
J Laryngol Otol 2000;**114**:302–4

Dear Sir,

We read with interest, the case report titled ''Brown tumour of hyperparathyroidism in the mandible associated with atypical parathyroid adenoma'' by Goshen O *et al.*[1] It is indeed the first report of mandibular brown tumour as the presenting feature of primary hyperparathyroidism (PHPT) due to parathyroid adenoma, but definitely not very uncommon in our experience. Also there have been reports of such mandibular tumours in patients with parathyroid carcinoma in the past.[2] The case discussed in the report however, had atypical parathyroid adenoma. Only long term follow up can conclusively rule out malignancy in such cases as histological features alone cannot diagnose parathyroid carcinoma conclusively. Though brown tumour in the mandible is a rare manifestation of PHPT, we have encountered three such cases in the last ten years and would like to share our experience.

During the 10-year period, 1990–1999, we at Sanjay Gandhi Postgraduate Institute of Medical Sciences, Lucknow, India, have managed 40 patients of PHPT with overtly symptomatic osteitis fibrosa cystica. Three of these patients had brown tumours of the mandible, which drew the patients' attention to seek medical advice. Though, on further questioning all three patients were found to have symptoms attributable to PHPT, much before appearance of the ''jaw tumour''. All these three patients had sporadic PHPT. These patients aged 13, 16 and 35 years, had moderate hypercalcaemia, low serum phosphorus, extremely high serum alkaline phosphatase (5464, 732, 608 IU/L) and serum intact PTH (1156, 955, 105 pg/ml) levels respectively. All of them had subnormal or low normal serum 25 hydroxy vitamin D, and had frank radiological features of osteitis fibrosa cystica, and had multiple fractures and brown tumours. The renal function tests were normal. All the patients underwent parathyroidectomy. The gland weights were 3117, 5000, 2000 mg respectively. In the follow up at nine and 15 months, their serum calcium and intact PTH levels have remained within normal limits. The case reported by Goshen O *et al.*,[1] as with our three patient with jaw tumours, highlights the need to consider PHPT as one of the differential diagnoses. Such patients, especially those in early childhood, should undergo careful clinical and investigative work up to rule out familial syndromes, such as ''jaw tumour-PHPT familial syndrome'' and MEN. Often, patients with jaw tumour are diagnosed only after undergoing core biopsy or even surgical biopsy of the bony tumour, as was the case with the youngest of our patients.

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References

1 Goshen O, Aviel-Ronen S, Dori S, Talmi Yoav P. Brown tumour of hyperparathyroidism in the mandible associated with atypical parathyroid adenoma. *J Laryngol Otol* 2000;**114**:302–4
2 Masson EA, Mac Farlane IA, Bodmer CW, Vaughan ED. Parathyroid carcinoma presenting with a brown tumour of the mandible in a young man. *Br J Oral Maxillofac Surg* 1993;**31**:117–9

Author's reply

Thank you for bringing to our attention the letter regarding our paper discussing brown tumour of the mandible induced by atypical adenoma of the parathyroid gland. We fully agree with the authors that brown tumour of hyperparathyroidism is not uncommon. Yet, as the authors of the letter also point out, ours is the first report of such a tumour associated with atypical adenoma rather than with adenoma or carcinoma. While histologically differentiating atypical adenoma from carcinoma is tricky at best, our pathologists are assured of their diagnosis. We applauded Drs Kar, Agrawal and Mishra for their impressive experience and thank them for their comments.

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