of patchy disease. The most common histopathological form of acute myocarditis is a lymphocytic pattern. The mainstay of treatment in acute myocarditis is inotropic agents and circulatory support. The efficacy of intravenous immunoglobulin (Ig) and immunosuppression remains unproven. Studies have demonstrated mortality benefits with early IG and steroid administration.

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Fig 2. Histology specimen from the endomyocardial biopsy demonstrating extensive myocyte necrosis and phagocytosis (P). Immunohistochemistry has been performed highlighting the T lymphocytes (L).

The authors have no conflicts of interest

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MOLECULAR PROFILING OF GLIOMAS - TIME FOR A REGIONAL SERVICE.

Editor,

Gliomas form a heterogeneous group of intrinsic primary brain neoplasms in terms of pathological and clinical features. Low-grade (WHO grade II) gliomas (e.g. astrocytomas and oligodendrogliomas) inevitably recur and progress to higher grade (WHO III-IV) anaplastic tumours. Although they have traditionally been classified using histological criteria, there is increasing evidence that gliomas can be further subtyped based on molecular profile which can predict prognosis and response to treatment.

Long term follow-up data has demonstrated a significant survival advantage with anaplastic oligodendroglioma (AO)/oligoastrocytoma (AOA) tumours co-deleted for chromosomes arms 1p and 19q following combined chemo-radiotherapy compared with non-1p19q codeleted cases. These findings validated in both European (EORTC 26951) and North American trials (RTOG 9402) have meant that 1p19q status predicts post-surgical treatment. The current standard of care is that co-deleted cases receive chemoradiotherapy while non-deleted cases receive only radiotherapy due to the lack of efficacy of combined treatment in this group.

Prior to this recent change in practice, all patients with anaplastic oligodendroglial tumours were treated with radiotherapy upfront and received chemotherapy (typically procarbazine, lomustine and vincristine) on relapse. The aim of this regional retrospective study was to establish as a baseline NI clinical outcomes using this pre-1p 19q stratification as a comparator for future outcomes studies.

Fig 1. Kaplan-Meier survival curves for anaplastic oligodendroglial (AO) versus anaplastic oligoastrocytoma patients treated in NI over a 5-year period (2007-2012).

RESULTS

Clinical, pathological and molecular profile data (available in 20 cases) were analysed in 58 consecutive patients with a histological diagnosis of anaplastic oligodendroglial tumour diagnosed over a five-year period (2007 to 2012). The median survival of all patients was found to be 53 months (95% CI 22-84 months). The median survival of patients with AO (n=38) was found to be 81 months (95% CI 37-125 months). The median survival of patients with AOA (n=20) was found to be 19 months (95% CI 14 to 25 months). Log-rank analysis confirmed that AO patients had a significantly longer median survival than those with AOA tumours (p=0.023) comparable with other reports (Fig. 1).
Patients with the 1p/19q co-deletion (n=13) had a median survival of 74 months (95% CI 21-127 months), while those without the co-deletion (n=7) had a median survival of 60 months (95% 47-74 months) although the difference was not significant to the small size of this preliminary dataset (p=0.782).

**DISCUSSION**

Our review of anaplastic oligodendrogial tumours treated "pre-1p19q stratification" indicates our clinical outcomes are comparable with other published reports. This study serves as an important baseline for future comparative studies following the recent change in practice. It is also a requirement of ongoing national cancer peer review to report regional outcomes for patients and benchmark them with the national standards. Furthermore, with the emergence of molecular profiling of all gliomas as a mandatory requirement in the forthcoming amended WHO diagnostic criteria, it will be important to have access to a regional service that can provide molecular profile in tandem with routine histology reports. Not only will this ensure our patients receive the same standard of care as other UK neuro-oncology centres but also minimise anxiety associated with delays in molecular profile reports returning from outside institutions.

The authors have no conflict of interest apart from the pressing clinical need of a regional molecular profiling service.

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