A statement on tumour involvement at the resection margin including the circumferential margin was noted in 91.5% of reports. Because involvement of the circumferential margin is a major predictor of local recurrence, it is essential for all pathology reports of rectal cancer to have this information, including distance from the advancing edge of rectal tumour to the circumferential resection margin. Reporting of this feature by pathologists, particularly in the early reports of this series, was scanty. Even though the main mode of metastasis of colorectal cancer is lymphatic spread, all three data items regarding lymphatic spread were reported inadequately.

Patterns of inadequacy in this study suggest that using a proforma in histopathological reporting helps maintain consistency and facilitates communication between pathologist and surgeon. For pathologists unwilling to abandon the free-text style of reporting, we suggest incorporating a checklist of data items from the NMDS in the final report.

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Filarial antigens detected in urine using the immunochromatographic card test

The immunochromatographic card test (ICT) for filarial antigens is considered sensitive and specific for active *W. bancrofti* infection [1,2], and can be performed with only 100 µl of blood. However, even finger-stick blood draw meets with some resistance and can pose a discernible risk wherever high rates of HIV, hepatitis C, or other blood-borne illnesses prevail. So the ability to screen urine to detect filarial infection has obvious advantages. We sought to determine whether filarial antigens could be rapidly detected in patients' urine samples using ICT.

Blood and urine samples were collected under approved protocols (Lady Ridgeway and University of Colombo Ethical Review Committees) from children admitted to Lady Ridgeway Hospital in Colombo, and from children admitted to Ragama Hospital in Gampaha. These government administered hospitals are located 20 km apart in adjacent districts of the Western Province of Sri Lanka where *Wuchereria bancrofti* filariasis is considered endemic. Blood samples were collected from 135 children (6 months to 10 years) who were scheduled to have blood drawn for clinical purposes. Informed consent was obtained from guardians before routine blood draw. According to manufacturer guidelines, 100-200 µl of fresh venous blood samples were transferred to BINAX New ICT testing kits to assay *Wuchereria bancrofti* antigens. Reacted kits were read independently by two investigators and preserved by digital photography. Children testing positive by whole blood ICT also provided urine samples within four hours of blood draw. 80-100 µl of urine were applied to ICT testing kits. As with blood, urine samples could be identified as negative or positive within 10 minutes. Guardians of ICT-positive children were offered treatment with diethylcarbamazine (DEC).

Of 135 blood samples, only 4 produced two pink bands (control and test) indicative of circulating *Wuchereria bancrofti* antigens. The children in question all resided in Gampaha District and had been admitted to hospital for persistent fever. Urine specimens from these children were tested, and ICT was positive for the presence of filarial antigens in their urine as well (Figure 1A, B). One child, a girl of 9 years, was admitted in March. Her blood and urine samples tested positive by ICT and she received
Filarial antigens have been described in the urine of microfilaraemic patients [3], and their slow disappearance following treatment with DEC. We report that all children identified as antigenaemic during the course of this study also tested positive by urine ICT. Our results appear to confirm the excretion of filarial antigens in the urine and indicate compatibility of urine with ICT testing. The persistence of filarial antigens in the untreated boy's urine coupled with disappearance of antigen from the urine of a DEC-treated girl, suggests that urine ICT is specific.

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