that direct method may be negative.

The purpose of this letter is to point out that, although buffy coat smears may not be reliable as a general test for bacteraemia, they may often give a vital and usually almost instant clue in the emergency diagnosis and management of meningococcal septicaemia.[4] Possibly gonococcal septicaemia may be similarly detectable. Smears from either capillary tubes or Wintrobe tubes are suitable, and I hope it is not too obvious or insulting to point out that hot breath and handkerchiefs should be avoided in the cleaning of slides to be used in searching for micro-organisms.

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[2] Fagan DG, Goodall HB, Al Hasso ARA. The occurrence of nuclear masses in the pulmonary capillary bed in infants. *Bibl Anat* 1973;**12**:41-5.
[3] Goodall HB. Giant nuclear masses in the lungs and blood in malignant malaria. *Lancet* 1973;ii:1124-6.
[4] Humphrey AA. Use of buffy-layer in the rapid diagnosis of septicaemia. *Am J Clin Pathol* 1944;**14**:358-62.

UK National microbiological quality assessment scheme

May I comment briefly on one aspect of the report by JJS Snell *et al* in your issue of January 1982.[1]

The truism that special attention will be given to quality control specimens is self evident but is it not entirely for the reasons advanced by the authors that laboratories will wish to appear to be efficient. For example, experience of the scheme shows that a Microbiology Quality Control Laboratory (MQCL) specimen with a history of "whooping cough" has a statistically more significant chance of yielding a growth of *Bordetella pertussis* than does a routine specimen from a patient with a similar history. A recent example of such a specimen required plating on three separate occasions before *Bordetella pertussis* was isolated. Clearly a routine specimen is not likely to be treated in a similar manner. In general, participants in the scheme have come to accept that "positive" results from MQCL specimens are more likely than negative results. Perhaps there should be a higher percentage of true negative specimens issued to correct this bias.

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Reference

[1] Snell JJS, de Mello JV, Gardner PS. The United Kingdom national microbiological quality assessment scheme. *J Clin Pathol* 1982;**35**:82-93.

Dr Snell and colleagues reply as follows:

We accept Dr Watson's valid point that MQCL quality assessment specimens are more likely to yield positive results than routine specimens and that this may lead to laboratories exercising extra care in examination of the former. We do try to include a reasonable number of negative specimens in our distributions but an increase to the level found in routine specimens would necessitate a reduction in the number of positive specimens which are more useful in revealing to participants deficiencies in their media and techniques. We accept that it is very difficult to ensure that proficiency testing specimens are treated in exactly the same way as routine specimens although we believe that laboratories will derive maximum benefit from the scheme if they are examined by the same staff as would examine the equivalent routine specimen. The important point is that laboratories should be aware that their performance with proficiency testing specimens may be better than with their routine specimens. These factors make it essential that quality assessment specimens are treated as an adjunct rather than as a substitute for internal quality control.

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Correction

Diagnosis of *Legionella pneumophila* infections by means of formolised yolk sac antigens

The correct NCTC numbers for the *L pneumophila* strains used for preparing formolised yolk sac antigens described in the above paper (February 1982)[1] are as follows:

Serogroup	*Strain*	*NCTC number*
1	Pontiac—1	11191
2	Togus—1	11230
3	Bloomington—2	11232
4	Los Angeles—1	11233
5	Cambridge—2	11417
6	Oxford—1	11287

Reference

[1] Harrison TG, Taylor AG. Diagnosis of *Legionella pneumophila* infections by means of formolised yolk sac antigens. *J Clin Pathol* 1982;**35**:211-4.