and swabs. The use of plastic syringes, now readily available, brings this technique within reach of the routine diagnostic bacteriology laboratory.

References

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Letter to the Editor

Coulter Blood Count

May we comment on the paper by Hamilton and Davidson (*J. clin. Path.*, 1973, **26**, 700-705). We are glad that they have pointed out that with the Coulter counter model S

$$\frac{\text{Hb}}{\text{PCV}} = \frac{\text{MCH}}{\text{MCV}} = \text{MCHC}$$

In our experience MCV and MCH normally move together and divergence, other than when due to impaired haemoglobinization of the red cells (iron deficiency, thalassaemia, anaemia of infection), suggests a need to re-calibrate the Coulter. If the lower limit of the MCV is 80 fl, then this corresponds to an MCH of 27 pg. An MCV of 80 and an MCH, for example of 26.7, usually suggests machine error. When both values are still within the normal range, divergence of MCV and MCH may be suggested by an abnormal MCHC as shown in the example in the table.

Change in MCV on storage of blood occurs if the specimens are left at room temperature, but not if they are kept at 4°C, at least for up to 120 hours.

Finally, a fall in the MCV and MCH is the earliest detectable change in the

Coulter blood count in iron deficiency, and precedes any fall in the MCHC.

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Note from Dr Yvonne Cossart

In my review of Professor A. J. Zuckerman's interesting book, *Hepatitis Associated Antigen and Viruses* (*J. clin. Path.*, **26**, 728), I commented on his apparent attribution of 'the recognition of post-transfusion hepatitis' to himself. I am pleased to find that this was a misinterpretation of his reference to a chapter in an earlier book, *Virus Diseases of the Liver*, where a number of the original references may be found.

	Correct Coulter Setting	RBC Drift	Normal Range when Trapped Plasma Excluded from PCV
Hb	14.5	14.5	—
RBC	4.93	5.20	—
PCV	42.3	44.5	—
MCV	86	86	80-90
MCH	29.4	27.9	27-32
MCHC	34.3	32.6	32.9-35.5