All our patients were taking non-steroidal anti-inflammatory drugs. We are, therefore, clearly unable to exclude drug therapy as a cause of the abnormalities in liver function tests. Clarification of this aspect would require monitoring of the above biochemical parameters in patients not receiving drug therapy.

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References

- Gardner, M. D., and Scott, R. (1978). Frequency distribution and 'reference values' of plasma alkaline phosphatase (EC 3.1.3.1) activity in the adult population of a Scottish new town. *Journal of Clinical Pathology*, **31**, 1202-1206.
- Golding, D. N. (1973). Haematology and biochemistry of ankylosing spondylitis (Letter). *British Medical Journal*, **2**, 663.
- Kendall, M. J., Lawrence, D. S., Shuttleworth, G. R., and Whitfield, A. G. W. (1973). Haematology and biochemistry of ankylosing spondylitis. *British Medical Journal*, **2**, 235-237.
- Kennedy, A. C., Allam, B. F., Boyle, I. T., Nuki, G., Rooney, P. J., and Buchanan, W. W. (1975). Abnormalities in mineral metabolism suggestive of parathyroid overactivity in rheumatoid arthritis. *Current Medical Research and Opinion*, **3**, 345-358.
- Morgenstern, S., Kessler, G., Auerbach, J., Flor, R. V., and Klein, B. (1965). An automated *p*-nitrophenylphosphate serum alkaline phosphatase procedure for the Auto Analyzer. *Clinical Chemistry*, **11**, 876-888.

Anaphylaxis and systemic mastocytosis

We were interested by the report of what appears to be the first case of fatal anaphylaxis in a patient with systemic mastocytosis (Dodd and Bond, 1979) since we recently observed a similar case.

This 50-year-old man had had urticaria pigmentosa for 20 years and intermittent flushing of the face for four years. The diagnosis of systemic mastocytosis was based on typical bone lesions, invasion

of bone marrow by mature mast cells as shown on biopsy, hepatosplenomegaly, and a leucoerythroblastic blood picture. There was a threefold increase of blood and urine histamine levels.

The patient died shortly after a bee sting. No previous history of insect hypersensitivity was known. He was in circulatory collapse with a low central venous pressure; haemolysis and disseminated intravascular coagulation were documented. As pointed out in the report of Dodd and Bond, a fatal outcome of systemic mastocytosis is rarely related to anaphylaxis. Although the association of systemic mastocytosis and fatal insect hypersensitivity in our patient may be merely coincidental, the dramatic outcome suggests that in some cases an offending agent, such as a bee sting, a drug reaction, or an infection, may precipitate mast cell degranulation and death in systemic mastocytosis.

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Reference

- Dodd, N. J., and Bond, M. G. (1979). Fatal anaphylaxis in systemic mastocytosis. *Journal of Clinical Pathology*, **32**, 31-34.

Priority test request form

In the February issue of the *Journal of Clinical Pathology* a special form was described for requesting results to be telephoned from the laboratory (Henderson, 1979). This form included the name and telephone number of the requesting doctor only as an optional detail. Telephoning results disrupts the work of a laboratory, and we present data showing that it can also introduce errors. The use of forms that would increase the number of telephoned results might well be a disservice to both the laboratory and the patient.

In 1976 it was the practice in this laboratory to telephone results, on demand, to a number of wards and clinics in the hospital. The technician giving the results would read them in the laboratory, and a nurse or doctor would write them down on pre-printed pads. The recipient of the results was asked to read back the transcribed data before they were agreed to be correct.

We examined 172 sets of haematology results which had been telephoned to either the haematology ward or the intensive care unit in this hospital. These telephoned copies were compared with the result recorded on the back-copy of the appropriate laboratory report. Only 169 telephoned ward copies had the patient's name clearly recorded and only 13 included the patient's case record number (CRN). The CRN is a particularly important identifier when neither the surname nor address can distinguish individuals clearly. One hundred and forty-one telephone copies bore the correct date. There were 12 instances in which the copy of the results recorded at the ward differed from that given on the laboratory report (Table). Some of these differences were trivial but at least five were substantial.

Comparison of telephoned results recorded at the ward with the correct laboratory report

Test	Ward telephone copy	Laboratory report
Haemoglobin (g/dl)	13.4 15.3 10.9	10.8 15.2 10.5
White cell count ($\times 10^9/l$)	17.5 38.0 43.0 6.4 8.9 13.0	7.5 3.6 4.3 6.5 7.4 13.9
Haematocrit (%)	39 31	37.9 32.1
BCR	6.8	1.8

That no harm befell those patients whose results were mistranscribed may have been fortuitous. It was more probably an indication that these results were either not looked at critically or, because they were telephoned, not taken seriously. In either case there was every reason to discontinue the practice of regularly telephoning results. We believe that this has saved the laboratory from wasting time and has protected the patient. In those cases where it is necessary, rather than convenient, for results to be telephoned the likelihood of significant error being introduced must be considered by both the donor and recipient of the data.

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