*Numbers of cultures obtained on various media*

| Specimen | No of specimens | ZN positive | No of positive cultures on: | | | |
|---|---|---|---|---|---|---|
| | | | LJ | LJ+P | NSK | SK |
| Urine | 783 | 7 (0·9%) | 7 | 7 | 7 | 9 |
| Sputum | 608 | 18 (3·0%) | 9 | 16 | 17 | 19 |
| Cerebrospinal fluid | 123 | 1 (0·8%) | 2 | 2 | 2 | 3 |
| Gastric washings | 10 | 1 (10%) | 1 | 1 | 1 | 1 |
| Pleural fluid | 395 | 0 | 1 | 1 | 1 | 2 |
| Pus | 240 | 9 (3·8%) | 7 | 7 | 7 | 7 |
| Tissues | 312 | 13 (4·2%) | 9 | 10 | 13 | 14 |
| *Total* | 2471 | 49 | 36 | 44 | 48 | 55 |

LJ = Löwenstein-Jensen.
LJ+P = Löwenstein-Jensen with 0·5% sodium pyruvate.
NSK = liquid Kirchner.
SK = selective liquid Kirchner.
ZN = Ziehl-Neelsen.

load. The use of a selective Kirchner medium in routine isolation does have the disadvantage that a culture result is not possible for at least nine weeks after initial incubation. In those cases where only the selective Kirchner was positive the number of viable mycobacteria present in the original was very low. The selective Kirchner also has the advantage that it can act as an enrichment medium, allowing the mycobacteria to increase at the expense of any other bacteria present. In those specimens where large numbers of mycobacteria are present and contaminating bacteria absent, quicker results will be obtained with conventional culture media. The use of a selective Kirchner should therefore be seen as an addition rather than a replacement.

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**References**

[1] Mitchison DA, Allen BW, Manickavasagar D. Selective Kirchner medium in the culture of specimens other than sputum for mycobacteria. *J Clin Pathol* 1983;**36**:1357–61.
[2] Marks J. The culture and identification of mycobacteria. *PHLS Monograph 5*. Laboratory Methods, 14–23.
[3] Ghosh HK, Cobb M, Pacey DP, Conklins S. Experience with a simplification of the Petroff method for laboratory diagnosis of mycobacteria in sputum. *Pathology* 1978;**10**:257–61.

## Measurement of creatine kinase by reflectance spectroscopy and reagent strips—effect of EDTA

In our recent assessment of the measurement of creatine kinase activity,[1] we showed considerable inhibition by EDTA of both the Seralyzer and the LKB/optimised reagent assays.

Although the property of EDTA to sequester bivalent metal cations required for the activation of creatine kinase is well recognised, the concentration of EDTA present in most commercial blood collection tubes (about 1·5 mg/ml blood) was not thought to be high enough to cause interference with these creatine kinase assays.

In the original study, Sterilin EDTA blood collection tubes were used. We have repeated this study using commercial EDTA tubes from three sources: a new batch from Sterilin and tubes from Trident and Labco, all containing essentially the same concentration of EDTA. Creatine kinase assays were performed on the Seralyzer and with the BCL optimised (37°C) reagents on both the LKB reaction rate analyser and the Centrifichem analyser. No appreciable inhibition by EDTA was found with the Seralyzer or with either of the two liquid chemistries with a wide range of creatine kinase activities.

The EDTA tubes used in the original study are now thought to have been rather old, although we have been unable to determine the date of manufacture.

Three conclusions may be drawn from these studies:

1 The Seralyzer creatine kinase system and the conventional liquid chemistries studied do not suffer interference from most commercial EDTA blood collection tubes.

2 EDTA tubes of recent purchase only should be used.

3 In order to minimise any increase in EDTA concentration, these collection tubes should be filled with the recommended volume of blood.

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**Reference**

[1] Stevens JF, Tsang W, Newell RG. Measurement of the enzymes lactate dehydrogenase and creatine kinase using reflectance spectroscopy and reagent strips. *J Clin Pathol* 1983;**36**:1371–6.

## Is enrichment culture necessary for the isolation of *Campylobacter jejuni* from faeces?

We were interested to read the discussion of the relevance of enrichment culture to the isolation of campylobacters from human faeces.[1] We have used enrichment in modified Preston broth[2] as part of our method for campylobacter isolation since August 1982. Since that time 33 campylobacter isolations have been made from about 2000 specimens of human faeces in this laboratory. Of these 33, direct plating on to Preston[3] and Skirrows'[4] agars failed to show the presence of campylobacters in six specimens, and isolation was achieved only by the use of enrichment.

Of the six samples which were positive by enrichment culture only, two were from patients whose symptoms had declined and therefore represent "convalescent specimens" as described by Hutchinson and Bolton.[1] The remaining four specimens, however, were from a single patient and were taken before the onset of diarrhoea (one) and during the acute phase of the illness (three), which lasted 12 days.

We therefore support the view of Hutchinson and Bolton[1] that enrichment culture has little effect on the isolation of campylobacters from most patients with acute diarrhoea, provided that a good selective agar is used and that the delay in culturing specimens is minimal. It should be recognised, however, that in some cases the use of enrichment culture is necessary for the isolation of campylobacters from patients with acute campylobacter enteritis.

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**References**

[1] Hutchinson DN, Bolton FJ. Is enrichment culture necessary for the isolation of *Cam-*

*pylobacter jejuni* from faeces? *J Clin Pathol* 1983;**36**:1350–2.
[2] Bolton FJ, Coates D, Hinchliffe PM, Robertson L. Comparison of selective media for the isolation of *Campylobacter jejuni/coli*. *J Clin Pathol* 1983;**36**:78–83.
[3] Bolton FJ, Robertson L. A selective medium for isolating *Campylobacter jejuni/coli*. *J Clin Pathol* 1982;**35**:462–7.
[4] Skirrow MB. Campylobacter enteritis: a "new" disease. *Br Med J* 1977;ii:9–11.

# Book Reviews

**Antibiotics for Surgical Infections.** PJ Sanderson. (Pp 262; £24·50.) John Wiley. 1983.

There is a wealth of reliable information and wise guidance in this potentially useful book. After a short introduction it begins with a 28 page survey of the more important and available antibiotics, then continues with chapters on their use (mainly therapeutic) in the various branches of surgery. The last chapter, on the choice of antibiotics and the assessment of new ones, is especially sound but might have been better combined with chapter 2 so that the general principles of antimicrobial therapy could be found all in one place. There is some advice on the prophylactic use of antibiotics in the various specialist chapters, but a general discussion of the principles of antibiotic prophylaxis would have been useful. There is a reference list at the end of each chapter but the inquiring reader will have difficulty in relating this to specific topics because there are no references in the text.

Rarely have I reviewed a book in which there was so little to fault in the scientific material; but rarely have I reviewed one of similar size that took me so long to read—because it was such hard reading. Essential material, for which a reader will long search without the help of a good index, is entangled in a tautological forest of awkward and unclear sentences that call for frequent rereading. If there is to be another edition of this book, and I hope that there is, skilled editing would reduce it to little more than half the present size without loss of facts but with great gain in clarity and accessibility of content.

ROBERT BLOWERS

**Gestational Trophoblastic Diseases.** Report of a WHO Scientific Group. WHO Technical Report Series 692. (Pp 81; paperback Sw fr 60.) World Health Organisation. 1983.

This slim paperback volume is part of the World Health Organisation Technical Report Series, and was produced by a committee of distinguished authorities including clinicians, epidemiologists, and pathologists. It is written in a clear, concise, and didactic style, and an enormous amount of useful information is contained in its 80 pages. The emphasis is mainly towards clinical aspects of trophoblastic disease, and discussion of the pathology, although comprehensive, is not surprisingly rather superficial. Nevertheless, this is an excellent report, right up to date, and with a good reference list. At just over £2 it represents tremendous value and I recommend every department which deals with gynaecological pathology to buy it.

CW ELSTON

# Some new titles

The receipt of books is acknowledged, and this listing must be regarded as sufficient return for the courtesy of the sender. Books that appear to be of particular interest will be reviewed as space permits.

**Paralytic Shellfish Poisoning.** BW Halstead in collaboration with EJ Schantz. WHO Offset Publication No 79. (Pp 60; Sw fr 6.) World Health Organisation. 1984.

**The Human Brain and Spinal Cord.** Functional Neuroanatomy and Dissection Guide. Lennart Heimer. (Pp 402; Soft cover DM 69·60; US$ 27·00.) Springer. 1983.

**Fluid Dynamics as a Localizing Factor for Atherosclerosis.** Ed G Schettler, RM Nerem, H Schmid-Schönbein, H Mörl, C Diehm. The Proceedings of a Symposium held at Heidelberg, 1982. (Pp 230; DM 58; US$22·50.) Springer. 1983.

**Copper and Lymphomas.** MJ Hrgovcic and CC Shullenberger. (Pp 251; $95·50.) CRC Press Inc. 1984.

# Notice

**Supraregional assay service booklets—further copies**

The supraregional assay service (SAS) set up by the DHSS in January 1974 is still very active. Provided it receives the requests via consultants in pathology departments it undertakes certain difficult, infrequently requested assays free of charge. The repertoire is contained in the SAS booklet, which was sent to all those who are registered users of the SAS.

It has been decided to make copies of the SAS booklet available for educational purposes, and for information for those who are not registered users. However, any requests for SAS tests have to be made through the consultant or top grade scientist in charge of the laboratory, to whom results are initially sent. Requests should not be made directly by any other member of the NHS staff to the SAS.

Copies of the SAS booklet are available, and the cost is greatly reduced if a cheque is made payable to Westminster Medical School and sent direct with the order to Professor JR Hobbs, Westminster Hospital, 17 Page Street, London SW1P 2AR.

They can be purchased as follows:

1 copy ..... £7.00
2 copies .... £12.00
3 copies .... £17.00
4 copies .... £22.00
5 copies .... £27.00

This arrangement avoids the costs of further correspondence and invoicing. The booklets will be despatched direct to whoever sends the order with the cheque.

Those preparing for the MCB or MRCPath will find very useful guidelines in this booklet with regard to the investigation of patients.

# Correction

We apologise to Professor Bartl and his colleagues for the error which occurred in their paper in the March 1984 issue (p 233).[1]
Owing to a printer's error figure appeared as a mirror image.

**Reference**

[1] Bartl R, Frisch B, Burkhardt R, Jäger K, Pappenberger R, Hoffmann-Fezer G. Lymphoproliferations in the bone marrow: identification and evolution, classification and staging. *J Clin Pathol* 1984;**37**:233–54.