showing no evidence of scarring, inflammation or neurogenic appendicopathy.\textsuperscript{2} We suggested that this appearance reflects a developmental failure of the mucosa to extend to the distal end of the organ rather than being the end result of previous or ongoing appendicitis. Clinical data were not included because the number of cases was far too small to draw any conclusions about presentation or management.

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Effect of a manually generated laboratory comment on requesting and performance of valproate assays

Valproate is employed in the management of epilepsy and bipolar disorders.\textsuperscript{1} Anticonvulsant therapy has traditionally been guided by monitoring levels. However, valproate concentrations do not correlate well with therapeutic and toxic effects,\textsuperscript{2} with concentrations varying by up to 100%.\textsuperscript{3} Therefore, routine monitoring is not recommended but measurement may be used to determine compliance. A recent study compared outcomes in epileptic patients with and without valproate monitoring and found no significant differences.\textsuperscript{4} However, routine monitoring is still advocated by the American Psychiatric Association.\textsuperscript{5}

Clinicians are often not aware of the specific indications for valproate measurement, resulting in many inappropriate requests. In 2004, our laboratory introduced a manually generated comment that was inserted by reception staff for indications other than assessing compliance. This stated the following: “Plasma valproate concentration is not a useful index of efficacy or a guide to toxicity. Regular monitoring is unhelpful and routine service provision has therefore been withdrawn. Should there be a recognised requirement for this patient, please discuss with [consultant staff]. Sample will be retained for 10 days”. We wished to determine the impact of introducing such a policy.

METHODS
We obtained all requests for valproate from the laboratory information system for the 12 months prior to introduction of the policy, and for four consecutive 12 month periods afterwards.

RESULTS
The results are shown in table 1. While the number of requests fell, the proportion of assays performed decreased but this was not statistically significant.

DISCUSSION
The number of assays performed fell after introducing the comment and eventually stabilised at <5% of the baseline level. This reflects the large number of inappropriate requests at baseline.

The large reduction in number of assays requested after 1–2 years probably reflects an educational effect, as a rejected request may result in decreased inappropriate requests subsequently. We expected this trend to plateau over time as the number of appropriate cases for checking valproate should not change significantly. However, we also expected a corresponding increase in the relative number of appropriate requests being performed, that is, the percentage of requests for compliance purposes. However, this was not the case and by 4 years of the policy, over 90% of requests were still being rejected. This may reflect the regular junior medical staff turnover and/or conflicting guidelines.

The valproate mean and upper limit fell significantly from the baseline level. This is likely to indicate that the assays were requested to determine compliance, that is, they were appropriate.

The introduction of a manually generated laboratory coded comment, with the assay not being performed unless the requester contacted the laboratory with a recognised indication, reduced the number of inappropriate valproate assays performed and helped inform clinicians when the assay is and is not indicated. This should prevent management decisions based on misleading results and be cost effective for the laboratory. Nevertheless, routine valproate monitoring is still supported in some quarters and a trial comparing outcomes of valproate use with and without routine monitoring in a psychiatric setting may be required to change opinions.

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BOOK REVIEW
Color atlas and text of pulmonary pathology, 2nd edition

Edited by Philip T Cagle. Published by Lippincott, Williams & Wilkins, 2007, pp 720, hardcover, £299.00. ISBN 078172081X

This book is an update of a work first released in 2004 as a tribute to Dr S Donald Greenberg. Like the 1st edition, the book is divided into 24 sections, grouped intuitively by broad categories of disease, with each section further divided into chapters describing specific entities. While the sections and most chapter headings have not changed significantly from the previous edition, photographs and text have been updated to reflect current classifications in a number of the sections. The most notable of these would be an update of the Transplant-Related Pathology section to reflect the 2007 revision of the working formulation for the diagnosis of lung allograft rejection,\textsuperscript{1} and an update of the Pediatric Pulmonary Pathology section to reflect the new classification scheme for diffuse lung disease in young children.\textsuperscript{2} Chapters describing primary and metastatic lung tumours in children have also been added.