Technical methods


Letter to the Editor

Candida Isolates

Regarding Dr R. C. Bartlett’s letter commenting on our paper (Stritzitz, Law and Holder, *J. clin. Path.*, 1973, 26, 405-408), we did not mean to imply all Candida isolates from any patient should be speciated. Our paper concerned burned patients infected with Candida and in the context of Candida isolated from the wounds, urine, and blood of compromised hosts we still feel that speciation is important.

While I concur with Dr Bartlett’s comment that ‘the decision to treat should be based on clinical evidence of infection, not the species isolated’, we have found this not to be the case when dealing with Candida infections. Because of the highly toxic nature of Amphotericin B, the decision to treat Candida infections is frequently delayed until the clinician is forced to treat or lose the patient. As we pointed out, many clinicians consider *C. albicans* the only Candida which is of clinical concern. When they receive a culture report stating that *Candida* other than albicans has been isolated from an infected patient, they may be lulled into a false sense of security and then finally be forced to treat with too little too late.

Our data showed that while all of the Amphotericin B MICs for *C. albicans* were 0-16 µg/ml or below, most of the MICs for *C. tropicalis* were at least one dilution higher, and in some cases two and three dilutions higher. This may imply that *C. tropicalis* infection could be a treatment problem, whereas *C. albicans* infection may not be. Support for this idea may be found in the fact that the first report, to my knowledge, of clinical isolates of Candida being resistant to Amphotericin B has recently been published (Woods, R. A., et al, 1974). These resistant isolates were *C. tropicalis* not *C. albicans*.

While we all would like to keep the costs of health care to a minimum, the attitude that we should only do that clinical microbiology which is ‘essential to diagnosis and treatment’, I believe to be incorrect. In the evolution of infectious diseases and in defining infection problems, the microbiology that was ‘essential to diagnosis and treatment’ yesterday is not the same as the microbiology that is ‘essential to diagnosis and treatment’ today; nor will today’s microbiology suffice tomorrow. We, the clinical microbiologists, must be alert to identifying new infection problems; the latest ‘emerging’ pathogens, and it must be our responsibility to warn the medical fraternity of these new dangers. If we don’t, who then?

IAN ALAN HOLDER
Department of Microbiology,
Shriners Burns Institute,
Cincinnati, Ohio 45219

Reference


Book reviews


Interest in the transplacental action of certain carcinogens was widely stimulated by the report from Boston in 1971 of a cluster of eight cases of adenocarcinoma of the vagina in young women; the mothers of all but one of them had received stilboestrol during their pregnancy. Although the transplacental carcinogenic activity of stilboestrol has not yet been reproduced in experimental animals, the general subject of transplacental carcinogenesis has been extensively investigated. A useful summary of current knowledge is presented in this book. Particular attention has been paid to the nitrosamines, and one group of them—the nitrosoualkyureas—has been clearly shown to act as transplacental carcinogens with the brain as the main target organ. The dose of the compound given and the stage of foetal development both appear to be crucial in determining the outcome—in particular, death or induction of malformations rather than tumours. Predictably, no tidy relationship appears to exist between teratogenic and carcinogenic activities, and many details of the actual mechanisms of transplacental carcinogenesis are still quite unknown.

The subject is, however, one of considerable potential importance. Tumours are now a major cause of death among children in advanced societies, and the
Letter: Candida isolates.

I A Holder

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