normal anatomy section of the palatine tonsil in his book, and certainly we did not regard this a teratoid tumour.

This hair, we think, is unlikely to have been ingested because there is a well defined follicle adjacent to normal tonsillar tissue. Ingested hairs would be expected to have associated fibrosis and giant cells—not seen in our case. Levels had been cut from our lesion and no fibrosis or giant cells were identified.

This case illustrates the beauty of histopathology—one photograph can give rise to several interpretations and perhaps we are both within a "hair's breath" of the truth.

**Dipstick urinalysis for bacteriuria**

We were interested to read the description by Doran and Kensit of the use of the Clinitec 200 to predict the presence of bacteriuria.1 This apparatus has been evaluated recently in a similar study in our laboratory.

A total of 1085 urine samples from hospital and community patients were examined. Each sample was tested with a multiple reagent strip for blood, protein, nitrite and leucocyte esterase and the results read semiautomatically by a Clinitec 200 reflectance photometer (Ames Laboratories, Slough, Buckinghamshire, England). One or more positive tests was scored as a positive result. The urine samples were then cultured semiquantitatively on cysteine lactose electrolyte-deficient (CLED) agar and counts of ≥10^6 organisms/ml taken as an indication of significant bacteriuria.

Of the 1085 samples, 726 (67%) were negative by the reagent strip tests but 18 (2%) of these subsequently grew significant numbers of bacteria on culture. Of the remaining 359 (33%), which were positive by the reagent strip tests, 120 (11%) were false positive results. The indices using the formulas described by Krieg et al2 are set out in the table.

Despite an apparently high degree of success in excluding bacteriuria, it must be remembered that in our study there were still 18 false negative results, accounting for 7% of all samples with culturably confirmed bacteriuria. This figure, which is similar to the 10% reported by Doran and Kensit,1 is substantial. Inevitably patients with urinary tract infection would fail to have the diagnosis made (or confirmed) and information about the antimicrobial sensitivity of the causal organism would never be available.

Because there were many fewer false positive results in our study, there was a considerable increase in the specificity and the predictive value for a positive reagent test. The specificity we report was also higher than the 38% observed by Lowe.3 It is interesting that our result is in keeping with the 76% specificity of manual dipstick urinalysis reported in a recent comparative evaluation of screening methods for bacteriuria in this journal.4 In that study, however, the relatively nonspecific protein test was excluded. The reasons for these discrepancies are not clear, but at a practical level would directly influence the number of urine samples unnecessarily cultured.

The method is not attractive unless the investment in time and expense of using the Clinitec 200 is more than compensated by a reduction in the work of culturing negative specimens. A further problem is that all inpatients are likely to have at least one dipstick urinalysis carried out on the ward and consequently the use of the Clinitec 200 in the hospital laboratory will duplicate tests already done—although they may be carried out more accurately.

There is not a clear cut case for the use of this method as a routine screening procedure in microbiology departments. It disappoints because of inaccurate results—negative results that lead to a missed diagnosis and positive ones that fail to reduce the workload. There is also no indication of a substantial financial saving. Perhaps the method could find a niche in screening selected patient groups such as pregnant women and children for asymptomatic bacteriuria.

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**References**

2 Krieg AF, Gambino R, Galen RS. Why are clinical tests performed? When are they valid? JAMA 1975:233:76-8.

**Matters arising**


This book gives a comprehensive account of the vulva and its pathology starting with the background embryology, anatomy, and physiology, ranging through the various clinical and pathological aspects of vulval disease, and even including historical and psychological considerations. Everything from nappy rash and the psychological effects of rape to techniques of DNA hybridisation is here. While it may be admirable to have such an all inclusive account of this anatomical area, it does beg...
Dipstick urinalysis for bacteriuria.

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*J Clin Pathol* 1989 42: 444
doi: 10.1136/jcp.42.4.444-a

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