⁶ Mukerji S, Ghopale N. Gliding motility of *Acinetobacter anitratus*. *J Clin Pathol* 1983;**36**:484.
⁷ Barker J, Maxted H. Observations on the growth and movement of *Acinetobacter* on semisolid media. *J Med Microbiol* 1975;**8**:443-6.

Dr Mukerji replies as follows:

I am well aware of the work done by the authors^(references 1-5 above) on twitching motility and fimbriation of *A anitratus*. The authors, however, have failed to appreciate my observation¹ regarding the peculiar "pendular type" of motility detected in batch 2 of NCTC 7844 (strain of Schaub and Hauber)² which was characteristic of a myxobacterium. Two subsequent batches did not show the same activity, probably because this property was affected by cell wall injury caused by freeze-drying. However they did develop surface gliding movement and other fresh isolates showed flexion and extension motility on our medium.¹ I hope the authors will agree that fimbriae did not produce the latter type of movement? There is other evidence to support NCTC 7844 being a myxobacterium.³ It secreted viscous gum and showed the characteristic capacity⁴ to penetrate soft agar in Stanier's salt agar base on testing for cellulolytic and proteolytic activities. For the former, strips of filter paper were put under the surface of agar and the strain inoculated over the strips. In 2-3 days the strains secreted viscous gum, produced etching around the growth and assumed rod-like morphology with a refractile outline which failed to stain well with Gram's. For proteolytic activity 0.1% skimmed milk was incorporated in the agar; the strain produced superficial pitting of the agar and etching phenomena outside the growth. This occurred within 3-5 days which suggested the capacity of the cells to penetrate soft agar (1%). These findings suggest that NCTC 7844 is a myxobacterium. This could be confirmed by hybridisation experiments with myxobacteria but as far as I know these experiments have not been carried out.

S MUKERJI
Habib Hospital,
159 Jail Road East,
Bombay 400 009, India

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² Schaub IG, Hauber FD. A biochemical and serological study of a group of identical unidentified Gram-negative bacilli from human sources. *J Bacteriol* 1948;**56**:379.

³ Mukerji S. A study of *Bacterium anitratum* and *B anitratum*-like organisms. University of Bombay: Ph.D thesis, 1974.
⁴ Stanier RY. Order VIII. Myxobacterales Jahn. In: Breed RS, Murray EGD, Smith NS, eds. *Bergey's manual of determinative bacteriology*. 8th ed. 1957:855.

Necrotising granulomatous prostatitis after transurethral resection

We enjoyed the recent article published in the September issue of your Journal by Lee and Shepherd.¹ We would like to add our experience of two cases who also had transurethral resection for benign prostatic hyperplasia and who later had recurrence of obstructive symptoms. Material removed at the second transurethral resection showed an identical histological picture to that described by Lee and Shepherd (Figure) and there was also no histological or clinical evidence of other causes of localised or generalised granulomatosis. However, tissue eosinophilia which was mentioned first by Hedelin *et al*² was not a feature in our material. It is of interest to note that the time interval of finding active necrotising granulomata was very variable and in our second case (Table) was after eight years.

As we also support their contention that these granulomata, which bore a striking resemblance to rheumatoid nodules, are the effect of trauma, we would like to postulate that they are related to tissue necrosis caused by diathermy in the initial transurethral resection procedure. The persistence

of these necrotising granulomata for a very long time, as in our second and their first case, together with a striking resemblance to rheumatoid nodules, would support the speculation that tissue necrosis is the cause of this reaction as it was hypothesised in the evolution of genuine rheumatoid nodules.

We think by now there is enough evidence in the literature^{1 2} to suggest that the relation of transurethral resection and necrotising granulomatous prostatitis is constant and hope that it will prevent further unnecessary investigations and in some cases empirical antituberculous treatment of the patients in question.

Time intervals between first operation (no granuloma) and second operation (granuloma found) in two cases

	Case 1	Case 2
Age (yr)	65	78
Operation 1	Transurethral resection—no granuloma	Transurethral resection—granuloma found
Interval between first and second operation	3 months	8 yr

A large necrotising granulomatous reaction bordered by a palisading layer of histiocytes (arrows) and a few multinucleated giant cells (arrow heads). Haematoxylin and eosin × 70.