cell types, including cells of the myeloid series, macrophages, and normal colonic mucosa (Burtin et al., 1973; 1975). Similar cross-reacting glycoproteins are also found in breast cyst fluid and normal breast duct mucosa (Kuo et al., 1973; Fleisher et al., 1974).

In view of the widespread presence of these cross-reacting antigens, any claims that tumours contain CEA based on studies using anti-CEA sera must be viewed with caution unless attempts have been made to absorb out unwanted activity against these related substances. The specificity of the immunohistochemical reaction cannot be proved solely by abolition of specific staining after absorption of the anti-CEA serum with CEA since this procedure will also tend to remove the cross-reacting anti-NCA activity (Burtin et al., 1973). In this connection it is perhaps noteworthy that Shousha and Lyssiotis (1979) state that absorption of their anti-CEA serum with CEA before use for immunoperoxidase staining diminished staining but did not abolish the reaction. Pretreatment of tissue sections with periodic acid has been shown to remove unwanted cross-reacting antibody activity with unknown tissue antigens (Isaacson and Judd, 1977), but the antibody used by those authors was already free from anti-NCA activity.

We do not wish to deny that breast carcinomas and possibly granular cell myoblastomas contain CEA but we feel that care should be exercised in the interpretation of results using commercially available antisera unless unwanted cross-reacting activity has been removed. Where this is not the case, the term 'CEA-like material' would perhaps be more appropriate.

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References


Skin as a source of Acinetobacter/ Moraxella species

Like Drs Al-Khoja and Darrell (Journal of Clinical Pathology, 1979, 32, 497) we too have studied the skin as a source of Acinetobacter/Moraxella species. Studies on inpatients with diseases of the skin show that both Acinetobacter and Moraxella can be isolated from normal or involved skin in about one-quarter of patients. We found that 26 of 98 patients with 'eczema', 20 of 53 with psoriasis, 7 of 15 with urticaria, and 4 of 26 with other miscellaneous diagnoses yielded isolates of these organisms. Carriage on involved skin was more common; 30 patients had these organisms on involved skin only, 15 from normal and involved skin, and 13 on normal skin (usually forehead or chest) only. Although clearly common on the skin, these organisms seldom cause skin infection (unpublished observations; Glew et al., 1977).

Acinetobacter and Moraxella are easily isolated on Cysteine Lactose Electrolyte Deficient Medium (Oxoid) but identification by micromethods such as API (20E) is unsatisfactory owing to their general lack of biochemical activity. (The absence of a pathogenic role makes it undesirable to use the more sophisticated tests such as cell wall composition, as routine tests show that the only regular difference is the oxidase reaction.) About half our isolates are oxidase-positive and are therefore classed as Moraxella (Buchanan and Gibbons, 1974). On this basis, however, one patient sampled five times yielded three 'acinetobacter' and five 'moraxella'. It seems that more accurate speciation is needed.

Retaillieu et al. (1979) reported Acinetobacter calcoaceticus as a hospital pathogen with a high summer prevalence.

The climate in the UK is not sufficiently constant to make a comparison of 'summer' and 'winter' samples meaningful, but we suggest that the summer maximum observed by these authors may be related to increased sweating in summer producing a more favourable environment for the proliferation of these skin inhabitants.

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