

ture from the confluent areas and incubation at 37°C yielded rapid growth which could be readily confirmed as gonococcal. The isolate shown in the Figure was an example of one yielding heavy recoveries at all three temperatures tested. At room temperature the only colonies seen were occasional commensals and contaminants. All cultures which grew at 25°C were confirmed by smear, oxidase tests, carbohydrate fermentation, and immunofluorescence. Many of them were dried for preservation.

It is now apparent that while all gonococcal strains may not be recoverable from clinical material at 25°C, a considerable proportion are and further studies may shed light on the diversity of the genus with regard to this characteristic.

No suggestion is made that these findings have any immediate application in the diagnosis of gonorrhoea although it is now obvious that isolation temperatures for the organism are not as critical as is generally believed. The higher region of the range does of course result in the more rapid growth rate and recovery of the organism. The findings however, do have considerable relevance in the accurate definition of the species and should be of interest in physiological and epidemiological studies of the organism and its disease.

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plasma pneumoniae (MP) infections significant increases in complement fixing (CF) antibodies against MP are often seen.^{1,2} This is probably due to components in the lipid antigen used in routine CF.³ If MP suspension is treated with Tween-ether after extracting the lipid components from the suspension, most CF activity is lost but the obtained antigen works well in enzymeimmunoassay (EIA) and these above mentioned false-positive reactions seen in CF are eliminated. This may have important implications in the routine serological diagnosis of MP infections.

Not infrequently, similar, presumably false-positive CF reactions are seen in infections of the central nervous system.⁵ In four patients with a microbiologically verified bacterial meningitis (three caused by *Haemophilus influenzae* and one by *Neisseria meningitidis*) significant increases of CF antibody levels against the MP lipid antigen were detected. When EIA with Tween-ether treated antigen was used no marked rises of antibody levels could be shown in the sera of these patients against MP although in control patients with respiratory infections during an MP epidemic EIA was found to be equally sensitive as the CF test in the serological diagnosis of MP (Table). Similarly, erroneous serological diagnoses in some patients with bacterial sepsis could be eliminated with EIA using the Tween-ether treated antigen.

In patients with aseptic meningitis and encephalitis significant CF antibody rises can occasionally be seen.⁶⁻¹⁰ Interestingly, our EIA results suggest that only a few of them (2 of 11) are true MP infections.

Precise serological diagnosis of MP is difficult if CF is used as the routine method. The introduction of EIA with Tween-ether treated antigen may improve the accuracy significantly in many clinical conditions.

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False-positive complement fixing antibodies against *Mycoplasma pneumoniae* in patients with bacterial meningitis

We have previously shown that in acute pancreatitis not associated with *Myco-*

Number of patients with EIA and CF increases of antibody levels against *Mycoplasma pneumoniae* in bacterial meningitis and pneumonia

	CF-positive/EIA-positive	CF-positive/EIA-negative
Bacterial meningitis	0/4	4/4
Pneumonia	4/4	0/4