Letters to the Editor

perspective, controlled study, we found that nitrofurantoin, administered orally from the first postoperative day until the catheter was removed, was highly effective in preventing bacteriuria in patients who came to operation with uninfected urine.6

In conclusion, we agree a knowledge of the prevalent bacteria in urinary infection is helpful but to rely on this alone in selecting agents to prevent postoperative septic complications is insufficient and may be dangerous.

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References

Dr Williams comments as follows: While agreeing that detection of bacteriuria and its treatment with an appropriate antibacterial agent at or before premedication is important, I cannot accept that this is an over-riding consideration. Admission procedures in some Units13 make this difficult to achieve and, as Gillespie et al state themselves, sepsicaemia also occurs in patients developing bacteriuria after operation; in Glasgow, bacteriuria arising postoperatively was more common than preoperative bacteriuria.3

Lengthy therapeutic courses of treatment are probably more likely to give rise to organisms resistant to multiple agents than short courses of chemoprophylaxis.4 If it is accepted that infection may occur after screening, or that screening may not be complete by the time of operation, then it is important to use a systemic agent which is effective “therapeutically” as well as “prophylactically”. Obviously no pre-determined drug or drugs can be relied upon to cope with every instance but our study5 assists a choice.

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Detection of bacterial antigens in cerebrospinal fluid

We read Dr Tompkins’ article on the detection of bacterial antigen in cerebrospinal fluid (July 1983) with interest.1 While agreeing that the coagglutination (COA) test does have advantages over counterimmunoelectrophoresis in terms of speed and ease of carrying out the test, we do have some reservations in the light of our recent experience. We examined specimens of CSF from two patients with meningitis, in both cases abundant polymorphs and Gram-negative diplococci were seen and Neisseria meningitidis (group B) was obtained on culture. The Phadebact COA test was carried out on the fresh CSF according to the manufacturer’s instructions. In neither case did the COA test detect meningococcal antigens. In contrast, testing the same specimens by CIE enabled us not only to detect meningococcal antigen but also to group the meningococci. This discrepancy is undoubtedly a reflection of the quality of the antibody used, perhaps that used in the Phadebact system should be replaced by one of higher affinity.

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Freeze dried cryoprecipitate and home therapy

The paper by our colleagues Hambley et al1 on freeze dried cryoprecipitate contains some reservations on its suitability for home therapy of haemophiliacs. Although the product used in this trial was recommended for reconstitution in 100 ml, it does reconstitute rapidly in 50 ml distilled water. The 860 units used per patient could easily be given in a total volume of as little as 100 ml.

The preparation procedure of the newer batches was modified to provide a more concentrated product with an average dose of 430 IU per bottle in a volume of 50 ml.2 Twelve batches of NHS intermediate FVIII concentrate recently used in this region had between 190 and 380 IU FVIII per bottle. Reconstitution volumes ranged from 20 to 50 ml with a final FVIII concentration of 7.6–12.8 IU/ml. The equivalent of 860 IU (two bottles of dried cryoprecipitate) used in this study could therefore have been given as three or four vials of intermediate concentrate in a final volume ranging between 67 and 113 ml depending on the batch in use. The other dose of 500 IU in 20–30 ml mentioned in the discussion of the paper could only be provided by a higher purity concentrate with a potency around 20 IU/ml.

An additional feature of dried cryoprecipitate, not mentioned in the paper, is that it is a small pool product and we believe like many others4 that its use reduces the rate of exposure to hepatitis