countries or in laboratories where the use of blood is a problem and technical expertise is limited the improved selectivity of the blood free medium will simplify the isolation of C jejuni from faecal specimens.

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References

Batch screening method for the detection of bacteriuria

With regard to the toxic effect of boric acid on bacteria in urine, the percentage of false negatives of 16% quoted by Dr Maskell is inaccurate. The studies referred to were not true comparisons, and the dip slide method used as the reference method is liable to an error of over estimation of about 10%. The percentage of organisms falling into the category of 10^9-10^10 organisms/l and >10^10 organisms/l mixed culture was 27.8% with the dip slide method, which is an unacceptably high percentage suggesting a poor standard of specimens. The authors concluded that the loss in positivity may be more apparent than real and that it was difficult to show a significant reduction in count in under 24 h.

Our own experience in a laboratory serving several acute hospitals and scattered domiciliary practices is that boric acid preservative solves more problems than it creates and is an excellent preservative for both white and red blood cells.

It is unfortunate that our published method of urine culture could be interpreted as a protocol introducing undue delay; the whole aim of our service in Bury is to provide rapid information for clinical use. We prepare a full plate culture and direct sensitivity on all urines with >10 white blood cells per mm^3 and aim to report on quantitative urine bacterial growth with a direct sensitivity test result and presumptive identity of organisms on the morning after the day of receipt of the specimen. This puts out between 85-90% of reports, and where further work is needed an interim report may be issued.

We believe that our approach is a cost effective method of providing rapid clinical reports. In processing over 30 000 urine specimens a year we can have less than a whole time equivalent of scientific officer time being dedicated to urinary work.

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References

The pathology of meconium ileus equivalent

Dr J Jeffrey et al describe sulphomucin in the ileum of adults with cystic fibrosis. They may be interested to learn that Dr S Spicer and I found sulphomucin in duodenum (where normally only sialomucins reside) in patients with cystic fibrosis and also in non-cystic fibrosis patients with duodenal ulcers. It thus seems unlikely that it is unique to that disorder. Moreover, increased sulphomucins are found in other epithelial sites in non-cystic fibrosis inflammatory disorders. Although it is tempting to explain the increased viscosity and other properties of cystic fibrosis mucus on this basis of increased sulphate content, the finding is probably nonspecific.

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References

Dr Jeffrey and colleagues comment as follows:
We are grateful to Dr Lev for the interest he has shown in our case report and we are, of course, familiar with his and Dr Spicer’s early publication on the histochemistry of mucus in cystic fibrosis. Their paper was not quoted because, to a large extent, their qualitative work has been confirmed and superseded by the quantitative study of Morrissey and Tymvos, who cite the 1965 article.

We agree with Dr Lev that the presence of sulphomucin in the small intestine is not unique to cystic fibrosis. Indeed, trace amounts of sulphomucin can be detected even in normal small intestinal mucosa (Wells, unpublished observations) though the acidic mucin component is, as we