Letters to the Editor

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.

DN HUTCHINSON
FJ BOLTON
Public Health Laboratory, Preston Infirmary, Preston PR1 6PS

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 $10^8$ organisms/l and $>10^9$ 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.

PETER KERFOOT
DUNCAN McGHIE
Clinical Microbiology Department, Bury General Hospital, Bury, Lancs BL9 6PG

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
stated, "almost exclusively non-sulphated". This does not detract, however, from the important finding of intense focal sulphomucin positivity in our case. We also agree that increased sulphomucins may be found in other epithelial sites in non-cystic fibrosis inflammatory disorders. In our paper we made no attempt to attribute directly the increased viscosity and other properties of cystic fibrosis mucus to increased sulphate production, though this was obviously implied. None the less, if this is the case it seems likely that the amount of sulphomucin produced, and not merely its presence, would be a decisive factor. Furthermore, any such effect would tend to be heightened in the terminal ileum due to the consistency of the faecal stream and the reduced diameter of the gut at the ileocaecal valve.

In 1965 Dr Lev and Dr Spicer stated that "the histochemically observed increase in sulfomucin (in cystic fibrosis) may be related to the abnormality of the secretion." While it is difficult to draw general conclusions from a single case we are surely implying no more than that. It is interesting that, 19 years on, Dr Lev appears to be modifying his conclusions in a letter to this journal.

1 JEFFREY
2 M WELLS
3 H FOX

Departments of Pathology, *University of Manchester and University of Leeds

References


Computers in histopathology

Details of our word and data processing system have already been published.1-4 The recent article by Dr Subbuswamy and others5 prompts us to describe an unpublished aspect of our system: the reference storage and retrieval facility. This development has been made possible by the design of the histopathology system, which allows areas of new interest to be accommodated easily. Such flexibility is of major benefit and should be aimed for in all systems.

Our laboratory sees relatively large numbers of cutaneous malignant melanoma, about 80-100 a year, and a special interest in this condition developed some years ago. With the advent of the histopathology computer (a DEC PDP 11/23) we took the chance to computerise the references gathered on this subject—currently about 300. The computer was simply programmed to provide a format on to which details of each article can be entered (Fig. 1). This required about 1 h of work. The first three sections are for the author’s details, and the choice of only the first three authors was quite deliberate; more could have been accommodated with ease. The next sections are for title, journal, year, volume, and page entries, followed by a section for an abstract or notes to be written. Finally, come the sections marked “codes” and “identity”. We have categorised the melanoma published work into 29 subtypes according to a simple numerical system (Fig. 2). The relevant numbers are inserted into the “codes” section, depending on the nature of the article—for example, MM01 for an article concerning prognosis. Most articles cover more than one aspect of the 29 subsections and so several code entries for each article is common. The section “identity” allows the consultant to identify those items which they have specified as needing further investigation.

With all entries appropriately coded it is possible to identify with ease common groups of emphasis—for example, all papers concerned with melanoma thickness. The computer takes literally only a minute to identify these common groups and then offers the choice of a view or print option, either numerically or alphabetically. Similar selections, singly or in combination, can be made on other parameters—for example, author, journal, or year—thereby

Fig. 1

Fig. 2

Format of Code=Nxxx

1=Prognosis 12=Regression 24=Non-skin sites
2=Type 13=LA 25=Fixed lesions
3=Immunology 14=Other melanin tumours 26=Animal
4=Histogenesis & Lesional 15=Lymphocytes 27=Pregnancy and
5=Evolution 16=Other metastases 28=Incidence
6=Behavior(clinical) 17=Stepping 29=Recurrent
7=Management/Treatment 18=Site
8=Thickness 19=Others
9=Levels 20=Chemistry
10=Hypomorphism 21=Pathology
11=Histology 22=Others
13=Lesion type
14=Lesion type
15=Lesion type
16=Lesion type
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