

- 5 Coppleson JA, Mufti GJ, Hamblin TJ, Oscier DG. Immunological abnormalities in myelodysplastic syndromes. II. Coexistent lymphoid and plasma cell neoplasms: a report of 20 cases unrelated to chemotherapy. *Br J Haematol* 1980;63:149-59.

Laboratory diagnosis of *Branhamella catarrhalis*

Ahmad *et al* have highlighted the problem of distinguishing *Branhamella catarrhalis* from the *Neisseria* genus¹ but their identification scheme of up to nine characterisation tests may not find favour in a busy diagnostic laboratory.

To rely on the failure of *B catarrhalis* to grow either anaerobically or on selective media is to place much emphasis on a negative test. Furthermore, it is recognised that *B catarrhalis* may grow on modified Thayer-Martin (MTM) medium, and may fail to grow on nutrient agar incubated at 22°C.² The lack of pigmentation of *B catarrhalis* is likely to be a more useful characteristic than its positive superoxol test. *N perflora*, *N pharyngis*, and *N mucosa*—all superoxol negative—are pigmented as are the common superoxol positive non-pathogenic *Neisseria*.³

The demonstration of the ability of *B catarrhalis* to liberate high concentrations of butyric acid from tributyrin is a useful diagnostic test^{3,4}: it can be carried out using commercial discs impregnated with tributyrin and phenol red (A/S Rosco). A positive reaction is indicated by a yellow colour after six to 12 hours' incubation at 37°C. If the indicator remains red after 24 hours the test is negative. *B caviae*, *B ovis*, and *B cuniculi* produce moderate amounts of butyric acid but are not encountered unless the specimen is of animal origin. All *Neisseria* strains produce negative results.

The colonial appearance of *B catarrhalis* will distinguish it from the pathogenic neisseriae *N meningitidis* and *N gonorrhoeae*. The following minimal criteria will differentiate *B catarrhalis* from non-pathogenic *Neisseria* species: lack of pigmentation, failure to produce acid from glucose, nitrate reduction, tributyrin and Dnase activity.

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References

- 1 Ahmad F, Young H, McLeod DT, Croughan MJ, Calder MA. Characterisation of *Branhamella catarrhalis* and differentiation from *Neisseria* species in a diagnostic laboratory. *J Clin Pathol* 1987;40:1369-73.

- 2 Doern GV, Morse SA. *Branhamella* (*Neisseria*) *catarrhalis*: criteria for laboratory identification. *J Clin Microbiol* 1980;11:193-5.
- 3 Wilson G, Wilkinson AE. *Neisseria*, *Branhamella*, and *Moraxella*. In: Parker MT, ed. *Topley and Wilson's principles of bacteriology, virology and immunity. Vol 2 Systematic bacteriology*. 7th ed. London: E Arnold, 1983:162-7.
- 4 Riou JY, Buisserie J, Guibourdenche M, Brault G, Carlier JP. Hydrolyse de la tributyrine par les *Neisseria* et les *Branhamella*. *Ann Microbiol* 1981;132A:159-69.

Dr Ahmad comments:

Dr Cooke has perhaps missed the point of our paper. We set out to discover the simplest way of accurately identifying *B catarrhalis* and differentiating it from other *Neisseria* species. Of course, there are many other tests that can be applied to achieve the same purpose. The main tests used in our study, in addition to usual microscopy and carbohydrate fermentation tests, were superoxol and Dnase activity. The growth on various commonly used culture media and under different conditions is recommended for difficult strains not identifiable by the routine techniques.

The colonial and microscopic appearance of *B catarrhalis* is very familiar to all experienced workers in respiratory bacteriology. One would not rely on this criterion alone. Similarly, pigmentation and even rough and smooth nature of colonies in the family *Neisseriaceae* is variable. Tributyrin hydrolysis is a valuable test, has recently been made commercially available, and could be used if so desired as an additional test. Nitrate reduction is yet another available test but, when using Dnase and superoxol tests, we found both to be unnecessary.

Vero toxin producing *E coli* in haemorrhagic colitis

Walker, Upson, and Warren tested 80 faecal samples from patients with bloody diarrhoea or microscopic evidence of red blood cells and found four with *Escherichia coli* 0157 and 22 with *Campylobacter*, *Salmonella*, or *Shigella*.¹ We have also looked for Vero toxin producing *E coli* in patients with haemorrhagic colitis. Freshly passed stools from 40 patients recently admitted to the Northwick Park Lister Infectious Disease Unit were quantitatively cultured on both selective and non-selective agar. Ten colonies of each type of coliform were subcultured for identification and further testing, including subculture from both the higher and lower dilutions inoculated. Fresh rectal biopsy tissue from 17 patients was homogenised and cultured in a similar way.

Fourteen patients yielded campylobacters, salmonella, or *Shigella*; one specimen contained *Entamoeba histolytica* trophozoites. No *E coli* were isolated from seven patients. *E coli* from the remaining 18 patients were sorbitol fermentors. Six biopsy cultures yielded sorbitol positive *E coli* and no biopsy yielded organisms not also found in the stool. These *E coli* strains were inoculated into syncase/glucose broth and tested for Vero toxin production.² A Vero toxin positive control strain obtained from Dr Sylvia Scotland (Colindale) and a Vero toxin positive strain isolated from a patient with haemolytic uraemic syndrome by Dr SP Borriello (CRC) were tested in tandem. Both positive control strains were positive on assay in Vero cells, but none of the *E coli* strains from patients with haemorrhagic colitis was.

Bloody diarrhoea without routinely recognised microbial or viral pathogens is a common presentation to an infectious disease unit.^{3,4} Vero toxin producing *E coli* are clearly responsible for some cases of haemorrhagic colitis in the United Kingdom. Our results, which agree with those of Walker *et al*, show that these organisms do not appear to be responsible for the common, sporadic, form of haemorrhagic colitis seen in the community.

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References

- 1 Walker CW, Upson R, Warren RE. Haemorrhagic colitis: detection of Vero toxin producing *Escherichia coli* 0157 in a clinical microbiology laboratory. *J Clin Pathol* 1988;41:80-4.
- 2 Willshaw GA, Smith HR, Scotland SM, Rowe B. Cloning of genes determining the production of vero cytotoxin by *Escherichia coli*. *J Gen Microbiol* 1985;131:3047-53.
- 3 Jewkes J, Larson HE, Price AB, Sanderson PJ, Davies HA. Aetiology of acute diarrhoea in adults. *Gut* 1981;22:388-92.
- 4 Mandal BK, Schofield PF, Morson BC. A clinico pathological study of acute colitis: the dilemma of transient colitis syndrome. *Scand J Gastroenterol* 1982;17:865-9.

Book review

Steroid Hormone Receptors. Their Intracellular Localisation. Ellis Horwood Series in Biomedicine. Ed CR Clark. (Pp 277; DM 125.) VCH. 1987. ISBN 0-89573-498-2.

This multi-authored book examines the ques-