Slide coagulase positive, tube coagulase negative Staphylococcus aureus

We read with interest the letter by Smyth et al and wish to report a similar organism isolated recently at our hospital. The organism was grown in six blood culture bottles from a 14 year old boy with hypertrophic cardiomyopathy. An extensive intramyocardial abscess was seen on echocardiography. The isolate was rapidly and unequivocally positive using fibrinogen sensitised sheep erythrocytes in a slide test to detect clumping factor (Staphyslide-Test, BioMérieux, France). Tube coagulase testing was repeatedly negative. The isolate was strongly DNase positive and produced acid aerobically from maltose, trehalose, mannitol, mannose and sucrose but not from xylose, cellobiase, nor raffinose. Nitrate was reduced, acetoin was produced, and the organism was sensitive to novobiocin. These tests confirmed the identification as Staphylococcus aureus.

We are at present changing our laboratory procedure from routinely performing tube coagulase testing in all staphylococci to the use of "Staphyslide" to test for S aureus with tube coagulase as an additional test for "Staphyslide" negative colonies. From over 300 tests run in parallel we have yet to find a false positive or a false negative slide test for a methicillin sensitive S aureus.

In the light of the experience with these cases, ours, and that of Smyth et al, laboratory staff should be aware of the rare occurrence of false negative tube coagulase tests. We consider "Staphyslide" to be a sensitive and specific test for speciation of S aureus and suggest that its use should be considered for early identification of S aureus.

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Reference

Hair "follicle" in tonsil

The description of a hair "follicle" growing in the palatine tonsil is a misinterpretation. I suggest that what the authors were viewing was flattened, normal tonsillar crypt epithelium closely adherent to a foreign fragment, possibly an ingested hair shaft. I, too, have seen hair shaft-like particles in the tonsil. These were, like the reported case, separated from the crypt epithelium by an amorphous layer—eosinophilic in my original (figure). A semblance of neither the glassy membrane nor the connective tissue sheath, which are characteristic of hair follicles, cannot, on the other hand, be identified in the tonsillar structure shown in the letter or in my own material.

Contrary to the statement in the letter of Hasleton et al, there is indeed a reference to hair follicles growing in the tonsil provided in my book. This is with regard to hairy polyp, or teratoid tumour, a neoplasm which usually occurs in the pharyngeal tonsil, but which may be sometimes seen in the soft palate adjacent to the palatine tonsil. It is highly unlikely, however, that an isolated hair follicle will ever be found in any part of the tonsil.

Sebaceous glands opening directly on to the oral mucosa—Fordyce spots—are common in the oral cavity, but they are never associated with hair follicles.

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References

Dr Hasleton et al comment:

We thank Professor Michaels for his comments, but we would like to make several points. Hair follicles are not mentioned in the