Screening for Covert Bacteriuria

SIR,—MacConkey's medium was intentionally made inhibitory so as to simplify work with Gram-negative bacteria of faecal origin. Some Gram-positive organisms will not grow on it at all, and the speed and profusion of growth of those that will are markedly altered by minor variations in its formulation. For this reason Mr. R. Hole's doubts (19 July, p. 160) about the use of CLED medium for urinary bacteriology, and his inference that MacConkey's medium is superior to it for this purpose, should not be accepted uncritically, because the exclusive use of MacConkey's medium must perpetuate a narrow view of the possible range of urinary pathogens.

The significance of Gram-positive organisms other than *Streptococcus faecalis* as causes of urinary tract infection has attracted rather low-key attention for many years, but the pathogenic role of certain strains of coagulase-negative staphylococci seems now as firmly based as is that of *Escherichia coli*. There is thus a good reason for suggesting that a non-selective medium like CLED should always be used in urinary bacteriology in preference to an inhibitory medium like MacConkey's. To take the opposite view is to extinguish not only a number of potential pathogens, but also the possibility of argument about them.—I am, etc.,

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Antibiotic Policy

SIR,—Mr. O. J. A. Gilmore and Dr. P. J. Sanderson (19 July, p. 161) have attacked the use of topical antibiotic prophylaxis of surgical wound sepsis without producing a shred of evidence for their statements that this policy encourages skin sensitivity and bacterial resistance. They extol the virtue of a topical application of povidone-iodine, but we have shown¹ that in potentially contaminated operations the rate of primary wound sepsis was almost three times as great after povidone-iodine prophylaxis (32%) as it was after intra-incisional instillation of cephaloridine 1 g dissolved in 2 ml of water (11%). The emergence of bacterial resistance associated with topical chemoprophylaxis has been recorded only after repeated applications of antibiotics for the control of secondary sepsis in burns.²

We have used cephaloridine successfully for the prophylaxis of wound sepsis in a series of controlled clinical trials in more than 1200 patients over the past four years. Scrutiny of the bacteriological records of organisms from all hospital patients in 1971 and 1974 showed a resistance rate to cephaloridine of 20.4% and 20.5% respectively. In no single species was there evidence of emergence of resistant strains. No patient in the entire series developed skin sensitivity or any other signs of toxicity. Nevertheless, though we are satisfied that at present our use of topical cephaloridine is not altering the hospital flora in any way, we shall continue our search for an agent which is both as effective as cephaloridine and not in use as a systemic therapeutic agent.—We are, etc.,

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- 1 Pollock, A. V., and Evans, Mary, *British Journal of Surgery*, 1975, 62, 292.
- 2 Lowbury, E. J. L., and Ayliffe, G. A. J., *Drug Resistance in Antimicrobial Therapy*. Springfield, Thomas, 1974.

Colour Disturbance as a Symptom

SIR,—I write in reply to Dr. M. J. Pleydell's question (19 July, p. 159) about the repercussions of colour disturbance in doctors and those in other occupations. I first learnt of my red-green colour blindness as an undergraduate when I was shown the Ishihara test. I remember being incredulous and a little resentful, and remonstrated with none less than Sir Charles Sherrington. I recall great difficulties with histology, and eventually had to bluff my way through using means other than colour with which to detect small nucleoli, etc. After the war I lived perhaps more exuberantly than some, and well remember my fellow registrars complaining (as now) how their small income was insufficient even for very modest social undertakings. I remember telling my wife I thought they were an over-cautious lot, saying "I get a statement from the bank every month and each time it seems bigger." She asked to see the statement, and I reversed my attitude abruptly when she pointed out it was in red.

The most serious implication in medicine is that of the recognition of cyanosis. I have become more aware of this shortcoming (though I was slow to realize it) and it is one reason why as a psychiatrist I would be most hesitant to give E.C.T. without an anaesthetist. One develops compensatory mechanisms but not to the point of reliability. Since one male in 12 is so affected it is a matter for wonderment that for innumerable years red and green have been the acknowledged signs for danger and safety. I am told that even a person with normal vision has difficulty seeing red traffic lights when the sun is shining on them. This is much more true of the colour blind. Why could such lights not be bisected, half red and half yellow and half green and half blue, or even have diagonal lines on red lights and stippling on green ones? It seems such a simple and inexpensive solution to such a common and important problem.—I am, etc.,

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SIR,—In reply to Dr. M. J. Pleydell (19 July, p. 159) may I relate my own experience of defective red/green colour vision? The abnormality was diagnosed by a colleague using Ishihara test cards when we were undergraduates and later confirmed at my army medical examination. The defect runs in my mother's side of the family in the usual sex-linked manner. The only way it has affected me personally is that I have always found great difficulty in seeing Ziehl-Neelsen-stained tubercle bacilli. The red devils always escape me. This, however, has never affected my profession as a gynaecologist and only meant that I skipped practical clinical bacteriology as a medical student and retired to the golf course.—I am, etc.,

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Vagotomy for Duodenal Ulcer

SIR,—We would like to comment on the controversy which has arisen in your columns between Drs. P. Madsen and O. Kronborg (21 June, p. 688) and Mr. D. Johnston and Professor J. C. Goligher (12 July, p. 101). The heart of this controversy appears to be the reliability of Hollander's criteria for interpreting the postvagotomy insulin test. These criteria are of some help in forecasting recurrent ulceration when they are applied to groups of subjects but of no value in the individual patient, a point which Hollander himself emphasized.^{1,2}

Our recent publications^{3,4} throw some light on this matter. The lack of reliability of the Hollander criteria is largely due to the variability of basal gastric secretion⁵ and also, to some extent, to errors produced by pyloric losses and duodenogastric reflux. Even without correcting for the latter factors the reliability of the insulin test is greatly improved by considering the acid output after insulin without reference to the basal. Male patients with a peak acid output (P.A.O._I) (uncorrected) in excess of 8 mmol/h have much greater than 50% liability to recurrent ulceration, while those producing less than 8 mmol/h have virtually no risk of recurrence. For example, this criterion applied to Kronborg and Madsen's data⁶ gives a "positive" result in all but two of their recurrent ulcer cases. One of these was a woman and we do not yet have sufficient data to establish the critical P.A.O._I in women, while the other was a man with a P.A.O._I of 7.6 mmol/h who may be an example of the need for correction for reflux and pyloric losses.³ A further advantage of our method of interpretation is that it seems to be independent of the length of time after vagotomy when the test is performed.⁴

It would be interesting to know what picture would emerge if both these groups of investigators recalculated their results along the lines we have described.—We are, etc.,

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- 1 Hollander, F., *Gastroenterology*, 1948, 11, 419.
- 2 Weinstein, V. A., et al., *Gastroenterology*, 1950, 14, 214.
- 3 Faber, R. G., et al., *Gut*, 1975, 16, 337.
- 4 Faber, R. G., et al., *Gut*, 1975, 16, 343.
- 5 Baron, J. H., *Gut*, 1963, 4, 136.
- 6 Kronborg, O., and Madsen, P., *Gut*, 1975, 16, 268.

Alternative to Slow-release Potassium Tablets

SIR,—It has puzzled me for years why physicians prescribe slow-release potassium tablets, with the known complication of intestinal ulceration. If oral potassium supplements are required with diuretic therapy the more palatable and better-tolerated equivalent is fruit juice. The sodium content is very low and average potassium contents per 100 g are as follows: apple juice 2.6 mmol (100 mg), grape juice 3.1 mmol (120 mg), grapefruit juice 3.8 mmol (150 mg), orange juice 4.9 mmol (190 mg), pineapple juice 3.6 mmol (140 mg), raspberry juice 3.6 mmol (141 mg).¹

A glass of fresh orange juice twice a day provides 25 mmol potassium and should not disturb fluid balance significantly. The juice can be ingested after meals and smaller