

URINARY TRACT INFECTIONS:

The Classical Diagnostic Approach

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*Treating the patient as has been the vogue,
you continue to get what you've always begotten.*

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I want first of all to thank the ICA for this opportunity to appear before you and discuss our mutual problem, affecting perhaps 100x as many patients in this country as are here represented. I'm sure some of you are here because you already believe in this work of mine. Others very skeptical of new ideas; or very confused by the thousands of pages of literature expressing well-kept traditional views on the subject. Many of you have wandered from pillar to post, treated, advised, disillusioned, referred dozens of times with no progressive amelioration from experts, researchers, institutes, and specialty centers. You have been there and know the scenario of disappointment — even to having removal of the bladder.

I think the one basic stumbling block to everyone's vision in UTI/IC is the gross lack of understanding of bacteriology itself. In this discipline we must realize that for diagnostic work, one has to distinguish between contaminants (no bearing on infection) and etiologic bacteria (which do have direct bearing on infection).

The first slide shows why in UTI, the doctors, laboratories, and patients are misled and misdiagnosed. This slide is a photocopy of a statement from Bailey & Scott's Diagnostic Microbiology: "as many as 60% to 80% of all urine specimens received for culture by the average hospital laboratory may contain only contaminants or no etiologic agents of infection." It does not take especially high level of interpretation to realize that transfer of such specimens to agar media for colony count cannot fail to produce a significant of contaminants. These are accepted by the lab and reported as agents of infection; hence a gross diagnostic error calling for antibiotics effective against contaminants and of no useful therapeutic value: leading only to chronic urinary tract distress.

This accepted concept in urine culture procedure fills the literature hundreds of times; and who is going to have any success arguing with the majority when it is so easy going along with tradition?

The second slide is a photo of a agar plate culture, highly speckled with thousands of colonies (including five colonies standing out in clean growth). If this were a urine culture there would be no difficulty accepting the massive colony growth as sufficient > 100,000 count for a positive culture. However, this is the culture from the throat of a student with symptoms of sore throat. Those five clean colonies were found to be hemolytic streptococci (the actual cause of the patient's condition) diagnosed, not by colony count but by classic pure culture technology to exclusion of all the thousands of contaminants also present. The point being made here is that all specimens received for culture are likely to contain high levels of contaminants. To find and recognize the etiologic agent among them requires classical pure culture technology. Plate counts are worthless. As indicated above, contaminants are easily found to exclusion of the causative agent: pointing to diagnostic error based on predominance of contaminants.

I've been a research/diagnostic microbiologist for over 50 years. As such I've had thousands of occasions to uncover the agent of infections and to advise many doctors even at bedside in this regard. A half-century in such consultation has made me a scientist you will not expect to find in abundance.

In the minds of the average people considering causes of UTI/IC, there seems to be an accepted attitude "You win a few and you lose a few," and it doesn't matter percentage-wise. This attitude is not acceptable in classical microbiology. Here, I contend that any wrong diagnosis is a 100% error and I can't accept it. A diagnostic error is essentially an impossibility in the hands of a trained microbiologist. By plate count, delegated to a lab technician, the error is well over 80%; that's the source of so many cases of UTI/IC: chronic cases that have

never been properly diagnosed.

While you are not interested in my life history, herein lies the secret to my new technology. You might hope that from my one voice “crying in the wilderness” might come words of wisdom as from a clinician, a physician with great insight experience, head and shoulders above all. To this day I assure you there is no such clinician, now or ever, who can make a reliable diagnosis regarding UTI on basis of tests done in anyone’s lab by the present-day plate count procedure. The fully reliable diagnosis by plate count has never been made, and never will. Physicians are not trained microbiologists in any sense. They do not see the plate count procedure except as invented by an armchair pseudo-scientist intending to become a hero with quick answers that sound logical but easily confuse or impress the physicians. Here I have a report that does just that.

I have a copy of an article printed in one of the most prestigious journals, reciting hundreds of pages of literature. This agglomeration of writings from 75 authors is supposed to assist doctors and labs alike in evaluation of UTI testing. The very first paragraph says just that. However on page 9 are given about 20 “reasonable laboratory interpretations” proposed on basis of lab reports as found for different levels of colony counts and other considerations. These are the reports: 5 possible UTI; 6 probable UTI; 1 doubtful UTI; 3 no UTI, etc; but no emphatically unquestionable Positive UTI. The plate count is notorious for taking you know where and this article even more so. How can anyone see logic and value in such interpretations.

As in all infections, including UTI/IC, there is only one group to definitive diagnosis, and that is by way of classic pure culture technology. It worked for Pasteur, Ehrlich, Koch and Zinsser and other past giants in microbiology; and it still works today. My half-century in these clinical studies bears witness that there is no substitute quick-route answer. The lab must separate, know and recognize the pathogen even from among three or more contaminants; focus on its isolation – by classical technology only! With the true facts behind him the physician has wisdom, otherwise he is just speculating playing the odds and it is the HCFA paying the bill, propagating more and more chronic cases.

This is the nature of my classical Urinary Research Center (URC) technology: it is 100% reliable. I have found the specific pathogens in essentially 100% of the symptomatic patients, and so can any other qualified laboratorian, who has the fortitude to venture away from jet-age traditions into well proven classical technology. This technology is available – the seriously interested physician must demand it for diagnosis of his patients. No more guessing games. Furthermore, we must demand it of the CDC, HCFA, and the FDA; these agencies have the capabilities as well as the authority and legal obligation, if they are willing to set aside the cheap tradition practiced everywhere. The health of over 750,000 chronic cases demands it. It must have Federal level attention! The classical pure culture technology must be instituted in all clinical laboratories. The elementary “quickie” plate count procedure must be outlawed as it is totally unreliable, witnessed by the thousands of chronic cases despairing for truth in clinical testing and treatment.