Attempts to transmit *Campylobacter* enteritis to dogs and cats

To the editor: An increasing number of reports have linked a fairly characteristic diarrheal syndrome in man with infection by *Campylobacter fetus* subsp. *jejuni*;[1-7] this organism may indeed be the most common bacterial agent of infectious diarrhea in man.

The epidemiology of the disease is not understood, but reports implicate chickens,[2-4] cattle[8] and dogs[3,5] as sources of the organism. Strains of the species recovered from infected humans cross-react serologically with strains from chickens,[2,4] in which they are described as causing focal hepatitis;[9] however, the relation of the strains infecting humans to those reported as causing "winter dysentery" in cattle[10] is not known.

The reports that dogs with diarrhea might be a source of infection for humans stimulated us to attempt transmission of diarrhea to puppies and kittens using strains of organisms recovered from children with diarrhea. Two strains (HSC S8014/77 and HSC S7363/77) from children at the Hospital for Sick Children in Toronto were used. Three 6-week-old kittens and three 7-week-old puppies were given orally 2.5×10^{10} organisms of both strains. Rectal swabs, taken daily, were inoculated onto the selective medium described by Skirrow[5] and incubated in GasPak jars (Baltimore Biological Laboratories, Cockeysville, Maryland; disposable generator envelopes supply a gas mixture containing carbon dioxide and hydrogen) for 48 hours. Colonies were identified as *C. fetus* subsp. *jejuni* on the basis of the general colonial morphology, the characteristic pinkness, the slow cytochrome oxidase reaction and the results of Gram staining.

C. fetus subsp. *jejuni* was detected in the feces of all the animals for 2 to 3 days after inoculation, but the only evidence of diarrhea was a transient attack in one dog 10 days after infection; *C. fetus* subsp. *jejuni* was not recovered from the diarrheal feces.

In a second experiment with a similar dose of a pure culture of HSC S8014/77 given to three 4-week-old puppies, organisms were detected in the feces during the first 3 days after inoculation but there was no evidence of diarrhea during the 10 days of the experiment.

On day 5 of the first experiment mild diarrhea began in one of us (J.F.P.); on day 6 blood and mucus were present in the stools, and moderate diarrhea, flatus and mild central abdominal pain were noted. During the next 3 days no such symptoms were present. *C. fetus* subsp. *jejuni* was recovered from the diarrheal feces and identified as described. Serum from blood samples taken 10 days and 58 days after the onset of this illness was tested against both experimental strains by a serum bactericidal assay. The 10-day serum gave a titre of 64 and the 58-day serum gave a titre of 16 when tested against strain S8014/77. No serologic response was present against strain S7363/77. The specific bactericidal antibody response to strain S8014/77 and the substantial fall in titre during late convalescence strongly suggested an etiologic role for *C. fetus* subsp. *jejuni* in this illness.

The implications of these results are twofold: (a) there is a risk to laboratory workers handling strains of this species, and (b) a dose many times the one that evoked diarrhea in a human did not cause diarrhea in six puppies and three kittens, which suggests that dogs and cats are far less susceptible, if at all, to infection than man. However, the organisms will survive, though possibly only transiently, in the intestinal tract, so that these animals may represent an indirect hazard to their owners. Work is continuing into aspects of disease in animals due to this organism.

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References

1. KING EO: Human infections with *Vibrio fetus* and a closely related vibrio. *J Infect Dis* 101: 119, 1957
2. Idem: The laboratory recognition of

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Vibrio fetus and a closely related *Vibrio* isolated from cases of human vibriosis. *Ann NY Acad Sci* 98: 700, 1962

3. WHEELER WE, BORCHERS J: Vibrionic enteritis in infants. *Am J Dis Child* 101: 60, 1961
4. BUTZLER JP, DEKEYSER P, DETRAIN M, et al: Related vibrio in stools. *J Pediatr* 82: 493, 1973
5. SKIRROW MB: Campylobacter enteritis: a 'new' disease. *Br Med J* 2: 9, 1977
6. Campylobacter enteritis. *Can Dis Wkly Rep* 3: 183, 1977
7. Campylobacter enteritis — Ontario. Ibid, p 198
8. Campylobacter enteritis — Colorado. *Morbid Mortal Wkly Rep* 27: 226, 1978
9. PECKHAM MC: Vibrionic hepatitis, in *Isolation and Identification of Avian Pathogens,* 3rd rev ed, HITCHNER SB (ed), American Association of Avian Pathologists, College Station, Tex, 1975
10. JONES FS, LITTLE RB: Vibrionic enteritis in calves. *J Exp Med* 53: 845, 1931

The wondering, wandering patient

To the editor: I believe Dr. A. Hurtig's idea that patients be provided with a booklet containing their relevant medical information to be extremely good (*Can Med Assoc J* 119: 19, 1978). On the other hand, as a patient whose 15 years of iatrogenic illness have caused me to view medical records with a somewhat jaundiced eye, I have some comments to make.

Most patients are told by their physicians that all medical information is confidential and is therefore to be kept secret from them. It seems that the legal and medical professions define privilege differently. To most people, including those in the legal profession, the presumption is that the privilege is attached to the patient, not to the doctor — that is, *only* the patient and the attending physician have a right to the information. Indeed, this is the reason people feel at liberty to "spill all" to their physicians — the mistaken belief that anything said will be kept in confidence. In actual practice it seems that anyone but the patient may have a right of access to this confidential information, including insurance companies, employers, government agencies and sundry others, often without the patient's knowledge or consent or both.

This explains why the patient may have no knowledge of his or her medical condition. Circumstances have improved in recent years since many patients can read prescriptions, and pharmacists are now legally required to label prescription bottles. In the past, pharmacists were wont to tell patients that what they were prescribed was none of their business.

It is true that some patients do not even know the name of the physician or the hospital in charge of the case. This occurs because often a sick person seeks medical advice, is refused information and turns to one doctor after another, seeking relief from misery. Alternatively, the physician, in all good faith, may refer a patient to a specialist, who in turn refers him or her to another specialist, ad infinitum. When asked the name of his or her physician the patient is likely to respond "I don't know. Dr. A. pulls my toe, Dr. B. looks into my eyes, Dr. C. listens to my heart and Dr. D. plays with my reflexes. When I ask for information I am inevitably told, 'Don't ask me. I'm not your doctor.'" In the meantime the patient has become a collection of parts, each of which is in the possession of numerous physicians; not one physician knows the sum of the whole. No wonder, then, that the patient is confused. Even worse, the patient has now in all likelihood been labelled as having Munchausen's syndrome; in the event that he or she turns up in an emergency room, what is left is likely to be incarcerated in a psychiatric ward or institution to be tortured indefinitely.

A booklet containing the appropriate medical history is not only viable economically and as a time-saver, but also may save the patient's life or liberty. It could also potentially save the patient's reputation, marriage, career and entire lifestyle.

Our Medic-Alert system is a good start in the right direction; however, its use depends upon patients' knowing what their medical condition is, what medication they are taking and the name of their primary physician or hospital or both. It would also obviate the problems that arise when physicians are confronted with the dilemma of choosing to believe either the patient or the hopelessly befuddled intern or resident who may have written a farce or pornography into