376). Clearly, 210 ml of undiluted sodium hypochlorite cannot come in contact with the entire fluid path, as it has a volume of 1100 ml.

We conclude the following:

1. The authors' study lacks sufficient control to allow them to conclude that their disinfection procedure was effective.
2. The authors' claim that Cobe's disinfection procedure is unsatisfactory must be rejected, for the authors *never used* Cobe's disinfection procedure.
3. The authors' study has not demonstrated the safety of their recommended procedure, and in fact, they warn of the unsafe aspects of introducing high strength sodium hypochlorite into the Centry 2. They present no guidelines for adequate rinseout, or for testing for residual sodium hypochlorite after using their procedure.

Cobe stands behind the cleaning and disinfecting procedures we have recommended for the Centry 2. We have demonstrated their safety and efficacy for their intended use. Users who elect to employ procedures other than those recommended by Cobe should recognize that they must bear full responsibility for demonstrating the safety and efficacy of those procedures.

Cobe is recognized throughout the hemodialysis community as a company committed to providing a high level of support to our customers. We have offered in the past, and will continue in the future, to offer the authors of this paper, and all Cobe equipment users, technical support to help assure safe, high quality hemodialysis therapy.

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Director, Hemodialysis Quality Assurance
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To The Editor:

We are pleased to have the opportunity to respond to the comments raised by Cobe Laboratories to our article appearing in Volume 2, Number 5 issue of Infection Control, *1981. We believe that the comments by Cobe of our study are the result of a misunderstanding. Initially, it is noted that since the implementation of our suggested disinfectant procedure, we have been using and continue to use Cobe Centry 2 Dialysis machines, and have purchased additional machines during this period. Our article was not intended to be critical of the manufacturer's Centry 2 machine nor of the manufacturer's responsiveness in attempting to resolve possible problems in the utilization of the machine. Rather, our article was intended to demonstrate that our suggested cleaning procedure between patient treatments yields better results than the manufacturer's recommended procedures in terms of bacterial counts.*

Specifically, we have in the past and continue to utilize the manufacturer's suggested 100 hour formaldehyde disinfectant process. Our suggested disinfectant process relates only to "between-patient" procedures and the results of our tests demonstrate that a significantly lower bacteria count is obtained utilizing our "full path" method rather than the manufacturer's suggested "partial path" procedure. Further, our test results included an analysis of water inlet counts. These results show a reduction in colony counts at the predialysis stage to microbiologically acceptable levels if our "full path" method is utilized, regardless of the quality of the inlet water.

The manufacturer asserts that our method may result in additional corrosive effect on parts of the dialysis machine. We have utilized our suggested procedure on a continual basis for the last 18 months and have experienced no adverse consequences vis-a-vis the operation of the machine or patient safety. It is opined that any such possible increased corrosion effect is remedied through the normal machine maintenance program.

Obviously, this is a brief response to comments made about our article. Should someone wish to discuss specific aspects of our study, we would be happy to share them.

Very truly yours,
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