concerns me in this type of criticism is the tacit dismissal of the research findings. I thought that listening to patients was the linchpin of clinical care. Was I mistaken?

—Cynthia Mathieson, PHD
Halifax

Only full support needed

The joint statement of the Canadian Paediatric Society (CPS), Dieticians of Canada, and Health Canada[1] is clearly placing the interests of the artificial baby milk industry ahead of the interests of mothers and babies. Furthermore, it pales in comparison to The American Academy of Pediatrics's recent widely published statement entitled, "Breastfeeding and the Use of Human Milk."[2] The AAP states, "Human milk is uniquely superior for infant feeding and is species specific; all substitute feeding options differ markedly from it... Exclusive breastfeeding is ideal nutrition and sufficient to support optimal growth and development for approximately the first six months after birth." It recommends a gradual introduction of solid foods and that breastfeeding continue for at least 12 months and thereafter for as long as mutually desired.

The AAP recommends that practitioners weigh thoughtfully the benefits of breastfeeding against the risks of not receiving human milk. It also recommends that only selected groups of infants might need vitamin D before 6 months of age. Meanwhile, the CPS and friends recommend that exclusive breastfeeding is good enough only for 4 months, solid foods are needed at 4 to 6 months, that vitamin D deficiency is a health concern in Canada, and that all breastfed babies need vitamin D supplements. They state that breastfeeding could continue up to 2 years of age and beyond. Canadian women do not need the CPS, Dieticians of Canada, and Health Canada's permission to do what is best for their babies. They need their support: 100%.

—Janet A. Zablocki, RN, IBCLC
Toronto

References

1. Nutrition for healthy term infants. Executive summary of a joint statement of the Canadian Paediatric Society, Dietitians of Canada, and Health Canada. *Can Fam Physician* 1998;44:1678-80 (Eng), 1680-3 (Fr).
2. American Academy of Pediatrics' Work Group on Breastfeeding. Breastfeeding and the use of human milk. *Pediatrics* 1997;100(6):1035-9.

Are we asking for trouble?

Although I eagerly follow the antibiotic overprescribing controversy, I think I have heard the same message a few times too many. Of course I agree with the message "it is important to limit antibiotic overprescribing," and I agree with most points in the article by Wang et al.[1] However, I have some problems with the idea of adding vancomycin to ceftriaxone for "empiric" therapy when

pneumococcal meningitis is suspected based on the presence of a positive smear result.

Does this mean that most of this pneumococcus is resistant or that we should use a higher dose of ceftriaxone or even a different third-generation cephalosporin like cefotaxime? Why not wait for the sensitivities? What is the real danger?

The idea of adding vancomycin goes against most other directives in the article. It is the same paranoia that treats every sore ear with amoxicillin or cefixime. It is the pot calling the kettle black. There might be a small benefit in outcome (it would be nice if the authors clarified this), but you can bet that we are asking for future resistance trouble if we continue this empiric therapy with our final line of antibiotics.

—David Larocque, MD, CCFP(EM)
Castlegar, BC

Reference

1. Wang EEL, Kellner JD, Arnold S. Antibiotic-resistant *Streptococcus pneumoniae.* Implications for medical practice. *Can Fam Physician* 1998;44:1881-8.

Response

The recommendation of adding vancomycin to ceftriaxone as empiric therapy of pneumococcal meningitis has been questioned. The rationale for this suggestion is that levels of β-lactams achieved in the cerebrospinal fluid (CSF) are significantly lower than levels achievable in the bloodstream. The CSF levels of such antibiotics are much closer to the minimal inhibitory concentrations (MICs) of non-susceptible *S pneumoniae.*

Meningitis is a life-threatening condition with known high frequency of sequelae if not treated adequately. Whereas most *S pneumoniae* are susceptible to usual first-line agents, one is trying to minimize morbidity and mortality in *all* patients. Thus, waiting for 1 to 2 days to obtain MIC results and adding vancomycin if resistance is confirmed would be inappropriate for such a life-threatening condition.[1] There have been numerous case reports of children getting worse while receiving ceftriaxone alone; they are summarized in the reference. Although such reports do not constitute high-level evidence, it would be unethical to perform a randomized trial of including or excluding vancomycin in first-line management of *S pneumoniae* meningitis.

The paper was directed at increasing rational antibiotic prescribing, not eliminating antibiotic prescribing. Treating a sore ear with amoxicillin is not comparable to broadening antibiotic coverage for suspected bacterial meningitis. They differ significantly both in numbers of patients who are treated with antibiotics and seriousness of complications if an error in antibiotic selection is made.

Although exposure to antibiotics in general is a definite risk factor for developing antibiotic resistance, I am unaware of any data suggesting that 48 to 72 hours of vancomycin while awaiting the results of antibiotic susceptibility testing has resulted in increased antibiotic resistance.

—Elaine Wang, MD, CM, MSC
Toronto

Reference

1. Paris MM, Ramilo O, McCracken GH Jr. Management of meningitis caused by penicillin-resistant Streptococcus pneumoniae. *Antimicrob Agents Chemother* 1995;39:2171-5.

Drug not considered a first-line agent

The articles in the September 1998 issue on using and prescribing antibiotics raised several reasons for concern. Another reason, not mentioned in any of the articles, is also found in an advertisement for Raxar[1] (grepafloxacin) for treating typical and atypical community-acquired pneumonia. No indication is in the ad, or for that matter in the prescribing information, as to whether grepafloxacin should be considered a first-line agent for this condition. However, phrases in the ad such as "With Raxar, lung concentrations are achieved quickly, and exceed the level required to eradicate the most common typical and atypical pathogens...." and "Raxar is generally well tolerated with a favourable safety profile" could easily lead clinicians to believe grepafloxacin is a first-line agent.

Grepafloxacin is a fluoroquinolone, similar to ciprofloxacin. Fluoroquinolones are not recommended as first-line agents for community-acquired pneumonia by the Canadian consensus guidelines,[2] *The Medical Letter*,[3] or the Ontario Anti-infective Guidelines.[4]

Drugs such as grepafloxacin should be reserved for serious infections where first-line agents have failed. Overuse of these products will quickly erode their usefulness as bacteria acquire resistance.

—Joel Lexchin, MD
Toronto

References

1. You thought lungs absorbed antibiotics. Until now, you were only partly right. Glaxo Wellcome; p. 1762.
2. Mandell LA, Niederman M, Canadian Community Acquired Pneumonia Consensus Conference Group. Antimicrobial treatment of community acquired pneumonia in adults: a conference report. *Can J Infect Dis* 1993;4:25-8.
3. The choice of antibacterial drugs. *Med Lett Drugs Ther* 1998;40:33-42.
4. Ontario Anti-infective Review Panel. *Anti-infective guidelines for community-acquired infections.* 2nd ed. Toronto: Queen's Printer for Ontario; 1997.

Antibiotic resistance offers opportunity for FPs

Thank you for the excellent September issue, which covered the antibiotic resistance problem.

FOR PRESCRIBING INFORMATION SEE PAGE 2560 ➔