Bacteria isolated from bloodstream infections at a tertiary care hospital in Dar es Salaam, Tanzania – antimicrobial resistance of isolates

To the Editor: Retrospective antimicrobial susceptibility profiles from bloodstream infection isolates in Tanzania indicated increasing antimicrobial resistance to the first-line and inexpensive antimicrobial agents.1 Prospective methicillin-resistant *Staphylococcus aureus* (MRSA) or extended-spectrum beta-lactamase (ESBL) screening should be accompanied by watching multidrug-resistant (MDR) isolates and their susceptibility to first-line antibiotics. MDR isolates in local circulation might still turn out to be susceptible to such drugs, as was found at Sant Parmanand Hospital, a 140-bed private, tertiary care, multidisciplinary hospital in Delhi. From January to November 2010, 5 MDR bacteria were isolated from patients with serious infections.

Isolates were identified by their phenotypic and biochemical characterisation. The antibiotic susceptibility was tested by disk diffusion methods following the Clinical and Laboratory Standards Institute (CLSI) criteria. MDR Gram-negative strains were defined to be resistant to meropenem, piperacillin-tazobactam, ceftazidime, amoxicillin-clavulanic acid and amikacin. The 5 MDR *Klebsiella pneumoniae* from 1 133 isolates were isolated from urine in 3 patients and from purulent material in 2. Isolates included *K. pneumoniae* (468), *Escherichia coli* (413), *Salmonella typhi/paratyphi A*, *S. aureus* (110), *Citrobacter* (2), *Pseudomonas aeruginosa* (106) and *Proteus spp.* (2). All 3 MDR isolates from urine were susceptible to tigecycline, 2 to ciprofloxacin and 1 each to ofloxacin or rifampicin. Both MDR isolates from purulent materials were susceptible to tigecycline, ofloxacin and chloramphenicol, while 1 each was susceptible to aztreonam or rifampicin.

An annual rather than a 5-year update1 on local antibiotic susceptibility profiles would be useful for clinicians, who would be able to refer to the previous local antimicrobial susceptibility pattern during pilot antibiotic prescription for their patients. This would be useful before results of *in vitro* susceptibility of isolates are available. For example, the first-line, inexpensive antimicrobials1 that were developed in the 1940s and 1950s would not be the initial choice among clinicians managing patients with severe MDR. However, they might be the only option available in some cases, even if the *in vitro* susceptibility profiles are dismal.1

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Tonsillectomy practice in South Africa

To the Editor: Tonsillectomy is a very common operation done by ENT surgeons and general practitioners in South Africa. Our impression is that the procedure and its peri-operative care vary greatly. We conducted a web-based survey (approved by the UCT ethics committee) to evaluate tonsillectomy practice among South African ENT surgeons and discuss the findings in relation to evidence-based practice from the literature. We report only on the controversial and interesting aspects. Ninety-three surgeons (27% of the ENT surgeons in active practice in South Africa) completed the survey, of whom 65 were in private practice.

**Method of tonsillectomy.** Sixty per cent of both public and state surgeons remove tonsils by conventional cold steel dissection, which has a lower bleeding rate than more recent techniques such as coblation and bipolar dissection.1

**Corticosteroids.** Forty-seven per cent of surgeons prescribe peri-operative steroids. A Cochrane Library report includes Grade A evidence that a single intravenous dose of dexamethasone is effective, relatively safe and inexpensive in reducing morbidity (pain, nausea and vomiting).2

**Antibiotics.** Sixty per cent of surgeons prescribe antibiotics, of whom 42% prescribe amoxicillin/clavulanic acid (Augmentin) and 38% amoxicillin. Although many surgeons believe these prevent postoperative bleeding, this is not supported by the literature.3

**Local anaesthesia.** Seventeen per cent of surgeons inject the tonsil bed with local anaesthetic. Although not believed to benefit postoperative pain, the latest systematic review seems to show a modest reduction in postoperative pain, and we suggest it as an adjunct to the normal analgesia.4

**Postoperative pain.** Tonsillectomy patients experience a great deal of pain. The mean time for cessation of pain is 11 days;5 most surgeons (80%) agreed with this. Eighty-nine per cent of respondents warned their patients about the 5-6-day ‘dip’, when patients typically called their surgeon and reported that pain had increased, and that they couldn’t eat, had become pyrexial and wished to visit the surgeon. There is only one report about this ‘dip’, in the journal Pain, which simply stated that pain declines after 3 days, but that 30% of the sample population made an unscheduled stop at the doctor between days 4 and 7.6

**Postoperative chewing gum.** Forty-nine per cent of surgeons advised patients to chew gum to reduce masseter muscle spasm and relieve pain. Only one study could be found that addressed this