

Conjunctivitis Doesn't Always Need an Antibiotic

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Most healthy children with conjunctivitis will get better by themselves and don't need an ophthalmic antibiotic, Peter W. Rose, M.B., and his colleagues reported.

"Parents should be encouraged to treat children themselves without medical consultation, unless their child develops unusual symptoms or the symptoms persist for more than a week," said Dr. Rose of Oxford (England) University, and his associates. They suggested that parents cleanse their children's eyes with lubricating eyedrops instead of rushing them off to the pediatrician at the first sign of

conjunctivitis (Lancet 2005;366:37-43).

The investigators randomized 326 children (mean age 3.3 years) with a clinical diagnosis of conjunctivitis to either chloramphenicol eyedrops (0.5%) or placebo (distilled water containing 1.5% boric acid and 0.3% borax). Parents applied the drops every 2 hours for the first 24 hours when the child was awake and four times a day until 48 hours after symptoms resolved.

After 7 days, 86% of those in the antibiotic group were clinically cured, com-

pared with 83% of those in the placebo group. When 307 of the children were followed up at 6 weeks, fewer than 5% in each group had experienced a relapse or new infection. Only one reaction—a case of swollen eyelids and face—was attributed to antibiotic treatment.

Baseline cultures showed that 80% of the children had bacterial infections. Among this group, the clinical cure rate did not differ significantly between chloramphenicol and placebo (85% vs. 80%),

but more of the chloramphenicol group than the placebo group experienced bacterial eradication (40% vs. 23%).

Although eradication is not necessary for a clinical cure, Dr. Rose and his associates said failure to achieve it could impact transmission. "Despite our results, antibiotic treatment might still reduce the absolute number, and, hence, transmissibility of pathogens, and further research might be necessary if antibiotics cease to be prescribed for this disorder." ■

Metapneumovirus Is Unseen Culprit In Bronchiolitis

Human metapneumovirus may be underreported as a pathogen in bronchiolitis and may lead to admittance to intensive care, especially when it infects infants in combination with human respiratory syncytial virus, reported Malcolm G. Semple, M.D., of the University of Liverpool (England), and his associates.

During the 2001-2002 winter season at one hospital, dual infection human metapneumovirus (hMPV) and human respiratory syncytial virus (hRSV) occurred at a significantly higher rate in infants with bronchiolitis who were admitted to the pediatric intensive care unit on mechanical ventilation (72%, 18 of 25) than in infants with bronchiolitis who were sent to the general wards (10%, 15 of 171). The investigators said that the temporal distribution of hMPV infections in infants in the pediatric ICU made it unlikely that the infections were nosocomial. In a subset of infants with complete clinical information, dual infection with hMPV and hRSV was not statistically significantly associated with disease severity in the retrospective study (J. Infect. Dis. 2005;191:382-6).

In nasopharyngeal aspirate and bronchoalveolar lavage samples that were taken at the same time from nine hMPV-infected infants on mechanical ventilation, hMPV was detected in only one nasopharyngeal aspirate and in all nine bronchoalveolar lavages. Of 18 infants who had mechanical ventilation, hMPV infection was found in bronchoalveolar lavages from 15 infants and in nasopharyngeal aspirates from 4 infants.

The discordance in the incidence of hMPV infection detected in bronchoalveolar lavages and nasopharyngeal aspirates raises the possibility that "hMPV infection during endemic seasons may be more common than is currently recognized and that it has been undetected because sampling from the lower respiratory tract is not possible on infants who do not require mechanical ventilation," Dr. Semple wrote.

—Jeff Evans

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