Four patients were chronic smokers, one was a diabetic, and seven (six receiving ampicillin and one receiving penicillin) were significantly undernourished. None had radiologic evidence of interstitial pneumonia, probably because most such patients are treated as outpatients. Patients were started randomly receiving either parenteral penicillin (1 million units IV every 6 h) or ampicillin (500 mg IV every 6 h), and on discharge they continued receiving oral antibiotics, with a total therapy duration of 10 days. Apart from routine blood and radiologic studies, special care was taken to identify any tubercle bacilli in the sputum.

Fourteen patients received ampicillin and six received penicillin. Five who received ampicillin and one who received penicillin had extended pneumonia (more than one lung zone involved or bilateral involvement). The sputum of one patient showed acid-fast bacilli, and antituberculous drugs were started. Response to treatment was good in all the other patients. All of them became afebrile by the fourth day, and none of the patients developed any of the complications of pneumonia. The mean hospital stays in the ampicillin and penicillin groups were 5.6 and 6.0 days, respectively.

A much more comprehensive study is necessary, including isolation of causative organisms and their drug sensitivities. However, this study does indicate that in the study population, most patients with CAP and radiologic features of lobar or bronchopneumonia who require hospitalization can be treated safely with parenteral ampicillin or penicillin, irrespective of the extent of the pneumonia and underlying nutritional status. Amoxicillin has the advantage of resulting in a marginally shorter hospital stay. A tuberculous etiology needs to be excluded, and bedridden, chronically debilitated, and immuno compromised patients are likely to require a broader antibiotic course.

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REFERENCES

To the Editor:

On the basis of a small study of their own patients, Dr. Prabhudesai and colleagues have determined that their patients who develop community-acquired pneumonia (CAP) and have only mild comorbidities can be treated with parenteral and later oral penicillin or ampicillin. This is a reasonable approach in countries in which more expensive antibiotics are “unaffordable.” For patients from whom a good quality sputum sample can be obtained, one might use a Gram’s stain to decide whether ampicillin is the more appropriate antibiotic choice for a particular patient, when Gram-negative bacilli are detected on smear.

An empiric trial of treatment with penicillin or ampicillin is possible, provided that patients are carefully observed for clinical deterioration and continued signs of infection. Prabhudesai and colleagues observed, as we have in our series, that patients with CAP generally respond quickly to therapy; if patients do not have a reduction of their fever in 48 h, I would suggest that antibiotic coverage be broadened to include aerobic Gram-negative bacilli and possibly the atypical sources of infection (Mycoplasma, Chlamydia, and Legionella).

Streptococcus pneumoniae is the most common organism in any group of patients with CAP, and both penicillin and ampicillin provide adequate antibacterial coverage of this organism. Studies of CAP have shown that even in patients infected with S pneumoniae of intermediate penicillin resistance, there is the same response to routine therapy as in those infected with a penicillin-sensitive S pneumoniae.

Dr. Prabhudesai and colleagues have pointed out that one must be aware of the organisms and microbial sensitivities present in the community in which one practices. They appropriately screen all of their patients for Mycobacterium tuberculosis, as they practice in a community with a high incidence of this infection. Knowledge of the infecting organisms and bacterial sensitivities in the local community permits one to prescribe the most appropriate antibiotics for an individual patient, decrease the development of antibiotic resistance, and save scarce medical resources as well.

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Anti-inflammatory Effect of Suplatast Tosilate on Mild Asthma
To the Editor:

Inhaled corticosteroids are generally recognized as effective in the suppression of eosinophil proliferation and migration into the bronchial mucosal of asthmatics. Suplatast tosilate (IPD; Taiho; Tokyo, Japan) is a novel capsular antiasthmatic drug that suppresses both IgE production and eosinophil infiltration through selective inhibition of interleukin (IL)-4 and IL-5 synthesis by helper T cells. The clinical and anti-inflammatory effects of IPD were assessed by symptom score, provocative concentration of histamine causing a 20% fall in FEV1, (PC20-histamine), induced sputum, and bronchial biopsy before and after 6 weeks of treatment with IPD capsules (300 mg/d tid or 400 mg/d bid) in patients with mild asthma. Eleven randomly selected patients aged 36 to 68 years (mean, 47.3 years) were treated with mild bronchodilators alone. The study protocol was approved by the Ethics Committee of Doai Memorial Hospital, and all subjects gave written informed consent. PC20-histamine was measured by the tidal breathing method after withdrawal of medications for at least 12 h. Sputum was collected by stepwise inhalation challenge with hypertonic saline (3 to 5%). Bronchial biopsy specimens were obtained from several bifurcations in eight patients by fiberoptic bronchoscopy. Bronchial mucosal tissues and induced