Results: Seven children had pneumococci isolated from their throat swabs. The isolates were universally resistant to trimethoprim, co-trimoxazole and sulphamethoxazole, 57% were resistant to tetracycline, 14% were resistant to erythromycin and 28% had intermediate sensitivity to ampicillin and cefuroxime. Twelve of the children had Hib isolated from their throat swabs. Of these 50% were resistant to trimethoprim with the remainder being of intermediate sensitivity and only one being sensitive. Of the Hib strains isolated 8% were resistant to ampicillin, co-amoxiclav, cefuroxime, ciprofloxacin and tetracycline. Four children were carrying both pneumococci and Hib.
Conclusions: In this group of children cotrimoxazole prophylaxis is prescribed to be given on three consecutive days of the week. We have demonstrated that isolates of Hib and pneumococci have considerable resistance to trimethoprim and sulphamethoxazole. The pneumococcal isolates also showed multiple resistance to the commonly used and available antibiotics for lower respiratory tract infections in resource poor countries. Widespread use of antibiotics within the orphanage may have given rise to resistance. This may be avoided by not using prophylaxis and/or limiting antibiotic treatment for uncomplicated upper respiratory tract infections.

28. Comparative clinical study of the tolerability and efficacy of two dosage azithromycin and claritromycin in the treatment of community acquired pneumonia in adults (progress report)

S. SCHOENWALD*, I. KUZMAN*, P. SESARTIC, J. VUKOVIC AND J. CULIG

**University Hospital of Infectious Diseases; Pliva d.d. Pharmaceutical Operations; Zagreb, Croatia*

Community acquired pneumonia (CAP) is a serious disease frequently treated empirically, which requires the selection of an antibiotic that covers all common pathogens and achieves good pulmonary concentrations. A total of 180 hospitalised adult patients with CAP will be included into the study according to a randomisation list. Patients are divided into three treatments group. Dosage regimens are shown in the table below:

TABLE

Treatment	Azithromycin	Azithromycin	Claritromycin
Daily dose	1×1500 mg	1×500 mg	2×250 mg
Days of administration	1	3	10

Control clinical examinations are performed 24 h, 48 h, 72 h, 10–14 days and 4 weeks after the initiation of treatment. Clinical and microbiological response rates, clinically significant abnormal laboratory values as well as the adverse event profile are followed.

Preliminary results indicate that 3-day, once-daily course of azithromycin is clinically effective and well tolerated as a 10-day, twice-daily course of clarithromycin in the treatment of CAP:

29. Invasive pulmonary aspergillosis with additional CMV infection at 4 years old boy

J. ZIO KOWSKI, D. CHMIELEWSKA-SZEWCZYK, J. PERADZY SKA, M. KULUS, U. DEMKOW*, J. LANGE, A. ZAWADZKA–KRAJEWSKA AND R. KOZIOEK

*Department of Pediatric Pneumonology, Allergology and Hematology, Warsaw Medical University. 01-184 Warsaw, 1 Dzialdowska St., Poland; *Institute of Tuberculosis and Lung Diseases, Warsaw, Poland*

A 4 year old, Caucasian boy was admitted to the hospital with primary diagnosis of pulmonary tuberculosis. On the basis of bronchoalveolar lavage culture and mycelium presence in pulmonary biopsy, the final diagnosis of invasive pulmonary aspergillosis was set. Additionally, in the 8th month of the disease duration, CMV infection was detected. Patient was treated with amfotericine B, 5-fluorocytozine and itraconazolum. Despite a full recovery obtained, in the follow up period pulmonary fibrosis, as a complication after fungal infection was detected. During 4 years of follow up, patient did not suffer from infections of respiratory system. Periodically performed immunological laboratory tests were negative. After recovery patient was vaccinated with Pneumo 23 and Vaxigrip (Pasteur–Merieux) vaccines.