Some of their criticisms are probably due to a lack of detail in our text. We do receive systematic weekly specimens from specific units for bacterial screening, but, in our study, we only selected diarrheal stools. As stated in Material and Methods, cells for fecal cytotoxin detection were examined after overnight and 48-h incubation. We observed 50 positive cases; all were already positive at the first reading. No additional specimen was positive after 48 h. Fifty-three of the 411 patients had at least one stool positive for a toxigenic isolate, giving a prevalence of 13%.

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I am writing about the contents of Supplement 1 to Volume 2 (December 1996 [1]). The article by Goldstein and his colleagues (p. S40) was excellent and I was glad to see that this group is in the growing band of investigators who have two guidelines. The diagrammatic representations of susceptible and resistant populations are excellent and it should be apparent to all from these diagrams just what ‘intermediate’ means. Table 1 is a good model for providing simple accurate information to antibiotic users. The article by Sirot, Courvalin and Soussy (p. S5) is also an excellent demonstration of how science should be applied to practical everyday procedures in the diagnostic clinical laboratory.

I was therefore very disappointed that so little attention had been given to these papers in the 1996 Statement on Breakpoints (p. S46). The ‘sensitive’ breakpoint for many antibiotics has not been related to the normal susceptible population of bacteria. Mode MICs are often greatly below the chosen breakpoint, so that many strains with low-level resistance are called ‘fully susceptible’, e.g. to aztreonam, many of the cephalosporins and the quinolones. This is because the susceptible level has been based on pharmacology and not on microbiology (see p. S8). These problems become greater if they are applied to more fastidious species as exemplified in your footnote 2 (on p. S48) regarding Streptococcus pneumoniae. Application of microbiological criteria to microbiological tests give a good definition of ‘sensitive’ à la Goldstein et al. The pharmacologic data should only be applied to defining the resistant population. All the other strains are intermediate.

A lot of time has been spent trying to simplify interpretations of susceptibility testing. I am glad that you are adding so many qualifications to the tables. The area of susceptibility testing is complex, and the exceptions to the rules are many. A move towards species-specific guidelines applied to a limited range of relevant antibiotics would provide greater clarity and fewer exceptions.

Thank you for your stimulating supplement, which I hope is studied carefully by all those carrying out the millions of susceptibility tests performed every day.

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Reference