Rifampicin therapy in shigellosis in infancy

Sir,

The article under this title by Naveh et al. (Archives, 1977, 52, 960) deserves comment. It seems beyond doubt that the 11 children referred by the authors made up an exceptional group, both from the protracted course of the diarrhoea (1 to 4 months) and from the unexpected resistance in vitro to antimicrobial drugs. Diarrhoea due to shigella is usually a self-limited disease lasting a few days (Roy et al., 1975). As with other acute bacterial diarrhoeas, prolongation of its course is generally not due to the infection itself, but rather to sugar intolerance or to some form of the postgastroenteritis syndrome (Gribbin et al., 1976).

Failure to respond to furazolidone is not surprising; drugs not absorbable by the intestine can hardly affect the course of diarrhoea caused by invasive bacteria such as shigellass (Drachman, 1974). On the other hand, the reported failure to respond to treatment with chloranphenicol, ampicillin, or co-trimoxazole to which the shigella revealed in vitro sensitivity is astonishing and difficult to understand; such a situation has been only sporadically reported (Haltalin et al., 1972).

Commenting on the good results obtained with rifampicin, Naveh et al. state that it is 'a useful alternative preparation in drug-resistant shigella infection ...', a contention which they justify insufficiently.

The Archives has a world wide readership which includes many of the developing countries, and it is in these countries that shigellosis, tuberculosis, and other infectious diseases are prevalent. Rifampicin occupies an important place in the treatment of severe tuberculosis. A superficial reading of the article of Naveh et al. could lead to the more liberal use of rifampicin in disease other than tuberculosis, and this would be undesirable. For this reason, it seems that a more accurate and descriptive title such as 'Rifampicin therapy in protracted and resistant shigellosis in infancy' would have been preferable.

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References


