amounts of which would have given highly misleading results.

No antibiotic regimen currently available provides total cover against the wide range of neonatal pathogens, although in our experience ceftazidime has distinct advantages over the alternatives bearing in mind that among our patients four of 30 bacteriaemia were due to pseudomonas. Colonisation with faecal streptococci occurs, and if ceftazidime treatment is to continue for more than five days it is our practice to add ampicillin to the prescription.

To condemn its use in neonates because it failed to clear infections that had previously not responded to treatment with other antibiotics, or where initiation of treatment had been delayed, is to apply quite unrealistic demands on any antibiotic. If treatment is started promptly ceftazidime is a very appropriate antibiotic for the initial blind treatment of neonatal sepsis.

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Dr Low and co-workers comment:

Drs de Louvois and Mulhall's wide experience using ceftazidime will be useful, when published, in improving the evaluation of this antibiotic.

Reasons for ceftazidime's ineffectiveness against the case of *Escherichia coli* meningitis and one of the cases of group B streptococcal sepsis were acknowledged in our paper. Without going into great details about the case of *Enterobacter cloacae*/enterococcal infection, this was not a matter of penicillin and gentamicin failing—this course of antibiotics had been stopped as the baby was well. He then became unwell with organisms resistant to ceftazidime.

The point about cerebrospinal fluid being contaminated with blood is well taken. There was some blood in the samples from cases 2, 11, 12, 35, and 42 and these results may be falsely high.

We find it inconsistent to state that ceftazidime is inappropriate for *confirmed* cases of group B streptococcal and *Staphylococcus aureus* infection, two of the commonest neonatal pathogens, while at the same time advocating its use for initial blind treatment. McCracken has recently written that most group B streptococcal meningitis is sterilised within 24 hours using ampicillin and gentamicin.[4] Unless this can be stated confidently about ceftazidime, surely there must be reservations about its usage.

References

[1] Pollock I, Mulhall A, de Louvois J. Ceftazidime in the treatment of neonatal infection. *J Hosp Infect* 1985;**6**:158–65.
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[3] Low DC, Bissenden JG, Wise R. Ceftazidime in neonatal infections. *Arch Dis Child* 1985;**60**:360–4.
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Toxic shock syndrome

Sir,

We read with interest the recent description of toxic shock syndrome by Buchdahl *et al.*[1] We have recently seen a case, also within the London area, which fulfils the diagnostic criteria, and which confirms the potentially lethal nature of the condition. A previously well 3 year old boy of Indian origin was admitted to hospital comatose, after a convulsion. There was a two day history of pyrexia, diarrhoea, and vomiting. On examination he was unresponsive to all stimuli. Rectal temperature was 42°C. There was an erythematous-purpuric rash on the legs, which subsequently spread to the trunk and arms. He was severely shocked, with a systolic blood pressure of 60 mm Hg and poor peripheral perfusion. Biochemical abnormalities included severe metabolic acidosis, hyponatraemia, hypocalcaemia, and raised blood urea (9 mmol/l) and transaminases. He was anaemic (haemoglobin 7 gm/dl) and thrombocytopenic (platelet count 47×10^9/l). The prothrombin and thrombin times were prolonged and fibrin degradation products were raised, indicating disseminated intravascular coagulation. Despite instituting all the intensive support measures outlined by Buchdahl *et al,* and the administration of intravenous penicillin, chloramphenicol, and cefuroxime, he died within 12 hours of admission. *Staphylococcus aureus*, sensitive to chloramphenicol and cefuroxime, was subsequently isolated from blood cultures.

In severe cases of toxic shock syndrome it may be difficult to distinguish the effects of toxin production from those of overwhelming septicaemia, and antibiotics should be given in addition to supportive measures. In young children meningococcaemia is the commonest cause of fulminant illness with a purpuric rash, and appropriate antibiotics are given before the availability of culture reports. Should further reports confirm the impression of an increasing incidence of toxic shock syndrome in children, perhaps antistaphylococcal treatment should also be considered in these circumstances.

Reference

[1] Buchdahl R, Levin M, Wilkins B, *et al.* Toxic shock syndrome. *Arch Dis Child* 1985;**60**:563–7.

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Dress of infants in health and illness

Sir,

I read with interest the paper by Eiser *et al.*[1] While working in Leicester I carried out a small survey with local health visitors to find out how infants were dressed and wrapped for sleeping and how mothers adjusted clothing and wrapping if the infant was ill. An unselected group of