population; the technical problem is that testing for antimicrobial susceptibility to obtain minimum inhibitory concentrations was only performed for strains resistant to methicillin by diffusion.\(^1\)

It may therefore prove more reliable to screen for penicillin resistant pneumococci using oxacillin discs that do not yield false sensitive results,\(^3\) so avoiding the risk of primary misclassification of clinical isolates responsible for invasive disease.

**References**


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Drs Klugman and Koornhof comment:

The recommendation for the use of oxacillin in preference to methicillin discs is based on the observation by Swenson et al\(^1\) that three of 34 strains resistant to penicillin were falsely identified as susceptible using a 5 \(\mu\)g methicillin disc, compared with 0 of 34 using 1 \(\mu\)g oxacillin discs after incubation on Mueller-Hinton sheep blood agar plates in ambient air. Jacobs et al\(^2\) showed that two of 29 compared with one of 29 were falsely identified as susceptible, using the two discs, respectively, after incubation on Mueller-Hinton agar with 5% lysed horse blood in ambient air. Neither of these differences is significant. Though a definitive answer to the advantages of one method over the other rests on an analysis of a larger number of strains, even a combination of the above data fails to show a significant difference between the tests, giving a false susceptibility rate of five of 63 (8%) with the methicillin disc compared with one of 63 (2%) with the oxacillin disc (\(\chi^2 = 1.57, p = 0.2\), with Yates' correction).

The 20% false susceptibility rate quoted by Dr Conde-Glez from another of our papers,\(^3\) is due to his misinterpretation of our presentation of all multiply resistant strains, identified in various day care centres, as multiply resistant penicillin susceptible (MRPS) strains. No inference of the prevalence of false susceptibility can be drawn from that study. A possible estimation of the true prevalence of penicillin resistance in urban and rural children may be calculated, assuming that for every 58 strains identified as resistant using the methicillin disc, a further five are missed. Using this estimation four additional strains to the 43 resistant strains were probably missed out of 206 isolates in the urban study, and three additional strains to the 30 resistant strains out of 96 in the rural study. We believe that the importance of these differences in carrier rates is unimportant.

We do agree, however, that primary misclassification of isolates responsible for clinical disease, especially meningitis, may be important in individual cases. The data of Jacobs et al\(^2\) indicate that neither test is 100% sensitive. In areas with high prevalence of endemic resistant pneumococci we recommend that minimum inhibitory concentrations be determined on all pneumococcal isolates from cerebrospinal fluid. Finally the distribution between resistant and immediately resistant strains cannot reliably be made with either of these disc tests\(^4\) and must rely on MIC data from minimum inhibitory concentrations.

**References**


**Post-streptococcal glomerulonephritis in Hong Kong**

Sir,

We were interested to read the recent report of Leung et al on post-streptococcal glomerulonephritis in Hong Kong.\(^1\)

It is now commonly assumed that this condition is rare in developed countries but our recent experience would lead us to think otherwise.

Since July 1985 we have documented a post-streptococcal aetiology in 11 of the 16 patients with acute glomerulonephritis referred to our unit. Nine of the 11 have been diagnosed since December 1986. We have recently reviewed the case notes of all 11 patients.

One obvious difference from the Hong Kong report is that macroscopic haematuria was the commonest presenting symptom in our series. It was present in eight out of 11 patients with only three having oedema as the main complaint. Group A \(\beta\) haemolytic streptococcus was isolated from the throat swabs of eight children, two of whom had received prior antibiotic treatment. In addition none children had a raised anti-streptolysin O titre, seven a low serum C3 concentration, and seven raised C3 degradation products.

In general the nephritis was mild and no patients required acute dialysis. Four required drug treatment for hypertension. One of our patients presented with a dense right hemiplegia having had eight days of haematuria at home. We noticed that one child in the Hong Kong series presented with a convulsion due to hypertensive encephalopathy and this further illustrates the acute morbidity and occasional mortality associated with this illness.

We also assume that the recent increased prevalence of post-streptococcal glomerulonephritis may be due to an
Correspondence

increase in nephritogenic strains circulating in our community. There have been no recent cases of rheumatic fever.

It is important that paediatricians should still consider the possibility of post-streptococcal glomerulonephritis. Children should be investigated in a thorough and consistent manner because as well as the acute problems an accurate diagnosis is essential for long term prognosis.\(^2\)

References


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Sir,

We read the article by Leung et al with special interest because post-streptococcal glomerulonephritis is also the commonest glomerulopathy in our community.\(^1\)

In 1986, 57 children with acute post-streptococcal glomerulonephritis were referred to the Clinic for Children Diseases in Skopje. (A Sajkovski, V Tasić, D Kuzmanovska. Acute post-streptococcal glomerulonephritis. Abstract presented at the Third Scientific Meeting of Yugoslav Nephrologists, Sarajevo, 1987: 75.) Two of them (3-5%) presented with hypertensive encephalopathy, nine (15-8%) with cardiovascular failure, and seven (12-3%) with uremic syndrome.

In 1982 we saw 85 children with acute post-streptococcal glomerulonephritis, of these 26 (30-6%) had hypertensive encephalopathy. The analysis of factors associated with the high incidence of acute post-streptococcal glomerulonephritis in our community showed that most of the children lived in unhygienic and very bad social, economic, and educational conditions. Preceding streptococcal infections had not been adequately treated and the signs of acute nephritis were not recognised until late; hypertensive encephalopathy then followed. Pyoderma and scabies impetiginisata are still important aetiological factors for acute poststreptococcal glomerulonephritis. Although there are a lot of differences between our communities, we think that acute post-streptococcal glomerulonephritis is still a 'social' disease and Leung's overcrowded living conditions need much more explanation.

Increased main urinary metabolite of prostaglandin F\(_{2\alpha}\) excretion in childhood migraine

Sir,

We read with interest the paper by Salfield et al on the effects of dietary vasoactive amines in the aetiology of childhood migraine.\(^1\) They found that dietary vasoactive amines did not influence childhood migraine.

We have not tried dietary manipulation but we measured plasma renin activity, plasma noradrenaline concentration, and 12 hour main urinary metabolite of prostaglandin F\(_{2\alpha}\) (PGF-MUM) excretion in children with a history of migraine (n=43).\(^2\) Children were divided into two groups: those with and those without headache at the time of investigation.

Urinary PGF-MUM excretion was significantly increased in children with headache (n=23) compared with those without headache (n=20) (1210 ± 780 ng/12 hours, p<0.05); the plasma renin activity and noradrenaline concentration did not show any difference between the two groups.

These findings suggest that simultaneous study on both dietary manipulation and hormonal investigation especially on prostaglandins may be needed to clear the conflicting results on the role of vasoactive amines in the aetiology of childhood migraine.

References


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