LETTERS TO THE EDITOR

Prophylactic Antibiotics for Skin Surgery?

Sir,

We read with interest the report by Maurice et al. on the need for prophylactic antibiotics in skin curettage (1). An increasingly elderly population with a greater prevalence of skin tumours (2) and the impact of United Kingdom health reforms, encouraging skin surgery by primary care physicians (3), have caused an expansion of dermatological procedures. Given the potentially catastrophic consequences of bacterial endocarditis, the need for prophylactic antibiotics in skin surgery should not be dependent on “an educated guess” (4).

Although two studies have investigated the incidence of bacteremia associated with skin surgery, both were conspicuous by their small sample size (5, 6) and to extrapolate to populations on this basis may be misleading.

Maurice’s investigations identified coagulase-negative staphylococcus as the predominant organism, present on 69% of skin lesions and therefore the most likely cause of bacteremia and possible endocarditis (1). We were surprised that amoxicillin was suggested as a suitable prophylaxis in patients at high risk of endocarditis. We have reviewed the sensitivities of coagulase-negative staphylococcal blood culture isolates, collected over the past 5 months in this hospital. Of 115 isolates just 11% were sensitive to amoxicillin (Table I). The only antibiotic to which all were sensitive was vancomycin. Vancomycin must be infused intravenously over an hour, to minimize the risks of hypotension and rash (7).

The incidence of bacteremia associated with skin surgery needs to be more precisely defined so that the benefit of an adequate antibiotic prophylaxis can be balanced against the inconvenience and potential morbidity of such a regimen.

REFERENCES


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Response to the Letter by Carmichael et al.

It was an oversight on our part that we used in the last paragraph of our paper “amoxicillin” rather than “antibiotic” because we too noted that most of the coagulase-negative staphylococci isolated from the skin lesions in our study were resistant to penicillin/amoxicillin. We agree that vancomycin would be the logical choice in the very few instances where prophylaxis is indicated and also agree that more information is required to assess the risks.

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