Sir,
The most common bacteria that colonizes and aggravates atopic dermatitis is *Staphylococcus aureus*, although other bacteria act similarly (1). Interestingly, *Acinetobacter* species are rarely cultured from atopic dermatitis, although one study found that 40% of health volunteers carried *Acinetobacter* species on their bodies, with *A. lwoffii* being the most common (2). We report a child with atopic dermatitis super-infected with multiple *Acinetobacter* species who visited our clinic. His latest dermatitis had started 2 weeks earlier. Treatment with topical corticosteroids and a short course of oral prednisone did not abate the disease (topical tacrolimus was not yet available). From the age of 1 month, he received multiple courses of erythromycin, amoxicillin, cephalexin and bactrim to treat his recurrent dermatitis and ear infections. He also used nystatin swish and swallow and oral fluconazole to treat thrush. At approximately 9 months of age, his skin, although clinically indistinguishable from typical impetiginized atopic dermatitis, had positive cultures for *A. lwoffi* and *A. anitratus*, resistant to β-lactam antibiotics. The latter is a cause of morbidity and mortality in intensive care units. The rash covered 20% of body area. The impetiginized rash cleared with 4 days of intravenous cefotaximine 550 mg every 8 h (200 mg kg\(^{-1}\) day\(^{-1}\)) and gentamicin 18 mg every 8 h (6.4 mg kg\(^{-1}\) day\(^{-1}\)) and emollients. Since no Gram-positive cocci were isolated, the rapid recovery suggested that the *Acinetobacter* were pathogens rather than contaminants. Heavy prior antibiotic use might have caused these unreported dual super-infections.

This case blends two disquieting trends in paediatrics, the increase in severity (3) and prevalence (4) of atopic dermatitis and the spread of unusual and treatment-resistant bacteria in the community (5). This case also highlights the need to culture impetiginized atopic dermatitis for effective treatment.

REFERENCES