older children. Patients with meningitis and/or hypotension should be given chloramphenicol intravenously as a loading dose of 25 mg/kg followed by 60 mg/kg/day in four divided doses. Sulfonamides, trimethoprim-sulfamethoxazole, gentamicin and ampicillin have been used for treatment of plague with varying success but are less effective than streptomycin. Penicillin, while bactericidal for Y. pestis in vitro, is not effective in the treatment of plague.5,7

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* The views expressed are solely those of the author and do not reflect the opinions of the Air Force Academy Hospital, the Air Force Academy or the United States Air Force.
Reprints not available.

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Letters

BCG SKIN INFECTION

To The Editors:

We read with interest the case report of Bacillus Calmette-Guérin (BCG) lymphadenitis written by Victoria and Shah.1 It is well known among pediatricians all over the world that the most common complications of BCG immunization are local subcutaneous abscesses and regional lymphadenitis.2 Other more rare complications have been reported such as disseminated BCG infection, osteitis and abnormal immunologic reactions. Distant inoculation of healthy skin with BCG through a small break in the skin is a complication which, as far as we know, has not been reported.

Our patient was an 11-year-old boy who was examined in the outpatient department of our hospital because he had two ulcerated lesions. He had been healthy until the present illness. Two months earlier he had received BCG vaccine because of a negative Mantoux test. (BCG is a routine immunization of Mantoux-negative school children at the age of 11 years in Greece.) Three weeks after vaccination he developed a localized swelling at the inoculation site which progressed to a scarred lesion. Two weeks later a similar one appeared over the left clavicle. According to his mother there had been previously a small insect bite at this point and he had scratched the area.

On physical examination there were a scarred ulcer on the deltoid area of the left shoulder and a freely movable ulcerated lesion of the skin over the left clavicle. The rest of the physical examination was normal.

The ulcer over the clavicle was aspirated and numerous acid-fast bacilli were seen on Ziel-Nielsen stain and smears. Culture on Lowenstein-Jensen medium yielded Mycobacterium bouis. Routine cultures of the lesion grew Staphylococcus epidermidis.

The patient was given antistaphylococcal therapy empirically (fusidic acid, 35 mg/24 hours) and was instructed to return to the outpatient department for a follow-up. The lesion on the deltoid area disappeared 2 weeks later leaving only a small scar. The lesion over the clavicle was scarred 8 weeks after the time of presentation. No antituberculous therapy was given to the patient.

We report this case because inoculation through a break in the skin is an uncommon complication which may result in diagnostic problems especially when the primary BCG lesion has already healed. Apart from the cosmetic effect of a scar the complication is self-limited without specific antituberculous chemotherapy.

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MISQUOTATION

To The Editors:

I should like to bring to your attention a quote by Gerber and Markowitz1 of a misquote by Dillon2 of my data which appears in the article, "Management of streptococcal pharyngitis reconsidered" in Table 3 of the September-October issue of your journal. My bacteriologic failure rates are quoted as 9% for cephalaxin and 14% for oral penicillin. The failure rates reported in Table 6 of my article3 are 10% for 84 cephalaxin-treated and 22% for 89 penicillin VK-treated patients. The difference is statistically significant, P < 0.05.

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