hand a practicing Pediatrician sways in favour of parents satisfaction and needs, some even at the cost of scientific standards. Both the extremes are irrational and should be decried and an optimal balance between these two responsibilities be maintained.

The authors have evaluated and compared four different drug regimens (augmentin, amoxycillin, co-trimoxazole and erythromycin) in the treatment of skin and soft tissue infections. The antibiotic sensitivity tests of isolates from 200 patients did not include cloxacillin and cephalixin, the two most important antibiotics in the treatment of pyoderma. Further it is observed that 90.5% of *Staph aureus* isolate & 94.2% of *Strep. pyogenes* isolates were sensitive to erythromycin. Clinical clearance after 7 days in children treated with erythromycin (11 mild & 15 moderate cases i.e. 26 cases) was 10 mild & 10 moderate cases. In comparison clinical clearance after 7 days in children treated with augmentin (13 mild & 12 moderate cases i.e. 25 cases) was 13 mild & 8 moderate cases. There seems to be no significant difference in the efficacy of the two regimens. Hence one needs to question whether therapy with augmentin is cost effective?

Demidovich CW et al [2] studied the causative bacterial pathogens of impetigo in children, to compare the effectiveness of three frequently used oral antibacterial treatment regimens and to correlate the antibiotic sensitivity of the bacterial isolates with clinical responses to treatment. Treatment failure (defined by persistence of lesions 8-10 days after initiation of treatment) occurred in 24% with penicillin V, 4% in erythromycin group and nil in cephalixin group. Further they conclude that cephalixin is the most effective treatment, erythromycin estolate is nearly effective and may be preferred on a cost effectiveness basis and penicillin V is inadequate for treatment. In another study of one hundred five *Staph aureus* infection occurring in 79 children, the authors [3] conclude that both erythromycin estolate and erythromycin ethyl succinate produce satisfactory clinical response in nearly all cases including patients with deeper soft tissue infections such as frunculosis and carbunclosis. The two cephalosporins used, cephalixin and cefaclor as well

as dicloxacillin also proved to be effective.

The current recommendation for treatment of skin bacterial infection including deep infection is to provide coverage of methicillin sensitive *Staph aureus* with dicloxacillin or first generation cephalosporin such as cephalixin. For penicillin allergy patients, clindamycin or clarithromycin is appropriate [4]. Topical mupirocin applied to the lesion three times is an equally effective alternative to systemic therapy [5]. These recommendation are with the background information that such treatment is necessary despite the facts that the disease is often self limited and that there is no convincing evidence that treating pyoderma will prevent subsequent glomerulonephritis. Added to this is the concept of essential drugs usage advocated by WHO, wherein antibiotics like augmentin is classified as a reserve antibiotic and to be used only in life threatening infections.

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REPLY FROM THE AUTHOR

Although many skin infections in children are still best treated with older agents, several newer antibiotics offer advantages in certain situations. In addition, changes in microbial antibiotic resistance patterns have altered the drug of choice for certain childhood skin and soft tissue infections [1].

Systemic antibiotics to eradicate *Staphylococci* and *Streptococci* are the treatment of choice in skin and soft tissue infections in children [1]. It is now recognised that penicillinase producing staphylococci are more likely to be responsible for impetigo than streptococci and account for 70% to 80% of childhood impetigo [2]. For impetigo secondary to an underlying skin disease, such as dermatitis, scabies, psoriasis or varicella, staphylococci are virtually always responsible [2]. Post-streptococcal glomerulonephritis may follow such infections of the skin if nephritogenic strains of streptococci are involved [3].

Beta-lactamase production is one of the most common forms of resistance to beta-lactam antibiotics. The most recent advances has been the introduction of beta-lactamase inhibitors, which, when combined with existing beta-lactam antibiotics, act synergistically by inhibiting plasmid mediated beta-lactamases of *Staphylococcus aureus* [4].

The antimicrobial spectrum of amoxycillin/clavulanic acid combination make them ideally suited for the treatment of serious infections of the skin and soft tissue when polymicrobial organisms

are suspected [4].

Most topical antibiotics including mupirocin ointment may result in clinical improvement but may prolong the carriage stage of pathogen on the skin [2]. Topical mupirocin ointment should not be used alone but reserved for cutaneous staphylococcal infections such as encountered in immunosuppressed children [5].

It is concluded that amoxicillin-clavulanic acid combination, with good coverage of *Staph aureus* and *Streptococci* is useful in mild skin and soft tissue infections in children or for oral treatment after an impatient course of intravenous antibiotics in moderate to severe skin and soft tissue infections in children [1].

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HARNESSING THE HUMAN RESOURCES IN AMC

Dear Editor,

A mandatory aptitude test given to newly recruited AMC Clerks resulted in 50% failure. The same test when given to Clerks with 2 to 12 years of service did not produce any different result. Medical units receiving newly qualified personnel of all the trades often complain of their inadequacies and inaptitude. Units are scared of new drivers as much as they are scared of themselves to drive in hilly terrain. It is said that fresh technical hands lack knowledge, skill, compassion and human touch. They are ill-disciplined, ill-tempered and unwary of policies and procedures.

It is a common belief that people join Army (AMC) as the last resort when all their attempts to pick up other jobs fail. Majority joins for sheer employment. Others join as part of family tradition or with the pressure from family. Army Medical Corps does not attract people who like to serve patients, who have patriotism, who love uniform, character building and sports. Personnel cling on to service for pay, perks, promotion, good living conditions, sports and adventure activities. All these are wrong.

A recent survey conducted among AMC recruits and serving soldiers revealed a different story. One-sixth of all recruits have aptitude to serve the patients. The aptitude is found to be increasing with service. Patriotism is not a myth. It has worked as a motivating factor for the new entrants and a hygiene factor for the serving soldiers. A surprising observation is that 'discipline' has acted as a catalyst for the intake of recruits and a binding factor for the middle level soldiers.

'Uniform' has impressed many to join AMC and it is found to be important even to the seasoned soldiers. The intake in AMC is not influenced by its 'image', but luckily many of the practicing soldiers are impressed by the 'present face'. The recruits who joined AMC as sport lovers have been disappointed. The survey shows that practically nobody joins AMC to imbibe the family tradition or to uphold the pressure from family.

One important factor is the changing priorities of the recruits and the soldiers. While only 6.4% of the recruits considers AMC as an avenue for employment, about 14% soldiers has accepted it as an employment. So is the case with job security. About 13% of the soldiers believes that AMC gives job security unlike 6% of the new entrants.

The survey was directed to find out from the serving soldiers what they liked and disliked the most in Army Medical corps. The first six attributes liked by 68% of the personnel are service to the sick, image, esprit de corps, discipline, service to the nation and uniform in that order. The survey showed that they were vehement and discreet in their dislike. Their dislike in just three factors like slow promotion, poor pay and allowances and poor living conditions was amounting to 68%. This is an interesting finding. While they are satisfied with the higher order needs like service to the sick, image, esprit de corps, discipline and service to the nation, they are dissatisfied with the lower order needs like promotion, pay and allowances and living conditions. This is an evidence of 'Frustration Tolerance' where there is a shift to higher needs without satisfying the lower needs. It is a curious finding. It should be utilised in harnessing the human resource in AMC.

A scanning through the intake pattern of AMC personnel indicates that about 50% of the recruits are above matrics although the entry rate requirement is only matric. A close scrutiny of the mark sheets reveals that the above highly qualified are just 'scrapers'. It may not be an asset. But the real asset is the survey findings-their aptitude, preparedness to serve the sick and the nation and their yearning for discipline, uniform and character building. The success of AMC will depend upon strengthening the assets of the new entrants and harnessing them to a desired generation. The onus is on organisation and not on the new entrants.

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HALITOSIS AND MOUTHWASHES

Dear Editor,

Halitosis (foul odour from mouth) is psychologically depressing and social embarrassment for the individual. To get rid of halitosis, patients often brush their teeth forcefully and frequently and rinse their mouth with different mouthwashes currently available in the market but the underlying cause remains untackled. This letter attempts to explain the cause of halitosis and highlight the adverse effects of mouthwashes.

Gastrointestinal problems like amoebiasis and giardiasis lead to coating of the tongue. The intake of tea, coffee, milk or food on a coated tongue often leads to a foul taste in the mouth. In acute maxillary sinusitis, patient complains of a foul odour along with the presence of postnasal drip and mucopurulent sputum. Diseases of the respiratory tract like lung abscess and bronchiectasis must be ruled out. Persons suffering from uncontrolled diabetes mellitus may have a typical acetone breath. In chronic renal failure, nitrogenous waste products like urea and non protein nitrogen (NPN) are retained in blood. One of the ways by which the body eliminates these is through the buccal and intestinal mucous membrane. The mouth has

a foul ammoniacal odour and white coating accumulates over the tongue. Uraemia results in swollen and haemorrhagic gums [1]. In acute fever, salivary secretion is inhibited and the mouth becomes dry. Food debris are not washed away and hence bacteria multiply leading to halitosis.

Intra-orally, halitosis may occur due to gingivitis, periodontitis, periodontal pockets, pericoronitis, deeply carious teeth with resultant stagnation of food debris and unhygienic dentures. Following tooth extraction or oral surgical procedures, patient is on a soft diet. Lack of normal chewing, slight bleeding and bacterial decomposition of blood gives rise to malodorous breath. Acute necrotizing ulcerative gingivitis (ANUG) has a characteristic metallic odour [2].

Mouthwashes generally contain an antiseptic such as benzalkonium chloride, antibiotic agents, essential oils used as flavours, alcohol, sodium perborate, zinc chloride, menthol, thymol, eucalyptol, glycerine and boric acid [3]. These substances can cause allergic reaction. Prolonged use of a mouthwash in which the alcohol concentration is high can induce white lesions in oral mucous membrane.