there can be disagreement between investigators. The definition of chronic bronchitis is well agreed upon [8] and was used as an entry criterion for our study. However, how many (and which) symptoms of exacerbation are most valid, and therefore necessary for the diagnosis of AECB, is a topic of debate. We are aware that some investigators require three symptoms and/or signs (increased sputum purulence, increased sputum production, and shortness of breath are usually included) [9]; however, in our study, we allowed the evaluating physicians to determine the clinical diagnosis of AECB. The criteria for community-acquired pneumonia were consistent with common definitions of this disorder [10]. The results were virtually identical between the two groups (patients with pneumonia or AECB; 95% and 93%, respectively). Hence, it is unlikely that we used “faulty” inclusion criteria for the AECB group in an attempt to alter (improve) our results.

As per the debate about treating AECB, we are aware of the high rate of viral (or undiagnosed “atypical”) causation. However, we noted the frequent use of antimicrobials by physicians for treatment of this clinical condition and merely sought to evaluate the clinical efficacy of dosing amoxicillin/clavulanate every 12 hours. Bacterial cultures, which yield a pathological organism in only 50% (or less) of cases, were performed in an attempt to identify the species causing both community-acquired pneumonia and AECB. The question of the accuracy of cultures for detection of AECB, debated because of the high rate of colonization in chronic lung conditions, was not the objective of our study. However, it is not clearly established whether a negative (or mixed-growth) result indicates a viral (or atypical) pathogen in these settings or if it reflects difficulty with collection and/or culture of adequate sputum. Further, we propose that if we failed to identify a large number of atypical pathogens, we might have seen higher rates of clinical failure among those patients; however, we did not see high failure rates. In addition, most data suggest that atypical organisms are a rare cause of AECB [11]. We agree that patients with viral AECB will not benefit from treatment with antibiotics.

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References

2. Hust MR. Comparison of the 24-hour pharmacokinetic profile of augmentin administered with food to healthy male volunteers as 1 g 12 hourly versus 625 mg 8 hourly, and as 625 mg 12 hourly versus 375 mg 8 hourly [report HH-1001/BRL-025000/2/CPMS-360]. Philadelphia: SmithKline Beecham Pharmaceuticals, 24 May 1994.

Cutaneous Adverse Reactions and CD4+ Cell Counts in Human Immunodeficiency Virus–Infected Patients Receiving Trimethoprim-Sulfamethoxazole

Sir—I read with interest the article by Veenstra et al. [1], who showed that a low CD4+ cell count at baseline was predictive of adverse reactions to trimethoprim-sulfamethoxazole (TMP-SMZ) during prophylaxis for Pneumocystis carinii pneumonia (PCP). These authors were unsure whether the discrepancy in the relation between the CD4+ cell count and adverse reactions to TMP-SMZ was explained by the different degree of immunodeficiency, the daily dose of TMP-SMZ, or the presence of active PCP. I believe that there is now strong published evidence that the explanation is the degree of immunosuppression.

For the subpopulation of the most immunocompromised HIV-infected patients (i.e., those for whom the average CD4+ cell count is <50/mm3), a lower CD4+ cell count (<25/mm3) confers protection against hypersensitivity reactions to high doses of TMP-SMZ for acute PCP [2] as well as to low doses of TMP-SMZ in rechallenged patients [3]. For the subpopulation of the least immunocompromised patients (i.e., those for whom the average CD4+ cell count is >150/mm3), a higher CD4+ cell count (>200/mm3) or percentage confers protection against hypersensitivity reactions to low-dose TMP-SMZ administered as primary prophylaxis for PCP [4, 5]. These last results were confirmed by Veenstra et al. [1]. In addition, in one of these studies, a higher CD4+ cell percentage appeared to confer protection against hypersensitivity reactions, with a 5% decrease in the risk per one-point increase in the CD4+ cell percentage [5].