

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 bacteraemia 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 bacteraemia 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 1). 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 bacteraemia 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

1. Maurice PDL, Parker S, Azadian BS, Cream JJ. Minor skin surgery. Are prophylactic antibiotics ever needed for curettage? *Acta Derm Venereol (Stockh)* 1991; 71: 267-168.
2. Roberts DL. incidence of non-melanoma skin cancer in West Glamorgan, South Wales. *Br J Dermatol* 1990; 122: 399-403.
3. Whimst WF, Leonard RA. Surgical pathology and general practice. *B M J* 1991; 303: 1149-1150.
4. Wagner RF, Grande DJ, Feingold DS. Antibiotic prophylaxis against bacterial endocarditis in patients undergoing dermatologic surgery. *Arch Dermatol* 1986; 122: 799-801.
5. Sabetta JB, Zitelli JA. The incidence of bacteremia during skin surgery. *Arch Dermatol* 1987; 123: 213-215.
6. Halpern AC, Leyden JJ, Dzubow LM, McGinley KJ. The incidence of bacteremia in skin surgery of the head and neck. *J Am Acad Dermatol* 1988; 19: 112-116.
7. Garretts JC, Peterie JD. Vancomycin and the "Red man's syndrome." *N Engl J Med* 1985; 312: 245.

Received December 17, 1991

Andrew J. Carmichael,¹ Peter J. A. Holt,¹ Paul Flanagan² and Brian I. Duerden,² Departments of ¹Dermatology and ²Medical Microbiology, University Hospital of Wales, Cardiff CF 4XW, United Kingdom.

Table 1. Sensitivities of *Staphylococcus epidermidis* blood culture isolates

Antibiotic	No of isolates	
	Resistant	Sensitive
Penicillin/Amoxicillin	103	12
Flucloxacillin	77	38
Erythromycin	71	44
Gentamicin	54	61
Rifampicin	2	113
Vancomycin	0	115

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.

P. D. L. Maurice, S. Parker, B. S. Azadian and J. J. Cream, Department of Dermatology, Charing Cross Hospital, London, United Kingdom.