

replaced by ceftazidime. The patient recovered slowly over the next 10 days but desquamation in the web spaces of his hands and feet was noted 10 days after the rash had started. Culture of the post-auricular surgical wounds and his throat grew *Staph aureus*, and *Staph aureus* was isolated from one of a pair of blood culture bottles after a 4 day extended incubation period. Three other paired blood cultures showed no growth. The staphylococci isolated from the wounds and blood culture were later identified as TSST-1 producing. Despite appropriate antibiotics the staphylococcus was still present on swabs taken from the ear wound 6 days after admission.

This case should serve as a reminder for all surgeons to be aware of the possibility of TSS even after a very minor procedure. This patient might have recovered more quickly if TSS had been diagnosed earlier and if a blood product containing gammaglobulin had been administered. High-dose antistaphylococcal antibiotics or tropical antistaphylococcal agents such as mupirocin have a limited value in established TSS because it is a toxin-mediated disease.

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HIGH INCIDENCE OF ANAPHYLACTIC REACTIONS TO CEFACLO

SIR,—Cefaclor is prescribed worldwide¹ and is one of the most frequently prescribed oral antibiotics in Japan. Many serum sickness type reactions to cefaclor have been reported.^{2,3} Patients administered cefaclor had a higher frequency of serum sickness type reactions and urticaria than those prescribed amoxicillin.⁴ Although several anaphylactic reactions to cefaclor were reported in Japan,⁵ such reactions have not been reported elsewhere. We have seen four cases of anaphylactic reactions to cefaclor prescribed in our hospital.

In the first case, a 27-year-old woman was given one 250 mg capsule of cefaclor with other drugs for treatment of an upper respiratory tract infection. Within 30 min urticaria appeared. When she revisited the hospital 1 h after taking the drugs, she fainted; systolic blood pressure was 70 mm Hg. Hydrocortisone, chlorpheniramine, adrenaline, and lactate Ringer's solution were administered immediately. Systolic blood pressure fell to 30 mm Hg but gradually increased to 94 mm Hg during the infusion of dopamine at 20 µg/kg/min for about 15 min. She was admitted and the dopamine infusion was tapered off over 6 h. She was discharged 2 days later. Intradermal skin-testing was done 10 months later. She reacted positively to 0.6 µg cefaclor. Cases 2 (a 51-year-old man) and 3 (a 33-year-old woman) had typical anaphylactic reactions. Both reacted positively to intradermal tests, the first to 0.6 ng and the other to 0.6 µg cefaclor. In the fourth case (a 73-year-old man) systolic blood pressure fell to 60 mm Hg about 40 min after he took a capsule of cefaclor and a tablet of bromhexine. Although skin-testing could not be done cefaclor was probably responsible because anaphylactic reactions to bromhexine have not been reported.

We have also seen 3 cases of haematological disorders (pancytopenia with liver damage, agranulocytosis, and agranulocytosis plus thrombocytopenia with shock) induced by cefaclor which was prescribed outside our hospital. All of these cases were confirmed to be cefaclor-induced by a lymphocyte stimulating test. Another case of severe anaphylactic reaction to cefaclor prescribed outside our hospital has been brought to our attention. A 57-year-old man had urticaria, dyspnoea, cyanosis, and stupor after taking one capsule of cefaclor, although he had, a fortnight before this, taken cefaclor safely for 5 days. He reacted positively to 0.6 µg intradermal cefaclor.

The number of patients to whom cefaclor has been prescribed at least once at our hospital between the introduction of cefaclor (March, 1982) and March, 1987, was 7972. Cephalixin, ampicillin, amoxycillin were prescribed to 24 421, 20 987, and 13 152 patients, respectively, between April, 1979, and March, 1987. The total number of patients to whom injectable penicillins and cepheims were prescribed at least once in this period was 10 936. The number of anaphylactic reactions reported in our hospital between April, 1979, and March, 1987, was: 4 to cefaclor, 1 to cephalixin, and 1 to ampicillin.⁶ The incidence per 10 000 patients of anaphylactic reactions was 5.02 for cefaclor, 0.41 for cephalixin, 0.48 for ampicillin, and zero for amoxycillin and for injectable penicillins or cepheims. The incidence of anaphylactic reactions to cefaclor was more than ten times higher than that to other antibiotics, including injectables ($p < 0.05$, Fisher's exact test).

In Japan, pharmaceutical companies are required to do postmarketing surveys for new drugs. There were no reports of anaphylactic reactions among 70 146 cephalixin takers and 57 970 amoxycillin takers, while 5 cases were reported among 35 146 patients on cefaclor. The incidence rate was significantly higher in patients on cefaclor than on cephalixin or amoxycillin ($p < 0.01$). The rate is lower than that of injectable cepheims (~0.024%) but higher than that of injectable cepheims (0~0.013%).

A fatal case of shock, probably induced by cefaclor, has been reported.⁵ Such a high incidence of anaphylactic reactions to cefaclor (about 1/2000) might require intradermal skin pretesting, as with injectable penicillins and cepheims. Cefaclor, however, is an oral antibiotic. We believe that cefaclor should not be recommended as a first-line drug.

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NEW LIFE FOR THE EEG

SIR,—Clinical neurophysiologists will find much to agree with in your April 30 editorial. The new methods of quantitative EEG and brain mapping have potential, both clinically and in research, but they need to be properly evaluated quickly, before enthusiasm outruns discretion and money is spent in the wrong places.

Where we would take issue is with your assessment of the current situation. To suggest that "Interest in the EEG has declined to a point where it is usually requested only in misguided attempts to 'exclude' seizures" is to deny the value of this investigation in many unexplained psychiatric illnesses. These include reversible metabolic disorders such as hyponatraemia, temporal lobe status, and atypical encephalitis presenting as acute psychosis or confusion—indeed, the EEG is underused in acute confusional states, perhaps the commonest neuropsychiatric disorder presenting in a general hospital. They also include epilepsy, or the more rare cerebral degenerative conditions, presenting as behaviour disorders in children. The need to exclude significant cerebrovascular disease or Alzheimer type dementia in patients who present with depression and anxiety in middle or old age is becoming more important, and the EEG is a useful tool in this respect.¹

It is wrong to state that interest in the EEG is now restricted to seizure disorders. In most hospitals EEG referrals are as likely to