QUESTION: I have two questions. First, did you screen the urine of these children, and if so, what did you find in terms of dip sticks?

RESPONSE: Unfortunately, we did not screen the urine, a question that Dr. Strauss immediately asked during that luncheon when we first talked about the study. It would have been simple enough to do but we were doing a great many other things, including photography, and we were limited to getting a certain amount of information. It certainly would have been useful and it would have been interesting to do several weeks after that visit as well, since we were getting the patients back in three weeks.

QUESTION: The second question I have is, what is your current recommendation in terms of the use of topical drugs to treat impetigo vs oral drugs?

RESPONSE: I think as a rule the topical drugs are most ineffective for cutaneous pyoderma. Now, I will use topical antibiotics for other disorders, acne for example. But not for cutaneous pyoderma, and I don't like a topical antibiotic in a disease that may have a sequella such as streptococcal disease; perhaps staphylococcal disease as well because of the spread to other family members, etc. who may be more vulnerable for a serious sequella. I don't use topical antibiotics for pyoderma.

QUESTION: I have two questions. First, did you make any attempt to see if the streptococcal infections were really nephritogenic or just simply strep infections? Second, was there any nephritis following staph infections?

RESPONSE: The second question was another one that Dr. Strauss had posed. We had no incidence of nephritis with staph infections. We had this patient population locked into a system and we had no incidence of post-staphylococcal renal disease in these patients. Again, when I was writing this protocol, conducting it, it was very early in my stay in Miami and I had little in hand. I was looking for research funds, looking for what I could get for what I most wanted. I certainly would have loved and would still like to repeat the study, looking for a number of things such as what you mentioned. It took us a long time; we had to lyophilize the staph before we had the funding to even phage type them. We found some very interesting things about the phage typing, too. It wasn't only group 2, type 71, for example, it was across the board groups 1, 2, and 3 in our own population. It would have been a very significant adjunct to the study as done and I would love to have had the funding to do them at the time.
QUESTION: As a point of interest, I've been in practice for six years, and from the day I walked into practice probably 90% of our skin infections have looked like staph and we've been treating them with anti-staphylococcal drugs. I just sat here amused that it took so long to change down here, though classically in the pediatric literature there have always been reports of nephritis in the warmer areas being skin and in the colder areas being throat. We've always had staph in our skin infections, for many, many years (in Long Island).

RESPONSE: We've always had staph in our skin infections for many years, too. I did my pediatric training in the same neighborhood. I was at Montefiore Hospital and at Albert Einstein. I was convinced in those years that we were seeing increased staph as well. But I defy you to find that in the pediatric literature.

RESPONSE: It's probably present at Einstein also. There I don't recall but I know that in our area it has clearly been staph for many years.

COMMENT: I felt the same when I was in New York, that we were seeing increased incidence, though not predominance of staphylococcal disease, not only in infants but also in the adolescent and young adult population. At Montefiore we had an adolescent program that went to 21-22 years of age. But, if you take a look at the reviews of pyoderma or the reviews of streptococcal disease, the last one being in the New England Journal around 1979-1980, they will tell you that streptococcal disease predominates as the pyoderma across the country, and mixed infections will be penicillin responsive. Find a reference elsewhere in the literature if you can; I would appreciate it. We wrote the one that will be in the Clinics of North America.

MODERATOR: I wonder whether I could impose upon our friend who knows so much about so many things and ask him to comment on the shifting patterns of infections or diseases that may or may not be related to infections.

COMMENT: First, it has been our impression that post-streptococcal glomerulonephritis is less frequently seen than we used to see it. Second, with rare exceptions, the disease is much less severe. I have seen two severe cases in the last few years, and one of those two was a Vietnamese boat refugee who required dialysis but then recovered completely. She had a very interesting finding. She had very severe tubulointerstitial involvement. If you look at the literature in the last 10 or 20 years, you hardly ever see tubulointerstitial involvement mentioned in post-streptococcal GN. But if you go back to the forties, to the early days of the association between streptococcal infection and renal disease, you will see that it is mentioned much more often. Now, in France there has been a reduction in the incidence of membranoproliferative GN. There was an abstract in Kidney International last year pointing this out. We have had the feeling that we are not seeing MPGN either. I'm not talking about Type II, but Type I, and I'm not saying that this is related to streptococcal infection. I'm just mentioning that there has been a change in the disease. In the northern United States and Canada there seems to be no impetiginous streptococcal glomerulonephritis but in the Artic among the Eskimo, it does occur.