Management with colistin

Dear Sir,

I read the article “Colistin and polymyxin B: A re-emergence”[1] with great interest. I heartily applaud the efforts of the authors to write this review article. However, I would like to add some more information in this regard.

Notably, *Proteus* spp., *Moraxella catarrhalis*, *Providencia* spp., *Serratia marcescens*, *Morganella morganii*, gram-negative cocci, and all gram-positive bacteria are resistant to colistin. Moreover, *Prevotella* and *Fusobacterium* spp. have variable sensitivity.[2] Hence, we should be careful using it against these bacteria.

Aerosolization of colistin into the airway can be complicated by bronchospasm, especially in patients with advanced lung disease and low baseline spirometry; bronchodilation prior to administration may be beneficial.[3] In addition, the prodrug colistimethate sodium should be reconstituted just before administration as nebulization so as to avoid excessive conversion to biologically active colistin, which can cause fatal airway or alveolar injury. In patients with pre-existing renal disease, dosage adjustments are required as impaired renal function may increase the risk for respiratory arrest.

Some more neurologic manifestations include psychosis, coma, convulsions, ptosis, diplopia, areflexia, dysphagia, and dysphonia.[4,5] Neuromuscular blockade is because of non-competitive blockade and thus it should not be used simultaneously with neuromuscular blocking agents. Capreomycin may also enhance this effect of colistin.

Prolonged use can cause fungal or bacterial superinfection, including *C. difficile*-associated diarrhea and pseudomembranous colitis; generally observed in more than 2 months postantibiotic treatment.

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References
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2. Li J, Nation RL, Milne RW, Turnidge JD, Coulthard K. Evaluation of colistin as an agent against multi-resistant Gram-negative bacteria.
Dear Editor,

The article by Haranath about "Patient Communication (SMS) in Intensive Care Unit (ICU)" is quite interesting to read and gives lots of messages to ponder over.[1] It is really a novel idea that a touch screen or any online keyboard-screen device can be used for gathering information from an intubated but awake patient. But the same may not be applicable for a pediatric population and quite often long-ventilated ones are very small but still awake and have senses in all respects. Music played to their ears and other external communication portals through the parents are quite often reassuring to those children who are awake. The problem accentuates in those who require long-term ventilation with associated problems of cognitive function.

While the issue of communication remains, the aspect of attentiveness needs to be patient-focused. I fully agree with the author that quite often the attention is directed toward a continuous monitor for hemodynamic file, but one has to remember that there is a patient at the end of the line and patient comes first for any assessment and interaction before any decision is made. This is where all the pictorial charts for easy understanding comes into play and these are very useful even in peripheral units. Last but not the least, if one has to do a frequent arterial blood sampling for assessment, then there is a definite role for an invasive arterial monitoring which avoids repeated arterial punctures. In adults, placing a radial artery catheter is not a technically challenging one and can be easily maintained for at least a week. Even in children, well-cared peripheral arterial catheters can be maintained for long duration lasting up to 3 weeks without any issues. Someone on ventilation for longer period can also have a central venous catheter in place through easily accessible route (internal jugular vein or subclavian vein or peripherally inserted central catheters depending on personal choice) and can be used for venous gas analysis.

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Reference
1. Haranath PS. Patient communication (SMS) in ICU. Ind J crit Care Med 2009;13:224-5.

Authors' Reply
I appreciate that you went through the article.[1,2] Just wanted to add a few points in reply.

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5. Lindesmith LA, Baines RD Jr, Bigelow DB, Petty TL. Reversible respiratory paralysis associated with polymyxin therapy. Ann Intern Med 1968;68:318-27.