has always seemed paradoxical that Canada, a country that is the fount of so much good work in evidence-based medicine and knowledge translation, does not have a national health library.[4]

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Competing interests: Jessie McGowan and Patrick Ellis are co-chairs of the National Network of Libraries for Health Task Force.

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Macrolide resistance in streptococcal pharyngitis

The infectious disease specialists in our hospital recently noticed increasing rates of complications in immunocompetent adults and children with streptococcal pharyngitis, secondary to treatment failure. Complications such as postpharyngitis erysipelas, retropharyngeal abscesses and sinusitis were all found to be associated with 1 factor: resistance to treatment with a macrolide (azithromycin) and a lincosamide (clindamycin).

We evaluated the epidemiology of resistance to erythromycin and clindamycin in group A *Streptococcus* in the population served by our hospital. During December 2006, 101 consecutive isolates of group A *Streptococcus* recovered from throat swab specimens (1 per patient) were tested in our microbiology laboratory by disk diffusion.[1] We found that 42.6% of the isolates were resistant to erythromycin and 39.6% to clindamycin, rates that are among the highest ever published.

Many previous studies have shown that the rate of resistance to a specific antibiotic is proportionally related to its use. The rate of prescription of azithromycin in New Brunswick is 2–3 times the Canadian mean, according to IMS Canada data made available to us by the Canadian Integrated Program for Antimicrobial Resistance Surveillance of the Public Health Agency of Canada through their antibiotic use database. This underlines the importance of following well-known but unfortunately neglected antibiotic guidelines. First, antibiotics should be prescribed only to treat obvious bacterial infections and only when an antigen-detection test or a culture or both are positive. Second, macrolides are considered to be a third-line therapy for streptococcal pharyngitis and their use should be limited accordingly. Penicillin V remains the treatment of choice and should be replaced by cephalosporins if the patient has a nonanaphylactic allergy to penicillin. Finally, if a macrolide must be used to treat streptococcal pharyngitis, its group A *Streptococcus* strain susceptibility should be tested on the specimen sent for throat culture to avoid clinical or microbiological treatment failure.

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1. Clinical and Laboratory Standards Institute. *Performance standards for antimicrobial susceptibility testing. Sixteenth informational supplement.* Doc no M100-S16. Wayne (PA): The Institute; 2006.

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Correction

A recent story[1] about the sale of the Sir Frederick Banting homestead that appeared in the News section should have stated that the 100-acre farm was bequeathed to the Ontario Historical Society. The *CMAJ* apologizes for any inconvenience this error may have caused.

REFERENCE

1. Fletcher K. Sir Frederick Banting homestead sold to developer, family outraged. *CMAJ* 2007;176(12):1691-2.

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