

B. Lung Abscess

1. *Evaluation*: Ineffective as a fixed dose combination.
2. *Comment*: A fixed dose combination of penicillin and streptomycin is not considered the regimen of choice. Most clinicians would rely primarily on large dose of penicillin G and on occasion would add another agent, depending on the flora found by culture.
3. *Documentation*: References 18-20.

C. Aspiration Pneumonia

1. *Evaluation*: Ineffective.
2. *Comment*: The term "aspiration pneumonia" is vague and will be considered here to represent the pulmonary inflammatory process that follows aspiration of acidic gastric contents incident to vomiting or the exclusion of aspiration of mixed bacterial flora of the oral cavity incident to alteration of consciousness from a variety of causes. This condition is primarily a chemical pneumonia and requires no antibiotic.

Small amounts of a single agent are sometimes used to prevent pneumococcal or streptococcal superinfection. If there is staphylococcal infection, better antimicrobials than these combinations are available. Aspiration of oral cavity microflora should be regarded as the initiating event for putrid (anaerobic) lung abscess (see indication B—lung abscess, supra).

3. *Documentation*: References 21-24.

D. Mediastinitis

1. *Evaluation*: Ineffective.
2. *Comment*: The invading organisms in mediastinitis are variable and have not been well defined. The microorganisms include both aerobic and anaerobic oral flora (*Streptococcus viridans*, anaerobic streptococci, *Bacteroides* species, fusiform bacilli, and *Enterobacteriaceae*). Although penicillin is effective against some of the potential pathogens and streptomycin against others, the amount of penicillin in these combinations is not sufficient for adequate therapy.

3. *Documentation*: References 25-27.

E. Peritonitis

1. *Evaluation*: Ineffective as a fixed combination.
2. *Comment*: Many types of peritonitis exist, e.g., spontaneous coliform peritonitis in patients with hepatic cirrhosis, pneumococcal peritonitis, tuberculosis peritonitis, and peritonitis secondary to rupture of an abdominal viscus in hospitalized or non-hospitalized patients.

There is little question but that antibiotic therapy has improved the prognosis in peritonitis secondary to fecal spillage. This has been most apparent, however, with aqueous penicillin G or tetracycline. Penicillin and streptomycin have been used together in such infections, but it is difficult to assess whether effectiveness is due to the penicillin or to the streptomycin.

3. *Documentation*: References 28-34.

F. Mixed Wound Infections and Abscesses

1. *Evaluation*: Ineffective as a fixed combination.
2. *Comment*: Antibiotic therapy in combination with proper local management has been effective in the treatment of mixed wound infections and abscesses. One would expect these fixed combinations of penicillin and streptomycin to be less effective than other agents in the treatment of postoperative wound infections, because the organisms most commonly encountered are often resistant to these drugs. Wounds following trauma are often contaminated with clostridia. These organisms are usually sufficiently non-susceptible to preclude their eradication with the recommended dosages of penicillin-streptomycin.

3. *Documentation*: Reference 35.

G. Abdominal Surgery in a Contaminated Area

1. *Evaluation*: Ineffective as a fixed combination.
2. *Comment*: This combination of antimicrobials has not been shown to prevent postoperative infection.
3. *Documentation*: References 30, 36-40.

H. Gonorrhea

1. *Evaluation*: Ineffective as a fixed combination.
2. *Comment*: The combinations offer no advantage over adequate dosage of penicillin alone. It is also noted that strains of *Neisseria gonorrhoeae* have been