Enterobacteriaceae, which are normal inhabitants of the intestinal flora, are among the most common human pathogens. They cause serious infections such as pyelonephritis, peritonitis, pneumonia, septicemia, and device-associated infections. They have the propensity to spread easily between humans, by hand carriage or contaminated food and water. Gram negative organisms like *Escherichia coli, Klebsiella* spp, and *Acinetobacter* spp, capable of producing overwhelming infections, have one thing in common viz. antibiotic resistance, occurring as a result of production of enzymes such as β lactamase. This is more relevant in the context of intensive care units (ICUs) harboring critically ill patients. Simple infections by these organisms become life threatening, when the antibiotics used against them become ineffective. This is particularly true for third generation cephalosporins. Additionally, the presence of MBL and Amp-C beta lactamases complicate the issue further. In our country, ICUs lack international standards in infection-control policies and time-bound surveillance systems for assessing the incidence of such potentially fatal infections.

Hospital staff, especially the nursing assistants and attendants, may not have the knowledge, practices, or skills to prevent transmission of such infections from themselves. In contrast, there is universal indiscriminate usage of third generation cephalosporins, not only in the ICUs, but also in the general wards. This gives rise to higher incidence of bacteria developing drug resistance. Particularly disturbing is the fact that there is paucity of new or promising agents for destroying Gram negative bacilli like *Acinetobacter* spp, *Pseudomonas aeruginosa*, beta lactamase producing *Klebsiella* spp., and *E. coli*.

In this context, the original article 'Beta lactamase as a cause of multidrug resistance in gram negative isolates' is very relevant. The high incidence of resistance noted in this study, especially to multiple drugs observed with high frequency among MBL and ESBL is of concern. This has probably resulted in significant narrowing of the therapeutic options for life threatening infections. It is also evident clinically, when high doses of third generation cephalosporins and fluroquinolones are given parenterally, it does not produce any life saving effect, leading to the overdependence on carbapenems and Vancomycin in critically ill patients. Already carbapenemase production has become a threat, especially in *Klebsiella pneumoniae* and *E. coli*. It is recently reported that, this has marked endemicity at least in the United States and Greece and is increasingly being reported from the rest of the world.

Detection of the patients and the carriers infected with enzyme producers is necessary for control of these infections. While the identification of these enzyme genes require advanced culture methods and molecular techniques, the detection of carriers is possible. Screening for carriers, if practiced universally will help to prevent development of nosocomial outbreaks by beta lactamase or carbapenemase producers, particularly by the Enterobacteriaceae.

Among the case reports of individual authors, the one that needs special mention is '*Pneumocystis jirovecii* pneumonia in an AIDS patient'. Even though Pneumocystis pneumonia (PCP) is common in human immunodeficiency virus (HIV) patients, the diagnosis can be made empirically, based on the presence of diffuse nodular opacities of both hila in the chest X-ray. Microbiological diagnosis is seldom possible, because of either the nonavailability of laboratory resources or early administration of antibiotics like Cotrimoxazole. Universal availability of such facility is essential especially because of the chances of misdiagnosing infection by *Mycobacterium tuberculosis*, as PCP.

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