Although a clinical criteria-based strategy is highly attractive, we also offered a “limited testing” option similar to the algorithm endorsed by the IDSA. Use of this approach would decrease the number of patients treated unnecessarily, (i.e., those treated despite the absence of GABHS) but at the cost of failure to treat some patients with GABHS (due to a false-negative rapid antigen test [RAT] result). Furthermore, if testing were applied to a broader proportion of patients (e.g., those who met 2 of 4 Centor criteria), it would almost certainly increase the number of patients treated unnecessarily (on the basis of a false-positive RAT result).

All of this is, of course, theoretical, as it is based on the notion that physicians would follow any of the various recommendations being proposed—of which there is no guarantee. One should not dismiss the observation that the high antibiotic prescription rate for adults with acute pharyngitis has evolved and persisted despite similar recommendations in previous clinical practice guidelines published by the IDSA in 1997 [8] and the American Heart Association in 1995 [9]. It is not unreasonable to speculate that the current “test-and-treat” approach may be part of the reason that we are in the current over-treatment predicament. If practicing clinicians do not adopt standard testing strategies as useful or practical, and if they are given no other “academic” approach to fall back on, it is not surprising that they frequently take the default path of prescribing antibiotics, given the abundant external pressure to do so. Add the fact that a mandatory testing strategy gives patients the message that they need to see their physician whenever they have a sore throat, and the problem is only magnified. Nonetheless, Bisno et al. [2] caution readers about rejecting long-held traditional teaching without having first evaluated a new strategy. In response, we would make the following points: (1) we hope that readers are familiar enough with the principles of evidence-based medicine to recognize the importance of healthy skepticism regarding “traditional teaching,” and (2) the impact of the IDSA guidelines, just like that of the CDC principles, has not been formally evaluated.

Practice guidelines are not self-implementing. They provide a useful framework for evaluating current practice patterns, and they inform practicing physicians of strategies to improve practice. Successful implementation strategies must take into account the myriad of clinical and non-clinical factors that influence physician behavior, such as patients’ expectations, time pressure on physicians, and concerns about patient follow-up. Reducing excessive antibiotic use for adults with acute pharyngitis is unlikely to result from the mere publication of the CDC principles or of the IDSA guidelines. Instead, these guidelines must be incorporated into broader, proven quality-improvement initiatives. It is the continuous evaluation of the impact of these initiatives, together with modification and reimplementation of recommendations, that will lead to sustained improvements in antibiotic prescribing practices.

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Linezolid versus Vancomycin for Methicillin-Resistant Staphylococcus aureus Infections

Sir—The new evidence from Stevens et al. [1] that linezolid is as effective as vancomycin against methicillin-resistant Staphylococcus aureus (MRSA) infections indicates that oral linezolid is an alternative to intravenous vancomycin for treatment of such infections. Unfortunately, the high cost of linezolid and the importance of not inducing resistance to it among staphylococci and enterococci make the routine use of linezolid against MRSA infections problematic.

Older data suggest that trimethoprim-sulfamethoxazole (TMP-SMZ) also may be as effective as vancomycin against MRSA infections [2]. In a randomized trial, all 47 patients with MRSA infections, including those with bacteremia, were cured, irrespective of antibiotic regimen [2].

Oral TMP-SMZ costs <1% of what linezolid costs, and it is highly bioavailable. In addition, TMP-SMZ is not appropriate

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for enterococcal infections. Many members of the Infectious Diseases Society of America (IDSA) Emerging Infections Network (EIN) now routinely use TMP-SMZ, with or without rifampin, for MRSA infections that are not life threatening, reportedly with success (unpublished data, J.R.J.). Although drug-drug interactions and patients’ drug intolerance do occasionally complicate or preclude the use of TMP-SMZ, it may be a convenient and inexpensive alternative to vancomycin that neither selects for vancomycin-resistant organisms nor requires intravenous access [2, 3].

A randomized trial comparing vancomycin, linezolid, and TMP-SMZ in the treatment of MRSA infections would be most timely. However, given the probable absence of an interested corporate sponsor, support for such a trial may be needed from nonprofit and governmental entities concerned with health care costs and antimicrobial resistance, including the National Institutes of Health, the Centers for Disease Control and Prevention, the US Food and Drug Administration, the IDSA, and the US Department of Veterans Affairs.

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