mycin than to select for MRSA with a cephalosporin.

Clearly, restriction of vancomycin use is essential to control the emergence and spread of vancomycin-resistant organisms. However, restricting the use of vancomycin for patients undergoing cardiac surgery may be self-defeating. Patients with MRSA infection associated with cardiac or vascular implants receive vancomycin therapy for weeks to months. Is it preferable to expose a large number of patients to a small amount of vancomycin or to expose a smaller number of patients who have infections associated with prosthetic material to vancomycin over a long duration of treatment? It is the latter scenario that has been associated with development of vancomycin resistance in staphylococci.

Hospital data on adherence to SIP guidelines may soon be required by the Centers for Medicare and Medicaid Services and/or the Joint Commission on Accreditation of Healthcare Organizations and will be available for public review. In addition, some third-party payers have identified compliance with these guidelines as an indicator for hospital incentive programs that are associated with millions of dollars of incentive money. Hospitals may be forced to choose between using an antibiotic that they do not believe is best for their patients and having unfavorable data revealed to the public. Without more evidence to support the use of cephalosporins for prophylaxis for cardiac and vascular surgical procedures involving implants, we feel strongly that the SIP guidelines should include vancomycin as an option for antimicrobial prophylaxis for these surgeries.

Acknowledgments

Potential conflicts of interest. C.E.C. received the 2000–2001 Smith Kline Beecham Junior Faculty Award. D.D.D. recently received research funding from Cubist Pharmaceuticals, is a consultant for Aventis Pharmaceuticals, and is on the speakers’ bureaus of Pfizer, Elan Pharmaceuticals, and Aventis Pharmaceuticals. R.L.P.: no conflicts.

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Reply to Chenoweth et al.

Sir—Chenoweth and colleagues [1] have recommended that guidelines for surgical antimicrobial prophylaxis include vancomycin as an option for patients who undergo cardiac or vascular surgery with implantation of prosthetic valves or foreign materials. They noted several issues concerning the use of vancomycin prophylaxis for patients who undergo cardiac surgery about which controversy still exists. We agree that documented β-lactam allergy is not the only reason for which the use of vancomycin as prophylaxis for cardiac surgery should be considered appropriate.

The Advisory Statement developed by the Surgical Infection Prevention Guideline Writers Workgroup was intended to provide an overview of published guidelines for antimicrobial prophylaxis and consensus on issues that were inconsistent or not addressed in the guidelines [2]. The Workgroup agreed that use of vancomycin for prophylaxis is appropriate for patients with documented allergy to β-lactam antimicrobials or with known colonization with methicillin-resistant strains of Staphylococcus. Although several published guidelines recommended the use of vancomycin for prophylaxis in institutions with a high prevalence of methicillin-resistant staphylococcal infections [3–5], there was no consensus on what constituted a “high” institutional prevalence, and the Hospital Infection Control Practices Advisory Committee stated in their guidelines that “the routine use of vancomycin in antimicrobial prophylaxis is not recommended for any kind of operation” [4, p. 260]. There was no consensus on what other indications support routine use of vancomycin for prophylaxis.

Zanetti and Platt [6] have provided a concise overview of some of the unanswered questions regarding antibiotic prophylaxis for cardiac surgery. There is still no evidence on which to base a threshold value for institutional or community prevalence of methicillin-resistant strains of Staphylococcus that would justify routine use of vancomycin for prophylaxis. It is unlikely that all patients who have surgery in an institution with a high prevalence of methicillin-resistant staphylococcal species are at the same risk of postoperative infection with these organisms, or that routine use of vancomycin prophylaxis in these institutions will prevent infection with methicillin-resistant organisms [7–9]. Is routine use of vancomycin for surgical prophylaxis appropriate for any institution or class of operations, or should the decision to use vancomycin prophylaxis be based on a careful assessment of individual patient risk? How does prolonged postoperative antimicrobial
prophylaxis contribute to the institutional prevalence of resistant organisms [10]? As Zanetti and Platt [6] point out, there is a need for additional research to answer these and other questions.

The issues raised by Chenoweth et al. [1] continue to highlight some of the potential unintended consequences of using for accountability purposes (i.e., public reporting and pay-for-performance programs) performance measures that were developed to improve the quality of care [11]. Although national rates of performance on the quality indicator for antibiotic selection in cardiac surgery that is consistent with published guidelines remained very high [10], we recognize that, in some institutions, other factors not accounted for in the performance measure may lead to poor performance on the measure. The leadership of the National Surgical Infection Prevention Project is working to resolve some of the problems associated with this performance measure and to address the uncertainties about use of vancomycin for surgical prophylaxis.

Acknowledgments

Potential conflicts of interest. D.W.B. and P.M.H.: no conflicts.

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Trends in Cancer Incidence Rates among HIV-Infected Patients

Sir—In their recent article, Bedimo and colleagues [1] provided estimates of temporal trends of cancer in persons with HIV/AIDS. Their findings for AIDS-defining cancer are consistent with previous studies [2, 3].

To further elucidate recent trends in incidence of non-AIDS-defining cancer, we reassessed the incidence before and after the introduction of HAART, as reported in recent publications [1, 3–6].

For all non–AIDS-defining cancers, the largest pooled analysis [3] (total observation time, 138,148 person-years [py]) showed an adjusted incidence rate of 210 cases per 100,000 py in 1997–1999, compared with 220 cases per 100,000 py in 1992–1996 (table 1). Conversely, Bedimo et al. [1] (7452 py) showed an increase in incidence rate from 327 cases per 100,000 py in 1989–1996 to 1087 cases per 100,000 py in 1997–2002 (rate ratio, 3.3; 95% CI, 1.7–6.6). The increase in incidence was largely attributable to cases of skin and anal cancers, tumors whose identification is largely influenced by medical surveillance in persons with HIV/AIDS and whose incidence rates greatly increase with older age.

For specific cancers, the incidence numbers were small, and 95% CIs were wide for all studies. Bower et al. [5] (42,158 py) showed that the incidence of HIV-related lung cancer increased from 8 cases per 100,000 py (95% CI, 2.3–32) before introduction of HAART to 67 cases per 100,000 py (95% CI, 31–139) in the HAART era (rate ratio, 8.9; 95% CI, 4.9–20.0). These findings were not confirmed by an Italian record-linkage study [4] (18,753 py), which showed no statistically significant change in incidence after the introduction of HAART (incidence in 1985–1996, 107 cases per 100,000 py [95% CI, 62–172]; incidence in 1997–1998, 141 cases per 100,000 py [95% CI, 37–364]) (table 1).

For all cancers, the British HIV cohort [6] showed increases in incidence from 35 cases per 100,000 py (95% CI, 15–72) before introduction of HAART to 92 cases per 100,000 py (95% CI, 54–150) after introduction of HAART. No study reported a statistically significant change in incidence rates for other cancers.

When the effect of HAART use on cancer risk was investigated using standardized incidence ratios (SIRs) (i.e., the risk increase compared with that of the general population), no clearer indications emerged. For all non–AIDS-defining cancers, Herida et al. [7] (224,780 py) found an increased SIR after the introduction of HAART among men but not among women. No differences in SIRs emerged in population-based studies conducted in Italy [8] (60,421 py) and Switzerland [9] (28,836 py).

The studies varied in design, number of