ors in emergency department diagnoses of pneumonia.

It seems reasonable to assume that, when guidelines become rules and infractions are punished, many patients will receive antibiotics unnecessarily. This coerced overuse will be a factor leading to increased antimicrobial resistance, an issue that remains one of the most profound infectious disease problems that the world faces in the near future.

Acknowledgments


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Guideline Tyranny: A Response to the Article by Baum and Kaltsas

To THE EDITOR—We wish to take issue with some of the points raised by Baum and Kaltsas in their recent article “Guideline Tyranny: Primum non Nocere” in Clinical Infectious Diseases [1]. We feel that some of their statements are misleading and that the authors inaccurately interpreted the Infectious Diseases Society of America-American Thoracic Society (IDSA/ATS) consensus guidelines regarding the management of community-acquired pneumonia (CAP) [2]. In particular, we object to the linking of the current IDSA/ATS guideline recommendations with the Center for Medicine and Medicaid Services (CMS) and The Joint Commission standards for time to first antibiotic dose.

The IDSA CAP guidelines of 2000 emphasized the importance of initiating therapy in a timely fashion: “an analysis of 14,000 patients showed that a >8-h delay from the time of admission to initiation of antibiotic therapy was associated with an increase in mortality. Antibiotic treatment should not be withheld from acutely ill patients because of delays in obtaining appropriate specimens or the results of Gram stains and cultures” [3, p. 370].

However, in the 2007 consensus guidelines that were produced jointly by the IDSA and ATS, a detailed discussion of “time to first antibiotic dose” is provided, and we specifically state that “the committee did not feel that a specific time window for delivery of the first antibiotic dose should be recommended” [2, p. S54]. This certainly cannot be construed as an endorsement of the 4-h recommendation.

Next, the authors raise the specter of antimicrobial resistance and invoke doomsday scenarios, such as AIDS, avian influenza virus capable of human-to-human transmission, and emerging drug resistance, which have “the capacity to affect every human being adversely” [1, p. 1879]. They then imply a causal association between antimicrobial resistance and the 4-h treatment rule without providing relevant data to substantiate an association.

The data that they do provide do not support their statement.

Baum and Kaltsas claim that most CAP treatment is begun in the emergency department, “often without sufficient proof that the patient is experiencing pneumonia rather than upper respiratory infection” [1, p. 1880]. Their statement is not supported by data and is not consistent with the 2007 IDSA/ATS guidelines, which explicitly state that a diagnosis of CAP requires a constellation of suggestive clinical features and a demonstrable infiltrate by chest radiograph or other imaging techniques, with or without supporting microbiological data. We do not see how this guideline statement could be much clearer.

If emergency department physicians are prescribing antibiotics for patients with respiratory symptoms that do not meet these criteria, such use is inconsistent with the guidelines. The solution is to improve practice standards, not to reject the guidelines.

Baum and Kaltsas [1] also bring up colitis due to *Clostridium difficile*. This is certainly a problem from both clinical and infection-control points of view, and it has had a significant impact on patient morbidity and mortality. The authors of the guidelines (several of whom have made substantial contributions to the literature on *C. difficile* colitis) are aware of this problem but do not believe that withholding antibiotics from patients with pneumonia is an appropriate preventive measure.

Baum and Kaltsas [1] did not show how the current IDSA/ATS CAP guidelines in any way support the CMS recommendations, and they have not established any link between the guidelines and increased antimicrobial resistance. They have, however, failed to mention that several studies have confirmed the positive outcome measures associated with the use of CAP guidelines, particularly a reduction in mortality among sicker patients [4–6].

We also have concerns about the authors’ use of hyperbole and some of their calculations. They state that “millions of patients with nonbacterial pneumonia would be unnecessarily treated with antibiotics” [1, p. 1880]. On the basis of available figures, there are ~4 million cases of CAP per year in the United States, and ~20% of the affected patients are hospitalized. The 4-h rule is more likely to be applied to patients who are ill enough to be either hospitalized or at least considered for hospitalization. Using Baum and Kaltsas’s [1] figure of a 29% incidence of viral infection, it is hard to see how millions of patients with nonbacterial pneumonia will receive unnecessary antibiotics. Most clinicians have difficulty distinguishing among cases of bacterial, viral, or viral with bacterial superinfection pneu-
monias. Further, viral pneumonias are excluded from the CMS audits, so this diagnosis should not be used to encourage antimicrobial abuse. Parenthetically, we note that a 29% overtreatment of viral pneumonia can hardly be singled out as a significant cause of antibiotic abuse. The inappropriate treatment of acute bronchitis, for example, is much more important from an antibiotic misuse perspective.

We as a group strongly support the principles of antibiotic stewardship and decry the unnecessary use of antimicrobial agents. However, we realize that there is a time and place for the initial empirical use of antibiotics. CAP is the most common cause of death from infection, and in most cases, there is no way to determine with certainty the microbial etiology prior to initiating therapy. The indefinite withholding of antibiotics is neither appropriate nor justified for patients who are seriously ill with CAP.

The 2007 IDSA/ATS CAP guidelines strongly support the use of diagnostic criteria followed by administration of appropriate antibiotic therapy as soon as possible but not according to a rigid time schedule. The evils alluded to by Baum and Kaltzas [1] are not caused by guideline tyranny; the problem lies in the disregard of guideline recommendations by CMS policy and practicing clinicians.

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