but conferred no significant advantage in terms of reducing the incidence of renal toxicity when given to patients with AIDS-associated cryptococcal meningitis. Finally, in a phase II clinical trial comparing AmB-IL with AmB in 5% glucose, Schöffski et al. did not observe an improved toxicity profile (clinical or renal) associated with AmB-IL in 51 cancer patients. The results of the present study add to the controversy.

Variations in the daily dosage of AmB-IL can modify patients’ ability to tolerate this formulation. Trissel recently questioned the compatibility of the combination of AmB and Intralipid and reported that a yellow precipitate appears after centrifugation. This could account for important variations between preparations in the amount of AmB delivered to patients. Preparation procedures can also greatly influence the stability and toxic potential of AmB deoxycholate in lipid emulsion (Drucker, M. M., personal communication).

AmB concentrations in lipid emulsions, rate of infusion and the total infusion volume may all play a role in patients’ ability to tolerate this formulation. Until the impact of these variables are determined, the precise role of AmB in lipid emulsions in the treatment of patients with severe fungal infections will remain unresolved.

Acceptability of non-inpatient intravenous antibiotic therapy in patients with infections in north-east Scotland


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Sir,

In the UK and elsewhere in Europe, patients with community-acquired infections who require intravenous antibiotic therapy are traditionally managed as inpatients. In contrast, in the USA, many of these patients are successfully managed in the community through non-inpatient intravenous antibiotic therapy (NIPIVT) programmes. Before introducing a comprehensive NIPIVT programme, however, it is first necessary to assess the need for and acceptability of such a programme in the target population; in the UK, data of this nature are currently lacking. In Dundee, we have observed that patients receiving NIPIVT experience an improved quality of life. Herein, we report the results of our preliminary investigations of the feasibility and acceptability of such a programme in north-east Scotland.

The study was based in two Scottish regional infectious disease units, Dundee and Aberdeen. Patients who had received any anti-infective agent whilst in hospital were eligible for evaluation. Information about each infective episode, together with details of the anti-infective therapy administered both in hospital and at home, were recorded. In addition, patients were given information leaflets describing NIPIVT and were encouraged to question the investigators regarding aspects of the therapy about which they were unclear. Patients were then asked a series of questions designed to determine if this option was acceptable and feasible in their particular cases, i.e., whether or not they were willing to undergo therapy at home, possessed a refrigerator for the storage of antibiotics, had easy access to a telephone for liaison with hospital-based staff and had access to either a car or public transport.

A total of 167 non-consecutive patients took part in the study. Fifty-four had skin or soft tissue infections (mainly cellulitis) and 61 had respiratory tract infections (32 of

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which were pneumonia or bronchitis and 29 of which were pharyngitis); the remainder suffered from a variety of other common community-acquired infections. Intravenous antibiotics were administered to 126 (75%) patients. Eleven (9%) of these continued to receive intravenous therapy, without complications, at home, 31 (25%) were switched to oral therapy while still in hospital and the remaining patients were switched to oral therapy at the time of discharge. The median duration of inpatient intravenous therapy was 5 days (range 1–33 days) and 115 (69%) patients received intravenous therapy for >48 h. The percentages of patients requiring prolonged (i.e., >48 h) intravenous therapy were highest amongst those with soft tissue or bone and joint infections (47 of 54 (87%) and four of four (100%) respectively).

Of the 167 patients surveyed, 126 (75%) indicated a willingness to undergo NIPIVT. Of these 126, 119 (94%) also met the feasibility criteria. Overall, 51% of patients were willing to participate, met the criteria of feasibility and had carers at home who, if necessary, could administer the antibiotics. The commonest reasons for preferring inpatient therapy were fear of the intravascular device, frailty, immobility and poor understanding of the concepts involved.

Although this was an ad hoc analysis of non-consecutive patients with infections, it has, none the less, revealed that there is potential for an NIPIVT programme to be adopted in north-east Scotland. A prospective study of consecutive patients is currently under way in Dundee.

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