To the Editor—We appreciate the comments provided by Parta et al regarding our article [1, 2]. In our study, the observed 6.2-day reduction in hospital stay in the post–polymerase chain reaction (PCR) group was, in part, attributed to the PCR test. The rapid result allowed for a decreased time to effective antimicrobial therapy and infectious diseases (ID) consultation and, therefore, shorter hospital stay. We believe that all three components contributed to the reduction in hospital stay. This has been validated by others [3].

We agree that patients with coagulase-negative *Staphylococcus* (CoNS) bacteremia present another opportunity for intervention and cost-savings if the culture is determined to be contaminated. We did not make interventions because of our high proportion of intensive care unit and immunocompromised patients. This population would require review by an ID physician to determine whether the culture was contaminated and, therefore, discontinuation of antimicrobial therapy. We are in the process of adding non-intensive care unit, immunocompetent patients with CoNS bacteremia in our stewardship interventions and appreciate the recent rapid PCR results of Parta et al [4].
Most (80% in the post-group) patients in our study were empirically treated with vancomycin. The decision to switch from vancomycin to daptomycin in the post-PCR methicillin-resistant Staphylococcus aureus (MRSA) group was based on our institutional stewardship criteria for vancomycin treatment failure. The criteria is defined as blood cultures positive for MRSA >5 days with vancomycin therapy, therapeutic vancomycin troughs (15–20 mg/mL), all known sources removed, and/or vancomycin minimum inhibitory concentration ≥2 mg/mL. For patients with a history of MRSA bacteremia treated with vancomycin, daptomycin was recommended. Although we appreciate that the median time to clearance of MRSA bacteremia was 8 and 9 days for daptomycin and standard therapy, respectively, in the study by Fowler et al [5], we do not wait 8 days to switch a patient from vancomycin to daptomycin if they meet our criteria. The effects of daptomycin on clinical outcomes, especially the decreased time to symptom resolution and the rate of health care use were evaluated in a prospective, open-label study involving patients with complicated skin and skin structure infections [6]. Control patients who received vancomycin were compared with patients who received daptomycin. Among all patients, the median duration of intravenous therapy was 7 days (range, 3–14 days) in the vancomycin group, compared with 4 days (3–13 days) in the daptomycin group ($P < .001$). The median antibiotic-related length of stay was 8 days (range, 3–19 days) in the vancomycin group, compared with 4 days (3–13 days) in the daptomycin group ($P < .001$). Among patients with community-acquired MRSA infection, the duration of intravenous therapy was 8 days in the vancomycin group, compared with 4 days in the daptomycin group ($P < .05$).

We find it interesting that we both studied the effect of rapid PCR-based reporting on the treatment of patients with positive blood culture results; however, we evaluated patients with bacteremia due to S. aureus, and Parta et al [1] focused on patients with infection due to Staphylococcus species other than S. aureus. Both studies provide valuable data to support rapid PCR testing as a way to improve time to appropriate antimicrobial therapy and decrease unnecessary drug pressure.

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