Affordable Care Act (ACA) [6]. That lack of expansion of Medicaid is a significant barrier for at-risk HIV-negative MSM in Atlanta. Los Angeles County has a large population of undocumented immigrants who lack access to healthcare, despite the ACA. As poverty is a significant risk factor for HIV [7], limited health insurance coverage among poor and undocumented MSM will affect those most at risk for HIV without adequate access to new biomedical prevention services. Use of similar models to visualize PrEP awareness and access by race, as we did in this Los Angeles County cohort, highlights the issues of lack of awareness, access, and uptake by race.

Note

Potential conflicts of interest. All authors: No potential conflicts of interest. All authors have submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Conflicts that the editors consider relevant to the content of the manuscript have been disclosed.

References


Clinical Infectious Diseases. 2016;62(3):402–3 © The Author 2015. Published by Oxford University Press for the Infectious Diseases Society of America. All rights reserved. For permissions, e-mail journals.permissions@oup.com. DOI: 10.1093/cid/civ860

Decreased Antibiotic Consumption in the Belgian Community: Is It Credible?

TO THE EDITOR—We read with great interest the article by Carlet about the World Alliance Against Antibiotic Resistance (WAAAR) declaration. It is stated that “in Belgium, a 34% decrease in community antibiotic consumption has been achieved mainly due to large awareness campaigns targeting healthcare professionals and the public” [1].

In fact, the most important national campaign promoting a rational use of antibiotics in the community took place between November 2000 and February 2001, allowing a reduction in antibiotic use by 10.2% when expressed in defined daily dose per 1000 inhabitants per day (DID) between 1997 and 2004, and by 36% when expressed as the reimbursed packages per 1000 inhabitants per day (PID), between 1997 and 2006 [2–4]. However, the most recent data, expressed in DID, show a significant increase of 15.7% between 1997 and 2013, and an even higher increase of 29.3% between 2004 and 2013 [4]. The difference between DID and PID is usually explained by the fact that the entire decade of the 2000s, the content of an average reimbursed package increased, both by increase of strength and size (ie, doubling the tablets for the most popular β-lactams). Also, the daily dosages of some antibiotics increased, particularly β-lactams, while the defined daily dose did not, leading some authors to consider the number of packages as a more appropriate way to quantify outpatient antibiotic consumption as well as the impact of national awareness campaigns in countries dispensing “complete packages” [5]. Nevertheless, Belgium remains one of the most important consumers of antibiotics in Europe despite efforts of the Belgian Antibiotic Policy Coordination Committee in 2006, 2008, and 2013 to promote rational antibiotic use through distribution of a national guide for ambulatory care [4, 6]. Moreover, there has not been any initiative toward institutional control of the quality of antibiotic prescriptions in our country. A retrospective study performed in March 2006 showed that fluoroquinolone prescriptions were inappropriate in 77.4% of cases, while their use continued to rise by 11.4% between 2006 and 2013 despite a lack of modification in posology, package size, or daily dose [4, 6]. There are no restrictions regarding antibiotics prescribed in the out-of-hospital setting, including nursing homes, despite the fact that physicians are not...
required to attend postcertification courses in the infectious diseases field.

In conclusion, Belgium is often considered as an example for the reduction of antibiotic consumption in the community. However, this reduction is only apparent when expressed in PID, whereas a significant increase is objectified when expressed in DID. In our daily practice, we continue to observe numerous cases of overuse and misuse of antibiotics in the community, as is illustrated with fluoroquinolones, and there are currently no data available about the quality of prescriptions in our country. We very strongly agree with the WAAAR statement regarding antibiotics as “special drugs and a treasure to protect,” not only in the hospital but also in the community, as outpatient antibiotic consumption represents >90% of the global amount of antibiotics used daily [1, 7].

Note
Potential conflicts of interest. All authors: No reported conflicts. All authors have submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Conflicts that the editors consider relevant to the content of the manuscript have been disclosed.

Frédéric Frippiat, Christelle Vercheval, and Nathalie Layios
1 Department of Internal Medicine, Division of Infectious Diseases and Immunology, 2 Department of Pharmacy, and 3 Department of Intensive Care Unit, University Hospital of Liège, Belgium

Significant Reduction of External Ventricular Drainage–Associated Meningoventriculitis by Chlorhexidine-Containing Dressings: A Before-After Trial

To the Editor—Meningoventriculitis (MV) associated with external ventricular drainage (EVD) is a serious complication in neurosurgical patients, and infections are mainly due to skin-derived bacteria [1, 2]. Currently, data on rates of EVD-associated MV are scarce, with estimate ranging from 2 to 20 cases per 1000 EVD days [3, 4]. Interestingly, for central line–associated sepsis, the positive impact of using chlorhexidine-containing dressings to reduce sepsis rates has been demonstrated in several trials [5, 6]. Owing to the analogy in pathogenesis and thus causative microorganisms of the 2 device-associated infections, we initiated a before-after trial aimed at decreasing MV infection rates by using chlorhexidine-containing dressings in each patient with EVD, after completing a pilot investigation for safety issues [7]. This intervention should not substantially increase daily workload or hospital running costs.

The intervention consisted of using a chlorhexidine-containing dressing (3M Tegaderm CHG; 3M) instead of a gauge dressing beginning on day 2 for each new EVD, from 1 October 2012 to 31 March 2015. All adults needing EVD at the neurosurgical intensive care unit, University Hospital Aachen, were consecutively enrolled during the 30-month intervention period. Continuous evaluation and calculation of the MV rates according to national and international surveillance protocols were performed as in previous years by an interdisciplinary and interprofessional health team twice weekly during infectious disease rounds (http://www.cdc.gov/HAI/surveillance/index.html; www.nrz-hygiene.de). The local ethics committee approved this investigation. Accumulated yearly rates were calculated followed by determining confidence intervals for individual rates based on Ulm’s method [8]. A Poisson regression model to the rates accounting methods was fitted to the data using proc GENMOD from SAS® version 9.1 software under windows XP for computations. Effects were assessed as significant in cases for which the P-value falls below the significance margin of 5% (.05).

During the 6 years before the intervention period, 42 months of discontinuous surveillance was performed. A total of 5383 EVD days were documented, and a total of 43 EVD-associated MV cases occurred. During the 30-months “after” study period, continuous surveillance was performed, documenting >10 000 patient-days, including a total of 2512 EVD days during which 5 cases of EVD-associated MV occurred. Statistical analysis revealed a significantly lower EVD-associated MV rate during the intervention period: 1.70 cases (standard deviation [SD], 3.88) versus 6.98 (SD, 5.67) per 1000 EVD days in the control phase (P = .005). This decrease was driven mainly by a reduction in MV cases caused by typical skin commensals, a finding in line with the working hypothesis concerning the antiseptic dressing (Table 1). Dressings were changed only every sixth day. No adverse events (eg, skin reactions) occurred.

This significant reduction in MV rates of >300-fold was observed in an already highly trained healthcare setting in which several previous interventions to prevent MV infections had been in place since 2005 and in which high compliance with hand hygiene (>80% compliance), written standard operation procedures for EVD placement and maintenance, and participation in surveillance were standard. In the context of the current national benchmark, this rate is much lower than the mean of 4.0 MV cases per 1000 EVD days and approaches the 25th percentile of 1.67 per 1000 EVD days (www.nrz-hygiene.de). Thus, our intervention significantly reduced rates of EVD-associated MV without increasing costs or workloads [9].