Costs associated with MRSA nares screens may be offset by the avoidance of unnecessary empiric anti-MRSA therapy, associated therapeutic monitoring, and potential adverse effects. Multiple studies have demonstrated a decrease in anti-MRSA therapy, serum-level monitoring, and costs with using MRSA nares screens [4, 5]. In addition, many healthcare facilities already utilize MRSA screens for infection prevention and control measures. Such institutions can collaborate with their infection control program and utilize MRSA nares screens for antimicrobial stewardship efforts, as well.

While it has been suggested that risk factors may be the optimal choice to drive therapy decisions, we would argue the performance of predisposing risk factors and clinical prediction models or risk scores for MRSA fall short, compared to nasal screens, in their predictive performance, as demonstrated in multiple studies [6, 7]. This can be partly attributed to both the relatively infrequent incidence of MRSA infection and the often non-specific nature of risk factors. Therefore, we believe nasal screens have strong and consistent clinical utility in the right prescribing setting.

An aim of antimicrobial stewardship programs is to minimize the inappropriate and unnecessary use of antibiotics and their associated adverse outcomes (ie, toxicities, resistance, and cost). Similar to incorporating any antimicrobial stewardship tool, including other rapid diagnostic tests, institutions should evaluate the potential value from utilizing MRSA nares screens for improving patient care.

Notes

Potential conflicts of interest. T. T. T. reports personal fees from Roche Diagnostics, BioFire Diagnostics, and GenMark Diagnostics, outside the submitted work. E. M. reports grants from T2 Biosystems, Astellas, and Sanofi-Aventis, outside the submitted work. All other authors report no potential 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.

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Clinical Infectious Diseases® 2019;68(7):1251–2

DOI: 10.1093/cid/ciy869

Use of Prophylactic Antibiotics in Aspiration Pneumonia

To the Editor—We read with great interest the recent article by Dragan et al [1]. A total of 200 cases (76 used prophylactic antibiotics and 124 did not) were included in their study, and they reported that the use of prophylactic antibiotics was of no benefit in aspiration pneumonia (AP). AP means anaerobic pneumonia. For this reason, it is absolutely necessary to use anaerobic-spectrum antibiotics in AP. In their study, 35 cases in the antibiotic group received ceftriaxone monotherapy, but there is no anaerobic effect of ceftriaxone monotherapy. This amount is almost half that of the prophylaxis group (n = 35, 46%). Therefore, the antibiotic prophylaxis group of the study had to be evaluated in (76 − 35 = 41) 41 patients. Consequently, the results of the study should be interpreted with caution. If all the patients in the prophylaxis group had received appropriate antibiotics, the results could be very different. We think that the published results do not reflect a real-life situation.

Note

Potential conflicts of interest. Both authors: No reported conflicts. Both 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.

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Clinical Infectious Diseases® 2019;68(7):1252

DOI: 10.1093/cid/ciy885

Reply to Karabay and Karabay

To the Editor—We thank Karabay et al for their interest in our study, in which we found no clinical benefit of antimicrobial prophylaxis compared to supportive care for the first 48 hours following an episode of clearly documented macroaspiration causing pneumonitis [1]. In their letter [2], they advance the argument that