et al. [1] was from an area where *Brugia* lymphatic filariasis is endemic. Since the end of 2001, we have routinely used the commercial ELISA version of the Og4C3 assay (Tropbio). Of the patients attending the consultation unit of our hospital who were immigrants from or residents of a tropical area, 165 were tested by ELISA (Bordier Affinity Products) for the presence of filarial antibodies and Og4C3, on the basis of the presence of clinical signs consistent with a filarial infection ( bancroftiasis, loiasis, or onchocerciasis), and/or blood eosinophilia. Of 17 patients who had significant filarial ELISA results (optical density of ≥900), 1 patient was found to be infected with hookworm, 5 had strongyloidiasis, and 2 probably had toxocariasis. None of the cross-reacting serum samples from these patients had detectable Og4C3 antigen.

Therefore, the possibility of bancroftian filariasis in patients 2, 8, 9, 13, and 15 from the study by Boggild et al. [1], who had a moderate level of antifilarial antibodies, appears to be questionable. The efficacy of diethylcarbamazine therapy cannot be considered circumstantial evidence of filarial infection, because this drug was found to be effective for treatment of toxocariasis [10].

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### Impact of Recommendations by Clinical Microbiologists on Antimicrobial Treatment in the Intensive Care Units of a Dublin Teaching Hospital

Sir—We read with interest the article by Lo et al. [1] regarding adherence to recommendations made during infectious diseases (ID) consultations. The data, which were from a prospective cohort study of 465 consultations at 2 large tertiary care centers, revealed an overall rate of compliance to recommendations of 80%. Compliance was higher when recommendations involved therapy, compared with those that involved diagnostic procedures (92% vs. 70%). Only 5% of consultations were made in the surgical intensive care unit (ICU). In his editorial commentary, Tenenbaum [2] highlights the fact that, at his institution, ID physicians have little impact when it comes to altering inappropriate antimicrobial use in the ICU. In this era of increasing concern about antibiotic stewardship, there have been a number of studies investigating the impact of ID consultative care on patient treatment in various settings [3–5].

In light of the findings by Lo et al. [1] and with regard to the difficulties highlighted by Tenenbaum [2], we would like to outline the consultative practice at the ICUs at our institution. Beaumont Hospital (Dublin, Ireland) is a 650-bed tertiary referral center and contains the national neurosurgical center for the Republic of Ireland. There is a 10-bed general ICU and an 11-bed neurosurgical ICU, both of which are open. On a daily basis, from Monday to Friday, a specialist registrar and/or consultant from the clinical microbiology service, together with a specialist registrar and/or consultant in intensive care medicine, review data for all patients in both ICUs. At other times, advice on patient treatment is given, if required, by the consultant clinical microbiologist on call. Recommendations are made on these daily rounds on the basis of clinical features, radiological findings, laboratory results (including microbiolog-

### Table 1. Characteristics of 264 therapeutic recommendations made for 178 patients

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>No. of recommendations made</th>
<th>No. (%) of recommendations followed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commence antibiotic treatment</td>
<td>69</td>
<td>69 (100)</td>
</tr>
<tr>
<td>Change antibiotic treatment</td>
<td>60</td>
<td>56 (93.3)</td>
</tr>
<tr>
<td>Discontinue antibiotic treatment</td>
<td>135</td>
<td>128 (94.8)</td>
</tr>
<tr>
<td>Total</td>
<td>264</td>
<td>250 (94.7)</td>
</tr>
</tbody>
</table>
ical data), changes in ventilatory support, and inotrope requirements, etc., to commence antimicrobial treatment. Recommendations are also made regarding diagnostic procedures.

Over a 3-month period from 1 May to 31 July 2004, using clinical microbiology service records, we retrospectively reviewed compliance with our therapeutic recommendations for 178 patients. Treatment modification (i.e., initiation, change, or discontinuation of antibiotic treatment) was recommended for 128 patients. In total, there were 264 therapeutic recommendations during the period (table 1).

These results demonstrate that consultation with a laboratory-based clinical microbiology service, delivered in collaboration with intensive care medicine, can ensure a very high degree of compliance with treatment modifications. The high level of acceptance of this service may be related to the fact that care is delivered by medically qualified clinical microbiologists who have undergone postgraduate training in general internal medicine and have then undertaken ≥5 years of training about all aspects of infection—diagnosis, prevention, and therapy. In addition, clinical microbiologists supervise hospital microbiology laboratories, so that a single individual ensures a direct flow of information from bench to bedside, resulting in patient-focused care.

In many US hospitals, microbiology laboratories are supervised by scientists and/or managers, patient consultation and antibiotic advice is provided by ID physicians, surveillance of hospital-acquired infection is undertaken by a hospital epidemiologist, infection prevention is the remit of infection-control practitioners, and liaison between the microbiology laboratory and the attending physician is undertaken by clinical pharmacists. In this arrangement, a lack of integration may result in inadequate communication between divisions, leading to a poor uptake of therapeutic advice. In the integrated model, the clinical microbiologist has a pivotal role in all aspects of “infection” as it pertains to the ICU. The system in operation in this hospital, as in much of Europe, improves antimicrobial stewardship and optimizes patient care.

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