empetive strategy raise value judgments regarding whether it is worse to miss treatment for someone who needs it or to treat someone who does not need it. Twenty years ago, most hematologists adopted the empirical strategy with amphotericin B deoxycholate, resulting in the unnecessary treatment of many patients. Better knowledge of the “fungal risk,” as opposed to a “fever of unknown origin,” new diagnostic procedures, and the availability of new antifungal drugs have led us to reconsider previous trade-offs in light of the benefits, harms, and costs of any antifungal treatment strategy, although several trials will be necessary to define an evidence-based antifungal strategy.

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Dichotomy between Content and Interpretation

To THE EDITOR—We appreciate Dr. Kunin’s comments on our recent article concerning catheter-associated asymptomatic bacteriuria (CAABU) [1], because his perspective is based on many years of experience with catheter-associated urinary tract infections (CAUTIs). His main concern was that we created “a syllogism compounded by a questionable dichotomy” [2, p. 1189]. We indeed found a dichotomy, but the dichotomy was between his commentary and the focus of our article.

Dr. Kunin raised several interesting questions about the pathogenesis and natural history of CAUTIs. However, our research interest was in an entirely different arena, that of physician antibiotic-prescribing behavior. What we were studying was how often physicians prescribed antibiotics in cases of truly asymptomatic catheter-associated bacteriuria. We found that, in our tertiary care teaching hospital, nearly one-third of episodes of CAABU were treated with an antibiotic. This treatment exposed the patient to the specific risk of recolonization or reinfection with antibiotic-resistant organisms and to the general risks associated with antibiotic administration, while adding unnecessarily to the cost of medical care. We suggested that a way to avoid this problem would be to avoid screening of asymptomatic patients by performing routine urinalyses and urine cultures, a practice that is all too common, especially in long-term care units. We agree with Dr. Kunin that treatment with antibiotics will not alter the natural history of CAABU.

Unnecessary antibiotic use is harmful on many levels. It exposes the patient to the risk of reinfection with more resistant bacterial flora, as well as to the development of other infections such as Clostridium difficile colitis. There is also an environmental risk when institutionalized patients are systematically overtreated, leading to selection of increasingly antibiotic-resistant flora.

We believe that teaching physicians when not to give antibiotics is as important as teaching them when to give antibiotics. The preliminary data presented in our article will help us to design appropriate interventions that will discourage physicians from treating CAABU. This goal is in accord with the Centers for Disease Control and Prevention campaign to prevent antimicrobial resistance among hospitalized patients, which instructs clinicians to “treat infection, not colonization” [3, p. 2]. Unfortunately, a significant gap between evidence-based guidelines concerning management of asymptomatic bacteriuria and clinical practice has been observed throughout the world, including our own Veterans Affairs medical center, as documented in our article. It is a syllogism to assume that our goals were anything other than to document the current state of overtreatment of CAABU.

Acknowledgments


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Reference