Table 1. Websites Determined to Be Comprehensive

<table>
<thead>
<tr>
<th>Institution/Hospital</th>
<th>URL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnes-Jewish Hospital</td>
<td><a href="http://bjhtoolbook.wustl.edu/">http://bjhtoolbook.wustl.edu/</a></td>
</tr>
<tr>
<td>Jackson Health System (Jackson Memorial Hospital) / University of Miami Health System (Sylvester Comprehensive Cancer Center)</td>
<td><a href="http://ugotabug.med.miami.edu/jmh-antimicrobial-stewardship-program/">http://ugotabug.med.miami.edu/jmh-antimicrobial-stewardship-program/</a></td>
</tr>
<tr>
<td>Johns Hopkins Health System (The Johns Hopkins Hospital)</td>
<td><a href="http://www.hopkinsmedicine.org/amp">http://www.hopkinsmedicine.org/amp</a></td>
</tr>
<tr>
<td>Maine Medical Center</td>
<td><a href="http://www.mainhealth.org/workfiles/mmc_em/Adult_Antimicrobial_Formulary_Guide.pdf">http://www.mainhealth.org/workfiles/mmc_em/Adult_Antimicrobial_Formulary_Guide.pdf</a></td>
</tr>
<tr>
<td>New York–Presbyterian Hospital– Columbia University Medical Center</td>
<td><a href="http://www.cumc.columbia.edu/dept/id/clinical_references.html">http://www.cumc.columbia.edu/dept/id/clinical_references.html</a></td>
</tr>
<tr>
<td>Stanford Hospital and Clinics</td>
<td><a href="http://bugsanddrugs.stanford.edu">http://bugsanddrugs.stanford.edu</a></td>
</tr>
<tr>
<td>The Cleveland Clinic Foundation</td>
<td><a href="http://www.clevelandclinicmeded.com/medicalpubs/antimicrobial-guidelines/">http://www.clevelandclinicmeded.com/medicalpubs/antimicrobial-guidelines/</a></td>
</tr>
<tr>
<td>The Nebraska Medical Center</td>
<td><a href="http://www.nebraskamed.com/careers/education-programs/asp">http://www.nebraskamed.com/careers/education-programs/asp</a></td>
</tr>
<tr>
<td>The Ohio State University Medical Center (Wexner Medical Center)</td>
<td><a href="http://fx.osumc.edu/asp/">http://fx.osumc.edu/asp/</a></td>
</tr>
<tr>
<td>UCLA Health System (Ronald Reagan UCLA Medical Center)</td>
<td><a href="http://www.asp.mednet.ucla.edu/pages/">http://www.asp.mednet.ucla.edu/pages/</a></td>
</tr>
<tr>
<td>University of Kentucky Hospital</td>
<td><a href="http://www.hosp.uky.edu/pharmacy/amt/default.html">http://www.hosp.uky.edu/pharmacy/amt/default.html</a></td>
</tr>
<tr>
<td>University of Wisconsin Hospital and Clinics</td>
<td><a href="http://www.uwhealth.org/antimicrobial-stewardship/main36408">http://www.uwhealth.org/antimicrobial-stewardship/main36408</a></td>
</tr>
<tr>
<td>Wake Forest Baptist Health</td>
<td><a href="http://www.wakehealth.edu/School/CAUSE/CAUSE.htm">http://www.wakehealth.edu/School/CAUSE/CAUSE.htm</a></td>
</tr>
</tbody>
</table>

provided by 11 (61%) and 10 (56%) sites, respectively. Fourteen (78%) websites not formulate restriction, of which 3 do not provide a list of restricted agents. Antimicrobial dosing recommendations and guidelines or clinical decision pathways are provided by 14 (78%) and 12 (67%) sites, respectively. Four (22%) provide information as one PDF document. Thirteen (72%) websites were determined to be comprehensive (Table 1).

Publicly accessible web-based resources provided by ASPs of leading US hospitals exist in limited numbers and are primarily maintained by large institutions. Institution-specific characteristics and resources vary vastly, representing opportunity for standardization and individualization. Institutional ASP websites may be a practical vehicle to provide accessible data to practitioners from numerous professions. Future research regarding the utility of these websites and initiatives to make institution-specific resources available on a mobile platform (eg, via apps) may be of value.

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.

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Antibiotic Prophylaxis for High-Risk Patients With Acute Q Fever: No Definitive Answers Yet

To the Editor—We read with interest the article by Million et al [1]. Their study attempted to answer an important question: does chemoprophylaxis after an episode of acute Q fever decrease the risk of Q fever endocarditis in high-risk patients? Q fever endocarditis developed in all patients with significant valvulopathy and no or incomplete antibiotic prophylaxis, in contrast to none of the patients who had completed 12 months of antibiotic prophylaxis. These data are in favor of prophylaxis in high-risk patients but raise several concerns.

First, because patients were recruited from a world-renowned referral center, only severe or complex acute Q fever cases may have been evaluated. Indeed, the prevalence of valvulopathies (43%) was approximately 10-fold higher than in the general French population. Q fever endocarditis was diagnosed a median of 44 days after acute Q fever, an extremely short interval compared with those in previously reported series [2, 3]. Of 4 reported definite Q fever endocarditis cases, 1 was diagnosed on the basis of positive blood polymerase chain reaction findings at day 11, which could well
reflect DNAemia observed in acute Q fever. [4] In our opinion, this should not be considered definite endocarditis. In addition, 8 of 18 patients (44%) without subsequent endocarditis started prophylactic treatment as late as 2–8 months after the diagnosis of acute Q fever, and, surprisingly, endocarditis developed within 2 months in 11 of 13 patients (85%) without prophylaxis. Moreover, most possible endocarditis cases had rather low immunoglobulin G phase I titers (1:800). Because the diagnosis of endocarditis in most patients with preexisting valvulopathy was based solely on marginally increased serological titers within a short time frame after acute Q fever, we are concerned that these cases may have been misdiagnosed and merely reflected increasing immunoglobulin G phase I titers, which can be observed until 6 months after acute Q fever [5].

Furthermore, potential side effects that accompany a 12-month antibiotic course with doxycycline and hydroxychloroquine were not discussed. In the study of 568 patients with a history of cardiac valve surgery living in an outbreak area in the Netherlands, reported by Kampschreur et al [6], Coxiella burnetii antibodies were detected in 20% of patients, of whom 8% had probable or proven Q fever endocarditis. If these patients had been offered prophylaxis, 92% of them would have unnecessarily received toxic antibiotics for 12 months.

Currently, in the Netherlands, routine evaluation for valvulopathies is not advised, based on prospective follow-up findings in a series of patients [7]. In a cohort of 85 patients with acute Q fever and a high prevalence of cardiac valvulopathy (39 of 85; 46%), chronic Q fever had not developed in any of them after 1 year of follow-up. The difficulty in the optimal workup after an episode of acute Q fever is also reflected in the recent formulations of the Centers for Disease Control and Prevention, which advise patients with acute Q fever to undergo careful clinical assessment, including assessment for vascular and heart valve defects, but make no specific recommendations on the most appropriate tools for this assessment [8]. In conclusion, prophylactic treatment for high-risk patients after an episode of acute Q fever can be beneficial, but which patients benefit from such strategy and the optimal duration of prophylaxis still need to be determined.

Note

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

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Reply to Kampschreur et al

To the Editor—We thank Kampschreur et al [1] for allowing us to clarify that the strategy applied in the large Dutch Q fever outbreak completely failed to prevent and detect Q fever endocarditis. A key point that has been completely neglected in this context is the preventive treatment of patients with symptomatic primary infection and significant valvulopathy, the efficiency of which was demonstrated in our prospective cohort study [2].

In a recent study performed in the Netherlands [3], 20 of the 32 patients (62%) classified as having “proven chronic” or “probable chronic” Q fever had a previous symptomatic acute primary infection. Furthermore, 9 (28%) had a predisposing valvulopathy, and 20 (62%) had a minor echocardiographic criterion; however, none of them benefited from antibiotic prophylaxis. It is also surprising that only 6 of these 32 patients (19%) had a further diagnosis of possible or definite endocarditis, because the authors recognized “chronic Q fever” in ≥20 patients with significant valvulopathy, without making a diagnosis of endocarditis. Given the rarity of the presence of vegetation or significant valvulopathy, the editors consider relevant to the content of the manuscript have been disclosed.

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