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Reply to Ressner et al

To the editor—We appreciate the com-
ments of Ressner et al [1] regarding our
invited article [2]. We agree that to be ef-
efective, efficient, as well as safe for patient
care, antimicrobial stewardship programs
need to be truly multidisciplinary and to
have clear and accurate communication
among the participants. A label of “peni-
cillin allergy,” even when incorrect, limits
antimicrobial de-escalation options and
shifts antibiotic selection toward broader
and more multidrug-resistant organisms-
selective classes of antimicrobials [3].
Staff nurses interact with the drug allergy
and antibiotic selection process at several
points. First, they often take the admis-
sion medication allergy history for the
in-patient record. Second, they review
the antibiotic order for safety before actu-
ally administering the medication to the

Figure 1. Flow chart of the approach taken at our institution to identify, rapidly assess, definitively evaluate, and properly categorize inpatients with a documented or reported allergy to penicillin or β-lactam allergy. This information is made available to the inpatient team and antimicrobial stewardship program during the current or future hospitalization, depending on the timing of evaluation.
patient. Third, they often receive microbiology laboratory reports first and check antimicrobial susceptibilities in respect to adequacy of current coverage and for (potential) alternative de-escalation choices. Fourth, if a possible allergic reaction occurs, it is usually the staff nurse who enters that “allergy label” into the permanent record. Nurses need to be trained to document the specific details of the adverse event (rash, nausea, etc.), rather than merely to check off “allergy.”

Lastly, at discharge from hospital, the nurse has the opportunity and responsibility for reviewing the medications, including antibiotics, with patients and their families. Unfortunately, electronic medical records, like family legacies of antibiotic allergy, can immortalize the label of penicillin allergy. Even when a patient has just received an uneventful course of beta-lactam therapy, the “Scarlet Letter A” (for penicillin Allergy) tends to surface again at the next emergency room visit. Allergy “de-labeling” has been advocated [4], but in clinical practice it is difficult to accomplish, especially between different hospitals with disparate computer programs.

We support Schwartz et al’s view [5] that broad-based successful antimicrobial stewardship can best be achieved with widespread antibiotic education to all healthcare professionals (medical, pharmacy, dental, and nursing). Such nationwide educational efforts are already underway in other countries [6]. This educational effort should be led by infectious disease and infection prevention practitioners via their professional organizations (IDSA, SHEA, APIC, PIDS) and the Centers for Disease Control and Prevention. This awareness of the antibiotic realities of the 21st century can then disseminate to the public at large to enable the better understanding of safe, appropriate antibiotic use that is the goal of all antimicrobial stewardship efforts worldwide.

Note

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PrEP Continuum of Care for MSM in Atlanta and Los Angeles County

To the Editor—We appreciate the recent study by Kelley et al who developed and applied a preexposure prophylaxis (PrEP) of human immunodeficiency virus (HIV) infection continuum of care for men who have sex with men (MSM) in Atlanta, Georgia [1]. The authors proposed a simplified framework, similar to the HIV care and treatment continuum [2], to monitor PrEP implementation in the following way: identify at-risk MSM; increase awareness of and willingness to take PrEP; ensure access to healthcare (including prescriptions); and ensure adherence to PrEP. The authors evaluated the proposed continuum within an Atlanta cohort of MSM and projected that only 15.2% of MSM in that cohort would be protected by PrEP, with black MSM significantly less likely than white MSM to be protected by the use of PrEP [1].

Using Kelley et al’s analytical framework, we analyzed a study sample of MSM in Los Angeles County, California, recruited from the geosocial network application, Grindr. From April 2014 through May 2014, we recruited black and Hispanic MSM on Grindr into a study of HIV self-test kit use [3]. Of 128 participants, 59 (46%) completed the survey. We found that only 60% (n = 35) of survey respondents knew about PrEP. Of those aware of PrEP, only 40% (n = 14) felt they could access PrEP (Figure 1). Those proportions are similar to the survey of and with access to PrEP found in the Atlanta cohort (50% and 28%, respectively). PrEP awareness estimates in MSM have ranged from 17% to 94% depending on the survey population [4, 5].

We found that black men had higher awareness of PrEP (89%) compared with Hispanic MSM (54% P < .05), and perceived access to PrEP was nonsignificantly higher among Black MSM (44% vs 20%). Further, men who reported heavy drinking were more than 6-times more likely to be aware of PrEP compared with moderate and nondrinkers (68% of heavy drinkers were aware of PrEP compared with 42% of moderate and nondrinkers), controlling for race, age, and education (adjusted odds ratio [aOR] = 6.19; 95% confidence interval [CI], 1.37, 28.02). Those who had been tested for HIV infection in the past 12 months had higher perceived access to PrEP (86%) compared with those who had not tested for HIV recently (22%), controlling for age, education, and race (aOR = 11.83; 95% CI, 1.09, 127.76).

The continuum of PrEP highlights the potential barriers to achieving a population-level impact of PrEP. Unlike California, Georgia has not opted to expand Medicaid programs under the