Letter to the Editor

Re: Reduction of broad-spectrum antibiotic use with computerized decision support in an intensive care unit

To the Editor: Investigators at the Royal Melbourne Hospital investigated effect of a computerized decision support tool on antibiotic use in an intensive care unit (ICU) in their adult surgical and medical ICU [1]. Undoubtedly, collateral and clinical use of microbiology results and the individual prescriptions matching the patient’s infectious agents would result in better health care and the reduction of the total and broad-spectrum usage. In innumerable resource-poor developing countries, that would not be a reality in the near future. Inadequate laboratory and computer support apart, there is no restriction on the on-the-counter sale of antibiotics. Moreover, antibiotics prescriptions are the exclusive prerogative of the clinicians. Clinicians are obliged to prescribe antibiotics immediately in their ICU cases with a clinical picture indicating a possible bacterial infection. Without any prejudice to the clinical scenario, parenteral antibiotics are the universal choice.

In poor countries, local epidemiology and resistance profile, based on the retrospective analysis of the patient’s infectious agent should be a better standard than the generic guidelines [1]. That has been attempted in the Sant Parmanand Hospital, a private tertiary care hospital in the Indian capital metropolis. Retrospective antibiotic susceptibility profiles are recommended for selection of broader spectrum antibiotics in medical and surgical ICU. The profile is updated periodically and shared with clinicians charged with ICU patient management. There are frequent dialogues between clinical microbiology and the clinicians handling patients in ICU and patients with aggressive infections.

The impact of the local epidemiology and bacterial susceptibility profile awaits orderly evaluation. Constant updates on emergence of any isolates resistant to different antibiotics have been of interest among clinicians. There is no intrusion on the prerogative of any clinician to prescribe antibiotics of choice. There is no resentment towards acceptability of the local resistance profiles. Rather than the generic guidelines [1], the local approach has been a footstep towards the critical goal: a better quality management of patients in ICU.

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Reference