

ities was seen in only one-quarter of patients. At 1 month, 78% of patients had clinical cures, and 53% showed resolution on radiograph.

The cohort was then split into two equal groups: one with radiographic deterioration, and one without radiographic deterioration. The researchers compared the groups for outcomes that included clinical cure at 1 month, mortality, and intervention during follow-up.

"We saw no difference in any of those three parameters; so, we can state that chest radiograph deterioration during follow-up was not associated with poor outcome," Dr. Bruns said at the confer-

ence sponsored by the American Society for Microbiology.

Clinical parameters that independently predicted delayed resolution of chest radiograph findings at 1 week included dullness to percussion, multilobar disease, high respiratory rate, and high C-reactive protein (CRP) level. CRP level greater than 200 mg/L at admission also predicted delayed resolution of chest radiograph abnormalities at day 28.

The authors noted that the number of interventions in patients with deterioration of chest radiograph findings was comparable to the number of interventions in other patients, suggesting that

physicians' decisions were not made solely on the basis of chest radiograph findings.

"Performing a chest x-ray to exclude a noninfectious cause of pneumonia within 4 weeks of initial diagnosis is not indicated, because at this point half of patients have radiographic findings that are a result of normal clinical course and do not necessarily indicate pathology," Dr. Bruns said. "Chest radiograph deterioration during follow-up was not associated with poor outcome, so in our opinion, routine in-hospital follow-up radiographs in severe CAP have no additional value." ■

## Approach to *C. difficile* Must Change

BY SHERRY BOSCHERT  
San Francisco Bureau

SAN FRANCISCO — Community-onset *Clostridium difficile* infection that is not antibiotic related has emerged as a multi-national problem that can be life threatening, said Dr. Sarah S. Long, chief of infectious diseases at St. Christopher's Hospital for Children, Philadelphia.

The conventional way of thinking about *C. difficile* infection was that it was usually associated with antibiotic use, mainly affected adults, was not life threatening, and seldom produced severe diarrheal illness in children. "Throw that [way of thinking] away. You have to start thinking and worrying about *C. difficile* as community onset without antibiotic exposure," Dr. Long said at the annual meeting of the American Academy of Pediatrics.

The more modern *C. difficile* shows antibiotic resistance that is probably caused

**The global occurrence of this antibiotic-resistant, toxin-producing organism could increasingly cause problems for 'an unprepared planet.'**

by widespread use of fluoroquinolones. It has mutated to lose a regulatory gene that normally suppresses production of toxin by the organism. The mutated form produces 16-20 times the amount of toxin as that of the organism without the gene deletion.

The global occurrence of this antibiotic-resistant, highly toxin-producing organism could increasingly cause problems for "an unprepared planet," she said.

Four healthy people died recently in Philadelphia from *C. difficile* infection after failing treatment with multiple antibiotics followed by colectomies. Two of the infections were in postpartum women. "*C. difficile* in pregnant ladies and post partum can be a very severe disease," said Dr. Long.

Clinicians should consider *C. difficile* infection in otherwise healthy patients with diarrhea persisting beyond 3 days, whether or not the patient has been exposed to antibiotics, especially if there's blood in the stool or the patient is feverish or toxic appearing. "Put that on your list of things to worry about alongside *Salmonella*, *Shigella*, *Campylobacter*, and ... *Escherichia coli*."

Culture isn't helpful for diagnosis. A test for toxin in the stool is the diagnostic test of choice. An enzyme immunoassay for toxin, which can give a result in 2 hours, is a good test. Specialists also may order a cytotoxin assay on stool. Nearly 90% of patients will respond to treatment with metronidazole for 10 days, but 20%-25% will relapse. Of those, half will relapse again after retreatment. There is no standard therapy for chronic recurrences, but a number of antibiotic regimens or fecal transplants have been tried. ■

### 66% of patients on lipid-lowering therapy have at least 1 lipid outside current recommendations<sup>1</sup>

That is nearly 2 out of every 3 patients who are currently taking lipid-lowering therapies. In fact, this same analysis found that over 25% of patients had 2 or more lipid abnormalities (LDL-C, HDL-C, or TG) outside current NCEP ATP III guidelines.<sup>1</sup>

<sup>1</sup> NCEP ATP III—Third Report of the National Cholesterol Education Program Adult Treatment Panel.

### Evidence has shown that each of the 3 major lipids contributes to CV risk<sup>2-4</sup>

High LDL-C has been extensively and conclusively linked to increased CV risk.<sup>2</sup> Evidence also suggests that low HDL-C increases CV risk, regardless of LDL-C level.<sup>2</sup> Elevated TGs may also compound CV risk, independent of LDL-C and HDL-C levels.<sup>3,4</sup>

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To learn more about how each of the 3 major lipids affects CV risk, visit [www.TotalLipids.com](http://www.TotalLipids.com).



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