Letters to the Editor

The Journal welcomes Letters to the Editor; if found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with journal style.

Failure of Prophylaxis for Bacterial Endocarditis: American Heart Association Registry

To the Editor:

The American Heart Association (AHA) recognizes that its current recommendations for antibiotic prophylaxis are necessarily empiric.[1] This situation has arisen because important clinical information on the efficacy of antibiotic prophylaxis of bacterial endocarditis is lacking. The present recommendations are therefore based upon secondary sources of information such as the relative propensity of various procedures to cause bacteremia, in vitro studies of bacteria recovered from the blood, the effect of antibiotics on bacteremias, the susceptibility of various heart lesions to infection, anecdotal case reports, and study of experimental models.

Although over 30 individual cases of apparent prophylaxis failure have been recorded in the literature, many of our colleagues have rightly pointed out that the evidence indicating that a significant number of prophylaxis failures actually occur is inconclusive. This question is of considerable medical and medicolegal importance because of the frequency with which measures to prevent endocarditis are called for, and because of the serious consequences of failure to prevent the disease.

In an attempt to accumulate useful epidemiologic data, the AHA Committee has established a Registry to record cases of apparent failure of antibiotic prophylaxis of bacterial endocarditis. We are now soliciting case reports. Notification may be made on a simple preprinted postcard, which will require only identification of the patient and the name, address, and telephone number of the person referring the case. These postcards will be made available to physicians and dentists and to any other person or organization requesting them from the AHA or from one of us. Alternatively, a case may be reported directly to one of us, at the address or telephone number

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listed below. After notification, one of us will follow up with a telephone call, in order to gather sufficient information to evaluate the case. All such information will be confidential.

Although there are obvious disadvantages to any retrospective evaluation such as this, the practical impossibility of conducting a prospective trial of different modes of prophylaxis has caused us to seek alternative means of gathering data. We hope that a useful body of information may be accumulated, which may influence future recommendations for prophylaxis of endocarditis.

Alan L. Bisno, MD
Chief, Division of
Infectious Diseases
University of Tennessee
Center Health Sciences
Room 241-Dobbs
951 Court Avenue
Memphis, TN 38163
(901) 528-5786

David T. Durack, DPhil, MD
Associate Professor and Chief
Division of Infectious Diseases
Duke University Medical Center
Durham, NC 27710
(919) 684-2660

David W. Fraser, MD
Chief, Special Pathogens Branch
Bacterial Diseases Division
Bureau of Epidemiology
Center for Disease Control
Atlanta, GA 30333
(404) 329-3687

Edward L. Kaplan, MD
Department of Pediatrics
Box 94
University of Minnesota
Minneapolis, MN 55455
(612) 373-8938

Mr. Mark A. Oliveira
Chief, Scientific Councils
American Heart Association
AHA National Center
7320 Greenville Avenue
Dallas, TX 75231
(214) 750-5431

References

1. American Heart Association Committee on Rheumatic Fever and Bacterial Endocarditis: Prevention of bacterial endocarditis. Circulation 56:139A, 1977

Indications for Urine Culture

To the Editor:

In the first problem of the April "Self-Assessment in Family Practice" I disagree with the answer which calls for "repetition of the urine culture and simultaneous administration of ampicillin" to a five-year-old girl with dysuria and a positive urine culture. In the discussion of this question it is stated that "one or two confirmatory cultures should be performed to document the infection."

A repeat urine culture will cost the patient's family or third-party payor between $15 and $40, and seems somewhat superfluous in this patient. In addition, a follow-up urinalysis might suffice to confirm the efficacy of therapy within one week after antibiotics were begun. Repetition of a urine culture two to seven days after antibiotic therapy is stopped is appropriate.

We in medicine, and especially in family practice, must be constantly aware of ways in which we can decrease the cost of care without compromising the care of our patients.

Robert E. Drickey, MD
Senior Fellow in Family Medicine
Department of Family Medicine
University of Washington
Seattle