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Chi è il chirurgo "champion"?

francesco cortese

U.O.C. di chirurgia d'urgenza / P.O. San Filippo Neri, Roma

Consulente Infettivologo ASLRoma1

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Sartelli *et al. World Journal of Emergency Surgery* (2018) 13:37
https://doi.org/10.1186/s13017-018-0198-x

World Journal of Emergency Surgery

COMMENTARY **Open Access**

CrossMark

Knowledge, awareness, and attitude towards infection prevention and management among surgeons: identifying the surgeon champion

Virulence 4:2, 192–202; February 15, 2013; © 2013 Landes Bioscience

How to educate prescribers in antimicrobial stewardship practices

Céline Pulcini[1,2] and Inge C. Gyssens[3,4,*]

[1]Service d'Infectiologie; CHU de Nice; Nice, France; [2]Faculté de Médecine; Université Nice-Sophia Antipolis; Nice, France; [3]Radboud University Nijmegen Medical Centre and Canisius Wilhelmina Hospital; Nijmegen, The Netherlands; [4]Hasselt University; Hasselt, Belgium

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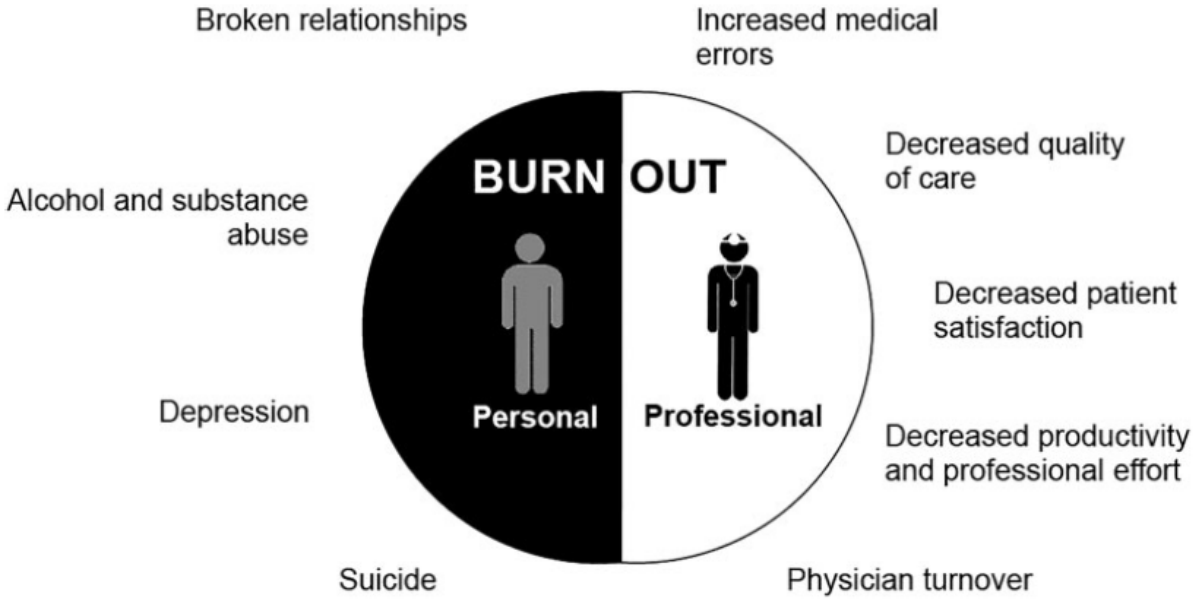
Surgeon Burnout: Defining, Identifying, and Addressing the New Reality

James C. Senturk, MD, PhD[1] Nelya Melnitchouk, MD, MSc, FACS[1]

[1]Department of Surgery, Brigham and Women's Hospital, Harvard Medical School, Boston, Massachusetts

Clin Colon Rectal Surg 2019;32:407–414.

Address for correspondence James C. Senturk, MD, PhD, Department of Surgery, Brigham and Women's Hospital, Harvard Medical School, 75 Francis Street, Boston, MA 02215 (e-mail: jsenturk@partners.org).



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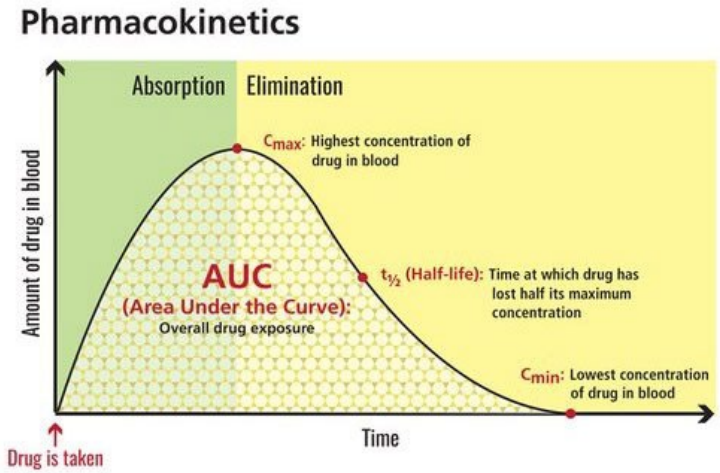

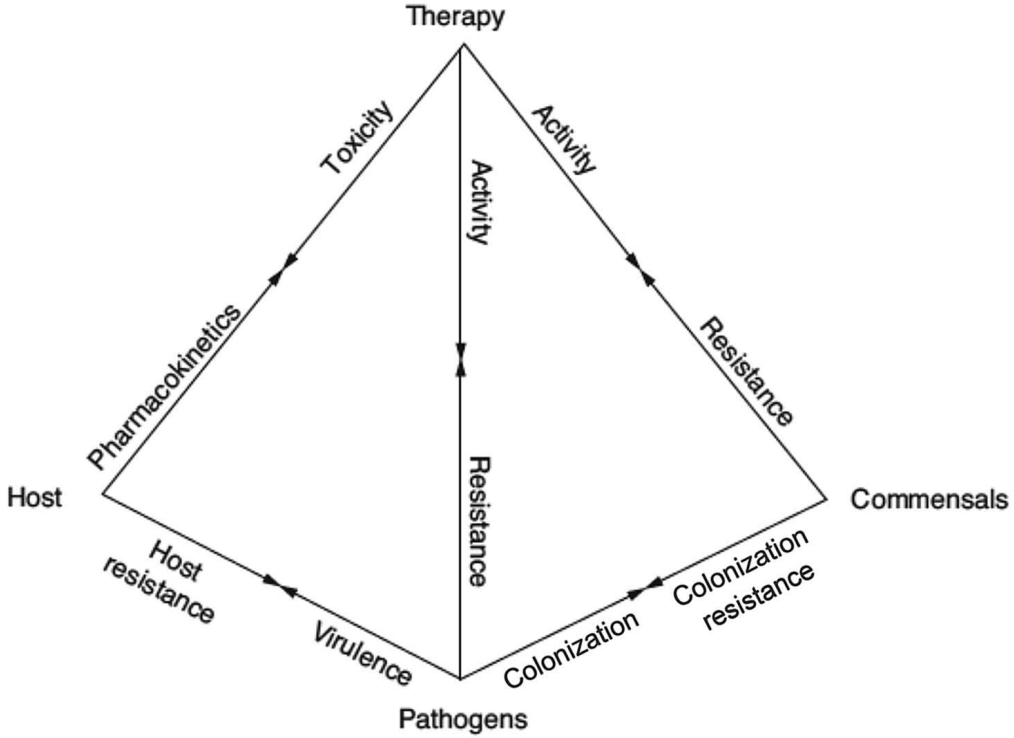

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Prevenzione e controllo delle ICA e degli MDRO: è ora di cambiare!

Dalla dissonanza cognitiva al tempio-*soft skill* …

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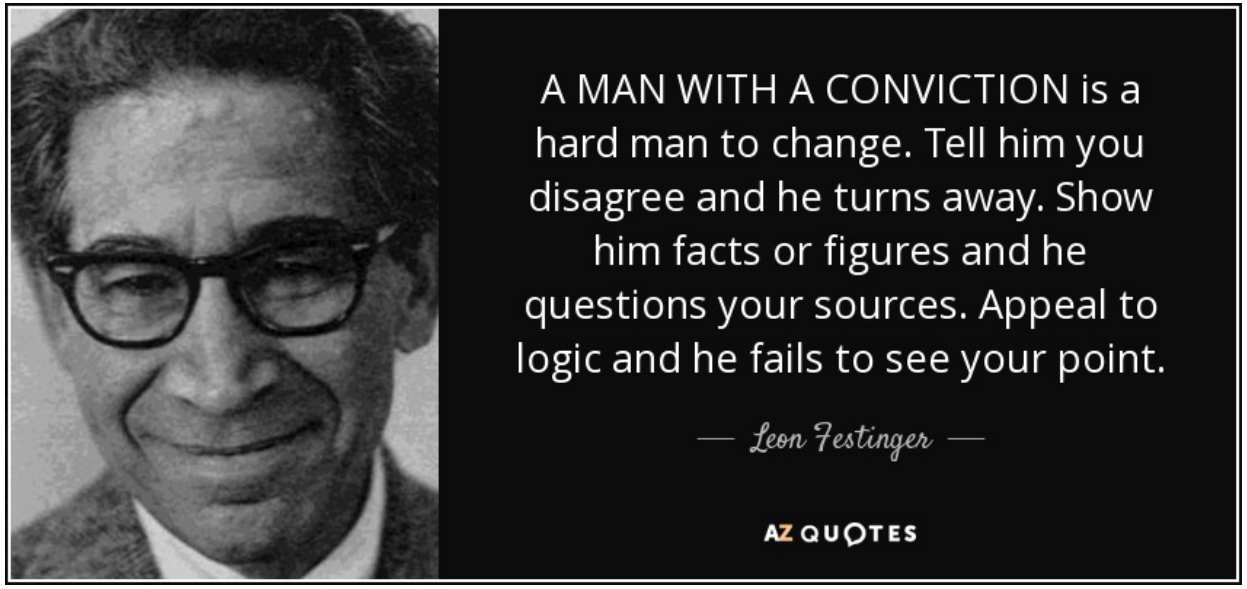
Dissonanza cognitiva



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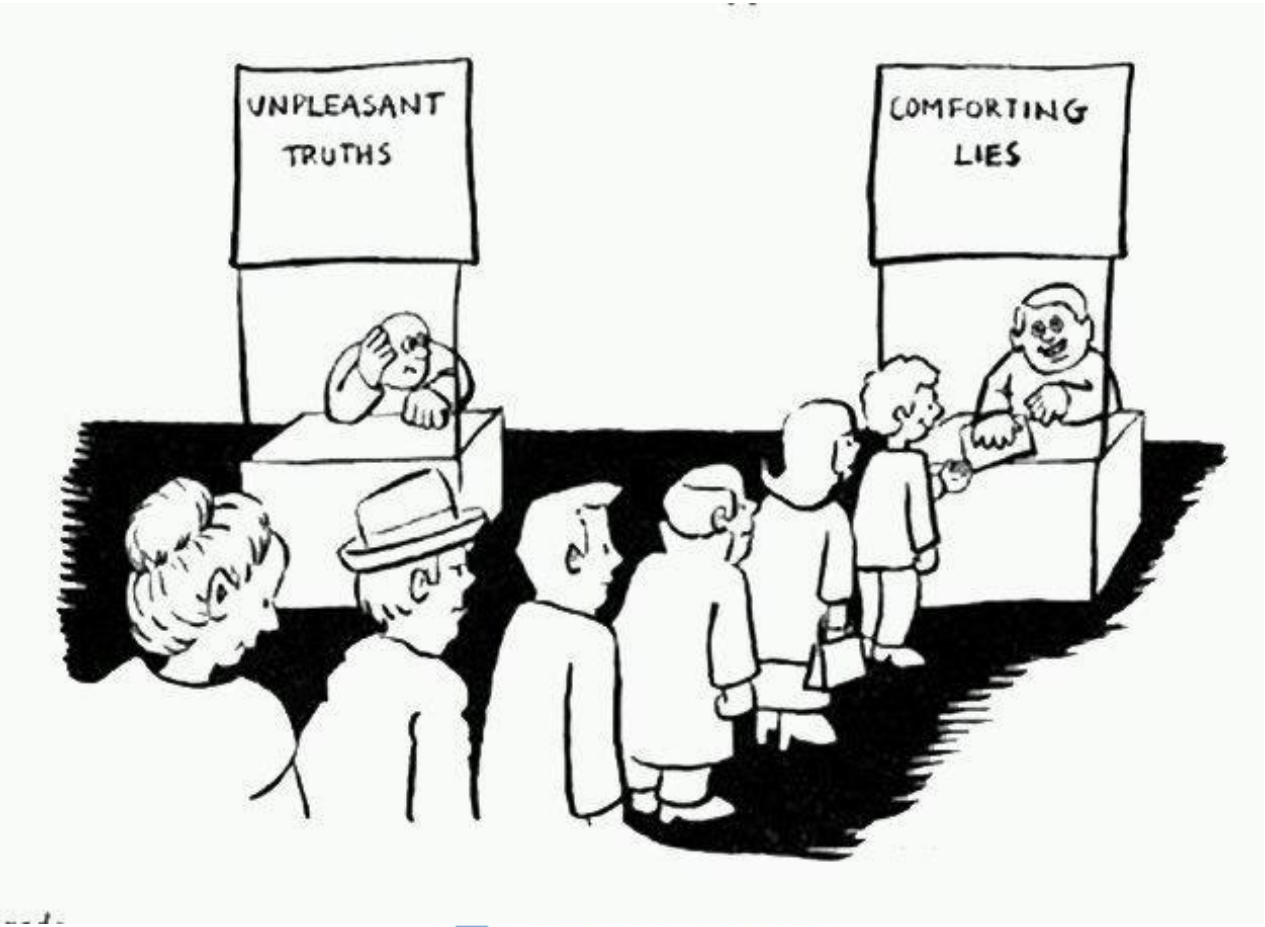

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MAJOR ARTICLE

Antibiotic Combinations with Redundant Antimicrobial Spectra: Clinical Epidemiology and Pilot Intervention of Computer-Assisted Surveillance

Robert C. Glowacki,[1,2] David N. Schwartz,[1,2] Gail S. Itokazu,[1,2] Mary F. Wisniewski,[1] Piotr Kieszkowski,[1] and Robert A. Weinstein[1,3]

[1]John H. Stroger, Jr., Hospital of Cook County, [2]University of Illinois at Chicago College of Pharmacy, and [3]Rush Medical College, Chicago, Illinois

Table 2. Most common redundant antibiotic combinations associated with intentional or unintentional physician prescribing errors.

Antibiotic combination	No. (%) of times redundant regimen prescribed[a] (n = 77)
Piperacillin-tazobactam and cefazolin	6 (8)
Vancomycin and cefazolin	5 (7)
Clindamycin and cefazolin	5 (7)
Levofloxacin and erythromycin	5 (7)
Clindamycin and penicillin	4 (5)
Cefoxitin and metronidazole	4 (5)
Clindamycin and piperacillin-tazobactam	3 (4)
Ceftriaxone and amoxicillin–clavulanic acid	3 (4)
Piperacillin-tazobactam and ceftazidime	3 (4)

[a] Thirty-nine episodes of administration of redundant antibiotic combinations that occurred once or twice are not listed.

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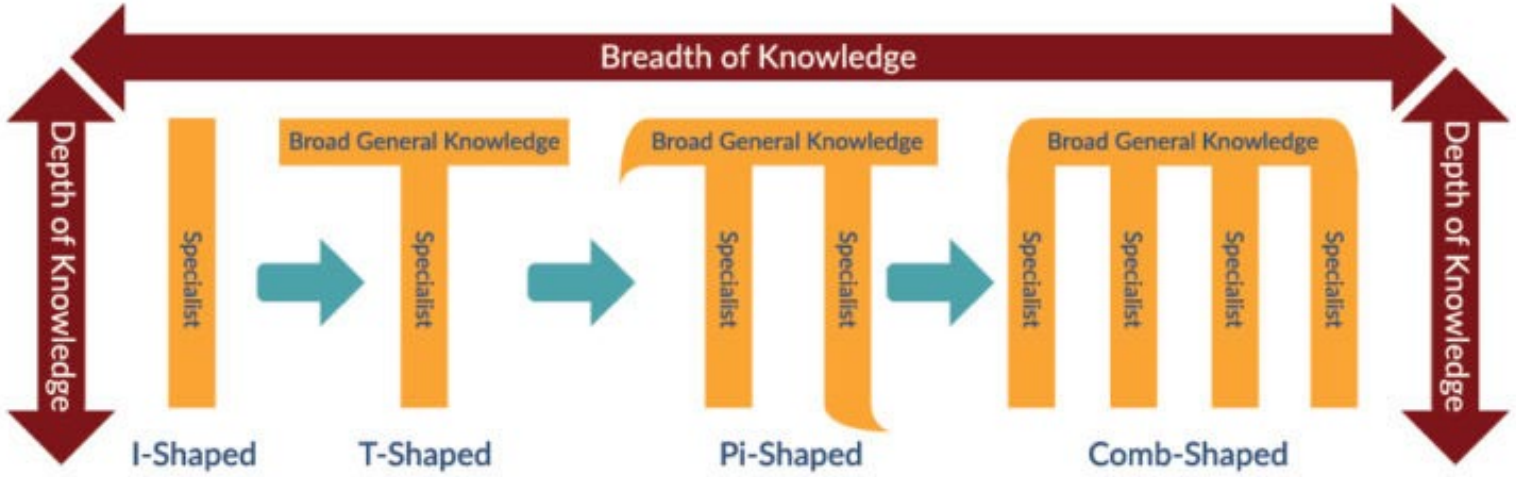

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Ottica additiva … *always learning.*

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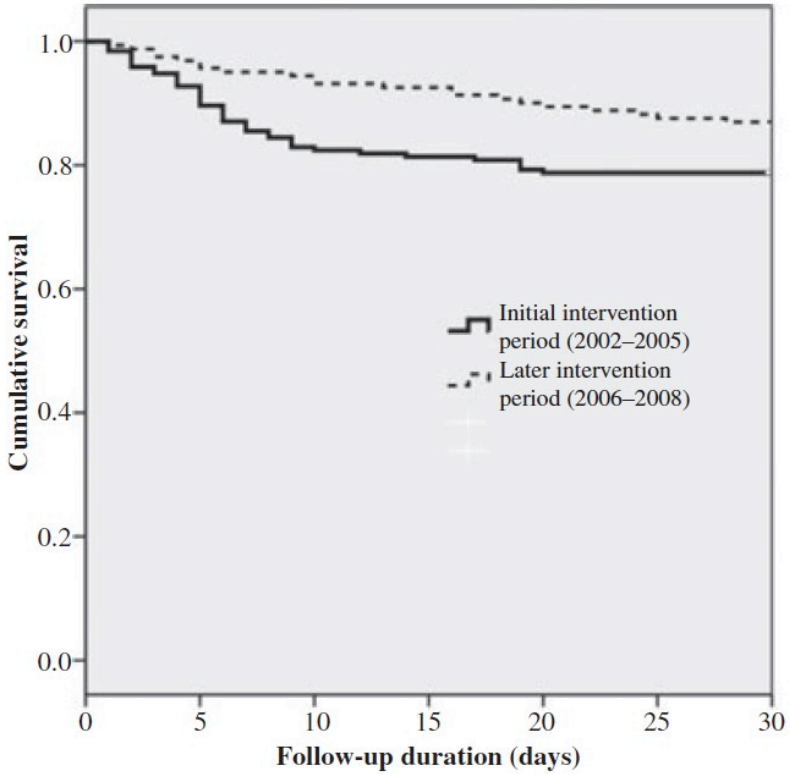
ORIGINAL ARTICLE — INFECTIOUS DISEASES

Close cooperation between infectious disease physicians and attending physicians can result in better management and outcome for patients with *Staphylococcus aureus* bacteraemia

M. Nagao[1,2], Y. Iinuma[1,2], T. Saito[4], Y. Matsumura[1,2], M. Shirano[1,2], A. Matsushima[1,2], S. Takakura[1,2], Y. Ito[1,3] and S. Ichiyama[1,2]

1) Department of Infection Control and Prevention, Kyoto University Hospital, 2) Department of Clinical Laboratory Medicine, Kyoto University Graduate School of Medicine, 3) Department of Respiratory Medicine, Kyoto University Graduate School of Medicine, Kyoto and 4) Department of Clinical laboratory, Shiga Medical Center for Adults, Shiga, Japan



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Telephone Consultation Cannot Replace Bedside Infectious Disease Consultation in the Management of *Staphylococcus aureus* Bacteremia

E. Forsblom,[1] E. Ruotsalainen,[1] J. Ollgren,[2] and A. Järvinen[1]

[1]Division of Infectious Diseases, Department of Medicine, Helsinki University Central Hospital, and [2]National Institute for Health and Welfare, Helsinki, Finland

	Died[a] (n = 24)	Survived (n = 81)	OR (95 % CI)	*P* Value
Age >60 y	9 (38)	34 (42)	0.83 (.33–2.12)	.69
Underlying diseases[b]				
Healthy or nonfatal disease	10 (42)	60 (74)	0.25 (.09–.65)	.003
Ultimately or rapidly fatal disease	14 (58)	21 (26)	4.00 (1.55–10.3)	.003
IDS consultation[b]				
Bedside[c]	7 (29)	64 (79)	0.11 (.04–.31)	<.0001
Telephone[c]	11 (46)	12 (15)	4.87 (1.77–13.4)	.001
No IDS[c]	6 (25)	5 (6)	5.07 (1.39–18.5)	.008
Radiology				
Transthoracic echocardiography	18 (75)	71 (88)	0.42 (.14–1.32)	.13
Transesophageal echocardiography	2 (8)	17 (21)	0.34 (.07–1.60)	.16
Whole-body CT	10 (42)	54 (67)	0.36 (.14–.91)	.027
Leukocyte indium-111 scintigraphy	6 (25)	29 (36)	0.59 (.21–1.67)	.32
Deep infection focus	18 (75)	63 (78)	0.86 (.29–2.48)	.86
Defervescence within 7 d	8 (33)	45 (56)	0.51 (.18–1.49)	.22

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Open Forum Infectious Diseases
MAJOR ARTICLE

Infectious Diseases Consultation Reduces 30-Day and 1-Year All-Cause Mortality for Multidrug-Resistant Organism Infections

Jason P. Burnham,[1] Margaret A. Olsen,[1] Dustin Stwalley,[1] Jennie H. Kwon,[1] Hilary M. Babcock,[1] and Marin H. Kollef[2]
[1]Division of Infectious Diseases and [2]Division of Pulmonary and Critical Care Medicine, Washington University School of Medicine, St. Louis, Missouri

Table 1. 30-Day and 1-Year Mortality and Readmission Rates by Drug-Resistant Pathogen Group and ID Consultation Status

Index Hospitalization Drug-Resistant Pathogen	30-d Mortality, %	1-y Mortality, %	Hospital Discharge Survivors, %	30-d Readmission, %	1-y Readmission, %
Staphylococcus aureus (n = 1674)	284 (17.0)	633 (37.8)	1412 (84.3)	428 (30.3)	840 (59.5)
ID consultation (n = 832)	87 (10.5)	259 (31.1)	753 (90.5)	240 (31.9)	457 (60.7)
No ID consultation (n = 842)	197 (23.4)	374 (44.4)	659 (78.3)	188 (28.5)	383 (58.1)
Enterococcus spp. (n = 807)	235 (29.1)	479 (59.4)	561 (69.5)	225 (40.1)	384 (68.4)
ID consultation (n = 359)	90 (25.1)	194 (54.0)	251 (69.9)	98 (39.0)	168 (66.9)
No ID consultation (n = 448)	145 (32.4)	285 (63.6)	310 (69.2)	127 (41.0)	216 (69.7)
Enterobacteriaceae (n = 1168)	185 (15.8)	434 (37.2)	975 (83.5)	298 (30.6)	585 (60.0)
ID consultation (n = 375)	31 (8.3)	116 (30.9)	329 (87.7)	85 (25.8)	202 (61.4)
No ID consultation (n = 793)	154 (19.4)	318 (40.1)	646 (81.5)	213 (33.0)	383 (59.3)
Acinetobacter spp. (n = 96)	35 (36.5)	53 (55.2)	61 (63.5)	13 (21.3)	33 (54.1)
ID consultation (n = 54)	16 (29.6)	27 (50)	37 (68.5)	7 (18.9)	21 (56.8)
No ID consultation (n = 42)	19 (45.2)	26 (61.9)	24 (57.1)	6 (25.0)	12 (50.0)
Pseudomonas aeruginosa (n = 190)	36 (18.9)	82 (43.2)	145 (76.3)	49 (33.8)	92 (63.4)
ID consultation (n = 77)	13 (16.9)	36 (46.8)	59 (75.3)	23 (39.0)	41 (69.5)
No ID consultation (n = 113)	23 (20.4)	46 (40.7)	86 (76.1)	26 (30.2)	51 (59.3)
Polymicrobial (n = 279)	65 (23.3)	151 (54.1)	185 (66.3)	63 (34.1)	115 (62.2)
ID consultation (n = 146)	25 (17.1)	85 (58.2)	93 (63.7)	31 (33.3)	57 (61.3)
No ID consultation (n = 133)	40 (30.1)	66 (49.6)	92 (69.2)	32 (34.8)	58 (63.0)

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Risk of Subsequent Sepsis Within 90 Days After a Hospital Stay by Type of Antibiotic Exposure

James Baggs, John A. Jernigan, Alison Laufer Halpin, Lauren Epstein, Kelly M. Hatfield, and L. Clifford McDonald

Division of Healthcare Quality Promotion, Centers for Disease Control and Prevention, Atlanta, Georgia

Conclusions. Our study identified an increased risk of sepsis within 90 days of discharge among patients with exposure to high-risk antibiotics or increased quantities of antibiotics during hospitalization. Given that a significant proportion of inpatient antimicrobial use may be unnecessary, this study builds on previous evidence suggesting that increased stewardship efforts in hospitals may not only prevent antimicrobial resistance, *Clostridium difficile* infection, and other adverse effects, but may also reduce unwanted outcomes potentially related to disruption of the microbiota, including sepsis.

516 ospedali / 14.120.553 casi

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cefalosporine III / IV generazione
fluorchinolonici
lincosamidi
beta-lattammici CON inibitori
vancomicina per os
carbapenemici

cefalosporine I / II generazione
macrolidi
tetracicline
metronidazolo
aminoglicosidi
vancomicina in vena

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DE GRUYTER Diagnosis 2019; aop

David E. Newman-Toker*, Adam C. Schaffer, C. Winnie Yu-Moe, Najlla Nassery, Ali S. Saber Tehrani, Gwendolyn D. Clemens, Zheyu Wang, Yuxin Zhu, Mehdi Fanai and Dana Siegal*

Serious misdiagnosis-related harms in malpractice claims: The "Big Three" – vascular events, infections, and cancers

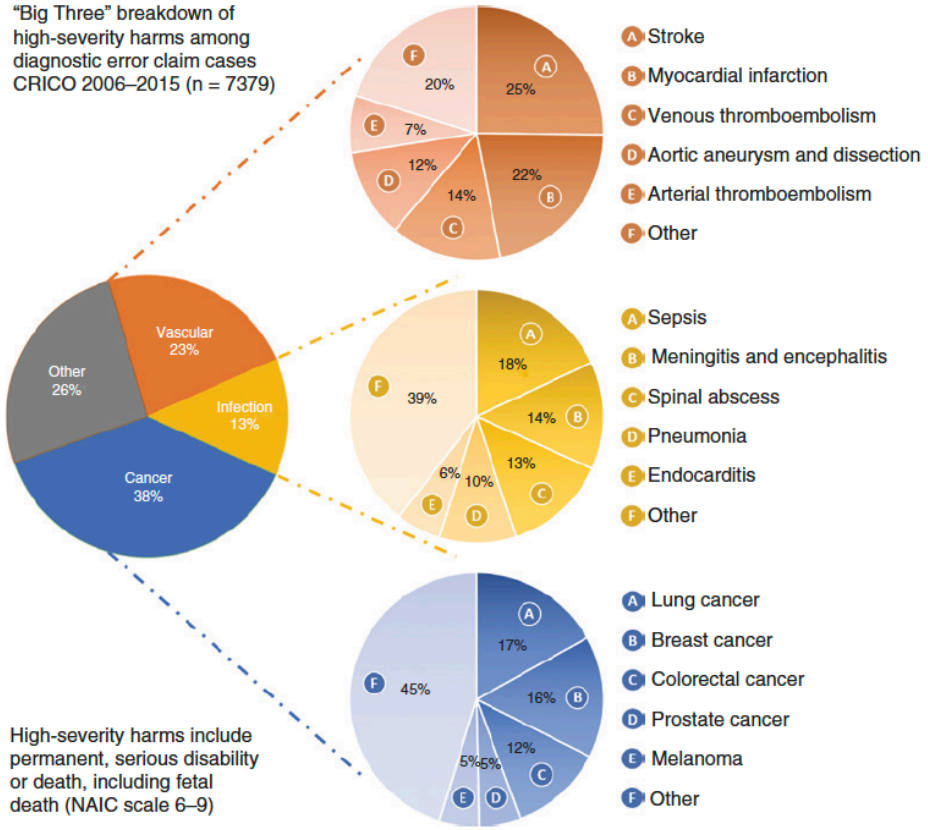

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Table 3. Clinical and Postmortem Causes of Death

		Clinical	Postmortem
Irreversible MODS	*n* (%)	134 (57)	121 (51.5)
Cardiovascular failure	*n* (%)	51 (21.7)	83 (35.3)
Intestinal ischemia	*n* (%)	14 (6)	5 (2.1)
Chronic peritonitis	*n* (%)	9 (3.8)	7 (3)
Pulmonary failure	*n* (%)	9 (3.8)	9 (3.8)
CNS failure	*n* (%)	8 (3.4)	3 (1.3)
Liver failure	*n* (%)	6 (2.6)	4 (1.7)
Uncontrolled hemorrhage	*n* (%)	4 (1.7)	3 (1.3)

MODS = multiple organ dysfunction syndrome; CNS = central nervous system.

Torgersen C et al Macroscopic postmortem findings in 235 Surgical Intensive Care patients with sepsis Anesth Analg 2009 Jun;108(6): 1841-7

180 pazienti / 76% focolaio settico attivo

80 (34%) 1 focus
72 (30.6%) 2 foci
21 (8.9%) 3 foci
7 (3%) ≥ 4 foci

Torgersen C et al Macroscopic postmortem findings in 235 Surgical Intensive Care patients with sepsis Anesth Analg 2009 Jun;108(6): 1841-7

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De Waele and Sakr *Critical Care* (2019) 23:386
https://doi.org/10.1186/s13054-019-2675-3

Critical Care

EDITORIAL Open Access

How I search for a sepsis source

Jan J. De Waele[1*] and Yasser Sakr[2]

Table 1 Recommended timing of source control procedures in patients with sepsis and septic shock

Emergent (within 1 h of diagnosis)	Urgent (within 6 h of diagnosis)	Delayed
Necrotizing skin and soft tissue infection debridement	Peritonitis with gastrointestinal leak	Infected pancreatic necrosis
CVC removal	Abdominal abscess	
Wound abscess drainage	Cholecystitis	
Peritonitis with abdominal compartment syndrome	Empyema drainage	

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"One size fits all" strategy …

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SURGICAL INFECTIONS
Volume 23, Number 3, 2022

DOI: 10.1089/sur.2021.323

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Different Surgeon, Different Duration: Lack of Consensus on the Appropriate Duration of Antimicrobial Prophylaxis and Therapy in Surgical Practice

Patrick T. Delaplain,[1] Haytham M.A. Kaafarani,[2] L. Andrew O. Benedict,[3] Christopher A. Guidry,[4] Dennis Kim,[5] Michele M. Loor,[6] David Machado-Aranda,[7] Tina S. Mele,[8] April E. Mendoza,[2] Gareth Morris-Stiff,[9] Rishi Rattan,[10] Jeffrey S. Upperman,[11] Philip S. Barie,[12] and Sebastian D. Schubl[1]; Scientific Studies Committee of the Surgical Infection Society*

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Annals of Internal Medicine

Excess Antibiotic Treatment Duratio
Hospitalized With Pneumonia

A Multihospital Cohort Study

Valerie M. Vaughn, MD, MSc; Scott A. Flanders, MD; Ashley Snyde
Anurag N. Malani, MD; Elizabeth McLaughlin, MS, RN; Sarah Bloe
Scott Kaatz, DO; Danielle Osterholzer, MD; Rama Thyagarajan, MI
and Tejal N. Gandhi, MD

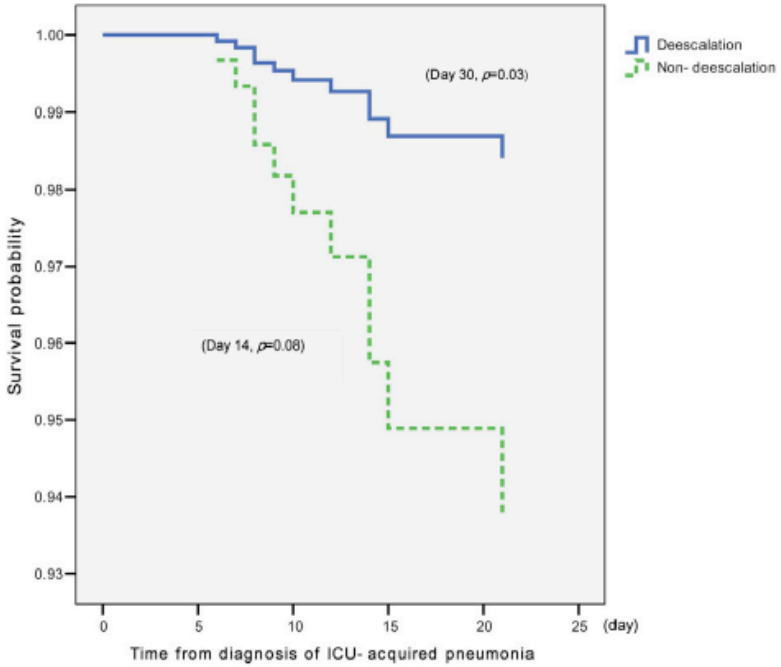

Figure 1 Pneumonia-related mortality between the de-escalation group and the non-de-escalation groups.

IDSA Infectious Diseases Society of America

hivma hiv medicine association

OXFORD

t's in a Name?

llege of Pharmacy, Missouri

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Percutaneously drained intra-abdominal infections do not require longer duration of antimicrobial therapy

Rishi Rattan, MD, Casey J. Allen, MD, Robert G. Sawyer, MD, Reza Askari, MD, Kaysie L. Banton, MD, Raul Coimbra, MD, PhD, Charles H. Cook, MD, Therese M. Duane, MD, Patrick J. O'Neill, MD, PhD, Ori D. Rotstein, MD, *and* **Nicholas Namias, MD**, *Miami, Florida*

...

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Postoperative Antimicrobial Prophylaxis Duration With Drain Use

19. In prosthetic joint arthroplasty, recommendation 1E applies: in clean and clean-contaminated procedures, do not administer additional antimicrobial prophylaxis doses after the surgical incision is closed in the operating room, even in the presence of a drain. (Cat-

...

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UOC MICROBIOLOGIA E VIROLOGIA

"ANTIMICROBIAL STEWARDSHIP": TABELLE DI SENSIBILITA' AGLI ANTIBIOTICI (2017)

microrganismi identificati nel 2017

GRAM POSITIVI

	Microrganismi implicati nei principali tipi di infezione batterica, nella ASL Roma 1	Percentuale di microrganismi SENSIBILI (criteri EUCAST)																
		Ac.fusidico	Ampicillina	Clindamicina	Ceftriaxone	Cefuroxima	Cotrimoxa	Daptomicin	Eritromcin	Gentamicin	Levofloxa	Linezolid	Oxacillina	Rifampicin	Teicoplani	Tetracicli	Tigeciclin	Vancomic
1	Staphylococcus aureus (n.348)	95	nd	57	nd	nd	96	98	50	92	43	100	43	89	100	93	100	100
2	Enterococcus faecalis (n.185)	nd	99	0	nd	0	0	nd	0	57 (*)	59	100	nd	nd	98	nd	100	98
3	Staphyloc. epidermidis (n.116)	66	nd	66	nd	nd	78	97	25	43	43	99	31	68	79	48	100	98
4	Enterococcus faecium (n.34)	nd	23	nd	nd	0	nd	nd	0	39 (*)	25	100	nd	nd	76	nd	100	73
5	Staphyloc. haemolyticus (n.26)	56	nd	64	nd	nd	52	100	8	19	23	100	11	75	100	20	100	100
6	Streptococcus pneumoniae (n.11)	nd	82	70	91	82	73	nd	54	nd	91	100	nd	nd	nd	45	nd	100

GRAM NEGATIVI

	Microrganismi implicati nei principali tipi di infezione batterica, nella ASL Roma 1	Percentuale di microrganismi SENSIBILI (criteri EUCAST)																
		Amikacina	Amox.clav	Cefepime	Cefotaxim	Ceftazidim	Ciprofloxa	Cloramfen	Colistina	Cotrimoxa	Ertapenem	Fosfomicin	Gentamicin	Imipenem	Meropenem	Metronida	Pip.tazob	Tigeciclin
1	Escherichia coli (n.758)	86	69	77	73	74	57	nd	97	70	100	96	84	100	100	nd	86	100
2	Klebsiella spp. (n.263)	82	61	65	65	64	58	nd	87	61	88	75	74	80	82	nd	86	100
3	Pseudomonas aeruginosa (n.167)	83	0	82	0	79	66	nd	92	0	0	nd	80	80	78	nd	86	0
4	Proteus spp. (n.151)	72	66	67	54	52	37	nd	0	37	99	53	58	nd	99	nd	88	0
5	Acinetobacter spp. (n.69)	nd	0	nd	0	14	10	nd	88	13	0	nd	16	12	12	nd	0	nd
6	Enterobacter spp. (n.66)	97	2	85	66	65	89	nd	87	90	97	55	90	95	97	nd	71	100
7	Serratia (n.23)	77	0	100	100	100	83	nd	0	100	100	95	100	100	100	nd	100	100
8	Bacteroides spp. (n.26)	nd	68	nd	nd	nd	nd	100	nd	nd	nd	nd	nd	96	nd	92	84	nd

MICETI (lieviti)

	Microrganismi implicati nei principali tipi di infezione fungina, nella ASL Roma 1	% SENSIBILI (criteri CLSI)					
		Amfoteric	Anidulafur	Caspofung	Fluconazol	Posaconaz	Voriconaz
1	Candida albicans (n.17)	100	nd	100	100	nd	100
2	Candida, altre specie (n.10)	100	nd	90	90	nd	100

ANTIBIOGRAMMA CUMULATIVO

NOTE:
- nd = antibiotico non testato, o dato non valido
- (*) Gentamicina alta concentrazione
- per la Candida sono stati valutati gli isolati da sangue, liquor e pus

BASATO SUI DATI 2017

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REGIONE LAZIO

Elaborato sugli isolamenti microbici delle UOOO di degenza dei presidi S.Filippo Neri, S.Spirito in Sassia, Oftalmico, S.Anna, Nuovo Regina Margherita e della CdC Salute Infermiera

Dati relativi agli isolati clinici unici di maggiore frequenza del 2017

Grazie, Marcello …

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Global Alliance for Infections in Surgery

Source control in the management of severe sepsis and septic shock: An evidence-based review

John C. Marshall, MD; Ronald V. Maier, MD, FACS; Maria Jimenez, MD; E. Patchen Dellinger, MD

Table 2. Ease of removal of colonized devices

Increasing risk associated with removal ↓	Urinary catheter Intravascular catheter Endotracheal tube Peritoneal dialysis catheter Prosthetic joint; orthopedic hardware Vascular graft Prosthetic heart valve Left ventricular assist device

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Clinical Infectious Diseases

IDSA FEATURES

IDSA Infectious Diseases Society of America · hivma hiv medicine association · OXFORD

Clinical Practice Guideline for the Management of Asymptomatic Bacteriuria: 2019 Update by the Infectious Diseases Society of America[a]

Lindsay E. Nicolle,[1] Kalpana Gupta,[2] Suzanne F. Bradley,[3] Richard Colgan,[4] Gregory P. DeMuri,[5] Dimitri Drekonja,[6] Linda O. Eckert,[7] Suzanne E. Geerlings,[8] Béla Köves,[9] Thomas M. Hooton,[10] Manisha Juthani-Mehta,[11] Shandra L. Knight,[12] Sanjay Saint,[13] Anthony J. Schaeffer,[14] Barbara Trautner,[15] Bjorn Wullt,[16] and Reed Siemieniuk[17]

AMERICAN SOCIETY FOR MICROBIOLOGY | Journal of Clinical Microbiology®

MINIREVIEW

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Targeting Asymptomatic Bacteriuria in Antimicrobial Stewardship: the Role of the Microbiology Laboratory

Zanthia Wiley,[a] Jesse T. Jacob,[b] Eileen M. Burd[c]

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TABLE 1 Microbiologic definition of asymptomatic[a] bacteriuria[b]

Criteria for ASB diagnosis
Two consecutive voided urine specimens (preferably within 2 wk) with the same bacterial species isolated in quantitative count of $>10^5$ CFU/ml in women, including pregnant women (1, 2)
A single voided urine specimen with one bacterial species isolated in a quantitative count of $>10^5$ CFU/ml in men (1, 2)
A single catheterized urine specimen with one or more bacterial species isolated in a quantitative count of $>10^5$ CFU/ml in either women or men (1) or $\geq 10^2$ CFU/ml of a single bacterial species from a single catheterized urine specimen (2)
Any urine specimen with $>10^4$ CFU/ml of group B *Streptococcus* is significant for ASB in a pregnant woman (3)

[a]No signs or symptoms referable to the urinary tract, e.g., typical urinary tract symptoms include urinary frequency, urinary urgency, lower abdominal pain, pelvic pain, and/or flank pain.

[b]Presence of more than one bacterial type indicates contamination with organisms normally found on the skin. The presence of yeast in the urine of asymptomatic patients is almost always the result of external genital tract colonization, and there are no consistent diagnostic criteria to define significant infection (7).

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XIV. What Is the Treatment for Urinary Tract Infections Due to *Candida* Species?

What Is the Treatment for Asymptomatic Candiduria?

Recommendations

97. Elimination of predisposing factors, such as indwelling bladder catheters, is recommended whenever feasible *(strong recommendation; low-quality evidence)*.
98. Treatment with antifungal agents is NOT recommended unless the patient belongs to a group at high risk for dissemination; high-risk patients include neutropenic patients, very low-birth-weight infants (<1500 g), and patients who will undergo urologic manipulation *(strong recommendation; low-quality evidence)*.

Clinical Practice Guideline for the Management of Candidiasis: 2016 Update by the Infectious Diseases Society of America

Peter G. Pappas,[1] Carol A. Kauffman,[2] David R. Andes,[3] Cornelius J. Clancy,[4] Kieren A. Marr,[5] Luis Ostrosky-Zeichner,[6] Annette C. Reboli,[7] Mindy G. Schuster,[8] Jose A. Vazquez,[9] Thomas J. Walsh,[10] Theoklis E. Zaoutis,[11] and Jack D. Sobel[12]

The presence of candiduria is the usual trigger for a physician to consider whether a patient has a urinary tract infection due to *Candida* species. The patients at most risk for candiduria are those who are elderly, female, diabetic, have indwelling urinary devices, are taking antibiotics, and have had prior surgical procedures [470–475]. In the asymptomatic patient, candiduria almost always represents colonization, and elimination of underlying risk factors, such as indwelling catheters, is often adequate to eradicate candiduria [471].

Multiple studies have noted that candiduria does not commonly lead to candidemia [471, 472, 476–480]. Several of these studies have shown that candiduria is a marker for greater mortality, but death is not related to *Candida* infection and treatment for *Candida* infection does not change mortality rates [476, 480, 481]. A prospective study in renal transplant recipients found that although mortality was higher in patients who had candiduria, treatment did not improve outcomes, suggesting again that candiduria is a marker for severity of underlying illness [482].

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Table 1. *Clostridium difficile* Infection Control Plan*

- Education
  - Yearly education for physicians, nurses, allied health professionals re: infection control
- Environmental Services
  - Enhance daily room cleaning ✓
    - Determine who is responsible for cleaning specific items in rooms ✓
    - Need more housekeeper full-time equivalents (FTEs) to adequately clean rooms ✓
    - Hypochlorite-based cleaning agent for isolation rooms ✓
    - Environmental Services monitors compliance and reports back to patient care unit, infection control, and hospital administration ✓
  - Enhance discharge room cleaning of all patient rooms
    - Assess need for more housekeeper FTEs to adequately clean rooms ✓
    - Use hypochlorite-based cleaning agent used for isolation room discharge cleaning ✓
    - Environmental Services monitors compliance and sends reports to patient care unit, infection control, and hospital administration ✓
- Single-use Devices for Isolation Rooms
  - Blood pressure cuff, thermometer, and stethoscope in every isolation room
    - Nursing staff monitors compliance and sends report to infection control and hospital administration
- Review policies re: cleaning portable equipment ✓
  - Determine who is responsible for maintaining cleaning and cleaning supplies ✓
- Personal protective equipment for isolation rooms readily available (gowns, gloves, masks as needed)
  - Need to be easily accessible and readily available ✓
  - Need appropriate sizes ✓
  - Need easily accessible and frequently emptied hamper bins ✓
    - Monitor compliance and report back to patient care unit, infection control, and hospital administration
- Robust antibiotic stewardship program for all hospital patient care units
  - Regularly scheduled prospective audits of antibiotic use with direct interaction and feedback to the prescriber
  - Formulary restriction and preauthorization requirements
  - Education of prescribers
  - Use evidence-based practice guidelines and incorporate into computerized provider order entry system based on national guidelines, local microbiology, and hospital antimicrobial resistance patterns
  - Assist in streamlining, or de-escalating empiric antibiotic therapy based on culture results, eliminating redundant combination therapy (done in ICUs)
  - Optimize antimicrobial dosing based on individual patient characteristics, causative organism, site of infection, and pharmacokinetic and pharmacodynamic characteristics of the prescribed drug (done in ICUs)
  - Assist in intravenous to oral conversion of antibiotics by developing clinical criteria and guidelines promoting conversion to use of oral agents (done in ICUs)
  - Audit antibiotic class and specific antibiotic use over time and report data to chief medical officer
  - Assist in narrow-spectrum antibiotic use
  - Limit quinolone & clindamycin use ✓ (done for trauma surgery patients)
  - Monitor process and outcome data and report to infection control, quality assurance, and hospital administration ✓
- Develop a tool to determine patients at high risk for *C. difficile* and automate orders for isolation precautions and *C. difficile* testing along with automated notification of physician and nursing team caring for individual patients
  - Empower nurses to initiate contact precautions and order *C. difficile* toxin assay on patients with diarrhea without a physician's order as part of a nursing protocol ✓
- Improve sensitivity of *C. difficile* testing
  - Change *C. difficile* testing method to a more sensitive method ✓
  - Increase frequency of testing done by microbiology laboratory ✓
- Develop a medical/surgical guideline for *C. difficile* management ✓
  - Incorporate into computerized provider order entry system
  - Monitor compliance and outcome data and report to hospital administration
- Develop a medical/surgical rapid response team for severe *C. difficile* management
  - Monitor outcome data and report to hospital administration
- Consider expanding isolation precautions for patients with *C. difficile* infection for the duration of hospitalization

* ✓ = completed task; otherwise in process or will be addressed.

Clostridioides difficile

- Robust antibiotic stewardship program for all hospital patient care units
  - Regularly scheduled prospective audits of antibiotic use with direct interaction and feedback to the prescriber
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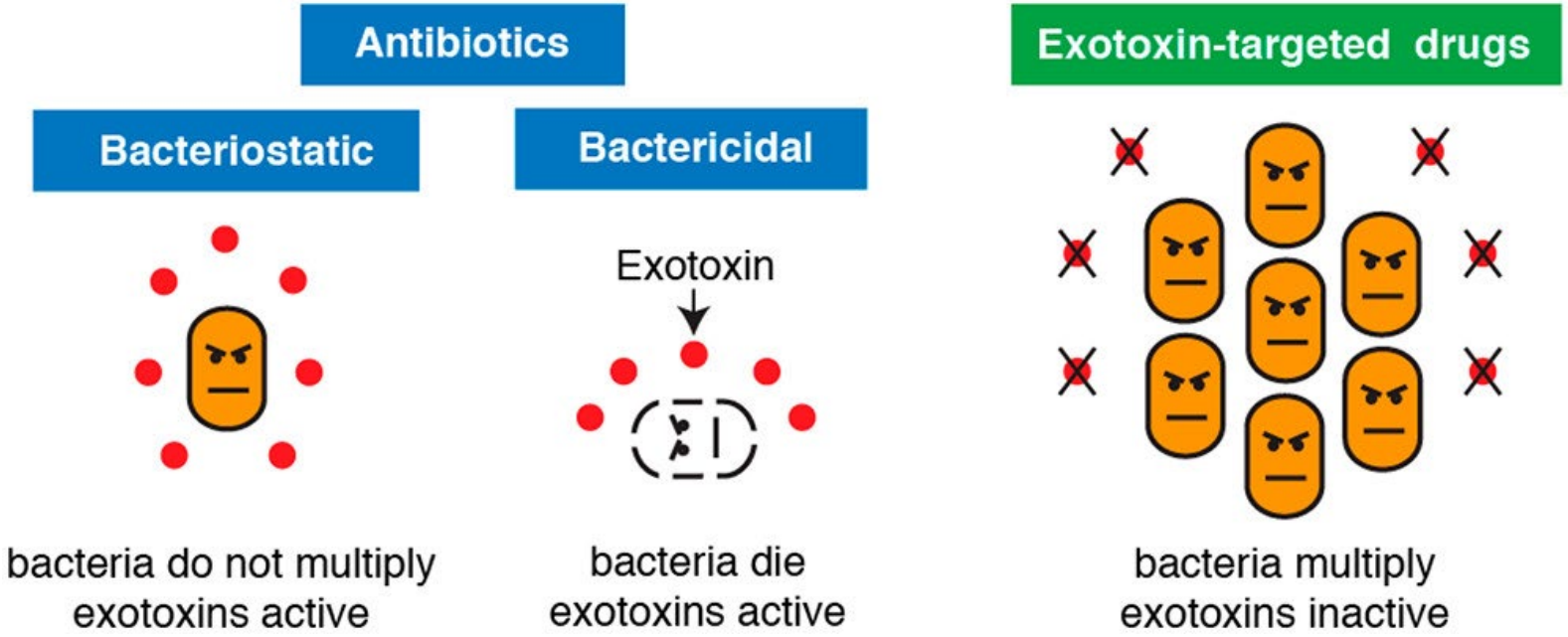
ACS Infectious Diseases

pubs.acs.org/journal/aidcbc Review

Exotoxin-Targeted Drug Modalities as Antibiotic Alternatives

Moona Sakari, Arttu Laisi, and Arto T. Pulliainen*

Cite This: ACS Infect. Dis. 2022, 8, 433–456 Read Online



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Sartelli *et al. World Journal of Emergency Surgery* (2020) 15:28
https://doi.org/10.1186/s13017-020-00308-1

World Journal of Emergency Surgery

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Hey surgeons! It is time to lead and be a champion in preventing and managing surgical infections!

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