TIGHT GLUCOSE CONTROL CAN BACKFIRE IN ICU, PAGE 10

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BOB BEVERLY/WVU BIOMEDICAL COMMUNICATIONS

The antimicrobial stewardship program uses education to help avoid an "us versus them" phenomenon, Dr. Arif R. Sarwari said.

Program Combats Resistant Infections

BY JEFF EVANS
Senior Writer

BETHESDA, MD. — The antimicrobial stewardship program at the health sciences center of West Virginia University, Morgantown, has been successful in reducing resistance in some pathogens, while generating more questions about others, according to Dr. Arif R. Sarwari, the program's director.

In its first 5 years, the program at the tertiary care teaching hospital principally used prospective auditing methods and protocols for antibiotic cycling, coupled with educational strategies, to reduce the use of specific antibiotics and, in some instances, see a drop in rates of resistance.

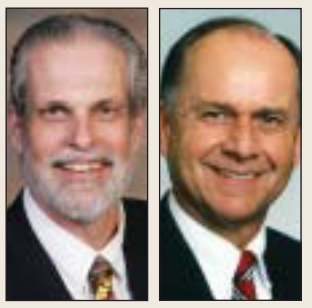
Such results may not have been possible without the support and involvement of administrators and clinicians from different specialties, many of whom are members of the university's Antimicrobial Review Subcommittee and participated in the creation of the program. Cooperation is necessary because the interventions needed in various departments may differ and may cross a variety of disciplines, Dr. Sarwari said at an annual conference on antimicrobial resistance sponsored by the National Foundation for Infectious Diseases.

The antimicrobial stewardship program began in 2003 and follows many of the recommendations in guidelines issued by the Infectious Diseases Society of America and the Society for Healthcare Epidemiology of America (Clin. Infect. Dis. 2007; 44:159-77), said Dr. Sarwari, who is a member of the committee.

It is unclear which combinations of modalities for reducing antimicrobial resistance work best, and "until I have 15 different institutions using 15 different combinations and putting their results out there, how do I know which one works and which one

See **Program** *page 6*

INSIDE



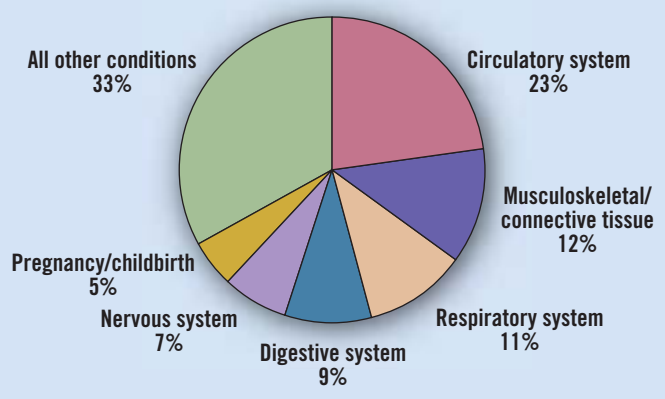
Joint Commission Debate
Point/Counterpoint considers proposed revisions to medical staff standard.
PAGE 5

Acute Severe Hypertension
Management of this common, life-threatening condition is often faulty.
PAGE 9

EMR Subsidies
Some hospitals are moving slowly to help affiliated physicians purchase the required software.
PAGE 15

VITAL SIGNS

Circulatory Conditions Accounted for the Largest Portion of Hospital Costs in 2006



Note: Based on data from the Healthcare Cost and Utilization Project.
Source: Agency for Healthcare Research and Quality

ELSEVIER GLOBAL MEDICAL NEWS

Surgeon General's 'Call to Action' Puts Focus on DVT, PE

'Hospitalists will play a pivotal role.'

BY DENISE NAPOLI
Associate Editor

WASHINGTON — In response to physician groups concerned about the high incidence of deep vein thrombosis and pulmonary embolism, Acting Surgeon General Steven K. Galson has issued a Call to Action statement.

In concert with the statement, which was released at the second annual meeting of the Venous Disease Coalitiion, the National Heart, Lung, and Blood Institute has awarded 5 years' worth of funding to eight research groups investigating venous thromboembolism treatments and prevention. Ongoing studies include a multicenter, randomized clinical trial of genotype-guided dosing of warfarin therapy, which is currently the most commonly used treatment for prophylaxis of recurrent venous thromboembolism, according to Dr. Elizabeth Nabel, director of clinical research at the NHLBI.

The major push to address the rising incidence of DVT and PE dates to a 2006 meeteen former Surgeon General Richard H. Carmona and advocates. As a member of the Coalition to Prevent DVT, Dr. Frank Michota, director of academic affairs in the department of hospital medicine at the Cleveland Clinic, spoke on public advocacy at that meeting.

See **Surgeon General** *page 2*

$3 Million Grant Targets ICU Bloodstream Infections

BY MIRIAM E. TUCKER
Senior Writer

The Agency for Healthcare Quality and Research has awarded a $3 million, 3-year contract aimed at reducing central line–associated bloodstream infections in hospital intensive care units nationwide.

The new funding was announced in a telephone press briefing on Oct. 1, the day that Medicare's new rule of nonpayment for certain hospital-acquired infections—including central line–associated bloodstream infections—went into effect.

The intervention, which was found effective at Johns Hopkins University in Baltimore and in Michigan hospitals, includes five specific evidence-based procedures: hand washing, full-barrier precautions during catheter insertion, site cleaning with chlorhexidine solution, avoiding the femoral site, and removing unnecessary catheters.

Intensive care units also used daily goals sheets to improve communication among clinicians, a comprehensive unit-based safety program, and an intervention to reduce ventilator-associated pneumonia.

"The need to align payment with the quality of care delivered is long overdue, and this policy is really a large first step toward that goal. … I believe we have to pull as many different levers as we can to solve these problems," said Dr. Peter J. Pronovost of Johns Hopkins University, when asked to comment on the connection between the Medicare policy and the AHRQ funding.

The AHRQ grant, to be awarded to the Health Research and Educational Trust, an affiliate of the American Hospital Association (AHA), continues the agency's previous funding for work led by Dr. Pronovost initially at Johns Hopkins and subsequently by his group in collab-

See **$3 Million** *page 13*

Avoiding DVT

Surgeon General *from page 1*

"Hospitalists will play a pivotal role in the success of this Call to Action," Dr. Michota said. "This is where hospitalists have an opportunity to develop, encourage, and pull through the systems of care that will guarantee all patients at risk for DVT are identified and that those found to be at risk will receive evidence-based methods of prophylaxis."

Dr. Michota, medical editor-in-chief for Hospitalist News, added that he believes hospitalists are "more focused on this issue than any other specialty, including pulmonologists and cardiologists. Venous thromboembolism is one of the hospitalist's clinical core competencies."

Hospitalists have been instrumental in the development of "reminder systems, preprinted order sheets, and multidisciplinary protocols so that no patient falls through the cracks in regards to DVT prevention," he observed.

Further, there are new incentives to ensure that more hospitalized patients receive appropriate prophylaxis.

As of Oct. 1, 2008, any DVT or PE acquired during an inpatient stay in association with total knee and hip replacement procedures will have "payment implications," according to the Centers for Medicare and Medicaid Services (Hospitalist News, August 2008, p. 1).

Just how many patients are affected annually by venous thromboembolism is unclear. Without an autopsy, many fatal cases—perhaps as many as 50%—are misclassified as myocardial infarctions.

According to Dr. Roy S. Silverstein, chair of the committee of government affairs for the American Society of Hematology, the disease affects almost 1 million Americans annually, and "the estimated number of deaths from PE is higher than the combined number of deaths from breast cancer, HIV disease, and motor vehicle crashes."

Dr. Galson put PE- or DVT-related deaths at 100,000 annually, with 350,000-600,000 Americans contracting DVT or PE each year.

The American Heart Association estimated the incidence of venous thromboembolism to be 250,000 to 2 million cases per year (Circulation 2002;106:1436). Meanwhile, upcoming studies put the annual number of cases somewhere in between those estimates.

The risk for DVT is known to be greatest among hospitalized spinal cord injury patients. Among those who do not receive VTE prophylaxis, the risk of developing a deep vein thrombosis (DVT) is 60%-80%.

Without VTE prophylaxis, the DVT risk is 40%-60% among hip and knee surgery patients, 20%-40% among patients undergoing major general surgery or gynecologic procedures, and 10%-20% for patients with acute illnesses like pneumonia.

"There is now a public acknowledgment that this is a very significant health care issue that deserves attention from multiple facets of the medical community," Dr. Thomas Wakefield, head of vascular surgery at the University of Michigan, Ann Arbor said in an interview.

"We've known for a long time that (DVT and PE are) significant problems; however, since the conditions don't belong to one group or another and span so many specialties, it has been difficult to mobilize and raise awareness."

Dr. Wakefield noted that the NHLBI initiative is an excellent start, but additional studies are needed, including studies of newer drugs and pharmacologic therapies with fewer adverse effects and interactions, and less need for monitoring than has warfarin.

Among the other studies worthy of consideration are investigations of short- and long-term outcomes associated with more aggressive interventions for DVT and PE. One such study, which has been funded by the National Institutes of Health and is slated to start soon, will compare pharmacomechanical thrombolysis plus standard anticoagulation to standard anticoagulation alone for the treatment of significant proximal venous thrombosis. ■

Booklets Focus on DVT Prevention

Preventing Hospital-Acquired Venous Thromboembolism: A Guide for Effective Quality Improvement is a 60-page booklet that includes case studies and is "designed to help hospitals and clinicians implement processes to prevent dangerous blood clots," according to Dr. Carolyn Clancy, director of the U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality, which published the booklets.

"Your Guide to Preventing and Treating Blood Clots" is a 12-page consumer booklet summarizing the causes and symptoms of blood clots, ways to avoid them, and what to expect from treatment.

Free copies of both booklets are available either by calling 800-358-9295 or by sending an e-mail to ahrqpubs@ahrq.hhs.gov.

Warfarin Genotype Study Set to Begin

The National Heart, Lung, and Blood Institute is about to launch its first-ever multicenter, double-blind, pharmacogenetic trial—one focused on warfarin therapy.

The COAG (Clarification of Optimal Anticoagulation Through Genetics) trial aims to determine whether targeting patients according to their genotype during the initiation of warfarin therapy would lead to better and safer anticoagulation control, especially in patients with deep vein thrombosis (DVT), according to an NHLBI representative. Results are anticipated in 2011.

Warfarin is the most commonly used blood-thinning treatment, and the 10th most prescribed medication in the United States, with more than 21 million prescriptions per year, according to the NHLBI. Patients with certain genotypes have been shown to metabolize warfarin better than do others, and some researchers believe that there may be an optimal genotype for toleration of the drug. "It is hoped that prospectively using the genetic information in addition to the clinical information will help clinicians determine better and safer initial dosing for specific patients," an NHLBI spokesperson said.

The COAG trial will be coordinated by the center for clinical epidemiology and biostatistics at the University of Pennsylvania, Philadelphia. By the end of 2008, study coordinators hope to begin enrolling 1,965 patients. Details are still being finalized, but the NHLBI spokesperson said that she expects participants will have to be starting on warfarin therapy with an indication of at least 3 months of treatment. They will likely have to be warfarin naive, and without any major contraindications to anticoagulant treatment.

To request more information on patient enrollment, send an e-mail to nhlbiinfo@nhlbi.nih.gov.

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