longed preclinical latency, which makes it impossible to completely eliminate potential iatrogenic transmission.

A diagnosis of CJD may emerge unexpectedly, and a multidisciplinary approach is essential to ensure that the welfare of patient and contacts is managed optimally. Risk assessment, through the use of a screening tool for nonemergency patients, and the comprehensive tracking of all instruments used in surgical procedures is required, as is available in many sectors of the manufacturing industry. Finally, clear, honest, and appropriate communication with patients and contacts, although difficult, is essential, not least because such patients may have to undergo additional surgical or dental procedures, in which case their instruments must be identified, withdrawn, and incinerated and blood donation is contraindicated. Disclosure is in the best interests of patients and is more likely to minimize damage to institutional reputations.

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Edmond G. Smyth, MSc, FRCPI, FRCPath;[1,2] **Michael Farrell, FRCPI, FRCPC, FRCPath;**[3] **Daniel G. Healy, MB, PhD;**[4] **Caoimhe Finn;**[5] **David O'Brien, FRCS(SN);**[6] **Donncha F. O'Brien, MD, FRCSI (SN);**[6] **Rachel Howley, PhD;**[3] **Patrick Turner, MSc;**[7] **Hilary Humphreys, MD, FRCPI, FRCPath**[1,2]

Affiliations: 1. Department of Microbiology, Beaumont Hospital, Dublin, Ireland; 2. Department of Clinical Microbiology, Royal College of Surgeons in Ireland, Dublin, Ireland; 3. Department of Neuropathology, Beaumont Hospital, Dublin, Ireland; 4. Department of Neurology, Beaumont Hospital, Dublin, Ireland; 5. Department of Infection Prevention and Control, Beaumont Hospital, Dublin, Ireland; 6. Department of Neurosurgery, Beaumont Hospital, Dublin, Ireland; 7. Central Sterile Supplies Department, Beaumont Hospital, Dublin, Ireland.

Address correspondence to Edmond Smyth, MB, Msc, FRCPI, FRCPath, Department of Microbiology, Beaumont Hospital, Dublin 9, Ireland (edmondsmyth@beaumont.ie).

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Reply to Smyth et al

To the Editor—We thank Smyth et al[1] for their letter reporting a recent situation consistent with the incidents described in our article,[2] wherein potential patient exposure to prion-contaminated instruments occurred after a surgical procedure involving an index patient who subsequently received a diagnosis of Creutzfeldt-Jakob disease (CJD). As indicated in our article, we agree that the best method to limit the occurrence of these scenarios is the advance identification of patients with potential CJD so that instruments may be managed appropriately. Use of a presurgery questionnaire, such as the one devised by Smyth et al,[1] may be helpful in this regard.

Our experience with evaluating these incidents has reinforced our belief that the determination of whether to notify potentially exposed patients is not as straightforward as Smyth et al[1] suggest, and a decision to notify may not always be in the best interests of the patients. In their own example, Smyth et al[1] explain that contacts and, it follows, those patients who were notified were defined as only those patients exposed to instruments in direct contact with brain tissue from the index case patient. This determination was made on the basis of an assessment of transmission risk. Examples of other factors that may influence this risk and be informative in making notification decisions include (1) the certainty of the CJD diagnosis in the index patient, (2) the number of times that a contaminated instrument was routinely sterilized before the potential exposure event, (3) the likelihood that the same neurological instrument set was used to treat the index patient and potentially exposed patients, and (4) the prognosis of the potentially exposed patients due to the underlying conditions that necessitated their procedures. To be clear, the above comments are not made to advocate either for or against notification of patients. Rather, they underscore that, because the variables and known facts of each incident vary, experts may differ in their opinion of whether notification is the ethically appropriate choice.[3] These decisions, given their potential effects, should not be made lightly.

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Ryan A. Maddox, PhD;[1] **Lawrence B. Schonberger, MD;**[1]

Ermias D. Belay, MD[1]

Affiliation: 1. Division of High-Consequence Pathogens and Pathology, National Center for Emerging and Zoonotic Infectious Diseases, Centers for Disease Control and Prevention, Atlanta, Georgia.

Address correspondence to Ryan A. Maddox, PhD, 1600 Clifton Road, Mailstop A-30, Atlanta, GA 30333 (rmaddox@cdc.gov).

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Antibiotic Burden Associated with Treatment of Asymptomatic Bacteriuria

To the Editor—We read with interest the report by Kelley et al[1] entitled "Evaluation of an Antimicrobial Stewardship Approach to Minimize Overuse of Antibiotics in Patients with Asymptomatic Bacteriruira." These authors used an observational retrospective study design to evaluate the impact of an antimicrobial stewardship program (ASP) educational initiative on asymptomatic bacteriuria (ASB) management at their institution. Select components of the educational initiative included in-service presentations targeted at physicians and pharmacists, posting of notifications and memorandums, distribution of pocket cards, and daily review of antibiotics for the treatment of urinary tract infections (UTIs) by ASP members. They found a decrease in empirical antibiotic administration from 66 (62%) of 107 patients before the initiative to 28 (26%) of 107 patients after the initiative ($P < .0001$).[1]

We agree with the authors that treatment of ASB presents a significant problem. The Infectious Diseases Society of America (IDSA) guidelines regarding ASB recommend against treating adults with ASB except pregnant women and individuals undergoing urologic procedures.[2] Administration of antibiotics when not indicated may result in adverse drug reactions, development of antibiotic resistance, and *Clostridium difficile* infection.[3,4] Therefore, we have also taken steps to evaluate the management of ASB at our institution and estimate the added antibiotic burden resulting from the treatment of ASB, focusing on patients with an indwelling urinary catheter. We outline the results of our evaluation here.

A comparative observational study of catheterized patients with ASB was conducted. Retrospective medical record review was completed for patients who met the following inclusion criteria: (1) age 18–89 years; (2) admission to an internal medicine or surgery service between November 1, 2011, and November 31, 2012; (3) a urine culture containing 10^4 colony-forming units/mL bacteria or greater; and (4) a urinary catheter in place for 24 hours or more before the culture was obtained. Patients were excluded on the basis of documentation of 1 or more of the following symptoms of a UTI: temperature 37.9°C or more, costovertebral tenderness, dysuria, urinary frequency, urinary urgency, rigors, new onset delirium, and increased muscle spasticity in quadriplegic and paraplegic patients. Additional exclusion criteria similar to those used by Kelley et al[1] included pregnancy; medical history of a solid organ transplant; known urinary tract anatomical abnormality; renal stones; malignancy; foreign bodies of the urinary tract; being scheduled for genitourinary manipulation within 24 hours of culture; candiduria; death or hospital discharge before culture results were available; or current incarceration. Patients were considered to be treated for ASB if an antibiotic targeted at the bacteria isolated from the urine was administered within 5 days of culture obtainment. If a patient received antibiotics for other reasons, this was not categorized as ASB treatment. Demographic and clinical information was collected and summarized for treated and nontreated patients and univariate analysis was performed to describe characteristics associated with ASB treatment. Human subjects research approval was provided by the Office of Responsible Research Practices institutional review board.

Medical records of 228 patients with bacteriuria were reviewed; 194 patients met exclusion criteria. The primary reason for exclusion was the presence of signs or symptoms of a urinary tract infection. Of the remaining 34 patients included in the study, 22 (65%) were treated for ASB. Among treated and nontreated patients, there were no statistically significant differences in demographic characteristics, urinalysis, or urine culture results thought to drive antibiotic prescribing in patients with ASB (Table 1). The mean ($\pm$ standard deviation [SD]) duration of in-hospital antibiotic therapy was 3.5 $\pm$ 2.1 days, and the mean ($\pm$SD) planned duration of antibiotic therapy as documented in the patient discharge summary was 7.4 $\pm$ 4.2 days. This equated to approximately 7 days of unnecessary antibiotic exposure per patient with ASB. Three patients were tested for *C. difficile* within 30 days of urine culture obtainment, but no patients had a positive test result.

The majority of research published on the treatment of ASB has been performed in nursing homes, but 3 additional studies have been conducted in the acute care hospital set-