

authors argue, in the case of readmissions at 30 days, the aspect that seemed to weigh most heavily on the quality of the prescription were the characteristics of the patient and not the dynamics of the HaH.

The study does not specify whether or not the mean hospital stay of 2.5 days included patients admitted directly to hospital at home from A&E. If they were not included, the stay was short enough for the HaH practitioner to have made the decision about de-escalation or sequential therapy with the same diligence as previously non-hospitalised patients, and would be another argument in favour of the differences observed being due to the profile of the patients. If the calculation of the mean stay included patients admitted from A&E (in which case the mean stay would be longer, considering only conventionally hospitalised patients), the deficiency in the treatment could have already occurred on the inpatient ward.

In summary, this is a necessary article alerting to the need to implement programmes for rational use of antimicrobials in hospital at home with the same rigour as in hospitals.

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Reply to “Rational use of antimicrobials in home hospitalization”[☆]



Respuesta a «Uso racional de antimicrobianos en hospitalización a domicilio»

Dear Editor,

In response to the published Letter to the Editor by Mirón Rubio,¹ we would like to respond with the following paper to clear up the questions, comments and clarifications which have emerged from our study.

First of all, as we acknowledged in the discussion, there may have been loss of information, as occurs in all observational studies involving review of medical records. Secondly, in relation to your comment on the potential increase in the antimicrobial spectrum when adapting treatments from conventional hospitalisation (CH) to hospital at home (HaH), we consider that there is a real risk of this treatment inertia occurring. It is for this reason that we consider it essential that physicians master the rational use of antibiotics and have adequate knowledge about the pharmacological properties of antibiotics, especially with regard to oral bioavailability. Also, the availability of a good nursing team and the appropriate medical devices (electronic and elastomeric pumps) would contribute towards making the use of antimicrobials in HaH comparable to that of CH. This issue is linked to the next point referred to in your letter, which calls into question our findings on the improvement in antibiotic management in patients who are transferred to HaH from Accident and Emergency. We acknowledge that the cases were not randomised and that no multivariate analysis was per-

formed, but in defence of our conclusion, we believe it needs to be taken into account that our variable of good prescribing quality used objective and subjective data and that it was protected by other variables such as tolerance to the oral route, the likelihood of resistance and clinical stability. Once again, we would like to point out that it is possible that good overall management of the patient by the same doctor, particularly if the dates for changes in treatment and the processes of good prescribing quality are established in a relatively automatic way at the beginning of admission on the premise that “the patient is doing well”, could lead to optimisation in the use of antimicrobials. It should be noted that several studies have already examined this type of measure, with surprising conclusions.^{2–4} In the prescribing of antimicrobials there are many cognitive biases that undermine their optimisation, like for example, considering the prototype of the older, comorbid patient in our study, the fact that the frailty of the patient and the general deterioration caused by pneumonia can be confused with the determining infectious factors. In other words, the patient is not going to heal faster because of more antibiotics, perhaps mobilisation measures,⁵ early discharge,⁶ nutritional counselling or respiratory rehabilitation may be more important. We also hope to have stimulated consideration as to whether there are occasions when administration of intravenous antibiotics is used to justify admitting a patient to HaH. We would like to stress that it is perfectly possible to admit a patient to HaH with oral antibiotic therapy, i.e. for all those patients who have infectious conditions but whose reason for admission may be frailty, the need for other treatments or close supervision by a hospital specialist with the ability to identify treatment failure faster.

Last of all, as regards the uncertainty about how the hospital stay was measured, we can clarify that patients who went directly to HaH from A&E were included. We have no doubt that a proportion of the factors determining poor prescribing quality occurred during the CH.

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In conclusion, we are pleased that you consider our work necessary; we too believe that there is great scope for research and improvement in HaH. It is our intention to expand this thread with future articles exploring other points of antimicrobial use in HaH.

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