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Cancel that picc line order; cholecystostomy tube and short course of antibiotics☆

DR. M. ASHRAF MANSOUR (Grand Rapids, Michigan): So first I would like to congratulate Dr. Walker on presenting a very interesting study on the ideal length of I.V. antibiotic course for patients who have a cholecystostomy. So the authors reviewed all the patients undergoing cholecystostomy in their hospitals. The first thing you should realize is that one in five patients ended up dying during the study and had to be excluded, and about one in five also had to be excluded because they had other confounding comorbidities or illnesses that also required antibiotics. They arbitrarily divided the length of treatment to less than a week or more than a week. In the efficacy of antibiotics was determined by the return of some parameters, such as fevers to normal pulse rate and white cell count. So I have three questions for you.

The first is, why did you decide on seven days or less or seven days or more? As you mentioned, the STOP IT trial showed that four days was adequate, and actually when you look at your data, the patients that had the short course, the average length of antibiotics was 3.6. So would it make sense for you to redo your analysis using four days as a cut-off? The second question is, just a simple question, how did the antibiotics get chosen? Were they based on bile cultures or did you just use broad spectrum antibiotics, and if you did, what kind of coverage was it.

And, finally, these patients had a cholecystostomy, and in the manuscript you said the cholecystostomy tube was removed in the operating room. What was the average length of leaving the cholecystostomy tube in place. Was it a week, two weeks, a month? It would be interesting to know that. Again, congratulations for doing an interesting study. As you probably learned from doing this, it's very difficult to do a retrospective study and get all the data points that you need to write a paper, but congratulations on doing a good job.

DR. WALKER: The only other study out there involving antibiotics and cholecystostomy tube – their cut-off was eight days. They showed that after eight days, patients get worse. So we chose seven days for that reason.

The different types of antibiotics – some patients had bile cultures, some didn't. That's why we didn't really report on it, because we didn't think it was that important. You're draining – if you drain an abscess, do you culture every abscess that you drain? We kind of went with the same thought that is you're removing the infection. There's really no point in testing to see what it was, but a majority of patients did have broad spectrum coverage, usually Vancomycin, Zosyn or Unasyn. And the third question, the tube removal, we did have dates for the patients that we had an operation, removed in the OR as well as dates when they removed. It was a little hard to try to calculate from when it was placed and when it was removed for the stats. That was the only reason why it wasn't included, but we do have dates for all of them. And I can give you ball park of the average.

DR. CHARLES LUCAS (Detroit, Michigan): Sometimes you see a patient who is sick as hell and has high drops to the gallbladder, too sick to have operation. You can palpate the gallbladder and you can very nicely get your cholecystostomy tube placed and the patient's better that evening. More often, when you have a patient who's septic from undetermined cause but has some sludge in the gallbladder, the internists think the gallbladder is the source and recommend cholecystostomy, but the gallbladder is not readily accessible, so you have to go through the liver in order to get the cholecystostomy tube performed. Those patients, in my experience, don't do well. I didn't hear in your presentation the separation of those patients who had the catheter go directly into the gallbladder or through the liver into the gallbladder.

DR. WALKER: We specifically did not look to see the site of placement for the tube, but it is something that we can look into.

☆ (Presentation given by Charles Walker, M.D.)

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