The Burden of Staphylococcus aureus Infections on Hospitals in the United States

Staphylococcus aureus has emerged as an important pathogen with a significant impact on the health care system. Noskin and colleagues describe the burden of this organism on a national level. From 2000-2001, S aureus was reported as a discharge diagnosis in 0.8% of all hospital stays. On a national level, the impact of S aureus is staggering: 2.7 million days in excess length of stay, $9.5 billion in additional hospital charges, and almost 12,000 hospital deaths annually. Therefore, the potential benefits to hospitals in terms of reduced resource utilization and improved patient outcomes from preventing S aureus are significant.

Barriers and Facilitators to Primary Care or Human Immunodeficiency Virus Clinics Providing Methadone or Buprenorphine for the Management of Opioid Dependence

Federal initiatives are promoting office-based management of opioid dependence, but physicians’ receptiveness to offering this care is not known. In a statewide sample of approximately 250 New York State clinics serving Medicaid enrollees, nearly twice as many clinics were willing to offer buprenorphine hydrochloride compared with methadone hydrochloride treatment. Receptiveness to treating opioid dependence was greater in clinics with human immunodeficiency virus specialty care, safe storage for narcotics, methadone program affiliation, more patients with chronic pain, and willingness to see drug users with other patients. Facilitators include immediate telephone access to an addiction expert and continuing medical education for training.

The Role of Patient-Physician Trust in Moderating Medication Nonadherence Due to Cost Pressures

Petitte and colleagues examined whether patients’ trust in their physicians moderates the impact of high out-of-pocket medication costs and other risk factors for cost-related adherence problems. A total of 912 patients with diabetes mellitus completed a detailed survey about their level of trust in their physician and medication cost problems. Even after adjusting for confounders, patients with low levels of physician trust were more likely to forgo medications in response to high out-of-pocket costs compared with patients with greater trust in their physician. Having a low income was only associated with cost-related adherence problems in the context of low physician trust. Patients who reported medication underuse for reasons other than cost were 4 times as likely to also report cost-related underuse, and those with depressive symptoms had more than twice the risk of cost-related underuse compared with other patients. Fostering a trusting physician relationship and addressing noncost barriers to adherence may reduce rates of cost-related medication underuse.

Regional and Institutional Variation in the Initiation of Early Do-Not-Resuscitate Orders

Do-not-resuscitate (DNR) orders are important in decision making about aggressiveness of care for patients in hospitals, but few studies have investigated the role of hospital factors or regional variation on the use of DNR orders. Zingmond and Wenger studied the use of early DNR orders (those written in the first 24 hours) among 819,686 persons 50 years and older admitted to 386 hospitals in California in 2000. Do-not-resuscitate orders were less likely to be written in for-profit hospitals and academic medical centers and more likely in the smallest hospitals. Standardized rates of DNR order use varied 10-fold across counties. The highest rates were among patients from rural areas. However, variation in use did not correspond well to county population, availability of hospital beds, or population density.

Incidence of Venous Thromboembolism in the Year Before the Diagnosis of Cancer in 528,693 Adults

Although echocardiography is widely used in the evaluation of cardiac structures and function, the prognostic value of echocardiographic assessment of left atrium size for risk stratification of cardiovascular death is unknown. Left ventricular mass and left atrium size were measured by using M-mode echocardiography in a representative population-based sample of 830 men. In this prospective study, those subjects in the highest tertile of left atrium diameter had a 2.3-fold risk of cardiovascular death compared with men in the lowest tertile of left atrium diameter. On the basis of this study, however, the association between left atrium size and cardiovascular mortality appears to be partially related to left ventricle hypertrophy.

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