October 2022 Sepsis Webcast Follow-Up Questions

1. **Are there recommendations for peripheral cultures in hem/onc patients with a new fever and a CVL?**
   Dr. Woods-Hill: *This was a challenging topic during our consensus work – ultimately, it was deemed safest NOT to try to reduce/defer cultures in NEW fever in a hem/onc patient with a CVL, given their risk for serious bacterial infections; so no specific recommendation was made related to Bright STAR for this specific patient scenario. We did write 2 recommendations for PERSISTENT fever in heme/onc patients with a CVL, published in our consensus manuscript.*

2. **Are any of the hospitals working on decreasing BC contamination rates as a part of this work? (Forgive me if I missed it.)**
   Dr. Woods-Hill: *Great question – not specifically as part of Bright STAR itself, but separately, I believe a few sites did begin some work around collection technique with a goal to reduce local contamination rates.*

3. **I am curious to hear more about the decision to focus on lowering blood culture utilization rather than obtaining blood cultures but reducing empiric antibiotics. Are the human behaviors of pairing these steps too engrained?**
   Dr. Woods-Hill: *Really interesting question. Personally (so not speaking for the entire Bright STAR team), I would say, we were not focused on trying to uncouple the culture-antibiotic dyad, because it seems that if someone is suspicious enough to order a test for bacteremia, empiric antibiotics is a reasonable action to take. So you either test and treat empirically, or you don't test – rather than end up a gray area of having sent a test, and that test COULD be positive, but not starting treatment for that test for another 48 hours potentially. You can definitely argue this another way, though! In addition, now speaking more from the Bright STAR perspective, our goal was to reduce other negative consequences of unnecessary testing (ie, iatrogenic anemia, wasted resources, prolonged hospital stays, possibility of actually introducing bacteria into a CVL), not just the antibiotic piece (though that is obviously very important). So, it just wasn't the focus of our work, but I think it's a very reasonable question to ask.*

4. **We are trying to address using the right line for the right patient. Have you noticed an association between drawing from smaller PICC lines (2.6fr) and increased infection and/or thrombus rates? How does your center approach 2.6Fr PICCS with regard to using them for lab draws?**

   Dr. Woods-Hill: *Thanks for this question. For Bright STAR, our look at CLABSI was not in so much detail as to be able to say anything, unfortunately, about line type or line size and infection risk. We plan a deeper dive, though, so potentially could say more in the future. I definitely understand the challenges with small PICC lines and the risk/benefit decisions about drawing labs from small lines vs placing something like an arterial line. At CHOP, we have a vascular access pathway that tries to standardize these things to the best of our ability. But I personally do not know any specific relationship between drawing labs from a 2.6Fr PICC and infection risk. I could try to look more at our internal data and get back to you, though.*