may lead to cases in other patients or healthcare workers. In case an infection is not correctly attributed to a nosocomial origin, the cost might not be charged to the appropriate payer. Finally, the nosocomial origin of certain infections might be found at a later stage and may trigger lawsuits.[18] Transmission of HIV and HCV infections through blood transfusions illustrates this important potential problem.

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Clindamycin Restriction Decreases *Clostridium difficile*-Associated Diarrhea

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Investigators from Hunter Holmes McGuire Veterans' Affairs Medical Center (VAMC) conducted a prospective, observational cohort study to characterize the impact of hospitalwide clindamycin restriction on the incidence of *Clostridium difficile*-associated diarrhea (CDAD).

Clinical data were corrected on hospitalized patients with symptomatic diarrhea, and data on antibiotic use were obtained from hospital pharmacy records. An outbreak of CDAD was caused by a clonal isolate of clindamycin-resistant *C difficile* and was associated with increased use of clindamycin. Hospitalwide requirement of approval by an infectious disease consultant of clindamycin use led to an overall reduction in clindamycin use, a sustained reduction in the mean number of cases of CDAD (11.5 cases/month vs 3.33 cases/month; $P<.001$), and an increase in clindamycin susceptibility among *C difficile* isolates (9% vs 61%; $P<.001$). Although a parallel increase was noted in the use of other antibiotics with antianaerobic activity, including cefotetan, ticarcillin-clavulanate, and imipenem-cilastin, the hospital realized overall cost savings due to the decreased incidence of CDAD.

The authors concluded that hospital formulary restriction of clindamycin is an effective way to decrease CDAD. It also can lead to a return in clindamycin susceptibility among isolates and can effect cost savings to the hospital.

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