observation is therefore consistent with previous reports that have been unable to show that N95 masks were superior to 3-ply masks in preventing transmission to HCWs performing AGPs. Further randomized control trial on ascertaining the effectiveness of the N95 respirators or medical masks in preventing HCWs from SARS-CoV-2 are warranted.

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Sphingomonas paucimobilis infection among a patient with a history of injection drug use: An opportunity for improvement of medical chart documentation

Michael A. Goulart MPH, CIC, Marko Predic MS, CIC and Chad D. Neilsen MPH, CIC

Infection Prevention and Control, University of Florida Health Jacksonville, Jacksonville, Florida

To the Editor—At our level 1 academic trauma center in northeastern Florida, a patient developed a central-line–associated bloodstream infection (CLABSI) with *Sphingomonas paucimobilis*, an aerobic gram-negative bacillus that more commonly occurs in immunocompromised persons and is less commonly associated with nosocomial transmission.[1–3] This patient was a female in her late twenties who was admitted for multifocal pneumonia after several days of cough and shortness of breath. Her medical history was remarkable for Hodgkin's lymphoma, chronic hepatitis C infection, thrombocytopenia, neutropenia, excoriation, tobacco use, and injection drug use (oxycodone). She denied current drug use. A double-lumen power peripherally inserted central catheter (PICC) was placed and dressed with a transparent dressing and chlorhexidine-gluconate impregnated antimicrobial disc (BioPatch) according to hospital policy. Approximately 1 month into her stay, blood cultures were positive for *S. paucimobilis*. Medical staff had documented patient noncompliance with hospital polices, such as dressing changes, on multiple occasions. After a 57-day stay, the patient was discharged to home hospice.

Whether the patient acquired *S. paucimobilis* due to her immunocompromised state and/or noncompliance with hospital policies is unknown. There was a paucity of information regarding her past history of injection drug use, as documented by clinical staff during her admission. Current injection drug use may have contributed to the development of the CLABSI. Walayat et al[4] noted the isolation of *S. paucimobilis* in an injection drug user, which presented itself as acute phlebitis; these authors suspected the patient acquired the organism from using toilet water to mix heroin prior to injecting.[4] We urge clinicians to thoroughly document past drug use, especially among past and current injection drug users, to note when suspected drug use has occurred, and/or to note suspicion if a patient has accessed their own vascular catheter. This is critical in wake of the ongoing opioid epidemic linked to injection drug use, which has affected many states across the United States, including Florida, which has also been facing an ongoing outbreak of the hepatitis A virus. Since January 2018, more than one-third of reported cases in the state have reported injection drug use.[5] According to the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network definitions, even if a patient accesses their own vascular catheter during their hospital stay, whether through injection drug use or other means, and it meets the CLABSI case definition, it is still attributed to the reporting facility.[6] The CDC recommend that risk mitigation include a sitter for the patient and/or removing the tunneled catheter as soon as clinically

Author for correspondence: Michael Goulart, E-mail: michael.goulart@jax.ufl.edu

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possible. Providing a sitter may not always be feasible, especially in light of ongoing novel coronavirus pandemic.[6]

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Antimicrobial stewardship programs and convalescent plasma for COVID-19: A new paradigm for preauthorization?

Michael P. Stevens MD, MPH[1], Payal K. Patel MD, MPH[2,3] and Priya Nori MD[4]

[1]Healthcare Infection Prevention Department, Virginia Commonwealth University Health System, Richmond, Virginia, [2]Infectious Diseases Section, Ann Arbor VA Medical Center, Ann Arbor, Michigan, [3]University of Michigan, Ann Arbor, Michigan and [4]Division of Infectious Diseases, Department of Medicine, Montefiore Medical Center, Albert Einstein College of Medicine, Bronx, New York

To the Editor—Antimicrobial preauthorization is a core strategy utilized by antimicrobial stewardship programs (ASPs).[1] ASPs have played an important role in coronavirus disease 2019 (COVID-19) response efforts, including in the preauthorization of novel therapeutic agents such as remdesivir.[2,3] On August 23, 2020, the US Food & Drug Administration (FDA) released an emergency use authorization (EUA) for the use of convalescent plasma in treating hospitalized patients with COVID-19.[4] An important question is what role, if any, ASPs should play in the convalescent plasma distribution process. To our knowledge, ASPs have never been involved in the preauthorization of blood products like convalescent plasma. There are numerous potential advantages and disadvantages to consider regarding ASP involvement in the convalescent plasma preauthorization process (Table 1). The effectiveness of convalescent plasma in the treatment of COVID-19 is still unclear. The data regarding convalescent plasma use are limited. As of June 22, 2020, the Infectious Diseases Society of America (IDSA) COVID-19 treatment guidelines recommend the use of convalescent plasma only in the context of a clinical trial.[5] Importantly, enrollment in existing trials has been potentially compromised by the EUA announcement. Major scientific organizations will likely continue to support guidelines emphasizing convalescent plasma use only in the context of clinical trials. It is also possible that additional study data will become available that will influence convalescent plasma use. This uncertainty about the optimal role of convalescent plasma supports the use of preauthorization to allow for real-time adjustment of convalescent plasma use in a controlled, optimized fashion.

Many ASPs have been responsible for the creation and maintenance of COVID-19 treatment guidelines and are ideally situated to inform frontline clinicians about the optimal use of convalescent plasma relative to other therapies. Preauthorization, coupled with local treatment guidelines, would enhance the optimal use of convalescent plasma. Additionally, the new convalescent plasma EUA may increase demand for convalescent plasma use, resulting in timely access issues. A preauthorization process utilizing the best available evidence would facilitate providing convalescent plasma to patients who may benefit.

Health systems would benefit tremendously from ASP involvement in the COVID-19 convalescent plasma distribution process. ASPs can provide guidance for incorporation of convalescent plasma into local treatment guidelines, can provide insight and guidance based on their experiences with other COVID-19 focused EUAs (including hydroxychloroquine, now revoked[6], and remdesivir[7]), and can help develop processes for convalescent plasma eligibility screening and preauthorization. If health systems do not adopt preauthorization for convalescent plasma, we recommend that use be carefully monitored to ensure that this resource is being used optimally. ASPs have proven integral in COVID-19 response efforts—investing in and scaling up ASP resources will assist health systems adapt and respond to evolving pandemic challenges.

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Author for correspondence: Michael P. Stevens, E-mail: michael.stevens@vcuhealth.org

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