
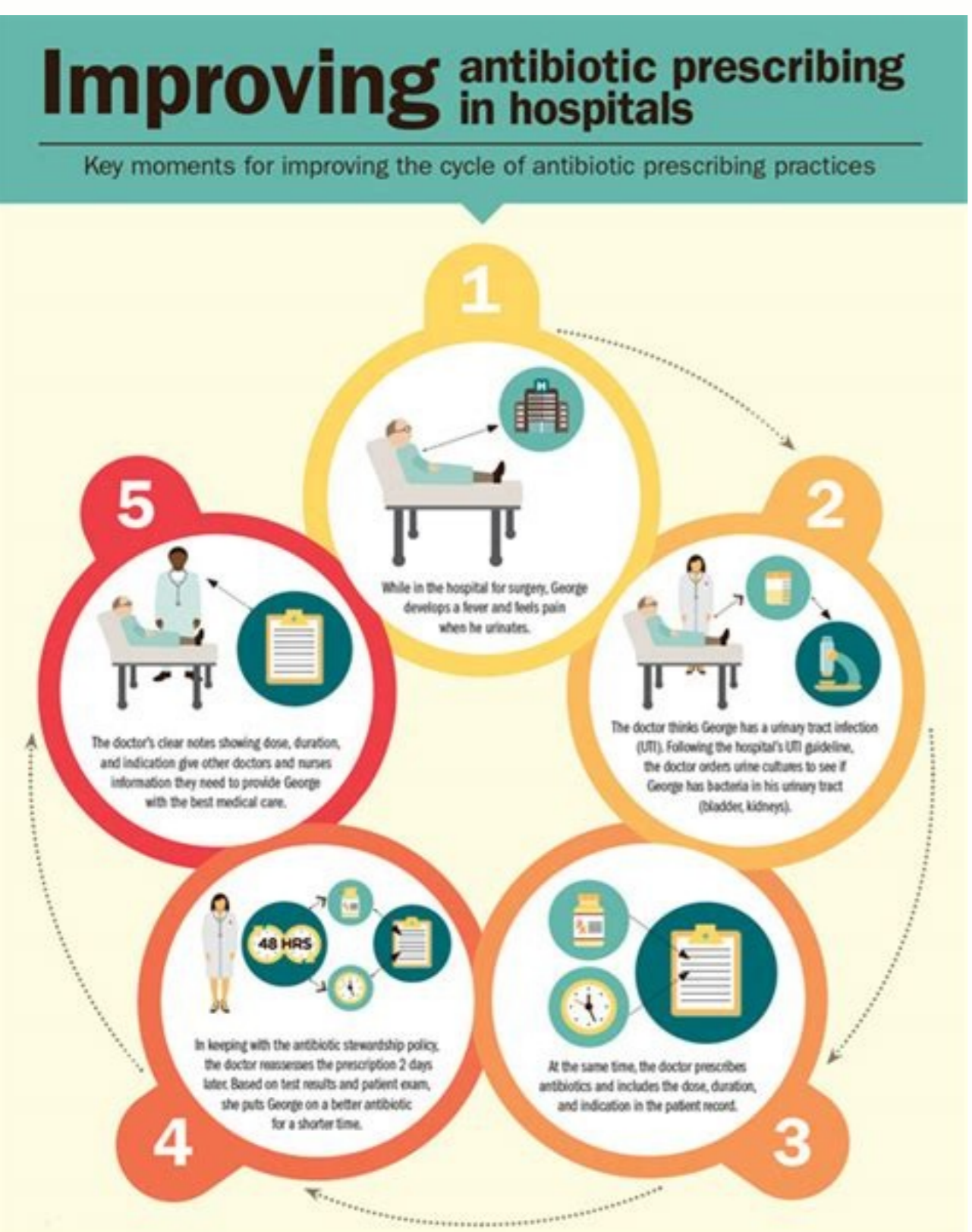
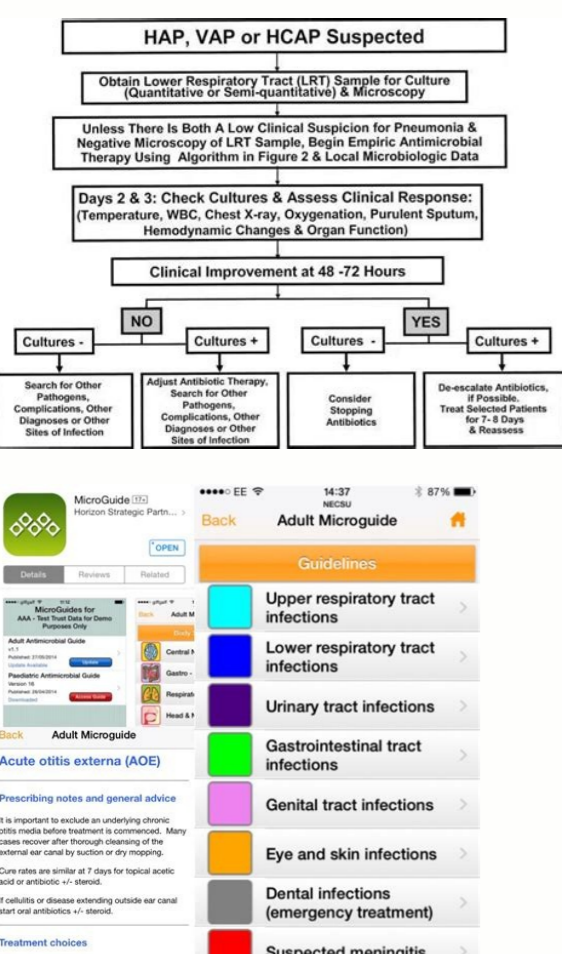


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were diagnosed by intensivists. Interrater reliability between RAs for VAEs was high (κ , 0.71).¹ The clinical correlation between VAE surveillance and intensivists' clinical assessments was poor.

It is crucial to know that using κ value to assess agreement is a common mistake in reproducibility analysis. There are 2 important weaknesses of using a κ value to assess agreement of a qualitative variable: First, it depends upon the prevalence in each category, which means that it is possible to have a different κ value with the same percentage for both concordant and discordant cells! The κ value also depends upon the number of categories.²⁻⁵ In such situations, a weighted κ is the preferable test because it gives an unbiased result. Moreover, for reliability analysis, an individual-based approach should be applied instead of a global average, which is usually applied for assessing the validity (accuracy) of a test.²⁻⁵ Finally, reproducibility (ie, precision, reliability, repeatability, calibration) and validity (ie, accuracy, discrimination) are completely different methodological issues that should be assessed using appropriate tests.⁴⁻¹⁰ It is crucial to know that to assess validity, sensitivity, specificity, positive predictive value (PPV), negative predictive value (NPV), the most appropriate tests are likelihood ratio positive and likelihood ratio negative as well as diagnostic accuracy and odds ratio.⁶⁻¹⁰

Kerlin et al concluded that prospective surveillance using VAE criteria is more reliable than traditional VAP surveillance and clinical VAP diagnosis; the correlation between VAEs and clinically recognized pulmonary deterioration is poor. Such a conclusion may be misleading due to the inappropriate use of a statistical test to assess reliability and validity.

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Improved Outcomes When Antibiotic Prescribing Guidelines Are Followed by Healthcare Providers: A Colombian Example to Encourage Adherence in Hospital Settings

To the Editor—Over the past decade, the prevalence of antibiotic resistance has increased alarmingly worldwide, prompting the General Assembly of the United Nations to label this problem as the greatest threat to human health, sustainable development, and security. Latin American countries are largely affected by antibiotic resistance, which has not only persisted but spread, mainly due to mobile genetic elements carrying several resistance determinants.¹ Antimicrobial stewardship (AMS) and infection prevention are complementary, multidisciplinary approaches for curbing bacterial resistance.²

In Colombia, AMS programs have had a positive impact on optimizing antibiotic use, reducing resistance trends and even saving healthcare costs.³⁻⁶ Locally developed antibiotic guidelines, based on epidemiological surveillance and clinical studies, assist healthcare providers in clinical decision making, thereby mitigating the overuse and misuse of antibiotics. To the best of our knowledge, no studies have addressed the degree to which healthcare providers in Colombia adhere to antibiotic guidelines when prescribing antibiotics to treat existing infectious disease.

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