

treatment is generally with a triazole (e.g. fluconazole) for at least 14 days after the last positive blood culture. The fungal isolate should be fully identified, as species other than *Candida albicans* are often resistant to triazoles.

If the patient remains febrile after removal of the device, three sets of blood cultures should be obtained. Endocarditis or septic thrombophlebitis should be suspected if blood cultures remain positive for more than 48 hours after the device has been removed.

Conclusion

Catheter-related sepsis is a common complication of modern medical therapy. Reduction of this complication may be achieved by minimising intravenous access. If there is no absolute need for intravenous access, remove the intravenous line. Use peripheral access rather than central venous catheters wherever possible. When central venous catheter access is necessary, use peripherally inserted venous catheters or tunnelled/implanted lines if possible. If bloodstream infections occur, removal of the intravenous line is essential, with only a few exceptions (Hickmans- or Portacath-associated bloodstream infections with low virulence organisms such as coagulase-negative staphylococci).

REFERENCES

1. Collignon PJ. Intravascular catheter associated sepsis: a common problem. *Med J Aust* 1994;161:374-8.
2. Managing bloodstream infections associated with intravascular catheters. *Drug Ther Bull* 2001;39:75-80.
3. Crump JA, Collignon PJ. Intravascular catheter-associated infections. *Eur J Clin Microbiol Infect Dis* 2000;19:1-8.
4. Maki DG, Weise CE, Sarafin HW. A semiquantitative culture method for identifying intravenous-catheter-related infection. *N Engl J Med* 1977;296:1305-9.

FURTHER READING

Raad I. Intravascular-catheter-related infections. *Lancet* 1998;351:893-8.

Self-test questions

The following statements are either true or false (answers on page 47)

7. Removal of the catheter is necessary in patients with catheter-related bloodstream infections caused by *Staphylococcus aureus*.
8. Central venous catheters inserted at the subclavian site have a higher risk of infection than those inserted into the femoral vein.

Book review

Paediatric Pharmacopoeia

Melbourne: Women's and Children's Health, Royal Children's Hospital; 2002.

The book is available in three formats. (Prices include GST but not postage.)

- Paediatric Pharmacopoeia, 13th ed. \$49.50
- Paediatric Pharmacopoeia—Pocket Prescriber, 1st ed. \$9.90
- Paediatric Pharmacopoeia e-book. \$99
- 3-set package, one copy of each. \$143

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The three versions of Paediatric Pharmacopoeia make up an excellent resource to help with the prescribing of drugs to children. They are published by the Pharmacy Department of the Royal Children's Hospital, Melbourne. In their current format they are very useful references for doctors treating children in hospital or emergency department settings.

The Pocket Prescriber appears to be a new publication. It offers an alternative to Frank Shann's Drug Doses¹, which is the current booklet used in hospitals throughout the country to help calculate doses in children. The Pocket Prescriber is a larger, heavier and more expensive booklet than Drug Doses (86 mm wide versus 72 mm wide, 100 g versus 50 g, \$9.90 versus \$6.50), but still fits into the top pocket of my standard

business shirt. It is filled with excellent information and it is good to see the antibiotic guidelines in the booklet. It is well presented with a much sturdier red cover than Drug Doses and I think its slight increase in size and weight means that it will be less easy to lose on the wards. This booklet should be an essential piece of equipment for all doctors working with children in a hospital setting. Hospitals should ensure that staff who prescribe and administer drugs to children have a copy of this book and refer to it frequently because I am certain that it could lead to fewer prescribing errors in hospital care.

The Paediatric Pharmacopoeia, 13th edition, is another very useful little book that contains some extra information and specific warnings about each drug. The e-book is easy to navigate and has the most potential to be a useful resource for general practitioners and paediatricians who are prescribing for children in the community. It is easy to find the immunisation schedule, and with time the guidelines may start to have more relevance to community-based rather than hospital-based care. The e-book does contain information about the presentation options of particular drugs (i.e. tablet and mixture strength) and the different trade names available in Australia. I believe the e-book could be improved by including information regarding Pharmaceutical Benefits Scheme prescriptions to make this package of resources more applicable to doctors working outside the hospital setting.

REFERENCE

1. Shann F. Drug Doses. Parkville, Victoria: Royal Children's Hospital; 2001.