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Preoperative Testing in Patients Undergoing Cataract Surgery.

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the range observed in the general population.[4] Thus far, data from more than 2000 propranolol-treated infants in clinical studies and a compassionate-use program in France have been reassuring, but we agree that there is a need for large studies assessing longer-term outcomes.

To date, propranolol is by far the best-studied beta-blocker in infants. We believe that any assessment of its benefits and potential risks should take into account that the efficacy and safety profiles of alternative drugs used for this condition are not as well documented.

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Preoperative Testing in Patients Undergoing Cataract Surgery

TO THE EDITOR: I read the article by Chen et al. (April 16 issue)[1] with interest, because I have had several discussions with ophthalmologists at my institution about requests for unnecessary preoperative evaluations and testing (complete blood count, blood chemical profile, electrocardiography) before cataract extraction. The response has been, "Yes, I know they are not needed or recommended, but the hospital will not let me operate without them." At least in some situations, what looks like a provider-related practice pattern could be the result of institutional requirements that should be changed but so far have not been.

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1. Chen CL, Lin GA, Bardach NS, et al. Preoperative medical testing in Medicare patients undergoing cataract surgery. N Engl J Med 2015;372:1530-8.

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THE AUTHORS REPLY: We agree with Saver that the ongoing use of routine preoperative testing in patients undergoing cataract surgery may result from institutional requirements rather than the practice patterns of individual providers. Other authors have reported that physicians order testing because of tradition, medicolegal concerns, or the belief that another physician expects testing before cataract surgery.[1,2] Although it may be difficult to change institutional dogma and entrenched practice patterns, we believe that physicians should feel empowered to question and update policies and protocols that have not kept up with current evidence-based recommendations in order to provide better and higher-value care to their patients. In 2000, the American Academy of Ophthalmology issued a clinical statement recommending against the use of routine preoperative testing in patients undergoing cataract surgery, and the organization updated this statement in 2014.[3] For low-risk elective ambulatory procedures such as cataract surgery, patients in their usual state of health should be allowed to proceed to the operating room without any further workup.[3-5]

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Since publication of their article, the authors report no further potential conflict of interest.

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Clostridium difficile Infection

TO THE EDITOR: The review article on *Clostridium difficile* infection by Leffler and Lamont (April 16 issue)[1] updates previous reviews and will serve as a valuable reference. The authors address the association between acid suppression and the risk factors for *C. difficile* infection. We would suggest that evidence of the association of the use of proton-pump inhibitors (PPIs) with *C. difficile* infection is more compelling than posited. In addition to biologic plausibility, a large, prospective, observational study by Loo et al.[2] showed a strong association between PPI use and the development of infection due to *C. difficile*, and this association has been recognized by the Food and Drug Administration.[3] Observational studies also have shown that continuous PPI use is common in patients with *C. difficile* infection (in 40 to 60% of patients) and may be associated with an increased risk of recurrence.[4,5] Furthermore, approximately half of PPIs in patients with *C. difficile* infection are prescribed continuously without an evidence-based indication.[5]

We recognize the limitations of observational studies. However, it seems reasonable to acknowledge this potential association and discontinue the unnecessary use of PPIs in patients who are at risk for a first or recurrent *C. difficile* infection.

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No potential conflict of interest relevant to this letter was reported.

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TO THE EDITOR: Leffler and Lamont do not mention the potential therapeutic role of nontoxigenic strains of *C. difficile* in the prevention of recurrent *C. difficile* infection. Results of previous studies involving hamsters and small samples of patients[1-3] spurred a recent randomized, controlled trial that showed a significantly lower rate of recurrence of *C. difficile* infection among patients who received the oral nontoxigenic *C. difficile* strain M3 than among those who received placebo (11% vs. 30%, P=0.006).[4]

The mechanism of action is probably due to the competition between nontoxigenic strains of *C. difficile* and toxigenic strains of *C. difficile* for the same metabolic or adherence niche in the gastrointestinal tract. This mechanism was shown by the high correlation between fecal colonization