a broader mandate of professional responsibility than just providing emergent care, we hope to raise the collective responsiveness to the needs of the public.

Mr Fesnak and Dr Rajput express concerns about physicians’ professional responsibility to promote fair and ethical stewardship of health care resources. Physicians may be uncomfortable with their role when they define their professional responsibilities from the narrow perspective of the physician “at the bedside” and only as an individual, direct care provider. Taking a systems view of professionalism offers a more expansive understanding of how physicians can influence and promote the fair and ethical stewardship of health care resources. Physicians can pursue a range of activities via professional organizations and advocacy efforts to fulfill their responsibility to advance fair and ethical stewardship of health care resources. We agree that this is a shared responsibility that must be carried out in collaboration with payers, policy makers, and the public. But we also reaffirm the critical role of the medical profession in this important work. As the United States continues to confront unsustainable growth of health care spending, it is imperative that physicians engage in the collective effort to ensure that limited resources are effectively deployed to optimize health and health care for all residents.

Finally, we agree with Dr Gale that key Supreme Court decisions pertaining to professionalism provide important context for understanding professionalism in the current environment. However, we interpret these rulings as largely consistent with the “systems view” of professionalism, recognizing that medical care is delivered in the context of the organizational and policy environment. We do not view these decisions as limiting physicians’ professional responsibilities as individual clinicians or as members of the profession as a whole. Further, the legacy of court decisions in this area does not obviate physicians’ collective responsibility to continue to reflect on and more clearly articulate the profession’s expectations of physicians in service of society.

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Conflicts of Interest Disclosures: All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

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RESEARCH LETTER

Intravesical Bacille Calmette-Guérin in Patients With Asymptomatic Bacteriuria

To the Editor: Asymptomatic bacteriuria is common in adults and does not require treatment.1 Practice guidelines, however, recommend antibiotics to sterilize the urine before urological procedures.2 Although intravesical bacille Calmette-Guérin (BCG) therapy for high-risk superficial bladder cancer is not specifically mentioned, urologists are reluctant to administer BCG to infected patients because of a possible risk of bacterial or BCG sepsis or an abrogated response to BCG.3 On the other hand, antibacterial treatment of asymptomatic bacteriuria leads to treatment delay and promotes antibiotic resistance. This study investigated whether intravesical BCG is safe and effective in bladder cancer patients with asymptomatic bacteriuria.

Methods. Two hundred consecutive patients with bladder cancer seen as outpatients in the urology department at Memorial Sloan-Kettering Cancer Center by 1 surgeon between January 1, 2009, and December 31, 2010, were eligible. All agreed to participate and provided oral informed consent. None was febrile or had symptoms of a urinary tract infection (UTI). On the first day of treatment, each patient submitted a clean-catch voided urine sample for bacteriologic studies. Patients then underwent instillations of BCG through a small urethral catheter once a week for 6 weeks and did not receive antibiotics. Patients were monitored each week during treatments and then weekly by telephone. Febrile UTI was defined as fever 102°F or greater and a positive urine culture. After the first culture, no further urine cultures were obtained unless prompted by fever and symptoms. At 3 months, patients were evaluated for response to BCG by cystoscopy and biopsy. The sample size was based on a projected proportion of at least 20% of patients with bacteriuria,1 and at least 5% developing a UTI, with no difference between infected and uninfected patients. χ² test was used to test the correlation of bacteriuria with the frequency of UTI and response to BCG therapy, with a 2-sided significance level of .05. Data analyses were conducted using SPSS version 19 (SPSS Inc, Chicago, Illinois). The study was approved by the hospital’s institutional review board.

Results. The median age of the patients was 67 years (range, 36-93 years), and 148 (74%) were male. None of the patients had previous UTIs. All had received a single intravesical dose of a broad-spectrum antibiotic 2 to 4 weeks previously at the time of their transurethral tumor resection. None had an indwelling catheter or used self-catheterization. Sixteen patients had diabetes. None was taking immunosuppressive medications.

All 200 patients received 6 doses of BCG without receiving antibiotics, and all were evaluated at 3 months. Fifty-
one patients (25%) had significant single-organism bacteriuria at baseline (TABLE). Only 1 (1.9%; 95% confidence interval, 0.86%-3.1%) developed a subsequent febrile UTI after completing induction BCG therapy. Another patient with sterile urine developed a UTI. The UTIs developed 1 week and 3 weeks, respectively, after the patients completed 6 weeks of induction BCG therapy. Both infections resolved with oral antibiotics. None of the patients was admitted for bacterial or BCG sepsis. UTI developed with equal frequency \((P = .15)\) despite presence of bacteriuria, and there was no difference \((P = .97)\) in the 3-month response to BCG between infected and uninfected patients (Table).

**Comment**. In this study, instillation of BCG into bladder cancer patients with asymptomatic bacteriuria did not result in sepsis or reduced response. The study is limited by a small number of patients treated by 1 surgeon in a single center. If the findings are replicated, screening urinalysis and culture to detect and treat bacteriuria in afebrile patients with bladder cancer may be unnecessary before starting weekly intravesical BCG therapy, as long as attention is paid to meticulous instillation technique and patients are closely monitored. Such a strategy would result in timely administration of BCG therapy and avoid overuse of antibiotics.4

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**Conflict of Interest Disclosures:** The author has completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.


**CORRECTION**

**Clarified Text Description:** In The Rational Clinical Examination article entitled “Does This Patient Have Splenomegaly?” published in the November 10, 1993, issue of *JAMA* (1993;270[18]:2218-2221), the description of “Percussion of Traube’s Space” has been clarified. In the middle column on page 2219, the paragraph should read as follows: “The patient is supine, with the left arm slightly abducted for access to the entire Traube space (after its description by Ludwig Traube, who ascribed its disappearance to pleural effusion, not an enlarged spleen), defined by the sixth rib superiorly, the anterior border of the spleen, and the left costal margin inferiorly (Figure 4). With the patient breathing normally, the surface of this triangle is percussed across 1 or more levels from its medial to the lateral margin, which is approximately the midaxillary line. Normal percussion yields a resonant or tympanitic note. Splenomegaly is diagnosed when the percussion note is dull.12”