increase the serum concentration of risperidone and increase the risk of adverse effects, such as priapism in our patient. The superimposed injectable long-acting preparation of risperidone, which has an additive effect in its oral form, has been postulated to be the cause of paradoxical priapism.[7] The development of prolonged erection or priapism in patients treated with antipsychotic agents has been linked to the following: (1) an increased dose of medication, (2) the restarting of medications after a period of nonadherence, (3) the switch to a different class of drug, or (4) the use of a combination regimen of antipsychotics.[8] Several studies have shown that *Ginkgo biloba* has vessel-dilating properties; it increases nitric oxide activity or acts directly on the endothelium, as for example by inhibiting cyclic adenosine monophosphate phosphodiesterase activity.[9,10] Anecdotal evidence suggests that *Ginkgo biloba* can be used in the treatment of erectile dysfunction.[11] It has also been reported to reverse selective serotonin reuptake inhibitor–induced sexual dysfunction.[12,13] Nonetheless, no evidence has been reported that *Ginkgo biloba* alone can cause priapism. Although our patient did not use *Ginkgo biloba* to treat erectile dysfunction, he may have experienced an additive or synergistic effect between *Ginkgo biloba* and risperidone; however, further studies are needed to clarify this issue. We also could not ascertain why the risperidone-priapism reaction precipitated by *Ginkgo biloba* required 2 weeks. This drug reaction could be either dose dependent or idiosyncratic.

In conclusion, herbal medicines may potentiate the adverse drug effects of preexisting treatment regimens. Clinicians should be aware of the potential adverse effects and drug-drug interactions of a complementary medicine, particularly in patients being treated with antipsychotic agents.

Yen-Yue Lin, MD
Shi-Jye Chu, MD
Shih-Hung Tsai, MD
Tri-Service General Hospital,
National Defense Medical Center
Taipei, Taiwan

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Bloodstream Infection Prevention Practices

To the Editor: We read with interest the enlightening survey of Krein et al[1] on adherence to the 3 major recommended practices for preventing catheter-related bloodstream infections. In that context, as everyday internists, we also encounter a substantial lack of adherence to other Category 1A recommendations of the CDC.[2] Specifically, Krein et al's research does not address recommendations to: (1) periodically assess the knowledge of persons involved with catheter insertion and management, (2) replace administration sets upon suspicion of infection, (3) clean ports with 70% alcohol before access, (4) avoid routine culture of catheter tips, (5) use designated trained personnel for catheter insertion, (6) promptly remove the intravenous line when it is no longer needed, and (7) assess the risks and benefits of insertion. Expensive lines are often used indiscriminately and for prolonged periods to facilitate convenient blood drawing, a consideration that commonly overrides all others in day-to-day practice. Not mentioned in the CDC recommendation is the potential risk and cost associated with a "dedicated lumen policy," which is in place at many institutions. According to this policy, parenteral nutrition must be administered only through catheter lumens that have not previously been used for other purposes (thus necessitating insertion of a new line if the lumens of an existing line have been used for other purposes).[3]

We believe that, in addition to the research conducted by Krein et al, it is important to survey for these other, less commonly stressed recommendations. Adherence, if found to be suboptimal, may be improved through aggressive education and policies; for example, the completion of a brief risk-benefit assessment checklist could be required when catheter insertion is contemplated.

Nishith K. Singh, MD
Dharmesh Mehta, MD
Southern Illinois University School of Medicine
Springfield

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In reply: We appreciate the interest by Drs Singh and Mehta in our study and agree that many other bloodstream prevention practices warrant attention. We explicitly limited the number of practices included in the survey to avoid overburdening the respondents and to encourage a high response rate. However, we acknowledge that in doing so we excluded other important practices, such as avoiding femoral lines. We agree with Drs Singh and Mehta that the removal of unnecessary catheters is important and that greater attention should be paid to the indications for catheter placement. Indeed, strategies that encourage prompt removal or reduce the use of certain devices are important not only for preventing bloodstream infection but also for preventing other types of device-related infection, such as urinary tract infection.[1] Finally, we too would encourage further research in this area. In addition to surveys, we recommend that this work include a range of methodological approaches, both qualitative and quantitative. For example, although educational efforts can be important, the qualitative work conducted as part of our current study suggests that dedicated staff—specifically PICC (peripherally inserted central catheter) nurses or PICC teams—can play a vital role in identifying and promoting practices to decrease catheter-related bloodstream infections. The importance of issues such as dedicated staff was not readily evident from the data we collected through the survey.

Sarah L. Krein, PhD, RN
Sanjay Saint, MD, MPH
Veterans Affairs Ann Arbor Healthcare System
Ann Arbor, MI

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CORRECTIONS

Incorrect number: In the editorial by Caplan entitled "Should Physicians Participate in Capital Punishment?" published in the September 2007 issue of *Mayo Clinic Proceedings* (*Mayo Clin Proc.* 2007;82:1047-1048), an incorrect number was published on page 1047, third paragraph, left-hand column, fourth sentence. The sentence should read as follows: Six nations (including the United States) permit the execution of children (defined as **<18** years of age).[4]

Incorrect title of book: In the "Book Reviews" section in the August 2007 issue of *Mayo Clinic Proceedings* (*Mayo Clin Proc*. 2007;82:1018), an incorrect book title was published. The title should read as follows: "**Cancer** Pain Management," edited by Michael J. Fisch and Allen W. Burton….

The Editor welcomes letters and comments, particularly pertaining to recently published articles in *Mayo Clinic Proceedings*, as well as letters reporting original observations and research. Letters pertaining to a recently published *Proceedings* article should be received no later than 1 month after the article's publication. A letter should be no longer than 500 words, contain no more than 5 references and 1 table or figure, be limited to no more than 3 authors, and not be published or submitted elsewhere. It is assumed that appropriate letters submitted to the Editor will be published, at the Editor's discretion, unless the writer indicates otherwise. Priority is given for the importance of the message, novelty of thought, and clarity of presentation. The Editor reserves the right to edit letters in accordance with *Proceedings* style and to abridge them if necessary.