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A Multifactorial Trial to Prevent Serious Fall Injuries. Reply.

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tients in the 320-μg–budesonide triple-therapy group (1.6%) and 40 deaths among those in the glycopyrrolate–formoterol group (2.8%). Among the 2611 patients who had bronchodilator reversibility, there were 3 deaths in the 320-μg–budesonide triple-therapy group (0.5%) and 9 in the glycopyrrolate–formoterol group (1.3%). Therefore, with regard to mortality in our trial, the benefits with triple therapy as compared with glycopyrrolate–formoterol were not driven by bronchodilator reversibility.

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

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A Multifactorial Trial to Prevent Serious Fall Injuries

TO THE EDITOR: In the Strategies to Reduce Injuries and Develop Confidence in Elders (STRIDE) study (July 9 issue),[1] Bhasin et al. evaluated the effectiveness of individualized recommendations to prevent fall injuries. We find the lack of significant success with this strategy to be wholly unsurprising. Referrals or recommendations alone are insufficient to reduce falls.[2] The STRIDE intervention successfully expanded the role of primary care providers to include fall-risk screening, assessment, and individualized care plans. It did not include any direct procedural interventions (e.g., exercise, medication management, home safety modifications, and vision care) or the necessary extensive support to ensure their receipt.

Within the constraints of our current primary care system, the STRIDE strategy omitted essential intervention components of successful, multifactorial programs to prevent falls. No measures to evaluate the adoption of the intervention and adherence to the program were included. In an earlier commentary in the *Journal* regarding pragmatic trials, Ford and Norrie noted that "a trial that is dominated by poor adherence to the protocol or poor delivery of the intervention is of limited use."[3] The STRIDE study showed that screening, assessment, and care planning to reduce the risk of serious falls can be added to primary care. Now it is essential to design pragmatic trials that also include the most important components of fall prevention: exercise, medication management, home safety modifications, and vision care.

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THE AUTHORS REPLY: In response to the comments by Hartley and colleagues: the STRIDE study was designed and implemented as a pragmatic trial within health systems with the use of those resources that were available. In designing the intervention, we worked closely with the health care systems to determine what was feasible and also included a patient motivation component to engage patients in their individualized care plans. We agree that if we had conducted an efficacy study that ensured that all components of the intervention were delivered, our study might have had a larger effect size.

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Infections Associated with Resterilized Pacemakers and Defibrillators

TO THE EDITOR: The study by Khairy et al. (May 7 issue)[1] provides a potential solution to limited access to cardiac implantable electronic devices in low-income and middle-income countries. Despite the availability of data on the safety of resterilized devices, there is apprehension among cardiologists regarding postoperative infections associated with the reuse of cardiac implantable electronic devices.[2]

The overzealous and indiscriminate use of antibiotic agents in developing countries is contrary to guideline recommendations.[3] The preventive role of antibiotic prophylaxis is established, but the postoperative use of antibiotic agents has not been shown to reduce the risk of infection with a new implant.[4,5] Furthermore, guidelines for the use of antibiotics after implantation of resterilized devices have not been clearly defined.

Given the prevailing uncertainty around this issue, can the authors provide more information about the antibiotic regimens used both with new and with resterilized devices in their study? This information may help us to understand whether the use of more potent antibiotics or antibiotics used for a longer duration in patients who have received resterilized devices than in those who have received new devices influences the risk of infection. This issue needs to be settled before recommendations can be made regarding the routine use of resterilized devices.

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

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TO THE EDITOR: The article by Khairy et al. contributes important data regarding the safety of cardiac implantable electronic devices with respect to infection rates and device-related deaths. However, we think that in order to further reassure physicians, patients, and the general public, all device malfunctions (not just those leading to death) must be reported. In their 2011 systematic review of reuse of pacemakers, Baman et al.[1] define device-related malfunction as "a defect in the structural or electric integrity of the pulse generator," and they report 13 events (e.g., set screw abnormalities and spontaneous reprogramming) among 2150 patients.

Because implantable cardioverter–defibrillators (ICDs) are more complex devices than pacemakers, the concern regarding unreliable functioning is even greater. Our center[2] has had experience with almost as many resterilized ICDs as those described in the study by Khairy et al. (157 and 158, respectively), and we have not seen any malfunctions in reused ICDs.

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