
CME Posttest

THERAPEUTIC DECISIONS IN THE CARE OF HIGH-RISK ANTIFUNGAL PATIENTS: A CASE-BASED APPROACH *Empiric Management of Patient With Febrile Neutropenia*

Release Date: October 6, 2006

CME Instructions

To receive documentation of your participation in this CME activity for a total of 1 hour of CME credit, please complete the following steps:

1. Read the newsletter carefully.
2. Complete the CME Posttest included in this newsletter.
3. Mail your CME Posttest to:

Liz Alter
The MedEd Group, LLC
56 Clarken Drive
West Orange, New Jersey 07052
Fax: 973-847-5624
4. After reading the newsletter, complete the CE Evaluation Survey and mail or fax it to the above.
5. This posttest and the evaluation survey must be received by October 6, 2007 for you to be eligible to receive CE credit.

NAME

SPECIALTY

STREET ADDRESS

CITY

STATE

ZIP

PHONE NUMBER

FAX NUMBER

EMAIL

Posttest Questions

1. Fever is defined as a single oral temperature of ___ or a temperature of ___ for ≥ 1 hour.
 - a. $\geq 38.4^{\circ}\text{C}$, $\geq 38.2^{\circ}\text{C}$
 - b. $\geq 38.3^{\circ}\text{C}$, $\geq 38.0^{\circ}\text{C}$
 - c. $\geq 38.5^{\circ}\text{C}$, $\geq 38.1^{\circ}\text{C}$
 - d. $\geq 38.1^{\circ}\text{C}$, $\geq 37.9^{\circ}\text{C}$

2. Which of the following statements is FALSE regarding the diagnosis of an *Aspergillus* infection?
 - a. On CT, the most characteristic findings are the halo sign in early disease and the air crescent formation, which appears later.
 - b. Blood cultures are rarely positive.
 - c. Branching hyphae on tissue biopsy are a definitive indicator of *Aspergillus*.
 - d. Positive galactomannan antigen can help support the diagnosis of *Aspergillus*

3. Which of the following antifungal agents is approved for empiric therapy of febrile neutropenia?
 - a. Amphotericin B deoxycholate
 - b. Itraconazole
 - c. Voriconazole
 - d. Caspofungin

4. Which antifungal agent has activity against Zygomycetes?
 - a. Voriconazole
 - b. Itraconazole
 - c. Caspofungin
 - d. Amphotericin B

5. Which of the following statements is FALSE concerning empiric antifungal treatment trials?
 - a. The primary end point of treatment success is typically based on a composite of 4 individual end points.
 - b. One individual end point of treatment success is no breakthrough fungal infection.
 - c. Defervescence is often a major driver of treatment success.
 - d. Very large patient populations would be required to measure individual end points.

EVALUATION FORM

THERAPEUTIC DECISIONS IN THE CARE OF HIGH-RISK ANTIFUNGAL PATIENTS: A CASE-BASED APPROACH

Empiric Management of Patient With Febrile Neutropenia

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EVALUATION FORM – PLEASE PRINT CLEARLY

The School of Pharmacy of the University of North Carolina respects and appreciates your opinions. To assist us in evaluating the effectiveness of this activity and to make recommendations for future educational offerings, please take a few minutes to complete this evaluation form. Please note that a CE Credit Form is issued only upon receipt of your completed evaluation form and posttest.

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING THE APPROPRIATE RATING:

5 = Outstanding 4 = Good 3 = Satisfactory 2 = Fair 1 = Poor

EXTENT TO WHICH PROGRAM ACTIVITIES MET THE IDENTIFIED OBJECTIVES

Upon completion of this activity, participants should be able to:

- | | | | | | |
|---------------------------------------------------------------------------------------------------------------|---|---|---|---|---|
| • Review the prevalence and changing resistance patterns of mycoses in high-risk hematology/oncology patients | 5 | 4 | 3 | 2 | 1 |
| • Discuss the rationale for early versus late initiation of empiric antifungal therapy | 5 | 4 | 3 | 2 | 1 |
| • Evaluate the latest findings on the use of antifungal agents for empiric therapy in neutropenic patients | 5 | 4 | 3 | 2 | 1 |
| • Describe the differences among lipid amphotericin agents for antifungal management of high-risk patients | 5 | 4 | 3 | 2 | 1 |

Please describe some specifics of what you learned as a result of this activity.

OVERALL EFFECTIVENESS OF THE ACTIVITY

- | | | | | | |
|-----------------------------------------------------------------------------------------------------|---|---|---|---|---|
| Objectives were related to overall purpose/goal(s) of activity | 5 | 4 | 3 | 2 | 1 |
| Related to my practice needs | 5 | 4 | 3 | 2 | 1 |
| Will influence how I practice | 5 | 4 | 3 | 2 | 1 |
| Will help me improve patient care | 5 | 4 | 3 | 2 | 1 |
| Stimulated my intellectual curiosity | 5 | 4 | 3 | 2 | 1 |
| Overall, the activity met my expectations | 5 | 4 | 3 | 2 | 1 |
| Presentation was educational and not for the purpose of promoting any commercial product or service | 5 | 4 | 3 | 2 | 1 |

Will the information presented cause you to make any changes in your practice? ___ Yes ___ No

If yes, please describe any change(s) you plan to make in your practice as a result of this activity.

How committed are you to making these changes? 5 (Very committed) 4 3 2 1 (Not at all committed)

Additional comments about this activity?

Do you feel future activities on this subject matter are necessary and/or important to your practice? ___ Yes ___ No

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Please list any other topics that would be of interest to you for future educational activities:

The program was educationally unbiased and not promotional: ____ Yes ____ No

If no, please explain: _____

Specialty: Infectious Diseases Hematology Oncology Bone Marrow Transplant Solid Organ Transplant

Degree: MD DO PharmD RPh NP RN BS PA Other _____

IF YOU WISH TO RECEIVE CREDIT FOR THIS ACTIVITY, PLEASE FILL IN YOUR NAME AND ADDRESS AND MAIL ALONG WITH YOUR POSTTEST TO:

Release Date: October 6, 2006

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The MedEd Group, LLC
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I certify my actual time spent to complete this educational activity to be ____ hour(s) [not to exceed 1.0 hours].

Signature _____

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