It is obvious to us that following the most recent AHA guidelines for the prevention of infective endocarditis will unavoidably have the effect of unnecessarily creating several new cases of infective endocarditis each year. We are at a loss to understand how these AHA recommendations (2), which we believe should be revised, are in the best interests of the HCM patient population.

We rely on guidelines. When large amounts of data exist, we rely on expert summaries to distill the data and to make evidence-based recommendations. When data are more scarce, we rely on experts to thoughtfully weigh the existing data along with their own experience, balancing risks and benefits, and make recommendations in the best interest of patient welfare.

It might be said too often, or might be said not often enough, that guidelines are only guidelines. It remains imperative, especially when data are scarce, to understand the nature of guideline recommendations, including the presence or absence of data to support them. Ultimately, the savvy clinician should help his or her patients individually weigh the relative risks and benefits of any diagnostic test, or any therapeutic or prophylactic intervention. This author thanks Drs. Maron and Lever for their discussion regarding my paper (1) and for adding their voices to those of other physicians who, having cared for patients at risk of or suffering from endocarditis, raise concern about the new antibiotic prophylaxis guidelines (2), ask whether they represent the best balance of risk versus benefit, and ask whether these recommendations are the most likely means to adequately protect our patients (3–5).

REFERENCES